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Strengthening leadership and capacity for evidence-informed decision-making in Africa: The SECURE Health Programme

New programme is working with the Ministry of Health and Parliament in Kenya and Malawi to identify and address individual and institutional capacity barriers to research and data use.

Prof. Fred Segor (Principal Secretary, Kenya Ministry of Health) follows a presentation during the launch of the SECURE Health programme steering committee at the Ministry of Health Offices in Nairobi on May 8, 2014.

Dr. Nicholas Muraguri, the Director of Medical Services makes his keynote address during the launch of the SECURE Health programme on August 5, 2014.

Decision-makers in Africa are increasingly recognising the importance of applying evidence in policy and practice. However, actual evidence use remains sub-optimal due to many factors including weak networks between researchers and policymakers, ineffective dissemination of research evidence, weak capacity among policymakers to apply research evidence, and politics and individual interests, among others. In the last decade, there have been concerted efforts to build the capacity of researchers in Africa to produce credible research evidence and disseminate this in ways and formats that are accessible to policymakers. However, there has not been much focus on building the capacity of policymakers to source, appraise and use research evidence.

The SECURE Health programme, our response

In response to this gap, the African Institute for Development Policy (AFIDEP) has rolled out a programme whose aim is to optimise individual and institutional capacity in accessing and utilising data and research evidence in decision-making for health in Kenya and Malawi. Dubbed 'SECURE Health' (Strengthening Capacity to Use Research Evidence in Health Policy), the programme has two main objectives:

- Optimising institutional leadership and capacity to enhance evidence use
- Enhancing individual skills and capacity of policymakers in the health ministry and the legislature in accessing, appraising and using evidence

To achieve these objectives, the programme is working with the Ministry of Health (MoH) and Parliament in Kenya and Malawi to identify and address bottlenecks to evidence utilisation through focused high-level advocacy, targeted policy dialogues, training workshops for mid-level policymakers, science policy cafés, internships, increased participation of policymakers in research forums and of researchers in policy forums, and strengthening of various institutional support mechanisms for evidence use.

The three-year SECURE Health programme, running from Nov 2013-Oct 2016, is being implemented by a consortium of five institutions led by AFIDEP. Other institutions include the College of Medicine at the University of Malawi; the Consortium for National Health Research (CNHR) – Kenya; the East, Central and Southern Africa Health Community (ECSA-HC); and FHI 360. The UK Parliamentary Office of Science and Technology

>>Continued overleaf

AFIDEP News is the newsletter of the African Institute for Development Policy. It is published twice a year to provide our stakeholders with updates of AFIDEP's programmes and highlight emerging policy issues in population change and public health.

in this issue

(POST) is a collaborating partner leading implementation of one of the programme's interventions on building the capacity of parliamentary staff in Kenya and Malawi through internships at the UK Parliament.

The expected immediate outcome of the programme is **enhanced institutional and individual leadership and capacity to use research evidence and data in decision-making**. This should lead to the programme's overall outcome of **increased demand and use of research evidence in health sector decision-making in Kenya and Malawi** that should ultimately help reduce disease burden in the two countries through improved health policies and intervention programmes.

Programme beneficiaries centrally engaged

The SECURE Health programme has been developed on the premise that for any capacity building programme to be more effective, the beneficiaries have to appreciate the importance of the programme and their actual needs have to inform the development of the programme's interventions. Thus, during the programme's just-concluded inception phase (Nov 2013-July 2014), AFIDEP has held extensive consultations with senior and mid-level officials in the Ministry of Health and Parliament in both countries and conducted a comprehensive needs assessment. The information generated has been used to refine the programme's interventions to ensure they address the actual needs of the beneficiaries.

Demonstrating the importance and demand for the SECURE Health programme, both the Ministry of Health and Parliament in Kenya and Malawi have come on board as partners in the programme to ensure that they are centrally involved in the design and delivery of the programme interventions. In each country, a steering committee comprising senior Ministry and Parliament officials, has been established to provide strategic guidance and leadership to the programme.

Launching the programme's steering committee in Kenya on May 8, 2014, the Principal Secretary for Health, Prof Fred Segor, said, "the SECURE Health programme is in tandem with our efforts for the realisation of the Ministry's goals because we need programmes that support our use of data in enabling us to make better decisions and plans." Last year, the Ministry of Health in Kenya established a Health Research and Development Division to spearhead research utilisation. The division has now incorporated the SECURE Health programme as part of its work plan to support achievement of its objectives.

In Malawi, the SECURE Health programme has been incorporated under the Malawi Knowledge Translation Platform (KTP), whose main purpose is to engage national-level policymakers, researchers and implementers in a coordinated approach to generate and utilise health-sector research in Malawi more effectively. During AFIDEP's high-level consultations in Malawi to introduce the programme to the Ministry in February 2014, the Principal Secretary, Dr. Christopher Kang'ombe said, "the programme has come at an opportune time and will enhance the other activities that are on the ground in the Ministry". He advised that the SECURE Health programme be embedded in the Ministry's research division to ensure that it supports the realisation of the Ministry's goals.

The Malawi Parliament has signed a Memorandum of Understanding with the SECURE Health programme in order to formalise the partnership; this demonstrates the importance that the institution has placed on the programme.

The Kenya SECURE Health Programme was launched on August 5, 2014, in an event that marked the beginning of the programme's implementation phase.

L-R: *Prof. Adamson Muula (College of Medicine, University of Malawi) and Mr. Roosevelt Gondwe (Acting Clerk Parliment, Malawi) during the MoU signing ceremony in July 2014.*

Speaking at the launch event, Dr. Nicholas Muraguri, the Director of Medical Services at the Ministry of Health, outlined the ways in which the Ministry will address barriers to research use. Among these included the formation of advisory teams that would, every year, synthesise emerging research evidence on the different health policy issues and advise him on the policy options that the Ministry needs to take in order to tackle the issues, and the revival of the library within the Ministry. These interventions are clearly central to the SECURE Health programme, and thus, we will work closely with Dr. Muraguri in his efforts to strengthen evidence uptake within the Ministry.

To ensure that the impact of the SECURE Health programme extends beyond Kenya and Malawi, lessons from the two countries will be shared through ECSA-HC's annual regional platforms that convene 10-member states in East, Central and Southern Africa.

In their own words

"I appreciate the comprehensiveness of your programme; you are not just focusing on internships, but also doing workshops and engaging senior management."

Ms. Velia Manyonga, Principal Research Officer, Parliament of Malawi.

"Listening to this programme makes one salivate because it has come at a very opportune time. In Parliament we have a huge skills gap. As clerks, we are never trained about our work, we learn on the job. So this programme will be critical on building our skills on research use."

Mr. Mike Chiuswa, Head of Committees, and principal Clerk Assistant, Parliament of Malawi.

"The programme should target all committee clerks within parliament in its training since clerks are not specialised and are often assigned different committees. We also have two research staff who should be part of the training."

Mr. Roosevelt Gondwe, Acting Clerk of Parliament, Malawi, advising the SECURE Health programme on effective ways of working with the Parliament on its training interventions.

"...the SECURE Health programme will contribute to filling critical skills gaps and other missing support mechanisms in research use within Parliament".

Mr. Bonnie Mathooko, Head of the Research Unit, Parliament of Kenya.

The SECURE Health programme is funded under DFID's larger programme on Building Capacity to Use Research Evidence (BCURE). Details on the BCURE programme and other partners can be found at http://bcureglobal.wordpress.com.

Missed opportunities: Countries not leveraging HIV/AIDS services for improved maternal and child health

It is believed that since HIV/AIDS receives more resources compared to maternal and child health, integrating it in maternal and child health services will strengthen the maternal and child health platform, which has remained weak over the years due to limited funding.

Mothers wait in line to have their children immunised at a health centre.

Research indicates that majority of expectant women in most sub-Saharan African countries attend antenatal clinics. A good proportion of these women deliver in health facilities. Research also indicates that majority of children under five years receive essential vaccines through the healthcare system in most sub-Saharan African countries. It makes sense therefore that providing HIV/AIDS and family planning (FP) services as part of the antenatal care (ANC), delivery, and newborn and child health services can greatly increase access to these services and save lives.

Even then, we know that HIV/AIDS programmes have been historically set up as parallel programmes within the healthcare system in most countries. In recent times, however, there is increasing focus on the need to integrate HIV/AIDS and FP services into the existing maternal and child health platform to increase access to HIV/AIDS care.

In a recent study funded by the Bill and Melinda Gates Foundation, AFIDEP found that although sub-Saharan African countries have made varied policy responses to calls for integration of sexual and reproductive health (SRH) and HIV/AIDS, they face similar challenges in making service integration a reality. The study, conducted in the Democratic Republic of Congo (DRC), Malawi, Tanzania and Zambia, sought to provide an understanding of the landscape of maternal, newborn and child health (MNCH), FP, and the HIV/AIDS burden, service deficiency and integration efforts in Eastern and Southern Africa. The purpose was to provide the Gates Foundation evidence that can inform the Foundation's future investments for promoting integration in sub-Saharan Africa.

A major challenge that all study countries face is weak health systems, including vertical structures and planning mechanisms within the government (e.g. within the Ministry of Health and between the Ministry and the National AIDS Commission); inadequate funding, especially for sexual and reproductive health issues including maternal health; insufficient and inadequately skilled health workers; lack of equipment; weak supply chain systems occasioning frequent commodity stock-outs, and weak monitoring and evaluation systems to monitor integrated services.

Although there have been calls for integration using the maternal, newborn and child health platform since 2008, many countries including the four study countries, have not made much progress in enabling integration through this platform. At policy level, only Tanzania has developed guidelines for enabling the integration of maternal, newborn and child health and HIV/AIDS services. Malawi is in the process of developing a strategy for integration of sexual and reproductive health and HIV/AIDS services, whereas DRC and Zambia do not have integration policies, strategies or guidelines. DRC and Zambia, however, argue that their broad health sector policies have adopted the primary health care principles, which underscore service integration, and do not therefore see the need for an integration policy.

At service delivery level, there are various integration programmes being implemented in the four countries. The prevention of mother-to-child transmission of HIV/AIDS (PMTCT) programme remains the major integration effort with reasonably high levels of coverage in Malawi, Zambia, and Tanzania, but quite low in DRC. There is, therefore, substantial scope to ensure universal access to PMTCT treatment for the many HIV-positive expectant women or HIV-exposed infants to help reduce mother-to-child transmission of HIV. The four countries could benefit from ongoing advocacy and programme efforts to integrate PMTCT and MNCH, which research has shown could reduce the loss of follow-up of many mothers and infants.

Other integration programmes in the four countries range from integration of FP into HIV testing and counselling, FP into HIV care and treatment, HIV into FP, FP into PMTCT, PMTCT into MNCH, and FP and HIV/AIDS into MNCH. Notably though, most of these programmes are funded by donors, implemented by non-governmental organisations, and are implemented on pilot basis in a few regions/districts/health facilities. Funding agencies largely fund parallel programmes on different aspects of SRH/MNCH, FP and HIV/AIDS through different implementers. Consequently, there is a myriad of programmes collaborating with the Ministries of Health in these countries to offer different models of integrated services.

The study revealed that there is limited conscious effort in the four countries to expand HIV/AIDS and FP services through the widely used maternal and child health platform. In fact, the maternal and child health programmes remain greatly underfunded in all four countries, a factor that hinders integration.

Stakeholders in the four countries were in agreement that the maternal and child health platform provides important opportunities for increasing the uptake of HIV/AIDS and FP services. Even then, there was agreement that the platform needs to be strengthened –increased funding, adequate human resources and strong monitoring and evaluation processes– if efforts to integrate HIV/AIDS and FP services within the maternal and child health services are to be effective.

The study identified five main potential areas where funding agencies, including the Gates Foundation, could prioritise in order to strengthen countries' efforts for enabling service integration as summarised here:

1. Funding agencies should fund integrated programmes as opposed to funding MNCH, FP and HIV/AIDS programmes separately.

The shift in PEPFAR funding in 2009 to focus on integration of maternal and child health and FP services in its HIV/AIDS programme has been noted as having greatly contributed to enabling the provision of integrated services in many sub-Saharan African countries. This demonstrates that if integration efforts start within funding agencies, then these will more likely translate to service integration in health facilities in the beneficiary countries.

2. Strengthen governments' capacity in policy development, planning, operationalisation and coordination of partner efforts.

This study and others highlight the challenge of government's weak capacity to enable effective policymaking, planning, operationalisation of policies and coordination of partner efforts. It is important to note that this is a challenge whose solution may be complex, and therefore critical for funding agencies to think through and consider piloting this kind of support in one country in order to draw lessons for sustained improvement, but also for informing similar efforts in other countries.

3. Strengthen critical functions of the health system.

The weak health system functions in most sub-Saharan African countries remain major hindrances to effective integration efforts. The critical functions that need urgent investments to support integration efforts include the human resources, commodity supply chain, and the monitoring and evaluation. There are various ongoing efforts by governments and partners to address these challenges, but there is need for these efforts to be reinforced or scaled-up.

4. Strengthen community level provision of integrated MCH, FP and HIV/AIDS information and services.

Provision of community level information and services remains a critical life-saving interventions in most African countries given the huge challenge with accessing facility-based services in rural and hard-to-reach populations, which form the bulk of populations in African countries. Given the demonstrated effectiveness of community level service provision as seen in Ethiopia, we believe that investments in interventions that enable the provision of integrated information and services at community level will enhance the reach of integrated services to the sub-populations most in need.

5. Increase funding for the maternal and child health platform.

It is widely acknowledged that the maternal and child health platform presents often missed opportunities for strengthening the provision of integrated services, including integration of FP and HIV into ANC, integration of FP and HIV into delivery and post-natal care, and integration of FP and HIV into child immunisation care. Despite these opportunities, there is limited funding for the maternal and child health platform, presenting an opportunity for funding agencies to prioritise funding this platform, which will in turn enhance integration opportunities.

"...there is limited conscious effort in the four countries to expand HIV/AIDS and FP services through the widely used maternal and child health platform..."

Dr. Zulu on the demographic dividend: 6 key investments will bring about economic transformation in Africa

Dr. Eliya Zulu (Executive Director, AFIDEP) unpacks the concept of the 'demographic dividend' and the opportunities for Africa to harness this dividend.

What is a demographic dividend in layman's terms?

This is the benefit that a country with high birth rates and high mortality can get if it makes the right investments to reduce birth rates rapidly. When birth rates go down, the population age structure changes (see Figure 1). In many African countries, the population age structure is shaped like a pyramid with a wide base, implying that there are more young children than the working age population. The result is that the working age population and the government end up spending most of their resources taking care of these dependants. Consequently, since the children are so many, the quality of healthcare, education and other social needs is poor since the working age population and the government cannot keep up with the vast needs of the dependants.

On the other hand, when birth rates decline, families start having fewer dependent children. This increase in the ratio of the working age population relative to the dependent children can give the country an impetus for accelerated economic growth. With more people working, you produce more as a country as with more workers who are spending less on childcare, more money is saved for investments in the future.

For a country to take advantage of this new age structure, it must ensure that the larger labour force is well-educated, highly skilled and gainfully employed. However, having a larger labour force alone does not mean that the country will have a demographic dividend. The country must simultaneously make the right investments in education, health, job creation and governance in order to realise accelerated economic growth.

Why is there so much hype today on the need for African governments to focus on harnessing the demographic dividend?

In sub-Saharan Africa, women are still giving birth to an average of 5 children per woman. This means the population age structure is very bloated at the base; it's a very young population. Therefore, we are increasingly realising that it's difficult for countries to develop when we have such a huge child dependency burden. Addressing the high population growth rate and reducing the high child dependency ratios is critical for Africa's development.

If we can facilitate a decline in fertility and help women and their partners have fewer children, then the fertility in Africa will reduce. If this is coupled with investments in socioeconomic sectors such as education, health, governance and job creation, then Africa has the impetus to achieve its socioeconomic development goals.

What are the strategic investments and policy priorities that African governments must put in place in order to harness the demographic dividend?

There are six main pillars for countries to harness the demographic dividend. First, you have to create the window of opportunity by ensuring sustained and **rapid decline in birth rates.** In sub-Saharan Africa, only 22% of women are using modern family planning methods, ranking very low against the global average of 54% of women using family planning. About 53 million women who want to delay the next birth or stop childbearing altogether in sub-Saharan Africa are not able to use modern methods of family planning. Some of the reasons include lack of access to family planning commodities due to stock-outs, inhibition by religious or cultural beliefs, fear of side effects mostly driven by myths, among others. Therefore, if governments and development partners invest in developing programmes that address these barriers of access and use of family planning, Africa can go a long way in reducing birth rates.

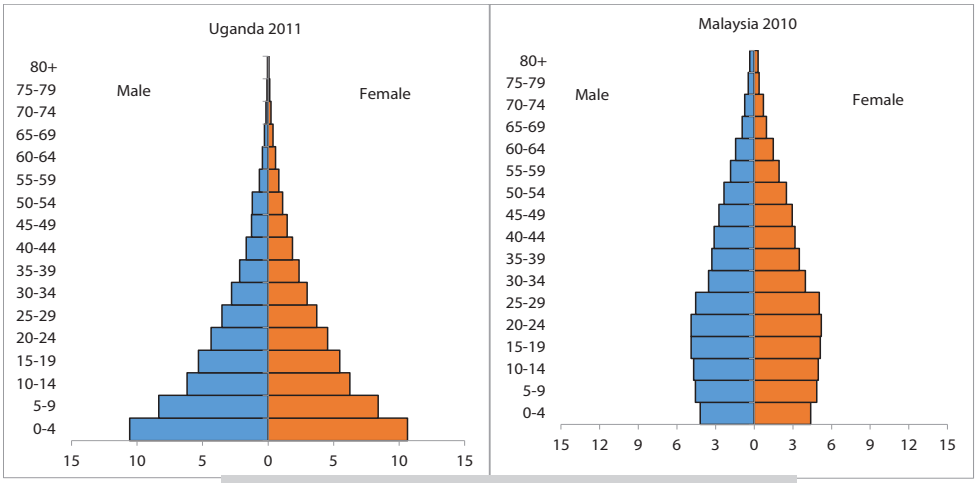


Figure 1: Population pyramids comparing Uganda and Malaysia.

In addition, investment in female education will keep more girls in school and they will be less likely to start having children early. In African countries, very large proportions of teenagers are either mothers or are pregnant. Consequently, their opportunities for progressing in life are cut short because of childbearing. Therefore, we not only have to invest in family planning but also in the **education and empowerment of women** in order to reduce fertility rates.

Second, African governments need to invest in **reducing child mortality.** Although we have made progress in reducing child mortality in Africa, the rate is much higher than the global average. If we continue the investments in immunisation to ensure children survive, this will give a greater impetus for reduction of fertility rates. When families are confident that their children will survive, then they'll give birth to fewer children.

These two pillars *open the window of opportunity* for a demographic dividend. The other four pillars [discussed below] help countries *achieve* the demographic dividend. Countries like Tunisia had a very rapid fertility decline. They had the window of opportunity, but because they did not make these other investments, they 'missed the boat' as far as achieving the demographic dividend is concerned.

The first of these other pillars is **investing in education.** One of the major problems we face in Africa is the low quality of our human capital. We need to invest in education and reform our education systems so that we have a skilled labour force that can compete globally and engineer the economic growth needed to facilitate the demographic dividend. African countries have been focusing a lot on achieving universal basic education. However, we now need to shift our focus to universal secondary education and aim at having more people in tertiary institutions which will grant the relevant skills to make our populations productive.

The second pillar is **investing in public health.** For a country to have a very productive labour force, it not only needs to be educated and skilled, but also healthy. More critically, countries need to invest in child nutrition as it affects how well children can learn and also impacts the quality of the future labour force. In addition, the rapidly emerging non-communicable diseases are a matter of concern as they are mostly affecting the working-age population and need to be dealt with urgently.

The third pillar is **steering economic growth and job creation.** If you have a big labour force that is well educated and healthy but there are no jobs for this population, the country will not achieve a demographic dividend. Africa is currently facing what we call 'jobless economic growth.' The continent has sustained growth even during the global economic recession. But when you dig deeper, you learn that this economic growth is neither reducing poverty significantly nor creating enough jobs.This is because the growth is mostly propelled by sectors that do not have a high job multiplier effect such as mining, investment in infrastructure, etc. Each country therefore needs to evaluate its economic set up and identify the industries that have a comparative advantage. These are sectors that can grow the national cake more and at the same time create more jobs.

The final pillar is **governance and accountability.** Corruption is one of the major challenges Africa grapples with. So much money leaks out of the government system. If we have zero-tolerance towards corruption and ensure the money collected through taxes, international aid and other avenues is invested in the people, there is a high likelihood that we will achieve the other three pillars. However, it is important to note that governance is not just about corruption alone, but also accountability and service delivery. We need to ensure that at every level of the development process, we come up with evidence-informed interventions that give the best value for money. We must also ensure that the people charged with the responsibility of providing services are held to account.

The pillars for harnessing the demographic dividend.
Adapted from: *Harnessing the Demographic Dividend: A PRB ENGAGE Presentation, 2013.*

If African governments do not make these investments, what will be the consequences?

African governments want to emulate the success that the Asian Tigers have had. These countries were at the same level of development as African countries in the sixties. However, they took a different development path and put emphasis on the empowerment of women and consequently their birth rates went down rapidly. However, African leaders are talking about emulating the Asian Tigers on the economic side. They want their countries to have high income and improved infrastructure, but are not looking at the social development aspects of that equation. The Asian Tigers not only invested in infrastructure and job creation, but also focused on women empowerment, invested in education and made sure that family planning was readily available. If our birth rates go down but we don't make these other investments, we will have a big labour force that is unemployed and the end result will be chaos as witnessed in Tunisia. Therefore, if we do not make all these investments, Africa will not develop as fast as we want it to. We will lose the opportunity to accelerate towards economic transformation.

Scholars have described the demographic dividend as a 'window of opportunity' that must be well-timed. What does this really mean?

The demographic dividend can only be harnessed by countries that are starting from a position of high fertility and high mortality. If these decline rapidly, the age structure changes, giving the country an impetus for economic growth. This change in age structure is not a long-lasting phenomenon and lasts for only a few decades. Once the base of the age structure is being undercut as birth-rates go down, you will have a big labour force.

Can Africa really harness the demographic dividend or is this an overstated phenomenon?

Some people argue that Africa is very different from East Asia and talking about the demographic dividend in relation to Africa is a waste of time. However, Africa has this unique opportunity as the window can open through accelerated fertility decline. Birth rates in Southern Africa have already gone down to about 2 children per woman. Therefore, we cannot say that it is against African culture for people to have fewer children. It's already happening. In addition, Africa has resources that East Asia didn't have such as oil. The massive remittances from the diaspora witnessed in Kenya and Uganda were also absent in the case of East Asia. It's not an easy feat, but if countries remain focused on what needs to be done, 2 to 3 decades from now, African countries will be at a better place.

African governments make efforts to harness the demographic dividend

In July 2014, the Ugandan government launched a report outlining its blueprint for harnessing the dividend, whereas the Tanzanian and Kenyan governments deliberated results of studies that explored the countries' opportunities for harnessing the demographic dividend.

L-R: *Dr. Kisamba-Mugerwa (Chairperson of the Uganda National Planning Authority), H.E Yoweri K. Museveni (President of the Republic of Uganda) and Dr. Jotham Musinguzi (Regional Director, Partners in Population and Development - Africa Regional Office) at the launch of Uganda's demographic dividend report on July 28, 2014 in Kampala, Uganda.*

Various African governments, including Uganda, Tanzania and Kenya, are beginning to make efforts that will steer them towards harnessing the demographic dividend. AFIDEP is centrally involved in these efforts, specifically providing the research evidence that is guiding governments' strategies for harnessing the demographic dividend. Through rigorous modelling and scenario building, AFIDEP is demonstrating to African governments the potential economic gains they can make if they invest boldly in reducing fertility, improving health and education, and creating jobs. Our initial analyses have focused on Uganda and Tanzania, where we are currently working with research and government agencies to model and share the critical evidence with top government officials in order to guide governments in making investments that will enable them to harness the demographic dividend.

President Museveni launches the Uganda demographic dividend report

H.E. President Yoweri Museveni launched the report *Harnessing the Demographic Dividend: Accelerating Socioeconomic Transformation in Uganda*, during Uganda's National Family Planning conference in Kampala held July 28-30, 2014. The report, which was commissioned by Uganda's National Planning Authority (NPA) and developed by various stakeholders led by AFIDEP, outlines the policy options the country needs to take to harness the demographic dividend.

In his remarks, the President singled out family planning as a critical ingredient for the country's development efforts saying, "Family planning is good for the health of the child and the mother, for the wellbeing of the family, and the whole country …It's about holistic development that starts with the realisation that having too many children is not good for development."

Embracing the report's proposed policy decisions that would enable Uganda to achieve a demographic dividend, President Museveni said that he was happy that the population management discourse was finally focusing on how countries like Uganda can take advantage of its population dynamics to accelerate socioeconomic transformation, rather than the narrow focus on controlling population growth. He noted that the core aspect of these efforts in Uganda will be a focus on reducing the high child dependency burden, enhancing economic reforms and job creation, and investing in human capital development in the way that Malaysia had done between 1960 and 2010.

"In order for [our] big population to be advantageous like in India, China and Brazil, we [also] need to invest in education, health, infrastructure development and job creation. That is why I am happy that the issue [on family planning] is now being looked at from the demographic dividend perspective…," he emphasized. "…If all [we] do is control the population and reduce fertility without looking at the other factors, [we] won't go far as a country."

AFIDEP led the development of the report, working closely with local experts from Makerere University, policymakers from Uganda's National Planning Authority, and development partners from UNFPA. The findings from the report show that Uganda can harness a sizeable demographic dividend if it adopts policies and priority investments aimed at creating a globally competitive economy that would accelerate economic growth and job creation on one hand, and accelerate reduction in fertility through voluntary and rights-based interventions and education, on the other hand. If simultaneous investments are made in family planning, education, health and economic reforms, the per capita GDP will increase from the current US$ 506 to US$ 8,821, in 2050, a near achievement of Vision 2040 target, and the country will earn a demographic dividend of US$ 3,483.

This kind of top-level political leadership for the demographic dividend efforts as demonstrated by Uganda is critical in ensuring that countries prioritise and operationalise the policy and programme decisions they make in order to harness the demographic dividend.

Tanzania deliberates opportunities for harnessing the demographic dividend

On July 25, 2014, AFIDEP experts led the deliberation of the findings of a study report on Tanzania's opportunities for harnessing the demographic dividend with senior government officials. The report entitled *Prospects and Challenges for Harnessing the Demographic Dividend in Tanzania,* was produced by AFIDEP in liaison with local experts from the University of Dar es Salaam and sponsored by Pathfinder International.

Citing the report, Dr. Eliya Zulu, AFIDEP's Executive Director, said that given Tanzania's high population growth momentum due to high fertility, the country is guaranteed of having a large population. Thus, even if Tanzania's fertility rate declined to 2.1 by 2040, the country's population will still increase to around 180 million by 2100. Noting that more than half of Tanzania's population will live in urban areas by 2050, Dr. Zulu posed the question, "Will these urban areas be engines of economic growth or poverty hubs?" He called on the Tanzanian government to take advantage of its youthful population by investing in education, family planning, empowerment of women, job creation and infrastructure in order to achieve the set development goals.

Emphasizing this message, Dr. Joel Silas of the University of Dar es Salaam said, "If we simultaneously invest in economic as well human development, the population age structure will shift to have more working age people." He singled out the important role of family planning saying, "Family planning plays a big role in capital formation as reduction in fertility will result in increased savings, which can then be invested in the economy." Dr. Joel indicated that according to the study, Tanzania could earn a demographic dividend of US$3,147 by 2015 if the country invested in both economic sectors (job creation, infrastructure and industrialisation) and social sectors (education, health, family planning and empowerment of women).

Speaking at the meeting, Tanzania's Deputy Minister of Finance Mr. Mwigulu Nchemba, acknowledged that a change in age structure to more working age people compared to dependants was vital for Tanzania's economic growth. He said, "All development strategies talk of poverty reduction but with such a high population growth rate, there is no doubt that we will not achieve the development envisaged." He went on to say that this is the right time for Tanzania to take the right path in creating more jobs for its youth and planning a better future for its children.

Reiterating this message, Prof Rutasitara, Deputy Executive Secretary in the President's Office Planning Commission said, "We should not only want the [population] numbers, but these [population] numbers should also be healthy, well-educated and more productive."

A participant at the meeting cautioned that the focus on job creation should not be on creating casual jobs, but jobs that will improve the lives of the youth. Another participant advised the Planning Commission to coordinate the plans of the different sectors so that the country can achieve common development goals.

The meeting, which was held at the Protea Courtyard Sea View Hotel, Dar es Salaam, was also attended by senior representatives from various non-governmental organisations and development agencies.

Kenya too discusses opportunities for harnessing the demographic dividend

On July 15, 2014, government and non-government stakeholders in Kenya convened in Nairobi to deliberate the results of a study that explored the opportunities for Kenya to harness the demographic dividend based on the USAID-funded Health Policy Project's *DemDiv Model*.

Presenting the modeling results and their implications, Hon. Rachael Nyamai, Chairperson of the Committee on Health in Kenya's National Assembly, said that the results showed that Kenya's average income (per capita GDP) would increase from the current level of US$907 to US$6,693 by 2050 if the country's development efforts are focused exclusively on economic reforms and ignore education and family planning. However, if the country concurrently invests in all these sectors, the average income will rise to US$11,288, giving a demographic dividend of US$4,595.

Hon. Nyamai noted that the achievement of a demographic dividend is not 'automatic.' Rather this is a window of opportunity that a country must earn by making deliberate, timely and concurrent investments in family planning, education, job creation and governance. To create this window of opportunity, Hon. Nyamai noted that Kenya should increase access to family planning services by addressing the high incidence of stock-outs of family planning commodities. In addition, the government must invest in quality education to ensure the working-age population is skilled, and reform Kenya's economy to ensure that it creates enough jobs for the big labour force that it will have. With fewer children to take care of and a higher income, families will be able to save more money, invest more in education and healthcare for their children, and the quality of life will improve.

Speaking at the meeting, Kenya's Economic Planning Secretary, Mr. Stephen Wainaina indicated that Kenya cannot achieve the socioeconomic transformation envisaged in Vision 2030 if the country does not empower and take advantage of its youthful population. "We need to see how the youth can be agents of development," he said. He went on to indicate that Kenya needs to reform its economy in order to create enough quality jobs, which is critical for achieving a good quality of life for its citizens and avert socioeconomic upheaval as witnessed in the 'Arab Spring.' He concluded by saying, "Planners need to wake up. Policymakers must act. We need to craft wise policies and make smart investments for Kenya to benefit from the demographic dividend and achieve our Vision 2030 development goals."

The forum was convened by the National Council for Population and Development (NCPD) and attracted senior government officials from a cross-range of ministries including Devolution and Planning, Health, Labour, Education, Environment, and representatives from development agencies, the civil society and academia.

AFIDEP is a member of the NCPD-led Demographic Dividend Technical Working Group that produced the demographic dividend modeling results for Kenya, and is charting the way forward in guiding further analysis and exploration of policy options that Kenya should adopt in order to harness the demographic dividend. Further dissemination of the modeling results will be made to County government officials.

Evidently, the AFIDEP-led twin studies in Uganda and Tanzania, and the one in Kenya, show that African countries can harness a sizeable demographic dividend if they put the right policies in place and make bold investments in family planning, education, job creation and women empowerment.

In pictures: AFIDEP inaugural board meeting

The AFIDEP board of directors held their inaugural meeting from February 3-5, 2014 at the Southern Sun Hotel, Nairobi. AFIDEP staff and partners got to meet the new members at a cocktail event on February 4, 2014 at the Serena Hotel, Nairobi.

*Meet the new AFIDEP board of directors and senior management. **L-R:** Dr. Eliya Zulu (Executive Director, AFIDEP), Prof. Nyovani Madise (deputy board chair), Ms. Pamela Onduso (board member), Dr. Bocar Kouyaté (board member), Prof. Francis Dodoo (board chair), Dr. Samson Wasao (Director of Research, AFIDEP), Mr. Mike Eldon (board member), Dr. Yazoume Yé (board member), Dr. Martha Campbell (board member), Dr. Rose Oronje (Communications and Policy Engagement Manager).*

***R-L:** Dr. Martin Atela (AFIDEP staff) interacts with AFIDEP board members, Dr. Bocar Kouyaté and Mr. Mike Eldon.*

*AFIDEP partners mingle at the cocktail event. **L-R:** Prof. Moses Oketch (APHRC) and Dr. Martha Campbell (AFIDEP board member).*

*AFIDEP staff and partners catch up. **L-R:** Ms. Violet Murunga (AFIDEP), Dr. Marsden Solomon (FHI 360), Dr. JPR Ochieng'-Odero (CNHR), Dr. Ruth Musila (AFIDEP), and Ms. Eunice Mueni (AFIDEP).*

***L-R:** Dr. Eliya Zulu (Executive Director, AFIDEP) enjoys a light moment with Dr. Charles Nzioka (Head, Division of Health Research & Development, Kenya Ministry of Health).*

***L-R:** Prof. Francis Dodoo (AFIDEP board chair) chats with Dr. JPR Ochieng'-Odero (CNHR).*

Health research-to-policy conference in Kenya: Ministry commits to ensuring policies are evidence-informed, calls for a knowledge-sharing platform

"We shall not allow any new health policy which is not supported by research evidence ..." Prof. Fred Segor, Principal Secretary, Ministry of Health.

R-L: *Dr. Rose Oronje (Communications and Policy Engagement Manager, AFIDEP) leads a plenary session at the Research-to-Policy Dialogue. Looking on is Prof. Richard Muga (Vice Chancellor, Great Lakes University of Kisumu).*

The Kenya Ministry of Health in collaboration with the Consortium for National Health Research (CNHR), the National Commission on Science and Technology (NACOSTI) and AFIDEP, convened a high-level conference to deliberate the barriers and opportunities for increased research use in decision-making in Nairobi from June 19-21, 2014.

Speaking at the conference, Prof. Fred Segor, the Principal Secretary (PS) for Health, said that the Ministry would not allow any new policy that is not supported by research evidence. To make this a reality, the PS committed to continue strengthening the Ministry's newly established Division of Health Research and Development (DHR&D) through financial and human resource support.

Acknowledging that research evidence is often not considered in decision-making, the PS said, "There's an enormous gap between what we know and what we do… Even the most high quality research evidence doesn't make sense to policymakers unless it is first objectively converted to specific clear policy options… Using research evidence to inform policy and practice needs to move from being a mere discussion to reality."

The PS called on the delegates to spearhead the formation of a knowledge-sharing platform in the health sector that would enable increased deliberation and consideration of research evidence in decision-making within the Ministry. He further challenged the conference delegates to chart a clear direction for the development of a national as well as county-specific health research agenda.

The annual conference, which was the third of its kind, saw delegates ranging from the county and national government, development agencies and programme implementing organisations convene in Nairobi to share experiences and insights on how to improve health in Africa. Researchers from various institutions shared engaging presentations on new research on various issues, translating evidence to policy, and evaluating implementation programmes, among others. Policymakers, on the other hand, shared current challenges experienced in utilising evidence for decision-making at both the national and county levels.

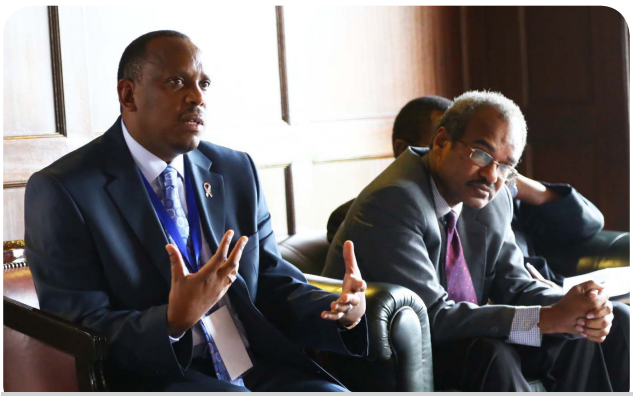
Science cafés 'fire up' conference deliberations

In a break from the last two conferences, this year's conference featured three science cafés on priority health issues that policymakers are grappling with, namely:

- Tackling maternal and newborn mortality at national and county levels
- Halting the rising incidence of non-communicable diseases (NCDs) in Kenya
- Policy responses to problems associated with 'recreational' consumption of illicit brews and substances such as khat (miraa)

The science cafés provided a platform for critical deliberative discussions on the ways in which research evidence can be used to address these priority health policy issues. The participants overwhelmingly applauded the café model as an engaging policy dialogue mechanism, and called for more similar forums in future to deliberate other urgent health policy issues in the country. The science café sessions are part of the interventions of the SECURE Health programme. The programme used the research-to-policy conference to test its pioneer cafés and gather feedback for informing the organisation of future cafés.

Prof. Fred Segor (PS, Ministry of Health) addresses delegates at the conference opening.



Debate hots up as delegates enagage during a science café on tackling maternal and newborn mortality at national and county levels.

Hon. Binty Omar, County Executive Committee (Health) member Mombasa County, contributes during a panel discussion on county-specific health challenges.

Delegates follow conference proceedings.

List of publications

Peer-reviewed journal articles

1. Campbell, M.M., Casterline, J., Castillo, F., Graves, A., Hall, T.L., May, J.F., Perlman, D., Potts, M., Speidel, J.J., Walsh, J., Wehner, M.F., **Zulu, E.M.** (2014). Population and climate change: who will the grand convergence leave behind? *The Lancet Global Health, 2*(5), e253 - e254. doi:10.1016/S2214-109X(14)70021-X.
2. **Oronje, R.N.** (2013). The Kenyan national response to internationally agreed sexual and reproductive health and rights goals: a case study of three policies. *Reproductive Health Matters, 21*(42), 151-160. [http://www.rhm-elsevier.com/article/S0968-080%2813%2942749-0/abstract].

Research reports

1. **Oronje, R., Atela, M., Murunga, V., Longwe, A., & Zulu, E.** (2014). *Landscape analysis of MNCH, FP and HIV/AIDS integration in Eastern and Southern Africa*. Nairobi: AFIDEP and the Bill and Melinda Gates Foundation.

New staff

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Using research evidence to generate political will for adolescent sexual and reproductive health

An adolescent girl.

AFIDEP has launched a programme, "Strengthening Use of Research Evidence in Adolescent and Youth Sexual and Reproductive Health" (enSURE Adolescent and Youth SRH), to provide policymakers in the Ministry of Health in Kenya and Malawi the research evidence needed to inform the formulation and design of effective policies and programmes for improving young people's health.

Poor sexual and reproductive health of young people in Africa remains a major developmental challenge in the region. For instance, in Kenya and Malawi, the median age at which adolescents initiate sexual activity is 18 years. In addition, only 2 in 10 adolescent girls who are sexually active use contraceptives. These trends are not unique to Kenya and Malawi – they typify what is happening across the sub-Saharan Africa region.

Evidence further shows that pregnant adolescent girls are at increased risk of pregnancy-related deaths. In addition, young people are at increased risk of sexually transmitted infections (STIs) and HIV infection. These poor sexual and reproductive health indicators negatively affect the development of young people and broader socio-economic development of the region. Many young girls who become pregnant while in school are forced to drop out and most are not able to return to school after giving birth.

Although most countries in Eastern and Southern Africa have made considerable progress towards improving access to sexual and reproductive health information and services for young people, they continue to grapple with how to accelerate their progress. Young people's sexual and reproductive health is not prioritised at policy, resource allocation and programme implementation levels. As acknowledged by Dr Bartilol Kigen, Head of the Reproductive and Maternal Health Unit (Kenya Ministry of Health), "… the needs in the adolescent and youth sexual and reproductive health programme are many but few resources are allocated to address them. We also have very few partners to support the programme."

Furthermore, societal stigma associated with young people's sexuality, opposition by religious institutions and parents towards efforts to make critical sexual and reproductive health services available to young people, and cultural practices that put the sexual and reproductive health young girls at risk, curtail efforts by governments to fully address this issue.

The evidence gap

Lack of research evidence that illustrates the investment case on socioeconomic benefits of investing in adolescents' and youths' sexual and reproductive health as well as cost-effective interventions is a major challenge for policymakers.

There is also limited access to in-depth analysis of existing data, and weak technical capacity to synthesise, translate, package and use research evidence in decision-making processes.

The wheels of change

Through this programme, AFIDEP seeks to support policymakers in the Ministry of Health in Kenya and Malawi to access and use research evidence in the formulation and design of effective policies and programmes for improving young people's sexual and reproductive health. This includes identifying evidence gaps, synthesising, translating and repackaging the evidence, and promoting and facilitating its use in decision-making.

In both Kenya and Malawi, AFIDEP has partnered with the Reproductive and Maternal Health Unit and the Reproductive Health Directorate, respectively on the programme. Together with these government agencies, AFIDEP has identified actual evidence gaps that policymakers are experiencing. The programme will also engage with the media and parliamentarians to increase the public awareness of the benefits of safeguarding young people's sexual and reproductive health. To catalyse leadership, commitment and implementation of more effective policies and programmes for young people's sexual and reproductive health across the sub-Saharan Africa region, the programme will synthesise, translate and disseminate research evidence on regional and global best practices in responding to young people's sexual and reproductive health challenges using existing regional platforms such as those convened by the East, Central and Southern Africa Health Community (ECSA-HC), the East African Community (EAC), and the Southern African Development Community (SADC).

To enhance sustainability of the programme in increasing application of research evidence in decision-making, the programme will support skills training of policymakers responsible for adolescent and youth SRH in Kenya and Malawi.

The "enSURE Adolescent and Youth SRH" programme is funded by the Norwegian Agency for Development Cooperation (NORAD) – Global Health Section.

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