Focusing Dignity

Health
Employment
Education
Migration
Social Protection
Humanitarian

Fellowship
Training
Alliance
Advisory
Certification
Demo Project

Kenya
India
Ghana
South Africa
Nigeria
Philippines
Indonesia
Colombia

Kisumu
Mombasa
Siaya
Makueni
Migori
Delhi
Goa
Telangana
A&N Islands
Arunachal Pr.

Focusing Dignity

Learnings from product research

IDinsight | Dignity initiative

GDI Global Development Incubator

Focusing Dignity:
Learnings from product research

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About IDinsight

IDinsight uses data and evidence to help leaders combat poverty worldwide. Our collaborations deploy a large analytical toolkit to help clients design better policies, rigorously test what works, and use evidence to implement effectively at scale. We place special emphasis on using the right tool for the right question, and tailor our rigorous methods to the real-world constraints of decision-makers.

IDinsight works with governments, foundations, NGOs, multilaterals and businesses across Africa and Asia. We work in all major sectors including health, education, agriculture, governance, digital ID, financial access, and sanitation.

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GDI was born to build. We match ambitious leaders, strong ideas, and capital with the implementation power required to launch and scale transformational social impact ventures.From an initiative's discovery to its operational building blocks, we are committed, embedded, and deeply invested in the success of our initiatives. Together, we work toward impact at scale.

We have launched 90 initiatives, 30 have exited, and together they have raised more than $903 million in capital.

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Executive Summary

Disrespect for dignity is common and harmful. Over half of women giving birth in facilities worldwide experience mistreatment, and more than a third of Africans seeking medical care report being treated with little or no respect. The evidence strongly suggests that this matters — patients will travel twice as far and wait five times longer to be treated with respect, and respectful maternity care halves maternal complications and postpartum depression. This amounts to a profound broken promise by governments and development actors who proclaim dignity as a core value.

We aim to reposition dignity from an aspirational value to a practical experience of citizens encountering public systems. Dignity should be measurably felt, as a consequence of interventions and cultures at scale.

This report presents the evidence and analysis behind four foundational strategic decisions for advancing dignity in public services towards this goal. We draw on published academic evidence, 48 practitioner interviews, and quantitative data from authoritative international sources.

We conclude that:

- **Dignity applies in many sectors - but health is the most promising for dignity partnerships now.** A structured comparison across five candidate sectors — health, employment, education, social protection, and humanitarian — concludes that while all **health possesses a particularly strong foundation for dignity-focused work.** It is the only sector with validated measurement tools, WHO-endorsed frameworks, systematic reviews spanning hundreds of studies, and an active advocacy ecosystem that has translated evidence into institutional standards. No other sector offers comparable prevalence data, causal evidence on the consequences of disrespect, or scalable delivery infrastructure.
- A scoring framework applied to 37 low- and middle-income countries identifies four high-ranking countries: **Kenya, India, South Africa and Ghana.** We select Kenya and India because, among the top-ranked countries, we have the strongest existing relationships and networks. In a further scoring exercise, we identify the most promising states and counties there for exploring such partnerships.
- We diagnose a series of well-documented interlocking failures of systems that together produce indignity. Dignity is widely recognised in law, policy and rhetoric. Yet this recognition has not been operationalised

through measurement, feedback and accountability mechanisms. Health workers operate under severe time pressure, volume-based performance targets, and hierarchical cultures that reward compliance over compassion, creating "benevolent indignities". Interventions to date have been fragmented and subscale. Many people work on dignity, but they do not know one another.

- Therefore, dignity champions need community**.** A comparative assessment of six intervention models — training, coalitions, advisory consulting, certification, demonstration projects, and fellowships — concludes that **fellowships for public sector health leaders offer the strongest pathway to durable change, and the best match for our diagnosis.** The theory of change proposes that transformed leaders, equipped with evidence and embedded in a supportive community, can shift institutional cultures from the inside — moving dignity from a rhetorical commitment to a lived reality in the daily interactions that matter most to patients.

This is a moment for dignity. For all the progress the world has made, tens of millions of patients are still preventably dying. The politics of contempt is rampant, public service is being slashed, and health expertise is met with fear and doubt. New tech creates opportunities and dilemmas. There are leaders championing dignity right now. They need community and evidenced solutions, to really make change in their systems. That is the path forward, if we are to repair services, respect citizens and keep the lofty promises proclaimed in our value statements.

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The state of Dignity

"I am so scared to ask anything...Now I am worried they'll scold me, so I just don't say much. They treat me like I'm stupid and just give me prescriptions...but now I don't even know what problem I have in my uterus." - Female patient at a Government Hospital[1]

Dignity matters all around the world. People value dignity - because it makes a huge difference to their health. Patients in Zambia said they would be happy to wait five times longer, and travel twice as far, to be treated with respect.[2]

They are right to care so much: the evidence shows that more respectful interactions deliver individual, programmatic and societal benefits. For instance, respectful maternal care halves maternal complications, and postpartum depression.[3]

Yet people frequently experience disrespect, especially in Sub-Saharan Africa. Around a third of interactions with African governments are disrespectful of dignity.[4] In India, experience of respect has been especially volatile, though trending markedly positively.[5]

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[1] Subramani, S. (2025). Passive patient culture in India: Disrespect in law and medicine. Routledge. https://doi.org/10.4324/9781003129998
[2] Zanolini, A., Sikombe, K., Sikazwe, I., Eshun-Wilson, I., Somwe, P., Bolton Moore, C., Topp, S.M., Czaicki, N., Beres, L.K., Mwamba, C.P., Pry, J., Qin, E., Tang, Z., Simbeza, S., Glidden, D.V., Holmes, C.B., & Geng, E.H. (2018). Understanding preferences for HIV care and treatment in Zambia: Evidence from a discrete choice experiment among patients who have been lost to follow-up. PLOS Medicine, 15(8), e1002636. DOI: 10.1371/journal.pmed.1002636
[3] Sudhinaraset, M., Landrian, A., Afulani, P. A., Diamond-Smith, N., & Golub, G. (2020). Association between person-centered maternity care and newborn complications in Kenya. International Journal of Gynecology & Obstetrics, 148(1), 27–34. https://doi.org/10.1002/ijgo.12978
[4] Wein, T., Roy, A., Luo, A., Zhong, J., Villasmil, N., Baek, Y., & Marshall, K. (2025, June 26). Dignity Analysis: Insights from Afrobarometer and Arab Barometer Surveys. IDinsight. https://www.idinsight.org/article/dignity-analysis-insights-from-afrobarometer-and-arab-barometer-surveys/
[5] Wein, T. (2026, February 15). Experiences of respect in 167 countries. Linkedin. https://www.linkedin.com/pulse/experiences-respect-167-countries-tom-wein-pgc5e/?trackingId=JxKa07ZaRXCzVYfhyO%2BvgA%3D%3D

Our aim should be that every part of every government recognises every citizen's full human dignity, no matter their power.

That challenge seems particularly acute right now. For all the progress the world has made, tens of millions of patients are still preventably dying. The politics of contempt is rampant, public service is being slashed, and health expertise is met with fear and doubt. New technology is creating opportunities and dilemmas.

Yet there are leaders championing dignity right now, because they see the discordance between values and practice. They need time, community and evidenced solutions, to really make change in their systems. We must respect citizens, and repair services, together.

Defining dignity

Definitions of dignity vary hugely, and many people mean several things at once when they invoke it. The multiple approaches to dignity can be reasonably classified into four loci: dignity of the body, dignity of the person, dignity of merit, and dignity of the people.[6] A fair workhorse definition for our purposes is:

"Human dignity is the inherent value that every individual possesses equally by virtue of being a human being, independent of one's abilities, characteristics, or actions. Respect for human dignity is acknowledgement of that inherent value by individuals, institutions, and society." (Perrin et al, 2022).

[6]Wein, T. (2025, June 19). Dignity in development: Evidence and gaps in respecting people worldwide [Seminar]. Institute of Development Studies, Brighton, United Kingdom. https://www.ids.ac.uk/events/dignity-in-development-evidence-and-gaps-in-respecting-people-worldwide/

Our work so far

Over eight years of work (four under the aegis of the Dignity Initiative at IDinsight) we have gathered evidence and explored different modes of partnership.

2018-2021	Understanding dignity
2022	Gathering allies
2023	Honing in on impact
2024	What works for dignity
2025	Building cultures of dignity

Throughout that time, we have learned alongside friends and partners. We have:

- Tested with charities: Catholic Relief Services, GiveDirectly, Tostan, Legado, One Village Partners, Rocket Learning, Indus Action, Saajha, Trickle Up, Life Skills Collaborative, Social Justice Movement, Dasra, and Digital Green;
- Been supported by funders: GiveWell, Wellcome, The Life You Can Save, CIFF, Agency Fund, National Endowment for Democracy, and Porticus;
- Together with researchers from: IDinsight, University of Notre Dame, Busara, Institute of Development Studies, and University of Pennsylvania.

This work has clarified our understanding of what it takes to achieve impact and systemic change for dignity. It has taught us that work for dignity can have greater power when it brings the many people who care about this together in a community, to advance continual evidence-based experimentation on what works in terms of interventions and sustaining culture change - above all with governments.

We have been reminded that dignity can easily be a buzzword or a pleasant talking point, and reaffirmed our commitment that dignity efforts count when they deliver real and noticeable change to those our organisations seek to serve.

The need to combine specific interventions with wider cultural change and good measurement has been particularly brought home to us in our collaborations with Catholic Relief Services, GiveDirectly, and internal change within IDinsight. We have tested what works with them, and with Busara and University of Pennsylvania researchers especially. The power of assembling a community to advance this is something that we have observed in coalitional work with organisations like Tostan, our collaborations with Porticus, the Rebuild India initiative at Dasra, and observing the models of organisations like Agency Fund.

These learnings directly inform our diagnosis and prescriptions discussed in the remainder of this report.

Things we think we know
• Dignity is a prominent commitment in many legal, regulatory, values and rhetorical documents. • Dignity matters to many people, and they are willing to pay to be respected. • People frequently encounter disrespect. • That disrespect is frequently from ostensibly well-intentioned institutions - it is benevolent indignity. • This can be measured. • Respect leads to a wide range of positive consequences - for individuals, institutions and society. • People may mean at least five different things when they talk about dignity - it is multivocal. • There is quite a lot of variation in experiences of respect for dignity. • Dignity is most important when we are most vulnerable. • Place is among the most important predictors of variation. So are people's expectations of how they should be treated. • Some institutions have prominently wrestled with creating cultures of dignity. • Dignity is closely associated with many other important constructs, such as recognition, agency and equality. • Some sectors, such as health, have much more extensive discourses on dignity.

The opportunity now

This is a moment for dignity. More than half of poor patients face disrespect from doctors.[7] Half then drop out of treatment.[8] Our dignity failings drive away those who most need our help.

For all the progress the world has made, tens of millions of patients are still

[7] Hakimi, S., Allahqoli, L., Alizadeh, M., Ozdemir, M., Soori, H., Turfan, E. C., Sogukpinar, N., & Alkatout, I. (2025). Global prevalence and risk factors of obstetric violence: A systematic review and meta-analysis. International Journal of Gynecology & Obstetrics, 169(3), 1012–1024. https://doi.org/10.1002/ijgo.16145
[8] Kasaye, H., Scarf, V., Sheehy, A., & Baird, K. (2024). The mistreatment of women during maternity care and its association with the maternal continuum of care in health facilities. BMC Pregnancy and Childbirth, 24(1), Article 129. https://doi.org/10.1186/s12884-024-06310-8

preventably dying. The politics of contempt is rampant, public service is being slashed, and health expertise is met with fear and doubt. New technology creates opportunities and dilemmas. There are leaders championing dignity right now. They need community and evidenced solutions, to really make change in their systems.

When we fail, dignity becomes a buzzword, so we must build collaborations with a clear pathway to impact. That is at the heart of IDinsight's philosophy that evidence is most worthwhile to the extent that it serves impact.

This report focuses on an urgent task: moving the work on dignity from learning, to real change in the world. It examines how we may move from testing ideas with individual small actors to the public sector, where real impact lies. It argues that to do so, we must focus our work on dignity on particular places and sectors, refining the theory of change.

That commitment comes from our belief that - while more learning is always needed - this is an inflection point where those working on dignity must apply their ideas more practically and in a more focused way to achieve the maximum impact.

"We would prefer to have respect... Unfortunately these things happen only to the rich people." - Activist, Nairobi

What we wish we knew

- What practices in service interactions best affirm dignity? In what combination and at what dosage, and where and when, do these work?
- What is the (quantified) impact of respect for dignity on other outcomes?
- What aspects of internal culture best sustain service interactions that affirm dignity?
- Can an organisation change to become one that affirms dignity, given its existing culture and the systems it operates in? What must it do, and how long does it take?
- What is the relationship between dignity and scale? Are larger organisations linearly less respectful?
- What is the relative importance of preventing experiences of disrespect vs creating positive experiences of respect?
- What is the relative importance of an equally large movement in experience of dignity, given differing starting points?
- How do expectations and prior experiences mediate experiences of dignity?

Sector prioritisation

If dignity is relevant to everything, we have little guidance on where to build expertise and partnerships. Which sector is the most promising for dignity partnerships?

Our discussions have concluded that the health sector offers the strongest combination of documented need, measurable outcomes, existing infrastructure, and proven tractability for dignity-focused efforts.

Across low- and middle-income countries (LMICs), an estimated 5.0 million people die annually not because they lacked access to healthcare, but because the care they received was poor quality.[9]

Dignity violations in healthcare are staggeringly common: a global meta-analysis of 117 studies spanning 37 countries estimates that 55% of women experience mistreatment during facility-based childbirth.[10]

We considered five sectors as candidates for a dignity focus: employment, migration, education, social protection, and health. Each has important dignity concerns, and productive work can be done to build cultures of dignity in each. This section presents the comparative case and then examines health's unique advantages in depth.

"They should not treat us if we were children and decisions should not be made without consulting us. This is dignity." - Colombian IDP[11]

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[9] Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., ... & Pate, M. (2018). High-quality health systems in the Sustainable Development Goals era: Time for a revolution. The Lancet Global Health, 6(11), e1196–e1252. https://doi.org/10.1016/S2214-109X(18)30386-3

[10] Ansari, H., & Yeravdekar, R. (2020). Respectful maternity care during childbirth in India: A systematic review and meta-analysis. Journal of Postgraduate Medicine, 66(3), 133–140. https://doi.org/10.4103/jpgm.JPGM_648_19

[11] Holloway, K. (2019). Dignity in displacement: Case studies from Afghanistan, Colombia, the Philippines and South Sudan (HPG Integrated Programme 2017-19. From the Ground up: Understanding Local Response in Crises). Overseas Development Institute. https://www.odi.org/publications/11285-dignity-displacement-case-studies-afghanistan-colombia-philippines-and-south-sudan

Structured comparison

This section applies seven criteria symmetrically across five candidate sectors — health, employment, education, social protection, and humanitarian — to identify which sector offers the strongest foundation for dignity-focused partnerships. Each criterion is rated on a three-point scale (Strong / Moderate / Weak) based on the best available evidence.

Criterion	Health	Education	Employment	Social Protection	Humanitarian
1. Prevalence data	**Strong**	**Strong**	Weak	Weak	Weak
2. Causal evidence	**Strong**	**Strong**	Moderate	Moderate	Weak
3. Measurement tools	**Strong**	Weak	Moderate	Weak	Weak
4. Institutional frameworks	**Strong**	Moderate	**Strong**	Moderate	Moderate
5. Advocacy ecosystem	**Strong**	Moderate	Moderate	Weak	Weak
6. Delivery infrastructure	**Strong**	**Strong**	Weak	Moderate	Weak
7. Funding landscape	**Strong**	Moderate	Weak	Moderate	Weak
Rating (/21)	**21**	**16**	**12**	**11**	**8**

Criterion 1: Prevalence of dignity violations

Can we cite a multi-country estimate of how often people experience disrespect in this sector?

Health: STRONG. A global meta-analysis of 117 studies across 37 countries estimates that 54.5% of women experience mistreatment during facility-based childbirth.[12] The 2024 Afrobarometer survey of 53,444 respondents across 39 African countries found that 36% of people who sought medical care reported being treated with little or no respect.[13] These are multi-country, methodologically standardised estimates with large sample sizes.

Education: STRONG. UNICEF estimates that approximately 1.6 billion children regularly endure violent discipline (physical punishment or psychological aggression) at home, and that roughly 330 million under-5s are physically punished.[14] In Sub-Saharan Africa, around 35% of boys and girls report experiencing physical bullying in the past 12 months. Corporal punishment remains legal in schools in 62 countries, 22 of which are in Africa. The evidence base here is extensive, though the framing is "violence" and "discipline" rather than "dignity" per se — an important conceptual distinction.

Employment: WEAK. No global prevalence estimate for workplace dignity violations exists that is comparable to the health or education data. The ILO estimates that 27.6 million people are in forced labour globally,[15] and workplace violence and harassment surveys exist for individual countries, but there is no standardised multi-country measure of dignity violations in employment. IDinsight's own research on gig workers in India, Indonesia, Kenya, Nigeria, and South Africa documents dignity violations qualitatively but does not generate prevalence estimates.

Social protection: WEAK. The UNICEF Transfer Project's multi-country evaluation of 13 government cash transfer programmes in Africa explicitly acknowledged that it included "no direct measure of 'dignity'".[16] A 2023 Cochrane systematic review of 41 qualitative studies found that recipients experienced both empowerment and stigma,[17] but no global prevalence estimate for dignity exists.

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[12] Hakimi, S., Hajizadeh, K., Hasanpour, S., Oözer, E., & Mirghafourvand, M. (2025). Global prevalence and risk factors of obstetric violence: A systematic review and meta-analysis. International Journal of Gynecology & Obstetrics. https://doi.org/10.1002/ijgo.16145
[13] Afrobarometer. (2024). Summary of results: Afrobarometer Round 9 surveys in 39 African countries, 2021/2023.
[14] UNICEF. (2024, June 11). Nearly 400 million young children worldwide regularly experience violent discipline at home [Press release]. https://www.unicef.org/press-releases/nearly-400-million-young-children-worldwide-experience-violent-discipline
[15] ILO. (2022). Global estimates of modern slavery: Forced labour and forced marriage. International Labour Organization.
[16] UNICEF Office of Research – Innocenti. (n.d.). Transfer Project. https://www.unicef-irc.org/research/transfer-project
[17] Yoshino, C. A., Sidney-Annerstedt, K., Wingfield, T., Kirubi, B., Viney, K., Boccia, D., & Atkins, S. (2023). Experiences of conditional and unconditional cash transfers intended for improving health outcomes and health service use: A qualitative evidence synthesis. Cochrane Database of Systematic Reviews, 2023(3), CD013635.

Humanitarian: WEAK. The Overseas Development Institute's Dignity in Displacement project (2017–2019) found a "dearth of literature analysing whether humanitarian interventions really do uphold and further — or indeed detract from — the dignity of crisis-affected people".[18] No comparable multi-country prevalence data exists, despite widespread rhetorical use of dignity language in humanitarian standards.

Criterion 2: Causal evidence on consequences of disrespect

What rigorous evidence exists that dignity violations in this sector cause downstream harm?

Health: STRONG. The Lancet Global Health Commission found that 5.0 million excess deaths annually in LMICs occurred among people who sought care but received inadequate quality.[19] A discrete choice experiment in Zambia found patients would travel twice as far and wait five times longer to be treated with respect.[20] Person-centred maternity care has been associated with halving maternal complications and postpartum depression.[21] The 2025 OECD PaRIS survey found that trust in healthcare systems drops by 30 percentage points when care is not person-centred.[22] The Staha intervention in Tanzania reduced odds of mistreatment by 66%.[23] This body of evidence includes RCTs, quasi-experimental designs, and large-scale observational studies with specific effect sizes and causal pathways documented.

Education: STRONG. To the extent that violence can substitute as an outcome for disrespect for dignity, Gershoff and Grogan-Kaylor's (2016) meta-analysis of 111 effect sizes representing 160,927 children found that spanking was significantly linked with 13 of 17 detrimental outcomes, including increased antisocial behaviour and mental health problems.[24] Raising Voices' Good School Toolkit RCT in 42 Ugandan schools demonstrated a 17-percentage-point reduction in physical violence from staff to

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[18] Mosel, I., & Holloway, K. (2019). Dignity and humanitarian action in displacement. Overseas Development Institute.
[19] Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., ... & Pate, M. (2018). High-quality health systems in the Sustainable Development Goals era: Time for a revolution. The Lancet Global Health, 6(11), e1196–e1252.
[20] Zanolini, A., Sikombe, K., Sikazwe, I., Eshun-Wilson, I., Somwe, P., Bolton Moore, C., ... & Geng, E. H. (2018). Understanding preferences for HIV care and treatment in Zambia: Evidence from a discrete choice experiment. PLoS Medicine, 15(8), e1002636.
[21] Sudhinaraset, M., Landrian, A., Afulani, P. A., Diamond-Smith, N., & Golub, G. (2020). Association between person-centered maternity care and newborn complications in Kenya. International Journal of Gynecology & Obstetrics, 148(1), 27–34.
[22] OECD. (2025). PaRIS Survey: Patient-Reported Indicator Surveys. https://www.oecd.org/health/paris/
[23] Kujawski, S. A., Freedman, L. P., Ramsey, K., Mbaruku, G., Mbuyita, S., Moyo, W., & Kruk, M. E. (2017). Community and health system intervention to reduce disrespect and abuse during childbirth in Tanga Region, Tanzania. PLoS Medicine, 14(7), e1002341.
[24] Gershoff, E. T., & Grogan-Kaylor, A. (2016). Spanking and child outcomes: Old controversies and new meta-analyses. Journal of Family Psychology, 30(4), 453–469. https://doi.org/10.1037/fam0000191

children.[25] Causal identification is strong, particularly for education's impact on mental health and learning.

Employment: MODERATE. The organisational justice literature is extensive. Colquitt et al.'s (2001) meta-analysis of 183 studies demonstrated that procedural, distributive, interpersonal, and informational justice each independently predict job satisfaction, organisational commitment, citizenship behaviour, and performance.[26] Higher organisational justice has been associated with reduced coronary disease, mortality, and metabolic syndrome.[27] [28] A field experiment with refugees (Betts et al.) found that workers randomly assigned to employment showed significant improvements in mental health and life satisfaction, with non-pecuniary benefits valued at 60% of the wage. However, the evidence is overwhelmingly from high-income country workplaces. The causal identification is moderate — many studies are correlational, though some RCTs of organisational justice training exist.

Social protection: MODERATE. Over 1,000 rigorous studies of cash transfers exist, and some document psychological and dignity-adjacent effects. However, the evidence on dignity specifically is qualitative and indirect. Studies consistently show that cash transfers improve recipients' sense of autonomy and reduce shame relative to in-kind transfers, but these are inferred mechanisms rather than directly measured dignity outcomes. The Cochrane review (Yoshino et al., 2023) documents both empowerment and stigma, but without direct dignity measurement, the causal pathway from programme design to dignity outcomes remains theorised rather than quantified.

Humanitarian: WEAK. Evidence on the consequences of dignity violations in humanitarian settings is largely anecdotal or qualitative. Debates on feedback mechanisms, accountability to affected populations, and the merits of cash versus in-kind aid touch on dignity indirectly, but no rigorous study has quantified the causal effect of dignified versus undignified humanitarian assistance on downstream outcomes. ODI's Dignity in Displacement project concluded that operationalising dignity in humanitarian contexts barely extends beyond rhetorical commitments.[29]

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[25] Devries, K. M., Knight, L., Child, J. C., Mirembe, A., Nakuti, J., Jones, R., ... & Naker, D. (2015). The Good School Toolkit for reducing physical violence from school staff to primary school students: A cluster-randomised controlled trial in Uganda. The Lancet Global Health, 3(7), e378–e386.
[26] Colquitt, J. A., Conlon, D. E., Wesson, M. J., Porter, C. O. L. H., & Ng, K. Y. (2001). Justice at the millennium: A meta-analytic review of 25 years of organizational justice research. Journal of Applied Psychology, 86(3), 425–445. https://doi.org/10.1037/0021-9010.86.3.425
[27] Elovainio, M., Ferrie, J. E., Singh-Manoux, A., Gimeno, D., De Vogli, R., Shipley, M., ... & Kivimäki, M. (2010). Organisational justice and markers of inflammation: The Whitehall II study. Occupational and Environmental Medicine, 67, 78–83.
[28] Gimeno, D., Tabák, A. G., Ferrie, J. E., Shipley, M. J., De Vogli, R., Elovainio, M., ... & Kivimäki, M. (2010). Justice at work and metabolic syndrome: The Whitehall II study. Occupational and Environmental Medicine, 67, 256–262.
[29] Mosel, I., & Holloway, K. (2019). Dignity and humanitarian action in displacement. Overseas Development Institute.

Criterion 3: Validated measurement tools

How many validated, published instruments specifically measure dignity or respectful treatment in this sector?

Health: STRONG (12+ tools). The sector has produced at least 12 validated measurement instruments, including the Mothers on Respect (MORi) index, the Mothers' Autonomy in Decision Making (MADM) scale, the CHOICES tool, the Childbirth Experience Questionnaire (CEQ-2), the Person-Centred Maternity Care (PCMC) scale (validated in both Kenya and India), and the Effective Health Care composite.[30] Beyond maternity care, Chochinov's Patient Dignity Inventory has been extensively validated in palliative care. The DHS Program has conducted over 400 surveys in more than 90 countries since 1984. This infrastructure is unmatched.

Employment: MODERATE (2–4 tools, limited validation). The Workplace Dignity Scale (WDS) is an 18-item validated instrument,[31] with an independent replication study confirming reasonable psychometric properties.[32] There is also a separate five-factor WPD scale.[33] However, all validation studies to date have been conducted in high-income countries (predominantly the US), and no LMIC validation exists. The organisational justice literature offers well-validated instruments,[34] though these measure justice rather than dignity per se.

Education: WEAK (0 dignity-specific tools). No validated "dignity in education" measurement tool exists. School climate surveys, bullying prevalence instruments (e.g., GSHS), and violence tracking tools (UNICEF MICS modules) overlap with dignity concepts but do not measure dignity directly. The concept is operationalised through proxies — corporal punishment prevalence, school safety perceptions, teacher–student relationship quality — rather than through purpose-built dignity instruments.

Social protection: WEAK (0 tools). No validated instrument exists for measuring dignity in social protection. The UNICEF Transfer Project evaluation explicitly noted the absence of a direct dignity measure. Stigma scales exist for specific programmes, but these are context-specific and not standardised across countries.

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[30] Cantor, A. G., Jungbauer, R. M., Skelly, A. C., Hart, E. L., Jia, Y., Tilden, E. L., & Chou, R. (2024). Respectful maternity care: Dissemination and implementation of perinatal safety culture to improve equitable maternal healthcare delivery and outcomes (Comparative Effectiveness Review No. 269). Agency for Healthcare Research and Quality. https://doi.org/10.23970/AHRQEPCCER269
[31] Thomas, B., & Lucas, K. (2019). Development and validation of the Workplace Dignity Scale. Group & Organization Management, 44(1), 72–111. https://doi.org/10.1177/1059601118807784
[32] Scott-Campbell, C., & Williams, M. (2020). Validating the Workplace Dignity Scale. Collabra: Psychology, 6(1), 31. https://doi.org/10.1525/collabra.337
[33] Tiwari, B., & Sharma, H. R. (2019). Dignity at the workplace: Evolution of the construct and development of workplace dignity scale. Frontiers in Psychology, 10, 2581. https://doi.org/10.3389/fpsyg.2019.02581
[34] Colquitt, J. A., Conlon, D. E., Wesson, M. J., Porter, C. O. L. H., & Ng, K. Y. (2001). Justice at the millennium: A meta-analytic review of 25 years of organizational justice research. Journal of Applied Psychology, 86(3), 425–445. https://doi.org/10.1037/0021-9010.86.3.425

Humanitarian: WEAK (0 tools). Despite dignity language pervading humanitarian standards (Core Humanitarian Standard, Sphere), no validated tool exists for measuring whether humanitarian interventions uphold dignity. Accountability to affected populations (AAP) frameworks include feedback mechanisms but do not directly measure dignity outcomes.

Criterion 4: Institutional frameworks and standards

Does the sector have international normative frameworks that explicitly use dignity language and create accountability mechanisms?

Health: STRONG. The WHO Quality of Care framework explicitly embeds experiential quality — including dignified care — alongside clinical effectiveness. The WHO Quality of Care Network (established 2017) encompasses 11 countries with mandates covering patient experience. The Respectful Maternity Care Charter, developed by the White Ribbon Alliance and supported by a Global Council of over 100 organisations and 340 members, articulates enforceable rights grounded in international human rights law (WRA, 2011/2019). The 2018 Lancet Commission on High Quality Health Systems declared that "efficient financing of poor quality care is no one's vision of success" (Kruk et al., 2018), embedding experiential quality into the Universal Health Coverage agenda. India's LaQshya programme and NHRC 20-point Charter of Patients' Rights create national-level accountability mechanisms. The framework creates measurable obligations, not merely aspirational commitments.

Employment: STRONG. The ILO Decent Work Agenda is arguably the most established normative framework invoking dignity-adjacent concepts in any sector. ILO Convention 189 on Domestic Workers (2011) was explicitly grounded in dignity language. The ILO's Declaration of Philadelphia (1944) asserts that "all human beings, irrespective of race, creed or sex, have the right to pursue both their material well-being and their spiritual development in conditions of freedom and dignity." However, enforcement mechanisms are weak — Convention 189 has been ratified by only 36 countries as of 2024 — and the organising frame is "decent work" and "labour rights" rather than dignity per se.

Education: MODERATE. The UN Convention on the Rights of the Child (Article 19) mandates protection from all forms of violence. UNESCO guidelines address school violence. The Global Initiative to End All Corporal Punishment of Children tracks legislative progress across 66 countries that have achieved full prohibition. However, dignity as a positive educational practice — rather than the absence of violence — has no equivalent normative framework. SDG 4 references quality education but does not specify dignity.

Social protection: MODERATE. ILO Recommendation 202 (Social Protection Floors, 2012) references dignity in its preamble. The SDGs include target 1.3 on social protection coverage. However, no equivalent to the Respectful Maternity Care Charter exists — no international standard specifies what dignified social protection delivery looks like, and

no accountability mechanism exists to hold programmes to dignity standards.

Humanitarian: MODERATE. The Core Humanitarian Standard (CHS) and Sphere Standards both invoke dignity, and the CHS Alliance provides certification. However, ODI's analysis found that dignity language in humanitarian standards remains largely rhetorical, with no validated measurement tools and no grassroots movement holding agencies to account for dignity specifically (ODI, 2019). The CHS creates process requirements rather than dignity outcome standards.

Criterion 5: Advocacy ecosystem

Is there an organised constituency pushing for dignity as a named outcome, with demonstrated policy wins?

Health: STRONG. The White Ribbon Alliance, founded in 1999, operates through 14 national alliances across Sub-Saharan Africa and South Asia. The Global Respectful Maternity Care Council now convenes over 100 organisations and 340 members. Partners in Health has led the way in advocacy. This ecosystem has achieved concrete policy wins: Kenya's national respectful maternity care framework, India's LaQshya programme, the WHO's inclusion of experiential quality in UHC frameworks, and the Lancet Commission's endorsement. These are instances where evidence on dignity has been translated into institutional standards and measurement accountability.

Employment: MODERATE. The domestic workers' movement (anchored by SEWA in India and the International Domestic Workers Federation) secured ILO Convention 189 in 2011 — a binding international standard grounded in dignity-adjacent framing. WIEGO provides important supplementary advocacy for informal workers. The Global Living Wage Network spans 25 countries. However, the organising frame is "decent work" and "labour rights," not dignity per se, and the movement's power concentrates in formal-sector unions with limited reach into informal economies where dignity violations are most acute.

Education: MODERATE. The Global Initiative to End All Corporal Punishment of Children has tracked legislative progress and advocacy has contributed to full prohibition in 66 countries. Raising Voices has achieved demonstrable impact in Uganda. However, dignity as a positive educational practice has no equivalent advocacy network. Campaigns are organised around violence prevention rather than dignity promotion.

Social protection: WEAK. ATD Fourth World is notable but operates on a small scale. Poor people's movements exist but are fragmented and rarely use dignity as their organising frame. Debates in social protection are dominated by technocrats and economists. No equivalent to the White Ribbon Alliance exists.

Humanitarian: WEAK. The CHS Alliance exists but has not achieved policy wins specifically attributable to dignity framing. Accountability to affected populations has gained traction as a process standard but not as a dignity outcome. No grassroots

movement holds humanitarian agencies to account for dignity specifically.

Criterion 6: Scalable delivery infrastructure

What is the size and structure of the workforce through which dignity interventions could be delivered?

Health: STRONG. The global health workforce exceeds 70 million workers,[35] projected to reach 84 million by 2030.[36] Each worker has multiple daily patient interactions, making training-based dignity interventions inherently scalable. Facility-based care creates identifiable points of interaction where dignity can be observed and improved.

Education: STRONG. UNESCO estimates approximately 70 million teachers globally. Each has daily, sustained contact with students over years. Schools are identifiable institutions with hierarchies, cultures, and accountability structures analogous to health facilities. This makes education a strong comparator to health on delivery infrastructure — a point the current report underplays.

Employment: WEAK. No equivalent delivery channel exists. Interventions must go through employers, who have no obligation to participate. Formal-sector workplaces can be reached through regulatory compliance or industry associations, but the informal economy — where dignity violations are most acute — has no delivery infrastructure at all. ILO inspectorates are chronically under-resourced.

Social protection: MODERATE. Social protection programmes involve periodic contact (enrolment, payment collection, recertification) rather than continuous interaction. The workforce is smaller and more episodic than health or education. However, large national programmes (e.g., India's MGNREGA, Brazil's Bolsa Família) do create identifiable bureaucratic interfaces where dignity could be improved.

Humanitarian: WEAK. Humanitarian workforces are project-based, with high turnover and short deployment cycles. Interventions must be redesigned for each emergency context. The sector lacks the permanent institutional infrastructure that enables sustained culture change.

Criterion 7: Funding landscape

What is the realistic philanthropic and public funding available for dignity-specific work in this sector?

Health: STRONG (~$600–700 billion total). Health dominates both bilateral ODA and philanthropic giving. Even after recent ODA cuts, domestic government spending and philanthropic commitment remain substantial. Multiple funding streams coexist —

[35] OECD. (2023). Health at a Glance 2023: OECD Indicators. OECD Publishing.
[36] Liu, J. X., Goryakin, Y., Maeda, A., Bruckner, T., & Scheffler, R. (2017). Global health workforce labor market projections for 2030. Human Resources for Health, 15(1), 11.

government budgets, bilateral ODA, multilateral institutions, and private philanthropy — providing some resilience. Respectful maternity care specifically has attracted funding from Gates Foundation, Wellcome Trust, MacArthur Foundation, Packard Foundation, Robert Wood Johnson Foundation, and Hewlett Foundation. Health is the only sector where "dignity" frequently appears as a named outcome in major funder strategies.

Education: MODERATE (~$250–350 billion total). Large domestic budget lines, with ODA of approximately $16–18 billion (2023), perhaps declining 20% in 2025. Philanthropic giving to LMIC education is approximately $2–3 billion annually, dominated by Mastercard Foundation, LEGO Foundation, and education-focused family foundations. Some funders (Malala Fund, Echidna, Oak Foundation) use dignity language, but no major education funder has made dignity a strategic pillar.

Employment: WEAK (~$10–15 billion ODA). The ILO's biennial budget is approximately $900 million. Philanthropic funding for labour rights and workplace dignity is small — perhaps $500 million globally — from Ford Foundation, Open Society Foundations, and a handful of labour-focused funders. Despite the ILO's "decent work" frame, philanthropic funding for workplace dignity specifically is negligible.

Social protection: MODERATE (~$350–500 billion total). Almost all of this is in non-discretionary national cash transfer programmes. ODA for social protection is comparatively small (~$5–6 billion), and philanthropic funding is negligible. The sector is relatively insulated from ODA cuts but has no external philanthropic infrastructure to build on.

Humanitarian: WEAK (~$35–45 billion total). Faces the steepest cuts of any sector: 21–36% projected decline from 2023 to 2025. Almost entirely donor-funded with minimal domestic government or philanthropic substitution. Dignity language is pervasive in humanitarian standards, but no major funder treats dignity as a funded programmatic outcome in this sector.

Interpretation

Health scores Strong on all seven criteria — a convergence that no other sector achieves. Education is the closest competitor, with Strong ratings on prevalence data, causal evidence, and delivery infrastructure. Its principal weakness is the absence of validated dignity-specific measurement tools and a dedicated advocacy ecosystem organised around dignity as a positive frame (as opposed to violence prevention). Employment has the strongest normative framework through the ILO, but lacks the prevalence data, measurement infrastructure, and delivery channels that would make dignity interventions scalable.

Health's advantage over education is probably more moderate than the report's current framing suggests. The decisive advantages of health are: (1) validated tools that can measure change, (2) an active advocacy ecosystem that can translate programme results into policy pressure, and (3) a facility-based delivery model where interactions

are discrete, observable, and improvable. These are real advantages for a fellowship programme that needs to demonstrate measurable impact to funders within a 3–5 year timeframe.

The need to focus on the public sector

The case for focusing on government health systems, rather than charities, private providers, or academic institutions, rests on a simple arithmetic of scale. As Kevin Starr has argued, an NGO expanding its direct services might reach 50,000 people in five years; the same NGO helping government adapt its intervention could reach 3 million.[37] The numbers are not close. Governments make the rules, hold the mandate to serve all citizens, and command budgets that dwarf philanthropy by orders of magnitude. In India, annual government spending exceeds private giving by a factor of fifty.[38] Even the largest effort by a charity to deliver services directly will be comparatively small.[39] The logic applies with particular force to dignity. The citizens who most need respectful care - the poorest, the most marginalised, those with the least choice - overwhelmingly encounter the health system through government facilities.[40] It is in district hospitals and community health centres, not in private clinics or NGO programmes, that the daily interactions which affirm or deny dignity take place at population scale. The development sector's instinct to build parallel systems — its own clinics, its own training programmes, its own measurement tools — has produced many pilots of what works but few cases of tested interventions being taken up through government at the scale necessary for real change.[41] As Dan Honig's research on public sector performance demonstrates, the binding constraint is often not the absence of good ideas but whether frontline workers are trusted and empowered to apply them.[42] The fellowship model addresses this directly: it invests in government insiders who already understand the system's constraints and power dynamics, rather than placing external advisors who risk substituting for local capacity. The goal is not to build a parallel architecture for dignity but to strengthen the one that already exists. That is, for better or worse, the public sector.

Critically, building an intervention for NGO delivery and then hoping government will adopt it later is not a reliable path. Government-implemented programmes produce effect sizes 113% smaller than those delivered by NGOs and research

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[37] Starr, K. (2024). Big bet bonanza. Stanford Social Innovation Review. https://doi.org/10.48558/WWH5-Y773
[38] Rajani, R., & Hanstad, T. (2025). Helping NGOs and funders make the 'big shift' to working with government. Stanford Social Innovation Review. https://doi.org/10.48558/75RE-2E08
[39] Starr, K. (2025). Big aid is over. Stanford Social Innovation Review. https://doi.org/10.48558/H27Z-AZ93
[40] Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., ... & Pate, M. (2018). High-quality health systems in the Sustainable Development Goals era: Time for a revolution. The Lancet Global Health, 6(11), e1196–e1252. https://doi.org/10.1016/S2214-109X(18)30386-3
[41] IDinsight Dignity Initiative. (2024). Dignity What Works Guide [Interactive database]. https://dignity-what-works.softr.app/
[42] Honig, D. (2024). Mission-driven bureaucrats. Oxford University Press.

centres, reflecting the difference between the controlled conditions of a pilot and the realities of bureaucratic implementation at scale.[43] Over 60% of published development RCTs were implemented by NGOs or researchers rather than government, yet 96% generalised their findings as though implementer identity did not matter.[44] Interventions must be designed for public systems from the outset, not retrofitted after proof of concept in a charitable setting.

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[43] Vivalt, E. (2020). How much can we generalize from impact evaluations? Journal of the European Economic Association, 18(6), 3045–3089. https://doi.org/10.1093/jeea/jvaa019
[44] Peters, J., Langbein, J., & Roberts, G. (2018). Generalization in the tropics — development policy, randomized controlled trials, and external validity. World Bank Economic Review, 32(3), 567–585. https://doi.org/10.1093/wber/lhx020

Location prioritisation

Country selection

This section presents a systematic comparison of 37 low- and middle-income countries, scored across six dimensions, to identify the most promising countries for dignity-focused health partnerships.

Several countries score promisingly highly, including South Africa and Ghana, but Kenya and India are selected as priority countries, because among the high ranking countries they are the ones where IDinsight and GDI have the most developed experience and networks - something that is strongly determinative of potential impact.

Analytical Framework

Health Infrastructure Filter

Countries were excluded from scoring if they failed on two or more of four minimum thresholds: UHC Service Coverage Index below 35 (WHO, 2021), physician density below 0.05 per 1,000 population (WHO GHO), maternal mortality ratio above 800 per 100,000 live births (MMEIG, 2020), or skilled birth attendance below 40% (DHS/WHO).

Six Scoring Dimensions

Dimension 1: Health Infrastructure Capacity (1–5). This measures whether the health system can support dignity interventions. We think stronger health systems are better positioned to take up dignity interventions at present. Indicators: UHC Index, hospital beds per 10,000, physicians per 1,000, skilled birth attendance. Sources: WHO GHO, DHS.

Dimension 2: Governance and Devolution (1–5). Indicators: World Bank Government Effectiveness percentile (WGI 2023), Corruption Perceptions Index

(Transparency International 2024), whether health services are formally devolved. We are looking for well administered health services, since they are more likely to sustain interventions and digest technical advice. Devolution is critical because the partnership model operates at subnational level.

Dimension 3: Civil Society and Partnership Environment (1–5). Indicators: Freedom House score (2025), CIVICUS Monitor civic space rating (2024–25), Open Government Partnership membership, English as working language. Willingness to partner with external actors can roughly be approximated through these.

Dimension 4: Dignity in Law and Policy (1–5). Indicators: explicit constitutional dignity protection, constitutional right to health, patients' rights charter, WHO Quality of Care Network membership, national respectful maternity care policy. Sources: Constitute Project, OHCHR treaty body database, WHO QoCN, government policy documents. Partnerships are most promising in countries that have an existing commitment to dignity.

Dimension 5: Citizen Experience (1–5). Indicators: Afrobarometer Round 9 respect data (African countries, 2021–23), People's Voice Survey quality ratings (Doubova et al., Lancet Global Health, 2023), institutional delivery rates (DHS). Data availability varies substantially across regions; Asian countries lack a pan-continental equivalent to Afrobarometer. Partnerships can have the greatest impact where citizens currently experience disrespect and dignity performance is low.

Dimension 6: Operational Feasibility (1–5). Indicators: IDinsight office or project presence, Fragile States Index (Fund for Peace 2024), English language status, GDP per capita (World Bank 2023). These capture practical implementation constraints.

Composite scores sum the six dimensions (maximum 30) plus the Experience binary (maximum 1) for a final maximum of 31. Countries scoring 20 or above are classified High; 16–19 as Medium; below 16 as Low.

Results: Top-Ranked Countries

The table below presents 37 Low and Middle Income countries scored according to their prioritisation on the six criteria listed above. D1 = Health Infrastructure Capacity; D2 = Governance & Devolution; D3 = Civil Society & Partnership; D4 = Dignity in Law & Policy; D5 = Citizen Experience; D6 = Operational Feasibility. Comp = Composite (D1–D6, max 30); Exp = Experience binary; Final = Comp + Exp (max 31).[45]

Country	D1	D2	D3	D4	D5	D6	Comp	Exp	Final	Class
South Africa	5	3	5	4	4	4	25	0	25	High
Ghana	4	2	5	5	3	4	23	0	23	High
Kenya	4	2	2	5	3	4	20	1	21	High
India	3	3	2	4	2	5	19	1	20	High
Colombia	5	3	2	4	3	2	19	0	19	Medium
Philippines	4	3	3	3	1	4	18	0	18	Medium
Indonesia	4	3	3	3	1	3	17	0	17	Medium
Zambia	4	1	4	2	2	4	17	0	17	Medium
Malawi	3	1	4	4	2	2	16	0	16	Medium
Rwanda	3	4	1	4	1	3	16	0	16	Medium
Vietnam	5	4	1	2	2	2	16	0	16	Medium
Senegal	2	2	3	1	3	4	15	0	15	Low
Sri Lanka	5	1	2	1	2	3	14	0	14	Low
Tanzania	1	1	1	5	3	3	14	0	14	Low
Nigeria	1	1	2	5	1	3	13	0	13	Low
Sierra Leone	1	1	4	3	2	2	13	0	13	Low
Uganda	2	1	1	5	1	2	12	1	13	Low
Bangladesh	3	1	1	3	1	2	11	0	11	Low
Ethiopia	1	1	1	4	1	2	10	1	11	Low
Liberia	2	1	4	1	1	2	11	0	11	Low
Morocco	4	1	1	2	1	2	11	0	11	Low
Nepal	3	1	2	3	1	1	11	0	11	Low
Zimbabwe	3	1	1	3	1	2	11	0	11	Low
Egypt	4	1	1	2	1	1	10	0	10	Low
Pakistan	3	1	1	2	1	2	10	0	10	Low
Cambodia	4	1	1	1	1	1	9	0	9	Low
Cote d'Ivoire	2	1	2	2	1	1	9	0	9	Low
Myanmar	4	1	1	1	1	1	9	0	9	Low
PNG	1	1	3	1	1	2	9	0	9	Low
DRC	2	1	1	2	1	1	8	0	8	Low
Madagascar	1	1	2	2	1	1	8	0	8	Low
Mozambique	2	1	1	2	1	1	8	0	8	Low
Niger	1	1	2	2	1	1	8	0	8	Low
Burkina Faso	1	1	1	1	2	1	7	0	7	Low
Haiti	1	1	1	2	1	1	7	0	7	Low
Mali	1	1	1	2	1	1	7	0	7	Low
Afghanistan	1	1	1	1	1	1	6	0	6	Low

[45] Full data for all 37 countries in accompanying spreadsheet.

Why Kenya and India

We have chosen to select Kenya and India as countries in which we recommend pursuing dignity partnerships. South Africa (25) and Ghana (23) score highest on the composite. Kenya (21) and India (20) rank third and fourth. Given the natural inexactitude of such a process, we consider these scores to all be within an informal margin of error. We note the following observations about Kenya and India in support of this decision.

1. Unmatched legal architecture for dignity in healthcare

Kenya scores 5/5 on Dimension 4 (Dignity in Law)—the only country to achieve the maximum. Its 2010 Constitution uniquely combines an explicit dignity right (Article 28), a justiciable right to health (Article 43), a formal patients' rights charter, WHO QoCN membership, and a national respectful maternity care framework. India scores 4/5, with the Supreme Court's progressive interpretation of Article 21 creating functionally equivalent protections, complemented by the NHRC's 20-point Charter of Patients' Rights (2018), QoCN membership, and the LaQshya respectful maternity care programme. South Africa matches on constitutional provisions but lacks QoCN membership and a dedicated RMC policy. Ghana has QoCN membership and an RMC policy but only directive-principle health rights.

2. Devolved health systems enable the subnational partnership approach

Devolved countries offer far more opportunity to partner with different 'laboratories' for policy innovation. Kenya's 2010 devolution to 47 county governments is the most comprehensive health devolution in sub-Saharan Africa. India's constitutional assignment of health as a state subject gives state governments genuine policy autonomy. This creates natural variation for comparative learning across jurisdictions. South Africa's provincial system offers similar devolution, but Ghana's health devolution remains only partial, limiting county-level partnership possibilities.

3. Existing organisational ecosystem and research depth

IDinsight and GDI have extensively worked across these two countries. No comparable relationship base exists for South Africa or Ghana. Both countries host IDinsight offices (Nairobi, New Delhi), which the scoring captures through D6. What it cannot fully capture is the depth of the surrounding ecosystem: KEMRI-Wellcome Trust (Kenya), Aastrika Foundation (India), Jacaranda Health (Kenya, expanding), White Ribbon Alliance chapters in both countries, the Heshima Project's legacy infrastructure in Kenya, and India's National Quality Assurance Standards programme.

4. The Experience dimension captures irreplaceable relational capital

The Experience flag (contributing 1 point each) reflects a real strategic asset: years of fieldwork, published research, and trusted relationships in both

countries. This includes direct conversations with Kenyan national values trainers, Indian Chief Medical Officers, IDinsight's Public Financial Management team working with Kenyan county governments, and organisations like Noora Health and the Instiglio Government Empowerment Network operating in both countries. Starting in a country without this relational foundation would require 12–18 months of relationship-building before any programme could launch—a significant opportunity cost for a resource-constrained initiative.

5. Cross-country learning potential

Kenya and India represent two very different health system architectures (devolved county model versus federal state model), two regions (East Africa and South Asia), and two different dignity challenges (Kenya's high MMR suggesting a quality-of-care gap; India's documented 71% disrespectful maternity care prevalence). The Person-Centred Maternity Care scale has been validated in both countries, enabling direct comparison. The People's Voice Survey covers both. No other country pair offers this combination of comparability and contrast.

Limitations

This framework is subject to several important caveats. First, quantitative indices compress complex realities into single numbers; a CIVICUS 'Repressed' rating for both Kenya and India obscures the fact that both have vibrant, active health-focused civil society organisations even as broader civic space narrows. Second, data availability is uneven: Afrobarometer covers African countries only, the People's Voice Survey covers 14 countries, and constitutional analysis depends on judicial interpretation that the Constitute Project cannot fully capture. Third, the scoring thresholds (e.g., UHC ≥ 45 for one point, ≥ 60 for two) are judgement calls that could reasonably be set differently. Fourth, the Experience flag is inherently subjective and reflects one organisation's network; a different organisation would produce different flags. These measures are fuzzy, and several countries in the Medium tier—Colombia, Philippines, Indonesia—could be strong candidates with different weighting or additional relationship-building. The framework narrows the field and structures the reasoning; it does not substitute for the relational intelligence that must guide final decisions.

Subnational prioritisation

This section presents the findings of a systematic subnational assessment conducted by a team from the Harris School of Public Policy at the University of Chicago, in partnership with IDinsight.[46] The analysis identifies Indian states and Kenyan counties where dignity-focused health partnerships are most likely to gain traction and produce measurable change.[47] It combines four dimensions of data—health infrastructure, partnership receptivity, dignity intention in legislation, and citizen perceptions of dignity in healthcare—into a composite framework that ranks subnational jurisdictions by their readiness for partnership. The focus here is on High Potential Impact locations: places that demonstrate receptivity and legislative intention around dignity, but where citizens report low levels of dignified care. These are the locations where the gap between aspiration and experience is widest, and where intervention has the greatest potential to close that gap.

We recommend the following locations as the most promising to explore future dignity partnerships:

- **India: Andaman and Nicobar Islands, Arunachal Pradesh, Delhi, Goa, Telangana**
- **Kenya: Kisumu, Makueni, Migori, Mombasa, Siaya**

Rationale: why subnational selection matters

India has 28 states and 8 union territories; Kenya has 47 counties. Health is devolved in both countries. As multiple interviewees emphasised, identical national programs produce vastly different results depending on local governance capacity. Neha Raykar (IDinsight) noted that choosing the right state is crucial, advising against the largest and poorest states where basic needs dominate, and instead targeting states that are more progressive with slightly higher human development. Gursimran Wadhawan (IDinsight, ex-Ministry of Health) stressed that securing state-level endorsement is essential before contacting individual medical officers. For Kenya, the IDinsight Public Financial Management team identified that while some national buy-in is necessary, the county level is where operational partnerships can be built. Mwaniki Muriithi, a Kenyan national values trainer, confirmed that the health sector is the most promising for dignity work because of its broad citizen interface and substantial budget allocation. A rigorous, data-driven approach to subnational selection therefore replaces subjective judgement with a defensible framework for allocating limited resources.

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[46] The Harris School of Public Policy team was: Aishani Mathur, Wenzhong Long, Sahithi Vincy Salikineedi, Kerem Tasdan, Joseph diTommaso, and David Yoon.
[47] Full datasets and analysis code are available here.

Analytical framework

The assessment applies a four-stage filtering and scoring model. Each stage generates a normalised index (0–1) for every subnational unit. The stages are as follows.

Stage 1: Health Infrastructure Filter: Subnational units were first screened for a minimum threshold of health infrastructure, on the grounds that dignity partnerships require a functioning health system to improve. For India, data were drawn from the National Health Profile (2023) for infrastructure and Statistics Times (2025) for population, using two proxies: hospital beds per capita and hospitals per capita. For Kenya, data came from Moses et al. (2021), a mixed-methods performance assessment of county healthcare systems, drawing on DHIS2 for beds and IntraHealth for provider counts. Each region received a normalised score for each proxy, which were averaged to create a healthcare infrastructure index. Regions falling below a minimum threshold were filtered out of subsequent analysis.

Stage 2: Partnership Receptivity Index: This index measures the density of non-governmental organisations operating in each subnational unit as a proxy for the enabling environment for external partnership. For India, data were sourced from the NITI Aayog Darpan portal (2026) and Statistics Times (2025) for population. For Kenya, data came from the NGOs Coordination Board Annual NGO Sector Report (2022) and statskenya.co (2024) for population. NGO counts were standardised per 100,000 population and normalised between 0 and 1. We note that this is inexact: NGO activity may spill over from neighbouring regions experiencing active conflict, or cluster around administrative centres.

Stage 3: Dignity Intention Index: This index measures the extent to which subnational governments use dignity-related language in their legislation and policy documents. For India, documents were sourced from PRS Legislative Research, covering the period 2010–2025, selecting up to 30 most recent documents per state and one recent health-related Act per state. For Kenya, documents were sourced from official county websites and the National Council for Law Reporting, also covering 2010–2025, with 2–58 legislative files identified per county.

A Dignity Lexicon of 106 validated terms was constructed through a multi-stage process. First, approximately 600 recurring terms were extracted using frequency-based text analysis across compiled dignity literature, including IDinsight's Dignity Initiative publications, WHO guidance on dignity in healthcare (2023), Fernandez et al. on patient experiences of respect, Puthussery et al. on respectful maternity care, and Bohren et al.'s typology of mistreatment during childbirth. AI-assisted screening removed irrelevant terms. Conceptual and contextual screening then retained 106 terms aligned with dignity constructs, spanning seven dimensions: core dignity concepts (dignity, respect, humane, compassionate); rights and citizenship (rights, citizen, participation, agency,

empowerment, charter); accountability mechanisms (accountability, transparency, grievance, complaint, redressal, ombudsman, feedback); autonomy and privacy (autonomy, consent, confidentiality, privacy); inclusion and equity (equity, inclusion, discrimination, stigma, marginalised, vulnerable, disability); service standards and professionalism (professionalism, ethics, communication, safety, accreditation); and health and service access markers (maternity, newborn, sanitation, cleanliness, telemedicine, appointment). A Dignity Density measure was calculated for each state or county by dividing the total number of dignity-related words by the total word count across all compiled documents for that jurisdiction. There is limited variation in the density of dignity-related language across subnational jurisdictions; rankings should not be interpreted as definitive. The absence of explicit dignity-related language may reflect that these norms are already deeply embedded within institutional practices. In cases where data were missing, averages were used to impute values.

Stage 4: Dignity Perception Index: This index captures how citizens experience dignity when interacting with health services. For India, three proxies were combined: respect and privacy data from the Longitudinal Aging Study in India (LASI, 2017–2018), and waiting times data from the National Family Health Survey (NFHS-5, 2019–2021). For Kenya, a single proxy was used: respect data from Afrobarometer Round 9 (2023). For India, LASI respect and privacy questions were limited to respondents aged 45 and above; waiting times and privacy were included for better data coverage. For Kenya, some counties had very small sample sizes after cleaning the Afrobarometer respect data for unknowns - nine counties had sample sizes below 20 after cleaning: Garissa, Elgeyo Marakwet, West Pokot, Tharaka Nithi, Isiolo, Vihiga, Laikipia, Tana River, and Marsabit.

The four stages above generate separate scores for each subnational unit. To move from these individual indices to actionable recommendations, the analysis classifies each jurisdiction as High, Medium, or Low on three dimensions (partnership receptivity, dignity intention, and dignity perception), based on quartile thresholds:

- Bottom 25% → Low
- Middle 50% → Medium
- Top 25% → High

High Potential Impact (H, H, L) identifies places with good receptivity and demonstrated intention, but where citizens report low levels of dignified care. This represents the most compelling targets for intervention: these are jurisdictions where governments have signalled commitment to dignity and where partnership infrastructure exists, but where a measurable gap persists between policy aspiration and citizen experience.

For places that scored in the medium range or showed a mix of high and low across dimensions, the research team applied additional qualitative judgement: background research and knowledge of each location; reduced emphasis on Kenyan counties with Afrobarometer sample sizes below 20; comparison of each variable score relative to other closely ranked jurisdictions; and less emphasis on the dignity intention variable (given its limitations) with more emphasis on partnership receptivity and dignity perception.

Recommendations

The following jurisdictions are recommended as High Potential Impact partners: places with high partnership receptivity and high dignity intention, but low citizen perceptions of dignified care.

India

State / UT	Receptivity	Intention	Perception
Andaman and Nicobar Islands*	High	Medium	Low
Arunachal Pradesh*	High	Medium	Low
Delhi	High	Medium	Low
Goa	High	Medium	Low
Telangana	Medium	High	Medium

** Additional natural disaster or political risk.*

These states share a common profile: high or medium NGO density relative to population, above-average use of dignity-related language in their legislation, but poor citizen experiences of dignity in healthcare settings. Telangana appears as a borderline case with medium scores on two dimensions but high dignity intention, and was included based on qualitative assessment. The Aastrika Foundation, a key partner in respectful maternity care, identified Telangana as the state with the strongest performance and commitment to dignity in health. Goa was previously identified in the Dignity Collaborative's own state assessment as one of the strongest smaller states for proof-of-concept work, scoring 22 out of 30 across health infrastructure, progressive politics, social movements, population homogeneity, bureaucratic responsiveness, and manageable size. Delhi presents particular interest given its large population and role as a national reference point, though the complexity of its governance structure is a consideration. Andaman and Nicobar Islands and Arunachal Pradesh are both flagged for natural disaster or political risk.

Kenya

County	Receptivity	Intention	Perception
Kisumu	High	Medium	Medium
Makueni	Medium	Medium	Medium

Migori	Medium	Medium	Low
Mombasa	High	Medium	Medium
Siaya	High	Medium	Low

The Kenyan recommendations cluster in the western and coastal regions. Kisumu, Mombasa, and Siaya all scored high on partnership receptivity, reflecting strong NGO ecosystems. Siaya and Migori both show low citizen perceptions of dignified care, indicating the greatest gap between institutional intent and lived experience. Makueni has been recognised as a progressive county in Kenyan governance and was previously mentioned by the IDinsight PFM team as a county that has been open to new approaches. Mombasa's role as Kenya's second city and a major health service hub gives it particular strategic importance. IDinsight has existing relationships with counties including Nakuru, Kilifi, Kisumu, and Meru, with members of the PFM team having worked directly with these county governments. The group of women governors (G7), which includes Homa Bay, Nakuru, Meru, Kirinyaga, Machakos, Kwale, and Embu, was identified as a potential source of champions.

Interpretation

These recommendations should be treated as a structured starting point for further relationship-building, not as a final selection. Several important caveats apply. First, the analysis captures conditions at the time of data collection; political and institutional circumstances shift. Second, the data proxies are imperfect: NGO density is a rough measure of partnership receptivity, legislative word frequency is a rough measure of intention, and the perception surveys each have demographic or sample size limitations detailed above. Third, several interviewees—including Ron Abraham, Akshay Narayanan, and Gursimran Wadhawan—emphasised that the binding constraint on state selection is not data but relationships: whether one has, or can build through partners, a trusted connection to someone in the state or county health system who is personally motivated to advance this work. The quantitative framework narrows the field; relational intelligence must guide the final decisions.

Product prioritisation

What activities would best advance the dignity agenda? We considered six major ‘product’ models: training courses, membership alliances, advisory consulting, certification, demonstration projects, and fellowships.

We conclude that leadership fellowships for government health professionals offer the strongest evidence-to-impact ratio, even though the evidence base remains thinner than advocates might wish.

Fellowships are the clearest match to our systems diagnosis, best navigating the institutional pressures and providing a clearer sense of community to sustain change than other possible activities. Across evaluations of programmes in sub-Saharan Africa and South Asia, fellowships consistently demonstrate what other models largely fail to achieve: durable shifts in how health leaders think, relate, and act within their institutions. The mechanism is primarily identity transformation rather than knowledge transfer; fellows emerge with altered professional identities, expanded peer networks, and concrete institutional projects that outlast the programme itself.

Systems diagnosis

An intention to affirm dignity is hamstrung by institutional pressures

We diagnose a series of well-documented interlocking failures of systems that together produce indignity. Dignity is widely recognised in law, policy and rhetoric: over 160 national constitutions invoke it, the WHO embeds experiential quality in its care framework, and India's NHRC has issued a 20-point Charter of Patients' Rights.

Yet this recognition has not been operationalised. No country routinely measures whether its citizens are treated with respect. The feedback loop between patient experience and system response is broken: patients know they are being mistreated, but this information rarely reaches the officials who design health services. Accountability mechanisms exist on paper but fail in practice: India's

LaQshya certification programme contains respectful care criteria, yet most hospitals currently fail the audit; Kenya's constitutional commitment to dignity (Article 28) coexists with 36% of healthcare encounters reported as disrespectful. The incentive architecture compounds the problem. Health workers operate under severe time pressure, volume-based performance targets, and hierarchical cultures that reward compliance over compassion,[48] creating what Perrin has termed "benevolent indignities", where well-intentioned institutions systematically violate the dignity of those they serve.[49] Interventions to date have been fragmented and subscale.

Therefore, dignity champions need community

Champions for dignity need community, and they do not yet have one. Jeremy Shiffman's research on how health issues achieve political priority identifies four prerequisites: strong actor networks, powerful framing ideas, favourable political contexts, and compelling issue characteristics.[50] Dignity in health services has the last three; the evidence is strong, the framing resonates, and the political moment is ripe, but the first is structurally weak.

Many people are already working on this, especially within healthcare: the White Ribbon Alliance's 14 national chapters, many of the partners we have collaborated with, the WHO Quality of Care Network's 11 member countries. There is a flowering community of people working on relational public services, researchers across dozens of universities, and motivated officials inside ministries. Yet our interviews and collaborations show that they do not know each other, lack a shared evidence base, and have no institutional home for coordinating their efforts. Yet the network has a hub-and-spoke shape: a few individuals are known to many, but most people working on dignity do not know each other. The result is a system in which the aspiration for dignity is far better established than the infrastructure to deliver it.

The closest thing to a global community is the Human Dignity and Humiliation Studies network, founded by Evelin Lindner in 2001, which has convened over a thousand scholars across more than 20 annual conferences and produced a substantial body of transdisciplinary scholarship.[51] But HumanDHS is primarily academic; it does not focus on practitioners seeking measurable impact, and it

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[48] Subramani, S. (2025). Passive patient culture in India: Disrespect in law and medicine. Routledge. https://doi.org/10.4324/9781003129998
[49] Perrin, P. B. (2025). Understanding and addressing "benevolent indignities": Unintentional violations of human dignity by well-meaning international actors. World Development, 189, Article 106882. https://doi.org/10.1016/j.worlddev.2025.106882
[50] Shiffman, J., & Smith, S. (2007). Generation of political priority for global health initiatives: A framework and case study of maternal mortality. The Lancet, 370(9595), 1370–1379. https://doi.org/10.1016/S0140-6736(07)61579-7
[51] Lindner, E. G., Hartling, L. M., & Spalthoff, U. (2012). Human Dignity and Humiliation Studies: A global network advancing dignity through dialogue. In T. Besley & M. A. Peters (Eds.), Interculturalism, education and dialogue (pp. 66–82). Peter Lang.

does not engage the government officials who control the systems where dignity is most at stake. This matters because the evidence on how health issues rise to political priority consistently shows that diverse networks, linking advocates, researchers, funders, and policymakers, generate attention and resources far more effectively than technically focused communities talking mainly to themselves.[52] The history of successful health movements reinforces the point: HIV/AIDS, tobacco control, and newborn survival all achieved political priority through broad coalitions that connected evidence producers to political actors, not through academic networks alone.[53] Informal coalitions are particularly important in sustaining momentum because they create "accountability politics" — the capacity to hold powerful actors to their stated commitments — which formal institutions alone cannot generate.[54] The dignity field has the evidence, the moral clarity, and the motivated individuals. What it lacks is the connective tissue.

We suggest that this is in part why there are so many pilots of what works in dignity, but few completed trials,[55] and even fewer cases (outside of maternal health and end of life care) of tested interventions being taken up beyond individual hospitals or single charities, reaching the scale through government that is necessary for real change.[56]

Product comparison

How to generate community? Training programmes hit a transfer ceiling that fellowships avoid

The evidence on standalone professional training is extensive and sobering. A meta-analysis of 89 empirical studies found that training transfer to workplace behaviour is moderate at best, with work environment factors — supervisor support, opportunity to perform — proving more predictive of transfer than the training itself.[57] A survey of 150 organisations documented the decay: 62% of

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[52] Smith, S. L., & Shiffman, J. (2016). Setting the global health agenda: The influence of advocates and ideas on political priority for maternal and newborn survival. Social Science & Medicine, 166, 86–93. https://doi.org/10.1016/j.socscimed.2016.08.013
[53] Shiffman, J., Schmitz, H. P., Berlan, D., Smith, S. L., Quissell, K., Gneiting, U., & Pelletier, D. (2016). The emergence and effectiveness of global health networks: Findings and future research. Health Policy and Planning, 31(Suppl. 1), i110–i123. https://doi.org/10.1093/heapol/czw012
[54] Keck, M. E., & Sikkink, K. (1998). Activists beyond borders: Advocacy networks in international politics. Cornell University Press.
[55] IDinsight Dignity Initiative. (2024). Dignity What Works Guide [Interactive database]. https://dignity-what-works.softr.app/
[56] Rajani, R., & Hanstad, T. (2025). Helping NGOs and funders make the 'big shift' to working with government. Stanford Social Innovation Review. https://doi.org/10.48558/75RE-2E08
[57] Blume, B. D., Ford, J. K., Baldwin, T. T., & Huang, J. L. (2010). Transfer of training: A meta-analytic review. Journal of Management, 36(4), 1065–1105.

trainees apply what they learned immediately, 44% at six months, and just 34% at one year.[58] A further integrative review estimated that 66–85% of learned content is never implemented.[59] This has also been visible within IDinsight's experience, where building capacity of individuals has generally been less impactful than other project modes.

The evaluation architecture compounds the problem. The Association for Talent Development found that approximately 90% of organisations evaluate training at the level of participant satisfaction, but only 54% measure behaviour change and roughly 35% assess organisational results.[60] For continuing medical education specifically, a meta-analysis of 31 RCTs found an overall effect size of just r = 0.28 (small to medium), with passive methods yielding even weaker effects (r = 0.20).[61] A systematic review concluded bluntly that widely used CME methods such as conferences have little direct impact on improving professional practice.[62]

Asynchronous online courses face steeper headwinds. An analysis in Science of every MOOC offered by MIT and Harvard on edX from 2012–2018 found average completion rates of 3–6%, with only 1.43% of learners from low-development countries.[63]

Fellowships circumvent the transfer problem by design: they create action-learning projects embedded in fellows' own institutional contexts, peer cohorts that create accountability, and identity-level change through reflective practice. The evaluation of the Oliver Tambo Fellowship Programme found the programme's most consistent outcome was profound self-examination — qualitatively different from knowledge acquisition and far more resistant to decay.[64]

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https://doi.org/10.1177/0149206309352880

[58] Saks, A. M., & Belcourt, M. (2006). An investigation of training activities and transfer of training in organizations. Human Resource Management, 45(4), 629–648. https://doi.org/10.1002/hrm.20135

[59] Burke, L. A., & Hutchins, H. M. (2007). Training transfer: An integrative literature review. Human Resource Development Review, 6(3), 263–296. https://doi.org/10.1177/1534484307303035

[60] Association for Talent Development. (2016). Evaluating learning: Getting to measurements that matter. ATD Press.

[61] Mansouri, M., & Lockyer, J. (2007). A meta-analysis of continuing medical education effectiveness. Journal of Continuing Education in the Health Professions, 27(1), 6–15. https://doi.org/10.1002/chp.88

[62] Davis, D. A., Thomson, M. A., Oxman, A. D., & Haynes, R. B. (1995). Changing physician performance: A systematic review of the effect of continuing medical education strategies. JAMA, 274(9), 700–705. https://doi.org/10.1001/jama.1995.03530090032018

[63] Reich, J., & Ruipérez-Valiente, J. A. (2019). The MOOC pivot. Science, 363(6423), 130–131. https://doi.org/10.1126/science.aav7958

[64] Doherty, J., Gilson, L., & Shung-King, M. (2018). Achievements and challenges in developing health leadership in South Africa: The experience of the Oliver Tambo Fellowship Programme. Health Policy and Planning, 33(suppl_2), ii50–ii64. https://doi.org/10.1093/heapol/czy017

Coalitions proliferate but rarely produce proportional results

When we examine case studies of success, informal coalitions of actors are almost always present and important.[65] Yet surveying the field of deliberately created coalitions shows that few succeed. Multi-stakeholder alliances represent the dominant institutional architecture of global health, yet the evidence on their effectiveness is troubling. After a decade of research into 45 transnational initiatives, one major review concluded that these are not effective tools for accountability or protecting rights holders.[66] Academic analysis of the World Summit on Sustainable Development partnership database found that up to 70% were inactive,[67] and subsequent analysis suggested failure rates as high as 84%.[68] The most structured vision of how coalitions might work comes from the collective impact framework, but the most rigorous evaluation of 25 collective impact initiatives found that for only 3 of 8 deep-dive sites was collective impact the primary driver.[69]

Multiple interviewees echoed this concern. Alliances are challenging to build and maintain due to the labour-intensive work of relationship and alignment management. Tina Anjouma, reflecting on the Racial Equity Index experience, noted that the initiative overfocused on building and not enough on public-facing advocacy and partnerships, and that many funders and organisations were interested but unwilling to fund. Fellowships create a different kind of network — one built on deep interpersonal bonds, shared identity, and mutual accountability among a small cohort, rather than institutional membership agreements. That can become the basis for a future community supporting collective action, possibly under the banner of a formalised coalition.

Advisory models can substitute for capacity rather than building it

The experience of IDinsight in working with external partners is informative here. Our most impactful advisory work relies on deep collaborations focused around a single clearly defined decision. Telling people to be more respectful in their work in general doesn't work. This is also visible in the Dignity Initiative's experience of supporting internal change within IDinsight. IDinsight's Dignity Report 2025 found that centralised advisory models — where a specialist team

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[65] Shiffman, J., Schmitz, H. P., Berlan, D., Smith, S. L., Quissell, K., Gneiting, U., & Pelletier, D. (2016). The emergence and effectiveness of global health networks: Findings and future research. Health Policy and Planning, 31(Suppl. 1), i110–i123. https://doi.org/10.1093/heapol/czw012
[66] MSI Integrity. (2020). Not fit-for-purpose: The grand experiment of multi-stakeholder initiatives in corporate accountability, human rights, and global governance. MSI Integrity.
[67] Pattberg, P. H., Biermann, F., Chan, S., & Mert, A. (Eds.). (2012). Public–private partnerships for sustainable development: Emergence, influence and legitimacy. Edward Elgar.
[68] Dodds, F. (2015). Multi-stakeholder partnerships: Making them work for the post-2015 development agenda. Global Research Institute.
[69] Kania, J., & Kramer, M. (2011). Collective impact. Stanford Social Innovation Review, 9(1), 36–41.

offers guidance when consulted — hit a ceiling fast: advice became repetitive, uptake depended on the specialists' availability, and dignity remained an add-on rather than a reflex.[70] Across the sector, identical incentives and systems produce different dignity outcomes depending on the organisational culture underneath. The binding constraint is not knowledge of what respectful practice looks like, but whether the institution's culture rewards or punishes it in the daily moments that matter. Sustainable change requires moving from advising individuals to reshaping the institutional environment they operate in.

The global development sector spends approximately $15–20 billion annually on technical assistance. Yet a landmark UNDP review found that decades of technical assistance had often not made a lasting impact, failing to lead to self-reliance.[71] Advisors deployed as facilitators frequently shift to substitution under pressure, and technical advisers are expected to perform government functions outside the terms of reference.[72] Sustained capacity emerges from endogenous processes, yet the act of providing external assistance can undermine those very processes.[73]

Several interviewees reinforced this finding. Rakesh Rajani emphasised that trust is the currency of change and that deep personal relationships drive systemic change. Ron Abraham proposed that the intervention should work through well-qualified NGOs already implementing programmes, using their relationships rather than building from scratch. Fellowships address the capacity substitution problem by investing in insiders who already understand institutional culture and power dynamics, rather than placing external advisors.

Certification drives compliance but not necessarily improvement

A systematic review of 76 studies found a consistent positive effect of hospital accreditation on safety culture and process measures, but results on mortality were paradoxical, and patient satisfaction was unrelated to accreditation.[74] Research on means-ends decoupling has shown that organisations optimise for measurable certification criteria rather than genuine improvement, and that in LMIC contexts, accreditation programmes increased the likelihood of discontinuation once external assistance ceased.[75] India's LaQshya programme,

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[70] IDinsight Dignity Initiative. (2025). The Dignity Report 2025. IDinsight. https://www.idinsight.org/article/2024-dignity-report/
[71] UNDP. (1993). Rethinking technical cooperation: Reforms for capacity building in Africa (Berg Report). United Nations Development Programme.
[72] Oxford Policy Management. (2020). Technical assistance: A framework for analysis. OPM.
[73] Brinkerhoff, D. W., & Morgan, P. J. (2010). Capacity and capacity development: Coping with complexity. Public Administration and Development, 30(1), 2–10. https://doi.org/10.1002/pad.559
[74] Hussein, M., Pavlova, M., Ghalwash, M., & Groot, W. (2021). The impact of hospital accreditation on the quality of healthcare: A systematic literature review. BMC Health Services Research, 21(1), 1090. https://doi.org/10.1186/s12913-021-07097-6
[75] Bromley, P., & Powell, W. W. (2012). From smoke and mirrors to walking the talk: Decoupling in the contemporary world. Academy of Management Annals, 6(1), 483–530.

while valuable as a quality framework, illustrates this tension: hospitals pursue certification as an end, sometimes at the expense of the relational care that dignity requires (Supriya Bansal, Ansh).

The leverage point argument favours investing in people

Donella Meadows's hierarchy of system leverage points provides the theoretical framework.[76] Training and certification operate at shallow leverage points — adjusting parameters and information flows. Coalitions and consulting work at intermediate points by restructuring rules and feedback loops. Fellowships target the deepest leverage points, changing the goals, mental models, and self-organising capacity of the system through transformed leaders. The binding constraint is not knowledge, tools, or external resources but the capacity and agency of the people running the system.

A systematic review found that in 5 of 7 studies, champions were positively associated with increased uptake of health system innovations.[77] Multiple practitioner interviewees confirmed this from experience: GDI's lessons on fellowship models identified that selection is the most strategic design choice, that community building is a feature not a side benefit, and that impact measurement is a universal pain point. Nicole Pflock (Instiglio GEN) reported that the biggest barrier for civil servants is lack of community. Tony Senanayake described Mulago's fellowship as providing unmatched support through tangible funding, a powerful network, and a credibility signal. Taylor Thompson said the community was the best part of his experience with Echoing Green.

Assessment: fellowships are the closest match for our diagnosis of the challenges in the dignity system

Product	Assessment
Training courses	Training addresses knowledge gaps, but the system diagnosis identifies culture and incentives — not knowledge — as the binding constraint; meta-analytic evidence confirms that only 34% of trainees still apply learning at one year, because the institutional environment they return to has not changed.
Membership alliances / coalitions	Coalitions address the fragmentation problem directly, but deliberately constructed ones have failure rates as high as 84%, and the dignity field's need is less for institutional membership

https://doi.org/10.5465/19416520.2012.684462
[76] Meadows, D. H. (1999). Leverage points: Places to intervene in a system. Sustainability Institute.
[77] Miech, E. J., Rattray, N. A., Flanagan, M. E., Damschroder, L., Schmid, A. A., & Damush, T. M. (2018). Inside help: An integrative review of champions in healthcare-related implementation. SAGE Open Medicine, 6, 1–11. https://doi.org/10.1177/2050312118773261.

	agreements than for the deep interpersonal bonds and shared identity that drive sustained action.
Advisory consulting	Advisory models can sharpen specific decisions, but the diagnosis identifies a broken feedback loop between patient experience and system response. Centralised advisory models hit a ceiling fast, with advice becoming repetitive and dignity remaining an add-on rather than a reflex.
Certification	Certification targets accountability mechanisms that the diagnosis identifies as existing but ineffective; yet evidence on means-ends decoupling shows that organisations optimise for measurable certification criteria rather than genuine improvement, and India's LaQshya experience illustrates the tension — hospitals pursue the certificate as an end, sometimes at the expense of the relational care that dignity requires.
Demonstration projects	Demonstration projects generate evidence of what works, but the diagnosis identifies not a shortage of pilots but a failure to move from pilots to system-wide adoption — and the voltage-drop literature shows that interventions designed in NGO settings systematically underperform when transferred to government implementation.
Fellowships	Fellowships target the deepest level of the diagnosis — the incentives, norms, and institutional cultures that produce indignity — by transforming the identity and agency of insiders who already operate within the system, while simultaneously building the community and connective tissue that the field currently lacks.

Honest trade-offs that fellowship advocates must confront

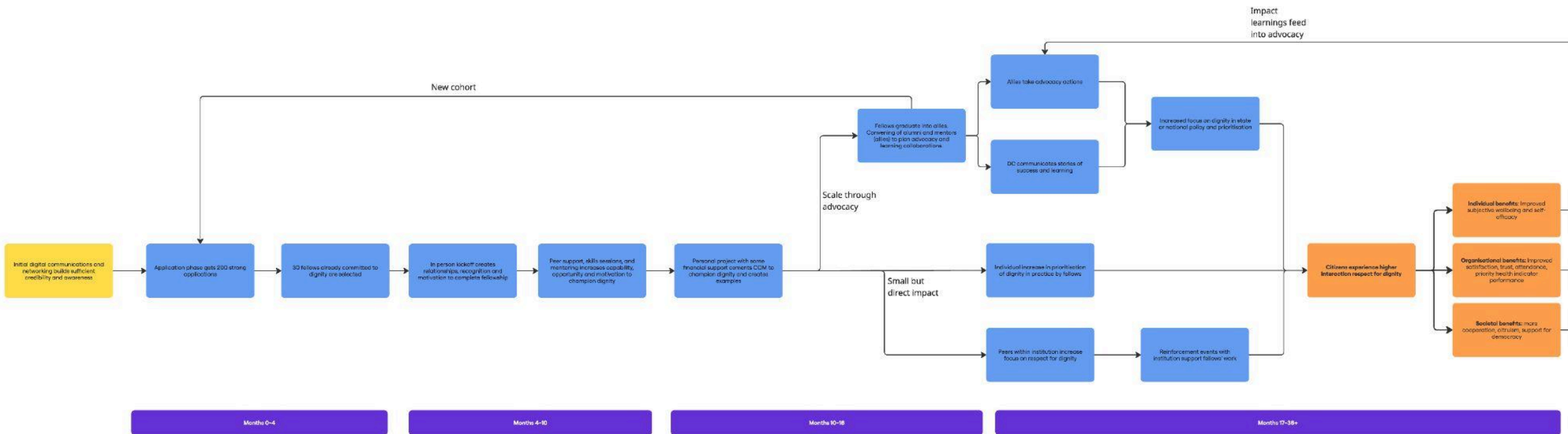
The case for fellowships is strong but not unqualified. First, the evidence base is dominated by pre-post designs without control groups. An industry report found that only 26% of fellowship organisations had performed any programme evaluation.[78] Second, fellowships are inherently small-scale: Afya Bora has graduated 161 fellows over a decade; India's HPSR Fellowship selects 20 per year. Third, contextual factors mediate impact heavily — the Scottish Quality and Safety Fellowship evaluation found system-level impact was mediated by a wide range of contextual factors.[79] Fourth, no single model is sufficient; the learning health systems literature identifies eight domains that must function simultaneously. Fellowships address leadership and culture directly,

[78] IREX & ProFellow. (2020). 2020 fellowship industry report. IREX.
[79] Aitken, L. M., Burmeister, E., Clayton, S., Dalais, C., & Gardner, G. (2011). The impact of Nursing Rounds on the practice environment and nurse satisfaction in intensive care: Pre-test post-test comparative study. International Journal of Nursing Studies, 48(8), 918–925. Note: Verify the specific Scottish Quality and Safety Fellowship evaluation cited; this may be Miller et al. (2016) in BMJ Quality & Safety.

competencies partially, and the remaining domains hardly at all.

The comparative evidence, imperfect as it is, points toward fellowships as the intervention with the most plausible pathway to durable systems-level change.

Theory of Change



The full theory of change diagram can be viewed in Miro here.

We aim to produce more respectful outcomes in services. The evidence shows that this yields individual, programmatic and societal benefits.

The fellowship rests on a specific causal claim: that transformed leaders, embedded in their own institutions and connected to a growing community of peers, can shift institutional cultures from the inside — moving dignity from rhetorical commitment to lived reality in daily patient interactions. This section specifies the mechanisms through which we expect that transformation to occur, the assumptions on which the theory depends, the risks that could derail it, and the evidence supporting each link in the causal chain.

To achieve these, our theory of change proposes beginning with initial digital communications and networking to build sufficient credibility and awareness. If this is successful, we would achieve at least 200 applications to the fellowship program. This would allow selection of 30 committed fellows. They would undertake an in-person kickoff, learning activities with peers and mentors, and a personal project over a 12 month fellowship.

Through this, the fellows would prioritise dignity more fully in their own work, and diffuse this to their peers at the institution (with reinforcing events to support this diffusion). This would achieve a small scale direct impact on dignity outcomes.

Greater impact would be achieved by graduating the fellows into a community of allies, together with their former mentors, taking advocacy actions reinforced by amplifying communications from this dignity initiative. As the number of advocacy actions mounts and the cohort grows year by year, this would result in increased pressure on national and subnational policy and practice towards dignity, as well as increasing clarity about which actions best affirm dignity in those contexts.

Mechanisms and assumptions

Level 1: Individual transformation (Months 1–12)

Identity shift through reflective practice and peer accountability: The fellowship's primary mechanism at the individual level is not knowledge transfer but identity transformation. The India HPSR Fellowship evaluation found that its most important function was serving as an "external catalyst" to an "unlearning" process — deliberate reflection in which old ways of thinking and acting are questioned, challenged, and adapted. The Oliver Tambo Fellowship Programme evaluation found the programme's most consistent outcome was "profound

self-examination" — qualitatively different from knowledge acquisition and far more resistant to decay.

This operates through three reinforcing sub-mechanisms:

- **Reframing:** Fellows learn to see their own systems through a dignity lens — recognising dignity violations they had previously normalised, and identifying the institutional routines and power dynamics that produce them. The foundation track's early emphasis on "unlearning" addresses this directly, drawing on concepts from the capability approach and procedural justice traditions. As Dilshad S (IDinsight) observed in our theory of change discussions: "Telling people about practices is not really yielding results. You have to focus on the underlying organisational culture."
- **Peer cohort effects:** A cohort of approximately 30 fellows creates mutual accountability that no individual training can replicate. Across our practitioner interviews, community and peer connection were consistently identified as the most valued element of fellowship programmes. Nicole Pflock (Instiglio GEN) reported that the biggest barrier for civil servants is lack of community. Taylor Thompson described the community as the best part of his Echoing Green experience. Tony Senanayake described Mulago's fellowship as providing unmatched support through tangible funding, a powerful network, and a credibility signal. The evidence from WomenLift Health India (Avantika Dhingra) suggests that peer groups form effectively even with limited in-person time, though in-person kickoffs strengthen the initial bond.
- **Sustained motivation in adversity:** The COM-B framework (Capability, Opportunity, Motivation) structures our understanding of individual-level change. Fellows arrive with relatively high motivation; the fellowship's primary individual contribution is sustaining that motivation through adversity — providing skill and knowledge (Capability), helping fellows spot opportunities to practise dignity in difficult moments (Opportunity), and managing the bandwidth constraints that Indian and Kenyan health officials face constantly.

Assumptions at Level 1

1. **Sufficient intrinsically motivated candidates exist.** We assume that among the Senior Medical Officers, their colleagues, hospital supervisors, and county health team members in our target jurisdictions, at least 200 will apply for 30 places — yielding a selection ratio that allows meaningful quality filtering. Vishan Pattnaik (Mission Karmayogi / IDinsight) confirmed that intrinsic motivation varies across states and subgroups, and advised targeting states where constraints on

bureaucrats are lower.

2. **Fellows can protect time for the fellowship.** Indian bureaucrats frequently lack control over their schedules. Vishan Pattnaik noted that "getting people away from their jobs for four or five days would be very difficult unless the programme is very explicitly state-mandated." Advance warning does not significantly help with the short-term chaos and unexpected events (minister visits, emergency responses) that frequently disrupt schedules. The fellowship design mitigates this through predominantly virtual engagement after the initial kickoff, but the constraint is real.
3. **Self-selection does not produce an unrepresentative cohort.** The most intrinsically motivated and high-performing individuals are typically the "hardest to spare" and are therefore sent for training least often. Open application works better than nomination (confirmed by GEN experience).

Level 2: Institutional culture change (Months 6–18)

Fellows as internal change agents, reshaping the institutional environment they operate in: The binding constraint on dignity in health facilities is not knowledge of what respectful practice looks like, but whether the institution's culture rewards or punishes it in the daily moments that matter. IDinsight's Dignity Report 2025 found that centralised advisory models — where a specialist team offers guidance when consulted — hit a ceiling fast: advice became repetitive, uptake depended on the specialists' availability, and dignity remained an add-on rather than a reflex. Identical incentives and systems produce different dignity outcomes depending on the organisational culture underneath.

The fellowship addresses this through three sub-mechanisms:

1. **Diagnostic projects.** Each fellow conducts a dignity audit of their own facility — identifying hotspots where disrespect concentrates, mapping the routines and power dynamics that produce them, and designing an improvement initiative. This is the project track's core contribution. It generates locally relevant evidence and gives fellows a concrete vehicle for engaging their institution. Supriya Bansal (Ansh) confirmed that India's LaQshya programme creates a powerful institutional incentive: hospitals want certification, but most currently fail. Getting them over the line of the dignity audit could be a powerful hook for fellowship projects.
2. **Institutional permission and visibility.** The fellowship creates formal ceremony and institutional recognition — a letter from the fellow's supervisor granting permission, public acknowledgement of the fellowship award, sharing sessions with colleagues. These are deliberate design choices to shift the fellow's institutional positioning from individual enthusiast to sanctioned change agent. The two-person model

(selecting a senior person who nominates a more junior colleague from their institution) creates continuity and internal coalition.

3. **Diffusion through reinforcing events.** As fellows move through their projects, the programme organises reinforcing events — convenings, presentations to institutional leadership, peer exchanges — that make the fellow's work visible to colleagues and superiors. The theory is that dignity practices spread not through top-down mandates but through demonstration, storytelling, and social proof within the institution.

Assumptions at Level 2

4. **State-level permission can be secured.** In India, formal permission from state bureaucracy is almost certainly required before inviting government officials to participate in an external fellowship. Gursimran Wadhawan (IDinsight, ex-Ministry of Health) stressed that securing state-level endorsement is essential before contacting individual medical officers. This is the single most significant operational prerequisite, and failure to secure it would prevent the fellowship from launching in a given state. The mitigation strategy is to work through partner organisations already embedded in state health systems, and to target smaller, more progressive states where relationships can be built faster.
5. **Fellows remain in their posts long enough to effect change.** Administrative transfers are a systemic feature of Indian bureaucracy. Fellows may be transferred mid-programme to a different facility or district where they have no established relationships and where their project is irrelevant. Kenya's county system presents less transfer risk, but political changes following elections can reshuffle county health leadership.
6. **One or two individuals can shift institutional culture.** This is the theory's most ambitious assumption. The evidence from champions literature is cautiously supportive: a systematic review found that in 5 of 7 studies, champions were positively associated with increased uptake of health system innovations (Miech et al., 2018). But the learning health systems literature identifies eight domains that must function simultaneously; fellowships address leadership and culture directly, competencies partially, and the remaining domains hardly at all. The two-person model and the institutional engagement activities are designed to increase the odds, but a single fellowship cannot transform a hospital culture on its own.

Level 3: System-level change (Year 2 onwards)

Compounding advocacy through an expanding alumni network. The theory's system-level claim is that graduating fellows, joined by their mentors and connected through an alumni community, become an advocacy force — profiling what works, sharing testimony, and carrying proven practices to state- and county-level decision-makers. Each cohort's graduation overlaps with the next cohort's recruitment, so alumni serve as mentors and selection judges, and the community compounds rather than dissipates.

This operates through three sub-mechanisms:

1. **Evidence aggregation.** The diagnostic projects and improvement initiatives across 30 fellows per cohort generate a body of locally grounded evidence about what works for dignity in specific Indian and Kenyan health system contexts. This evidence — specific practices, specific facilities, specific before-and-after measurements — is far more persuasive to state-level officials than generic international guidance. As Dilshad S framed it: "Build up what works and hotspots through the projects, take them to state government as great practices from your state."
2. **Opinion infrastructure.** Alumni take advocacy actions — public testimony, essay-writing, speaking at conferences, engaging with state health leadership during planning cycles. The annual rhythm is designed around this: September–November is the optimal window for engaging Indian and Kenyan officials, aligning with the NHM PIP development cycle and Kenyan county budget planning. These actions are individually small but collectively create a growing body of visible advocacy for dignity in health.
3. **Network compounding.** The Mawazo Institute's experience with alumni engagement offers a practical model: small community-of-practice grants in which alumni apply for funding to collaborate with other alumni across countries, creating real work with real funding and placing responsibility for community-building on the alumni themselves. The GDI team's lesson on fellowship models was explicit: "Community building is a feature, not a side benefit."

Assumptions at Level 3

7. **Alumni remain engaged after graduation.** The Mawazo Institute acknowledged they "haven't really cracked alumni management even though they think it's important." Alumni engagement is effortful and requires continued programming, funding, and reasons to stay connected. Ivy Migue (AfricaOps) raised the practical question: after the fellowship, can alumni access resources? Do they have money to act?

The design proposes alumni convenings, small grants, and involvement in future cohort selection, but sustained engagement beyond 2–3 years is unproven.

8. **30 fellows per cohort is sufficient to generate policy pressure.** Afya Bora has graduated 161 fellows over a decade; India's HPSR Fellowship selects 20 per year. These are small numbers relative to health workforces of millions. The theory is that well-placed individuals can have outsized influence — but the evidence for this at the fellowship-to-policy level is thin, dominated by case studies and self-report.
9. **The political environment remains permissive.** The fellowship requires a governance environment that tolerates, if not actively supports, external engagement with government health officials. CIVICUS rates both Kenya and India as "Repressed" for civic space. Both countries have vibrant health-focused civil society, but broader civic space is narrowing. A political shift toward hostility to external engagement could render the model inoperable.

Risks, failure modes and mitigation

The following risks are presented in approximate order of severity, with proposed mitigations.

Critical risks (could prevent the programme from launching)

Failure to secure state-level permission in India. Without formal endorsement from a state health department, Indian officials cannot participate. Mitigation: Work through partner organisations (Aastrika Foundation, IDinsight's existing state relationships) already embedded in state health systems. Start with smaller, more progressive states (Goa, Telangana) where relationships can be built faster. Accept that some states will say no and plan for this in the recruitment pipeline.

Insufficient seed funding. The programme requires philanthropic investment before any fellows are recruited. The fundraising environment for new initiatives is challenging, particularly in the current ODA climate. Mitigation: Customising narrative and language to each funder while maintaining the core evidence base. Target smaller family foundations for seed funding while cultivating larger institutional funders (Gates, Wellcome) for scale funding.

Serious risks (could significantly reduce impact)

Fellow transfers mid-programme. Indian administrative transfers could move fellows to facilities where their projects are irrelevant and their institutional relationships are disrupted. Mitigation: Select fellows who do not expect transfer (though they may not know); use the two-person model so that if one is transferred, the other maintains continuity; design projects that build transferable skills and analytical frameworks, not just facility-specific interventions.

Training transfer decay. The meta-analytic evidence cited in the product prioritisation section shows that 62% of trainees apply learning immediately, but only 34% do so at one year. While the fellowship is designed to circumvent this through embedded projects and peer accountability, it would be naive to assume all 30 fellows will sustain changed practice. Mitigation: The alumni network, reinforcing events, and overlapping cohort design are specifically intended to counteract decay. Build measurement of sustained practice change into the evaluation design from the outset.

Evaluation weakness. Only 26% of fellowship organisations have performed any programme evaluation (IREX & ProFellow, 2020). The Scottish Quality and Safety Fellowship evaluation found that system-level impact was mediated by a wide range of contextual factors. Without credible evaluation, the programme cannot demonstrate impact to funders or adapt its design based on evidence. Mitigation: Build evaluation into the design from inception. Invest in baseline dignity measurement at fellows' facilities before the fellowship begins, and repeat measurement at 12 and 24 months. Use the PCMC scale (validated in both Kenya and India) to enable direct comparison.

Manageable risks (likely to occur but can be absorbed)

Cohort attrition. Some fellows will drop out due to personal circumstances, professional pressures, or loss of motivation. The Mawazo Institute had one explicit dropout across multiple cohorts (due to medical issues) and maintained engagement even in a cohort that lacked a fellows fund for the first half of the programme. Mitigation: Recruit slightly above target (35 for 30 seats); invest heavily in selection to identify commitment; provide flexible engagement options for fellows under temporary pressure.

Alumni network decay. Sustaining alumni engagement beyond the initial post-graduation glow requires ongoing investment, resources, and reasons to participate. Mitigation: Small community-of-practice grants; involvement in future cohort selection and mentoring; annual convenings; public advocacy opportunities that provide individual professional benefit (publications, speaking invitations, leadership visibility).

Political sensitivity. Dignity work can be perceived as criticism of government performance. Officials may be reluctant to participate in a programme that implicitly acknowledges dignity failures in their facilities. Mitigation: Frame the fellowship as a professional development opportunity focused on quality improvement, aligned with existing government commitments (LaQshya, Kenya's national values framework, WHO QoCN membership). Use the language of government aspirations, not external critique.

Interview conclusions

Across 48 practitioner interviews, several patterns emerged that inform the theory of change directly.

Where interviewees converged

- **Selection is the most consequential design choice.** This was the single most consistent finding across the GDI team, WomenLift Health, Mawazo Institute, Instiglio GEN, and Echoing Green alumni. The Mawazo Institute reported that asking about a candidate's "vision and big idea beyond their current job" was the most predictive selection question. The GDI team's synthesis concluded: "Recruitment is the most strategic design choice in any fellowship."
- **Community matters more than curriculum.** Every fellowship practitioner we interviewed rated peer connection above formal learning content. The GDI team's overall lesson was that "impact measurement is a universal pain point. Funders like fellowships but struggle to articulate their systemic ROI unless it's built in from the start." This suggests that the fellowship's theory of change should foreground the community mechanism rather than the knowledge-transfer mechanism.
- **Institutional buy-in must precede individual recruitment.** Gursimran Wadhawan, Vishan Pattnaik, and the IDinsight PFM team all emphasised that state or county-level endorsement must be secured before reaching individual officials. In India, this is a binding operational prerequisite. In Kenya, county health teams have more autonomy, but some national buy-in is necessary to keep counties moving.

Where interviewees disagreed

- **Whether insider or outsider theories of change are needed.** Supriya Bansal (Ansh) argued for complementary accountability work and "frankly, public shaming" alongside insider fellowship models — community lawyers, getting negligent officials named in the press or WhatsApp groups. Ron Abraham proposed working through established NGOs rather than building new infrastructure. Rakesh Rajani emphasised that trust and deep personal relationships drive systemic change, cautioning against institutional approaches that substitute for relational work. These are not contradictions — but they suggest the fellowship alone is necessary but not sufficient.
- **How much in-person time is required.** The Mawazo Institute varied this substantially across cohorts. Their second cohort met only at graduation (three days); their third never met in person at all. More in-person time strengthened connections to the organisation running the fellowship but did not dramatically change peer-to-peer bonds. This is relevant for budgeting and for the feasibility of gathering Indian officials whose schedules are unpredictable.

A viable model for fellowships for dignity

There is a viable model for fellowship that could be taken up by a variety of providers and partners.

The theory of change is plausible but unproven. Its strongest links — individual identity transformation through reflective practice and peer cohorts — are supported by qualitative evaluations of comparable fellowship programmes, though none with rigorous counterfactual designs. Its weakest links are at the system level: the claim that 30 alumni per year, however well-placed, can generate sufficient advocacy pressure to shift state or national policy is aspirational rather than evidence-based. The programme's credibility with funders depends on being honest about this — demonstrating measurable individual and institutional change in the first cohort, while building toward the system-level impact that will take multiple cohorts to achieve.

Donella Meadows's hierarchy of system leverage points provides the theoretical framework: training and certification operate at shallow leverage points (adjusting parameters and information flows); coalitions and consulting work at intermediate points (restructuring rules and feedback loops); fellowships target

the deepest leverage points (changing the goals, mental models, and self-organising capacity of the system through transformed leaders). The argument is not that this will certainly work, but that it targets the right level of the system — and that no lighter-touch intervention has a plausible pathway to the kind of durable culture change that dignity requires.

How it would operate

The fellowship begins with a competitive application process, with recruitment timed to align with national health planning cycles — November to January in India, matching the NHM PIP window — and supported by partnerships with state health leadership to build a high-quality pipeline. Selected fellows gather for an in-person kickoff of two to three days, where the emphasis is on relationship-building: forming peer groups, establishing shared language and norms, meeting mentors, and beginning to see their own systems through a dignity lens. From there, two overlapping tracks run across the year. A six-month foundation track grounds fellows in concepts of dignity, reflective practice, and practical tools through facilitated virtual sessions, monthly mentor meetings, and peer group exchanges — front-loaded in the early months around unlearning and reframing, then shifting toward application. In parallel, a nine-month project track has fellows diagnose dignity hotspots in their own facilities, plan an improvement initiative, and implement it with light-touch support, so that learning is tied to tangible change from the outset.

As fellows move through their projects, they build the evidence base and the stories that feed the programme's broader advocacy ambitions. Graduating fellows join a growing circle of alumni and allies whose principal role is to advocate for systemic change — profiling what works, sharing testimony, and carrying proven practices to state-level decision-makers. The annual rhythm is designed for sustainability: each cohort's graduation overlaps with the next cohort's recruitment, so that alumni can serve as mentors and selection judges, and the community compounds rather than dissipates. A structured pause between cohorts allows the team to learn and adapt the programme before the next round begins.

The table below describes a likely annual rhythm for this work, and discusses the international, Kenyan and Indian policy and advocacy context around which this must function.

Month	Context - India	Context - Kenya	Context - Intl	Fellowship	Other org priorities
Jan	State PIP Consolidation. Busy period.	Midyear performance review.	WEF. WHO planning.	Finalise recruitment by now	Fundraising push. Planning
Feb	National budget presented. Many admin re-orgs and transfers. National Programme Coordination Committee (NPCC) reviews and approves state PIPs. Busy period.	Planning units begin bottom-up planning. Busy time.	WHO planning.		
Mar	Fiscal year ends. National budget approved. Many admin re-orgs and transfers. National Programme Coordination Committee (NPCC) reviews and approves state PIPs. Busy period. Is National Common Review Mission here? Check this	Budget proposals submitted to National Assembly for approval. County budget hearings and public participation processes. Busy time.		Graduation of previous cohort. Kickoff fellowship in person.	Convening
Apr	Fiscal year begins. Relatively calm. Annual operational plans finanlised. Record of Proceedings & Fund Release. National elections in election years. Individual performance review process begins. Individual workplans developed.	Treasury finalizes national budget. County budget hearings and public participation processes. Busy time.	Skoll World Forum	Mentorship, peer support, skills sessions	International advocacy and fundraising
May	PIP development cycle begins. Record of Proceedings & Fund Release sent from national to states. Relatively calm. Annual operational plans finanlised.	Busy time.	World Health Assembly. WHO decisions. Most important events.	Mentorship, peer support, skills sessions	International advocacy and fundraising
Jun	Monsoon - travel and health challenges. Record of Proceedings & Fund Release sent from national to states	Fiscal year ends. Finance bill. Busy time. Institutional performance contracts negotiated. Annual individual Appraisal	G7. H20 Annual Summit.	Mentorship, peer support, skills sessions	
Jul	Monsoon - travel and health challenges. Record of Proceedings & Fund Release sent from states to districts	Fiscal year starts, new budgets implemented. Year-End performance Self-Evaluation Institutional performance contracts signed. Annual individual Appraisal	Financing for Development Conference	Mentorship, peer support, skills sessions	Prepare advocacy content. Midyear review
Aug	Monsoon - travel and health challenges. Independence Day. Guidelines for fund Utilization sent by District to Blocks	Treasury issues circulars about following year budget. Review of prev year institutional performance. Elections during election years. Individual performance targets set.	WHO Regional Committee for Africa		Best time to engage with Kenya officials.
Sept	Monsoon - travel and health challenges. Guidelines for fund Utilization sent by District to Blocks. Annual Common Review	County Dept of Health begins planning - County Budget Review and Outlook Paper (CBROP).	UN General Assembly	Launch individual projects	Best time to engage with India and Kenya officials.

	Mission for national health mission performance.	Review of prev year performance. Annual Health Sector Report			
Oct	PIP development cycle intensifies. Ministry of Health and Family Welfare issues planning guidelines and resource envelopes to states for future NHMs. Village Health Plan for upcoming FY submitted to the Block	Mashujaa day. Review of prev year performance. County Budget Review and Outlook Paper (CBROP)	World Health Summit. World Bank/IMF Annual Meetings	.	Best time to engage with India and Kenya officials.
Nov	Block Health Action Plan Consolidation. Individual performance review finalized.	Health sector Annual Operational Plan review summit; Treasury releases Budget Outlook Paper. Annual performance evaluation report published	G20	Launch recruitment	Final chance for India and Kenya advocacy
Dec	District Health Action Plan (DHAP) Development. Ministry of Health and Family Welfare is bidding for resources from the Finance Ministry.	Sector Working Group hearings. Auditor-General reports deadline. County Dept of Health complete vision for next year. Annual performance evaluation report published			Fundraising push. Learning and reflection.

Note: Kenya government dates often slip. India state elections may be throughout the year.

Appendix: Interviews

We conducted the following interviews with practitioners and scholars over the course of this work, supplementing data analysis and internal discussions.

1. Karen Levy, Fit for Purpose (18 March 2025)
2. Rakesh Rajani, JustSystems (25 March 2025)
3. Esther Wang, Elevate Prize (25 March 2025)
4. Nate Peterson, CGIAR (27 March 2025)
5. Tina Anjouma, Racial Equity Index (16 April 2025)
6. Noelle Lee Okoth, Wellspring (12 April 2025)
7. Temina Madon, Agency Fund (13 April 2025)
8. Sukhmani Sethi, ex-Porticus (19 August 2025)
9. Neha Raykar, IDinsight (2 September 2025)
10. Joel Bubbers, Independent coach (4 September 2025)
11. Torben Fischer, IDinsight (4 September 2025)
12. IDinsight PFM team (8 September 2025)
13. Ilana Kessler, Learning Alliance (8 September 2025)
14. Karan Nagpal, IDinsight (23 September 2025)
15. Signe Sorensen, YCompassion (26 September 2025)
16. Mallika Sobti, IDinsight (8 October 2025)
17. Torben Fischer, IDinsight (9 October 2025)
18. Dilshad S, IDinsight (22 October 2025)
19. Habiba Banu, Spiro Health (25 October 2025)
20. IDinsight PFM team (31 October 2025)
21. Torben Fischer, IDinsight (5 November 2025)
22. Mwaniki Murithii, Kenyan civil servant (7 November 2025)
23. Rachel Strohm (10 November 2025)
24. Dilshad S, IDinsight (10 November 2025)
25. Gautam John, Rohini Nilekani Philanthropies (13 November 2025)
26. Aastrika Foundation (18 November 2025)
27. Tony Senanayake, Fortify Health (19 November 2025)
28. Dilshad S, IDinsight (19 November 2025)
29. Ron Abraham (21 November 2025)
30. Supriya Bansal, Ansh (24 November 2025)
31. Ivy Migue, AfricaOps (25 November 2025)
32. Avantika Dhingra, WomenLift Health India (28 November 2025)
33. Nicole Pflock, Instiglio Government Empowerment Network (28

November 2025)
34. Akshay Narayanan, Harvard India Health Systems Project (28 November 2025)
35. Varsha Venugopal, Suvita (28 November 2025)
36. Taylor Thompson, Echoing Green graduate (28 November 2025)
37. Global Development Incubator team (2 December 2025)
38. Torben Fischer, IDinsight (2 December 2025)
39. Dr Saurabh Sharma, former CMO and health advisor (December 2025)
40. Majka Burhardt, Legado (3 December 2025)
41. Emily McNair, IDinsight (3 December 2025)
42. Liz Hague, IREX (5 December 2025)
43. Fiona Moejes & Damaris Ndua, Mawazo Institute (10 December 2025)
44. Dilshad S, IDinsight (11 December 2025)
45. Anantvijay Singh, Dasra Rebuild India (11 December 2025)
46. Gursimran Wadhawan, IDinsight and ex-MOH (16 December 2025)
47. Ed Jurkovic, Notre Dame Institute for Social Concerns (16 December 2025)
48. Vishan Pattnaik, Mission Karmayogi / IDinsight (18 December 2025)