



Report

Leaving no one behind in the health sector

An SDG stocktake in Kenya and Nepal

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Abbreviations

AMP	Aid Management Platform	KHSSP	Kenya Health Sector Strategic and Investment Plan
ANC	Antenatal Care	KMoH	Kenya Ministry of Health
ASAL	Arid and Semi-Arid Lands	KSh	Kenyan shillings
CBS	Central Bureau of Statistics	KDHS	Kenyan Democratic and Health Survey
CCI	Composite Coverage Index	KNBS	Kenyan National Bureau of Statistics
CHU	Community Health Unit	KODI	Kenya Open Data Initiative
CHV	Community Health Volunteer	LDO	Local Development Officer
CIAA	Commission for the Investigation of Abuse of Authority	MCA	Member of County Assembly
CRA	Commission on Revenue Allocation	MDG	Millennium Development Goal
CSO	Civil Society Organisation	MICS	Multiple Indicator Cluster Survey
DAC	Development Assistance Committee	MoF	Ministry of Finance
DDC	District Development Committee	MoFALD	Ministry of Federal Affairs and Local Development
DFID	Department for International Development	MoH	Ministry of Health (Kenya and Nepal)
DHIS	District Health Information System	MP	Member of Parliament
DHO	District Health Office(r)	NCD	Non-Communicable Disease
DHS	Demographic and Health Survey	NGO	Non-Governmental Organisation
DPHO	District Public Health Office(r)	NHIF	National Hospital Insurance Fund
DTCO	District Treasury Comptroller Office	NHSP	Nepal Health Sector Programme
EDP	External Development Partner	NHSS	Nepal Health Sector Strategy
EHCS	Essential Health Care Services	NHSSP	Nepal Health Sector Support Programme
FCGO	Financial Comptroller General Office	NMoH	Nepal Ministry of Health
FCHV	Female Community Health Volunteer	NPC	National Planning Commission
FGD	Focus Group Discussion	NRs	Nepalese rupees
FY	Fiscal Year	ODA	Official Development Assistance
GDP	Gross Domestic Product	ODI	Overseas Development Institute
GESI	Gender Equality and Social Inclusion	OECD	Organisation for Economic Co-operation and Development
GHED	Global Health Expenditure Database	PEFA	Public Expenditure and Financial Accountability
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (German Federal Enterprise for International Cooperation)	PEPFAR	US President's Emergency Plan for AIDS Relief
GoN	Government of Nepal	PFM	Public Financial Management
H4L	Health for Life	PHC	Primary Health Care
HDI	Human Development Index	PHC-ORD	Primary Health Care Outreach
HFOMC	Health Facility and Operation Management Committee	PHCC	Primary Health Care Centre
HIS	Health Information System	PHCRD	Primary Health Care Revitalisation Division
HISP	Health Insurance Subsidy Programme	RCU	Research Coordination Unit
HIV	Human Immunodeficiency Virus	RMNCH	Reproductive, Maternal, Newborn and Child Health
HMIS	Health Management Information System	SAARC	South Asian Association for Regional Cooperation
HP	Health Post	SDG	Sustainable Development Goal
IDP	International Development Partner	SHP	Sub-Health Post
IMF	International Monetary Fund	STD	Sexually Transmitted Disease
INGO	International Non-Governmental Organisation	TA	Technical Assistance
JAR	Joint Annual Review	TB	Tuberculosis
JFA	Joint Financing Arrangement	THSUC	Transforming Health Systems for Universal Care (World Bank Project)
		TRIPS	Trade-Related Aspects of Intellectual Property Rights

UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VDC	Village Development Committee

VMG	Vulnerable and Marginalised Group
WCF	Ward Citizen Forum
WHO	World Health Organization

Executive summary

The SDGs and leaving no one behind

The Sustainable Development Goals (SDGs), approved by 193 Member States of the United Nations (UN), paint an inspiring vision of what the world could look like in 2030. Consisting of 17 goals and 169 targets, this ambitious agenda will shape development efforts for the next 15 years.

A fundamental tenet of the SDGs is the concept of ‘leaving no one behind’. This entails tackling marginalisation and ensuring that the needs of the poorest are front and centre (UN, 2015). The SDG Declaration (ibid.) is clear that ‘the left behind’ refers to particular people whose identity means that they face discrimination, and who lack both voice and power. It ‘include[s] all children, youth, persons with disabilities (of whom more than 80% live in poverty), people living with HIV/AIDS, older persons, indigenous peoples, refugees and internally displaced persons and migrants’ (ibid.). Although only a few of the SDGs have specific references to the imperative to leave no one behind, the principle is implicit in all of them.

This report provides an early stocktake of SDG progress in Kenya and Nepal, with specific reference to health.

The SDGs for health

Health is considered central to the attainment of sustainable development, good health is an outcome produced by many factors beyond health service provision, and investments in health contribute to the broader development progress of a country (UNGA, 2014a; 2014b). The SDG that directly relates to health is Goal 3: ‘Ensure healthy lives and promote well-being for all at all ages.’

The SDG outcome document draws a direct link between health and the aspiration to leave no one behind. It says: ‘To promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage (UHC) and access to quality health care. No one must be left behind’ (UN, 2015). One of the most challenging aspects of achieving the SDG health targets is delivering services to those most in need and those who are hardest to reach (Wong, 2015). This is the main focus of this stocktaking exercise.

Rationale and approach

The concept of leaving no one behind is elusive. Despite frequent references, its meaning remains open

to interpretation, and there is a risk that it will not be adequately implemented or monitored.

The purpose is two-fold, first, to map out a quasi-baseline which could be used to measure future progress. Second, to develop a methodology that brings together assessment of three elements essential to delivering on the leave no one behind commitment: data, finance and institutions.

To do this we adopted a working causal model based on the idea that, in an ideal world, data about those left behind in health care ought to drive policies and financial arrangements that result in effective service delivery to them. For this causal chain to function effectively, however, it must be supported by appropriate technical and political arrangements. Thus, in each country we identified the ‘left behind’ by creating a list of marginalised groups drawn from the SDG outcome documentation, supplemented by country-specific markers. We then assessed the extent to which these groups are left behind in health care by analysing data from the latest Demographic and Health Survey (DHS), measuring access to health services through the World Health Organization’s (WHO) Reproductive, Maternal, Newborn and Child Health (RMNCH) Composite Coverage Index (CCI). We considered how well finance was allocated to those groups, both in terms of their geographical location and the kinds of services and infrastructure that would most benefit them. We then used a combination of literature review, key informant interviews and focus group discussions (FGDs), at national and sub-national levels, to illuminate the political and technical dimensions of exclusion from health care services.

Kenya

Since before Independence, Kenya has had an unenviable reputation as one of Africa’s most unequal countries, in which certain communities have felt more or less permanently excluded. After the political violence that followed the 2007 general elections a new political settlement emerged, embodied in a Constitution that explicitly recognised the rights of minorities and marginalised groups, devolved power to 47 local counties and provided electoral incentives for the President to govern in a more inclusive way. This provided an opportunity to address inequalities of the past, and helped to align the country with the commitment to leave no one behind.

Nevertheless, our analysis finds that significant inequalities remain. Rural households, the income poor

and ethnic minorities tend to have worse health care coverage. The people furthest behind are concentrated in a group of northern counties bordering Somalia and Uganda. In some of those counties, even wealthier households have worse coverage than poorer households in other parts of the country, while poorer households lag far behind the national average.

Fortunately, several progressive developments promise to address this. Kenya's new Constitution enshrines the principle that revenue raised nationally should be shared equitably between national and county governments. The resulting Equitable Share grant is weighted so that poorer counties receive more money per capita from the centre than richer ones. Kenya's Vision 2030 and key health policy documents recommend increasing the share of resources earmarked for preventative care, accelerating progress towards UHC and providing adequate access to health and related services. Since 2014 the amount of public finance going to health has increased, with counties spending a greater share of their resources on health than the national Government had done previously. In addition, various health finance reforms have been pro-leave no one behind. For example, fees have been abolished at public dispensaries and health centres, and for women giving birth at public hospitals. Kenya also has a continent-leading, health-specific administrative data system and a Kenya Health Data Collaborative promises to make data more widely available and strengthen the pressures for evidence-based policy-making. The Kenya Open Data Initiative (KODI), through which ministries and counties are encouraged to share their data on an open portal, may also bring health dividends in the future.

Nevertheless, persistent challenges remain. Survey data is not collected regularly enough and there is considerable sampling error, with some populations thought to be missing or underrepresented. Absolute levels of expenditure remain insufficient and there is too much focus on curative rather than preventative care, with the community health system comparatively neglected. While much donor funding is progressive from a leave no one behind perspective, there is no systematic correlation, and this funding is likely to decrease in coming years.

The country's big bang devolution (establishing a new level of government with political, financial and administrative autonomy all at once), while creating opportunities, has also led to problems. In some counties, disruption to health professionals' pay and superannuation has triggered industrial action, coordination of public and non-state providers has suffered, and national capacities for disease control have been weakened. The new Constitution, while creating incentives for a more pro-poor distribution of resources among counties, does little to address disparities *within* them. Health spending is sometimes driven more by political horse-trading and rent-seeking than evidence, while decision-making in some counties has been hamstrung by political struggles between

governors and members of county assemblies. None of this is likely to improve the position of those left behind.

Nepal

Against a historical backdrop of exclusion, division and fragility, Nepal boasts a long commitment to pro-poor policy, and has recently succeeded in achieving substantial progress in reducing poverty. The 2006 Peace Accord represented the start of a new era of inclusion and the Constitution of Nepal (2015) builds the foundations of a more inclusive and equal society for the large number of vulnerable groups.

Despite this, our analysis found significant disparities in rates of poverty and human development outcomes between castes, ethnicities and geographic regions. The population has high levels of overlapping vulnerabilities to poor health outcomes. Like Kenya, the worst health care coverage is seen among the poorest families, those living in rural areas and minority ethnic groups.

Yet there is much to be optimistic about: recent governments, in an attempt to address the root causes of insurgency, have competed to expand access to services for the poor, resulting in a strong rural service delivery system on which future efforts to tackle health inequities can be built. Essential health services are free for all, and a Vulnerable Community Development Plan has been established to ensure that principles and procedures relating to marginalised groups are integrated in the health sector. There is strong coordination with development partners supporting a range of inclusive health policies. Firm policy commitment has been backed by sustained and coordinated financial resources targeted towards pro-poor health programming. Rural service delivery is supported by a cadre of Female Community Health Volunteers (FCHVs) who reach even the most remote villages and contribute to reliable data collection.

Yet we also identified important obstacles to future progress. A major weakness in Nepal's data system is that survey data are aggregated to clusters of districts in 'eco-development zones', not to the district level, limiting its usefulness for policy and planning. Politically, Nepal is in a long transition towards federalism. In the interim, there is no system of locally elected political representation. While our Kenya research shows that local democracy is not itself a panacea, current arrangements in Nepal are insufficiently responsive to the most vulnerable people. Limited discretionary financing at district level is a key contributor, with existing bureaucratic protocols unsuited to kaleidoscopic patterns of local exclusion. And while Nepal's health policies are generally progressive, key implementation weaknesses – whereby budgets are not translated into outputs – present significant obstacles. Improving health coverage among the most marginalised groups will be costly, and policy commitments that seek to leave no one behind in health will require additional financing.

Conclusions

Responding to a combination of domestic pressures and international influence, Kenya and Nepal have, in recent years, adopted a framework of rules and policies that align them with the commitment to leave no one behind, including the area of health care. There is progress in data production and financial flows, helping to address long-standing patterns of marginalisation. Nevertheless, financing shortfalls, data gaps and political games within the rules often work against the interests of marginalised people, and threaten to send Kenya and Nepal off-track.

To remedy this, we propose a number of reforms that would contribute to identifying those left behind and responding to their health care needs. On data, more frequent surveys that make more of an effort to capture marginalised groups are needed, that use sampling frames at the appropriate sub-national political levels. On finance, more resources are required that are better aimed at those left behind, and over which, at least in the case of Nepal, there is more local discretion. We also identify a need for more accurate data about what health finance is being spent on, especially in Kenya. On services, we urge that an increased emphasis be placed on preventative rather than curative care, and improved community health systems. In Kenya, national and local levels, and state and non-state providers, need to be better coordinated, with Nepal's Collaborative Framework providing one possible model.

More generally, our use of an interdisciplinary methodology demonstrates the multifaceted interconnectedness of data, finance and institutional problems, an understanding which we hope can be transferred to other country contexts. To take one example, data about those left behind in health care in Kenya is weak, partly because the community health worker system is insufficiently funded, which is partly a result of a political preference for investments in tangible facilities, which itself is partly related to the desire of politicians to concentrate resources in heavily populated areas, which are not generally home to those left behind. It cannot be assumed, then, that better data, finances, technical institutional reforms or increased democracy will, by themselves, solve this problem. Rather, coalitions will need to be built that connect reform champions inside and outside government with marginalised communities, working in politically smart and experimental ways to generate support for an improved community health service, better able to collect evidence about the health needs of marginalised groups, and present this to politicians, officials and development partners in ways that unlock more funding, generate better policies and improve health governance. This is especially true for remote, ecologically fragile and militarily insecure areas, where, as our report shows, those left behind in health care are concentrated, yet where solutions are scarce.

1. Introduction: the SDGs and leaving no one behind

1.1 What are the SDGs? What does leave no one behind mean?

The SDGs, approved by all 193 Member States of the United Nations, provide an inspiring vision of what the world could look like in 2030. Consisting of 17 goals and 169 targets to spur action in areas of critical importance to humanity – people, planet, prosperity, peace and partnership – this ambitious agenda will significantly shape development efforts for the next 15 years.

A fundamental tenet of the SDGs – now also known as Agenda 2030 – is the concept of leaving no one behind. This entails tackling marginalisation and ensuring that the needs of the poorest are front and centre in the achievement of all the goals. Indeed, the SDG outcome document specifies that the goals should be met for all segments of society, with an endeavour to reach those furthest behind first (UN, 2015). Goal 10 – the inequality goal – includes the specific target: ‘By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status’ (Target 10.2).

In this report we examine who is being left behind in Kenya and Nepal, how far behind they are and what is being done about it.

The SDG Declaration (UN, 2015) is clear that ‘the left behind’ refers to people whose identity – their membership of one or more groups – means that they face specific discrimination, and lack both voice and power. It states: ‘Those whose needs are reflected in the Agenda include all children, youth, persons with disabilities (of whom more than 80% live in poverty), people living with HIV/AIDS, older persons, indigenous peoples, refugees and internally displaced persons and migrants’ (paragraph 23). Elsewhere it states: ‘We emphasize the responsibilities of all States ... to respect, protect and promote human rights and fundamental freedoms for all, without distinction of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth,

disability or other status.’ It does not define what ‘other status’ could mean (this depends on national context), but it is clear that many minorities and other groups are considered excluded.

It also emphasises that those left behind includes poor people, and extends to the concept of multi-dimensional poverty. Paragraph 24 reads: ‘We are committed to ending poverty in all its forms and dimensions, including by eradicating extreme poverty by 2030.’ This includes resource allocation. The paragraph on partnerships in the document’s preamble stresses that it focuses in particular on the needs of the ‘poorest’ as well as the most vulnerable. It also stresses the importance of everyone being able to live their lives in dignity (UN, 2015).

The leave no one behind concept is, therefore, about whether a person’s characteristics (inherent or perceived) exclude them from the opportunities enjoyed by others. These characteristics may fuel each other. A woman with disabilities who lives in a rural area, for example, may well suffer from intersecting forms of inequality.

If this vision to leave no one behind becomes a reality by 2030, as planned, it will correct the course of the current trajectory of international development, which has been one of extraordinary progress but deepening inequality. During the period of the Millennium Development Goals (MDGs) too great a focus on average progress at national level masked major disparities within countries: between urban and rural areas, men and women, and ethnic, language and caste groups, among others (UN ESCAP, 2013).

Although there are specific references to the imperative to leave no one behind in only a few of the 17 SDGs themselves, all of the goals are imbued with the principle. Leaving no one behind represents a genuinely integrated agenda that will be achieved only if there is progress on a wide range of policy fronts.

1 See methodology section for a further explanation of why this sector was selected in particular. See Overseas Development Institute (2016) for the results of the roads stocktake exercise.

The SDGs and health

For this leave no one behind stocktaking exercise, we have chosen to focus on health.¹ The SDG that directly relates to health is Goal 3: ‘Ensure healthy lives and promote well-being for all at all ages.’ There are 13 targets associated with it (listed in Box 1.)

In this report we focus our attention on sub-goal 3.8, universal health coverage, which arguably underpins efforts at leaving no one behind across the other sub-goals and targets also. One of the most challenging aspects of achieving the goal is delivering services to those *most* in need, and more specifically to those who are *hardest* to reach (Wong, 2015).

Data and leave no one behind

Improved data will be essential to achieving the SDGs (UN IEAG, 2014). This is not only for the purposes of monitoring implementation, but also for designing and delivering the relevant policies. There are several populations that are discriminated against about whom we know too little (ibid.). These include women (Buvinic et al., 2014), persons with disabilities and those who are mentally ill (Samman and Rodriguez-Takeuchi, 2013). Few of the MDG indicators were able to shed light on the particular situations of migrants, refugees, older persons, minorities and indigenous peoples (UN, 2016). Without access to these data, it is extremely challenging for governments

Box 1. SDG Goal 3 and its targets and means of implementation²

Goal 3: Ensure healthy lives and promote well-being for all at all ages

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

Source: UN (2016) ‘Sustainable Development Goal 3: ensure healthy lives and promote well-being for all at all ages’. New York, NY: United Nations (sustainabledevelopment.un.org/sdg3).

² While the means of implementation across the goals are reflected in Goal 17, and the Addis Ababa Action Agenda (UN, 2015b) the specific means for each goal are listed by letters underneath the relevant target. So for Goal 3, there are four means of implementation listed, 3a–3d.

and others to assess the specific scale and locus of need, and allocate budgets efficiently for poor and marginalised people. In effect, it means that the populations that need policy interventions most are the least visible to policy-makers.

SDG Target 17.18 calls for efforts to build capacity to enable data disaggregation by factors, including income, sex, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant to specific national contexts (WHO, 2016a).

With specific reference to tracking UHC outcomes, there are three challenges as set out by the first joint WHO and World Bank monitoring report on UHC: first, sourcing reliable data on a broad set of health service coverage and financial protection indicators;³ second, disaggregating data to expose coverage inequities; and third, measuring effective coverage, which both includes whether people receive the services they need and also takes into account the quality of services provided and the ultimate impact on health (WHO and WB, 2015).

Rationale for the study

The idea of leaving no one behind is much lauded, but still elusive. In spite of multiple references to the concept in the SDG outcome document, its ambiguous and cross-cutting nature create a danger that it will not be implemented or monitored in the same way as other aspects of the SDGs. For this reason, we sought to develop a methodology for studying the progress of leave no one behind and also its impediments.

Building on ODI's work on data, its expertise in institutions, political economy and understanding the delivery of reforms, alongside research on financing needs for the SDGs, the aim of this research is to deliver

a **leave no one behind stocktake** in Kenya and Nepal. These two countries were chosen because of the relatively high quality of data available in both, existing country knowledge within ODI, partners in those countries, and differing circumstances: one lower middle-income country, as classified by the World Bank (World Bank, 2015), and one low-income fragile state (Nepal) recovering from a significant exogenous shock: the Nepal earthquakes in 2015, which affected 5.6 million people (UN Dispatch, 2015). Nepal is also interesting as it is a DFID leave no one behind 'trailblazer' country: that is, the DFID Nepal office is highly engaged with this agenda and committed to supporting it in-country.

The purpose of these case studies is two-fold. First, to take stock of the current situation and thus enable the mapping out of a quasi-baseline of who is being left behind. This includes analysing who is marginalised in terms of health care coverage, as well as budget and expenditure data. It is hoped that this will be useful to the respective governments, as well as civil society, academics and others wanting to review progress. Second, to establish a multifaceted methodology that brings together assessment of 'data ecosystems', capacity and capability of institutions and allocations and impacts of public financing, which can be adapted for other countries and over time.

The work was carried out by a cross-institute team comprising researchers from ODI's Growth, Poverty and Inequality programme; the Politics and Governance programme; the Development Strategy and Finance Programme and the Public Finance and Institutions Programme. It was supported by local researchers in each country.

³ Note that the financial protection indicator was changed in late 2016 to 'Proportion of population with large household expenditures on health as a share of total household expenditure or income' as opposed to 'number of people covered by health insurance or a public health system per 1000 population' (IHP+, 2012).

2. Conceptual framework

2.1 Definitions

Defining ‘those left behind’ is a crucial element in determining how to ensure inclusion and to allow the mapping of the state of progress towards achieving Agenda 2030.

Across countries, regardless of their macroeconomic condition, certain groups have been historically ‘left behind’ when it comes to the benefits of development programmes and practices. Some demographic characteristics of these marginalised groups are country-specific.⁴ However, there are markers of excluded groups that are nearly universal across countries – such as those in chronic poverty, those living in rural locations, those engaged in agriculture, women, the children and elderly, ethnic and religious minorities and indigenous populations, and those with minimal formal education. The propensity of marginalisation is even more acute for sub-groups that fall in the overlap of multiple conditions of exclusion – such as poor rural women and uneducated indigenous communities.⁵

In this study, we identified in the following way those left behind: first, we created a list of marginalised groups on the basis of (i) groups identified in the SDGs as being vulnerable to marginalisation; and (ii) marginalised groups identified in the Kenyan and Nepali context. We then assessed the extent to which these groups are left behind in terms of access to health care, as measured by the CCI of reproductive, maternal, newborn and child health (RMNCH) service delivery. Data was drawn from the latest DHS.

Health services coverage is measured through the CCI of RMNCH service delivery devised by the WHO. The index is an average of eight health interventions spanning family planning, maternal and newborn care, immunisation and management of sick children.⁶ We believe that the ability of a health system to deliver high CCI scores across social groups will be highly correlated with its ability to achieve UHC, understood in the SDGs as access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines

for all.⁷ Thus, we believe it is a reasonable proxy for a country’s performance when it comes to leaving no one behind in health.

The key drivers of exclusion that we evaluate are: household income, geographic location of the household, age and education level of women receiving RMNCH health services, and whether households belong to minorities. In doing so, we benchmark the degree of marginalisation in Kenya and Nepal to international levels determined by the WHO from similar exercises in other developing countries.

The centrality of politics

Knowing who is being left behind in a country is one thing, actually doing something about it another. Insofar as politics is about ‘who gets what, when and how’ (Laswell, 1936), creating policies to improve the lives of the marginalised is an inherently political process.

For example, and as we have seen, one of the goals of leaving no one behind from health is UHC. However, no country has ever succeeded in making affordable health care available to all without either employing progressive rates of taxation or pooling resources for health insurance. In the first scenario, the rich subsidise the poor, and in the second the healthy subsidise the sick (and sometimes the poor as well) (Bump, 2010; Savedoff et al., 2012). To get to this situation usually requires an arduous political process of building an imagined community and confronting vested interests.

Further, to provide a health care system capable of reaching all, hard choices have to be made about the package of services on offer. Are sophisticated forms of curative care affordable? If not, resources have to be diverted from these kinds of care, often beloved of doctors and the middle classes, into more mundane forms of preventative and primary care for the poorer majority. And if the percentage of national resources spent on health is to increase, money must be taken away from something else, such as defence or consumption. All are political choices.

4 See ODI series on ‘Who is being left behind in sub-Saharan Africa, Asia and Latin America?’ (www.odi.org/publications/10288-left-behind-africa-asia-latin-america-sdgs).

5 See Healthy People (n.d.) for a summary of common drivers of disparities in health benefit access (using the case of the United States), and also Centers for Disease Control and Prevention (2013).

6 The notion of RMNCH continuum of service delivery for mothers and children is explained at PMNCH (2016). The details of the index composition and computation are at Health Equity Monitor (n.d.).

7 Note that the financial or demand side of progress to UHC requires another metric.

Box 2. The Composite Coverage Index (CCI) of reproductive, maternal, newborn and child health (RMNCH) service delivery

This indicator, devised by the WHO, captures access to health interventions spanning family planning, maternal and newborn care, immunisation, and management of sick children. The primary sources of data for this analysis are publicly available DHS and Multiple Indicator Cluster Surveys (MICS) – both of which are large-scale, nationally representative household surveys that collect data through standardised, face-to-face interviews with women aged 15–49 in 93 low- and middle-income countries (WHO, n.d.a; GHO data, n.d.b).

The CCI is a weighted average coverage of eight interventions; it gives equal weight to four stages in the continuum of care: family planning, maternal and newborn care, immunisation, and management of sick children. The weighted average is calculated as:

$$CCI = \frac{1}{4} * (FPS + \frac{SBA + ANCS}{2} + \frac{2DPT3+MSL+BCG}{4} + \frac{ORT + CPNM}{2})$$

where FPS is family planning needs satisfied, SBA is skilled birth attendant, ANCS is antenatal care with skilled provider (at least one visit), DPT3 is three doses of diphtheria-pertussis-tetanus vaccine, MSL is measles vaccination, BCG is the vaccination that protects against tuberculosis, ORT is oral rehydration therapy for children with diarrhoea, and CPNM is care-seeking for pneumonia. The data is disaggregated along the three most prominent dimensions of inequality/exclusion: economic status, education level and place of residence (for additional details of computation methodology and selection of constituent indicators, see WHO (n.d.b)).

The index ranges from 0% to 100%, where 100% indicates that the members of the household have access to all eight health care services across the four stages of needs enumerated above. The World Health Organization maps trends of CCI in low- and middle-income countries, which facilitates the benchmarking of levels of access in Kenya and Nepal to comparable international levels (WHO, 2015).

The WHO uses CCI as a measure of health access globally for a set of reasons. First, the constituent indicators of this index are clearly enumerable separately, and it incorporates multiple health interventions, thereby minimising the susceptibility of the indicator to outliers. Second, these indicators reflect almost universally accepted, desired and achievable targets – such as immunisations. Third, they are not contingent upon access to any expensive proprietary intervention that are not affordable for sections of the population. Fourth, they pertain to health needs during a critical but fairly universal health need of families – around childbirth – and are thus not biased by extraneous health needs that differ from household to household. And fifth, we use WHO international comparison to benchmark any given country or region to the theoretical limit (of 100%) as well as to levels actually achieved by other countries. There are, however, alternative measures of access to health care – such as distance to hospital, time taken to visit a hospital, number of health care workers for a given population size – each of which have pros and cons. It could also be argued that health needs around childbirth are a narrow perspective of health care. A counter-argument is that this is one period of life when, regardless of health status of the household members, there are universal and almost identical health care needs. On balance, the CCI appears to be able to capture the essence of access to health while avoiding some common health need biases.

The WHO has provided internationally comparative levels of CCI for individual countries, as well as groups of countries based on their geographic and economic classification (see comparative data in the Global Health Observatory Health Equity Monitor (GHO data, n.d.c) using the data visualisation tool). This allows us to benchmark health access in Kenya and Nepal in a much wider context while still permitting us to track their country trends over time.

Even if increased resources can be allocated to the right forms of health care, there is no guarantee that these resources will be well spent. Different branches of the administration, and different types of health providers, need to be effectively coordinated to ensure that resources are used efficiently. Money has to be effectively managed. Health care professionals need to be incentivised to do their jobs well. In remote areas, health workers need to be recruited, retained and incentivised to do their job effectively, which can be a challenge in many countries (Chaudhury et al., 2006; WHO, 2016b; GHWA, 2014).

In some cases, communities have to be motivated to seek appropriate health care, or to support vulnerable

sub-groups to receive treatment. Health services are also sometimes improved when ordinary people are consulted about their health care needs and about how they experience the health care system. Monitoring, motivating, supervising, consulting – activities inextricably bound up with health governance – are all inherently political.

Any adequate study of a country's readiness to leave no one behind must therefore take political factors into account. Indeed, even the generation of data that allows us to identify those left behind and monitor their progress has a political dimension, insofar as resources have to be found for data collection, data agencies need to be managed, choices must be made about what categories of person to

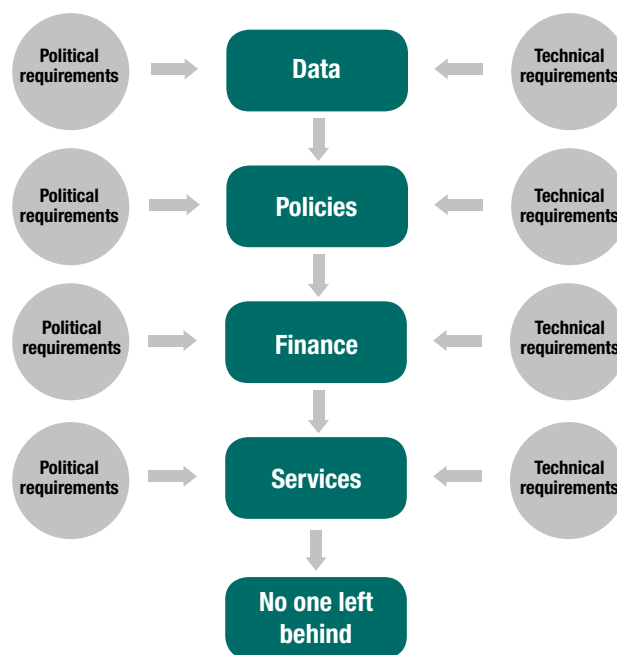
collect data on, and so forth. In asking, ‘Who in Kenya and Nepal is being left behind, why, and what can be done about it?’, this study thus takes an explicitly political-economic focus.

Conceptual framework

To frame our inquiries, we adopted a working causal model based on the assumption that in an ideal world, data about the most marginalised will inform policy decisions about SDG implementation. These policy decisions will in turn generate a sufficient level and type of finance to fund the services that are needed to ensure that, as our outcome, no one is left behind. For each link in this chain to function effectively, however, a number of political and technical requirements need to be in place. For example, there needs to be political will to generate accurate data about ‘those left behind’, as well as the technical capacity to do it. There needs to be a balance of power or political dynamic that is favourable to translating this data into meaningful policies, and the policies need to be technically sound, or at least formulated in such a way as to allow experimentation and correction when things go wrong. Likewise, a set of both technical and political questions surrounds the ability to translate pro-poor policy into actual financial flows that are able to reach service providing departments or agents. Finally, additional technical and political factors impact on whether funding for services actually translates into frontline providers doing their jobs in ways that are conducive to ensuring that no one is left behind. At every link in the chain there is a danger that processes will be captured by groups with interests insufficiently aligned with a successful realisation of leaving no one behind.

Our research was designed to assess the extent to which this causal chain was functioning in the requisite way, and if not, why not.

Figure 1. A working causal model



Research methods

In addition to the quantitative approach to determining who is being left behind in our study countries, we used a combination of desk-based literature review, key informant interviews and FGDs to illuminate the political and technical dimensions of our conceptual framework. For each level of enquiry we asked questions about the combination of structures, institutions and actor interests that underpinned the situations that were encountered. We also used financial data to trace financial flows and reveal to what extent declared policies were translated into actual expenditure.

Our sub-national site selection was designed to facilitate a comparison between two broadly similar poor sites with different health outcomes. By this method it was hoped to gain potentially generalisable insights into how to get better performance in challenging conditions. In Kenya we chose the counties of Narok and West Pokot, and in Nepal the districts of Kapilvasthu and Pyuthan. More details about the countries, whom we interviewed, and the sites we chose can be found in [Annex 1](#).

3. Kenya

3.1 Introduction

Since before Independence, Kenya has had an unenviable reputation as one of Africa's most unequal countries. Its uneven pattern of political-economic development, in which certain communities felt more or less permanently excluded (see Box 3), was one of the underlying causes of the serious political violence that followed the 2007 general elections, in which more than 1,000 people died. Amid fears that the conflict could escalate, Kenya embarked on a peace process producing, ultimately, a new political settlement and Constitution that provided a remarkable opportunity to address the inequalities of the past.

Demands by smaller ethnic groups for a greater degree of devolution have been a common feature of Kenyan politics since before Independence. This was reflected in Kenya's first Constitution, but eroded over the course of the 1960s. Nevertheless, it remained a focus, to a greater or lesser degree, for pro-democracy movements, civil society activism and three subsequent draft constitutions – none of which, however, had successfully passed into law. After the violence of 2007, which was attributed, among other things, to a top-heavy, winner-takes-all political system, constitutional reform gained new impetus. In 2008 a Committee of Experts was tasked with creating a new Constitution, building on the previous (rejected) drafts, and taking into account the views of the public. Approved by referendum, the 2010 Constitution contained groundbreaking provisions to devolve power to 47 newly created

Box 4. Some key articles of the Kenyan Constitution

Article 138 (4) A candidate shall be declared elected as President if the candidate receives—

(a) more than half of all the votes cast in the election; and

(b) at least twenty-five per cent of the votes cast in each of more than half of the counties.

Article 174. The objects of the devolution of government are—

(e) to protect and promote the interests and rights of minorities and marginalised communities;

(f) to promote social and economic development and the provision of proximate, easily accessible services throughout Kenya;

(g) to ensure equitable sharing of national and local resources throughout Kenya;

The Constitution also makes explicit reference to 'minorities and marginalised groups' (see Box 5) and, at Article 56, enjoined the state to enact 'affirmative action programmes' to ensure, among other things, that these groups, 'are provided special opportunities in educational and economic fields', 'are provided special opportunities for access to Employment' and 'have reasonable access to water, health services and infrastructure'. Article 21, meanwhile, entreats public officials to address the needs of 'vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of

Box 3. Historical origins of inequality in Kenya

Between 1895 and 1963 Kenya was governed as a Protectorate and then as a Crown Colony of Great Britain. During this time many Europeans and Asians settled, developing large farms in the cooler climes of what became known as the White Highlands, together with supporting industries around Nairobi and other towns. The *Kikuyu*, the traditional inhabitants of this part of Kenya, experienced the greatest benefits of colonialism, such as missionary education, as well as its harshest depredations. The 1950s Mau Mau uprising was a *Kikuyu*-dominated revolt against colonial rule, but also a civil war, which pitted the mainly *Kikuyu* victims and beneficiaries of colonialism against one another.

Kenya's first president, Jomo Kenyatta, was a *Kikuyu*, and his tribe dominated the largest political party. He used the power of the State to redistribute land and business opportunities from settlers to his kinsmen and allied groups (Lynch, 2006; Willis and Chome, 2014; Bedasso, 2015; Carrier and Kochore, 2014). Agricultural extension, health and education services, meanwhile, were concentrated in the areas of high economic potential, reinforcing existing patterns of inequality.

In 1978, power passed from Kenyatta to Daniel Arap Moi, an ethnic *Kalenjin*, before being won back in 2002 by Mwai Kibaki, another *Kikuyu*. Throughout the entire period, politics revolved around competition for economic resources by ethnic 'big men' and their followers, with smaller groups consistently marginalised.

minority or marginalised communities, and members of particular ethnic, religious or cultural communities’, while Article 27 (8), provides that the ‘State shall take legislative and other measures to implement the principle that not more than two-thirds of the members of elective or appointive bodies shall be of the same gender’ – which in practice has led to the creation of women’s special seats.

Consistent with this, the Constitution provided financial provisions to improve resource allocation to counties, including a guarantee that at least 15% of revenues would be allocated to counties through the Equitable Share, according to principles including: the developmental and other needs of counties; economic disparities within and among counties and the need to remedy them; and the need for affirmative action in respect of disadvantaged areas and groups. There is also provision for an ‘Equalisation Fund’ to narrow the gap between marginalised areas and the rest of the population, and also a Commission on Revenue Allocation (CRA) to determine how the Fund would work. Using a County Development Index of health, education, infrastructure and poverty, combined with expert analysis and its own marginalisation survey, the CRA subsequently identified 14 counties as marginalised – shaded red in the map below (CRA, 2013). They form a subset of 23 counties classified as arid and semi-arid lands (ASALs). The ASALs have historically been excluded from development initiatives and are predominantly home to Kenya’s pastoralists, among whom incidence of poverty is high and access to services poor (FAO, 2012).

Box 5. Kenya Constitution, Article 260

“‘marginalised community’ means

(a) a community that, because of its relatively small population or for any other reason, has been unable to fully participate in the integrated social and economic life of Kenya as a whole; (b) a traditional community that, out of a need or desire to preserve its unique culture and identity from assimilation, has remained outside the integrated social and economic life of Kenya as a whole; (c) an indigenous community that has retained and maintained a traditional lifestyle and livelihood based on a hunter or gatherer economy; or (d) pastoral persons and communities, whether they are— (i) nomadic; or (ii) a settled community that, because of its relative geographic isolation, has experienced only marginal participation in the integrated social and economic life of Kenya as a whole;

‘marginalised group’ means a group of people who, because of laws or practices before, on, or after the effective date, were or are disadvantaged by discrimination on one or more of the grounds in Article 27 (4);”

Kenya Law Reform Commission, <http://www.klrc.go.ke/index.php/constitution-of-kenya/161-chapter-seventeen-general-provisions/429-260-interpretation>

Box 6. The Equitable Share

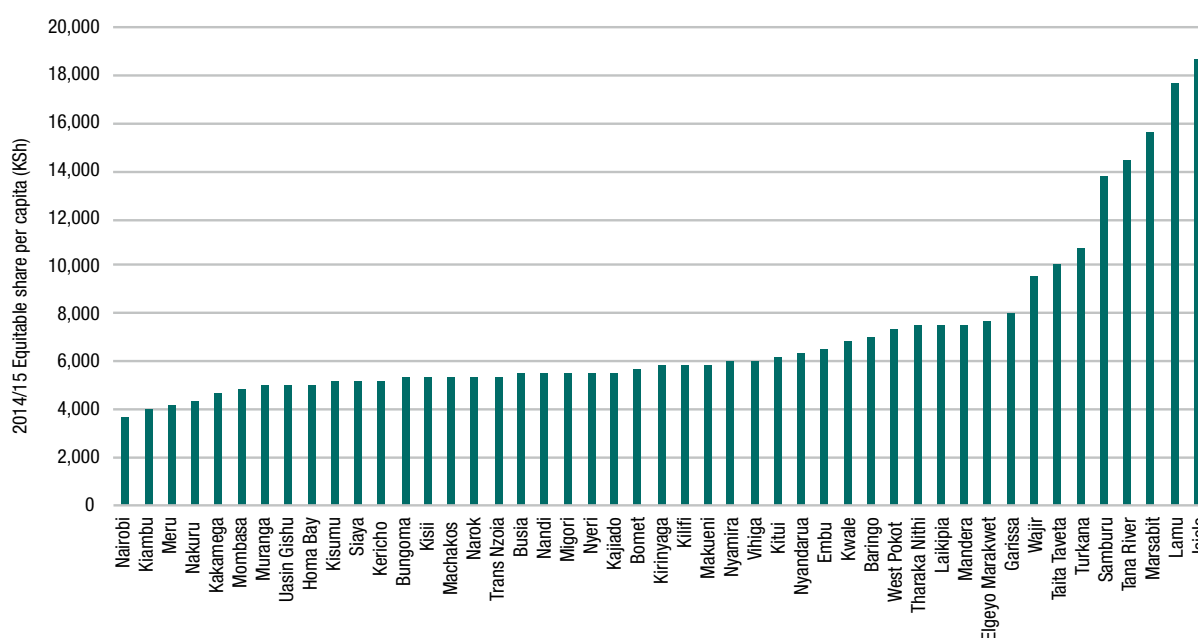
Kenya's counties are mostly financed by a large unconditional grant, the Equitable Share, which makes up over 80% of total county revenues. The Equitable Share is required by the 2010 Constitution, which entitles counties to receive not less than 15% of nationally raised revenue (at last audit). The amount actually allocated to counties since devolution was implemented in 2013/14 has been well above this, at more than 20% of national revenues.

The Equitable Share is allocated between counties by a formula set by the Senate every five years (and can only be amended by the National Assembly with a two-thirds majority), based on advice from the Commission on Revenue Allocation (CRA). At the start of the devolution process, a transitional formula was voted on for three years from fiscal year 2013/14 to fiscal year 2015/16. The CRA has stated that the formula has two objectives: service delivery and redistribution. The service delivery objective is reflected in parameters for population, which reflects the main driver of expenditure needs for a county; a basic equal share which reflects the fixed costs of setting up and running a county government; land area which serves as a proxy for the cost of delivering services; and a fiscal responsibility parameter, which aims to incentivise counties to exercise fiscal discipline, as required by the Constitution. A parameter for the poverty gap is used to achieve the redistribution objective (CRA, 2012; 2014).

Each parameter is assigned a weight which reflects the amount of the total Equitable Share which is to be distributed by that parameter (so, if the weight is 50%, half of the total Equitable Share funds are distributed according to that parameter). The weights on each parameter are as follows: basic equal share (25%), population (45%), poverty gap (20%), land area (8%) and fiscal responsibility (2%). The amount allocated to each county is based on the county's share of the national total. The amount a county receives thus depends on the weight on a parameter, and how it compares to other counties on that parameter.

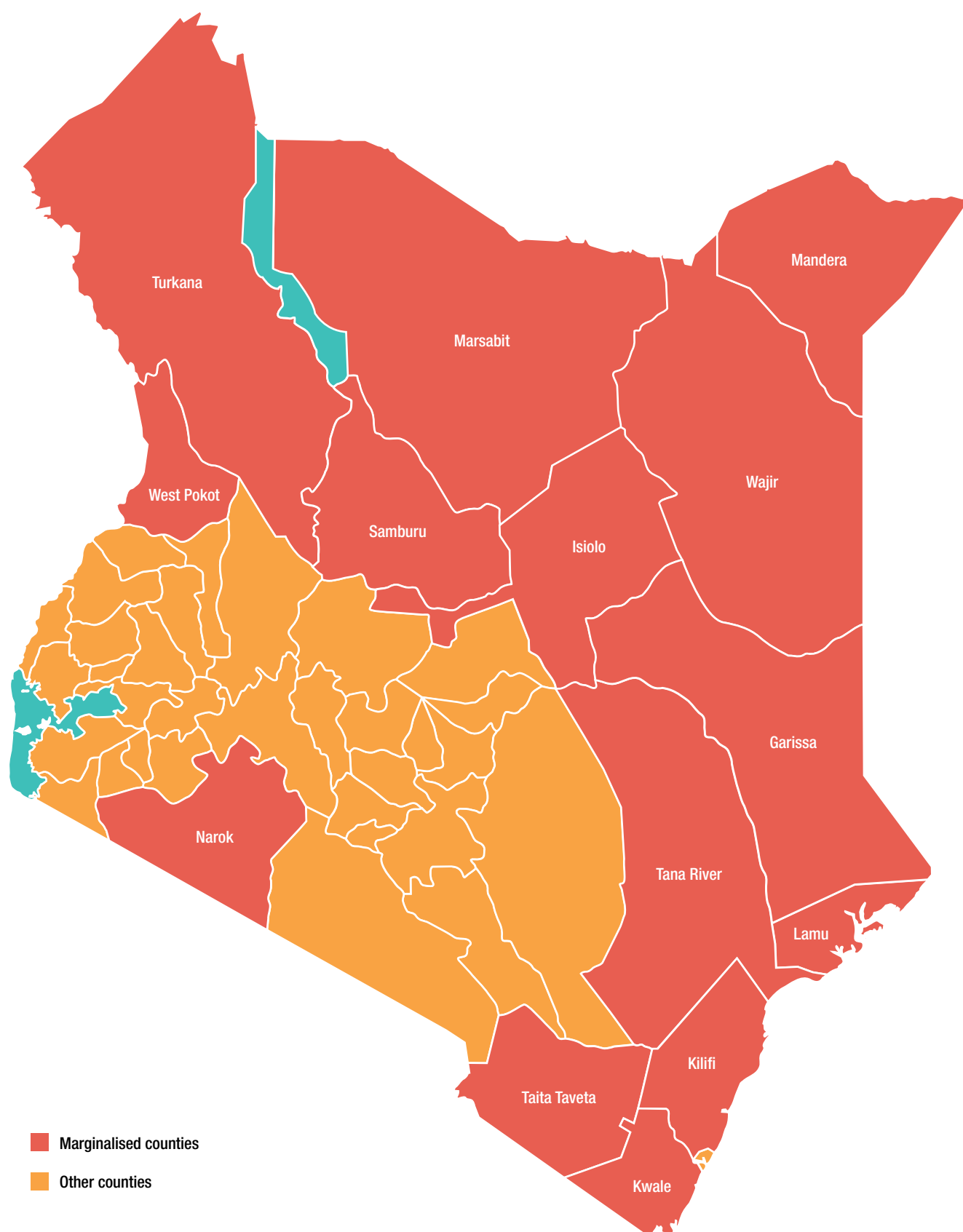
The relatively low weight on population, and relatively high weights on the poverty gap and on the equal share means that poorer counties with smaller populations receive higher per capita allocations. The formula quite strongly redistributes towards counties with these characteristics, resulting in large per capita differences in the amount of funding provided to counties. The county with the highest per capita allocation (Isiolo) receives more than five times the per capita allocation of the county with the lowest per capita allocation (Nairobi). It is also notable that the counties receiving large per capita allocations are all in the former Coast Province (Taita Taveta, Tana River, Lamu), or in the north of the country (Marsabit and Isiolo are in the northern part of former Eastern Province; Samburu and Garissa in the northern part of the former Rift Valley Province; and Wajir in the former North Eastern province).

Figure 2. 2014/15 Equitable Share per capita (KSh)



Source: authors' own calculations. Equitable Share data is from the County Allocation of Revenue Act, 2014 and population data from the 2009 census.

Figure 3. Map of marginalised counties



Source: CRA (2013) 'CRA chairman launches marginalization policy'. CRA Blog, 1 March. Nairobi: Commission on Revenue Allocation.

Our interviews with Kenyan state and non-state actors suggested that this geographical approach to marginalisation has been quite widespread. Interviewees emphasised that these areas of Kenya are marginalised because of ‘historical reasons’ (KA04, KGO16)⁸ compounded by a challenging terrain and climate. Nevertheless, the concept is under review, since one senior government official admitted that ‘there is no common understanding of leaving no one behind. It is not well understood and it will take some time before Kenyans understand what it means’. The Ministry of Devolution and Planning, for example, tasked with implementing an ‘SDG roadmap’, has no settled definition of the concept. Meanwhile, the Ministry of Health (MoH) is progressing towards a more population-based approach that recognises inequalities *within* counties rather than just *between* counties. The gradual shift has been influenced by the World Bank’s Vulnerable and Marginalized Group Framework (World Bank, 2013),⁹ which has been adapted – in consultation with communities – for the Kenyan context and is set to broaden the scope of programming, at least in the health sector, beyond the ‘marginalised counties’. Previously the World Bank-funded Kenya Health Sector Support Project aimed to support

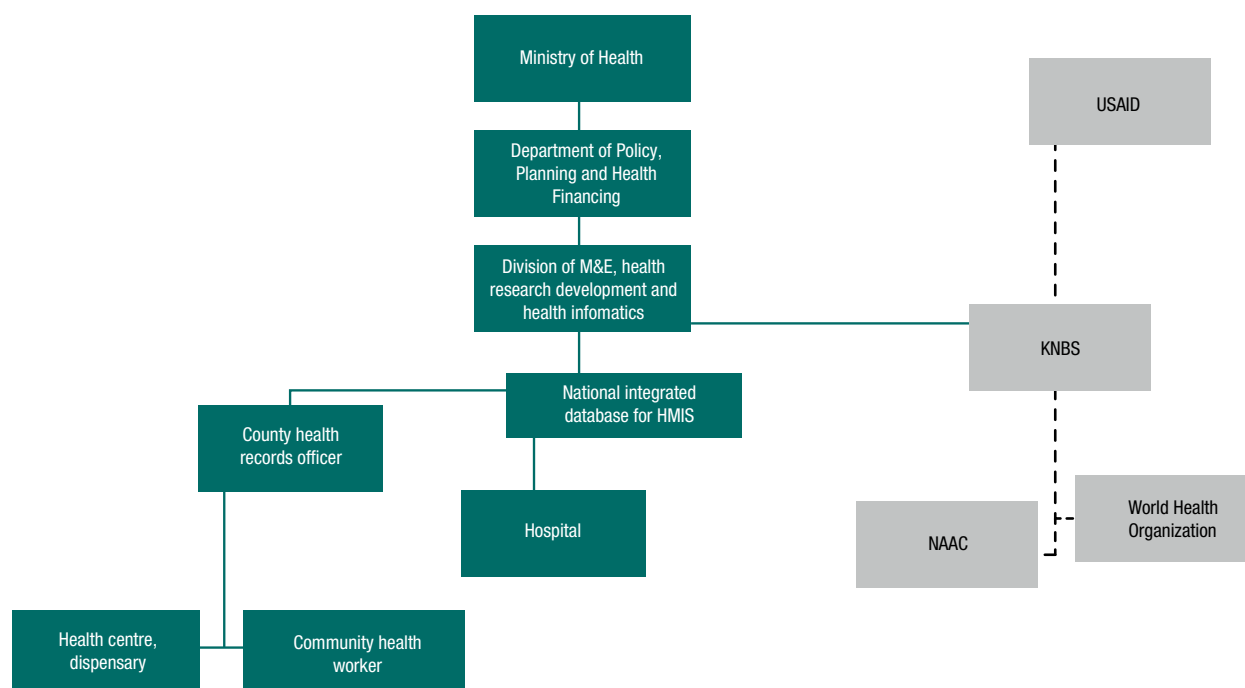
marginalised groups in the 20 ASAL counties, and one additional county (Migori) in which health indicators were poor (KGO3). More recently however the World Bank’s new Transforming Health Systems for Universal Care Project (THSUC) will apply the framework to its support of all 47 counties ‘in order to address critical gaps in improving utilization of quality PHC services’ (KMoH, 2016).

3.2 What do we know about who is left behind?

The Data ecosystem in Kenya

As global calls for a ‘data revolution’ have become stronger, the Africa Data Consensus has gathered some momentum around data issues (Africa Data Consensus, 2015). Throughout the continent, there has been increasing recognition of the potential role of data in enabling social development. This section describes the Kenyan national data ecosystem for health. As the colour coding in Figure 4 shows below, there are two main types and sources of official data: administrative data, which is shaded in green, and household survey data, shaded in grey.

Figure 4. The Kenyan health data ecosystem



Note: Administrative data collection systems are denoted in blue; household survey based data efforts are denoted in green. A dotted line indicates partnerships.

Source: Authors’ elaboration based on KMoH (2014a) 2013 Kenya Household Health Expenditure and Utilisation Survey. Nairobi: Ministry of Health.

⁸ A phrase used in interviews to describe a pattern of historical inequality where economic and political resources were directed to areas formerly known as the White Highlands and in and around Nairobi, at the expense of the areas in the west and the north of the country.

⁹ For example, the Kenya Water Security and Climate Resilience Program (KWSCR), funded by the World Bank, and managed by the Ministry of Environment, Water and Natural Resource, identifies the *Sengower, Ogiek, Turkana, Rendille, Gabra, Ajuran, Maasai, Illchamus, Aweer, Pokot, Endorois, Boni* and *Watha* as vulnerable and marginalised. Other projects run by other ministries identify different collections of groups.

Administrative data

Until 2010, Kenya had a ‘non-functioning [health data] system with major problems of reporting from the districts’ (WHO, n.d.). In 2011, however, it became the first country in sub-Saharan Africa to adopt a completely online national Health Information System in 2011: DHIS 2. Under this system, primary data is gathered at the local facility level by health care providers and at community level by community health workers, using paper-based monthly reports. These are then sent to the county health records officer for keying into the web-based DHIS 2 (in larger counties the information is collated at the sub-county level) (KGO5). Higher level health facilities, such as county and referral hospitals input their data directly onto the DHIS 2 system (Karuri et al., 2014).¹⁰ The data should then be available for use at county level, as well as feeding up into MoH planning and policy organs. These relationships are shown on the left-hand side of the diagram.

Household surveys

Simultaneously, the MoH receives data generated by the Kenyan National Bureau of Statistics (KNBS). Depicted on the right-hand side of the diagram, the KNBS is a Kenyan government institution working in partnership with organisations including the National AIDS Control Council, USAID and the WHO. It undertakes numerous surveys and produces statistical reports – e.g. the KDHS, MICS, Global Adult Tobacco Survey, and Kenya Malaria Indicator Survey, and, critically, the national census.¹¹ A significant range of health indicators can now be reliably disaggregated to the level of the county which can provide a critical asset for evidence-based decision-making and resource allocation (KMoH, 2016b).¹² Although there are problems with some aspects of Kenyan official statistics, which we discuss below, we nevertheless draw on this data to make our own calculations about who is being left behind in health care coverage.

Non-governmental data sources

There are also various non-governmental health data sources which may be able to mitigate some limitations of data availability. A Kenya Health Data Collaborative was adopted in 2016 in which major priority areas were agreed upon by national and county governments and other

stakeholders including civil society, non-governmental organisations (NGOs), private sector and development partners. The Collaborative was formed with the common aim of improving health data, and decision-making data for the health sector in the country that is easy to access, analyse and use for performance improvement (KMoH, 2016b).¹³

The KODI, through which ministries and counties are encouraged to share their data on an open portal, may also bring health dividends in the future (ICT Authority, n.d.).

3.3 Who is being left behind in health care coverage?

In this section we analyse Kenyan household survey data to estimate who is being left behind in Kenya and where they live. Readers less interested in quantitative analysis and more interested in the political-economic drivers of inclusion and exclusion, may wish to skip this section and jump to the [next section](#).

The patterns of CCI across 47 counties in Kenya to identify the characteristics of health service access mirror the conclusions from a broader WHO assessment from a cross-country assessment spanning over 45 low and middle-income countries. In short, the patterns reveal that there are four main dimensions driving disparities in access to health services that lead to segments of the Kenyan population facing much greater challenges to health benefits:

1. Income: the poor (bottom 40% of the household income distribution).
2. Geographic location: rural households.
3. Education: households in which women have low levels of formal education (primary or less than primary schooling).
4. Ethnic identity: households that are not in the five most populous ethnic groups nationally.

Patterns of health care access also vary significantly by county. Overall, across counties, widely excluded groups have much greater variability in their levels of access to health services relative to those not excluded. In some counties, households with the poorest access have only slightly worse access to health services than

10 Due to lack of internet and fluctuating electricity in some areas, an offline data entry feature has also been introduced. Shortly after the introduction of the DHIS 2 and its initial roll-out in October 2011, Kenya reached 80% completeness (WHO, n.d.).

11 The government has also recently engaged in the international initiative Performance Monitoring and Accountability 2020 (PMA2020) which aims to provide powerful, real time, household level survey data – although its scope is limited to family planning and health data.

12 In 2016, Kenya launched the Health Data Collaborative at the national level which brings together global health partners to work with different countries to strengthen national health information systems, improve the quality of their health data and track progress toward the health-related Sustainable Development Goals without replicating initiatives within one country. The initiative is only starting to be implemented, and none of the interviewees mentioned it during conversations.

13 In addition, the Kenya Open Data Initiative (KODI) (www.opendata.go.ke), launched in July 2011, is intended to make Government development, demographic, statistical and expenditure data available in a digital format for researchers, policymakers, information and communications technology developers and the general public.

other households; while there are other counties where almost everyone has poor access. In this latter group of counties, which are among the 14 counties officially designated as marginalised by the Kenyan Government, the level of access for the general population is much lower than the national average across most main dimensions of exclusion. Meaning, the worst health access for marginalised groups is in marginalised counties; and the extent of exclusion in these counties is also the greatest.

Detailed patterns in access to health services

The average CCI in Kenya is 76%. This places Kenya among the top half of more than 45 low- and middle-income countries and higher than the median CCI level of 70.2% for countries so classified by the World Bank (ICT Authority, n.d.). However, there are wide variations within the counties in Kenya, and notably among the dimensions of disaggregation that match similar results in other developing countries.

Along the dimension of **economic/income inequality**, at one extreme are counties such as Nyandurua, Nyeri and Makueni where households in the bottom 40% of the income distribution have greater CCI scores than the top 60% of the income distribution, although the differences were marginal. At the other extreme, poor households in counties such as Mandera and Marsabit score less than 50%, and the gap with their wealthier neighbours exceeds 30 percentage points (Figure 5). In fact, in seven of the 47 counties, households in even the top 60% of the income

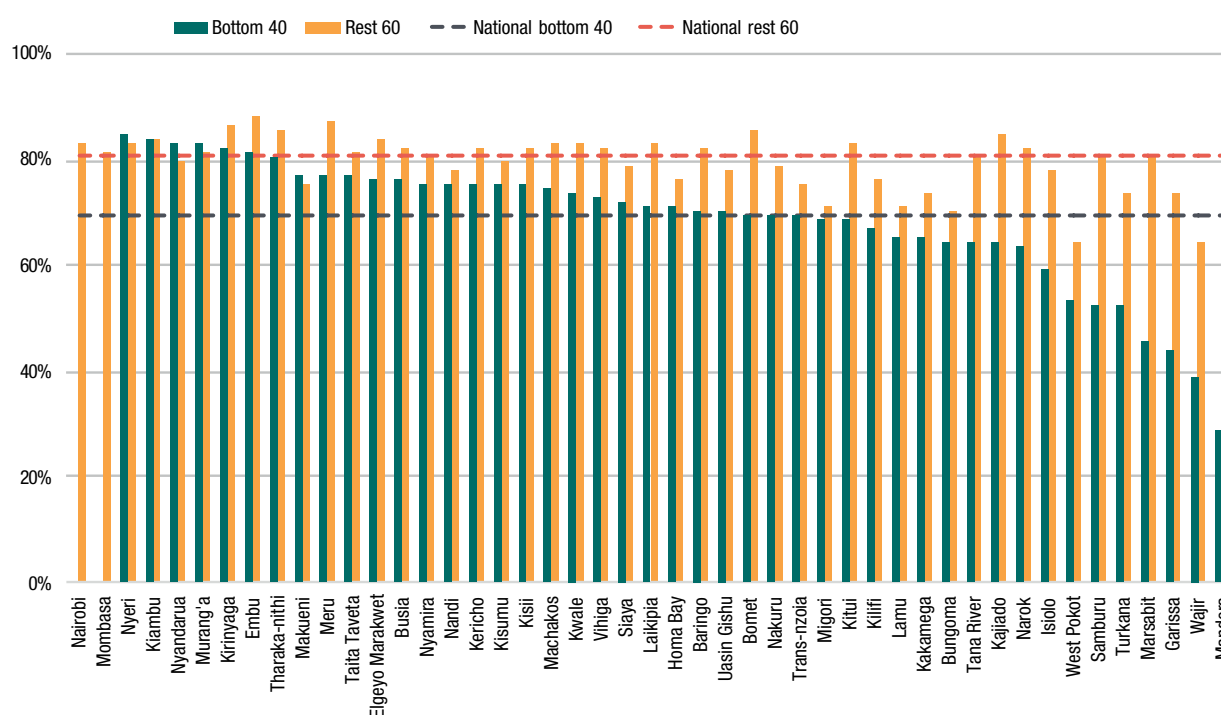
distribution fare worse than the national average. In these counties – such as West Pokot, Wajir and Mandera – nearly everyone is marginalised from access to health when compared to national and international benchmarks. Moreover, in these counties with lowest overall health access, the degree of disparity is also the highest – compounding their obstacles to of health care.

The **geographic location** of households is a significant determinant of access to RMNCH services. While nationally the difference between urban and rural households is eight percentage points (urban 81% and rural 73%), in nine counties there is no systematic difference between urban and rural locations. And in these counties, the overall level of health service access is fairly high (CCI close to 80%).

However, there are counties where rural households have significantly less health care coverage. In Mandera, Garissa and Marsabit, the difference between urban and rural locations is almost 30 percentage points. In addition, rural households in counties such as Mandera and Wajir have CCI scores of less than 40% – which is almost half the national average (Figure 6).

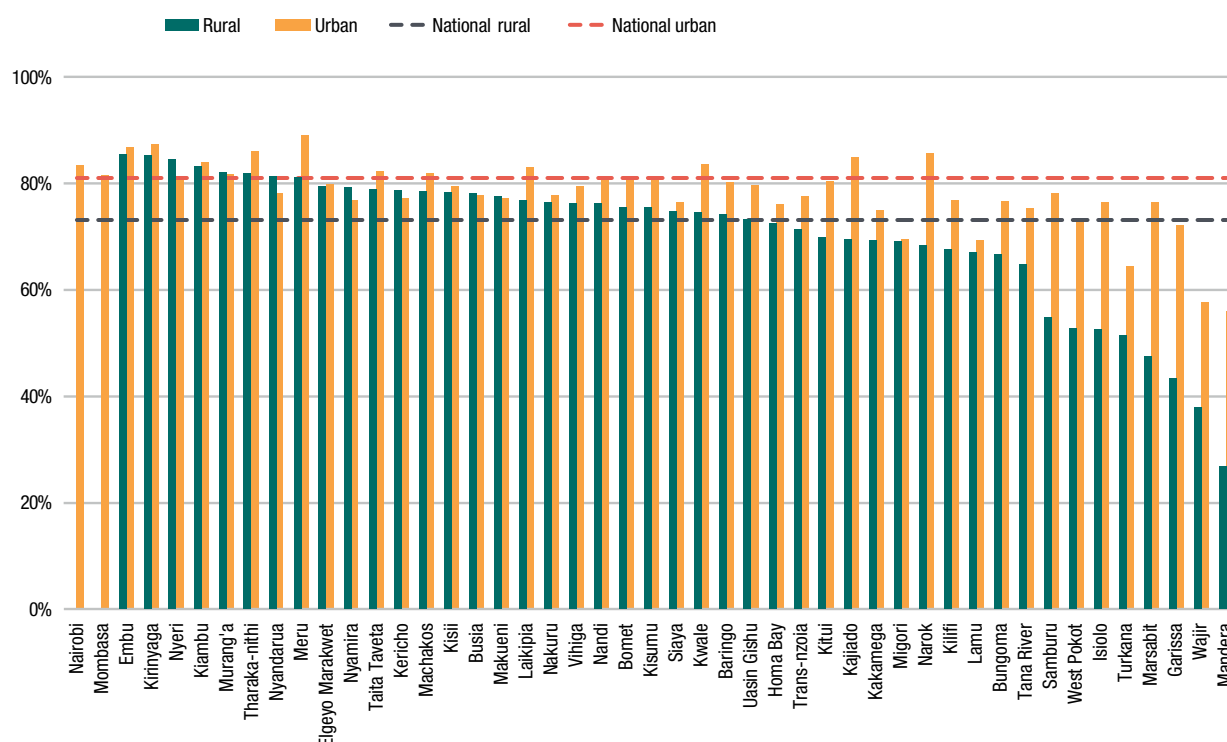
Given that the sources of primary data are household level surveys, we acknowledge the possibility that the indicators systematically under-represent nomadic and pastoralist communities. In so far as they are not fully represented in the data sample, their lack of representation may lead to under-reporting of being left behind.

Figure 5. Health access by income quintiles, average CCI in counties



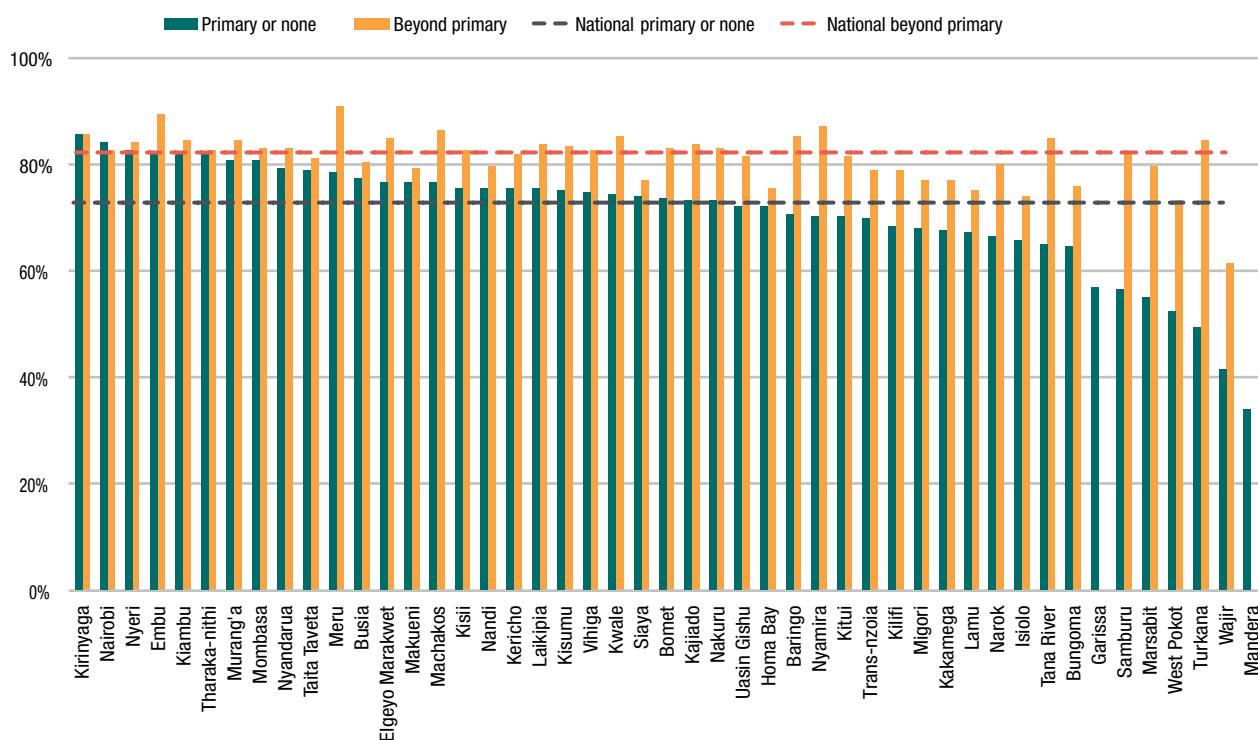
Source: Authors' computations using 2014 Kenya Demographic and Health Survey database.

Figure 6. Health access by geographic location, average CCI in counties



Source: Authors' computations using 2014 Kenya Demographic and Health Survey database.

Figure 7. Health access by education level of woman/mother, average CCI in counties



Source: Authors' computations using 2014 Kenya Demographic and Health Survey database.

The **level of education** is, however, a notable marker for disparity in access to health services. For instance, in Wajir, women with at most primary education had a low CCI score of 42% whereas the average for this category of women nationally exceeded 73% (a difference of more than 31 percentage points). The gap between those with education beyond primary level and those without exceeded 10 percentage points in as many as 17 counties (out of a total of 47) and exceeded 25 percentage points in Turkana and Samburu counties (Figure 7).

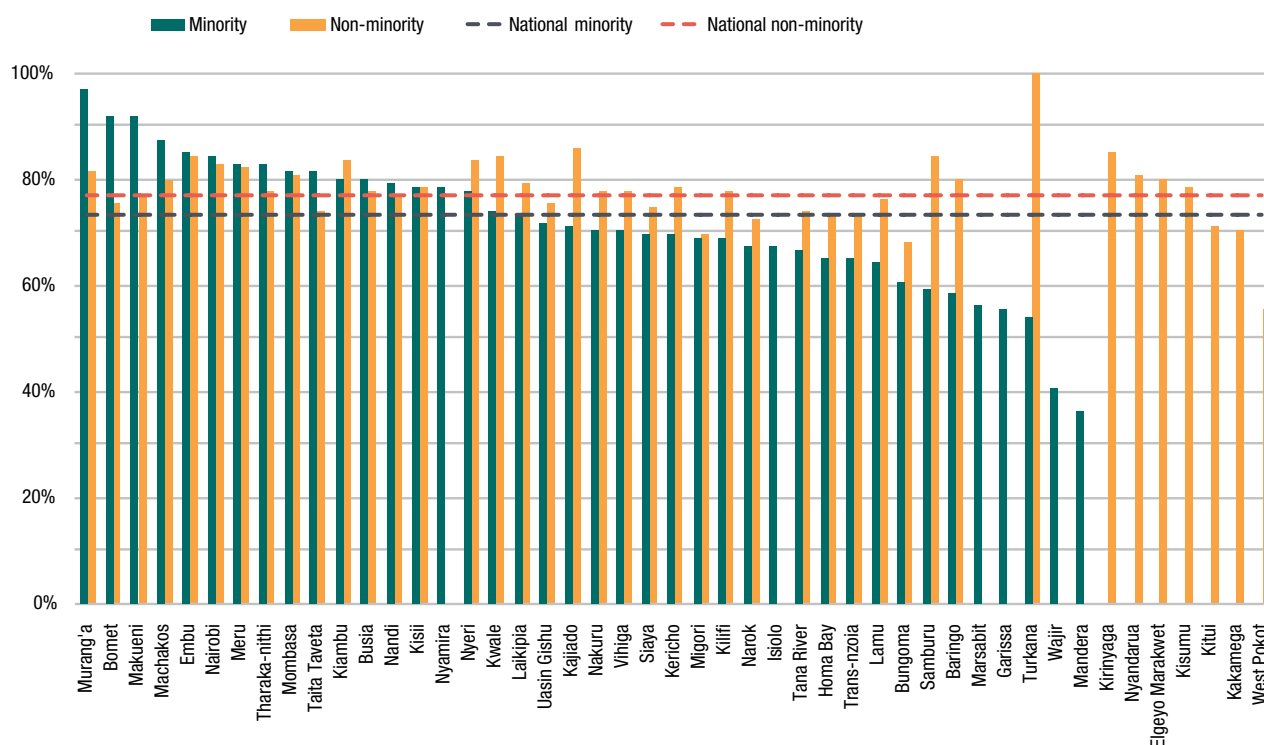
Minorities – based on ethnicity, religion, physical appearance or ability – tend to face marginalisation from basic civic amenities in almost every country. In Kenya, ethnic identity is a strong driver of identity, as well as distinction between communities. While ethnic communities are fairly dispersed in their numbers nationally, we consider the following ethnicities to be the non-minorities: *Kikuyu* (22%), *Luhya* (14%), *Luo* (13%), *Kalenjin* (12%) and *Kamba* (11%).¹⁴ The remaining ethnicities constitute about 34% of the national population. Our motivation for using national distribution of ethnicities to map disparity in access to health services at a county level is that broad health access decisions including key fiscal allocation decisions are made at the national level – where minorities typically have less

clout and are more vulnerable to marginalisation, even though these national minority communities might not be minorities in specific counties. Illustrations are Wajir and Mandera counties, which have a single dominant ethnic group (*Somali*) who are a minority nationally but not so in those specific counties.

The evidence suggests that, nationally, there appears to be no striking difference in access to health services based on ethnic identity (Figure 8). However, this overall reflection masks significant heterogeneity in access at a county level. In eight counties, minority communities enjoy better health access than their non-minority counterparts; in the predominantly urban counties of Nairobi and Mombasa, there is no perceptible difference between the groups; in a large number of counties, minorities clearly suffer from a deficit in access to these services. In such counties with evidence of significant disparity, the minority communities have much less access than the national average, whereas the levels of non-minority groups manage to have access levels close to or even higher than the national average. There is a lack of data on health access to ethnic minorities in as many as seven counties.

To assess any significant **gender disparity** in access to health services, we evaluated the rates of measles vaccination among infant boys and girls. In the

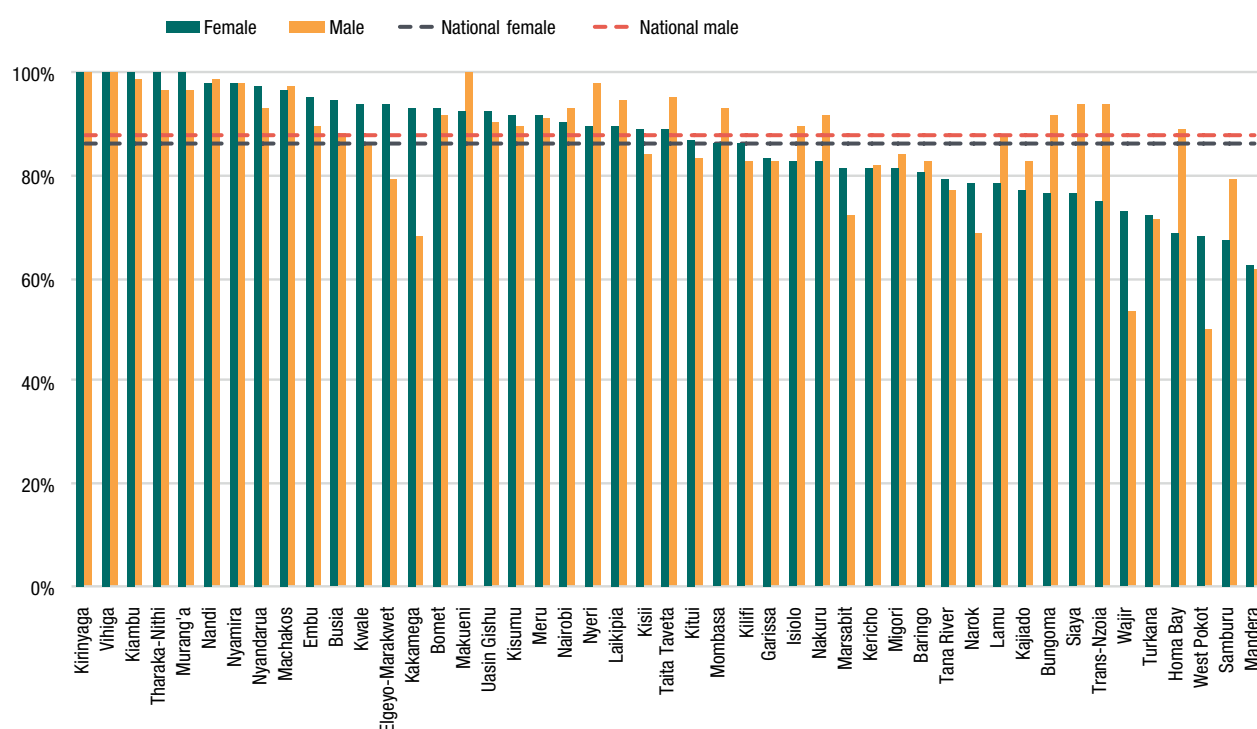
Figure 8. Health access by ethnic minorities versus non-minorities, average CCI in counties



Source: Authors' computations using 2014 Kenya Demographic and Health Survey database.

14 We use data from the CIA's 'The world factbook' for size of ethnic groups.

Figure 9. Health access by gender, proportion receiving measles vaccination



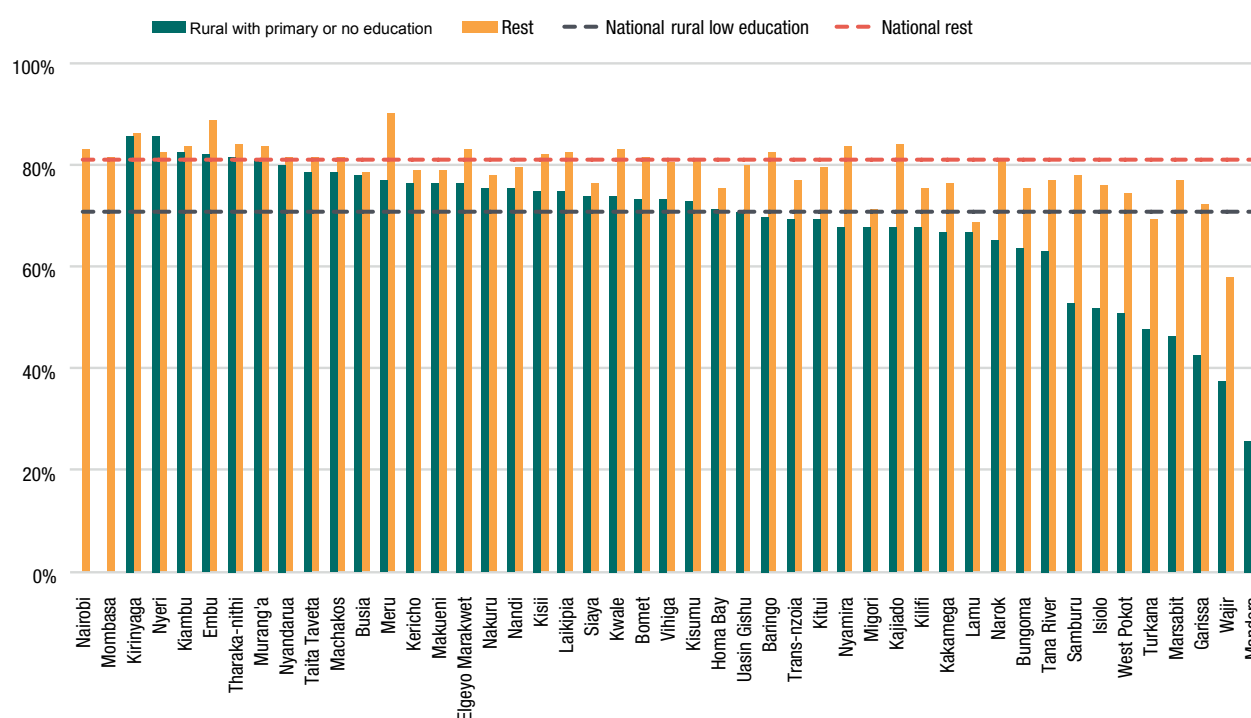
Source: Authors' computations using 2014 Kenya Demographic and Health Survey database.

absence of clear consensus on appropriate measures to assess gender disparity on access to health, the measles vaccination rate of newborn children is one metric to detect the presence of and elicit the extent of difference based on gender. Measles vaccination is a gender-neutral health intervention; it is administered to infants before their health needs begin differing across gender or before individual health characteristics or environmental factors begin dominating and dictating health needs; it requires fewer follow-up visits that could create additional sources of bias in the data; it is relatively low-cost to administer and hence relatively impervious to household economic conditions; universal vaccination coverage expansion is a priority initiative subsidised by the national Government and international agencies such as UNICEF (WHO, 2016c; UNICEF, 2002); and finally, the coverage rates are relatively easy to enumerate and record. Given this, we would expect to see parity in immunisation rates between boys and girls within counties – even if there are differences in vaccination rates between counties. Consequently, where we find a significant difference, there is strong *prima facie* evidence that gender discrimination against infants is occurring, for some indeterminate reason.

While there was hardly any difference nationally between infant boys and girls in their rates (boys 88% and girls 86%), there are wide disparities across counties. In some counties, such as Homa Bay and Trans-Nzoia, vaccination rates for girls lag those of boys by almost 20 percentage points. Conversely, in Kakamega and Wajir, the vaccination rates among boys lag those of girls by 25 and 19 percentage points respectively (Figure 9). These county-specific differences in health coverage among genders – starting from the very early stages of life – are intriguing and worthy of further investigation. Moreover, it should be noted that other forms of gender discrimination may still be prevalent, even where vaccination rates for girls and boys are similar.

The extent of exclusion from health services is exacerbated for population cohorts caught in the **overlapping individual dimensions of exclusion**. For example, a group of people who are marginalised in more than one way, such as low education *and* living in a rural area, experience a greater degree of marginalisation than if they only had *one* of those dimensions of exclusion. The extent of difference in CCI in 10 counties is larger than 15 percentage points, and as high as 33 percentage points in the extreme case of Mandera (Figure 10).

Figure 10. Health access for rural and low education versus the rest, average CCI in counties



Source: Authors' computations using 2014 Kenya Demographic and Health Survey database.

The evidence above of multiple dimensions of exclusion reinforces other patterns witnessed earlier: access levels of non-marginalised groups do not vary across counties much, but those of marginalised groups do. And the levels of exclusion are highest in counties with low overall levels of health access. The comparison of ethnic minorities in rural areas versus the rest, also reveals similar patterns of exclusion. The variation in access to health services is much greater in the rural minority sub-group than it is for the other groups.

Fortunately, as we shall see in the section below, Kenya is making significant strides towards addressing at least some of these disparities, in terms of progressive constitutional and policy commitments, and financial flows to back them.

3.4 Drivers of progress towards leaving no one behind in health

Progressive policy commitments

Kenya's alignment with an agenda to leave no one behind can be traced at least as far back as 2006, when the country launched its Vision 2030 exercise (GoK,

2007a; GoK, 2007b).¹⁵ Vision 2030 is Kenya's blueprint for transforming the country into a newly-industrialised middle-income country. It is based on three pillars: economic, social, and political. The social pillar, which most interests us, aims at a 'just and cohesive society enjoying equitable social development in a clean and secure environment' (GoK, 2007b). It includes far-reaching commitments to health, education, sanitation, and the environment. There is also a vision for 'Gender, Youth and Vulnerable Groups', and a commitment to 'Equity and Poverty Elimination' intended to, 'reduce the number of people living in absolute poverty to the tiniest proportion of the population' (GoK, 2007a: 21).

A product of extensive national and international consultation, the Vision was apparently influenced by emerging debates around the post-2015 agenda, helping to explain its alignment with many of the 2030 Sustainable Development Goals (SDGs).

In the specific area of health, Vision 2030 recommends devolving funds and management responsibility from the national Government to district medical officers, and also shifting the balance of the national health bill from curative to preventative care, which will involve revitalising Community Health Centres (18). It also pledges that the

¹⁵ Vision 2030, only released in 2007, was unable to forestall the serious violence that accompanied the 2007 general elections. Nevertheless, the post-violence 2010 Constitution dovetails with its commitments. Under Part Two of the Bill of Rights, for example, the Constitution guarantees that: every person has the right 'to the highest attainable standard of health, which includes the right to health care services, including reproductive health care' (43. (1) (a)) and also that, 'A person shall not be denied emergency medical treatment' (43. (2)). Further, the Constitution's commitment to devolution squares with Vision 2030's prior aspiration for a devolved health system.

Government, ‘would provide access for those excluded from health care for financial reasons’ by means of a National Health Insurance Scheme (18). Post-2010 the health service has indeed been devolved, with the new structure illustrated in Figure 11 below.

The current long-term framework for Kenyan public health is the Kenya Health Policy (2014–2030), informed by both Vision 2030 and the 2010 Constitution. Although it predates the UN Agenda for Sustainable Development, the Policy has several ambitious policy objectives which are clearly in line with the targets of SDG 3:

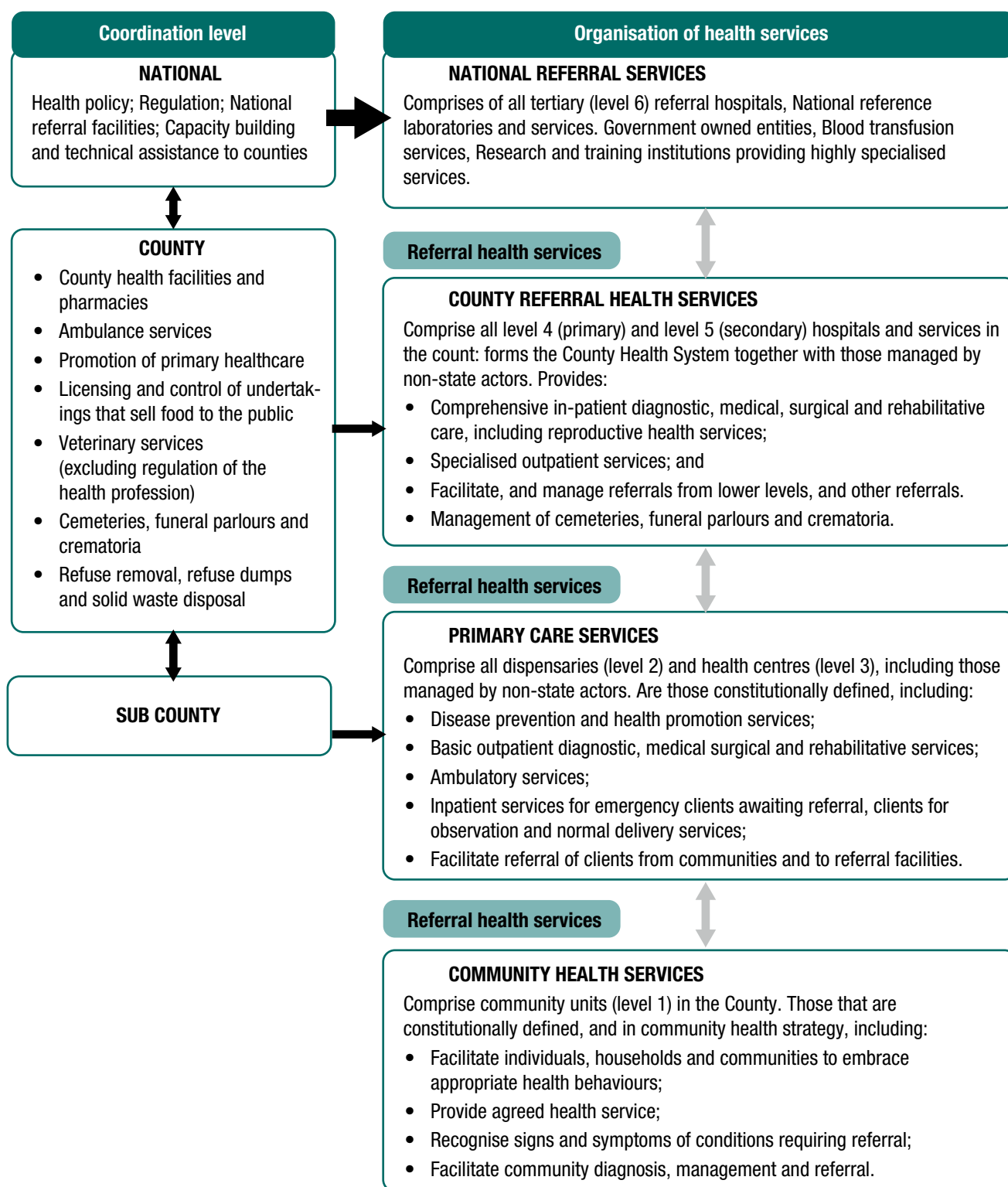
1. Eliminate communicable diseases (matches SDG Target 3.3)
2. Reverse the trend on non-communicable diseases (NCDs) (matches SDG Target 3.4)
3. Provide essential health care services (matches SDG Target 3.8). (KMoH, 2014a)

In addition to these objectives are a number of policy commitments relating to access, demand and quality (KMoH, 2014a). Notable among them are that

All persons shall have adequate physical access to health and related services, defined as ‘a) living at least 5km from a health service provider where feasible, and having the ability to access the health service’; b) Financial barriers hindering access to services will be minimized or removed for all persons requiring health and related services; guided by the concepts of UHC and Social Health Protection; and c) Socio cultural barriers hindering access to services shall be identified, and directly addressed to ensure all persons requiring health and related services are able to access them (KMoH, 2014b: 37).

The structures through which these policies are implemented are depicted in Figure 11.

Figure 11. Organisational structure of the Kenyan health system



Source: KMoH (2014b) *Kenya Health Policy 2014–2030: towards attaining the highest standard of health*. Nairobi: Ministry of Health.

A medium-term framework supports the Kenya Health Policy: the Kenya Health Sector Strategic and Investment Plan (KHSSP) 2014–2018. It is mainly concerned with accelerating progress towards UHC, which it defines as attaining ‘equitable, affordable, accessible and quality health care for all’, and which will involve improving the numbers of available services, scaling up coverage, and reducing the financial implications of using services (p.x). A cornerstone of the policy is the Kenya Essential Package for Health, comprising a basic and expandable set of health care interventions intended to be available as UHC unfolds (KMoH, 2014b).

A number of other policy initiatives, projects, programmes and mechanisms help operationalise the Plan’s ambitions. For example, the Government is increasing the scope of the National Hospital Insurance Fund (NHIF) – the official insurance system that covers inpatient and outpatient services for all, following the national treatment guidelines. Historically, this has been funded by mandatory payroll contributions from formal sector workers (Lagomarsino et al., 2012); however, the NHIF is now expanding its benefits package and attempting to expand enrolment to informal sector workers. In addition, the Government with the support of development partners is rolling out a flagship project (under Vision 2030) to expand coverage to the most vulnerable groups: the Health Insurance Subsidy Programme (HISP) for the poor, administered by the NHIF and the Ministry of Labour. During its pilot phase, HISP has only targeted those registered for cash transfers with the National Safety Net Programme – Older Persons and Persons with Severe Disabilities, and Orphans and Vulnerable Children. These schemes entitle eligible individuals to free health care at the point of delivery, with health providers reimbursed by the NHIF. They have enrolled over 300,000 people (KGO1). HISP is scaling up from 2016, using a more sophisticated interagency social protection council, whereby existing eligibility data will be used in conjunction with KNBS household data.

Other notable policy measures include the removal of user fees for primary health care and maternal health services both of which have been backed by new financial transfers (see below). Participants at our focus group in Kibera (see [Box 8](#) below) agreed that maternal health services were improving, and had noticed a big push on the part of Government to reduce maternal mortality (CHWFGD1). Mothers in remote rural wards, however, did not appear to be reaping the same benefits from their entitlement to free maternity services (FGDs mothers 1,2,3,4) (see [Box 9](#)).

On the demand side, a number of initiatives are in place to improve uptake of services from vulnerable groups who have disproportionately poor health access. They target health-seeking behaviour, health awareness, healthy lifestyles of citizens and making sure the populace are well informed; one of the principle mechanisms for delivering

these is the national Government’s Strategy for Community Health. Under the devolved system the county governments have responsibility for implementing this strategy, and many interviewees echoed the Constitution by emphasising the importance public participation. In this case it means empowering Kenyans to ‘take charge of improving their own primary health care’ in such a way that services are responsive to local needs (KMoH, 2014b). Addressing the utilisation problem in vulnerable populations is one of the expected outcomes of greater participation and is supported by constitutional arrangements such as the requirement to have representation of vulnerable groups, as in the case of women’s special seats. There was a sense of optimism from government officials about what this might be able to achieve (KGO10, KGO11), ‘What can women in the assembly do to promote the well-being of women? They can encourage other women. They are role models. They allocate resources and funding to women’s programmes, they bring the village women in groups, to empower them, how to be self-sufficient’ (KGO11).

Progressive financial formulae

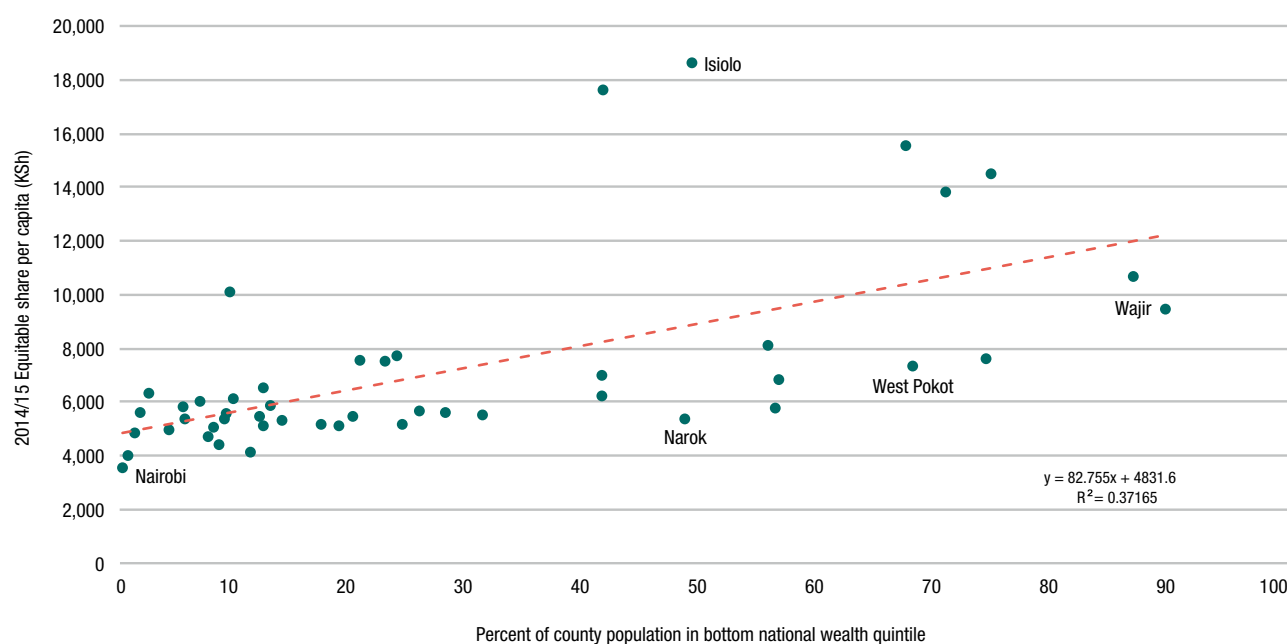
The 2010 Constitution enshrined the principle that ‘the public finance system shall promote an equitable society’ (201. B). Expenditure should ‘promote the equitable development of the country, including by making special provision for marginalised groups and areas’ (201. B. iii). To this end, revenue raised nationally would be shared equitably between national and county governments (202.1), with counties receiving ‘not less than fifteen percent of all revenue collected by national government’ (202. 2). The Equitable Share is an unconditional grant, thus county governments are free to allocate the resources as they deem fit within the confines of the public finance principles of effective provision of public services

Subsequently, the CRA determined that the Equitable Share would have a significant poverty weighting. This means that it is disproportionately weighted towards poorer counties, and, all other things being equal, more likely to benefit the poor.

This progressive allocation is shown in the chart below. Wajir, the county with the highest percentage of its population in the bottom income quintile, receives more than double the Equitable Share per capita of Nairobi, the county with the smallest percentage. Isiolo, with the highest per capita allocation, receives almost five times that of Nairobi.

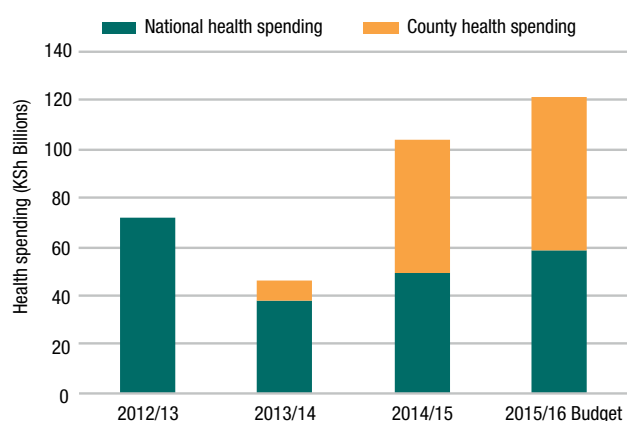
These measures are likely to be partly responsible for a positive impact on health spending. The MoH’s budget was cut by just over 60% between 2012/13 and 2013/14, but once county allocations are factored in, health allocations in 2015/16 had increased by around 70%, as shown in Figure 13. This increase appears to be driven by counties choosing to allocate a larger amount to health care than was previously allocated by the national Government.

Figure 12. Correlation between Equitable Share per capita and percentage of population in bottom wealth quintile, by county



Source: Authors' own calculations. Equitable Share data is from Controller of Budget (2015), population data from 2009 census, wealth quintile data calculated from the 2014 Demographic and Health Survey.

Figure 13. National and county health spending, 2012/13–2015/16



Source: Kenya National Bureau of Statistics (2016), Tables 6.8 and 6.16.

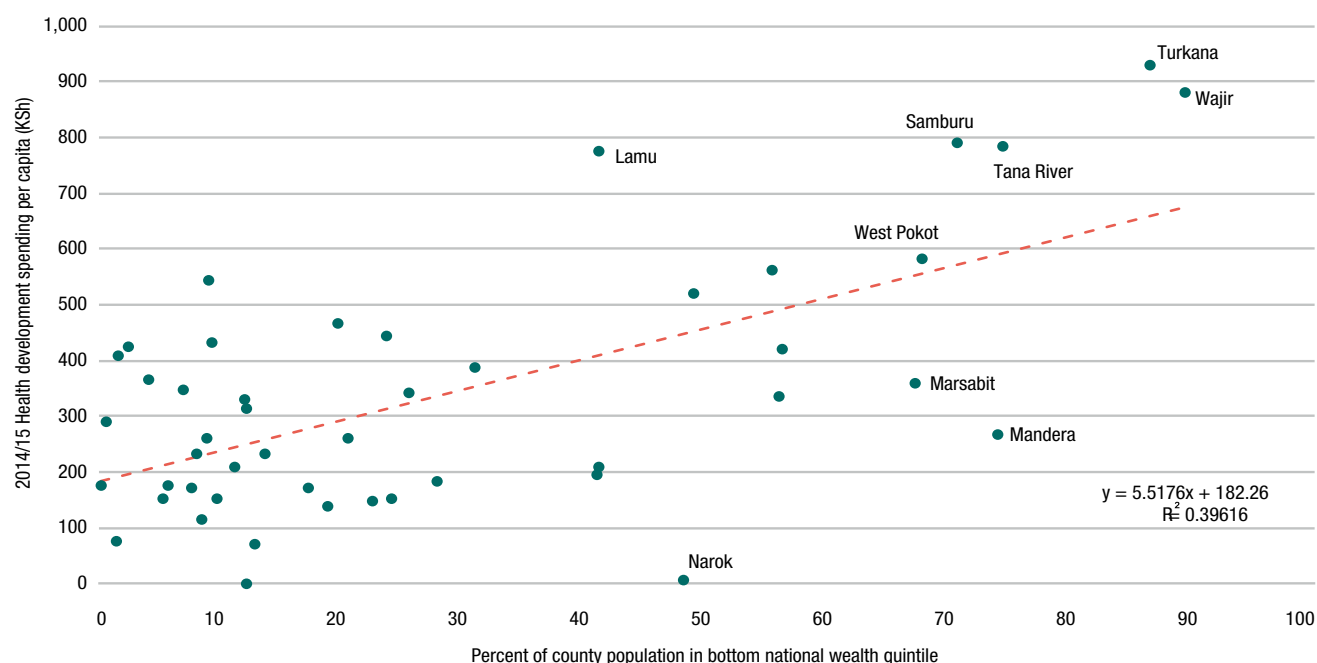
There is also some evidence that counties are tending to use the additional resources they have been given to start to close service delivery gaps. There is a positive correlation between the proportion of the county population in the bottom wealth quintile and health development spending per capita. Development spending is essentially capital spending on constructing and equipping new facilities, or acquiring ambulances and other equipment. As this is higher in counties with a higher proportion of the poor, this suggests that counties could be using the new

distribution of resources to invest in closing the gap in service delivery with better-off counties.

And although we lack reliable quantitative data for how effectively counties *target* resources at the poor, there are grounds for thinking that, generally speaking, county health spending should be more pro-poor than central Government spending. This is for two reasons. First, counties are responsible for the lower tiers of health delivery, which are more likely to be utilised by those left behind. Similarly, Kenyans living in rural areas depend to a significantly greater extent on public facilities than Kenyans in urban areas. In 2013, people in rural areas used public providers for 65% of visits, as compared to 43% of visits by people in urban areas (KMoH, 2014a). Kenyans in the poorest wealth quintile are more likely to use public health facilities than the richest quintile, and those in the poorest quintile predominantly seek care at public health centres (*ibid.*). In 2013, 70% of outpatient visits by the poorest quintile were to public facilities, as compared to only 36% of outpatient visit by the richest quintile (*ibid.*). Qualitative insight into some less progressive influences on choices made by county officials on fund allocation are described below ([section 3.5](#)).

The Constitution also provided for the creation of an Equalisation Fund into which 0.5% of all revenue collected by the national Government would be paid (204. 1), for the purpose of providing 'basic services including water, roads, health facilities and electricity to marginalised areas to the extent necessary to bring the quality of those services to the level generally enjoyed by the rest of the

Figure 14. Correlation between health development spending per capita and percentage of population in bottom wealth quintile, by county



Source: Authors' own calculations. Health development spending data is from Controller of Budget (2015), population data from 2009 census, wealth quintile data calculated from the 2014 Demographic and Health Survey.

nation, so far as possible' (204. 2). Since the Fund only came on stream this year and no projects have yet been undertaken, it is too early to assess its impact.¹⁶

In addition to this devolution-induced shift, a range of health finance reforms have been aimed at those left behind. For example, on assuming power the Jubilee Alliance fulfilled its pre-election pledge of abolishing fees charged at public dispensaries and health centres, and for women giving birth at public hospitals. In addition to eliminating these user fees, the Government put in place large new grants to compensate county facilities for their loss.¹⁷ While these grants are only equivalent to 5% of the 2015/16 Equitable Share, and so look relatively insignificant in overall county spending, they are equivalent to 21% of total budgeted county spending on health.

The Constitution also enshrined the principle of 'openness and accountability, including public participation in financial matters' (201. A). The 2010 Constitution and the 2012 Public Finance Management Act aspire to the 'democratization of public finance' (Lakin, 2016). They require a significant amount of public participation in the county budget process, with the chance to comment on the key financial allocation decisions a county takes (Public Finance Management Act, 2012, Article 207). These new

arrangements ostensibly create a window of opportunity in which ordinary people, including those left behind, can influence the allocation of health resources.

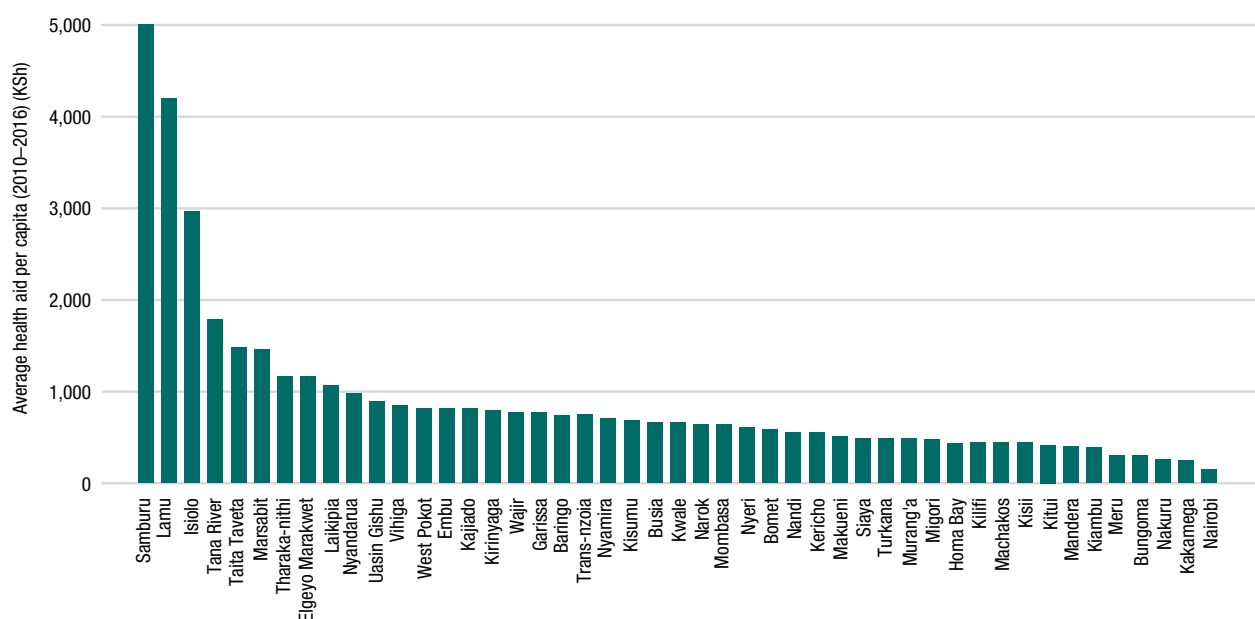
Donor funding

Despite an increased supply of Kenya Government funds to the health sector in recent years, a large proportion of its health spending is still financed by donors, who accounted for 57.1% of the total health development budget in FY 2014/15 (KMoH, 2015). Donor contributions are focused on several key areas including HIV/AIDS, malaria control and reproductive health care. Much of that funding, in particular the US President's Emergency Plan for AIDS Relief (PEPFAR), which is equivalent to around 30% of all health expenditure, takes place off-budget (IDP1). This makes it difficult to trace exactly what percentage of donor funding is aligned, either intentionally or unintentionally with the leave no one behind undertaking. However, much of it undoubtedly is. Not only do many PEPFAR and Gavi funds target vulnerable groups directly (children; people living with HIV/AIDS), but major donors such as the World Bank are helping to finance health insurance subsidy schemes for the poor, and do so with explicit recognition of their vulnerability and marginalisation. Moreover,

¹⁶ First disbursement and projects under the Equalisation Fund is happening in fiscal year 2016/2017. They will be undertaken in the 14 target counties by national government ministries.

¹⁷ In 2015/16, the Free Maternal Health Care Grant amounted to KSh 4.3 billion, and the User Fees Forgone Grant to KSh 0.90 billion. Figures are from the County Allocation of Revenue Act, 2015.

Figure 15. Average per capita health aid per country, 2010–2015 (KSh)



Source: E-promis database.¹⁸ Available at e-promis.treasury.go.ke/. Notes. Data refers to project costs in KSh. National level data was divided equally by county and added to the aid per county.

the donors we spoke to also reported a disproportionate amount of their funds targeting marginalised counties in the north and east of the country (IDP1, IDP2). These claims are supported by overall figures which show that the counties receiving the highest average health aid per capita between 2010 and 2015 like Samburu, Lamu and Isiolo are among the most marginalised (Figure 15). However, other marginalised counties, for example Mandera, which our statistical analysis identified as a case of acute deprivation, receive relatively low levels of health aid. Additionally, it is important to stress that our regression analysis finds *no significant correlation* between poverty and health aid per capita.

3.5 Persistent challenges

Although the previous section has noted a number of positive developments in Kenya's policies and finance, there remain several challenges when it comes to leaving no one behind in health. The next section discusses these with respect to inappropriate levels and patterns of expenditure, and unintended consequences of devolution.

Inadequate and poorly allocated financing

Inadequate levels of finance

We saw in the previous section that the Equitable Share contributes to a pattern of health spending in Kenya that is broadly in line with the aspirations to leave no one behind; the Equalisation Fund, once operational, ought also to work in this direction. Nevertheless, there are reasons to think that, even if the distribution of expenditure is moving in the right direction, levels of expenditure remain insufficient.

One of our informants spoke of serious shortfalls in staff and training, which could not be rectified at current spending levels (NGO2). Average health spending at county level is well below the estimate by the Centre on Global Health Security Working Group on Health Financing of \$86 per capita as necessary to deliver an essential set of health interventions for all. The county with the highest per capita health budget in 2014/15 was Lamu, at KSh 5,587 (around \$57) per capita. Most counties spend much less. For instance, Narok, one of our case studies, spends \$22 per capita on health care; reaching the \$86 per capita average by 2030 would involve annual expenditure growth of 11% a year. Moreover, \$86 per capita is a national average, and is likely to seriously underestimate the real cost of providing health care to the most remote populations.

¹⁸ E-promis is an electronic platform that tracks budget and performance management of Kenya.

Meeting even the \$86 target nationally would require expenditure of around KSh 10,000 per capita.¹⁹ This would only be affordable to the counties if resources from national Government were substantially increased, as for all but five counties the amount required is larger than their entire 2014/15 Equitable Share allocation. In total, the amount that would be needed to fund this would be KSh 321 billion, or more than doubling the Equitable Share. As this amounts to more than 20% of Kenya's budget, it is unlikely that sufficient resources could be found by reallocations within the national budget or extra funds from development partners. Even if all counties were to make reallocations within their budgets so that health spending accounted for 40% of funds (the level of allocation made by the counties that allocated the most funds for health in 2014/15 budgets) then this would only reduce the cost slightly to KSh 284 billion.

What would be a more realistic target within current resource constraints? For all counties to increase their per capita health allocations to KSh 3,000, in line with the fourth highest per capita allocation to health (the other counties make much higher allocations of above KSh 4,000 per capita) could be achieved if counties allocated 40% of their revenues to health, coupled with a more modest increase of KSh 18 billion, equivalent to an 18% increase in the Equitable Share, or 1% of the 2014/15 national budget. This suggests that, while meeting international benchmarks for health financing is still some way off in Kenya, significant increase in allocations to health are viable through a combination of reallocation of county budgets and some additional funding from the centre. Achieving this would require substantial engagement with counties to convince them of the benefits of allocation to health, close monitoring of their health spending, coupled with financial incentives to commit more resources, such as a matching grant.

A potentially less progressive county funding formula

Somewhat worryingly from a leave no one behind perspective, the CRA is currently recommending that the poverty weighting on the Equitable Share be reduced from 20% to 18%. This would be partly off-set by the proposed introduction of a new development parameter (with a weight of 1%) which would be based on access to water, electricity and roads.²⁰ This aims to 'capture economic disparities and developmental needs of counties' and compliments the parameter on poverty to ensure that counties with the greatest developmental needs get additional resources to bring services to the level enjoyed in other counties (CRA, 2016). However, of more concern is the proposal to further increase the basic equal share from 25% to 26%. The basic equal share aims to provide

a minimum level of funding for key administrative functions which are similar across all county governments. But it is hard to believe this should be over a quarter of a county budget. The International Budget Partnership proposes that it should be 'no more than 15% and probably less'. (IBPK, 2014). As it stands, the formula unjustifiably favours counties with smaller populations over those with larger ones, given that the basic share does not vary according to county size.

Box 7. Kenya's resource constraints

Kenya's revenues are around 20% of gross domestic product (GDP). This is similar to other middle-income sub-Saharan African countries such as Côte d'Ivoire and Ghana (IMF, 2016a: 93, Table A19). Close to 50% of Kenya's revenues come from direct taxes on individuals and firms, 40% on indirect taxes (customs duties, VAT and excise) and the remainder from other fees and charges (IMF, 2016b).

Kenya's spending is currently significantly higher than its revenue, at around 28% of GDP. The fiscal deficit has grown over the last decade from around 2% to around 8% of GDP, largely as a result of increases in infrastructure spending (IMF, 2016b). This borrowing included Kenya's first international bond issue in 2014, which at \$2 billion was the largest debut bond issue by an African country. The government is now seeking to reduce the fiscal deficit and tighten fiscal policy by containing the wage bill and increasing revenues (National Treasury, 2015).

This suggests that any increases in spending in order to leave no one behind need to come from reallocations within existing government spending, or from making efficiency savings. Increased revenues over the coming years will go towards reducing borrowing, rather than on 'new' spending.

Mismatches between preventative and curative spending

Expenditure shortfalls are compounded by the fact that money is sometimes spent on the wrong things, with too much focus on curative rather than preventative care (World Bank, 2014b). Health spending should be more focused on the lowest levels of the health care system if it is to reach those left behind.

We saw in the previous section that Vision 2030, the Kenya Health Policy and the Kenya Health Sector Strategic Plan all emphasise preventative care, implying an increasing proportion of resources going to lower

19 This was estimated by updating the \$86 per capita estimate for inflation, then deducting the spending currently made by national government (around KSh 1,500 per capita).

20 The concern is the development parameter of 1% is rather small given that it is potentially the only one that takes direct service delivery levels into consideration. From a leave no one behind perspective it should weigh more. See the IBP-Kenya memorandum to CRA (IBP-K, 2014).

levels of the health care system such as community units, dispensaries and health centres, as opposed to hospitals. Prior to devolution, although Kenya had a relatively high provider to population ratio of 1.69/1000 (for all cadres of providers), this was very unequally distributed with rural dispensaries being extremely understaffed and hospitals being if anything overstaffed. 'Rural dispensaries have 20 percent fill rates of their nursing establishments, while district hospitals have 120 percent fill rates. Approximately 25 percent of the [Human Resources for Health] budget for the entire public sector is taken up by the two referral hospitals' (Luoma et al., 2010).

Following devolution, it has become hard to track how the allocation of spending between curative and preventative care has evolved, as county budgets and expenditure reports are not prepared on a consistent programmatic basis showing the split in spending between primary care levels (community, dispensaries and health centres) and secondary care levels (level 4 and 5 county hospitals). Although there are positive trends in terms of the overall allocations to health, as described above, it is not possible to track whether this is being mainly allocated to primary or secondary health.

That said, there is evidence that the bias towards curative health continues to exist at national level, despite the intent of the policy statements. Following devolution, the Government announced a plan to lease a range of specialised medical equipment for two hospitals in each county, at a total cost of KSh 38 billion over seven years.²¹ The stated aim was to bring specialised care within reach of the mass of the population.²² As one informant said to us, 'Most of the people in the counties, when they think of health, they think of hospitals. I was aghast when I found out that counties wanted hospitals equipped with dialysis, cancer treatment centres, etc.' (KA2).

More fundamentally, such decisions show that the national Government does not yet seem to have adapted to the logic of devolution, whereby it is the responsibility of counties to provide services and for the national Government to limit itself to a policy, financing and monitoring role. Indeed, the Council of Governors initially went to court to stop the deal on the grounds that national Government is interfering in a service that is a county mandate (*Daily Nation*, 2016). There is little justification for such direct capital purchases and the experience of other countries suggests that such in-kind transfers tend

to be plagued by several problems, which the leasing scheme demonstrates.²³ The in-kind transfers are not well allocated, with all counties receiving sets of equipment for two hospitals regardless of their population (the smallest county, Lamu has a population of 101,539; the largest, Nairobi, has a population of 3.1 million), the existing standard of hospital equipment or local medical needs.

Some counties have rejected the offer of new equipment because they lack the staff to use it or the resources to maintain it (NGO3). Equivalent funding could have been provided to counties to choose how to spend, instead of a one-size fits all in-kind grant that is not fiscally efficient and undermines local autonomy and flexibility (Shah, 2006).

Insufficient investment in Community Health

While upgrading county hospitals is one of the flagship projects of the KHSSP, it is interesting that it appears to have taken precedence over another of the Plan's strategic priorities, the countrywide scaling up of high impact community health interventions (KMoH, 2014b: 15). Community Health Volunteers (CHVs) are the lowest level of the Kenyan public health service, and are the providers with the closest proximity to communities. We heard differences of opinion about quite how central they will be to leaving no one behind (IDP1, KA2), but it seems plausible that they are among the more feasible ways of reaching some of Kenya's more remote and sparsely populated areas. In densely populated slum areas CHVs can also have a positive impact on promoting good hygiene, healthy lifestyles and appropriate health-seeking behaviour (CHWFGD1).

Community-based practitioners (of which there are many models) have been described by experts as 'the world's most promising health workforce resource for enabling health systems in resource-constrained settings to reduce the burden of disease from serious, readily preventable or treatable conditions' (Perry and Zulliger, 2012b). Renewed enthusiasm for community health programming can be found in many African, Asian and Latin American countries. The Ethiopian Health Extension Programme is arguably one of the most successful examples, and has been the basis of a number of other programmes in other African countries. It is designed to improve equitable access in health services and achieve basic health care coverage using a large cadre of salaried

21 The figure for seven years comes from the annexes to the 2016 County Allocation of Revenue Bill.

22 'In 2015, we began to deliver the promise of effective, modern, hi-tech healthcare to all Kenyans. In addition to the national, referral hospitals, we shall have two hospitals in every county equipped with facilities to screen and treat conditions that have caused patients, in the past, to travel abroad at great cost. Already we have equipped 15 hospitals and our target is to complete the remainder by June 2016 to bolster access to health services. Additionally, the Government has in place a programme for 100 fully fitted containerised clinics with particular focus being improved services to informal settlements,' the President said. *Daily Nation* (2016).

23 In South Africa, national government carried out water sector capital projects for local governments, which created as many problems as they solved. The allocation of the projects lacked transparency, and some local governments were not aware of the project allocation or its purpose, local governments were unable to operate and maintain the investment once the project had been completed, and in-kind support complicated local government oversight and planning for service delivery (Financial and Fiscal Commission, 2009).

female health extensions workers who are trained for a year to deliver 16 essential health packages. There are usually two community health extension workers (CHEWs) in each village health post supported by a large network of community volunteers (Kok et al., 2015).

Kenya has had a community health policy since the 1980s, but it has never been particularly well-financed. And although CHVs, in conjunction with development partners, have been instrumental in some areas in combating diseases such as tuberculosis (TB) and HIV/AIDS, arguably their potential remains unrealised (KA2). From 2006 the Community Health Strategy was structured around community units of approximately 5,000 population, served by up to 50 CHVs offering basic promotive and preventative services and linked to primary health facilities through two CHEWs. A review of the strategy identified important weaknesses relating to coordination, motivation and retention of CHVs, poor monitoring and evaluation mechanisms, and lack of community financing mechanisms (KMoH, 2014b). The strategy was therefore revised. In the current Strategy for Community Health (2014–2019) five CHEWs are supported by just 10 CHVs for the same population, with the CHVs working as mobilisers for health activities and in supporting referrals. In this system the CHEWs are trained for six months, whereas the previous strategy required pre-service training in nursing or public health. The experiences of the CHVs we met are described in [Box 8](#).

The strategy describes a number of ways in which the previous shortcomings could be overcome, but robust data are lacking and the new strategy is being rolled out at different speeds and levels of enthusiasm. Anecdotally, it was felt that most areas fall well short of the target. Informants in our Kibera focus group told us that the local CHEW was managing over 40 CHVs; one of the CHVs present was managing 72 households amounting to over 400 people (CHWFGD1). In other areas it could be one CHEW to 100 CHVs (NGOFGD1). Further, there is ambiguity over the status of CHVs and their incentivisation, yet this was documented as one of the main failings of the previous strategy. Available budget documents do not reveal any allocations to CHVs for their remuneration (see [Box 8](#)), and it is unlikely that county governments will prioritise such costs: ‘The problem is that MCAs [Members of County Assemblies] will never approve of paying for CHVs or other software costs’ (KGO09). Indeed, some counties appear not to recognise the role of CHVs at all.

Anecdotal evidence suggests that CHEWs also often work on a volunteer basis, as they are not paid by either local or national Government. According to one of our NGO interviewees, ‘CHVs do the bulk of the work in the community and Government uses their data, but they are forgotten or not recognised, yet they are the ones required for SDG achievement’ (NGOFGD1). The MoH has a Community Health and Development Unit,

which is supposed to monitor, support and supervise the counties. However, it works on a demand-led basis and many counties appear not to want to avail themselves of its services (KA2).

Imbalances between capital and recurrent spending

In addition to a possible misallocation of resources between curative and preventative care, there are signs that there is an imbalance between capital and recurrent spending. Hard data is difficult to come by, and the picture appears to vary by county, but some informants told us that the counties are investing heavily in staff, to the detriment of infrastructure, drugs, and equipment, while others told us the opposite. If this investment is taking place, it would seem that health expenditures need to be better planned and coordinated. In our own fieldwork we were told of new health centres that lacked staff and equipment, standing for the most part idle. Our informants in the Kibera slum district of Nairobi, for example, told us that the local health facility had acquired an ambulance, but it had no driver or paramedics, and there was no number to call (NGOFGD1). Informants differed, however, about how serious a problem this was, with some suggesting that it was understandable and acceptable for heavy capital investment to dominate the first years of devolution, with investment in staff and equipment to come later (KA1). By contrast, one FGD informant was of the opinion that MCAs prefer to spend money on infrastructure so they can take a cut of the construction costs (NGOFGD1).

Corruption

Another problem is corruption. There is a perception in many counties that corruption is rife – part of a general trend in which devolution is interpreted as delivering a wide variety of local political actors, ‘their turn to eat’ (D’Arcy and Cornell, 2016). The health service was singled out as one of the areas prone to corruption in 11 counties in a recent survey of corruption at county level. The survey suggests that average size of bribes paid at service delivery points was KSh 14,992 (a figure which seems implausible) (Ethics and Anti-Corruption Commission, 2016). By contrast, a 2014 survey found that 10% of service users had to pay bribes, with the average amount being KSh 1,883. Whatever the level, unofficial payments are likely to be a deterrent to health-seeking among those most left behind, many of whom subsist on very low incomes. Potentially even more serious is the embezzlement of funds meant for projects, and diversion of essential supplies and drugs to private facilities owned by health officials (KA1).

Slow progress on the demand side

Also on the demand side, Kenya’s progress towards UHC is moving slowly. As we have seen, significant steps have been made in rendering primary care and maternal care free at the point of delivery and providing funds to compensate

providers (although some counties have complained about late delivery of funds, including those visited for this study). There is also evidence that funds remain inadequate, with serious overcrowding at some public facilities (NGO2, CHVFGD1).²⁴

Social health insurance is expanding, but slowly. National scale-up started only in 2016 and, at the time of this research, less than 1% of the population was enrolled in the HISP (KGO1). Since devolution, the money available to central Government for subsidising health care has been in decline, with an increasing proportion of resources going to county level. Few counties to date have taken a keen interest in health insurance, and there are concerns that data used by HISP have not been very sensitive to some factors of exclusion. Minority ethnicities, for example, may not be well captured. There is, therefore, a proposal that in some areas, where poverty levels are very high, everyone should be enrolled (KGO03).

Box 8. Community health in Kibera

We held a focus group discussion with CHVs in Kibera, a poor area of Nairobi, sometimes referred to as Africa's biggest slum. They explained their work to us and commented on the local health provision landscape. Standing out from the discussion was the poor quality of public services versus the high quality of NGO-provided services. Local public facilities had long queues and lacked drugs, they said. Also, it was necessary to pay for more specialised forms of care. If you are diagnosed with cancer, 'You will just go home to die'. Consequently, local residents preferred to visit Kibera South, a facility run by AMREF. AMREF, however, would soon be withdrawing and handing the clinic over to the Government. 'Kibera South is our hope. They care, they are committed,' said one. 'We don't know how we are going to survive when government takes over Kibera South,' said another, explaining that, while NGO facilities were closely supervised, in Government facilities supervision was distant. They pleaded with us to find another donor for Kibera South. There were also containers in each village, part of an initiative to deliver health services in informal settlements. However, the containers did not appear to be properly supported. Only some were operational, and even there it was difficult to be attended to. When we suggested that they might use their Member of Parliament (MP) or MCA to help ensure that health facilities were well run, they responded that political representatives did not care about such things. Elections in Kibera were determined by a combination of ethnic voting and cash handouts, not the quality of services.

Currently, the subsidy programme is dependent on donors, which is not a sustainable solution (KGO1) as donor funding is likely to decrease rather than increase in coming years, and Kenya has already transitioned to lower middle-income status. Informants also told us that donor programmes such as PEPFAR have formed a critical element in strengthening the entire health system, and that winding them down is therefore likely to have detrimental knock-on effects (FGDNGO1, IDP1).

Unintended consequences of devolution

Coordination problems

Kenya's devolution has been of the 'big bang' variety, in which major responsibilities for health were transferred to newly created, democratically elected county governments, and this has inevitably created some problems. Some of these may be teething troubles, others may be more enduring (Lakin, 2013). With respect to the former, counties are now responsible for paying the salaries and superannuation of health workers and also overseeing their career progression; new systems have been introduced under which user fees previously retained at facility level are being remitted to county treasuries. In some counties, health staff have been paid late, in others they feel that opportunities for career progression and training have been disrupted. At the time that this research was being conducted, health workers were on strike in three counties, part of a wider trend of unprecedented industrial action in the health sector (IDP1, KA3, NGO3).

Under the new devolved structure for health, the national level was tasked with policy-making and monitoring responsibilities, and the county level with actual service provision. However, interviewees told us that the two levels are taking time to adapt to their new roles. Further, some of the systems for vaccinations and disease control have allegedly been weakened by being devolved, a trend which may be partly responsible for a long-lasting cholera epidemic (Kilonzo, 2016). Some informants doubted whether the new system was resilient enough to cope with the outbreak of a major epidemic such as Ebola (FGDNGO1, IDP1, NGO2).

Contradictory political dynamics

Devolution has created a new set of political dynamics in which a plethora of actors compete for resources at both national and local level (Cheeseman et al., 2016). Fluid though they are, these dynamics, seem likely to lead, at best, to only a partial fulfilment of leaving no one behind. The reason is that the new Constitution, while creating incentives for a more pro-poor distribution of resources among counties, does little to address disparities within them (D'Arcy and Cornell, 2016).

24 Note that the testimony reproduced in Box 8 on Community health in Kibera was corroborated within the focus group. However, we lacked the resources to triangulate this testimony with outside sources, thus it should be treated with an appropriate level of caution.

Under the new Constitution, political power at county level is divided between the Governor, who controls the executive branch of government, and a legislature – the County Assembly – made up of Members of County Assemblies (MCAs) who represent wards (KA1, KA3). Simplifying somewhat, each financial year the executive presents budget proposals to the Assembly, in which the Governor's interests are likely to weigh heavily. Governors are directly elected by simple majority in a countywide poll. According to the logic of political competition, then, the Governor is likely to want to concentrate spending on heavily populated areas with a lot of votes, especially those with a high percentage of 'swing' voters. However, in Kenya, one of the key drivers of poverty and marginalisation is remoteness, and remote areas tend to be sparsely populated. Thus, other things being equal, it is likely that marginalised areas will continue to be so (KA3).

The Assembly then has a chance to amend the budget, partly on the basis of public consultation. At this point, individual MCAs tend to lobby for more resources for their wards. This is likely to lead to some redistribution in favour of more marginalised areas. However, there is typically considerable horse-trading among MCAs at this point, with some opting for health projects, some for other types of project, and many for half-funded projects, operating on the principle that, 'Half a loaf is better than none' (KA1). There is some evidence, confirmed by our own fieldwork, to suggest that the operating principle among councillors is a norm of equity, where equity means that each MCA gets a roughly equal share of the budget (Lakin, 2016). This norm has been reinforced in some counties by the creation of Ward Development Funds, which guarantee that a certain amount of the budget will be distributed and administered at ward level (Githinji, 2016).²⁵

From a leave no one behind perspective this is likely to represent progress on the previous state of affairs. As one of our interviewees stated: 'Some places never dreamt they would see a dispensary – even if the health worker is only there once a week' (KA1). However, it is worth noting that a norm of equity, thus constituted, will not be sufficient, in many counties, for those left behind to catch up. Marginalised areas need a *disproportionate* share of resources, not an equal share. What is really required, then is a norm of *affirmative action*, something that was recognised by the Constitution when it made provisions for the Equalisation Fund, but which does not currently apply within, as opposed to between, counties.

Indeed, the issue of intra-county inequalities, which are acute not only in poor counties such as Wajir, but also in richer ones such as Nairobi, is arguably a major oversight of the new Constitution. One could even argue that the

new Constitution has created a political settlement which ensures a more equitable distribution of resources among ethnic elites, who tend to dominate county politics, but it has done little to ensure a more equitable distribution between elites and non-elites. As one veteran politician has said:

I have always suspected that the real logic for devolution was to allow ethnic elites a second chance to eat. After losing the contest at the national level for the presidency and the national government, which left a lot of elites very bitter and organizing their people to fight and resist the result of the elections, somebody must have said: 'You know what, this devolution can help us. For all these guys who don't make it at the top, let's give them a second layer of something that they can take home.' And I think to that extent it has worked (D'Arcy and Cornell, 2016: 256).

It is notable, for example, that the Constitution did little to alter Kenya's highly unequal pattern of private land and property ownership, a key driver of poverty, especially in urban areas. Moreover, devolution has created a new category of the ethnically excluded: those who are out of power at the central level and also out of power at the county level. The extent to which in years to come this category will coincide with those left behind remains to be seen, but it is a potential source of political discord that should be monitored (D'Arcy and Cornell, 2016). And although some donor programmes, such as the World Bank's THSUC, explicitly tackle intra-county marginalisation, they are insufficient by themselves to address the full scale of the problem.

It should also be noted that the politics of some counties have been highly conflictive, with tugs of war often developing between the Governor and MCAs over the nature of the Governor's projects, and the scale of MCAs' allowances and other emoluments. In some cases, this has paralysed the administration and, in others, MCAs' compliance has been bought by means of study tours and other perks, or, more crudely, straightforward bribes (KA1, KA3) (Harrod, 2014). Needless to say, these inefficiencies do not help in the effort to leave no one behind.

A word about the participatory dimensions of county budgeting is also in order. Counties are required by law to consult the public over their budgets, a process which typically takes place between the submission of budget estimates and budget approval. There is no standard format for public participation: in some cases it appears to be an open process and, in others, one involving only certain members of the community (KA1, KA3). According to one of our Kibera interviewees, 'The notice

25 We do not know whether the concentration of resources on more poor populous areas is also replicated at ward level, but it seems a reasonable assumption that might be addressed in future research.

to participate in the budget reading and discussion is placed in the office and not the community, so the community does not even know about it' (CHWFGD1). To our knowledge there have been no comprehensive surveys of the nature of this participation. However, anecdotal evidence suggests that it tends to be top-down and ritualistic, with the role of the public often reduced to commenting on a 'shopping list' of projects or thanking the county government for their efforts. Apparently in some of Kenya's rural communities, public criticism of authorities is frowned upon. This is compounded by the fact that in some cases Governors and MCAs prime or bribe opinion leaders to speak in favour of their proposals. Further, the most marginalised people are almost wholly focused on securing their own livelihoods, so unlikely to have the time to attend such meetings, which are in turn likely to be dominated by the better off (KA1, KA3).

In our own local fieldwork, for example, male focus group participants described local elders or the chief as their only link to MCAs, MPs and county authorities. Beyond this they had no interaction with officials, and would instead act collectively to overcome difficulties in their communities or seek credit with businessmen if necessary (FGD01, FGD02). They also described taking part in *barazas* (public meeting places) at which local plans were put forward, but health services were not discussed (FGD02). None of the women in our Narok and West Pokot focus groups were participating in public life, nor did we hear about any efforts to include them, despite frequently hearing about the Government commitment to active participation.

All of this evidence suggests that public participation has been a relatively ineffective tool when it comes to driving progress in terms of leaving no one behind. Box 9 below provides some insight into the demand-side problems that persist for women, who, experiencing overlapping exclusions, are truly left behind (as indicated in the data [section 3.3](#)). The *Maasai* and *Pokot* women in the communities we visited had very poor levels of education, little cash income, were inhibited by their husbands and lived far away from health services.

It is also important to mention the non-state sector. Around 40% of outpatient and 50% of inpatient services are provided by the non-state sector, with 'mission' clinics and hospitals, that are perhaps more likely to target the poor, accounting for 9% and 18% respectively (KMoH, 2014a: 17–19, 35–37). Under the new devolved structure, these diverse stakeholders are supposed to be represented in local health governance structures. However, interviewees told us that some of the new counties are failing to involve non-state actors fully, and that coordination has weakened as a result (NGOFGD1). Indeed, in some places the new health governance structure is not really operational, with links between community-level and county-level committees being particularly weak (NGOFGD1). Private providers are also significant in

Kenya. Although they are likely to target better-off people, the sector has spare capacity, and one of our interviewees argued that, with the right policies, this could be mobilised in the interests of leaving no one behind (NGO3).

Data deficits

The previous chapter discussed some positive trends in generating data on those left behind in Kenya. Nevertheless, much remains to be done.

As we saw, under the Health Management Information System/Demographic Health Survey (HMIS/DHS), health facilities now routinely collect data on the numbers of people accessing services, some of which is disaggregated by sex, remoteness and ethnicity. Unfortunately, health facility staff often lack capacity due to overwork, which means that data collection is not always accurate or complete: *'if a nurse goes for training or on leave, there is no report for that week or that month'* (KGO05). Further, data collection systems are not calibrated to capture fine-grained information about all potential categories of vulnerable and marginalised groups, *'In terms of data for now on VMGs [Vulnerable and Marginalised Groups], we don't have much yet ... The data on minorities is not really there, it is not disaggregated'* (KGO03). Consequently, policy-makers looking for information about such groups tend to rely on proxies, simply assuming that patients in areas where VMGs are concentrated are representative of those groups (KGO03). Although new health focal persons, responsible among other things for checking on reporting for minority groups, are intended to overcome some of these difficulties, the method of identification is blunt, not least because of the problems with official census data, discussed below. Electricity outages and internet connectivity problems can also impede data entry.

Another crucial problem with relying on facility level data is that next to nothing is provided about the health of populations that are not accessing facilities. Here, the system relies mainly on data collected by CHVs. Their monthly reports provide the most accurate picture of those living in remote areas with poor access to health facilities, and the data are ultimately incorporated into DHIS. Unfortunately, CHVs are very unevenly distributed, and only some of the community health units (CHUs) in the country are functioning.

In the counties we visited, community-sourced data did appear to represent an input to health planning. At the same time, the acknowledged inadequacies of the data constrained officials' ability to react appropriately to certain health challenges. Interviews with employees of an international NGO in West Pokot revealed that the uptake of data was limited because of the frequent failure of health officials to present data to MCAs in ways that facilitated engagement and discussion, leading to the figures being ignored in policy (NGO05). Health officials told us that MCAs displayed only mild interest in data: *'As a [health] department we can collect local data, we*

Box 9. Perspectives on health from a remote rural community in Narok

These insights are synthesised from one of the FGDs with mothers categorised as a poor access community.

The *Maasai* women from Enkoloriti almost never interacted with the health system, the physical environment in which they lived was harsh, water extremely scarce. Their diet was almost entirely dependent on their livestock: meat, milk and blood (one female respondent could not recollect ever having consumed any fruit or vegetables). Women talked of a reliance on themselves, 'witch doctors', 'medicine women' and traditional birth attendants for their family health care needs, and viewed them as accessible. If a child or family member was unwell the usual response from the woman was to collect herbs to prepare traditional remedies. If symptoms persist she would then visit the traditional doctor.

The focus group participants, none of whom knew their own age, but some of whom had the appearance of teenagers, all had borne between three and 12 living children. None of them had attended school or were literate. No woman had received antenatal or family planning services, nor given birth to any child in a dispensary or health centre, 'delivery is always done at home'. They trusted the (untrained) traditional midwives, and did not need to engage in any financial transaction for their services. However, they clearly stated that they would prefer to give birth at health facilities. This was not feasible as there was no means for a heavily pregnant woman to get to the health facility. Some women gave birth at home completely alone without assistance. It was a four-hour walk to the road and the nearest functioning dispensary, or a two-hour ride across rough terrain on a motorbike, *'someone can meet his or her death on the way, while walking to the dispensary'*.

Health knowledge. The only formal routine health service had been sought by some of the women was immunisation for their children – they had done this by travelling to the dispensary or during local immunisation events. Their awareness of the importance of immunisation came from radio campaigns and talking with friends. The women had heard of pills and implants for birth control from other women, but were very confused about them and were afraid that they would cause them to become sick. They felt that between two and four children was the ideal family size, and were eager to learn more about how they could avoid pregnancy. Women described how they were often pregnant within three to six months of giving birth to the previous child, and agreed that their husbands would never allow them to control this, *'We just depend on God to help us on when to give birth again.'*

Maternal and neonatal death in the community was not unusual, but the women did not think that these occurrences were notified to the administrative chief of the ward or any health personnel. The women were quite likely to ensure that new births were registered as this was a requirement for child immunisation. Two of the participants themselves had no formal identification papers. The participants were not aware of CHVs or any health professionals ever visiting their community, despite a dispensary having been built there.

The dispensary had been completed (*'several years ago'*), but it was not functional, had never provided any health services, equipment had not been provided and there was no staff. It was thought the MP had arranged for the county government to build it, but they were not aware of the MP ever having come to the community, and had no expectation that things would change.

have tools which help us to understand, for example in nutrition, we know that people are malnourished, the data are collected, the problem is they are not used' (KGO09).

Another potential source of information for policy-makers is public participation in planning meetings. For example, at the county level, the main sources of data cited in interviews to inform health policy in West Pokot and Narok were public participation forums, and not the DHIS. However, Kenya's new procedures for participation still leave much to be desired, as discussed in the section above.

Meanwhile on the 'household survey' side of Kenya's data ecosystem there are further problems. Remoteness and insecurity make it easy to miss out on some of the most marginalised, meaning that surveys routinely undercount people (Carr-Hill, 2013). Also, the types of question asked make it difficult to identify the distinct challenges faced by certain groups. For instance, no accurate figures exist on the number of people with disabilities in Kenya (Equal Rights Trust and Kenya Human Rights Commission,

2012). Neither are surveys conducted frequently enough: the DHS, for example, takes place only every five years.

An additional problem is that Kenya's devolution has increased demands for data, with a greater degree of disaggregation required. The KNBS relies heavily on the Treasury for its budget and, as with many national statistics offices, faces considerable resource constraints in terms of finances and human resources. Officials at the national level mentioned that while the KNBS has district offices funded by the national Government, those that have special needs (e.g. large, sparsely populated or remote districts) often do not receive commensurate funding. It is worth noting that interviewees commented that the President and Deputy-President have both been vocal supporters of improving data (KGO12, NGO04). However, currently their efforts are concentrated on their own offices and have yet to percolate effectively through the system (NGO06).

To help manage the shortfall in the need for and supply of data, a Research Coordination Unit (RCU) was established within the MoH in 2015. The current health policy emphasises research for policy, and guidelines have been developed on how policy should be linked to evidence. Yet the RCU does not have a specific mandate on generating data relating to those left behind (KGO04).

Considerations

Several future considerations and recommendations flow from this report, which we group under the headings of ‘More and better data’, ‘More and better targeted resources’ and ‘Measures to address intra-county inequality’.

More and better data

The 2010 Constitution created innovative financial instruments for promoting equity and narrowing the gap between marginalised and better-off regions. Those instruments are calibrated in part on data about the numbers of poor people living in particular counties. However, as we have seen, the poorest people are sometimes invisible to Kenya’s statistical agencies, thereby helping to perpetuate a situation in which some counties with large poor populations fail to receive their fair share of funds.

Inadequate or inaccurate data affects not just the distribution of the Equitable Share and Equalisation Fund, but also the distribution of subsidised health insurance. Conceivably, many Kenyans eligible for these schemes are not being enrolled because their income status is not known to, or is ignored by, the authorities. If Kenya is to make optimal progress on leaving no one behind, both in general and in terms of health, the statistical agencies need to be strengthened so they can collect accurate data about who the poor are and where they live.

Moreover, in the writing of this report, we encountered significant problems finding out what different counties were actually spending on health, and in particular on the breakdown between different types of health expenditure. As long as this data is not readily available, it is difficult to know how far spending is aligned with the goals of Vision 2030 and leave no one behind. We recommend that this data be collected accurately and publicised widely. Counties might also be monitored and ranked on their progress with respect to providing health services for those left behind.

Finally, we were told that MCAs did not make decisions on the basis of data, partly because health evidence is not presented to them and also because their financial decisions are motivated by more personal factors. This is likely to lead to inefficient use of resources, but could well improve if MCAs have their capacity to understand and use data strengthened.

More and better targeted resources

Our research has shown that although Kenya is moving in the right direction with respect to leaving no one behind, current resourcing levels, at least for health, are inadequate. We recommend that the Government redouble efforts to collect revenue and devote an increased share of its resources to the health sector. Further, we urge development partners to stay engaged with Kenya, despite its recent graduation to lower middle-income status, since millions of Kenyans continue to lack basic forms of health care. Donor spending could also be better targeted at those left behind.

We have also found evidence to suggest that the Government is not doing enough to shift the balance of health services from curative to preventative care. We recommend that the Government re-emphasise the importance of preventative and primary health care, including the community health system, and devote an increased proportion of resources to it. This will probably involve clarification on the issue of whether it is the national or county level that is responsible for hospital financing.

Several of our interviewees stressed that health is a multi-dimensional issue, affected by income poverty, infrastructure availability and education, among other things, and we urge the Kenyan Government and development partners to be mindful of this.

Measures to address intra-county inequality

Inter-class, intra-ethnic, intra-county inequality was arguably a major oversight of the new Constitution, which does little to address these issues, other than in the case of gender. We heard some evidence that political dynamics at county level are biased towards allocating resources to densely populated areas, which are often not the poorest. And although the tendency for MCAs to lobby for ward resources helped mitigate this, the operative norm of ‘equity’ is not well aligned with leave no one behind.

A number of measures can be considered. First, the electoral regulations around gubernatorial elections could be reformed, forcing the Governor to win broad-based support across the county. A modest step would be to mirror presidential election regulations; a more radical one would require a Governor to receive at least 25% of the vote in, for example, two thirds of wards.

Second, a financial instrument like the Equalisation Fund could be made to operate at county level. This would identify the most marginalised wards, and ensure that a disproportionate amount of resources was channelled there.

Third, MCAs could be consistently reminded that the Constitution urges affirmative action for marginalised groups, and that a norm of equity is unlikely to narrow the gap fast enough for no one to be left behind.

Better coordination of state and non-state providers

We have seen in this report that state and non-state actors and development partners all make a vital contribution to health. However, we have heard evidence that they are not presently being well-coordinated, a situation that has been exacerbated by devolution. Consequently, we think more effort needs to be placed on creating consensus around the new roles for national and local levels. In some cases, for example national disease control, this may involve either transferring some responsibilities back to the centre, or else creating new coordinating mechanisms to ensure

that disease outbreaks in one county do not have negative external consequences for others. In addition, counties need to be sensitised to the importance of making their new health governance structures work, and meaningfully involving the full range of health stakeholders working in the area.

More generally, we urge policy-makers working in any of the data, finance or health governance fields to be mindful of the interdependence of these areas when it comes to leaving no one behind, together with their interconnectedness to wider political structures.

4. Nepal

4.1 Overview: recent history of inclusion

The concept of leave no one behind in Nepal should be seen in the context of recent efforts to ensure fuller economic, political and social inclusion, against a long historical backdrop of exclusion and division. Since 1990, when democracy was restored, Nepal has achieved substantial progress in reducing poverty and building the foundations of a more inclusive and equal society. However, there are still significant disparities in the rates of poverty and human development outcomes between castes, ethnicities and geographic regions. The National Planning Commission (NPC) recognises that Nepal today still faces challenges:

Nepal is marred by gender, social and geographical exclusion and inequality in... human development outcomes and so needs to better target the delivery of development to the hardest-to-reach segments of society, those who have been excluded from development and those who have been overlooked. (NPC, 2015)

Although caste-based discrimination in Nepal has been illegal since the 1960s, the so-called high castes, *Brahmins* and *Chhetris*, continue to dominate politically and economically (Call and Kugel, 2012). Inequitable political representation and the exclusion of certain groups among the causes of the civil war that lasted from 1996 to 2006 (Bennett, 2005). Nepal's recent political history is pertinent to the understanding of these dynamics. Following a peace accord in 2006 the constitutional monarchy of Nepal was abolished, making way for a federal republic governed by an interim Constitution. The period since then has been characterised by political instability, short-lived governments and efforts to decentralise. Since 2006, political parties have failed to gain parliamentary majorities, resulting in a series of sometimes uncomfortable coalitions and a tendency for each new government to react against the previous government's policies, creating a profound problem for continuity of policies (INGO1, INGO2).

In 2015, after nearly a decade of negotiations, a new Constitution was promulgated. It faced criticism because for not resolving some persistent problems of marginalisation. While the Constitution provides the basis for the new federal model, in which Nepal will – eventually – be restructured into seven states, controversies over the terms of the political settlement have delayed the transition. Notably, populations from the Plain region (*Madesh/Terai*) of southern Nepal have demonstrated their discontent over

certain provisions; for example, the proposed boundaries of the new states and changes to the degree of proportional representation in Parliament, which they consider to be likely to perpetuate their marginalisation.

Definitions

Presently, there is no accepted universal definition of vulnerable and marginalised groups in Nepal, partly due to the political sensitivities and partly the difficulty of defining them in a country of 125 different social groupings within which there are 59 indigenous nationalities (*Adivasi/Janajati*) and multiple overlapping aspects of exclusion. The groups commonly recognised across policy discourse as the most disadvantaged include women and children, the poor and ultra-poor, *Dalits* (the lowest level in the caste hierarchy), some indigenous (*Janajati*) and religious groups and those with disabilities (NMoH, 2015; van Hees et al., 2014). Those at the intersection of these different forms of disadvantage are considered to be particularly vulnerable. The Nepal Federation of Indigenous Nationalities has classified *Janajati* groups into five different categories while characterising their economic and social features: endangered (10 groups), highly marginalised (12 groups) marginalised (15 groups) disadvantaged (20 groups) and advantaged (two groups), based on their population size and other socioeconomic variables (NMoH, 2016). The Muslims and *Madeshi* (a large indigenous group along the southern border), are considered among the most disadvantaged and marginalised (ibid., 2016). Whereas there was reluctance in the past to even use terms such as *Dalit* or acknowledge caste issues, these now feature prominently in the new Constitution (see [Box 10](#)), suggesting that social transformation – however gradual – is underway.

As Nepal awaits its full transition to a federal system, it is has established a multi-tiered system of 'local bodies', to which local decision-making power is partially devolved. There have been no local elections since 1997, and sub-national governance is managed through these local bodies, administered by civil servants, without elected leaders or councils. One of the primary roles of the local bodies is undertaking social and capital works such as infrastructure development (World Bank, 2014). This report refers to the important impact of the *old* structure of local bodies on leaving no one behind from health services. The principal components of the local system of governance and how these relate to issues of inclusion and participation are described in [Box 11](#).

Box 10. Inclusion in the Constitution of Nepal

The Constitution of Nepal (2015) sets out a series of rights and policies relating to inclusion, both generally and with respect to health. It declares that the Federation will protect an ‘egalitarian society based on pluralism and equality, inclusive representation and identity’ (Art. 56 (6)). It recognises a right to social justice and specifically identifies the following groups: ‘socially backward women, *Dalit*, indigenous people, indigenous nationalities, *Madeshi*, *Tharu*, minorities, persons with disabilities, marginalised communities, Muslims, backward classes, gender and sexual minorities, youths, farmers, labourers, oppressed or citizens of backward regions and indigent *Khas Arya*’ (Art. 42). These groups are guaranteed the right to employment in state structures and public service on the basis of ‘the principle of inclusion’. Women have the right to participate in all bodies of the state on the basis of the same principle and there is positive discrimination for women, as part of a ‘right to obtain special opportunity in education, health, employment and social security’ (Art. 38 (5)).

With respect to health, the Constitution states that, ‘Every citizen shall have the right to basic health services from the State, and no one shall be deprived of emergency health services’ (Art. 35 (1)) and also that, ‘every citizen shall have equal access to health services’ (Art. 35 (3)). A series of articles list the rights of specific groups relating to health; for example:

- Every woman shall have the right to safe motherhood and reproductive health (Article 38(2)).
- Every child has the right to health (Art. 39(2)).
- Special provision shall be made by law in order to provide health to (*among others*) the *Dalit* community (Art. 40(3)).
- Specific health measures are identified for indigent citizens and citizens of communities on the verge of extinction; the disabled; and victims of the civil war and armed conflicts and their families.

Source: Constitution of Nepal (2015)

4.2 Nepal's health system

Despite weaknesses in the health system, there has been considerable improvement in health outcomes during the MDG era (NMoH and WHO, 2015). Between 1990

and 2014, the infant mortality rate, the child mortality rate and TB prevalence and death rates declined dramatically. Thanks in large part to successful mass routine immunisation programmes, improved control of diarrhoeal diseases, basic nutrition interventions, increased

Box 11. Local bodies as governance mechanisms

At local level the administration is made up of a lower tier of village institutions and municipalities and an upper tier of districts. There are 75 districts, and around 217 municipalities and 3,157 villages.²⁶

District Development Committees undertake administrative functions of the district, and monitor and implement Government policy. They prepare the budget for District Council approval, supervise and audit VDCs and municipalities and should ensure equitable service delivery. DDCs are headed by a Local Development Officer – a civil servant – centrally-appointed from the Ministry of Federal Affairs and Local Development (MoFALD).

District Assemblies have a coordinating role, consisting of heads of each village council, organised through a District Coordination Committee.

Village Development Committees (VDCs): VDCs are subordinate to DDCs. Each is divided into wards (usually nine), which are the smallest units of local governance. Legally, members of the VDC should be elected; in the absence of elections there is usually a three-member committee chaired by an appointed secretary along with two nominated officials.

Municipalities have a similar role to VDCs over larger urban and peri-urban areas. Through the Local Self-governance Act 1999, they are more responsible for generating funds and ensuring service delivery than VDCs.

Councils comprise a representative of the political parties, municipal or VDC representatives, ward officials and nominated officials. They approve plans, budget, expenditure and programmes.

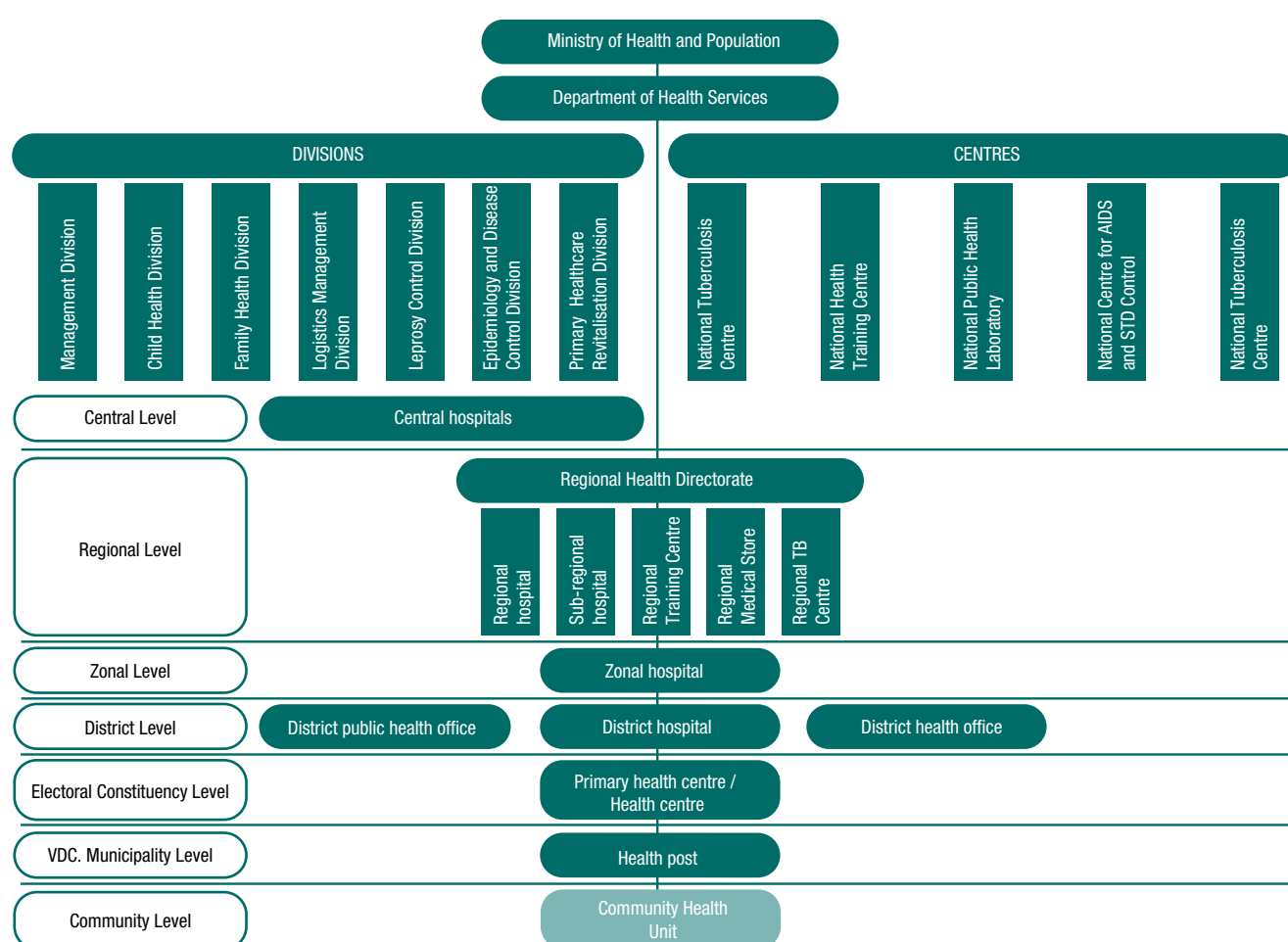
26 These figures are constantly changing, in 2014 there were just 58 municipalities, this number is increasing as more are created through the amalgamation of several VDCs. Correspondingly the number of VDCs has decreased, from more than 4,000.

breastfeeding coverage and improved TB treatment (NPC, 2015). Maternal mortality also appears to have declined impressively – based on WHO estimates – from 850 in 100,000 (1990) to 258 in 100,000 (2015) (NPC, 2015;). It should be noted, however, that these figures are contested, and census data indicates a higher estimated rate of mortality (Sharma, 2016), and other sources report a lower Maternal Mortality Rate of 190 (WHO, 2012).

Nepal's health infrastructure is weak, having been damaged during the civil war, and more recently by the earthquakes of 2015, which completely destroyed 11% of the country's public health facilities and damaged a further 19% (Health and Population Sector, 2015).²⁷ Access to health care is a problem due to the topography

and largely rural population, but Nepal has a long-standing commitment to improving equity in health service provision which is well aligned with leave no one behind aspirations and SDG3. The public health system is still centrally managed by the MoH, with a well-established primary health care system (see Figure 16). Each of Nepal's approximately 4,000 VDCs has a health post (HP),²⁸ whose staff and communities are supported by approximately 50,000 FCHVs assigned to each ward within the VDC. HPs generally serve a catchment population of approximately 10,000 people but this varies widely across Nepal's diverse topography of *Terai*, Hill and Mountain ecological zones. Nepal's development progress,²⁹ and increasing urbanisation, has seen VDCs

Figure 16. Organisational structure of the Department of Health Services



Source: Adapted from Department of Health Services dohs.gov.np/about-us/organization-structure/.

27 Some districts were significantly more affected than others. Including some which have sizeable populations that were already marginalised and which are in greater need of targeted efforts to ensure that health services are available. Facility numbers reported in this section are from the MoH 2014/15 Annual Report which may count damaged or destroyed facilities within the totals.

28 Since 2015 sub-health posts (SHPs) have been upgraded to HPs.

29 An administrative area can be declared a municipality if it meets certain criteria, including a minimum population requirement (which varies according to ecological zone) and can generate a minimum annual income.

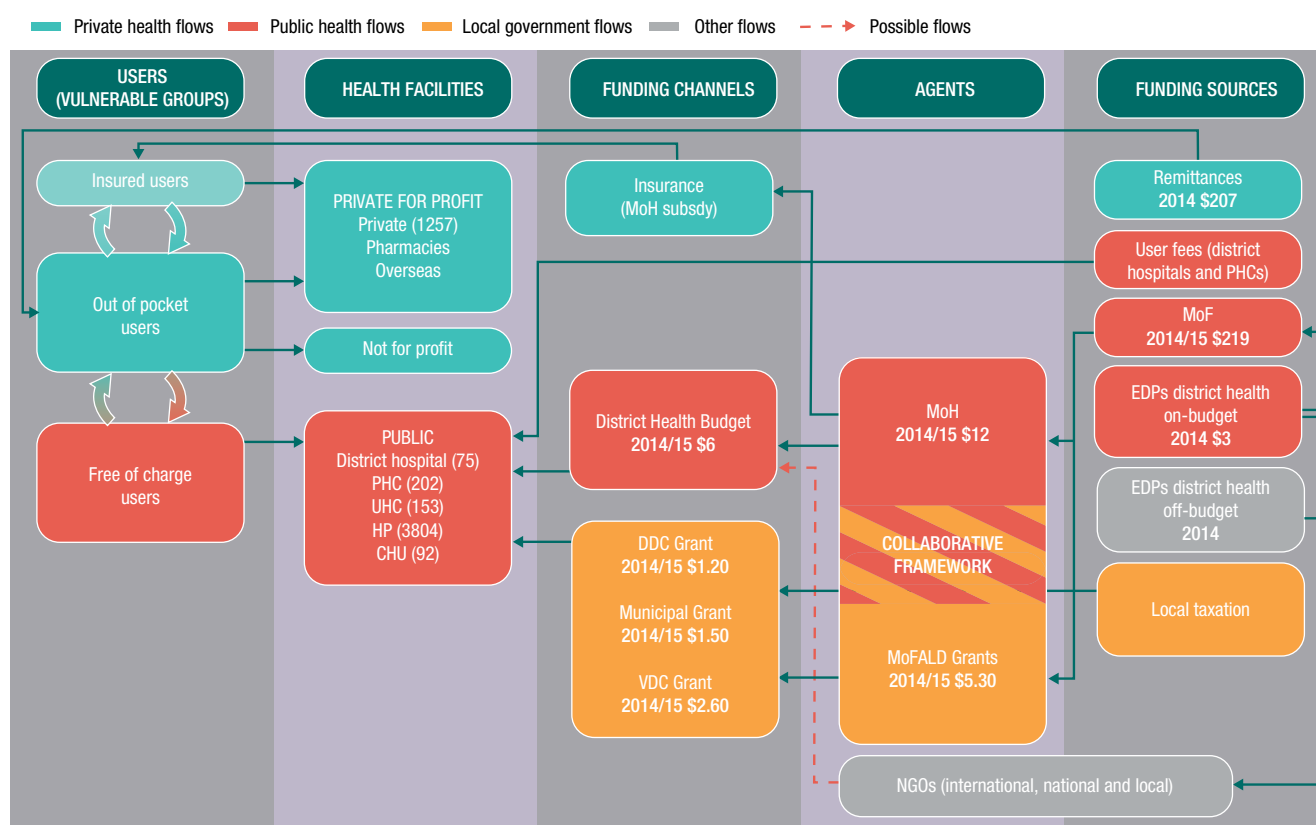
merged under Municipal Councils in which health services will increasingly be provided through primary health care centres (PHCCs). In reality, primary care services are also frequently provided in secondary and tertiary hospitals. The 2016 health strategy proposed new community health units (CHUs) to target the provision of basic health services to hard-to-reach populations which are now being established.

The main source of financing for the public health facilities is the district health budget. It is approximately \$6 per capita, and represented about 50% of the MoH budget for 2014/15 (NMoH and NHSSP, 2015). As much as half of this per capita district health budget is funded by Nepal's External Development Partners (EDPs) through on-budget support.³⁰ There are further off-budget EDP flows to public health facilities, the full extent of which is unclear.³¹ Another potential source of financing for public health facilities is from the budgets of local bodies – DDCs, Municipalities and VDCs – which are

financed through block grants from MoFALD as well as local revenues. Block grants to local bodies were \$5.3 per capita in 2014/15, and the allocations to municipalities and VDCs was more than doubled in the 2016/17 budget. A Collaborative Framework agreement between the MoH and MoFALD facilitates additional disbursement of funds to support health care provision according to priorities proposed by local bodies. Some public health facilities – hospitals and PHCCs – also charge user fees for certain services.

As depicted in Figure 17 below, marginalised or vulnerable service users may oscillate between being free-of-charge users and out-of-pocket users for a variety of reasons (some of which are discussed in subsequent sections). Since the 1990s the private sector has emerged as an increasingly important provider of health services (Mishra et al., 2015). There is an increasing reliance on out-of-pocket expenditure in poor and marginalised groups, and it accounted for an estimated 47% of total

Figure 17. Nepal's Health System from a VMG perspective



Note: Dollar amounts refer to total per capita flow in year specified, where information is available. Funding sources (e.g. \$207 for remittances and \$219 for MoF) refer to total per capita amounts available from these sources, not health allocations only. Numbers in brackets refer to number of facilities in country, where information is available.

30 Nepal's Aid Management Platform (AMP) records EDP on-budget disbursements at the district level for the 2014 annual year at \$3 per capita. The AMP does not currently distinguish in sufficient detail the percentages of these flows which are on-treasury compared with those that flow through other organisations such as NGOs in line with government systems. However, in the health sector the on-treasury health pooled fund was 59% of total EDP health funding recorded in the 2013/14 Red Book, which suggests that a significant proportion of on-budget health financing is also on-treasury.

31 The difference between on-budget support to the district level recorded in the AMP (\$3 per capita in disbursements for 2014) and total health sector ODA per the DAC Creditor Reporting System (\$6.5 per capita in disbursements for 2014) is \$3.5, which is an indication of other funds which may flow to public health facilities through off-budget channels such as NGOs.

health expenditure in 2014 (WHO GHED, 2016). Remittance flows are thought to account for a significant proportion of the financing of out-of-pocket health expenditures (Anderson et al., 2014). Health insurance pilot schemes are being rolled out – the 2016/17 budget speech proposes 2.5 billion Nepalese rupees in subsidies for 25 districts – but there is not enough evidence as yet to assess these (GIZ, 2011).

4.3 What do we know about who is being left behind?

The data ecosystem

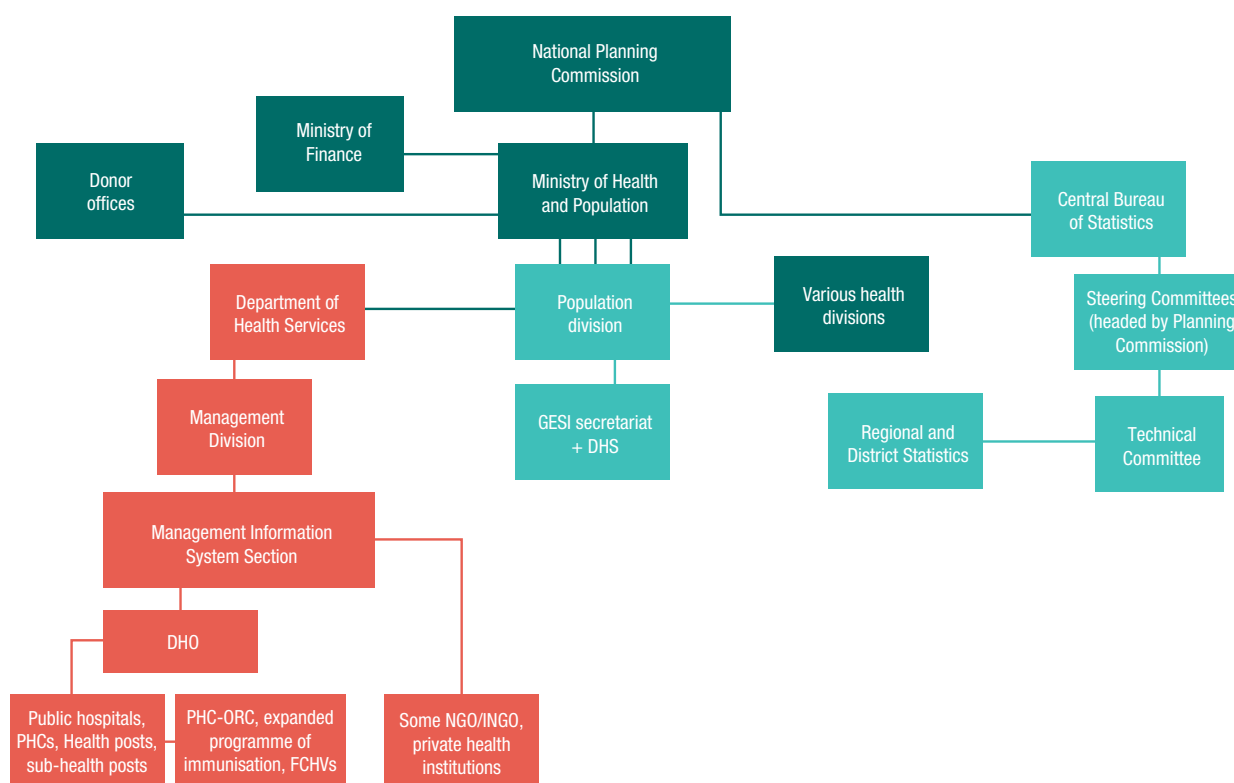
Nepal is generally recognised as having a reasonably good national statistical system, particularly relative to many other low-income countries, in terms of the Government's production and collection of timely and reliable data. The Central Bureau of Statistics (CBS), created in 1959, is the national statistical office and acts as the key node in the data ecosystem. The CBS, which has five regional offices, and statistical officers in many districts, undertakes regular

censuses and surveys, and leads on creating sampling frames for national household surveys. National statistics for health are coordinated through the MoH and CBS.

Figure 18 provides a visual representation of the public health data ecosystem, that shows how information is collected at the local level (village and district) and then aggregated and reported upwards to the MoH, before being reported on to the NPC and Ministry of Finance.

Administrative data – Health Management Information System (HMIS): In Nepal, the HMIS, one of 11 separate health-related information systems, is coordinated by the Management Information System (MIS) Unit within the DHS Management Division in the MoH (HEART, 2013). Data covering more than 200 indicators should be collected by staff at the facility level and by the Female Community Health Volunteers (FCHVs) on a daily/weekly basis through over 30 registers of questions. Health facility in-charges then meet together with the staff of a District Health Office (DHO) for monthly discussions in *ilakas* (clusters of 4–5 villages) and data is reviewed (NPGO1 and FCHV1). Some districts have started a transition to the DHIS 2 systems in which data are transferred

Figure 18. Nepal's health data ecosystem



Note: blue relates to the production of administrative data; green relates to the production of household survey data; orange are involved overall either in funding (Ministry of Finance, donors) or in supporting and shaping the data ecosystem (NPC, donors), or as data users (various health divisions). Source: Authors' elaboration based on Development Gateway (2014) and HEART (2013).

32 DHIS 2 (District Health Information System 2) is an open source software platform recommended by the WHO for GPS-supported electronic health information management systems and is being currently used in many low- and middle-income countries. For additional details, see our discussion on health management systems used in Kenya which was an early adopter of DHIS 2 platform.

from paper records to the digital system.³² Most of the HMIS data pertain to public services delivered through Government-run HPs, PHCCs and hospitals, although some limited private provider data is also fed in at district level (NPGO2). Disaggregation has been improved through incremental reforms to the HMIS. In particular, during the previous health programme (2010–2015) health care access data was disaggregated in records by six social groups (*Dalit, Janajati, Madhesi, Muslim, Brahmin/Chhetri* and ‘other’).

Household surveys are undertaken regularly in Nepal to provide nationally representative data on a wide range of indicators. The three main surveys are the Nepal Living Standards Survey, MICS and the DHS. The MICS and DHS are conducted every five years, two to three years apart from each other, so that data that can be compared across both surveys are available every couple of years to allow for regular tracking of progress. Questionnaires are often based on internationally agreed and comparable templates, but finalised in consultation with relevant ministries and stakeholders. These data are captured at the national level and disaggregated at most to the larger sub-national units (clusters of districts into ‘eco-development zones’), not to the district level.

4.4 Who is being left behind in health care?

As with Kenya, we identify cohorts in Nepal that appear to be marginalised in terms of access to health services, using the Nepal MICS 2014 data. The access to the health component of this survey instrument, developed by UNICEF, matches the DHS surveys. We preferred MICS 2014 data as it was more recent than the latest available Nepal-DHS (2011) data.³³ The advantage of using this database is that allows us to focus on (a) health policies and not outcomes; (b) multiple determinants of health; and (c) assess multiple dimensions of exclusion – both in isolation and in conjunction with each other. In doing so, it expands our understanding of the complex connections driving health care exclusion, while building on the strength of narrower assessments of existing approaches discussed above.

As described in the previous section, the MICS survey aggregates the metrics for access to health facilities into 15 ‘eco-development zones’. Since this clustering of districts is based on areas with reasonably shared broad developmental and spatial characteristics, we assume some degree of similarity (i.e. districts within each cluster tending, on average, to be more similar to each other than to those in other clusters). The lack of district-level data

Table 1. Mean CCI in each eco-development zone

Ecozone	Revenue (USD)	Total population	Revenue pc	Health budget pc	CCI
Eastern Mountain	3,213,892	390,475	8.23	13.56	64.5%
Eastern Hill	11,016,076	1,605,272	6.86	10.23	58.5%
Eastern Terai	342,144,739	4,014,903	85.22	3.77	70.9%
Central Mountain	33,597,506	519,825	64.63	9.81	71.9%
Central Hill	1,877,037,787	4,703,610	399.06	4.42	68.2%
Central Terai	1,328,636,643	5,001,543	265.65	3.78	67.6%
Western Mountain	449,564	19,024	23.63	94.33	66.3%
Western Hill	68,787,591	2,818,933	24.40	8.94	64.2%
Western Terai	361,810,104	2,232,892	162.04	3.52	70.8%
Mid Western Mountain	2,079,547	408,583	5.09	23.96	55.8%
Mid Western Hill	8,316,980	1,756,697	4.73	7.02	60.1%
Mid Western Terai	68,724,577	1,568,264	43.82	5.48	65.0%
Far Western Mountain	926,853	345,365	2.68	11.18	61.4%
Far Western Hill	4,189,745	1,018,645	4.11	10.51	58.7%
Far Western Terai	42,486,750	1,319,342	32.20	3.87	66.9%

Source: Authors’ computations using Nepal MICS 2014 database and NMoH and NHSSP (2015); Red Books.

³³ Nepal-DHS 2016 survey is in progress at the time of writing.

makes it impossible to assess how representative the eco-development zones are for various different indicators.

Again, we measure health access through the CCI of RMNCH service delivery, summarised in Table 1.

Nepal has an overall CCI index of 63.6%, which places it in the bottom half of the 70 countries for which WHO has comparable data, and below India, Pakistan and Bangladesh (GHO, n.d.).³⁴ This contrasts with health indicators such as life expectancy where Nepal with 69.6 years leads both India (68 years) and Pakistan (66.2 years). But the CCI ranking reflects similar trends with other broader life indicators such as the Human Development Index (HDI). Nepal, at 0.548 (on a 0–1 scale), trails both India (0.609) and Bangladesh (0.570), and is just marginally ahead of Pakistan (0.538). The data are based on Human Development Index for 2014 (UNDP, n.d.).

As well as poor overall levels of access to health services, we found evidence of three key drivers of disparity, among some known dimensions of determining access to basic services:

1. **Income:** households in the bottom 40% of the wealth distribution in the country have worse coverage than the top 60%.
2. **Geographic location:** households in rural areas have much worse coverage in almost all parts of the country.

Separately, clusters in the Terai region across the different development zones have higher coverage, and clusters in the Central region also appear to have higher coverage levels.

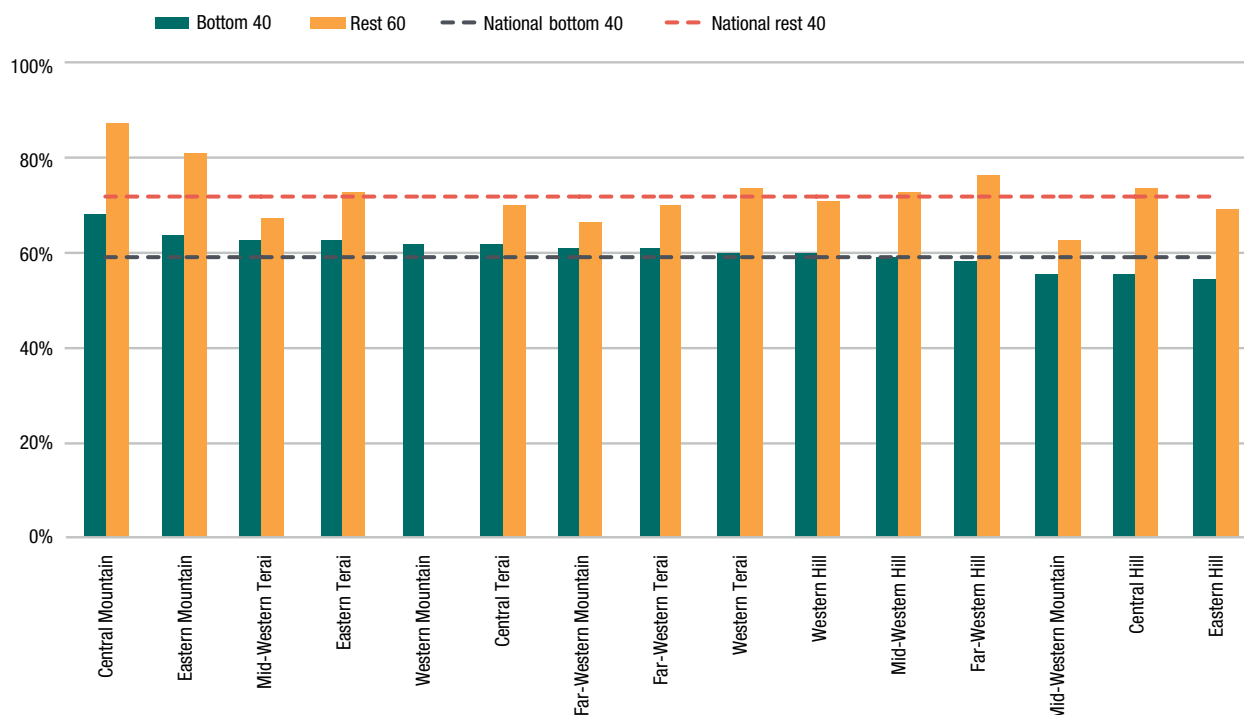
3. **Ethnic minorities:** the *Chhetris* and the *Brahmins* are the two largest ethnic groups in the country. They, along with certain other upper caste categories that enjoy similar socioeconomic status in the society, enjoy better coverage of services than the remaining groups (consolidated as ethnic minority).

First, we analyse these factors in isolation, and then in the final part of the analysis in this section, we analyse them in combination with each other.

Income inequality has consistently been a major driver of disparity in access to health services worldwide. The same pattern is also evident in Nepal. At a national level, CCI of the poor (bottom 40% of the wealth distribution) is 12 percentage points lower than that of the remaining 60% of the population. Disaggregating into district clusters, the wealthier households on average have greater access than those in the bottom 40% in each cluster.

There is, however, greater variability in the level of health access in the wealthier sections of the clusters – ranging from about 86% in Central Mountain cluster to about 59% in the Mid-Western Mountain region – a 27

Figure 19. Health access (average CCI) by income quintiles



Source: Authors' computations using Nepal MICS 2014 database.

34 The median score across all 70 countries is 70.2%. Nepal is the median country when ranked by CCI scores among only low-income countries (median value is 63.2%).

percentage point difference. In contrast, those in bottom 40% of each cluster have much less variance in their coverage; they range from 67% to 52% – a more modest 15 percentage point variation. We cannot, however, detect any relationship between geographic location of the cluster and the size of the income-based health access gap within the cluster (i.e. the gaps do not get systematically smaller or larger tracking geographically from the east to the west in Figure 19 above).

In contrast, the **geographic location of households (whether urban or rural)** remains a significant determinant of access to RMNCH services. Conforming with global trends, urban localities appear to offer better access to health facilities (Figure 19) in Nepal, too. The difference between urban and rural CCI is more than 10 percentage points in every cluster except for the Far-Western *Terai* region. This region, incidentally, does not have any major cities, but has smaller towns along the Nepal–India border, which could possibly explain the absence of improved health facilities in the non-rural areas there. Also, across the country, even the worst health access in urban localities is as good as, or better than, the best health access in any rural cluster. The location-driven disparity is therefore very distinct.

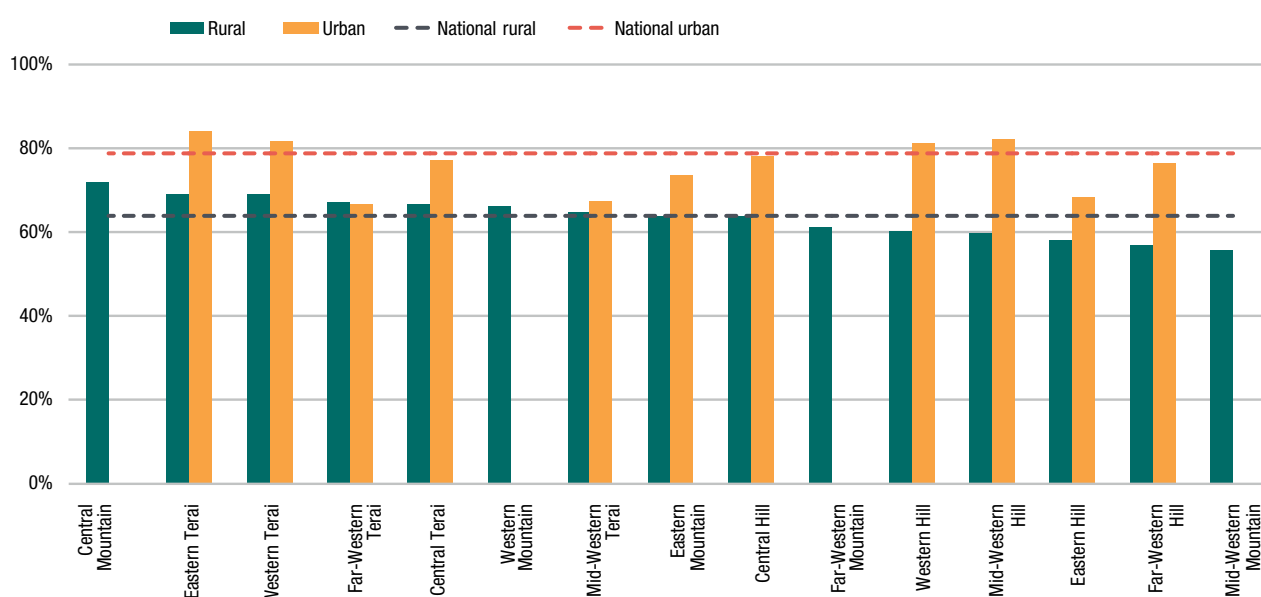
In addition, clusters in the *Terai* region across eco-development zones have higher health service coverage. The five *Terai* clusters all have higher than average aggregate CCI. This could be a reflection of the fact that the flat geographic terrain is more helpful for providing health facilities and year-round access to them. Access to

cross-border health facilities in these border districts might also be a factor in complementing health needs when these are not met through national facilities – and could lead to better health access assessments for households in these locations.

Similarly, the three eco-development zones in the Central zone are among the top five in the ranking of CCI. Kathmandu and its suburbs would account for the high access levels in Central Hill zone. The presence of arterial highways along the most important trade routes to both China and India through the Central zones could explain the higher standard of living, health facilities and health care coverage for these zones. Our data analysis unfortunately does not allow us to conclusively prove the cause of these patterns of health coverage, but the *prima facie* evidence is compelling.

As discussed in the analysis for Kenya, **minorities – based on ethnicity, religion, social class or disability** – tend to be marginalised from services in many countries, rich and poor. In Nepal, castes and classes within the Hindu community are the dominant determinants of (non-financial) social status. The *Chhetri* are the biggest ethnic group in the national population (16%) followed by the *Brahmins* (about 12%).³⁵ These two groups also comprise the top two tiers of the Hindu caste system. Hence we classify them as non-minority groups. The Census Bureau of Nepal designates some additional ethnic groups as non-minority despite their relatively small proportion of the national population.³⁶ These clans that are comparable socioeconomically to the *Brahmin* and *Chhetri* clans

Figure 20. Health access (average CCI) by rural/urban location



Source: Authors' computations using Nepal MICS 2014 database.

³⁵ The *Chhetri* are historically the warrior clan; the royal family in Nepal trace their lineage to the same ethnic group.

³⁶ These categories are regarded as 'pure' castes within the Hindu caste system, along with the *Chhetri* and *Brahmin*.

include *Rajput*, *Kayastha*, *Thakuri*, *Sanyasi* and *Dev*, and are hence included in the non-minority classification.

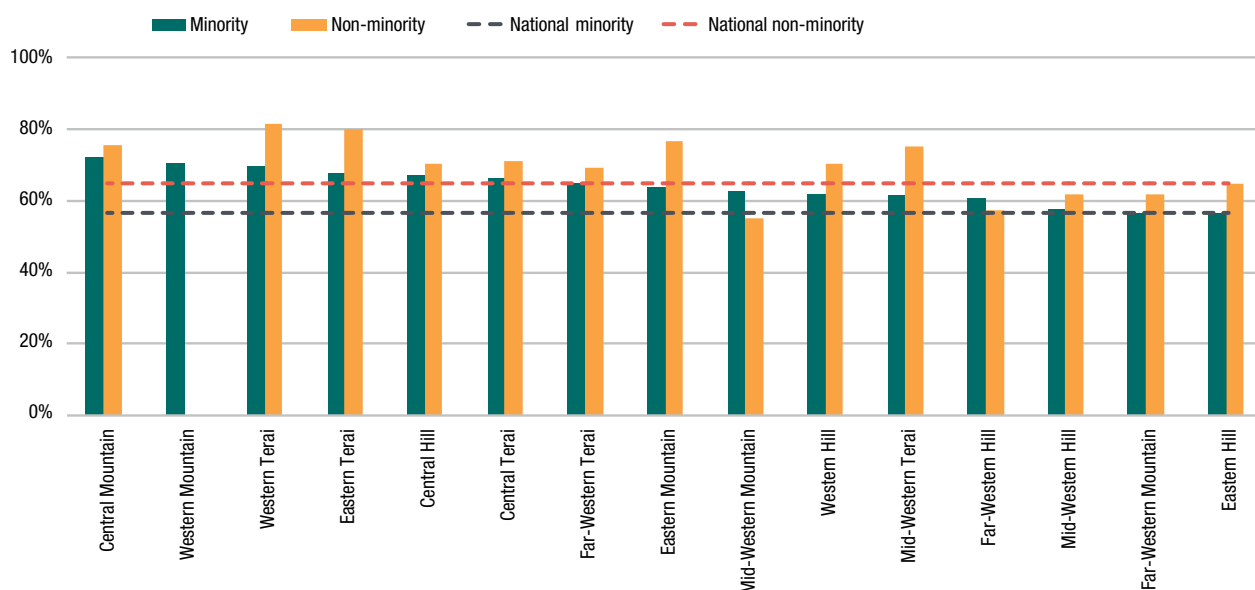
Using this classification criterion, we find that the minority communities in the clusters tend to be marginalised in all clusters except for the Mid-Western Mountain region. The extent of exclusion is most pronounced in the *Terai* regions (Figure 21).³⁷

As has been the norm internationally, the extent of exclusion is exacerbated for population cohorts that suffer

from multiple drivers of exclusion. In this instance, those who are ethnic minorities and also living in rural locations have a slightly higher degree of marginalisation than if they were just ethnic minorities (comparing Figure 21 to Figure 22).

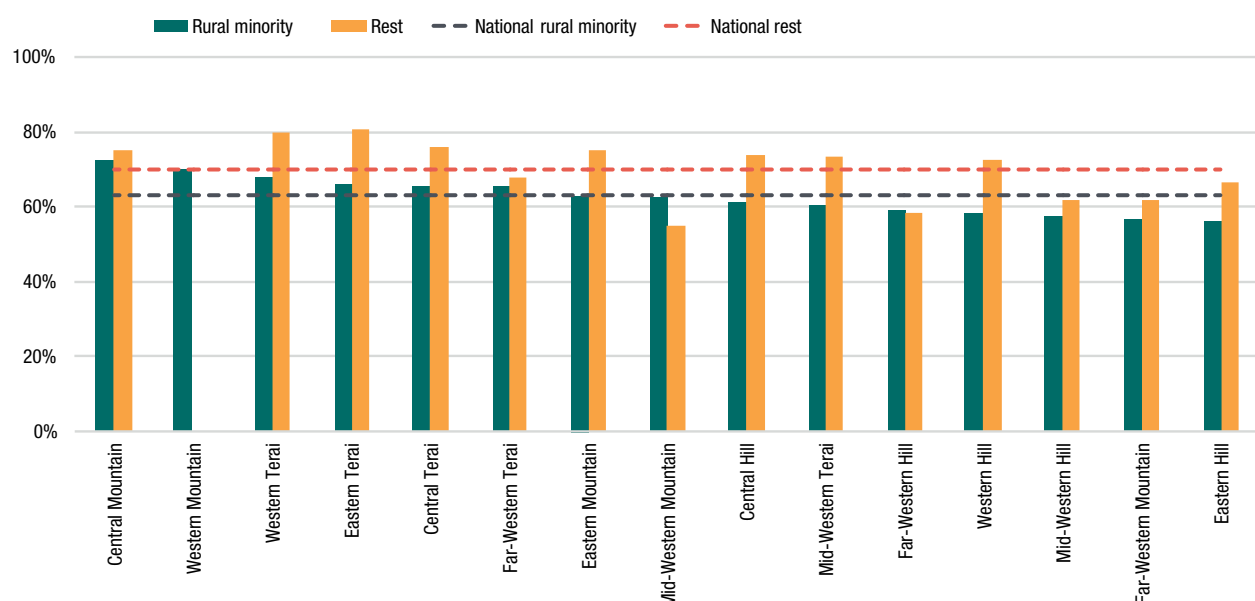
The extent of additional marginalisation is even more stark when comparing ethnic minorities who are poor, or ethnic minorities who are much less educated (primary education or lower), than if they were just poor or less

Figure 21. Health access (average CCI) by majority/minority: caste and ethnic groups



Source: Authors' computations using Nepal MICS 2014 database.

Figure 22. Health access for ethnic minorities in rural areas versus the rest, average CCI in district clusters



Source: Authors' computations using Nepal MICS 2014 database.

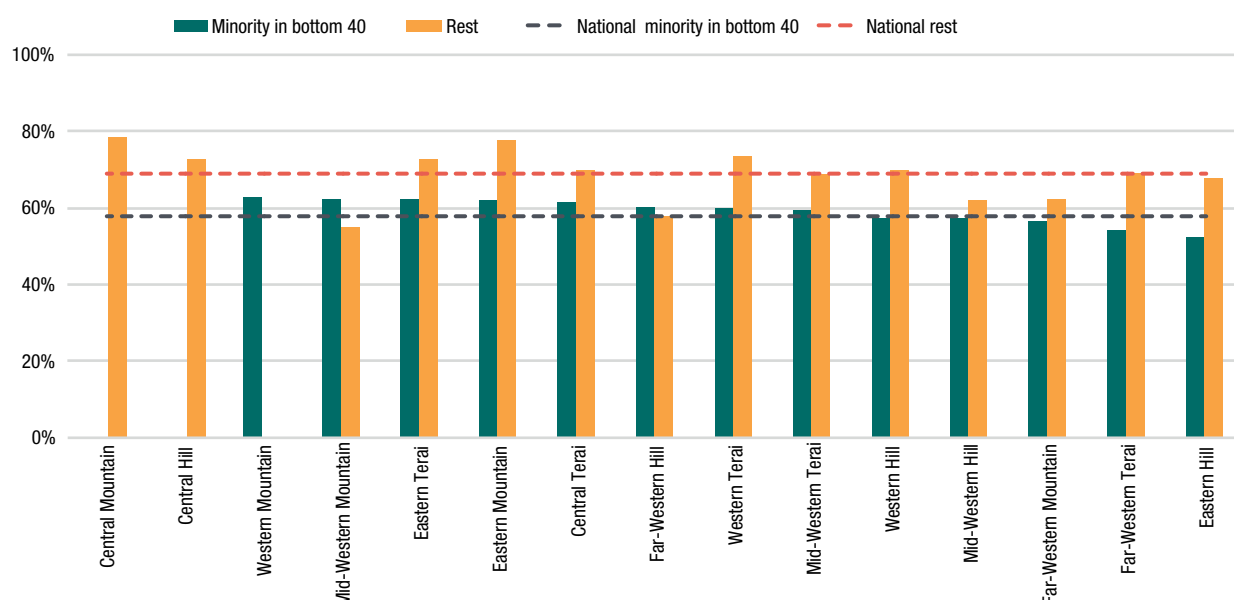
37 There was a lack of household respondents that matched our criteria for non-minorities in the Western Mountain zone, hence there are no corresponding levels of CCI for this group in Figures 21 and 22.

educated (Figures 22 and 23). For illustration, the level of CCI of rural households was 69.6%, whereas marginalised rural minority was 67.8% – the incremental decline in CCI (and increase in gap with non-marginalised) arising from the confluence of additional dimensions of exclusion. We see the same pattern across different clusters, as well across different combinations of dimensions of exclusion from health service coverage.

Note: There is some heterogeneity within eco-development zones, as illustrated by the maps of HDI scores below (Figure 24).³⁸ At one extreme is Central Terai where district-level HDI scores vary between Chitawan (scoring 0.551; dark blue – highest band) and at the other extreme Rautahat (scoring just 0.386; very light blue – lowest

band). The extent of variation between districts is less in other eco-development zones, as the following two figures indicate. Since health indicators are only one of three components of HDI using a single metric of life expectancy to indicate health condition, the HDI is related to this, but captures a very limited element of measuring access to health services. The patterns of HDI are thus suggestive, but not conclusive, of some variation of health access between districts. When differences among the eco-development zones were explored based on wealth quintile or socio-ethnic group through a simple binary disaggregation, some were of limited use, given the presence of fewer than 10 observations for some indicators.

Figure 23. Health access for ethnic minorities in the bottom 40 percentile by wealth versus the rest, average CCI in district clusters



Source: Authors' computations using Nepal MICS 2014 database.

Note: There is no data available for minorities in the bottom 40 percentile by wealth in the Central Mountain and Central Hill zones.

³⁸ HDI: the summary measure of average achievement in key dimensions of human development: life expectancy, education and standard of living.

The map displays the Human Development Index (HDI) values for each district in Nepal, categorized by eco-development zones. The zones are defined by thick black lines and labeled as follows:

- Far Western Mountains:** 0.386
- Far Western Hills:** 0.409
- Mid Western Mountains:** 0.392
- Western Mountains:** 0.529
- Central Mountains:** 0.458
- Eastern Mountains:** 0.496
- Far Western Tarai:** 0.466
- Mid Western Tarai:** 0.476
- Central Tarai:** 0.443
- Eastern Tarai:** 0.485

HDI values by district:

- Far Western Hills:** Bajhang (0.365), Bajura (0.364), Darchula (0.436), Humla (0.376), Mugu (0.397), Baitadi (0.416), Doti (0.407), Achham (0.378), Kailali (0.460), Kanchanpur (0.475), Dadeldhura (0.442), Jajarkot (0.393), Dailekh (0.422), Surkhet (0.476), Bardiya (0.466), Salyan (0.441), Rolpa (0.395), Rukum (0.431), Myagdi (0.490), Parbat (0.516), Syangja (0.527), Palpa (0.500), Rupandehi (0.498), Kapilbastu (0.432), Dang (0.485), Banke (0.475), Pyuthan (0.413), Arghakhanchi (0.482), Nawalparasi (0.493), Chitawan (0.551), Makawanpur (0.497), Kavrepalanchok (0.520), Nuwakot (0.466), Rasuwa (0.461), Gorkha (0.481), Dhading (0.461), Sindhupalchok (0.455), Dolakha (0.459), Solukhumbu (0.502), Sangkhuvagsabha (0.488), Taplejung (0.494), Panchthar (0.498), Terathum (0.527), Bhojpur (0.479), Dhankuta (0.517), Ilam (0.526), Jhapa (0.518), Morang (0.513), Sansari (0.496), Saptari (0.437), Siraha (0.408), Mahottari (0.388), Rautahat (0.386), Sariahi (0.402), Dhanusha (0.431), Sindhuli (0.440), Udayapur (0.475), Panchkula (0.437), Eastern Tarai (0.485), Central Hills (0.571), Central Tarai (0.443), Western Tarai (0.480), Mid Western Tarai (0.476), Mid Western Hills (0.430), Far Western Tarai (0.466), Far Western Hills (0.409), Far Western Mountains (0.386), Mid Western Mountains (0.392), Western Mountains (0.529), Central Mountains (0.458), Eastern Mountains (0.496).

Leaving no one behind in the health sector 55

4.5 Leaving no one behind: drivers of progress

Looking across the different dimensions examined in this study, our findings suggest that there are several important enabling factors already in place that will help to ensure that Nepali people benefit more equitably from improved access to health care. This section elaborates these positive drivers of progress.

Progressive policy commitments

Health policy and planning

The political settlement in Nepal is still in flux,³⁹ but overall there has been a history of pro-poor health policy since the 1990s. Successive recent governments have competed to expand access to services in response to the belief that poor services contributed to the alienation from the state which underlay support for the Maoist insurgency (Jones, 2012). Political commitment to achieving universal and equitable health coverage is articulated in the Constitution and a number of other policies. The past 30 years have seen a firm commitment from Nepal to the tenet that primary health care is the key to 'health for all'. and the Constitution pledges to 'ensure easy, convenient and equal access of all to quality health services'.

Nepal's success in improving health outcomes during the MDG era has been underpinned by a long-standing and consistent policy commitment to improve public health in remote areas where outcomes have been poorest. In 1991, the National Health Policy instituted major reforms to enable the delivery of health services to rural areas through the primary health care system. It was updated in 2014 when a new National Health Policy was launched, with a stated commitment to UHC and equity.

Since the 1990s, the National Health Policies have been supported by plans, strategies and programmes that have focused on trying to tackle the social determinants of health and improving access to services. The health sector plans outline five-year strategic priorities. Notably, the Second Long Term Health Plan (1997), followed by the first and second Nepal Health Sector Programme (2004 and 2010, respectively) and the new National Health Sector Strategy (NHSS) (2015–2020) are all aligned with the aspiration to leave no one behind, with an emphasis on equity and improving health access for poor and vulnerable groups.

Equitable access is the first of four pillars of the new NHSS.⁴⁰ The NHSS Results Framework (see Annex 3) sets an outline to review disaggregated analysis and indicators by different aspects of exclusion. It builds on the focus towards UHC and equity and is discussed in a Joint Annual Review between the Government and development partners.

External Development Partners have had an important role in supporting the evolution of more inclusive health policies.⁴¹ They agreed on the need to work inclusively in Nepal and in 2003, during the conflict, 10 donors formulated a set of Basic Operating Guidelines which recognised the importance of inclusion (Druzca, 2016). EDPs' support to the Government also led to opposition accusations of complicity in exclusion and the pursuit of a colonialist agenda, although there has been a positive shift in perceptions in recent years (Call and Kugel, 2012). Our interviews suggest that EDPs are now more narrowly focused on progressive and participatory initiatives that try to address the problems around exclusion in the health sector, rather than the politics of inclusion associated with federalism. Nepal's health sector was one of the front-runners of the aid effectiveness movement, establishing a Sector-Wide Approach and Pool Fund to combine Government and donor resources over a decade ago, and an International Health Partnership Country Compact.⁴² There are long-standing forums in place at national level to facilitate coordination, dialogue and mutual accountability between the Government of Nepal (GoN) and donors in the health sector. At district level, there are quarterly meetings between DHOs, EDPs and other local stakeholders, which are reportedly well-attended (NPGO2). It was widely acknowledged by our interviewees that the various joint review and planning processes are important (NPGO2, NPGO3, IDP1, IDP2). Several EDPs also noted that they are relatively well-coordinated among themselves, compared to their experiences in other countries, through mechanisms such as the fortnightly EDP forum and annual meetings, and the provision of long-term embedded technical assistance to the MoH (IDP1, IDP2).

This is when the partners become important, vital: every year in the family health division we have a planning meeting with all the partners, to see what worked last year and what has not, so at least we can see who is doing what, where, and we don't duplicate. It helps

39 The definition of political settlement followed here is 'the expression of a common understanding, usually forged between elites, about how power is organised and exercised' (DFID, 2010).

40 It was approved in 2015 but implementation of the strategy has been delayed following the earthquake. The four pillars are: equitable access to health services; quality health services; health systems reform; multi-sectoral approach. At the time of writing, the Implementation Plan and Financing Strategy have yet to be finalised and the existing Nepal Health Sector Programme II (NHSP2) was extended for a year.

41 In Nepal, official donors are referred to as External Development Partners, which is the terminology we have used here. However, for the interview coding we have used IDP (International Development Partner) for consistency with the coding for the Kenya section.

42 Although not all major donors use the Pool Fund, donor support to health in Nepal is relatively well-aligned with Government policies, programmes and systems, and so in this respect can be considered as contributing to a pro-poor, inclusive agenda.

the planning; you know what went well and where others will go and where the government is needed. It is critical. It gives you a good rationale to defend in front of the MoF (interview with INGO2).

It should be noted, however, that some GoN officials interviewed expressed the view that donor coordination had substantial room for further improvement (interviews with NPGO4, NPGO5).

Programming

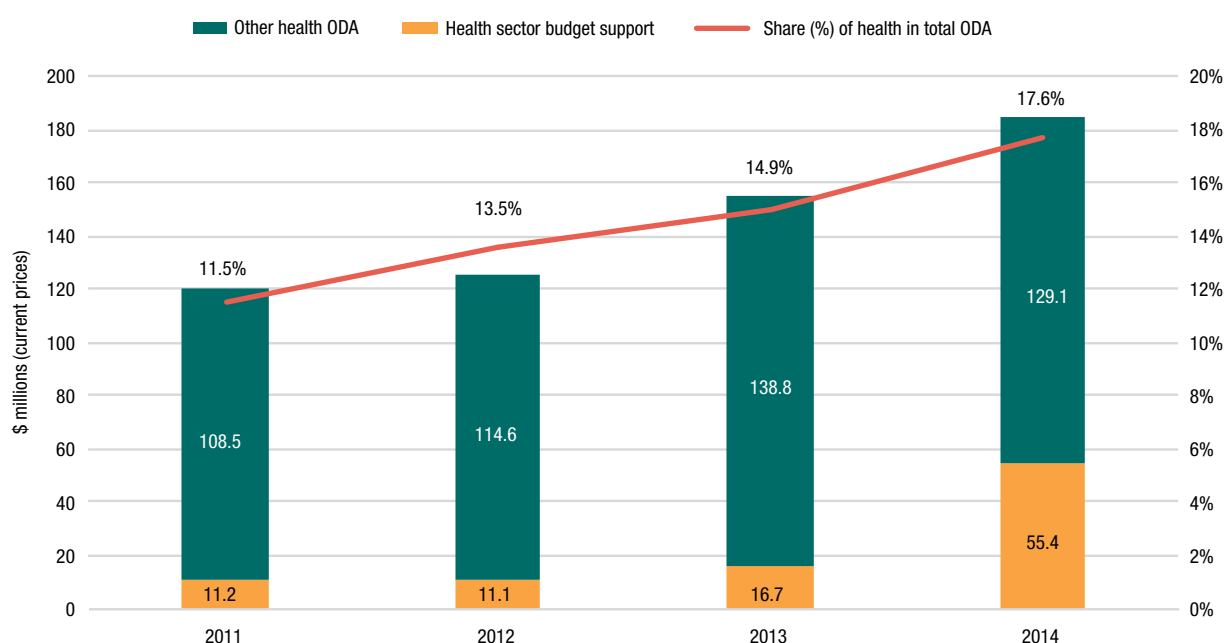
In order to remove financial barriers and improve access to delivery services, the Government of Nepal introduced financial incentives for pregnant women and health workers through the Safe Delivery Incentive Programme in 2005 and removed user fees for all types of delivery in public health facilities nationwide in 2009. These two initiatives are combined in the *Aama* programme. The programme explicitly targets those least likely to give birth in a health facility by providing incentives for women on a sliding scale according to the accessibility of region in which they live (Mountain, Hill or *Terai* districts).

The national Free Health Care Programme was introduced in 2006, targeting economically and socially marginalised individuals, and specific ethnic groups and geographical areas. It started with free emergency and inpatient services at district hospitals and primary health

care centres (PHCCs) for ultra-poor, poor, destitute, elderly, those living with disabilities and FCHVs. It was followed by the Extended Essential Free Health care from 2008, covering all users at all HPs and sub-health posts (SHPs), and later extended to essential health care services at all district-level facilities. Most recently, the Vulnerable Community Development Plan (2016) has been established to ensure that principles, guidelines and procedures relating to indigenous peoples and other marginalised groups are integrated and implemented in health sector practice. It includes a plan for consultation and participation, monitoring, institutional arrangements for implementation and capacity building.

Finally, for some years, the GoN has been moving towards introduction of national health insurance through the National Social Health Security Programme, for services beyond the free package of basic health care services. As stated in the 2016/17 Budget Speech: ‘I have made arrangement for phase wise implementation of “**National Health Insurance Plan**” with a view to perpetually ending of the situation where a citizen gets deprived of medical treatment merely because of poverty’ (Hon. Minister Paudel, 2016).⁴³ There will be a subsidy component to target poor and vulnerable individuals, to be linked to the roll-out of ‘poor identification cards’ by MoFALD. The major EDPs and the WHO have been working closely with the Government to develop financial

Figure 25. Official Development Assistance to the Health Sector,⁴⁴ 2011–2014



Source: OECD-DAC (2016) ‘Creditor Reporting System’. Paris: Organisation for Economic Co-operation and Development (stats.oecd.org/Index.aspx?DataSetCode=CRS1).

⁴³ Stated by the Honourable Finance Minister, Mr. Bishnu Prasad Paudel, Budget Speech of Fiscal Year 2016.

⁴⁴ Calculations based on OECD-DAC CRS codes ‘120: Health’ and ‘130: Population and Reproductive Health’.

and implementation mechanisms and respond to evidence gaps. Pilots began in 2015, but the poor subsidy element has not yet been piloted due to a delay in rolling out the MoFALD identity card scheme (IDP1).

These programmes have proved successful in terms of channelling external finance into the health sector, and increasingly through Government systems. As shown in Figure 26, total official development assistance (ODA) to the health sector has grown steadily since 2011, reaching \$184.6 million or \$6.5 per capita in 2014 (OECD-DAC, 2016).⁴⁵ The share of health in total ODA to Nepal has also increased steadily since 2011. Indeed, health has overtaken education as the sector receiving the highest amount of donor support in Nepal (NMoF, 2015).

The SDGs coincide with the new era of inclusion represented by the Constitution, but which started with the 2006 Peace Accord. The recent movements towards federalism are deeply bound up with inclusion and with the demands for fairer political representation by marginalised groups such as the *Dalit* and *Madeshi*.⁴⁶ Combined, these indicate potential for truly progressive agendas to continue.

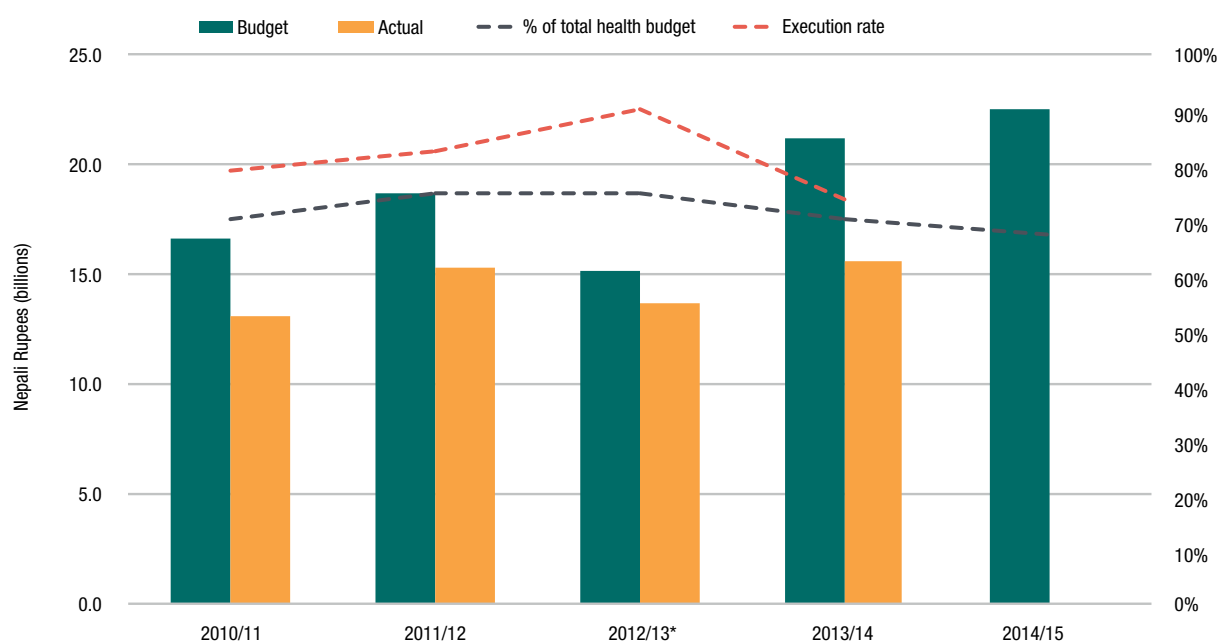
In keeping with this post-conflict focus on universality and inclusion, institutions in Nepal were involved early on with the SDGs, using them as a mechanism for reviewing

policy-making and the impact on the excluded. Nepal's NPC has taken on the responsibility of leading the SDG implementation strategy in cooperation with line ministries, EDPs and other stakeholders. Even before the 2030 Agenda for Sustainable Development was endorsed in September 2015, the NPC (supported by UNDP) published a preliminary report outlining draft SDG indicators (NPC, 2015). The report sets out Nepal specific SDG indicators and refers to the goal of leaving no one behind from health care.

Pro-poor and credible health budget

Firm policy commitment has been backed up by sustained and coordinated financial resources, which have been targeted towards the primary health care system and flagship pro-poor health programmes. Despite some budget issues the predominant feature of Nepal's health budget from a leave no one behind perspective is the credible execution rate of the sizeable component that is pro-poor (primary health care). This is largely because pro-poor health spending is generally not capital intensive. Nepal has put in place a robust cash management system,⁴⁷ along with a flexible human resource management system,⁴⁸ for the execution of recurrent budgets. This ensures the timely

Figure 26. MoH Essential Health Care Services (EHCS) budget and execution – 2010/11–2014/15



Source: NMoH and NHSSP (2015). *In 2012/13 Nepal failed to pass a budget.

⁴⁵ This was mostly driven by a large increase in bilateral assistance from the UK from \$22.7 million to \$66.1 million.

⁴⁶ More detailed coverage of the issues of inclusion and the concerns of the *Madeshi* movement can be found in Jha (2015).

⁴⁷ Nepal's Financial Comptroller General Office (FCGO) operates a Treasury Single Account (TSA) with a District Treasury Comptroller Office (DTCO) in each district.

⁴⁸ Health sector policies encourage the posting of trained health workers to their home districts, and vacancies may be filled on a contract basis with local contractors.

payment of the salaries of health workers and monitors the operating costs of health facilities, for the stable provision of essential health care services (EHCS) at the local level.

During the period of the previous health plan (NHSP2), essential health care services accounted for 71% of the budget on average. Though execution rates remained stuck at approximately 72% of the budget this was approximately in line or better than the execution rate of the overall health budget. Over the same period district-level budgets have accounted for on average 53% of the overall health budget with execution rates of 87% on average.

This credible focus on a progressive health care agenda, including flagship programmes such as *Aama*, has resulted in increasing amounts of aligned EDP resources and has placed Nepal on a relatively good footing with respect to tackling leave no one behind health issues. With the exception of 2015/16, the Pool Fund has increased in nominal terms every year since 2009/10 and, though its share of the overall budget has declined over time, it still accounts for approximately 20% of the overall MoH budget. Moreover, the execution rate of the Pool Fund has been impressive, rising from 73% in 2009/10 to 99% in 2013/14, and declines in real value of the Pool Fund and its share of the total MoH budget were encouragingly reversed in 2016/17.

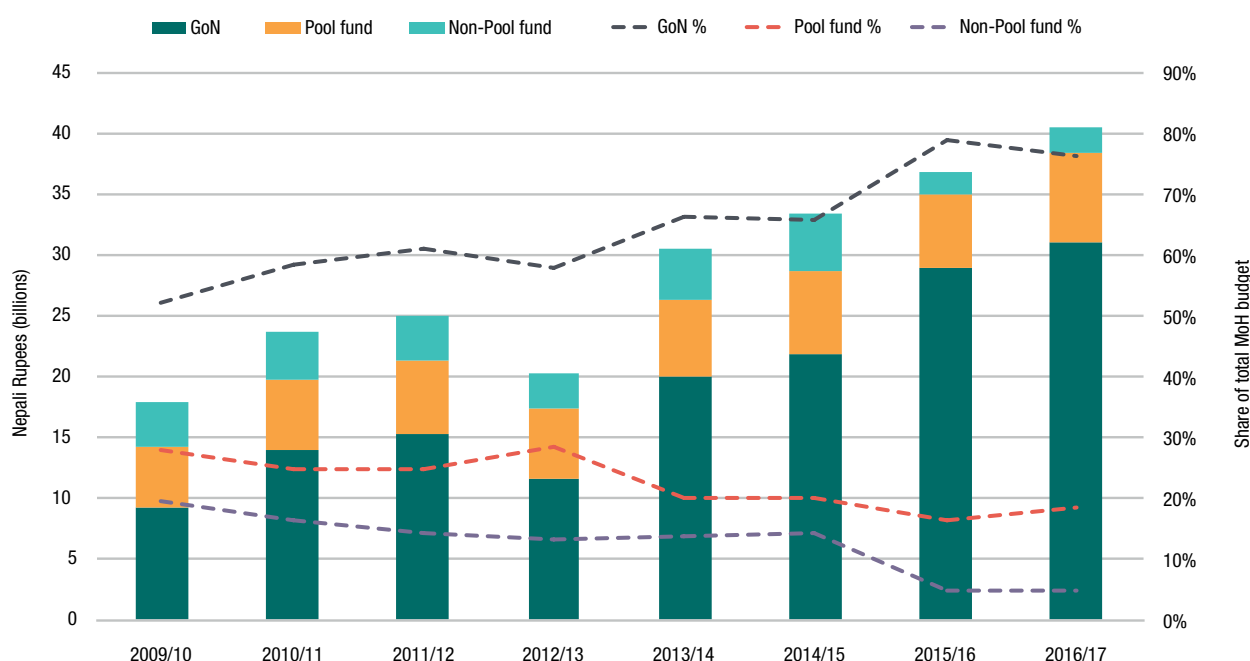
Progress in translating policy to rural and urban service delivery

Initiatives for improved outcomes in remote areas

The focus on rural service delivery has resulted in impressive gains in overall health outcomes, supported by some innovative approaches to deal with pockets of inequality. The Government has made a number of efforts to improve health services in rural areas, such as the establishment of HPs in every village, local recruitment of health workers, and other community-based programmes (Regmi et al., 2013). Advocacy to address the serious problems in rural service delivery, and in particular maternal health, was championed by mid-level health ministry officials with experience working in remote areas (INGO2, INGO8, IDP2; Engel et al., 2013). The progressive policies summarised in the previous section have had a strong impact on outcomes, particularly in rural areas, with the greatest benefits being felt in the poorest wealth quintile (Prasai, 2013). There is a generally enabling environment in Nepal for development partners to test new strategies to support the health sector, and the MoH is responsive to new evidence and lobbying, many of these efforts focus on tackling exclusion and inequality (NGO1, INGO 8, JM1).

One of the major improvements in remote areas has been in maternal health outcomes. Behavioural change is an important part of the reason for this, partly as a result of the improved economic circumstances of households and more widely available contraception. A very large number of NGOs and civil society

Figure 27. MoH budget by source of funds 2009/10 to 2016/17 (billions of Nepalese rupees)



Sources: NMoH and NHSSP (2015); Red Books; Budget Speeches.

organisations operating in Nepal have contributed to social mobilisation cooperating with Government to fill gaps. Grassroots social mobilisation initiatives, for example mothers' groups, have been instrumental in behavioural change: efforts to improve education and empowerment of women has brought greater awareness of how to mitigate risk during pregnancy and prevent unwanted pregnancy (Engel et al., 2013).

Crucial to health promotion are the cadre of FCHVs. Established in Nepal in 1988, these constitute the backbone of Nepal's rural health system. Described as an exemplary public sector community health worker programme (Schwarz et al., 2014), they are particularly important in the most remote areas, where they are highly trusted and relied upon by local communities, and act as the 'eyes and ears' of the health system (USAID et al., 2016). FCHVs focus on maternal and child health support services and the collection of local data that feeds into the national HMIS. They report good satisfaction with their role, despite lack of remuneration (FCHV; USAID et al., 2016), and our FGDs with women and interviews with health facility staff and FCHVs confirmed their value. In some remote places they are the main (and sometimes only) point of contact to discuss maternal and child health issues, birth preparedness, nutrition and sanitation. Many, although not all, FGD participants talked of their important role.

The FCHV is the only person who I can discuss my problems with; I don't know anyone else. (Madeshi FGD participant).

There are some known gaps in the capacity of FCHVs (discussed below) but there are also promising approaches to tackle these. For example, from 2009 the MoH piloted, through a formal public-private partnership, a programme to bolster clinical and community health services in the remote Western district of Achham, an area known for its poor maternal and child health outcomes. The programme aimed to improve local FCHV leadership and capacity by augmenting their limited supervision through establishing a new role of 'Community Health Worker Leader'. The leader oversaw FCHVs and conducted a range of weekly activities such as village-level meetings, training, and monitoring and evaluation. In addition, the programme provided a financial incentive. Learning from such approaches will be of great importance if FCHVs are to be able to expand their capacity to serve the needs of the most vulnerable.

Service delivery in urban areas

Nepal's focus on improving rural primary health care was, until 2015, to the detriment of urban health services (NPGO9). Since the 1999 Local Self-Governance Act, municipalities have been mandated to deliver health

Box 12. Developing the Urban Health Policy

One NGO (HERD*) was instrumental in leading advocacy for better urban health provision, an interview respondent described the following process:

1. Data: recognising that there were insufficient reliable official data on urban health outcomes, HERD collaborated to collect crude estimates to demonstrate that the urban poor were worse-off than the rural poor, and presented these to the Ministry and EDPs.
2. Collaborating with donors was important in order to put forward a unified voice to have a greater impact on the Ministry.
3. Stories that appeal to the emotions of policy-makers: obtaining the testimony of an urban FCHV who gave a candid and heartfelt explanation on film of how the health access in an urban slum was worse than in the most remote district of Nepal. Her message was: 'they have ANC, health-posts, outreach ... we have nothing but big hospitals, we are barred from free services, there is no primary health care structure here'.
4. Finally, using the donor and MoH Joint Annual Review Meeting as a platform to present the data gap, the crude health data and the human experience and propose an approach.

The outcome of the JAR meeting was an agreement and commitment from government to act: '*Hard evidence supported by contextual information can lead to strong policy, the message does get through ... we need to know the evidence, and then to understand what moves policy-makers ... to get "information download and synthesis"*' (NGO1). An Urban Health Policy was approved in 2015, with a vision to promote human development, prosperity and a healthy life in urban areas. The stated objective is to increase access and utilisation of quality health care services, particularly for women, poor, children and marginalised groups residing in urban areas, through the development and scale up of integrated urban health programmes. This is an important recognition and response by government for a left-behind population that was previously overlooked by policy.

* Health Research and Social Development Forum. See, for example, www.herd.org.np/resources/research-survey/urban-health-project-developing-strategy-improve-health-care-services.

services to the urban population, through the establishment of new urban health centres, but so far these have had limited reach. Data on health outcomes in urban areas are generally better than those living in rural and remote regions and were therefore not a policy priority. In the early 2000s, however, it became clear to some researchers that the national data were masking pockets of real deprivation in urban areas and a sizeable population who were not receiving adequate health services; these groups were largely invisible to health policy-makers (NGO1). Redressing this situation took a concerted effort by researchers, activists and EDPs, but has ultimately resulted in success, this process exemplifies the way that many health policy decisions get made, in short: the Government proved itself to be responsive to strong evidence, advocacy and appeals to policy-makers' 'emotional side' (NGO1) (see [Box 12](#)).

Foundations for strong local governance and community participation in the health sector

As described above, Nepal has an interim local governance structure comprising DDCs, VDCs and municipalities. They are funded through block grants from MoFALD and local revenues. Up to 35% of conditional block grants are earmarked for various disadvantaged groups, and local bodies must meet these and other minimum performance criteria in order to receive additional performance-based grants. Historically, local bodies have tended to direct their resources towards local infrastructure projects, particularly roads, rather than social sectors such as health (INGO3, NPGO3, NPGO6, IDP3). In order to strengthen local governance and place the health sector on the local development agenda, the MoH and MoFALD agreed a

Box 13. The Collaborative Framework

The Collaborative Framework was agreed between MoH and MoFALD in December 2013, building on the experiences of previous collaborations between the two ministries. As well as outlining the roles of the established local bodies, one of the agreed key principles of the framework is 'community empowerment, participation and accountability', which places an onus on the roles of Health Facility Operation and Management Committees (HFOMCs), Ward Citizen Forums (WCFs) and Community Awareness Centres (CACs). The agreement recognises the need to establish strong networks between these groups through social mobilisation. It also notes the need to strengthen the capacity of these bodies through technical assistance programmes in order to facilitate better-informed local planning and budgetary decisions with respect to the health sector. USAID's Health for Life initiative supports this framework through a five-year \$27.9 million programme providing technical assistance for capacity building in a number of districts.

Collaborative Framework in 2013. One of the rationales for the framework is described as 'a collaborative effort so that marginalised populations could have better access to quality health services and service utilization can be expanded further' (NMoH and MoFALD, 2013). It is one of the ways of supporting decentralisation in an environment without locally elected leaders (INGO4). The framework establishes a basis for collaboration

Box 14. Institutions supporting participation in health

Ward Citizens Forums (WCFs) are inclusive 25-member groups of community members (under the Local Governance Community Development Programme) at *ward* level to support the local government in identifying local development priorities, especially for the poor and excluded, recommending projects and coordinating government and NGO projects. In 2016 there were over 35,000 Ward Citizen Forums, with 844,000 members, of whom 44% are women. Government guidelines demand that local government projects and allocation of budgets be informed by WCFs in order to ensure bottom-up planning in the absence of local elections. They are made without representation of political parties and work as one of the proxies in the absence of elected local officials.

Citizens Awareness Centres (CACs) are grass-root level forums of approximately 25 members, including the most underprivileged members of the VDCs. Over 4000 CACs have been established across the country, with 117,700 members, of whom 71% are women. Donor support provides awareness and empowerment support to these organisations, including small livelihood improvement plan (LIP) grants to selected households. CACs are active in local planning through their representation at Ward Citizen Forums and the respective integrated village development planning forum at village level.

Health Facility Management Committees are the structure that, in the decentralised system, are responsible for operating and managing local health facilities. They consist of nine to 13 members: with the health facility in charge, a VDC political representative (chair), *Dalit* and women members, female community health volunteers and school teachers. The purpose is to make this local committee responsible for managing all affairs of the health facility. HFOMCs should meet at least once a month, and meet with the hospital quality of care committees three times a year to develop needs-based plans, audit the quality of care and take steps to improve it.

between the various local-level actors including NGOs (see Box 13).

Respondents were able to report successful instances of working with local governance mechanisms where the tendency for VDCs to allocate minimal amounts to health has been countered by targeted advocacy using the Collaborative Framework (INGO2, INGO4, INGO5). In the past decade, donors' support to marginalised groups has helped to increase their representation, furthered development in remote communities and introduced policy changes, including the introduction of quotas for civil service positions as well as state and public agencies (Call and Kugel, 2012).

There is an enabling environment for initiatives that enhance local governance and promote community participation to prioritise health. Our interviews yielded numerous examples of individual VDCs in our two study districts in which the system was being used as intended and local bodies were successfully lobbied for funds; for example, for FCHV incentives, supplies and equipment for birthing centres and even solar energy supply to health facilities (NPGO7, NPGO8, INGO4, INGO5). We heard testimonies from a range of projects and activities designed explicitly to be implemented through the Collaborative Framework, and which have potential to represent the needs of some of the most vulnerable members of society (INGO4, INGO5).

A great many projects have worked for years on community mobilisation, and increasingly these operate through the Collaboration Framework. The UNICEF District Investment Plan is one such approach, which stresses the need for community participation to engage with local government to secure resources for better access to health services, using institutions like the CACs and

the WCFs to make sure that the voices of communities are represented (INGO2). Another example is the Health for Life capacity-building project that recognises that a strong HFOMC is vital for improving representation. One part of the programme focuses on improving the member composition of the HFOMC through an 'Assembly of the People' to identify active and articulate members of communities that represent the needs or the most vulnerable. The approach is reported to have been a resounding success in the communities where it has been trialled with strong *Dalit* and female representation established as a result (INGO5). A further example of strengthening local capacity (used by H4L and others) is through collective use of local data to understand gaps in service delivery (e.g. which castes and ethnicities are not receiving services) that can be used to advocate for change.

Supportive movements for change in health: the media and civil society

Further to the Collaborative Framework, Nepal has a vibrant civil society, with active movements somewhat disconnected from the public health system that, nevertheless, are making an active contribution towards participation and the undertaking to leave no one behind. Civil Society Organisations (CSOs), in loose collaboration with NGOs and INGOs, have set up a 'Reaching the Unreached' coalition, which aims to act as a watchdog for Government implementation of policy and to monitor progress, primarily towards UHC and reducing inequities (Mahato, n.d.). More broadly, CSOs act as a voice for otherwise poorly represented groups, by Government participation in technical working groups and committees in addition to advocacy campaigns by CSOs themselves.

Box 15. Swasthya Khabar

Swasthya Khabar is a health magazine with a mission 'to change and improve the health system' that was initially set up with the objective of providing health care and health service information. It has grown from a print magazine to a popular online publication and mobile app, and has aspirations to start producing online health videos. It is accessed by Nepalis across the country, and now by a large number of migrant Nepalis around the world.

The magazine currently has two main functions:

1. To offer health information and advice – primarily online – through a network of volunteer doctors who respond to health queries submitted by the public. Popular advice topics are sexual and reproductive health, mental health (post-earthquake) and self-help.
2. To provide a platform from which to change policy and criticise politicians on issues such as insurance, national health programming, the future of health in the federal system and policy processes. They respond to information that comes from reporters from across the country: *'We are happy to be whistle blowers.'*

A staff member noted:

'Yes, we have impact. We have raised questions direct to the Minister, have contacted the investigation committee, have seen policy change. The Ministry takes us seriously, we call press meetings and ask them to respond to us, invite them to discuss issues and they do' (interview with JM).

Efforts by CSOs are augmented by the Nepali media, which has some appetite for coverage of health issues and shows potential for enhanced impact. Nepal's media has traditionally only given marginal attention to health issues, but in recent years increased space has been given to health news stories. We were informed that journalists were starting to question and publish issues relating to human resources for health, service access, resource allocation, misappropriation and service provision (JM1, JM2, NPHO9, IDP4) and can provide anecdotal evidence on the scope and influencing power of health journalism: *'Health journalism is growing, like the health website Swasthya Khabar, which is good,⁴⁹ I look at it every day, I have the app on my phone. There is also Health Today. Ministries are definitely taking notice of these, they are influenced, even if we don't have hard data to say that, it is observable'* (IDP4). *Swasthya Khabar* (see Box 15) is an innovative media platform that has several interesting potential areas that could be harnessed, such as the coverage of policy issues relating to marginalisation or using the mobile app to link health professionals to FCHVs.

4.6 Leaving no one behind: challenges and obstacles

Despite the promising work thus far to tackle exclusion and drive improved health outcomes, it is highly likely that 'more of the same' will not be sufficient to achieve the ambitions of the SDGs. Indeed, we were repeatedly told by interviewees that the low-hanging fruit has already been picked. In this section, we examine the major challenges and obstacles to progress that will need to be addressed.

Data are not systematically used to guide policy-making

Lack of district and sub-district level data: A major weakness in Nepal's data system is that survey data are disaggregated at most to the larger sub-national units (clusters of districts into 15 eco-development zones), not to the district level. The 15 eco-development zones are created by combining the three latitudinal 'ecological' (or topographical) zones – Terai, Hill and Mountain – and the five longitudinal 'development' regions – Eastern, Central, Western, Mid-Western and Far-Western.⁵⁰ This has been the most commonly used framework for geographic disaggregation in Nepal since the 1970s (NPC and UNDP, 2014). The most recent Human Development Report for Nepal describes the 'fallacy of this framework', explaining that, 'the concept of 15 eco-development regions has been redundant for all practical purposes of policy and programme formulation and assessment' (ibid.). Rather, it

is Nepal's 75 districts that are its key administrative units: sub-national policy analysis and planning decisions, as well as local resource mobilisation and financial flows from the centre are based on the district system.

The level of disaggregation required to track progress on the SDGs and in the context of leave no one behind will necessitate surveys that properly account for the multiplicity of different socio-ethnic groups in Nepal, and this will require much larger sample sizes. However, completing high-quality, regular, nationwide surveys is a major undertaking for any country, and Nepal's mountainous terrain and heterogeneous population distribution throws up particular challenges. This is currently limiting the feasibility of providing reliable data that is representative to district level, which would need a step-change in the survey sample size, requiring expensive and time-consuming fieldwork.

Disaggregation notwithstanding, there is quite limited use of data in Nepal to inform policy-making and planning at both central and local levels, despite the production of reasonably good data. In general, Nepal has made progress on improving the quality and availability of data, but little progress on the uptake of software for data analysis and dissemination (NPGO10). Mechanisms and incentives to ground policy and planning decisions in data-led evidence are weak.

HMIS data is very good and the data quality is generally very good, but it is questionable if the information is used efficiently to feed into policy and planning (IDP2).

Although the MoH produces an annual report using HMIS data, it is published with an 18-month lag, which means stakeholders do not have at their disposal the latest information, to hold the current national and local planning processes accountable.

According to one study involving 60 interviews with stakeholders across the data ecosystem, Government data producers view external users, such as academic researchers and students, rather than government officials, as the primary consumers of their data (Development Gateway, 2014). Some senior officials have gone so far as to suggest that *'data use is [a] formality'* in the planning process (ibid.). Though health workers and civil servants spend a great deal of time collecting and reporting data, much more effort goes into report production than goes into actual data use.

In the currently unstable political climate in Nepal, political pressure is likely to trump decisions that might otherwise be more evidence based (Development Gateway, 2014). In central Government, financial resource allocations to localities tend to be based in large part

49 The *Swasthya Khabar* website is swasthyakhabar.com.

50 In some surveys and studies, these are condensed further to nine, 13 or 14 by combining some of these, sometimes due to lack of data points. For example, there are no data points in the Living Standards Measurement Survey for the Western Mountains.

on historical patterns of provision. Also, allocations to certain issues, programmes or population groups are often driven by the political priorities of the day, which may derive from the personal priorities of politicians and/or successful lobbying by specific interest groups, rather than objective data.

Advocacy depends on the policy maker who is there with you, the right person at the right moment, but our government is so changeable, every few months there is someone new coming in, every time you educate one, explain what works and then that person is gone. If you have a person who doesn't understand public health or doesn't understand the programme then it will be a bottleneck (INGO2).

At the local level, there are limited skills, resources and capacity to conduct data analysis (Development Gateway, 2014). The low data-use culture at the centre may also be translating into a similar culture at sub-national level (NMoH, 2014). This results in a system in which local actors act predominantly as data collectors and aggregators, merely reporting upwards, rather than analysing and using this data systematically in their own planning.

Furthermore, while there has been an emphasis on monitoring access to services, less attention has been paid to the *quality* of health care and to the groups who are *not* accessing health care (and why). Some FCHVs may collect these data, but they are often overburdened, while others have insufficient capacity to collect data, given that the entry requirements for becoming an FCHV are quite low and many older FCHVs are not literate (FCHV1, INGO5). When asked to what extent local data were used to feed into local decision-making and planning, we were informed by FCHVs and HP staff that there was limited discussion regarding the data they collect. This is a missed opportunity for the local health system to be responsive to local problems (FCHV, INGO1). It seems that well-functioning monitoring and evaluation feedback loops are absent, and we heard from multiple respondents that health data are not routinely or effectively used to advocate for better health provision through the local bodies.

Policy to practice

Local governance

The long absence of elected local officials has meant that it is extremely difficult to assure strong mechanisms of local accountability. This is regarded as a fundamental obstacle to making sure that health services are delivered in a way that is responsive to the most vulnerable people within communities. Over and over again our respondents argued that the lack of local democracy and accountability was a

major hindrance to driving forward real and progressive local reforms (INGO5, INGO6, INGO7, IDP2, IDP3, JM2, NGO1, NPGO9). One respondent noted, *'The lack of local elections for 20 years means that the arms of government are not functioning: there is no accountability'* (INGO6). Another respondent felt that, *'Things would be smoother if decision-makers were locally elected, as at the moment all the decisions lie with one person and that person is a government-appointed official'* (NPGO9).

In the meantime, much of the management and implementation of local health services remains with DDCs, VDCs and municipalities. These local bodies have a level of discretion to approve as they see fit, but without explicit responsibility for service delivery or outcomes or requirements to report by sector, making it impossible to know how much local bodies (individually or collectively) are allocating to health or any sector (World Bank, 2014). While local bodies do report on development spending (which can be any mix of recurrent and capital allocations) and beneficiary type (which may include certain disadvantaged groups), it is impossible to create a clear picture of the extent to which local bodies are boosting health spending or tackling exclusion. According to one interviewee, *'The main problem is actually implementing policy and translating it to effective service delivery – the blockage being governance'* (INGO6).

Now that the new Constitution has been adopted, there are high hopes that the mandated local elections will follow in 2017, and that this will result in greater political stability and the possibility of accountable priority-setting processes, service delivery and resource allocation (NPGO5, JM1, IDP2, INGO5, INGO6). However, the detail of Nepal's new federal structure is still disputed, and smooth and conclusive local elections any time soon are not a certainty. Until then, the contested political procedures of federalisation – and the issue of who gets to decide what – will continue to dominate the national conversation about inclusion (JM1).

There are high hopes for federalism leading to reform, with stronger and better local decision-making, but the impact of the local elections on a more inclusive society may disappoint and the risks of cementing current political dynamics and exclusion remain. Although Nepal is transitioning from a unique set of local governance arrangements, democratic decentralisation should not be viewed as a panacea. It is not realistic to suppose it will *inevitably* result in better service delivery and better governance (Booth and Cammack, 2013; Crook and Manor, 1998).

Politics and realities of participation

The design of the Collaborative Framework between the MoFALD and MoH should promote pro-poor, participatory local governance, but not all stakeholders

are impressed. We were informed that the Government bought into the idea that empowering community groups would reach the unreached the poorest of the poor.⁵¹ But there was considerable criticism about some elements of the framework, and participation in reality was poor in the districts we visited.

Respondents in the districts suggested that local bodies tend to prioritise roads above all else, followed by electrification and the recruitment of teachers: health is rarely a top priority (NPGO3, NPGO6). This is at least partly driven by the prevalence of patronage politics, making it difficult for local bodies to work in the interests of the most vulnerable and marginalised groups (NPGO2, INGO5, IDP3, as well as FGDs). *'At local level there is institutional corruption, they eat the money ... The VDC has consensus from the political membership, they design a policy which restricts the way they are channelling funds, they then fund things from which they themselves will benefit'* (INGO5). Additionally,

Most of the nominations for the [village development] committee are political, so I am not involved at all. ... Sometimes we know that someone is not using the money correctly for the village, but we cannot bring it out as it brings enemies and we need to live together in a community in this village. I pointed out to a VDC officer that he is not doing his duty correctly, but it was of no use because no action was taken at all. Most of the times, it is a few influential people in the village who decide issues needed for the village, even issues on health, but the rest of the villagers have no role and are kept in the dark. (FGD)

The WCFs are one of the interim measures that should be able to contribute to better inclusion and access to health service, but they are described as being very vulnerable to political capture and not a guarantee of effective public participation by marginalised people. *'Inclusion is complex. It is hard to justify so many different "causes". It will take local mechanisms to make sure that the right people really are "included".'* (NPGO11). When asked about his participation in the WCF, one FGD respondent stated:

No, I have never participated. I do not even know when it happens and who is involved. There is a lot of politics and money involved, but we are unaware of it. ... I think only people who are close to the VDC officers are invited, the rest of us are unaware of it. We have never been called for open discussions in issue like this. (FGD)

Although local structures – right down to the health facility and operation management committee (HFOMC) in a village – are supposed to have representative composition, they are often self-interested. They can also lack sufficient capacity or empowerment to overcome entrenched local political dynamics or dominant actors/personalities (INGO5 and FGD).

In one of our study districts, we heard that the District Health Officer attends DDC planning meetings, but – as a representative of a central line agency – cannot influence the final decision other than by lobbying political leaders about service gaps and trying to persuade them that investing in health services would be economically beneficial and politically expedient (NPGO2). Furthermore, there is little incentive for strategic, coordinated and integrated decision-making and resource allocation at the district level (IDP).

The composition of the local bodies and the community institutions (such as WCFs and FOMCs) have clear guidelines to make sure that marginalised people are represented. It was, however, made clear to us at different levels that having a diverse membership of a local body or community group did not translate into impact or representation. We heard of numerous instances in which the system was failing: women and *Dalit* representatives are frequently reluctant to voice their opinions or attend meetings, or powerful local figures completely dominated the proceedings, or when a member of a marginalised group leaves a local body there may not be any effort to replace them (INGO5, IDP2, NPGO3).

We heard strong testimonies from the community participants of the FGDs – purposively selected as being in areas where service uptake was poor – indicating a complete lack of representation and participation. Either the mechanisms for participation were not reaching them or they were not functioning. Their exclusion took two forms, insufficient knowledge and insufficient opportunity. Insufficient knowledge means that participants did 'not know who the leaders are', and, particularly in the Muslim *Madeshi* community (Kapilvasthu district), women were not in a position to talk to the male representatives even if they did know who they were. As seen in the above quotes, there was also a perception of corruption, community participants were unwilling to get involved in structures they perceived as 'political' and which could stoke tensions in a community where there was already underlying poor cohesion.

Urban health

Urban health service delivery is another case where implementation of a new policy may be undermined by political concerns of stakeholders. *'The primary health care*

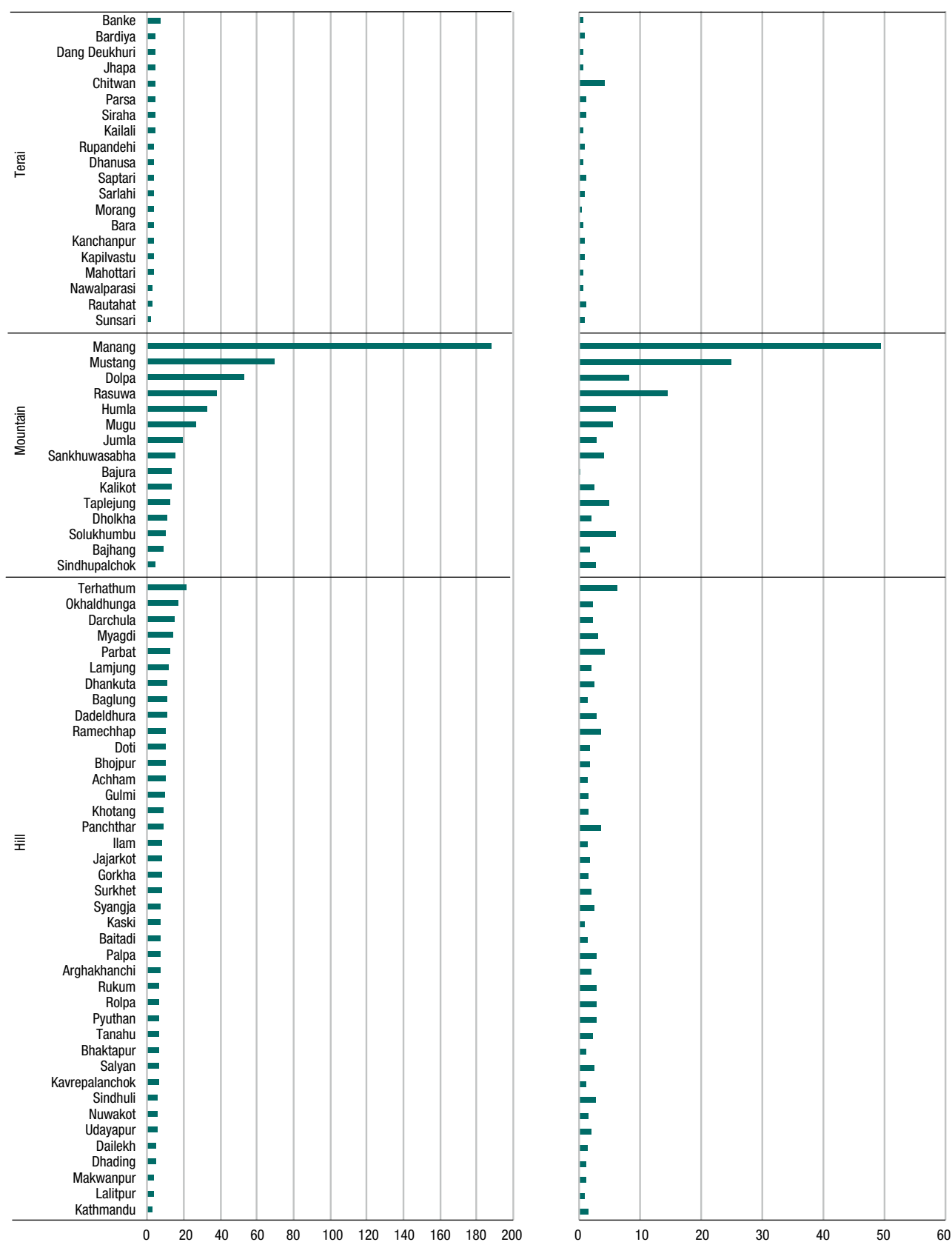
51 Examples include Ward Citizen Forums (WCFs) and Community Awareness Centres (CACs).

revitalisation department should fund the urban health clinic but they are only allocating a few per municipality and they are not operationalized, then there is irregular behaviour in the way the staff are hired' (NPGO9). We have seen that, until recently, there has been little focus on tackling the unmet health needs of the urban poor. In Kathmandu, there are a large number of tertiary hospitals and private health care providers, but very few options for normal working people or slum residents to access primary health care (NGO1). Despite the new urban health policy, several respondents had important concerns about the commitment to implementing it. There was a concern that urban funding does not actually reach the urban poor (INGO3) and that there is no provision or responsibility taken at all for the large numbers living in informal slum settlements.

Inequities in sub-national health financing with respect to those being left behind

There are inequities in sub-national budget allocations on a per capita basis which do not appear to be well justified on measures of exclusion. For 2014/15 the median district health budget allocation was \$7.37 per capita, with a maximum allocation of \$188 for Manang district and a minimum allocation of \$2.34 for Sunsari district (NMoH and NHSSP, 2015). Undoubtedly, some of these inequities in per capita allocations are the result of Nepal's historical efforts to provide services in more remote and sparsely populated areas, and indeed remoteness is a key dimension when it comes to efforts to leave no one behind. Nevertheless, current budget allocations tend to disproportionately favour some geographical groups over others, with seemingly little targeting of health outcomes (see Annex 1 for further details). This is the case for both total district budget allocations as well as district aid allocations (see [Figure 28](#) below).

Figure 28. District budget and aid spending patterns (\$ per capita)



Source: NMoH and NHSSP (2015), Nepal AMP.

Allocations are biased towards the mountain and hill districts over terai districts despite the fact that exclusion from healthcare is geographically widespread. Table 2 clusters district budget allocations according to the DHS eco-development zones. As can be seen from the table there is a bias in per capita budget allocations towards remoteness. With few exceptions lower population mountain and hill areas receive higher per capita allocations compared with larger population and *Terai* areas. However, the percentage of the population with deprived access to healthcare, as measured by the inverse of the CCI Index, indicates inequities in terms of targeting those being left behind. For example, despite having a higher population with deprived access the Eastern Hill per capita budget allocation is 75% of the Eastern Mountains.

Geographic inequities are largely the result of the policies associated with increasing access to basic health care in remote areas, and the associated economies of scale. The distribution of facilities is the key driver of the inequities in budget allocations. Existing health policies dictate that hospitals, PHCCs and HPs are distributed per district (though some districts may also have zonal or regional hospitals), per electoral constituency and per VDC respectively. But, zones with lower population-to-VDC ratios have higher per capita budget allocations, while low population zones also have lower population-to-hospital and population-to-PHCC ratios. Moreover, the cost of staffing health facilities in less densely populated remote areas is higher due to associated allowances. This places Nepal's health sector in a difficult position given that

remoteness, in terms of distance and terrain that needs to be traversed in order to reach a health facility (World Bank, 2014), still remains a significant constraint to the delivery of health services, and by extension for leaving no one behind. However, to date addressing remoteness has directed financial resources towards remote populations at the expense of other coverage-deprived populations in less remote zones.

The current inequities combined with other factors are a potential constraint to leaving no one behind in terms of health care. MoH's reliance on incremental budgeting over the use of a formula-based approach to sub-national budget allocations is likely to perpetuate the current inequities in budget allocations (GIZ, 2011). This may lead to a failure to address key demographic trends over the SDG period. Nepal's population is expected to shift from being 20% urban to 30% over the next 15 years (CBS, 2014), and there is also the view that most urban funding does not reach the urban poor, particularly in Kathmandu (NGO1). The status quo, in which those being left behind are relatively evenly disbursed geographically, suggests that additional funding for the health sector should flow on a population basis rather than historical incrementalism.

Key implementation weaknesses are undermining progressive health policies

Nepal's health policies are generally progressive, but key implementation weaknesses – whereby budgets are not translated into outputs – present significant obstacles to achieving the leave no one behind objectives. A number

Table 2. 2014/15 Budget allocations per capita by Eco-Development Zone (USD)

Eco-development zone	Budget pc	Total Pop	Pop/VDC	Pop-Hosp	Pop-PHC	Pop-HP	(1-CCI Index)	Deprived Pop
Eastern Mountain	94.33	19,024	656	9,512	19,024	679	35%	6,577
Eastern Hill	23.96	408,583	3,049	81,717	136,194	3,143	46%	185,918
Eastern Terai	13.56	390,475	3,309	130,158	65,079	3,309	37%	143,220
Central Mountain	11.18	345,365	4,667	172,683	115,122	4,864	41%	140,087
Central Hill	10.51	1,018,645	4,058	127,331	169,774	4,075	43%	434,592
Central Terai	10.23	1,605,272	4,033	178,364	94,428	4,236	43%	690,123
Western Mountain	9.81	519,825	3,489	173,275	86,638	3,610	29%	149,374
Western Hill	8.94	2,818,933	4,518	201,352	104,405	4,652	38%	1,075,176
Western Terai	7.02	1,756,697	5,372	195,189	117,113	5,559	41%	718,523
Mid Western Mountain	5.48	1,568,264	13,069	392,066	174,252	14,257	36%	571,884
Mid Western Hill	4.42	4,703,610	9,923	188,144	138,341	10,225	33%	1,535,098
Mid Western Terai	3.87	1,319,342	20,615	329,836	188,477	23,988	36%	478,569
Far Western Mountain	3.78	5,001,543	8,392	384,734	166,718	8,884	33%	1,670,068
Far Western Hill	3.77	4,014,903	10,268	446,100	154,419	10,970	31%	1,257,768
Far Western Terai	3.52	2,232,892	10,013	372,149	186,074	10,735	30%	674,647

Source: Authors' computations using Nepal MICS 2014 database and NMoH and NHSSP (2015); Red Books.

of supply-side issues undermine the demand for free health services and an increasing presence of private sector providers contributes to estimated high levels of out-of-pocket expenditure on health care (WHO GHED, 2016).⁵² These relate to procurement, implementation of capital budgets and standards around the quality of care. They arise from problems at the centre, while problems with the siting of health facilities are a local issue.

Procurement is in need of overarching reform (Nepal PEFA Secretariat, 2015), and this is particularly true with respect to the procurement of the 40 essential drugs provided free. Most diagnoses of the problem point to a number of interrelated issues.⁵³ All of these issues have manifested themselves in budgets with consistently low absorption, resulting in a decline over time due to the policy of the NMoF to cut under-executed budgets. The execution of the health procurement budget averaged just 57% from 2009/10 to 2013/14,⁵⁴ and by 2015/16 had fallen to just 22% of its 2010/11 nominal peak value.

Box 16. Drugs procurement and the Commission for the Investigation of Abuse of Authority

The Commission for the Investigation of Abuse of Authority (CIAA) is the body to tackle corruption of public officials (CIAA, 2016). In 2014, the CIAA filed a case against multiple public officials in the MoH, who were charged with misappropriating funds when procuring a drug used to control haemorrhage during childbirth. The drug was found to be substandard, and a greater than required supply had been procured (*Kathmandu Post*, 2014). The Special Court subsequently acquitted the officials (*My Republica*, 2016). The CIAA has been accused of pursuing this case, and other cases, overzealously, in some cases exceeding its legal mandate (*My Republica*, 2015). Since this episode, there have been acute shortages of drugs in Nepal, reportedly due partly to widespread fear among officials involved in procurement of being accused of wrongdoing, whether real or perceived: *'now, with the CIAA keeping a close eye, no one wants to take a risk'* (comment by anonymous official in *Spotlight*, 2014).

Similar problems with respect to weak capital expenditure implementation capacity also exist at the central level. There is a tendency for delays in the national

budget process, inadequate planning and cash management constraints to translate into capital expenditure being delayed to the third trimester and consistently under-executed (Engel et al., 2013; Nepal PEFA Secretariat, 2015). Capital expenditure absorption is even lower in the health sector than in the national average, despite the fact that the capital budget for health is declining in real terms (see Figure 28). This presents real difficulties for a health sector which claims to be trying to improve primary health care access: for the urban poor through the upgrade of facilities in new municipalities to urban health centres; for those in remote areas through extension services such as CHUs and the upgrading of SHPs to HPs; and for earthquake-affected communities through the reconstruction and rehabilitation of damaged facilities. The fact that the 'the Ministry of Health lacks an investment strategy to guide decisions on the split between recurrent and capital allocations in the annual budget' (NMoH and NHSSP, 2015) is also a significant constraint to any potential redress of the inequities in facility levels across districts. However, the central level capital expenditure implementation problems remain the overriding hurdle that needs to be cleared.

Supply-side *quality of care* issues are a further impediment to overcoming demand issues. Again the reasons for lack of quality care are multifaceted. However, an overriding issue noted by some NGOs and other observers is a failure by MoH to update staffing structures that have remained unchanged for over two decades. This has resulted in an erosion of capacity at district level and, in particular, a lack of doctors and/or skilled health workers in remote areas, *'Current public health capacity is nowhere near the level needed to serve the Nepali people'* (IDP2).

Similarly, failure to implement the practical elements (e.g. identity cards) of national policies on access to free health care for disadvantaged groups has meant lack of clarity for both medical professionals and patients as to what treatment should be provided free of charge at different facility levels.

As well as these central implementation issues, there are localised problems undermining the supply of health services to vulnerable and marginalised groups. Chief among these are problems in terms of siting health facilities close to marginalised populations due to the cost and difficulties of negotiating land. In a number of the VDCs visited in Pyuthan, both health workers and users complained about the difficulty of accessing HPs

52 Discussions with interviewees suggest that not all of these problems can be seen as supply side issues, noting that cultural preferences for branded drugs, often prescribed by public health workers with private practices, also play a significant role.

53 These include lack of adherence to prescribed competitive bidding rules; lack of credible procurement plans linked to budgets; weak institutional capacity; lack of procurement and specialist procurement cadres; perverse incentives for procurement staff with respect to job-related benefits and sanctions (NMoH and NHSSP, 2015); inefficient drug distribution from the centre to district level; lack of framework agreements; the use of suppliers that cannot meet the terms of their agreements; and an 'activist' procurement watchdog agency.

54 This figure excludes 2012/13 for reasons stated previously.

(NPGO13, NPGO14), while in Kapilvasthu there was a problem procuring land to upgrade SHPs so that they are fit for purpose (NPGO12 and FGDs). Similarly, minor upgrades of health facilities (e.g. equipping a birthing centre) falls within the purview of local bodies, but often falls outside their list of priorities.

Insufficient discretion at the local level

Lack of discretion within the health system poses challenges for the development of local responses to issues of marginalisation. Nepali society is extremely rich and heterogeneous, with hundreds of different groups spread fairly evenly across the country.

But not all people in each group are equally privileged or underprivileged: there are disparities within groups ... Nepal needs micro-planning (INGO7).

Inclusion is complex and will require a localised approach with more local discretion over how to allocate resources and run services – while still adhering to minimum standards and best practices – in order

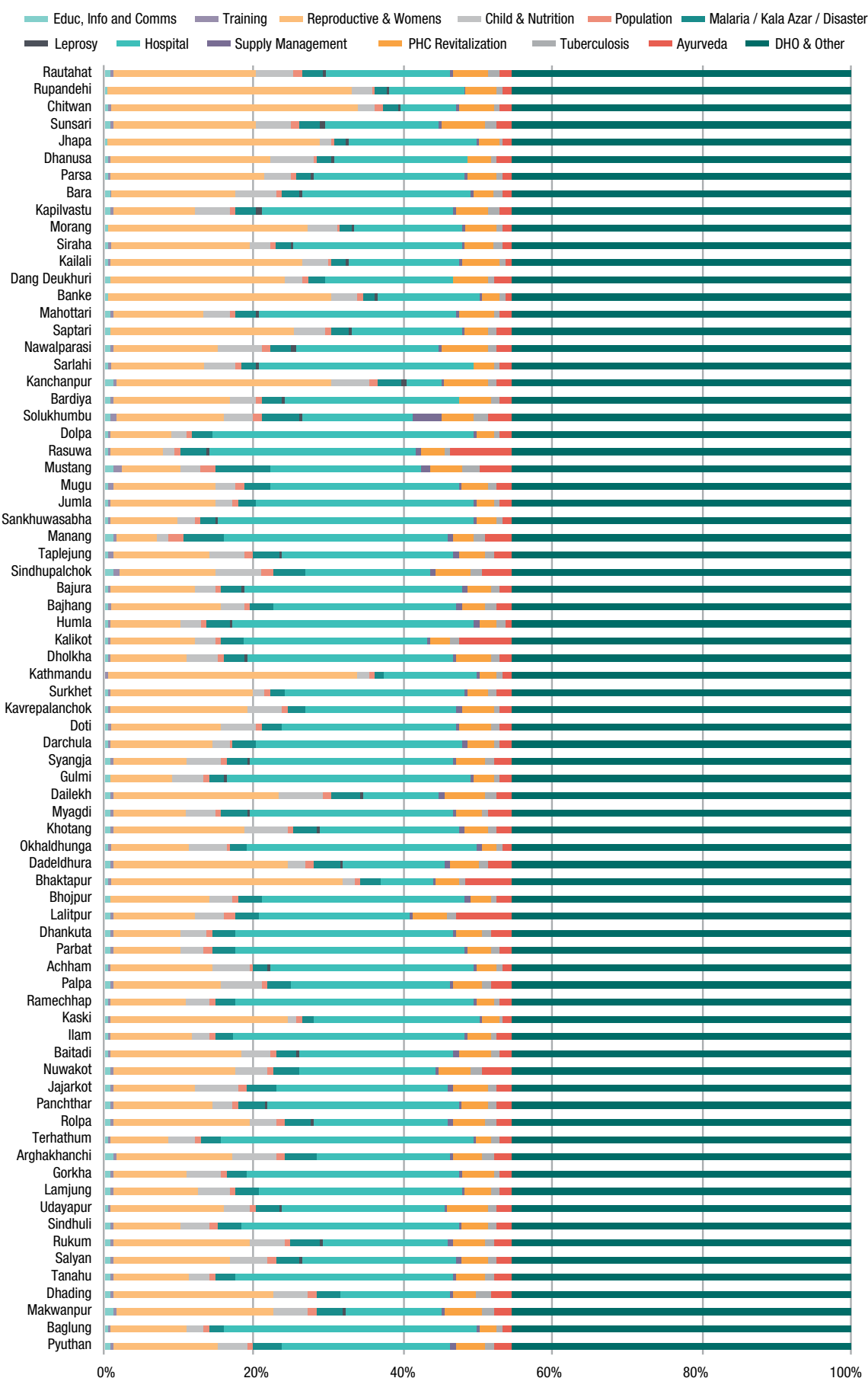
to solve the very specific challenges of leaving no one behind in each locality. Yet most of the health budget is decided centrally and allocated through nationwide vertical programmes, and districts appear to have little say over how their total district health budget is allocated across programmes.

Most funding is based on historic, regular programming started even as much as 20 years ago. Is this a good way to do it? No! The centre does not understand the reality of local demands and needs ... Planning should be done from the community level (NPGO2).

As can be seen in [Figure 29](#), programme allocations are relatively uniform across districts. Some programmes are simply a flat allocation to all districts,⁵⁵ despite the disease burden varying widely across districts. This places a burden on districts and their health facilities to run programmes that ought not to be priorities in the local context, so diverting scarce resources away from priority areas, exacerbating the equity issues.

55 Such as the Epidemiology, Malaria and Kala Azar Control and Disaster Management Programme.

Figure 29. District health budget by programme as a % of the total district budget



Source: District budgets 2014/15; NMoH and NHSSP (2015).

Despite apparently widespread support for increased local discretion throughout the health sector, efforts to introduce bottom-up planning have usually failed (INGO3, NPGO15). Respondents from both central and local institutions seem to agree that the local bodies currently lack the capacity to undertake good bottom-up planning (NPGO2, NPGO15, NPGO16).

Policy commitment to leave no one behind in practice

Improving health outcomes in the most marginalised groups will be costly, and policy commitments around leaving no one behind in health will require additional financing.

Rural health has made great strides in the last 20 years, but leaving no one behind will require considerable investment for limited returns. We identified a number of promising commitments that suggest a genuinely progressive environment, but many of these have yet to be realised, and there are still major service delivery gaps for most marginalised groups in rural and urban settings. Meanwhile, the health sector has inadequate institutional capacity to implement its progressive policies and programmes, which makes it difficult to reach those still left behind (NMoH, 2016). The urban health policy is unfunded, the UHC budget was not executed in 2015/16,⁵⁶ and addressing rural remoteness will increase unit costs. Meanwhile, though health is considered a priority in principle, the health budget has been declining across a range of indicators. This is of particular concern given that estimates based on the 2008/09 figures were deemed inadequate by some, even on a needs basis (GIZ, 2011).

Respondents were concerned that donors or government would be unlikely to commit to the high unit cost of reaching those who are still left behind as it might not be seen to fit the results and cost-effectiveness agendas of donors and Government.

For leave no one behind, payment by results is wrong, what do they mean by value for money? Reaching the unreached is valuable, but it is expensive.’ (NGO1). ‘We will eventually reach a plateau, after which it will be difficult to further reduce our maternal mortality. (interview INGO8)

The IMF has ‘encouraged the authorities to reverse this trend’ (IMF, 2015), while the MoH itself has noted the need to develop a National Health Financing Strategy for UHC (NMoH and NHSSP, 2015). However, among the central institutions responsible for budgetary allocations, the declining health budget is less of a cause for concern. As the IMF has noted,

Social spending had been rising steadily in absolute terms ... [post-earthquake] reconstruction spending would be on schools and health facilities ... [and] ... local governments also carry out social spending (IMF, 2015).

It argues that health services should, and are, being provided on a ‘needs’ rather than a ‘rights’ basis (NPGO5). Among those working more directly in the sector, there exist a range of views on the health budget share. While some have expressly stated that a greater allocation is needed and are disappointed at the ‘bad message’ that the declining share sends (INGO3, INGO7), others have expressed the opinion that governance around service delivery, rather than insufficient financing, is the key constraint with respect to achieving leave no one behind (INGO6).

Previously, the health budget was part of a rising tide, but new policies are now balanced with cuts to existing health programmes. MoH officials have described these cuts as ‘random’, while political priorities have also been parachuted into the health budget (NPGO15). The dissatisfaction being generated by the shrinking health budget is beginning to drip down. Frontline workers, whose motivation is critical to effective delivery (World Bank, 2014), are being asked to do more with less. Nevertheless, the central institutions face significant constraints including: difficulties in maintaining medium-term plans due to political instability; slow growth and stagnating domestic resources; an increasing number of international and domestic priorities; and an imperative to focus on reconstruction and infrastructure following the earthquake. Infrastructure spending should in theory stimulate the growth required to push domestic resources higher. Ironically, however, capital spending is Nepal’s most significant implementation bottleneck. The capital budget is persistently under-executed, with the overall budget being balanced in-year. This combination of factors casts extreme doubt on the sufficiency of financing for leave no one behind in the health sector. Unless the institutional blockages maintaining the status quo around the financing of the budget can be overcome, additional policies with regard to leave no one behind in health are likely to continue to be marginal, and funded by marginal cuts to other areas of the health budget. While the commitment of the political class and the civil service to deliver more equitable access to health care has also been questioned (Bennett, 2005), the most effective test of this proposition may be how these cadres work together to close the financing gap in future, particularly as post-earthquake reconstruction priorities begin to recede.

56 The UHC programme is not yet operational.

4.7 Considerations

Nepal's political settlement remains in flux, without a clearly identified process of how and when the bottlenecks delaying a federal system will be resolved. Here we outline some considerations for stakeholders in the health sector as Nepal plans how to achieve the SDG3 targets while leaving no one behind. There are some central barriers which will need to be overcome, as well as some shorter-term considerations for the ongoing journey towards federalism.

During the transition to a new sub-national architecture

Collection and use of data that reflect the subtleties of exclusion

Nepal is a heterogeneous society, with different groups and types of marginalisation spread across the country. This has created large differentials between districts, and also between groups within districts. Data disaggregated to eco-development zone level are not sufficiently sensitive to be responsive to highly localised inequities. While the district remains the administrative unit for local health resource allocation and decision making, then district-level health survey data will be essential to augment the existing HMIS data and create a complete picture of marginalisation in relation to health service access and coverage. These data can be used to develop policies and interventions that reduce health outcome differentials at local level.

Locally-led solutions based on local data rather than national definitions

The population of Nepal has high levels of overlapping vulnerabilities to poor health outcomes. The Constitution and national policies make special provision for many of the groups recognised as vulnerable to exclusion, but disadvantaged groups are geographically widespread and marginalised for diverse reasons. The national level definitions of those being left behind may, therefore, be only partially effective in identifying and locating them. Redressing the health care inequities of the marginalised is inherently a problem requiring local solutions.⁵⁷

While interim measures have been taken to develop more autonomous and responsive local institutions, these have important limitations. Centralised control over local budgets and lack of local accountability limit their effectiveness. The MoH and MoFALD could become enablers of locally-led solutions to marginalisation by introducing functional bottom-up planning processes using existing local structures. This could be done on an experimental basis using the many positive results from NGO and IDP projects that enhance the participation

and empowerment of marginalised community members and build technical capacity of local bodies for making decisions based on need. To succeed, however, they will need not just technical know-how, but a contextually sensitive and politically smart awareness of the factors that impede collective action around pro-poor health care, as has been shown for Kenya and elsewhere.

Incentivise local governments to engage by gradually providing more discretion over budgets

We have suggested that local governments and communities will need to have a greater say in how their health budgets are allocated. However, moving from centrally allocated to locally planned district budgets comes with some risks. Guidelines and parameters around the provision of greater autonomy in setting local health budgets, and substantial levels of capacity building in their implementation, would reduce the risks. The Collaborative Framework partners would be well placed to support this process. If more responsibility is handed over to local decision-makers to target marginalisation, it is important that initiatives are supported on the basis of need not political interests, and that funding reaches its intended targets so that the desired outcomes are achieved. This will need careful monitoring of the results and, again, substantial capacity building at the district level.

Conditional grants, such as the one currently being piloted by the MoH in a number of districts, may be effective in providing greater discretion, but these also have potential for leading to fragmentation of health budgets. There may be resistance to introducing greater discretion at the expense of maintaining allocations to current operations if it is felt that this poses a risk to how the health system currently functions. This implies that more discretion would require additional financing.

Ensure the positives are maintained throughout and following the transition

Currently Nepal's public financial management system does the basics of paying staff and operating costs on time quite well, and these are important aspects of delivering primary health care services to those most in need. Care will be needed to avoid disrupting the many positive aspects provided by the current system in this respect. Under a decentralised system, the MoH will need to consider minimum standards with respect to the balance of expenditure between primary, secondary and tertiary health care, as well as infrastructure and staffing, in order to ensure that it continues to provide a large and increasing portion of the population with access to primary health care services. The lessons learnt from the gradual

⁵⁷ For example, while health insurance subsidies may be effective in some districts where there are private sector providers, resources may be better spent on more CHUs in more remote areas. Similarly, while certain ethnic/caste groups in some districts may be well served by targeted awareness raising interventions, the same groups in other districts may be better served by a more general increase in access through the construction of further facilities or the purchase of specialised equipment.

implementation of local planning and increased discretion and capacity building can be carried over to the federal sub-national architecture and inform the development of a system of laws and regulations, avoiding the danger that they may act as a straitjacket later on if they are introduced too hastily.

Overcoming central barriers to leaving no one behind from health services

The SDGs have an overarching emphasis on improving equity and universality. Nepal made very strong progress in the MDGs which emphasised improving overall national health outcome averages; during the SDGs it will require a shift in approach. The major challenge for this is how, from all the excluded groups, to identify and reach the poorest group and tackle the causes of their being left behind.

Strengthen the FCHV cadre

Quality of care remains a problem, and poorer people often choose to pay to visit private providers. Remedying this will entail overcoming some of the gaps in human resources for health and drug procurement problems. But we also propose significant investment nationwide, in the FCHV programme, assisted by coordinated donor support may be appropriate. The FCHV programme has been highly effective at health promotion in Nepal's most remote regions, but the fact that FCHVs have a limited role beyond health promotion and data collection could be a real missed opportunity. There is scope for the programme to be further reaching and more effective at making sure

fewer people are left behind. One of the most effective ways of reaching the most underserved populations could be investing in updating the cadre of FCHVs so that their skills are enhanced, and they become a well-supported, integral part of the formal health system. Testing and evaluating a step-by-step expansion of a model similar to the approach to programme strengthening advocated by Shwartz et al. (2014) could be a sensible starting point. This involves improvement of local FCHV leadership; facilitation of structured weekly FCHV meetings; FCHV trainings at the village level; implementation of a monitoring and evaluation system for FCHV patient encounters; and provision of financial compensation for FCHV work.

Increase resources for health by increasing external financing for infrastructure

The IMF has recommended that the Government develop an externally financed infrastructure strategy that simultaneously addresses capital spending implementation bottlenecks. This approach is likely to benefit a strategy that leaves no one behind from health care coverage. As well as leading to the long-term growth required to increase domestic resources and social spending in the long run, in the short term this will lead to there being more domestic financing in the pot for the health sector.

5. Conclusion

This report has used a combination of quantitative and qualitative methods to identify who is being left behind in health care in Kenya and Nepal, as well as why and what can be done about it. On the quantitative side, we used the WHO's RMNCH CCI as our proxy for who had access to health care, and tracked it, using data from demographic and health surveys, for some commonly marginalised groups, disaggregating to sub-national levels.

Despite some limitations of the data, we found in the case of Kenya that, in most counties, poorer, rural households have worse health care coverage than wealthier ones, and that women with lower education have worse coverage than the better educated. The picture with respect to ethnicity is a bit more complex, but Kenya's big five ethnic groups do better than others in most counties. Generalising from the results is not entirely straightforward. However, they tend to confirm common perceptions that lack of health coverage is most serious in a group of northern counties that border Uganda and, in particular, Somalia: counties characterised by a pastoralist or nomadic way of life, ecological fragility and often personal insecurity related to terrorism or cattle raiding. In three counties – Mandera, West Pokot and Wajir – even the top 60% are doing worse than the national average of the bottom 40%. The predicament of the poorest in Mandera is particularly acute: there, the bottom two quintiles score less than 30% on the CCI, compared to almost 90% for the wealthiest two quintiles in Embu, the best performing county.

In Nepal, we also found that poorer households typically have worse access to health care than wealthier ones, a trend observed across district clusters. We found, too, that rural households tend to have worse access than urban households. In all but one cluster, ethnic minorities did worse than majorities, with the largest gaps in the Eastern Terai, Eastern Mountain and Mid-Western Terai regions. Lack of education is also associated with poor CCI coverage.

In addition to using demographic and health data, we used publicly available financial data to track whether resources were reaching the areas where marginalised groups are concentrated, together with document reviews, key informant interviews and focus group discussions to tease out the links between data, policy, finance and actual service provision.

The good news is that Kenya and Nepal are making considerable progress on the leave no one behind front in health.

This is most evident at the level of policy, where both countries have clear constitutional commitments and policy documents that are aligned, somewhat fortuitously in the case of Kenya, and more deliberately in the case of Nepal, with the 2030 Agenda. In Kenya, the Constitution acknowledges access to health care as a basic right, and advocates affirmative action programmes to ensure that minorities and marginalised groups are provided with reasonable access to health services. Policy documents commit the country to accelerating progress towards UHC. In Nepal, the Constitution guarantees citizens equal access to health care, paying particular attention to vulnerable groups such as women, children, the *Dalit* community and the disabled. Policies such as the Vulnerable Community Development Plan, the Collaborative Framework between the MoH and MoFALD and numerous social mobilisation efforts have been designed with a view to delivering on these goals.

Financing is also broadly aligned with leaving no one behind. Kenya's Equitable Share grant bestows higher levels of central funding on poorer counties, while several conditional grants make primary and maternal health care free at the point of delivery; social health insurance is also gradually expanding. The Constitution also mandated an Equalisation Fund which is intended to be spent in 14 'marginalised counties': these counties broadly overlap with ODI's analysis of where those left behind in health care are most concentrated. In Nepal, the health budget is heavily concentrated on primary and preventative health care: some 40 basic drugs are available free to the public, the country has an exemplary public sector community health worker programme, and, thanks to efficient budgeting, health staff and facility costs are routinely paid on time. The National Health Insurance Policy, due to be expanded in coming years, includes a subsidy component for the poor.

There has also been progress generating data pertinent to leaving no one behind. Kenya has a continent-leading HMIS and a Health Data Collaborative and an Open Data Initiative that are trying to make data more freely available. Nepal also has a robust health data collection system, facilitated by its impressive network of CHVs.

Nevertheless, serious shortfalls remain.

In Kenya, data are collected infrequently, marginalised populations are often omitted from official surveys, and infrastructural problems make data entry challenging. In Nepal, most data are not disaggregated to district level, making it difficult to know how marginalised populations

are actually faring. In addition, there is thought to be a significant ‘invisible’ urban population not captured in official statistics and neglected in health planning.

There are also demand-side issues. Policy decisions, whether *de jure* or *de facto*, are often not evidence based. In Kenya, county-level resource distribution decisions are sometimes based on political horse-trading instead of data about where the poorest live and their particular health needs. In Nepal, resource allocations to localities tend to be driven by a combination of historical precedent and political exigency, not data. The rapid turnover of governments at the centre while Nepal waits for transition to a genuinely federal system arguably exacerbates this.

These are not the only obstacles to leaving no one behind. In both countries, health resourcing levels are still short of what one would expect for achieving the Agenda by 2030, and will need to be significantly expanded. Moreover, money is not always spent efficiently or on the right things. In Kenya, there is still a bias towards curative care, evidenced by the relatively high level of resources devoted to district-level referral hospitals and the comparative neglect of the community health system. There is also evidence of policy incoherence with mismatches between capital and recurrent spending commonplace, and unpredictable resource flows from centre to locality, precipitating an unprecedented level of industrial action in the health sector. Some of these problems have been caused by the country’s ‘big bang’ devolution. While devolution has brought about some positive trends in health spending and staffing, it has also sparked numerous new political struggles over resources, most of which are unlikely to benefit those left behind.

In a sense Nepal suffers the opposite problem. There, the absence of local elections during the country’s long ‘transitional’ period has meant that local resource distribution has been dominated by entrenched interest groups and bureaucratic protocols. Even though the latter are aimed in part at addressing vulnerable groups’ needs, they are often too inflexible to accommodate the kaleidoscopic nature of micro-level marginalisation. In addition, Nepal’s generally well-functioning health service contains some significant pockets of ineffectiveness, in particular its drug procurement and capital expenditure arms, undermining the Government’s attempts to supply free primary care.

So, while on the face of things Kenya is experiencing rather too much politics in its health sector, and Nepal too little, it would be more accurate to say that both experience the ‘wrong sort of politics’, in which the broadly pro-poor rules established by the recent Constitutions are to a degree undermined by a set of games within the rules, in which the most powerful players are, unsurprisingly, not the most marginalised. Together with general resource constraints, these games weaken the links between data, policy, finance and services in our working causal model.

There is no easy fix. In the preceding pages we have set out the need for more and better data on who is left behind and where finances are going, more and better targeted resources, adopting a holistic approach to health financing, efforts to improve the accountability of decision-makers to marginalised groups, and increased discretion, at least in the case of Nepal, over local-level health spending.

Making recommendations and actually implementing them, however, are two different things. To succeed, actors with an interest in reform, which might include select government officials and politicians, development partners, civil society organisations and the media, as well as marginalised groups themselves, need to position themselves to counterbalance and ultimately outmanoeuvre vested interests with little to gain and potentially much to lose from these changes. Building networks and coalitions will be key. Perhaps the best example we found of this in our fieldwork was Nepal’s Collaborative Framework, a multi-stakeholder initiative that joins the MoH with MoFALD and Local Development, and, supported by development partners, enlists the participation of facility management committees and community groups, and at least opens the possibility of effective information sharing and coordination of actors with an interest in improving health for the poor. It will be well worth monitoring the performance of this programme in coming years, to see what lessons it holds for other dimensions of health in Nepal and further afield.

One final point: our data show that the people furthest behind are located in remote, ecologically fragile and militarily insecure areas. The challenges of providing a functioning health care system in such contexts is acute. If, however, the international community and nation states are serious about Agenda 2030, they must think creatively about solutions for such places.

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Annex 1. Methodological Appendix

Kenya

Kenya is a country of around 46 million people lying on the East African equator (World Bank, 2015). Culturally it is home to over 60 ethnic groups, of which the biggest are the *Kikuyu*, *Luhya*, *Kalenjin*, *Luo* and *Kamba* (Kurian, 1992). It has a Christian majority, with sizeable minorities of Muslims and followers of traditional religion, while ecologically it comprises a mixture of well-watered highlands suitable for cash-crop agriculture and low-lying ASALs better suited to pastoralism.

Despite recently graduating to lower middle-income status, it still has large numbers of very poor people, with an estimated 43.4% below the poverty line in 2005 (World Bank, 2015). Moreover, Government policy to date has not been especially effective in addressing these problems: in terms of progress towards meeting the MDGs, it was 13th from the bottom of 77 low-income countries in 2013 (UNDP, 2013a).

Our Kenya fieldwork was conducted in July and September 2016.

We conducted 61 individual and joint interviews with a total of 75 people. In Nairobi (n=32) these comprised individual interviews with government officials from the MoH, Ministry of Planning and Ministry of Finance, the National Hospital Insurance Fund, staff from UN agencies, NGOs, academia and think tanks working on health programming and research and data issues.

We also did fieldwork at two sub-district levels (see Table A1 and Box A1), in the counties of Narok and West Pokot. We spoke to health providers at community level (facility-in-charges at dispensaries, CHVs), the county governors and other local government officials at ward, sub-location and county level. They were selected according to their involvement with health programming, financing, administration, planning and data collection, and included MCAs from several wards. In West Pokot, one of the interviews took place in the form of an ad hoc group conversation with nine officials. In addition, eight FGDs were held: one with Community Health Volunteers in the Kibera district of Nairobi, one with health NGOs in Nairobi; three in each of the counties we visited; one group involving women who have had access to health services (full ANC and immunisation last pregnancy); one group involving women who have not had access (one or no ANC last pregnancy) and one group of men. The sites for FGDs were purposively selected for being remote, each group discussion comprised approximately 10 respondents of reproductive age, with representation of groups defined as marginalised.

As Table A1 below demonstrates, geographically both counties are overwhelmingly rural, being in the bottom three counties nationally in terms of urbanisation. Both also have international borders: West Pokot sharing a border with Uganda, while Narok neighbours Tanzania. Demographically, both have large numbers of pastoralists and both have a very young population. Economically,

Table A1. Summary profile of two districts in Kenya

County	Narok	West Pokot	National average	Minimum	Maximum
2014/15 total expenditure per capita (KShs)	7,826 Rank 33	7,970 Rank 34	7,728	4,509	19,858
2014/15 health expenditure per capita (KShs)	910 Rank 38	1,001 Rank 42	1,604	384	3,924
% of 12–23 months children fully immunised	58.5 Rank 40	31.2 Rank 47	61	18	93
% of live births delivered in a health facility in the last 5 years	38.6 Rank 39	25.8 Rank 43	61	18	93
International border	Yes	Yes			
% of urban population	6.9 Rank 46	8.3 Rank 45	32	7	100
Population density	459.5	364.4		282	988
% of population in bottom (national income)? quintile	48 Rank 36	68 Rank 42	20	0	89
Population	850,920	512,690	43,463	101,539	3,138,369
Share of population 0–14 years	53	52	42	30	54

Sources: Authors' own calculations based on data from Central Bureau of Statistics, Kenya Population and Housing Census 2009; 2014 Kenya Demographic and Health Survey; Office of the Controller of Budget (2015) 'Annual County Governments Budget Implementation Review Report'.

Box A1. Local fieldwork in Kenya: Narok and West Pokot

Narok lies in the Great Rift Valley in Southern Kenya and makes up part of the international border with Tanzania. Classified as an ASAL county, the highland Mau escarpments provide substantial areas of fertile agricultural land producing wheat and barley, while the lowlands are home to the Maasai Mara Game Reserve which is the largest source of income generated in the county. The population is predominantly *Maasai*. Traditionally, they have been semi-nomadic, and while there is a decline in their nomadic movements, they are still characterised by pastoralism (Bhandari, 2014). 38% of residents have no formal education, and 51% are only educated to primary level, and in some constituencies this level is much higher (Njonjo, 2013). Narok county ranks worst nationwide in access to improved water, and quite poorly in a range of health and poverty indicators. It is 39th out of 47 counties when it comes to the percentage of live births delivered in a health facility in the last 5 years, and 40th when it comes to immunisation rates for children of 12–23 months. Poorer households do much worse than richer ones when it comes to access to health services; urban households do much better than rural; and better educated mothers do much better than uneducated ones.

West Pokot also lies in the Rift Valley, further to the North and bordering Uganda. Characterised by harsh terrain and climate, West Pokot is also classified as an ASAL county (County Government of West Pokot, 2015). It also suffers from tribal clashes with the neighbouring Turkana people and cross-border instability with Uganda. The main livelihoods are pastoralism, agro-pastoralism and mixed farming. The *Pokot* people who reside in East Kenya and West Uganda have a traditional and male dominated governance system, and polygamous households are common. West Pokot ranks very poorly on a range of indicators, 38th out of 47 counties in the poverty index, and 46th in the proportion of people with secondary education, 44th and 45th in access to electricity and improved water respectively (CRA, 2013). In terms of access to health care, West Pokot does less well than Narok: it is 47th out of 47 for the share of 12–23 month children immunised, and 43rd out of 47 for live births delivered in health facilities. Rural households and uneducated mothers do particularly badly in relation to other households (CRA, 2013; KNBS 2009).

Sources: CRA, 2013; County Government of West Pokot, 2015; KNBS, 2009; County Government of Narok, 2015.

both are considerably poorer than the national average, and financially both are very similar in terms of per capita expenditure.

Despite these similarities, Narok performs consistently better on health indicators than West Pokot. To give just two examples, 39% of women in Narok have institutional births, compared to only 26% in West Pokot, and 58.5% of children in Narok were immunised against infectious diseases, compared to just 31.2% in West Pokot. Thus, while both counties do badly compared to the Kenyan national average (providing some general insights into the plight of those left behind), Narok fares less badly, providing the possibility of learning something about the conditions in which the plight of the marginalised is ameliorated. In the event, our short time in the field, plus our lack of personal familiarity with the counties (county selection being driven by data analysis rather than researcher familiarity), meant we were unable to build a systematic account of the institutional drivers of this difference. Nevertheless, both studies yielded some interesting qualitative findings on local politics and health, which we use to illustrate our overall analysis.

Nepal

Nepal is a small, landlocked country in South Asia, with a population of 28.5 million (World Bank, 2015). A low-income and least developed country, it is the second poorest in Asia, with gross national income (GNI) per capita of \$744 in 2015 (World Bank, 2015). Nepal has made impressive progress on the MDGs, especially in poverty reduction and basic health and education (UNDP, 2013). However, 15% of the population still live in extreme poverty (below 2011 purchasing power parity \$1.90/day) and 25% fall below the national poverty line (World Bank, 2015). Achieving the SDGs will demand an acceleration of economic growth from current levels of roughly 4% to 5% annually, as well as addressing entrenched dynamics of marginalisation (ibid.). Nepal has a richly diverse society; the most recent census listed 125 different caste and ethnic groups, which are distributed relatively heterogeneously across the country (Nepal CBS, 2014). However, historically there has been pervasive discrimination and inequality based on ethnicity, caste, religion and gender. Nepal successfully transitioned out of post-conflict status following the end of a decade-long civil war in 2006, and in 2015 promulgated a new Constitution, which will provide the basis for future democratic elections under a federal system. However, the terms of the political resettlement are still highly contested by some political parties and minority groups.

Our Nepal fieldwork took place from September to October 2016.

Table A2. Summary profile of two districts in Nepal

District	Kapilvasthu	Pyuthan	National average	Minimum	Maximum
2014/15 expenditure per capita (NRs/\$) ¹	63	100	164	50	1402
2014/15 health expenditure per capita (NRs/\$) ¹	3.6	6.7	12	2.3	159
% of children (<2yrs) who received the third dose of DPT3 vaccine ³	92% (93%)	>100%* 99%	93%	77%	100%
% of institutional deliveries (cluster) ³	17% (50%)	48 (56%)	52%	6%	>100%*
% children under one year fully immunised as per schedule. (cluster) ³	47% (95%)	>100%* (91%)	65.50%	55.80%	71.90%
International border	Yes	No			
Population density	329	174	163.6	3	4416
% of population in national bottom quintile of the wealth index ²	6%	74%	20%		
Population ⁴	571,936	228,102	17,845,468		
Share of population 0–14 years ⁴	38.25	43.22			

Sources: ¹FCGO; ²MICS; ³HMIS; ⁴Census, 2011.

* In order to present data disaggregated to district level this Table draws on administrative (HMIS) data so the population numbers (i.e. the denominator when looking at the % coverage) are estimates, meaning coverage levels are sometime over 100%.

Here, we adopted a different tack for district selection and, in addition to health outcomes data, we depended more on advice from local partners, government officials and donors to suggest districts that would present interesting and useful contrasts, choosing one in the country's Hill region (Pyuthan district) and one in the Terai region (Kapilvasthu district) so that we were able to gain insight from two out of the three ecological zones in Nepal. Nepal is divided into three 'ecological zones': Mountain, Hill and Plain (Terai). They tend to have distinct differences in health outcomes in relation to their topographic and demographic profile. For this reason, we were advised to ensure that our two sites were not located within the same ecological zone (see map at Figure 24).

About 45% of the population lives in the Hill regions and about 47% live in the Terai, where population density is much higher. We selected the Terai district of Kapilvasthu because it showed poorer health outcomes than other districts within the same cluster, despite having relatively good road infrastructure and reasonable health infrastructure. It also performed poorly in a mapping of marginalisation carried out by UNICEF (UNFCO, 2013). Our conversations with local experts suggested that the social, economic and political issues of such a district would be an interesting element of exclusion. Table A2 shows some health outcomes of Kapilvasthu relative to the cluster as a whole that highlight these issues. The district of Pyuthan is in the Hill area, and the difficult terrain means that infrastructure and accessibility are considerably poorer than Kapilvasthu. Pyuthan was selected on the basis of

its having similar problems in health access to other Hill districts, but with remote areas that were accessible to us within the time limits of the project. Our local partners already had connections in the two districts areas selected, which made it easier to generate rich data within a short time. Finally, we undertook some fieldwork in urban and peri-urban Kathmandu in response to suggestions from local experts that there are important gaps in urban health service delivery in Nepal.

38 interviews covering 47 respondents were carried out at national level to understand the perspectives of government officials, development partners from UN agencies, bilateral donors, INGOs and journalists. In Kapilvasthu and Pyuthan fieldwork involved visits to a number of health service providers at village level, interviews with FCHVs and HP staff as well as NGO programmers, district administrators, district health officials and community representatives. Four FGDs (two with men, two with women) were held between the two districts to obtain perspectives from those living in areas considered left behind in the country, using the same selection criteria as in Kenya. In urban and peri-urban Kathmandu we interviewed representatives from community groups (Ward Citizen Forums), staff from two government clinics and one private (NGO) clinic on the edge of a slum where we also had informal conversations with local residents about their health services.

Box A2. Local fieldwork in Nepal: Kapilvasthu and Pyuthan

Lying on Nepal's southern border with India, Kapilvasthu is in the *Terai* ecological zone of Nepal, and is characterised by low-lying plains, although there is some forested hilly terrain (up to 820 metres) in the northwest. It is a 'moderately ecologically vulnerable' district, with flooding and soil erosion common during the monsoon season. The population of 572,000 has a young population profile, with far fewer males than females in the district, due to the high levels of migration to India and beyond. The main occupation is agriculture, but a shortage of labour due to migration has affected the district's agricultural production capacity. The majority religion is Hindu (81%), but there is a substantial Muslim minority (18%) and a high number of groups categorised as marginalised, including the Muslim population, the *Madeshi* and *Tharu* indigenous groups (half of the district population), and there are overlapping layers of marginalisation. In terms of caste, the population comprises about 17% *Janajatis* and 13% *Dalits*, both of which are considered as marginalised. There is a long-standing tension due to land disputes between *Madeshi* and *Pahad* communities (both Muslim and Hindu). Well-being of women in Kapilvasthu is of particular concern, with social and gender-based exclusion in its *Madeshi* and Muslim communities. It has among the lowest contraceptive prevalence rates (31%) in Nepal. Only 14% of women deliver their babies with the assistance of a skilled birth attendant. Education outcomes of women is also poor, 45% of women are literate compared to 65% of men.

Pyuthan is located in Mid-Western Development Zone in the Hill region of Nepal in the Rapti zone. *Magars* represent about a third of the population and largely live in the highlands. A quarter of residents are *Chhetris*, followed by *Kami* (14%) and Hill *Brahmins* (10%). Agriculture is the predominant source of livelihood in Pyuthan, with 50% of men and 63% of women engaged in their own agriculture. Women make up 56% of the population, in part due to high levels of male migration out of the district for employment. About 32% of the population in Pyuthan was poor in 2011 as per the national definition. In terms of education, 58% of residents are educated to primary level or less, although the district has a relatively high literacy rate of 67%. International labour migration is a common trend in the district. The *Magars* are an ethnic community (which constitutes around 7% of the total population of Nepal) that comprises one third of the district population. The status of women among Hill and Mountain ethnic communities is better than in Kapilvasthu. Life expectancy of Pyuthan (64.33 years) is also lower than that of Kapilvasthu (67.56 years).

Sources: UNFCO (2013); CBS (2014); NPC and UNDP (2014).

At every stage, efforts were made to try and triangulate information using different informants and data sources. However, on some topics we were only able to get the opinions or experience of one or two interviewees. This will be apparent to the reader from the references, and our findings in such cases are appropriately circumspect.

In both countries we followed ethical protocols, informing potential interviewees of the purposes of the research, assuring them of confidentiality and seeking their consent.

Our interviews are coded as follows:

KGO	Kenya Government/Parastatal official
NGO	Non-Governmental Organisation representative
KA	Kenyan academic/policy analyst
IDP	International development partner (donor) official
LR	Local resident
NPGO	Nepal Government/Parastatal official
JM	Journalist or media
INGO	International non-governmental organisation official
FGD	Focus group discussion respondent
FCHV	Female Community Health Volunteer [Nepal]
CG	Community Group [Nepal]
FGDNGO	Health NGO Focus Group (Kenya)
CHVFGD	Community Health Volunteer Focus Group (Kenya)

A list of those interviewees who preferred to be named follows:

List of interviewees: Kenya

Name	Role/Organisation	Location	Interview code
Miriam Were	Retired expert on community health. Serving Chairperson of the African Medical and Research Foundation (AMREF)	Nairobi	KA
Omondi Otieno	Chief of Party. Capacities for Health	Skype	NGO
Mwanza Joachim Odongo	Policy planning and health care financing. Ministry of Health	Nairobi	KGO
Stephen Cheruiyot	Health Economist. Ministry of Health	Nairobi	KGO
Chimaraoko Izugbara	Head of Population Dynamics and Reproductive Health and Director of Research Capacity Strengthening. Africa Population Health Research Center (APHRC)	Nairobi	NGO
Ruth Kitetu	Head of Policy and Planning, Policy and Strategic Planning Unit. Ministry of Health	Nairobi	KGO
Donald Nyambane	Health records and information officer. Sub-county health management team, Narok West	Narok	KGO
Multiple	Community Health Volunteers. Narok West	Narok	KGO
Moffat Kangi	County Commissioner. Government of Narok	Narok	KGO
Shedd Simotwo	County Clerk. Government of Narok	Narok	KGO
Justus Yiaile,	Deputy County Clerk. Government of Narok	Narok	KGO
Vivien Sereti	County Executive Health. Government of Narok	Narok	KGO
Samuel Ogola	Senior Programme Officer. Kenya National Bureau of Statistics	Nairobi	KGO
Bitange Ndemo	Former Permanent Secretary. Ministry of Information and Communication	Nairobi	KGO
Emmanuel Manyasa	Manager, Uwezo. Twaweza	Nairobi	NGO
Cristine Akuto	Chief Officer Health. Government of West Pokot	West Pokot	KGO
Joseph Kieyah	Acting Programmes Coordinator. KIPPRA	Nairobi	KA
Muchiri Nyaggah	Executive Director. Local Development Research Institute (LDRI)	Nairobi	NGO
Benson Ruto Chumakemer	County Public Officer. Government of West Pokot	West Pokot	KGO
Ololtisati Kamwaro	County Speaker. Government of Narok	Narok	KGO
Abraham Rugo Muriu	Academic. Universitat Potsdam	Nairobi	KA
Phyllis Makau	Parliamentary Budget Office	Nairobi	NGO
Raphael Munavu	Commissioner. Revenue Allocation	Nairobi	KGO

Name	Role/Organisation	Location	Interview code
John Mose	Senior Analyst. Revenue Allocation	Nairobi	KGO
Job Otiwa	Senior Analyst. Revenue Allocation	Nairobi	KGO
Joseph Kiyeh	KIPPRA	Nairobi	KA
James Gachanga	KIPPRA	Nairobi	KA
Valerie Kikomi	Coordinator. Health Care Financing, Policy and Planning. Ministry of Health	Nairobi	KGO
John Kunya	State Department of Devolution. MPD	Nairobi	KGO
Patrick Ngichuru	State Department of Devolution. MPD	Nairobi	KGO
Albert Mwenda	Intergovernmental Affairs. National Treasury	Nairobi	KGO
Joseph Limo	Budget and Appropriations Committee. National Assembly	Nairobi	KGO
Makali Mulwa	Budget and Appropriations Committee. National Assembly	Nairobi	KGO
Gideon Ochandu	Budget and Appropriations Committee. National Assembly	Nairobi	KGO
Paul Okumo	Head of Secretariat. Africa Platform	Nairobi	NNGO
Anne Omolo	World Vision	Nairobi	KNGO
Elijah Don Bonyo	Associate Director. World Vision	Nairobi	KNGO
Lilian Otiso	Director of Services. LVCT Health	Nairobi	KNGO
Priscillah Chebet Mungo	Treasury (Budget and Planning)	West Pokot	KGO
Kennedy Tegeret	Treasury (Budget and Planning)	West Pokot	KGO
Esterlina Moseti	World Vision	West Pokot	KNGO
Chrsitopher Kibrop	World Vision	West Pokot	KNGO
Cynthia Nyakombo	World Vision	West Pokot	KNGO
Multiple	MCAs and Technical staff. County Assembly	West Pokot	KGO
Joel Ngolekong	West Pokot County Treasury (CECM) and Department of Health	West Pokot	KGO
Geoffrey Kibet Lokong	West Pokot County Department of Health (Finance and Administration)	West Pokot	KGO
Simon Kachapin	Governor. Governor's Office	West Pokot	KGO
Muchiri Nyaggah	Local Development Research Institution	Nairobi	KNGO
Mariam Nyaggah	Senior Economist. National Treasury	Nairobi	KGO

List of interviewees: Nepal

Name	Role/organisation	Location	Interview code
Anil Nyaupane	Editor in Chief. Swasthya Khabar Patika	Kathmandu	JM
Baikuntha Aryal	Joint Secretary. International Cooperation Coordination, Ministry of Finance	Kathmandu	NPGO
Bhogendra Dotel	District Public Health Officer and President of Public Health Association. District Public Health Office / Public Health Association	Kathmandu	NPGO
Deepak Karki	Health Advisor. DFID Nepal	Kathmandu	IDP
Bishnu Adhikari	Governance Advisor. DFID Nepal	Kathmandu	IDP
Nina Schuler	Social Development Advisor. DFID Nepal	Kathmandu	IDP
Rajendra Prasad Nepal	Financial Comptroller General. Financial Comptroller General's Office	Kathmandu	NPGO
Bhuban Prasad Kafle	Deputy Financial Comptroller General. Financial Comptroller General's Office	Kathmandu	NPGO
Murari Niraula	Under Secretary. Financial Comptroller General's Office	Kathmandu	NPGO
Franziska Fuerst	Team Leader. Senior Advisor, GIZ Nepal	Kathmandu	IDP
Valerie Broch Alvarez	Senior advisor. Senior Advisor, GIZ Nepal	Kathmandu	IDP
Damodar Adhikari	Deputy Chief of Party. RTI, Health for Life	Kathmandu	INGO
Kanchan Tamang Lama	Quality Assurance Specialist. Helvetas Nepal	Kathmandu	INGO
Lal Sankar Ghimire	Joint Secretary. National Planning Commission	Kathmandu	NPGO
Kalanidhi Devkota	Executive Secretary. Municipal Association of Nepal (MAUN)	Kathmandu	NPGO
Surya Prasad Acharya	Retired; formerly Joint Secretary. Financial Sector Management Division, Ministry of Finance	Kathmandu	NPGO
Purusottam Nepal	Member Secretary. Local Bodies Fiscal Commission, Ministry of Federal Affairs and Local Development	Kathmandu	NPGO
Mahendra Prasad Shrestha	Division Chief. Policy, Planning & International Cooperation Division, Ministry of Health	Kathmandu	NPGO
Lila Raj Poudel ?	Policy, Planning & International Cooperation Division, Ministry of Health	Kathmandu	NPGO
Suresh Tiwari	Director. Oxford Policy Management Nepal (embedded technical assistance in Health Sector Support Programme)	Kathmandu	INGO
Rajan Adhikari	Policy, Planning & International Cooperation Division, Ministry of Health	Kathmandu	NPGO
Sitaram Prasai	GESI Advisor. Nepal Health Sector Support Programme, supported by DFID	Kathmandu	NPGO

Name	Role/organisation	Location	Interview code
Sanjaya Aryal	Human Rights Project Officer. Office of the Prime Minister and Council of Ministers	Kathmandu	NPGO
Sushil Baral	Chairperson. Health Research and Social Development Forum (HERD)	Kathmandu	NGO
Rajeev Pokharel	Under Secretary. Policy, Planning & International Cooperation Division, Ministry of Health	Kathmandu	NPGO
Anne Austin	Nepal Health Sector Support Programme, supported by DFID		IDP
Pradeep Poudyal	Nepal Health Sector Support Programme, supported by DFID		IDP
Dipendra Raman Singh	Curative Services Division, Ministry of Health	Kathmandu	NPGO
Suman Aryal	Central Bureau of Statistics	Kathmandu	NPGO
Latika Maskey Pradhan	Assistant Representative. UNFPA Nepal	Kathmandu	INGO
Tirtha Man Tamang	Programme Officer, Population and Development. UNFPA Nepal	Kathmandu	INGO
Bobbi Rawal Basnet	Monitoring and Evaluation Officer. UNFPA Nepal	Kathmandu	INGO
Asha Pun	Maternal and Newborn Health Specialist. UNICEF Nepal	Kathmandu	INGO
Hendrikus Raaijmakers	Chief of Health. UNICEF Nepal	Kathmandu	INGO
Daniel Sinclair	Deputy Director of Health, Office of Health and Education. USAID Nepal		INGO
Chandra Rai	Country Director. Jhpiego Nepal	Kathmandu	INGO
Subhash Ghimire	Editor in Chief. My Republica	Kathmandu	JM
Multiple	Members. Ward Development Forum	Kathmandu Ward 4	CG
Susheel Lekhak	Executive Director . South Asian Institute for Policy Analysis and Leadership. Also, WHO Nepal	Kathmandu	IDP
Ransharan Chimaurya	Health Economics and Financing Unit. Ministry of Health	Kathmandu	NPGO
Jhapendra Bhandari	Health Economics and Financing Unit, Ministry of Health	Kathmandu	NPGO
Chudamani Bhandari	Department of Health Services (Insurance), Ministry of Health	Kathmandu	NPGO
Yuvaraj Pandey	Vice-Chairman. Poverty Alleviation Fund	Kathmandu	NPGO

List of interviewees: Kapilvasthu and Pyuthan

Name	Role	Organisation /Institution	Location	Interview code
Keshab Ghimire	Health Post In-charge, Sihokhor VDC	Health Post, District Public Health Office	Sihokhor, Kapilvasthu	NPGO
Multiple	Health Post In-charge, Assistant Health Worker Auxiliary Nurse Midwife	Banskhor Health Post,	Banskhor, Kapilvasthu	NPGO
Chandra Kant Neupane	Local Development Officer	District Development Office	Taulihauwa, Kapilvasthu	NPGO
Ranjan Pokharel	Communication Officer	District Development Office	Taulihauwa, Kapilvasthu	NPGO
Ganesh Thapa	Coordinator, Health for Life	Health for Life	Taulihauwa, Kapilvasthu	INGO
Multiple	Female Community Health Volunteer	Banskhor Health Post (2), Pipara Health Post (3)	Banskhor, Kapilvasthu	FCHV
Shiva Ghulam Kalvar	Technical Assistant	Pipara VDC, DDO	Pipara, Kapilvasthu	NPGO
Yogendra Bhagat	District Public Health Officer	DPHO	Taulihauwa, Kapilvasthu	NPGO
Multiple	Health Workers	Health Post	Okharkot, Pyuthan	NPGO
Multiple	Management and Staff	VDC	Okharkot and Bangemaro, Pyuthan	NPGO
Multiple	Health Workers	Health Post	Bangemaro, Pyuthan	NPGO
Krishna Shah	District Health Officer	District Health Office	Pyuthan	NPGO
Multiple	Technical Officer	District Development Office	Pyuthan	NPGO
Multiple	Accounting and Information Officers	District Treasury Comptroller Office	Pyuthan	NPGO
Multiple	Health Workers	District Hospital	Pyuthan	NPGO
Bikash Sahani	Health Workers	Primary Health Care Centre	Bhingri, Pyuthan	NPGO
Multiple	Management and Staff	VDC Secretariat	Bhingri, Pyuthan	NPGO
Multiple	Management and Staff	VDC Secretariat	Swargadwari Khal, Pyuthan	NPGO
Multiple	Health Workers	Health Post	Swargadwari Khal, Pyuthan	NPGO
Multiple	Technical staff	Municipal Council	Pyuthan	NPGO
Multiple	Local politicians		Pyuthan	NPGO
Multiple	Technical staff	Kalika	Pyuthan	NGO

Annex 2. SDG 3 indicators adapted to Nepal

Source: NPC (2015) *Sustainable Development Goals: 2016–2030 National (Preliminary) Report*. Kathmandu: Government of Nepal National Planning Commission.

Some of the target figures and indicators are not given in the following tables where these have yet to be agreed on or developed.

Targets for SDG 3: Ensure healthy lives and promote well-being for all at all ages with proposed indicators, current status and future projections				
Targets and Indicators	2014	2020	2025	2030
Target 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births				
3.1 Maternal mortality ratio (per 100,000 live births)	258	127	99	70
Target 3.2 By 2030, end preventable deaths of newborns and children under 5 years of age				
3.2a Neonatal mortality rate (per 1,000 live births)	23	14	8.5	1
3.2b Under-five mortality rate (per 1,000 live births)	38	23	13.8	1
Target 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, and combat hepatitis, water-borne diseases and other communicable diseases				
Target 3.3a By 2030, end the epidemics of AIDS				
3.3a1 HIV prevalence for the overall population aged 15–49 year (%)	0.2	0.13	0.06	0
3.3a2 HIV prevalence among men and women aged 15–24 year (%)	0.03	0.01	0	0
3.3a3 Proportion of population with advanced HIV infection receiving antiretroviral combination therapy (%)	38.8	61.8	80.9	100
Target 3.3b By 2030, end the epidemics of tuberculosis				
3.3b Prevalence of tuberculosis (TB) per 100,000 population	211f	132	66	0
Target 3.3c By 2030, end the epidemics of malaria				
3.3c Confirmed malaria cases (number)	1674	1046	523	0
Target 3.3d By 2030, end the epidemics of neglected tropical diseases				
3.3d1 Registered prevalence rate (per 10,000 of pop) for leprosy	0.83	0.52	0.26	0
3.3d2 Kalaazar (visceral leishmaniasis) cases (number)	325	203	102	0

Targets and Indicators	2014	2020	2025	2030
3.3d3 Average prevalence of lymphatic filariasis (%)	13i	8.13	4.06	0
3.3d4 Cases of dengue (number)	728	455	228	0
3.3d5 People die annually due to rabies (number)	100	63	31	0
3.3d6 Active trachoma cases (number)	136	85	43	0
3.3d7 Average prevalence of soil transmitted helminthes among school-going children (%)	15	9.38	4.69	0
Target 3.3e By 2030, combat hepatitis				
3.3e1 Confirmed cases of hepatitis A (number)	174	109	54	0
3.3e2 Confirmed cases of hepatitis B (number)	101	63	32	0
3.3e3 Cases of unspecified viral hepatitis (number)	173	108	54	0
Target 3.3f By 2030, combat water-borne diseases				
3.3f1 Annual incidence of diarrhoea (per 1,000 children under 5 years of age)	578	361	181	0
3.3f2 Children under 5 years of age with diarrhoea in the last two weeks (%)	12j	8	4	0
3.3f3 Cases of typhoid (number)	9549	5968	2984	0
3.3f4 Cases of cholera (number)	33	21	10	0
Target 3.3g By 2030, combat other communicable diseases				
3.3g1 Confirmed cases of Japanese encephalitis (number)	118	74	37	0
3.3g2 Confirmed cases of influenza (H1N1) (number)	204	128	64	0
Target 3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being				
Target 3.4a By 2030, reduce by one third premature mortality from non-communicable diseases				
3.4a1 Deaths (ages 30–70 years) from cardiovascular diseases (CVDs), cancers, chronic respiratory diseases and diabetes (%)	22.0	16.5	11.9	7.3
3.4a2 Deaths from NCDs out of all deaths (%)	43.7	32.8	23.6	14.5
3.4a3 Deaths from CVDs out of all deaths (%)	22.3	16.7	12.1	7.4
3.4a4 Deaths from cancers out of all deaths (%)	7.0	5.2	3.8	2.3
3.4a5 Deaths from chronic obstructive pulmonary diseases out of all deaths (%)	4.9	3.7	2.6	1.6
3.4a6 Deaths from diabetes out of all deaths (%)	1.7	1.3	0.9	0.5
Target 3.4b By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment				
3.4b1 People (aged 15–69 years) with raised total cholesterol (%)	22.7	17	12.3	7.5
3.4b2 People (aged 15–69 years) with raised blood pressure levels (%)	88.3	66.2	47.8	29.4
3.4b3 People (aged 15–69 years) not engaging in vigorous activity (%)	53.6	40.2	29	17.8
3.4b4 People (aged 15–69 years) who are overweight (%)	21.6	16.2	11.7	7.2
3.4b5 People (aged 15–69 years) who currently drink or drank alcohol in the past 30 days (%)	17.4	13.1	9.4	5.8
3.4b6 People (aged 15–69) who currently smoke tobacco daily %	15.8	11.8	8.5	5.2
Target 3.4c By 2030, promote mental health and well-being				
3.4c1 Mental health problems (%)	14.0	10.5	7.6	4.7

Targets and Indicators	2014	2020	2025	2030
3.4c2 Suicide rate (per 100,000 population)	25	16	8	1
3.4c3 Women (aged 15–24 years) who are very or somewhat satisfied with their life (%)	80.8	86.1	90.6	95
Target 3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol				
3.5 Hard drug users (estimated number)	91,534	65,790	44,337	22,884
Target 3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents				
Target 3.6a By 2020, halve the number of deaths from road traffic accidents				
3.6a1 Road traffic accident mortality (per 100,000 population)	33.7	16.8	-	-
Target 3.6b By 2020, halve the number of injuries from road traffic accidents				
3.6b1 Serious injuries (per 100,000 population)	71.7	35.9b	-	-
3.6b2 Slight Injuries (per 100,000 population)	163.7	81.9b	-	-
Target 3.7 By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes				
3.7a Contraceptive prevalence rate (modern methods) (%)	49.6	59.1	67.1	75
3.7b Proportion of births attended by SBA (%)	55.6	68.5	79.3	90
3.7c Adolescent fertility rate (births per 1,000 women age 15–19 years)	71	55.6	42.8	30
3.7d Antenatal care (ANC) coverage (at least four visits) (%)	59.5	70.9	80.5	90
3.7e Institutional delivery (%)	55.2	70	80.9	90
3.7f Postnatal care (PNC) for mothers (%)	57.9	70	80	90
3.7g Unmet need for family planning (%)	25.2	19.5	14.8	10
3.7h Proportion of demand satisfied for family planning (%)	-	-	-	-
3.7i Total fertility rate (births per women)	2.3	2.20	2.11	2
3.7j Households within 30 minutes travel time to a health facility (%)	61.8	85	87.5	90
3.7k Prevalence of uterine prolapse among women of reproductive age group (15–49 years) (%)	7	4.4	2.25	0.1
Target 3.8 Achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all				
3.8a Government health expenditure as % of GDP	5.3	6.31	7.16	8
3.8b Health facilities meeting minimum standard of quality of care (%)	-	-	-	-
3.8c Children age 12–23 months who received all vaccinations (%)	84.5	90.3	95.2	100
Target 3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination				
3.9a Deaths from hazardous chemicals (toxic substances, etc.) (number)	22	14	7	0
3.9b Illnesses from hazardous chemicals (toxic substances, etc.) (number)	1205	791	445	100

Annex 3. Sample from results framework and results chain

NMoH (2015b) *Nepal Health Sector Programme-III 2015–2020 [NHSP-III, 2015–20] Results Framework*. Kathmandu: Government of Nepal Ministry of Health and Population (nhsp.org.np/hwp-content/uploads/2015/01/NHSP-3-Results-Framework_jan25.pdf).

Goal: Improved health status of all people through accountable and equitable health delivery system										
Code	Indicator	Baseline			Milestones/ target		Data source	Monitoring frequency	Responsible agency	Assumption(s)/ Remarks
		Data	Year	Source	2017	2020				
G1	Maternal mortality ratio (per 100,000 live births)	281	2006	NDHS	151	127	NDHS	5 years	MoHP	Pregnancy related mortality ratio. Linear decline from 281 in 2006 with 5.5% ARR (WHO global estimate)
G2	Under five mortality rate (per 1,000 live births)	38	2014	NMICS	45	40	NDHS, MICS	3 years	MoHP	
	Wealth quintile									
	Lowest quintile		2014				NDHS, MICS	3 years	MoHP	
	Highest quintile		2014				NDHS, MICS	3 years	MoHP	
	Sex									
	Female		2014				NDHS, MICS	3 years	MoHP	
	Male		2014				NDHS, MICS	3 years	MoHP	
	Caste/ethnicity									
	Dalits		2014							
	Janajati		2014							
G3	Neonatal mortality rate (per 1,000 live births)	23	2014	NMICS	17	14	NDHS, MICS	3 years	MoHP	Thematic group
	Wealth quintile									
	Lowest quintile		2014							
	Highest quintile		2014							
	Sex									
	Female		2014							
	Male		2014							
	Caste/ethnicity									
	Dalits		2014							
	Janajati		2014							
G4	Total fertility rate	2.3	2014	NMICS	2.3	2.2	NDHS, MICS	3 years	MoHP	
	Caste/ethnicity									
	Dalits		2014							
	Janajati		2014							
	Muslim		2014							
	Area									
	Rural		2014							
	Urban		2014							
	Adolescent fertility rate per 1000 women	71	2014	NMICS						
	Caste/ethnicity									
G5	Dalits		2014							
	Janajati		2014							
	Muslim		2014							
	Area									
	Rural		2014							
	Urban		2014							

Summary of results chain

Output		→	Outcome	→	Goal
OP1a1	Health sector staff available at all levels in line with revised standards	OC1	Strengthened health system: HRH, Infrastructure, Procurement and Supply chain management	Improved health status of all people through accountable and equitable health delivery system	
OP1a2	Improved human resource education and competencies				
OP1b1	Health facilities are built or upgraded following standard guidelines				
OP1b2	Maintenance capabilities enhanced at regional and district levels				
OP1c2	Improved need-based procurement system				
OP1c1	Improved supply chain management	OC2	Improved quality of care at point-of-delivery		
OP2.1	Quality health services delivered as per the standard protocols/guidelines				
OP2.2	Quality assurance system strengthened				
OP2.3	Improved waste management	OC3	Equitable utilization of health care services		
OP3.1	Essential and basic health service packages are delivered				
OP3.2	Increased utilization of health services by unreached population				
OP3.3	Basic health service networks including referral system strengthened	OC4	Strengthened decentralized planning and budgeting		
OP4.1	Periodic and annual health plans and budget are developed and implemented by Local Bodies				
OP4.1	Institutional capacity for participatory planning, implementation and monitoring enhanced	OC5	Improved sector management and governance		
OP5.1	Ministry of Health and Population (MoHP) structure is responsive to health sector needs				
OP5.2	Improved management of private sector				
OP5.3	Development cooperation and aid effectiveness in the health sector improved				
OP5.4	Multi-sectoral coordination mechanisms strengthened				
OP5.5	Improved public financial management within MoHP				
OP5.6	Performance based system implemented	OC6	Improved sustainability of health sector financing		
OP6.1	Health financing system strengthened				
OP6.2	Social health protection mechanisms strengthened	OC7	Improved healthy lifestyles and environment		
OP7.1	Healthy behaviors and practices promoted				
OP7.2	Improved environmental and occupational health competencies developed within MoHP	OC8	Strengthened management of public health emergencies		
OP8.1	Improved preparedness for public health emergencies				
OP8.2	Strengthened response to public health emergencies	OC9	Improved availability and use of evidence in decision-making processes at all levels		
OP9.1	Integrated information management				
OP9.2	Research and studies conducted in priority areas				
OP9.3	Health sector monitoring and evaluation strengthened				

Annex 4. Additional budget charts in Nepal

Patterns of per capita District Budget Allocations

Per capita district allocations are highly skewed. While the mean allocation is \$12.61, the median is \$7.37, with a maximum allocation of \$187.92 and minimum of \$2.34. Allocations are biased towards the Mountain and Hill districts over *Terai* districts. While allocations are relatively even across *Terai* districts they vary across Hill districts, and substantially so across Mountain districts.

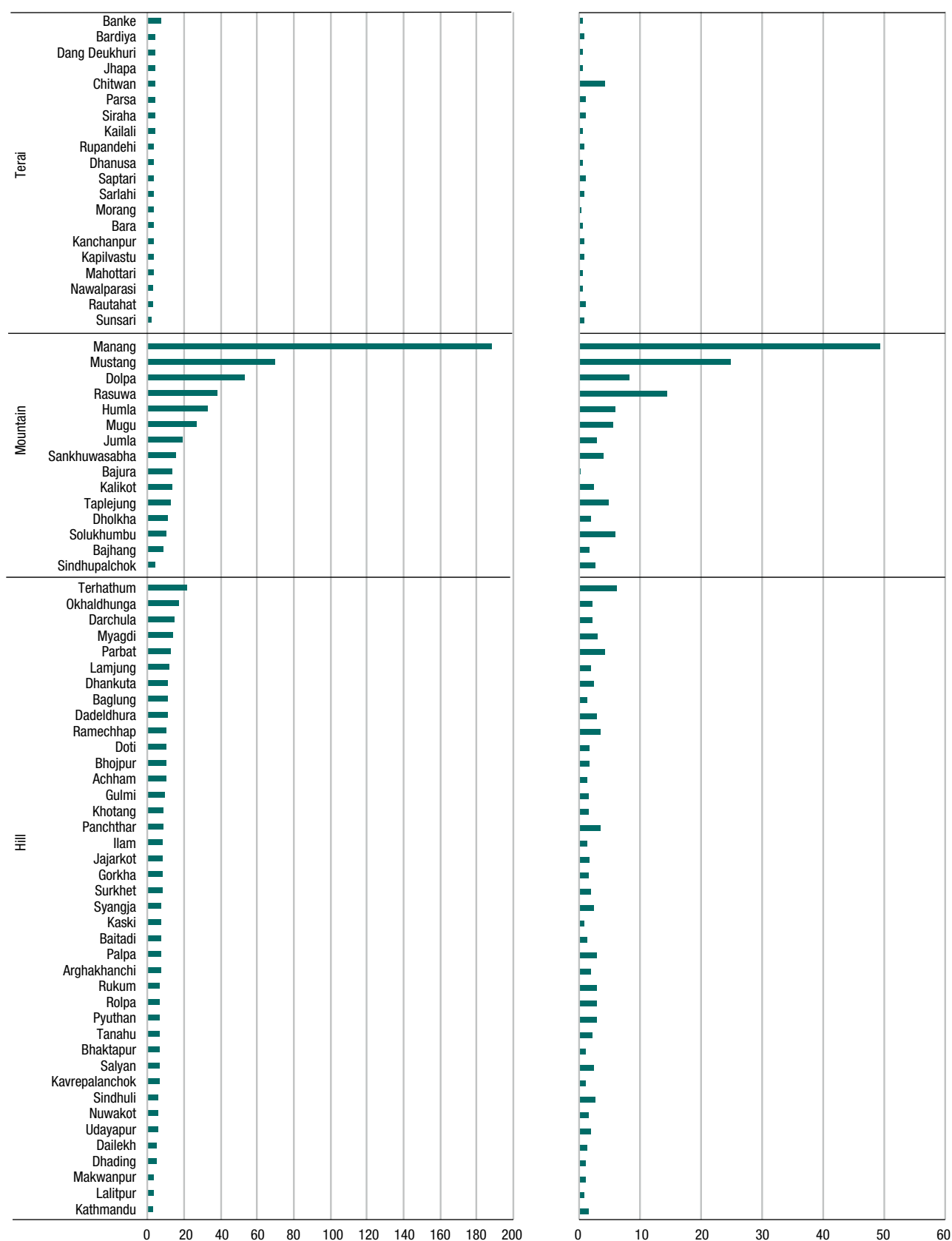
Table A3. Budget allocation summary statistics by ecozone

Ecozone	Mean	Median	Max	Min
Terai	3.99	3.81	7.02	2.34
Hill	8.73	7.80	21.53	2.67
Mountain	34.49	15.83	187.92	4.66

Source: NMoH and NHSSP (2015).

On-budget EDP health spending reinforces some of the larger per capita inequities in district health budgets (e.g. Manang, Mustang, Dolpa and Rasuwa in Mountain ecozones) but displays a slightly different pattern of district focus with respect to Hill districts (See Figure A1 below).

Figure A1. District budget and aid spending patterns (\$ per capita)



Source: NMoH and NHSSP (2015), Nepal AMP.

Health indicators and budget allocations

Indicators of maternal health do not appear to inform district budget allocations, including the Integrated Reproductive Health and Women's Health Programme Budget itself.

Districts which rank significantly above the average rate of 48% for the percentage of pregnant women having four ANC check-ups receive similar budget allocations to those significantly below the average, while districts with similar rankings receive significantly different budget allocations.

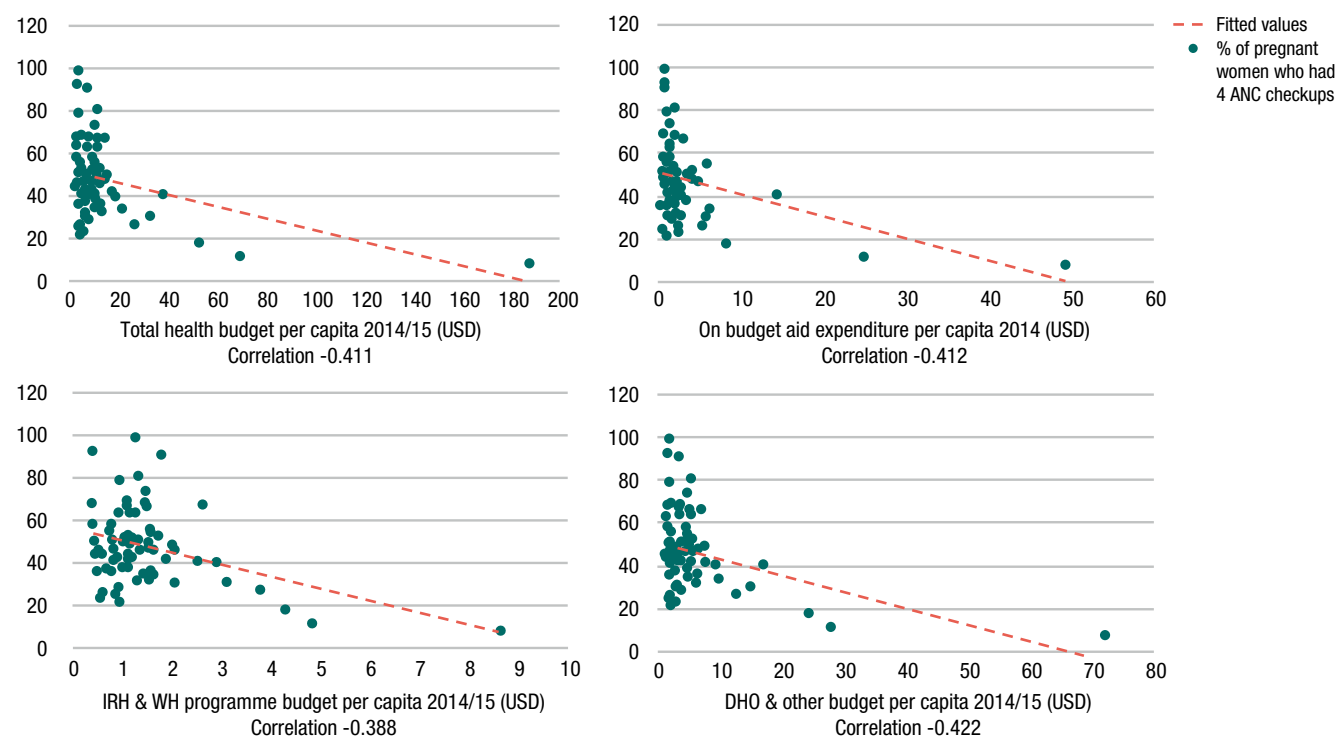
Furthermore, districts which rank below 20% receive disproportionately large budget allocations compared to districts that are just slightly above this threshold, suggesting that remoteness is the factor driving outlying budget allocations.

The observations are similar with respect to the percentage of births attended by a skilled birth attendant

(See Figure A2). While below average outliers appear to have been targeted with more financial resources this probably relates to the remoteness of these districts. Again, some high-performing districts receive similar allocations to some low-performing districts, while allocations to districts with similar rankings differ considerably.

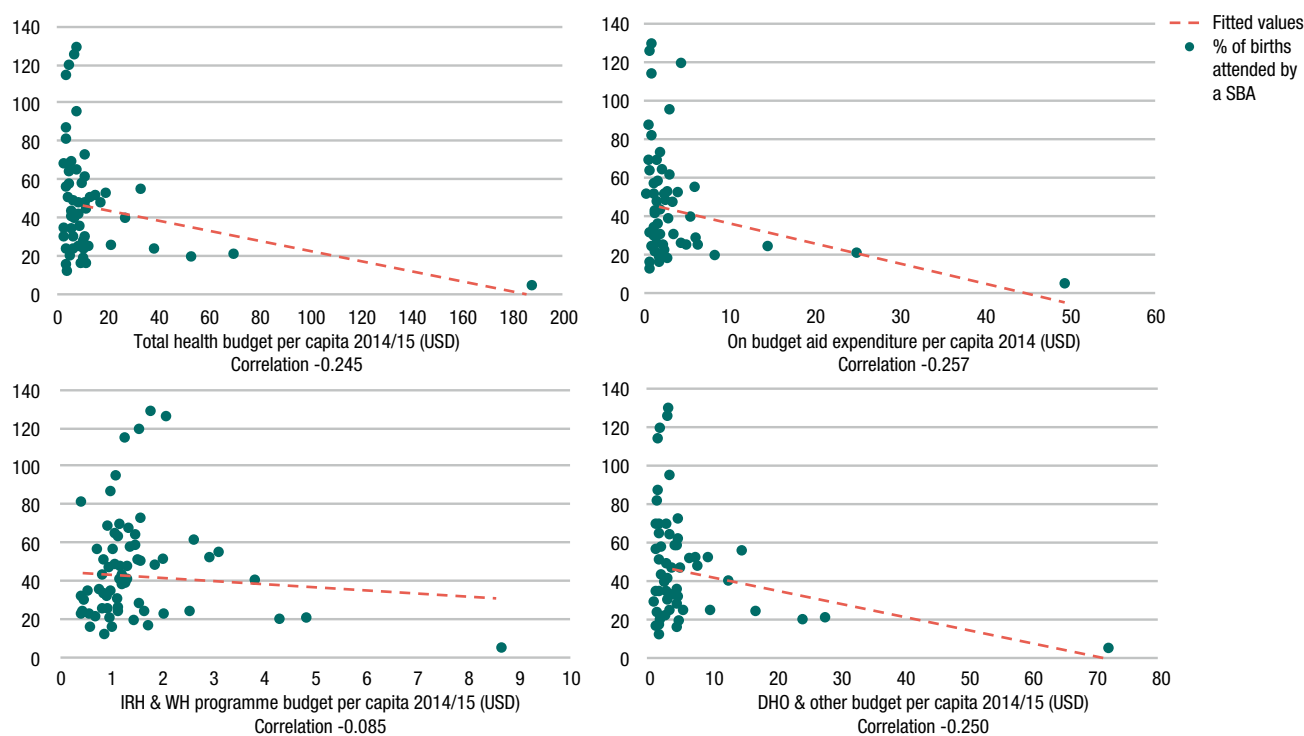
The findings are again similar with respect to relationship between financial resources and child health indicators. There is little variation in the Integrated Child Health and Nutrition Programme Budget, which is on average \$0.37 per capita, despite significant levels of variation in immunisation coverage (See panel 3 of Figure A3 below).

Figure A2. Financial resources and maternal health indicator 1



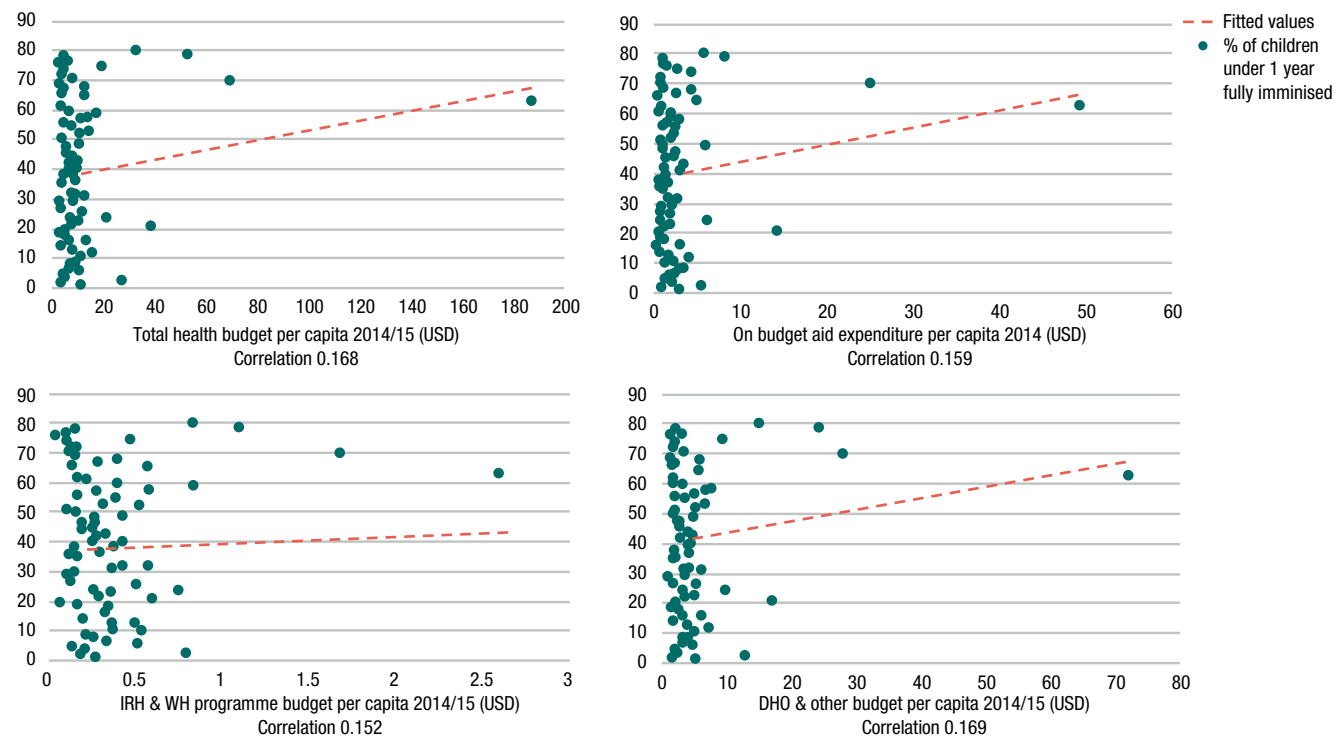
Source: NMoH and NHSSP (2015); Nepal AMP; NMoH Annual Report 2014/15; District-wide-budget 2014/15. 2014/15; District-wide-budget 2014/15.

Figure A2. Financial resources and maternal health indicator 2



Source: NMoH and NHSSP (2015); Nepal AMP; NMoH Annual Report 2014/15; District-wide-budget 2014/15.

Figure A3. Financial resources and child health indicator 1



Source: NMoH and NHSSP (2015); Nepal AMP; NMoH Annual Report 2014/15; District-wide-budget 2014/15.



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Cover photo: A mother brings her child to be vaccinated for TB during routine vaccinations at a district public health office, immunisation clinic, Pokhara, Nepal. © Jim Holmes for AusAID.

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