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Using Evidence to set the Agenda for Harnessing the Demographic Dividend in Africa

Most African nations struggle to provide quality jobs for their youth

By Bernard Onyango and Emmanuel Toili

Over the last few years, the concept of the demographic dividend has gained momentum among African decision makers as an important pathway to accelerated development. AFIDEP has been at the centre of promoting this paradigm in the region through advocacy and providing technical expertise to governments to assess the potential of their countries to harness the demographic dividend. In addition, AFIDEP assists these governments to identify the game-changer policy actions that will enable realisation of the maximum possible demographic dividend.

The *demographic dividend* is defined as the economic benefit arising from a significant increase in the ratio of working-age adults relative to young dependents that result from a significant decline in death and birth rates. The change in age structure that opens the window of opportunity to the demographic dividend is initiated by a rapid decline in the average number of children that women have.

To harness the demographic dividend, countries need to adopt comprehensive reforms and simultaneously invest in five key pillars:

Family Planning: Governments need to facilitate rapid fertility decline through facilitating use of effective contraceptive methods, enhanced child survival, and improved education and general empowerment of women.

Health: There needs to be adequate investments in health status to nurture a healthy and productive labour force.

Education and skills development: Countries should enhance investments in high-level education to develop a well-educated, skilled, and innovative labour force.

Economic reforms: The reforms are geared towards accelerating economic growth and job creation for the rapidly expanding labour force.

Governance: Governments must put in place fiscal policies and governance reforms that enhance savings, attract foreign direct investment (FDI) and ensure efficiency and accountability in use of public resources.

Highlights of activities over the past one year

AFIDEP conducted successful studies in four African countries that included Uganda, Tanzania, Mozambique and Zambia on how the respective governments can fully harness the demographic dividend.

Working with government ministries and agencies as the lead partner in the country studies has been a preferred strategy that promotes buy-in and cultivates commitment from the government. AFIDEP and Futures Group, with support from United Nations Population Fund (UNFPA), worked with Uganda's National Planning Authority (NPA) to assess the country's potential to harness the demographic dividend if it can initiate rapid fertility decline and invest adequately in its large youthful population to spur economic growth.

Uganda has the highest proportion of young people in the world constituting 53 per cent of the nation's population.

Following the successful study, endorsed by President Yoweri Museveni, the Ugandan government has embarked on a roadmap to identify and invest in key sectors to ensure the country will earn a sizeable demographic dividend.

The high profile study in Uganda led to a four-year partnership between AFIDEP and the UNFPA East and Southern Africa Regional Office (ESARO). Under this agreement, AFIDEP is providing technical assistance to governments in ESARO (comprising 23 countries) on the demographic dividend. Two country studies that commenced in

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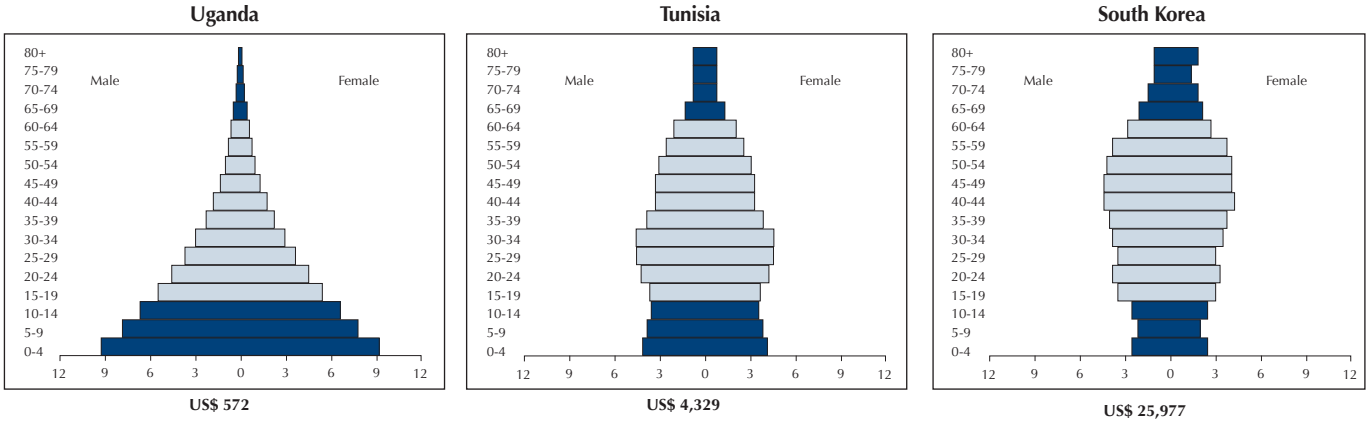
Africa Should Invest in Key Pillars to Harness

Population composition (%) by age-groups and GDP per capita (US$), 2015



Source: UN Population Division & World Bank

Countries like Tunisia and South Korea that have made the demographic transition from a population with many young dependents (age 0-14) to one with more people in the working-ages (15-64) have a much higher GDP per capita than a country like Uganda which is still dominated by many young dependents. The strategic integrated development investment decisions in South Korea over the years also account for its much higher income level compared to Tunisia which has also made the demographic transition but did not make adequate investments in sectors such as skills development and job creation.

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2014 in Zambia and Mozambique respectively, have been concluded under this agreement. In 2015, further studies are to be conducted in Malawi, Botswana, Rwanda, Namibia and Zimbabwe.

AFIDEP is also a key partner in the ongoing Kenya Demographic Dividend Programme that is implemented by the National Council for Population and Development (NCPD). AFIDEP also partnered with the University of Dar es Salaam to conduct a country study in Tanzania in 2014.

Country case studies highlights, Zambia and Mozambique

Zambia and Mozambique are the latest countries in which AFIDEP completed comprehensive demographic dividend studies. The process began in November 2014 and was led by the Ministry of Finance in Zambia and the Ministry of Economics and Finance in Mozambique.

Both countries have shown remarkable economic promise over the last decade averaging more than 6 percent annual GDP growth attributed to extractive industries (mainly copper in Zambia and coal and natural gas in Mozambique) and infrastructure development. However, the economic growth has not been inclusive and it is estimated that more than half the population in both countries live below the poverty line. The extractive industries driving economic growth have a poor job creation effect compared to the agriculture industry that supports the majority of citizens in the two countries, and yet is poorly developed. Further, most working-age people in both countries are either underemployed or unemployed.

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AFIDEP contributes to Kenya's Health Bill 2015

By Martin Atela and Joyce Mbiti

On 10 March 2015, the Kenyan Cabinet approved the Health Bill 2015. The Bill, which is currently under debate in parliament, provides guidelines on the management of Kenya's health system at the national and county levels. It also sets out regulatory guidelines on health systems functions such as healthcare services, service providers, health products and technology.

During its development and review phase, AFIDEP, together with the Kenya Medical Research Institute (KEMRI) and the International AIDS Vaccine Initiative (IAVI), convened a key research stakeholders' dialogue meeting to deliberate on the prioritisation of Research for Health (R4H) in the Bill. Specifically, the meeting, held on 27 October 2014, deliberated on ways of strengthening the R4H agenda in the Bill.

Gaps in the Bill that needed addressing

The meeting identified two critical gaps in the Bill that needed addressing: lack of clear funding commitment for R4H and lack of prioritisation of research evidence for policy.

a) Funding commitment for R4H

The participants outlined the need for clear R4H funding under the Bill's proposed National Research Fund (NRF). They also noted that R4H had continuously been under-funded yet critical evidence is needed for tackling Kenya's health and development challenges.

The health sector stakeholders proposed a provision for an emergency fund that caters to rapid response on emerging and re-emerging infectious diseases as seen in West Africa during the Ebola scourge.

Coming in the wake of the Ebola scourge in West Africa, participants proposed a provision for an emergency fund to cater for rapid response on emerging and re-emerging infections. The stakeholders were keen to have a definite figure allocated

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the Demographic Dividend by 2063

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Zambia and Mozambique have also experienced rapid population growth over the last few decades and this is characterised by the persistently high fertility rates. Recent studies show that the fertility rate in Zambia stands at 5.6 children per woman and Mozambique at 5.9 children per woman. This has resulted in both countries having a large youthful population.

This can be both an opportunity to harnessing the demographic dividend and a limitation for socioeconomic development. If these countries can initiate rapid fertility decline, invest adequately in human capital development, create enough decent jobs and improve governance, they can harness the full potential of the youth bulge to accelerate economic development. If not, then the resultant large young but dependent population will hold back socioeconomic development as both government and family resources will be stretched in a bid to provide basic needs and services.

To assess the potential of both states to harness the demographic dividend, AFIDEP used the *DemDiv* modelling tool developed by the USAID-funded Health Policy Project and implemented by the Futures Group. The modelling is based on four policy scenarios: Business-as-usual Scenario (little reform with lacklustre performance prevails), Economic Emphasis Scenario (maximum investments only in economic sector but other sectors excluded), Moderate Scenario (Economic Emphasis with moderate investments in family planning and education), and the Combined Scenario (optimum investments in all five pillars of the demographic dividend).

The results show that if Zambia and Mozambique can adequately invest simultaneously in all five sectors (family planning, health, education and skills development, economic reforms and job creation, and governance) under the Combined Scenario, they can reap sizeable economic benefits over the next 40 years. For instance, in Zambia, GDP per capita would rise from the 2013 estimate of US$ 1,839 to US$ 26,940 over this period. In Mozambique, it would rise from the 2011 estimate of US$ 557 to US$ 8,443.

On the other hand, the projections also reveal that due to the current large young population yet to start child bearing, the populations of both countries will continue to grow rapidly even under the most optimistic Combined scenario. Under this scenario, Zambia's population could more than double from 15 million in 2013 to 36 million in 2053, while Mozambique's population would almost triple from 23 million to 61 million between 2011 and 2051. This will give rise to an enormous challenge of job creation with the modelling study showing that both countries will have a large jobs deficit to deal with even when optimum investments are made in all the five sectors.

Among the key policy action recommendations arising from these studies therefore are: increased investments in family planning, child survival and women's education to lead to rapid fertility decline; strategies to ensure that young people attain at least secondary education and most receive relevant skills oriented tertiary education; emphasis on diversification of the economies and job creation strategies; and improvement in governance and accountability to facilitate the enabling environment for accelerated socio-economic development.

Advocacy in global arena

AFIDEP has been at the heart of global discourse on demographic dividend and has engaged in high level advocacy on the subject. Recent highlights include a high-level meeting in Addis Ababa, Ethiopia on March 29, where Dr Eliya Zulu, the Executive Director, was among keynote speakers who addressed ministers and development partners on how Africa can harness demographic dividend for Agenda 2063 (Read: *Africa focuses on harnessing demographic dividend* by 2063 www.afidep.org)

Dr Zulu also addressed the United Nations in New York on May 28 on 'National economic prospects based on time-critical investments in young people' (watch http://webtv.un.org/watch/unfpa-briefing-on-youth-and-the-demographic-dividend/4202095610001?page=3#full-text). On June 1, 2015, Dr Zulu also addressed the UN General Assembly on *'The Demographic Dividend and Youth Employment'* (Read: *AFIDEP Executive Director to address UN General Assembly on the demographic dividend and youth employment* www.afidep.org).

Health Bill Benefits from AFIDEP's Input

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for R4H out of the NRF allocation. This, they said, would encourage partners to co-fund research-for-health. Prof Gilbert Kokwaro, Director, Institute of Healthcare Management, Strathmore Business School observed that from his previous experience as a funder of R4H, there exists funders who would be keen to explore possibilities of co-funding R4H in Kenya.

b) Research evidence for policy

The meeting noted an apparent lack of a clear linkage between evidence generation and policy reforms and practice. To facilitate research uptake into policy and practice and to enable Kenya achieve its health and development targets, participants also proposed that the Bill prioritises research evidence for policy.

It was also noted that the Bill appoints a single agency to guide ethical approvals for health research. This, they said, is likely to stifle the development of health research, which still faces a lot of challenges.

The participants also pointed out the need for clarity on the composition and leadership of the National Research Committee (NRC) and its linkage to other agencies such as NRF.

c) Other gaps

Other critical issues that the meeting highlighted that needed to be addressed include:

a) Gaps in health leadership and governance - the Bill should outline clear structures to address the leadership gaps at the national and county health system levels;

b) Provisions for health systems strengthening – structures proposed in the Bill should directly address current gaps in the health system;

c) Clarity on the role of counties in the health system – this is key given that service delivery is a devolved function and the counties will play a critical role to ensure successful implementation of the provisions of the Bill.

These recommendations were compiled in a Communiqué that was submitted to the Constitutional Implementation Committee (CIC) in charge of developing and finalising the Bill for submission to Cabinet.

The meeting attracted over 25 participants representing major research and policy stakeholders in Kenya.

Using Research to Address Adolescent SRH in Malawi

Malawi youth at a training session. Programmes targeting youth according to their grouping and vocations has not been consistent with various risk-taking behaviours and vocations.

By Nissily Mushani

Like in most sub-Saharan African countries, addressing the adolescent sexual and reproductive health (SRH) remains a major challenge in Malawi. AFIDEP is seeking to contribute to addressing this challenge through its "enSURE" programme (i.e. Strengthening Evidence Utilisation in Programming on SRH for young people), which is also being implemented in Kenya.

AFIDEP and the National Youth Council of Malawi (NYCOM) convened stakeholders from the government and youth organisations to a Youth Dialogue on 'Strengthening Evidence for Action and Accountability on SRH' on November 20, 2014.

The forum noted a range of challenges that youth organisations face relating to data and research use including:

- Lack of access to key research findings;
- Lack of current data and research and best practices on tackling adolescent SRH issues;
- Rivalry among partners leading to reluctance in sharing data;
- Inadequate skills to generate and analyse current data; and
- Inadequate training in monitoring, research and evidence-based programming.

The forum also noted challenges on the side of government including:

- Contradiction of policies on similar issues, e.g. access to contraceptives was not allowed in schools yet the country did not have an agreed definition of a child, making it illegal to provide contraceptives to a certain category of young people; and
- The non-inclusion of youth in policy development and in deciding how the Youth Friendly Health Services (YFHS) and other policies should be monitored and evaluated.

Reinforcing use of research evidence and data

In order to reinforce use of research evidence and data, the forum highlighted the need for current research evidence and data concerning youth and Sexual and Reproductive Health Services (SRHR). On research, the forum highlighted the need for research on how to change misconceptions concerning SRH, especially when working with traditional leaders, communities and households.

The need for research on the role of parents in improving SRHR among children was also brought to the fore. Regarding data, the forum highlighted the need for data that focuses on young people's SRH issues in the rural areas as well as identifying gaps in knowledge concerning the connection between SRH and education. Further, the forum noted existing gaps on SRHR and HIV information on different risk groups and vocations for planning purposes (e.g. rural youth, street youth, and married adolescents, among others).

Consequently, programmes targeting youth according to their grouping and vocations had not been consistent with various risk taking behaviours and vocations.

The enSURE project seeks to enable increased access and use of research evidence to support the formulation and design of effective policies and programmes for improving young people's SRH outcomes and also to promote use of the evidence by policymakers, planners and programme implementers in Eastern and Southern Africa, Kenya and Malawi.

AFIDEP and Kenya's Ministry of Health to enhance national reporting on adolescent sexual and reproductive health

By Violet Murunga

In April 2015, the Reproductive and Maternal Health Services Unit of the Kenya Ministry of Health (RMHSU MoH) in collaboration with AFIDEP formed a Task Force to review and revise the existing national Reproductive Health (RH) Monitoring and Evaluation (M&E) tools to enhance reporting of Adolescent Sexual and Reproductive Health (ASRH) routine service utilisation data in Kenya.

The Task Force membership represented 15 key institutions implementing ASRH programmes, research and/or with expertise in M&E including the Ministry of Health (national and county officials), public and private health facilities (Kenyatta National Hospital and Family Health Options of Kenya) and key development partners.

The Task Force met twice in April and May 2015 to: i) identify gaps in the existing RH M&E tools and also M&E tools of other important programmes relevant to adolescent and; ii) recommend and negotiate revisions with the MoH Health Information System Unit (HIS) - the Unit responsible for developing/establishing and implementing MoH institutional M&E tools and processes.

The Task Force reviewed 5 RH M&E tools including 4 facility level registers [the Family Planning (FP), Antenatal Care (ANC), Maternity and Postnatal Care (PNC) registers] and the integrated RH monthly summary reporting form. In addition to reviewing the RH M&E tools, M&E tools from other programmes that address factors that influence ASRH outcomes were also reviewed in an effort to harmonise all tools reporting data relevant to ASRH. Key issues identified included sexual and gender-based violence (SGBV) including rape and female genital mutilation (FGM), PMTCT and Post-abortal care (PAC).

New ASRH indicators adopted

The Task Force successfully negotiated an increase in the ASRH indicators reported on the integrated RH summary reporting form from 2 to 8 and a revision of the age cohorts used for the 5 SGBV indicators reported on the integrated RH summary reporting form to closely align to the ASRH age cohorts.

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Investing in developing Africa's young population is central to the region's socio-economic development

By Violet Murunga and Eunice Mueni Williams

Harnessing the potential of young people to contribute to national development

The World Health Organization defines young people as between 10 and 24 years old. Out of approximately 1.1 billion people in Africa, 3 out of 10 (350 million) are young people aged 10-24 years and this population is projected to almost triple (906 million) by 2100. Africa's youthful age structure presents challenges but also opportunities for accelerating rapid economic growth and development in the region. If the age structure remains the way it is, the continent will continue to bear high child dependency burden that will make it difficult for the continent to improve the quality of its human capital and have adequate savings to enhance its economic productivity and job creation. If fertility declines rapidly resulting in a lower child dependency burden and a large population at working age adults, families will be able to save more money to invest in education and health of their children and for future investments. This phenomenon is known as the Demographic Dividend. However, the Demographic Dividend is not a guaranteed and can only be attained if the bigger working age population relative to dependents is appropriately skilled, healthy and has jobs to be gainfully employed. For Africa countries to harness a sizeable demographic dividend, governments must intensify their investments in education, skill development, sexual and reproductive health, and job creation for young people. The region has recorded some progress but much more remains to be done.

Young people in Africa are at a higher risk of sexually transmitted diseases, HIV, unintended pregnancy and illness or death associated with unsafe abortion than in other parts of the world mainly because of limited access to youth friendly sexual and reproductive health information and services.

Status of education, youth friendly health services and employment opportunities in Africa and implications for development

Education

Education is one of the key pillars of development and, given the incremental realisation of the benefits of improved education, investments in education are necessary from an early age in order to secure a skilled and productive population in the future.

Since signing onto the 1990 Education for All, a global commitment to universalise primary education and massively reduce illiteracy through expanding access to quality basic education for all children, youth and adults, many African governments have made some progress towards the achievement of this commitment. The gross primary and secondary school enrollment ratios have increased substantially and literacy rates have shown modest improvement as well. However, primary school dropout rates remain high and while the out-of-school population has declined it is estimated that 20 million adolescents are not enrolled in primary or secondary school in 2012, the majority of whom are girls.

Educational attainment is a major determinant of the quality of human capital of a country. Hence, African governments must increase access to all levels of education. In addition to increasing access to primary and secondary education, especially for girls, there is need to improve the quality of education which is a major concern in the region. Furthermore, there is need to expand access to tertiary education to meet the growing demand for this level of education as well as to address the discrepancy between university curricula and job market demands, which consequently reduces the employability of graduates.

Health

While typically considered healthy, young people are at an increased risk of poor sexual and reproductive health outcomes including sexually transmitted diseases, HIV, unintended pregnancy and illness or death associated with unsafe abortion. Poor sexual and reproductive health outcomes have far reaching implications on young people's development and wellbeing and their contribution to national development. For instance, early childbearing is linked to high fertility, high maternal mortality and high child mortality. High fertility and associated high child dependency burdens exert an enormous burden on the economy and undermines the capacity of families and governments to invest in human capital development.

Numerous policy documents in the regional highlight the need to address young people's sexual and reproductive health challenges. However, the statements are not matched with adequate resources. Furthermore, there are persistent socio-cultural and religious beliefs and practices that curtail efforts to expand access to sexual and reproductive health information and services to young people. Addressing these challenges is a matter of urgency if the region is to realize its development prospects and benefit from a sizeable demographic dividend.

Youth employment

In sub-Saharan Africa, the youth unemployment rate is double the total unemployment rate of the region (14% relative to 8% in 2012). Even for those who are employed, there are high levels of underemployment among young

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Africa's growth pegged on investing in the youth

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people. Youth unemployment creates a sense of idleness among youth that can lead to increased crime, mental health problems, violence, and drug use. Youth unemployment undermines economic productivity and innovation since young people can be instrumental agents of socioeconomic change and technological innovation.

In order to ensure that young people are gainfully employed, governments need to put in place economic policies that promote job creation and entrepreneurship. There is need to identify and invest in sectors that have high job multiplier effect, including agriculture, manufacturing, tourism and transport. The good news is that numerous opportunities exists. The continent is home to seven of the world's fastest growing economies and has abundant natural resources and a largely untapped financial services industry, manufacturing and communications and IT.

The way forward

Africa's big youthful population is both a potential challenge and opportunity for enhancing the continent's socioeconomic transformation and development. If the continent does not consciously invest in education, skill development, sexual and reproductive health, and job creation for young people, the continent's big youthful population will be wasted and the continent is likely to experience social unrest by having too many young people who are not economically engaged as experienced with the Arab Spring. The continent's development prospects can be hugely enhanced if smart investments are made to turn the big youthful population into quality human capital made of well educated, skilled, innovative, healthy and gainfully employed young people.

"For Africa countries to harness a sizeable demographic dividend, governments must intensify their investments in education, skill development, sexual and reproductive health, and job creation for young people"

Barriers to Research Use in the

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Clinical officers at a symposium in Malawi. Many professionals in the health sector lack technical skills in searching for research evidence, interpreting and adapting research for local contexts.

By Rose Oronje

A recent needs assessment of the status of research use in the health sector in Kenya and Malawi has identified a wide range of factors that are hindering policymakers within the Ministry of Health (MoH) and parliament from using research evidence in their work.

The study identified three categories of barriers, including access barriers, institutional barriers, and individual barriers; these are discussed in a bit more detail below. Respondents of the needs assessment included senior officials and technical staff within the MoH and parliaments in Kenya and Malawi.

Access barriers

Respondents argued that they did not have access to data and research so as to be able to apply these in their work. One of the main reasons why respondents lacked access to data and research was the lack of a repository for health research in each country where policymakers would easily source research for use in their work.

Currently, health research is scattered in various reports and journals, and there is no 'one-stop shop' where one would find all health research conducted in the country. Another reason was lacking subscriptions to journals and other online databases – neither MoH nor parliament in either country have invested in journal subscriptions to enable access to research necessary for informing policy decisions.

On the other hand, respondents did not seem to be aware of open-access research resources, which they could draw on to inform their work. Another reason was highlighted as poor packaging and dissemination of research evidence by researchers in the two countries.

Limited operations research was also highlighted as an issue, especially in Kenya, where respondents noted that most research available in the country is disease-specific, yet policymakers require operations research for informing decision-making. In relation to data, respondents indicated that the data collected through the HMIS systems were of poor quality and therefore not usable in policymaking.

Respondents also highlighted their own weak or lacking connections with the researchers and research institutions, which means that they often do not know which new research is coming up and so they have no access to it.

Institutional barriers

We classified a number of factors identified as hindering research use under institutional barriers because they related to enabling institutional systems and support mechanisms for research use. Respondents noted the limited funding that the two governments allocated to the generation of research as key barriers, which often meant that policymakers did not have the research evidence they really need to tackle policy challenges.

Inadequate staffing was also noted as a major challenge that was more pronounced in the parliament of Malawi, where it was noted that there are very few technical staff to support legislators. These few staff had competing demands, which made it challenging for them to have time to look for, synthesise and provide research evidence to legislators.

There was also the issue of lacking institutional guidelines for enabling data and research use in policymaking. Respondents argued that the presence of guidelines is a common practice in the health bureaucracy and that if there

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Public Health Sector in Kenya and Malawi

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were guidelines for data and research use, they would be inclined to apply the guidelines. The issue of lacking supportive infrastructure such as well-equipped libraries, institutional journal subscriptions, and relevant computer software for enabling research use were also highlighted as key barriers to research use.

Other barriers to research use classified under institutional barriers include: weaker institutional leadership for evidence use, lacking incentives for research use, weak institutional linkages between the MoH and parliament with research institutions, lacking institutional forums for deliberating new research, senior policymakers' suspicion of using research funded by donor agencies, political interests, and a lacking research use culture.

Individual barriers

A number of factors hindering research use were classified under individual barriers. A major barrier identified here was lacking technical skills required to enable research use. Most respondents indicated that they lacked technical skills in searching for or sourcing research evidence, in interpreting and adapting research for local contexts, synthesising findings from different studies into policy recommendations, and summarising research findings into clear policy recommendations for use by senior officials.

Going hand-in-hand with this barrier is the lack of knowledge of where to find research evidence – not knowing the leading health research databases available where they could source research evidence. Another individual level barrier mentioned was lack of time to use research especially in view of the limited staff and competing demands.

This is made worse by the fact that research evidence is often not well packaged for ease of consumption by policymakers. Another barrier reported was limited appreciation of the importance of research use among senior ministry and parliament officials. As such, these officials do not demand for research evidence or require their technical staff to use research evidence.

The barriers to research use identified in this study align with those identified in other studies; see *Oliver et al 2014, Liverani et al 2013, WHO 2007, Innvaer et al 2002,* among others.

This study was conducted as part of the inception phase of the SECURE Health (Strengthening Capacity to Use Research Evidence in Health Policy) programme in order to inform the programme's interventions. SECURE Health is being implemented in Kenya and Malawi for a three-year period and is funded by the UK's Department for International Development (DFID) under the Building Capacity to Use Research Evidence (BCURE) programme.

SECURE Health is led by the African Institute for Development Policy (AFIDEP) and implemented in partnership with the East, Central and Southern African Health Community (ECSA-HC), FHI 360, College of Medicine at the University of Malawi, and the Consortium for National Health Research (CNHR-Kenya).

The UK Parliamentary Office for Science and Technology is a collaborator on the programme. The programme is implemented in partnership with the MoH and parliament in Kenya and Malawi.

Launch of SECURE Health Programme in Malawi

By Nissily Mushani

Often, there's disconnect between research generation and utilisation in policymaking. AFIDEP's SECURE Health programme (Strengthening Capacity to Use Research Evidence in Health Policy) is working with Malawi's Ministry of Health and Parliament to identify and address individual and institutional capacity barriers to research and data use.

Following a successful inception phase in Malawi, the programme was launched in the country on November 12, 2014. The focus of the launch event was the deliberation of findings of a Needs Assessment conducted during the inception phase, which sought to provide an understanding of the status of health research use and related capacities and barriers in Malawi.

The study revealed that in MOH as well as in Parliament, policy-makers recognise the importance of using research evidence in decision-making, but in practice use of research evidence and data in decision-making is curtailed by a number of institutional and individual challenges and constraints including:

Malawi's Secretary for Health Mr Chris Kang'ombe and Dr Ruth Mwandira, Health Advisor, DFID during the launch of SECURE Health Programme on November 12, 2014.

- Lack of a mechanism for accessing research evidence and poor dissemination of the research evidence;
- Lack of incentives for staff to encourage the use of evidence in decision making;
- Lack of technical skills, time constraints resulting from high workloads and inadequate personnel;
- Lack of a well-coordinated and accessible national repository for health research; and
- Lack of relevant research evidence to improve services as such research is seen as an academic output and not for informing policy and programming.

The findings of the study mirrored the broader literature on the main challenges to research evidence use by government officials and legislatures.

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SECURE Health Programme launched in Malawi

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During the launch, Malawi's Secretary for Health, Mr Chris Kang'ombe noted that the SECURE Health programme was important as it would bridge the gap between research and healthcare provision through coordinated forums under Malawi's Knowledge Transformation Platform (KTP) and the National Commission on Science and Technology (NCST).

In relation to the Needs Assessment Study, Mr Kang'ombe called upon senior government health officials to critically analyse the results of the study and see ways in which the study's recommendations can be put into practice in the Ministry.

On the other hand, Malawi's Parliament Head of Research, Ms Velia Manyonga, noted that the programme had come at the right time when formulation of evidence-based policies is becoming really critical. She highlighted the need for the SECURE Health programme to also focus on stimulating parliamentarians to use evidence when formulating policies, rather than just focusing on the technical staff that support parliamentarians.

It was noted that members of parliament (MPs) hardly used evidence in their deliberations during house debates mainly due to lacking appreciation and capacity in evidence use. This issue was further compounded by the weak capacity of clerks and researchers in parliament to find and effectively communicate research findings to MPs. Ms Juliana Lunguzi, MP and chair of the parliamentary health committee, said that parliament should be provided with adequate data for analysis, debate and implementation.

Dr Ruth Mwandira, Health and HIV AIDS Adviser at DFID's Malawi office, noted that Malawi was among the few countries benefiting from DFID's funds for increasing health research use in decision-making. She urged that lessons learnt from the Malawi programme be disseminated to the public and other countries.

The launch of the SECURE Health Programme and the dissemination of the Needs Assessments Study brought together a diverse number of participants who welcomed the programme and looked forward to supporting programme implementation and drawing lessons that can be institutionalised to ensure a sustained research use culture in the health sector in Malawi. Some of the key recommendations that emerged out of the meeting included:

- The need for establishing a reliable and sustainable research repository. This could happen through collaborated efforts from various stakeholders;
- The possibilities of expanding the programmes interventions to district and ward levels; and
- The need for both Malawi's MoH and parliament to come up with sustainable means for the programme interventions.

National reporting on Adolescent SRH to be enhanced

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A few but important limitations influenced the ASRH indicators adopted by the Task Force including:

- Limited space on the integrated RH summary reporting form. As a result, disaggregation for age cohorts 10-14 and 15-19 was limited to 2 indicators, that for the age cohort 20-24 was limited to 1 indicator, and all other indicators were disaggregated for the broader age cohort 10-19.
- The age cohorts used for the SGBV indicators were aligned to the Sexual Offence Act which criminalizes defilement of children under 18 years. Therefore the SGBV age cohorts could only be revised to the extent that the revision remained aligned to the Sexual Offence Act. The Task Force was able to negotiate for the 10-17 years age cohort which would still meet the national gender programme's objectives to track defilement cases.

What next?

The proposed ASRH indicators were approved and adopted by the MoH Division of Health Information Management and M&E. The tools will be disseminated nationwide for implementation over the next 5 years. Periodic review of ASRH data reporting will be an important step towards addressing other bottlenecks to using data for decision making.

A more detailed account of this meeting can be found on www.afidep.org.

Violet Murunga, AFIDEP's Senior Knowledge Translation Officer and a specialist in Adolescent Sexual and Reproductive Health answers your question

Q. Should teenagers in Kenya be provided with condoms?

A. Teenage pregnancy and sexually transmitted illnesses are key health issues faced by adolescents in Kenya. Condom use is a key intervention for preventing these health issues among adolescents.

In line with the 1994 International Conference on Population and Development programme of action and Kenya's Constitution which promotes access to reproductive health services as a right for all people, the government allows adolescents to access condoms from community health facilities outside the school setting. The focus in schools is on providing sexuality education and linkages to community health facilities providing adolescent and youth friendly services where sexually active adolescents can access condoms.

There is still work to be done in terms of strengthening the sexuality education and expanding access to adolescent and youth friendly services. Currently, the Kenya Ministry of Education is in the process of domesticating the Eastern and Southern Africa Ministerial Commitment supporting sexuality education and sexual and reproductive health services for adolescents and young people.

AFIDEP's Science-Policy Café Urges the Kenyan Government to do more for Maternal Health

By Emmanuel Toili

Experts on maternal health have urged the government of Kenya to take further steps in order for the presidential directive on free maternity services to be more effective in reducing the death of Kenyan mothers.

The recommendations include the need for the government to rethink the financing strategy for the provision of free maternity services, ensure timely reimbursements to health facilities, equip facilities adequately, and increase in the numbers of health workers. These recommendations represent the key messages that emerged from the deliberations at AFIDEP's Science-Policy Café organised in collaboration with Kenya's Ministry of Health in Nairobi on February 12, 2015.

Prof Khama Rogo, a leading reproductive health expert in Kenya who moderated the café, noted that while the free maternity services policy has increased access to services, some regions in the country are recording numerous deaths of mothers from pregnancy-related causes. Prof Rogo cited Mandera County, where statistics show that 3,700 women die every year from childbirth or pregnancy-related causes.

The café emphasized the need for more effective interventions for the 15 counties that account for most maternal deaths in Kenya including the need for a special remuneration package for health workers to attract and retain them in facilities in these counties.

Professionals at the café noted that having the free maternity services policy without addressing the health worker shortage in rural and marginalised communities, the lacking health facilities, functional equipment and supplies will amount to nothing.

Delayed hospital reimbursements by government

The issue of delayed and inadequate reimbursements to health facilities was also noted as a major problem. Dr John Ong'ech, a senior official at the Kenyatta National Hospital, said that many times the reimbursements to health facilities were delayed and did not cover all the costs incurred in providing free maternity services.

This issue was further highlighted by Kisumu health executive, Dr Elizabeth Ogaja, who said delays in reimbursements were affecting the implementation of the directive in many facilities in the county.

Poor quality of services in public-owned health facilities - the 'Ngong Road' Phenomenon

The other problem highlighted was the poor quality of services in public health facilities. Participants at the café decried the poor supervisory and accountability mechanisms in public health facilities compounded by poor remuneration and huge workload, which resulted in the provision of poor quality services. They argued that the same health workers provide high quality services in private facilities and very poor services in public-owned facilities. Referring to this as the 'Ngong Road Phenomenon' in a light moment, Prof Rogo asked, what happens when health workers cross Ngong Road from the government-owned Kenyatta National Hospital to the private-owned Nairobi Hospital? Do they undergo some metamorphosis that forces them to provide different quality of services in the two hospitals?

Prof Khama Rogo, a leading reproductive health expert in Kenya addressing participants at the Science-Policy Café in Nairobi on February 12, 2015.

Need for a more effective funding mechanism – should we give women vouchers?

In addition to delayed reimbursements to facilities, participants highlighted the inadequacy of the funding, noting that the government only refunded facilities for deliveries and did not cover complications that accompany deliveries. Experts at the café argued that a better mechanism may be for the government to give vouchers to women so that they choose where to deliver. This would produce competition among facilities and result in improved quality of services.

Need for monitoring and evaluation to enable sustained improvement

The café noted that the current policy on free maternity services did not have a monitoring and evaluation (M&E) plan, and so more than two years after the directive, we really don't know its impact and evidence-based lessons of making it more effective. They called for a clear M&E plan that would not only measure the impact of the directive, but also draw lessons for continuous improvement.

Kenya should take advantage of the political will and support

Dr Eliya Zulu, Executive Director of AFIDEP, called on Kenya to take advantage of the political will and support for maternal health both by the President and First Lady to ensure that the poorest women can access quality maternity services in order to save lives.

"Many African countries are struggling to get political support for maternal health like what Kenya has, so we must take advantage of this and ensure services are available," he said.

AFIDEP organises Science-Policy Cafés in Kenya and Malawi once every six months under its SECURE Health programme as a way of providing a platform for accountability and deliberation of key policy issues, as well as enabling increased interactions among policymakers and researchers. The next cafés will be held in June 2015. The Malawi February café discussed adolescents and abortion in the country.

Welcome to our New Team Members!

Dr Bernard Onyango (Knowledge Translation Scientist) joined AFIDEP in October 2014. He is a sociologist with extensive experience in the field of population dynamics in sub-Saharan Africa. His work entails providing technical input in implementing knowledge translation to enhance the use of evidence in decision-making processes at national and regional levels. Bernard previously worked with the KEMRI-CDC programme in Kenya. He holds a PhD in Sociology from Brown University and was a trainee of its Population Studies and Training Center (PSTC).

Dr Grace Kumchulesi (Knowledge Translation Scientist) joined AFIDEP in April 2015. Her work involves synthesising and translating research evidence into outputs that can be easily used by policymakers and in policy engagement. She is an Economist by training and holds Bachelors and Masters degrees from the University of Malawi, and a PhD from the University of Cape Town.

Solomon Omariba (Knowledge Translation Officer) joined AFIDEP in April 2015 and his work mainly entails coordinating the implementation of research projects, management of knowledge translation, promoting application of research findings in decision-making processes and capacity building programmes.

Previously, he worked with CDC's Division for HIV and AIDS (DGHA) and Catholic Relief services (CRS) Kenya programme as a Technical Advisor for HIV Prevention, and the Kenya Ministry of Health.

Emmanuel Toili (Communications Officer) joined AFIDEP in November 2014. Prior to joining AFIDEP, he worked with the Management Sciences for Health (MSH) Kenya as a Website Content Specialist. He has also worked with the Nation Media Group as an Online Sub-Editor and the Kenya Broadcasting Corporation (KBC) as a Business Reporter and subsequently, an Online Editor.

Hector Mvula (Finance and Administration Officer) joined AFIDEP in December 2014. Prior to joining AFIDEP, he worked as an Accountant with Blantyre Print & Publishing in Malawi. He holds a Bachelor of Applied Accounting Auditing and Information Systems degree from Malawi College of Accountancy – School of Commerce. He is based at AFIDEP's Malawi office.

AFIDEP is looking for:

- **Director of Research and Knowledge Translation**
- **Communication and Policy Engagement Manager**
- **Knowledge Translation Officer**

Check our Website for details; www.afidep.org

AFIDEP delivers EIPM Training in Kenya and Malawi

AFIDEP's Strengthening Capacity to Use Research Evidence in Health Policy (SECURE Health) programme conducted four training workshops in Kenya and Malawi during March and April 2015 to strengthen the capacity of staff in the Ministry of Health and Parliament in Evidence-Informed Policymaking (EIPM). This infographic summarises the training workshops.

SECURE Health Evidence-Informed Policymaking Training March-April 2015

Why Training?

One of the key barriers to research use is lacking or weak skills among technical staff within government agencies required for searching & applying evidence.

76 staff staff members from the ministries of Health and Parliament in Kenya and Malawi were trained.

Staff Trained

Kenya 40 MoH & Parliament Staff

Malawi 36 MoH & Parliament Staff

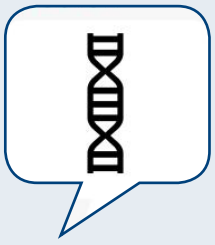
What did they learn about?

Foundation of Poliymaking

Defining a Policy Question

Accessing Evidence

Appraising Evidence



Synthesising Evidence

Applying Evidence

What were the Immediate Outcomes?

Trained Policymakers

- Defined clear Policy Questions
- Searched for evidence to answer the Policy Questions
- Assessed the quality of the evidence
- Synthesized the evidences into clearly written policy messages
- Developed draft Policy Briefs answering their Policy Questions

What Next?

One-year follow-up support for trained policymakers through:

- Email/phone contact
- 4 one-day follow-up workshops for further training, sharing experiences & deliberating final Policy Briefs

Symposium Deliberates Challenges and Opportunities for Research Uptake

By Emmanuel Toili

Research uptake experts from around the world converged in Nairobi February 9-12, 2015 to discuss the current thinking and practice in research utilisation as well as share technical expertise. The event, dubbed 'ResUp MeetUp Symposium and Training Exchange', was organised by AFIDEP and the Institute for Development Studies (UK) and funded by UK's Department for International Development (DFID).

Giving the Symposium's first keynote address, AFIDEP's Director Dr Eliya Zulu challenged participants to listen more to the questions and issues facing policymakers so as to guide research and uptake strategies. He noted that there was increasing demand for accountability, which was making the use of evidence by both the public and policymakers critical.

Dr Zulu however cautioned on the allure to overplay research results in order to demonstrate impact, noting that this was unethical.

Hon. Dr James Nyikal, a Kenyan legislator belonging to the parliamentary committee on health and a former Director of Medical Services, gave the second Keynote address. In his address, Hon. Nyikal noted that research objectives did not necessarily align with the interests of policymakers, and therefore emerging research evidence is often not taken up into policies and laws. To demonstrate the gap between policymakers and researchers, Hon. Nyikal said: "The researcher is in the university working day and night while a policymaker is in his office scratching his head".

He called for need to have research champions with knowledge translation skills who would bridge the gap between researchers and policymakers. He further suggested that "policymakers need to be peers in research process to strengthen uptake".

Hon. Nyikal concluded by challenging participants to build stronger lobbying groups and institutions to bridge the gap and facilitate linkages with policymakers in order to actualise research use in decision-making processes.

The third and final keynote address was given by Dr Peter Kimuu, Head of Policy, Planning and Healthcare Financing at Kenya's Ministry of Health (MoH). Dr Kimuu told participants that government was ready to use evidence, and challenged participants to provide the Kenya MoH with evidence on why there has been limited progress on reducing maternal deaths in Kenya despite a lot of investments over the last two decades. He said, "if you give us this evidence, we will use it because we really want to understand where the problem is with reducing maternal deaths".

He further emphasised the Kenyan government's commitment to using research in its decision-making processes for increased effectiveness. He cited the establishment of the Research Division within the MoH in 2013 as an indicator of the government's commitment to enabling increased research use in decision-making.

Participants at the ResUp MeetUp Symposium and Training Exchange held in Nairobi, Kenya from February 9 – 12, 2015.

The Symposium ran for the first two days (February 9-10, whereas the Training Exchange ran for the last two days (February 11-12). The whole event was attended by over 160 people from around the world, and was held at Nairobi's Southern Sun hotel.

Among others, the symposium deliberated effective practices in enabling research uptake, including:

- The need to incorporate research uptake strategies and activities from the beginning of research projects;
- The importance of basing research uptake strategies on the context and needs of the target users of evidence;
- The importance of effective monitoring and evaluation strategies to enable sustained learning and improvement of strategy;
- The need for adequate budgeting for research uptake to enable hiring of qualified and experienced professionals;
- The critical role of high-level institutional support for research uptake programmes; and
- The need for experts to also target other users of evidence in addition to policymakers including parliamentarians, civil society, media and the public or communities.

The Training Exchange event saw up to 17 short training sessions, ranging from writing 'issue briefs' to developing data visualisation, using film, planning communication activities, several sessions on blogging and digital communication, introduction to design and effective media engagement.

The ResUp MeetUp (Research Uptake) community is designed to help research uptake and communication professionals keep up-to-date with this rapidly evolving field.

Given the enthusiasm and interest generated by this premier research uptake event, AFIDEP and its partners will regularise the event into an annual or bi-annual gathering for exchange of experiences, ideas and skills.

NEXT ISSUE:

Dr Martin Atela, Knowledge Translation Scientist, speaks on the role the Cross - Border Health Integrated Partnership Project (CB-HIPP) plays on using Research Evidence to address HIV/AIDS and Health among key and mobile populations across East Africa.

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.

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