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Enhancing Research Evidence Use in Francophone Africa

Why Africa Needs an Agenda for Gender Data Generation, Translation and Use

How Data Is Building Resilient Health Systems in Africa

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AN AFRICA WHERE EVIDENCE IS USED CONSISTENTLY TO TRANSFORM LIVES

Editorial team:
Adaudo Anyiam-Osigwe | Charlotte Chisoni | Derick Ngaira | Edel Sakwa | Godfrey Pumbwa | Nhlanhla Dhaka | Ruckia Ibrahim-Nyirenda | Venancious Ngmenkom Tuor

Article authors:
Charlotte Chisoni| Derick Ngaira |Edel Sakwa | Godfrey Pumbwa | Jessie Mphande| Josephine Cherotich | Dr Magidu Nyende| Mark Malema |Dr Mziwandile Ndhlovu | Nhlanhla Dhaka| Ruckia Ibrahim-Nyirenda | Venancious Ngmenkom Tuor

Edition designers:
Edel Sakwa |Godfrey Pumbwa| Ruckia Ibrahim-Nyirenda

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Participants at the Regional Validation Workshop for the Agenda for Gender Data Generation, Translation, and Use for Africa in Nairobi, February 26–27, 2025

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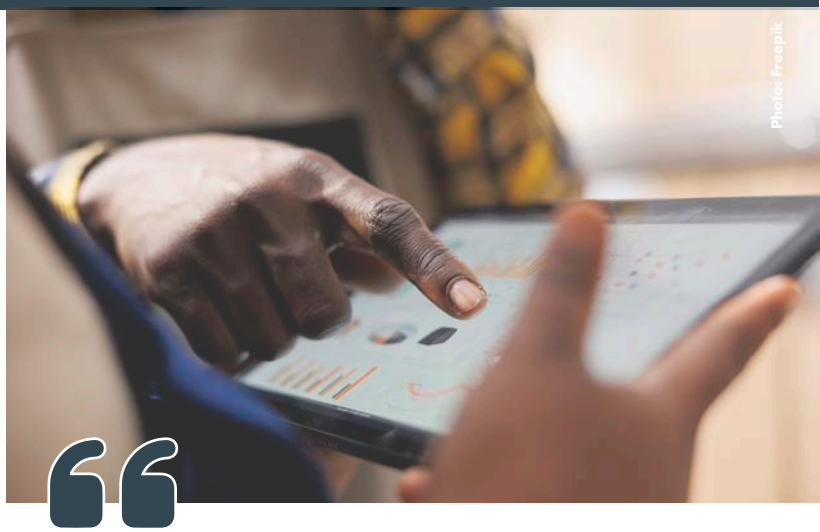
CONTENT

Enhancing Research Evidence Use in Francophone Africa

By Venancious Ngmenkom Tuor, Charlotte Chisoni and Jessie Mphande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The West African region is navigating a critical juncture, marked by macroeconomic instability, high debt burdens, weakening currencies, and worsening poverty indicators. According to the 2024 West African Development Outlook, regional growth slowed to 3.5% in 2023, inflation averaged 20.6%, and over 148 million people were classified as working poor. Debt-to-GDP ratio rose across most countries, while fiscal space narrowed amid recurring shocks, from electricity shortages to food insecurity. Leveraging evidence-informed decision-making (EIDM) is now more critical than ever to guide effective policy responses and development interventions.

Moreover, the use of evidence in policymaking is gaining momentum across Francophone West Africa driven by growing political will, institutional reforms, and increasing demand for data across sectors such as health, agriculture, and education. Countries such as Burkina Faso, Cameroon and Côte d'Ivoire have introduced national policies, frameworks, and partnerships that promote the use of evidence in decision-making. Yet, despite this progress, key barriers remain—including limited access to data, underfunding of research systems, and the dominance of English-language publications, which restrict evidence uptake in Francophone contexts.

To promote engagements among researchers, policymakers and EIDM actors in West Africa, the African Institute for Development Policy (AFIDEP), through the Evidence-Empowered Decision-Making for Africa's Renaissance (EEDAR) project, hosted a policy forum on 10 December 2024 to discuss strategies for enhancing evidence use in the Francophone West Africa region. The forum provided an avenue to gather insights from key actors on potential solutions to the barriers in EIDM across Anglophone and Francophone West African countries.

Held under the theme "Bridging the Evidence-To-Policy Gap: Exploring Priority Interventions Responsive to the Context of Francophone Africa", the forum discussed the drivers and barriers related to EIDM in Francophone West Africa and aimed at identifying opportunities and incentives that can enhance EIDM initiatives within the region. The discussions were facilitated by the findings from a landscape and political economy analysis (PEA) that included in-depth case studies conducted in Burkina Faso, Cameroon, and Côte d'Ivoire. These were complemented by a broader regional review that explored cross-cutting patterns, institutional dynamics, and policy trends shaping evidence use across Francophone West Africa. The forum drew a multitude of participants across 21 countries, eight of which were Francophone, thereby emphasising the importance of cross-learning among countries.

Through the EEDAR project, AFIDEP convened key stakeholders in Francophone West Africa to spark dialogue, share insights, and co-create strategies for strengthening evidence use in policymaking across the region

Drivers of EIDM in Francophone West Africa

Several factors have contributed to the increasing prioritisation of EIDM in policymaking across Francophone West Africa. One of the most influential drivers is political will. Governments are increasingly recognising the value of evidence in shaping national policies, particularly

in health, agriculture, and education. Côte d'Ivoire has institutionalised this commitment through mechanisms such as the Public Policy Evaluation Commission and the National Evaluation Policy, which was developed in 2022 to promote evidence use across government departments. Similarly, Burkina Faso has a National Development Plan for Research (2022–2026) that seeks to ensure research findings are integrated into national policy frameworks.

Beyond government commitment, sectoral demand for research has played a critical role in advancing EIDM. In Cameroon, for instance, the National Health Development Plan (2016–2027) integrates evidence into health system strengthening, particularly in the control of infectious diseases. In Côte d'Ivoire, the National Centre for Agronomic Research (CNRA), established in 1998, generates agricultural research that informs policy interventions aimed at improving food security and rural development.

A significant enabler of evidence use has been the emergence of knowledge translation platforms. Burkina Faso has developed various mechanisms to support research translation, including the National Agency for the Valorisation of Research Results (ANVAR), established in 1996, and the Knowledge Management and Transfer Unit (UGTC), which facilitate the dissemination of research findings to policymakers. These platforms help bridge the gap between researchers and decision-makers by ensuring that scientific evidence is accessible and policy relevant.

Collaboration between governments, universities, and research institutions has further strengthened the EIDM ecosystem. In Côte d'Ivoire, the Ministry of Education has partnered with Innovations for Poverty Action (IPA) to create Education Labs that generate policy-relevant evidence, ensuring that research findings are directly linked to decision-making processes. At the regional level, organisations such as the Economic Community of West African States (ECOWAS) have demonstrated the importance of evidence use in shaping policy responses. During the Ebola outbreak, ECOWAS worked closely with the Africa Centres for Disease Control and Prevention (Africa CDC) and local research institutions to integrate research into regional health governance, ensuring a coordinated response across member states.

Persistent Barriers to EIDM in the Region

Despite these positive developments, significant challenges continue to impede the institutionalisation of EIDM in Francophone West Africa. One of the most pressing issues is limited domestic funding for research. Governments in the region allocate minimal resources to research, making EIDM efforts heavily dependent on external donors. Burkina Faso, for instance, dedicates only 0.4% of its national budget to research, while Cameroon allocates 1%. As a result, external donors often dictate national research agendas, sometimes prioritising areas that do not align with the most pressing local needs.

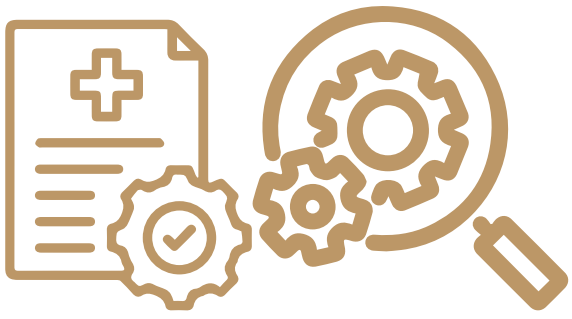
Weak engagement between policymakers and researchers further undermines the integration of evidence into policy processes. Decision-making structures in many countries remain highly centralised, with limited opportunities for researchers to engage directly with government officials. Consequently, researchers struggle to align their work with policy needs, leading to critical knowledge gaps that affect decision-making.

Another significant challenge is the availability and accessibility of data. In many cases, bureaucratic hurdles prevent researchers from accessing critical datasets, delaying the production of timely evidence. In Côte d'Ivoire, for example, administrative restrictions within institutions such as the CNRA have made it difficult for researchers to obtain agricultural data, limiting the potential for data-driven policy interventions. Additionally, weak data collection and management systems, particularly within health ministries, undermine the quality and reliability of available evidence.

Language barriers also pose a substantial obstacle to evidence use. Most high-quality research papers and policy briefs are published in English, making it difficult for Francophone researchers and policymakers to access relevant studies. A researcher in Burkina Faso noted that as most available research articles are in English, many researchers and decision-makers are discouraged from actively seeking out evidence. As a result, they tend to rely only on the limited range of resources available in French, which restricts their access to comprehensive and up-to-date information for policymaking.

As one official from Burkina Faso's National Institute of Public Health (INSP) explained: "*The majority of available research evidence is published in English, which limits its accessibility in Francophone contexts. Many policymakers are discouraged from seeking out evidence because it often requires reading through multiple English articles. Moreover, there is a lack of policy briefs and summaries available in French, making the process of using evidence even more complex for decision-makers.*" (Interview, 15 October 2024)

Political resistance to unfavourable evidence further complicates efforts to institutionalise EIDM. For instance, policymakers may downplay or disregard research findings that do not align with political priorities. One government official noted that decision-makers often prefer to highlight only the positive aspects of programmes, even when



evidence suggests otherwise, leading to policies that may not effectively address underlying challenges.

In addition to these barriers, the inadequate capacity for research translation limits the extent to which evidence is utilised in policymaking. Even when high-quality research is available, there is often a lack of mechanisms to translate findings into clear, concise content tailored to policymaker needs, such as policy briefs, evidence summaries, decision memos, or infographics. In Cameroon, for example, organisations such as FAIRMED have established research synthesis protocols, yet these efforts remain isolated and insufficiently integrated into national policymaking processes. Without effective translation, research remains inaccessible to decision-makers, further widening the gap between evidence production and policy implementation.

Strengthening EIDM: Recommendations for Action

Overcoming these barriers requires a strategic and multi-faceted approach. One of the most urgent priorities is increasing domestic investment in research. Governments must commit to allocating at least 5% of national budgets to research and innovation, in line with African Union recommendations. Establishing dedicated national research funds, such as Burkina Faso's National Research and Innovation Fund for Development (FONRID), could provide sustainable financing mechanisms for locally driven research initiatives. Performance-based funding models where research institutions receive funding based on clearly defined outputs or impact indicators should also be explored to ensure that research investments are aligned with national priorities and produce tangible policy outcomes.

Strengthening engagement between policymakers and researchers is another critical step. Institutionalising evidence-sharing dialogues through national research days, similar to Nigeria's Research Days for Maternal and Child Health, could foster stronger linkages between researchers and government officials. Embedding evidence units within government ministries, as demonstrated by IPA's Education Lab in Côte d'Ivoire, would also create opportunities for researchers to contribute directly to policy processes and ensure that research findings are incorporated into decision-making.

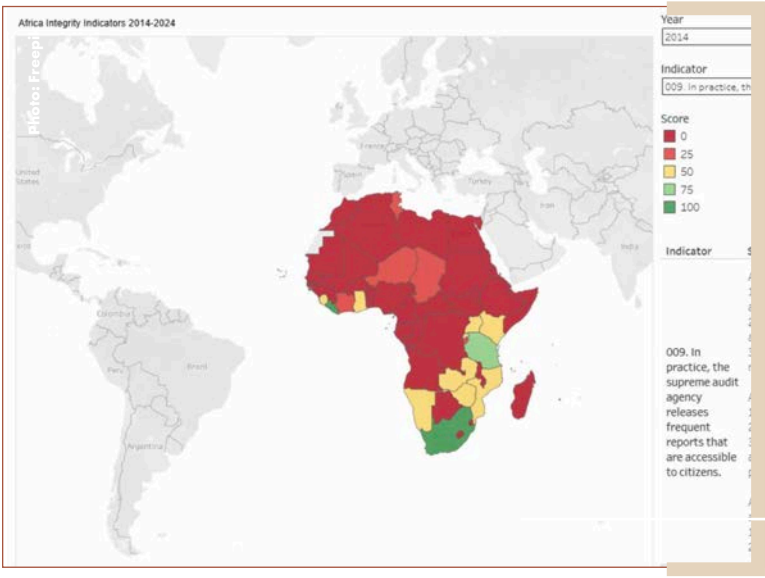
Improving data availability and management should be a key focus area for governments and research institutions. Investing in digital infrastructure for data collection, storage, and dissemination would ensure that policymakers have access to real-time, high-quality evidence. Establishing open-access research databases would further enhance transparency and accessibility, allowing decision-makers to use the best available data to inform policies.

Addressing language barriers is essential to ensuring that policymakers can access and use relevant research. The translation of key research findings from English to French should be prioritised to facilitate evidence accessibility in Francophone West Africa. Expanding bilingual evidence platforms, for instance through communities of practice, would also encourage cross-regional learning and collaboration, allowing policymakers to draw on insights from both Anglophone and Francophone countries.

Finally, strengthening research translation capacity would help bridge the gap between evidence production and policy implementation. Training researchers on policy communication and developing knowledge translation hubs, such as Cameroon's Evidence-Informed Policy Network (EVIPNet), would ensure that research findings are communicated in ways that are easily understood and actionable for policymakers. Institutionalising EIDM in national policies would further reinforce its importance. Governments should enact policies that mandate the use of evidence in decision-making and publicly recognise institutions that successfully integrate EIDM through awards, media recognition, and funding incentives.

Conclusion

Francophone West Africa has made significant progress in advancing EIDM, with increasing political will, growing sectoral demand for evidence, and strengthened regional engagement. Nevertheless, strengthening domestic investments in research, fostering collaborations, improving data systems, and embedding EIDM within governance structures will be critical to unlocking the full potential of evidence-driven policymaking in the region. By taking these steps, Francophone West Africa can bridge the evidence gap and build a sustainable culture of evidence use in governance, ultimately leading to more effective policies and improved development outcomes.



The Challenges of Data Collection in Unstable Countries: Perspectives from the Africa Integrity Indicators

By Dr Mziwandile Ndhlovu

Collecting reliable governance data from all 54 African countries is a monumental task that the Africa Integrity Indicators (AII), a project of the African Institute for Development Policy (AFIDEP), has successfully done for over a decade. Despite this success, it is still an onerous task, involving the differing contexts of the countries with varying levels of stability and security. Governance data is also very sensitive as it broadly defines a country's international profile. Several multilateral institutions, notably those focusing on economic issues, sometimes make generalisations for the continent despite having failed to gather reliable data in certain countries due to considerable difficulties. In all its history, AII has gone out of its way to ensure that data is collected in all countries against all odds.

Security of Contributors and Sources

The AII project relies on in-country lead researchers to lead data collection and expert reviewers to assist with quality control and peer review. They work on data revolving around judicial independence, electoral integrity, corruption, public procurement, political finance, freedom of expression and assembly, as well as minority rights which many authoritarian regimes would rather shield from public scrutiny. The AII project management team has faced significant difficulties in recruiting reliable researchers and peer reviewers in some unstable countries such as Sudan, Mali, Guinea, Eritrea, Somalia, Ethiopia, Libya, Central African Republic, Mozambique, Niger, Chad and Burkina Faso. These countries are either under military administration or are experiencing civil war/social strife. Several AII in-country contributors have faced harassment and victimisation for their work, and, in the worst of cases, some have endured arrest as was the case of the Algeria contributors for the 2022–2023 cycle.

The AII project has faced difficulties securing contributors in unstable countries, with these having mostly no responses following public calls for contributors. This is mainly because potential researchers fear the repercussions of working on a project of this nature. In some instances, researchers for such countries tend to be found in the diaspora communities of these countries, mainly in Europe and the Americas, who enjoy relative safety to work on sensitive issues of their countries of origin. Conducting research remotely comes with challenges, such as having reliable access to sources and data.

The AII project also highly relies on key informant interviews as a cornerstone of its data. It has proven to be challenging in unstable countries to get informants who are prepared to consent to interviews on the record. To circumvent this problem, the project allows for anonymous submissions. The project management team battles to limit the number of anonymous sources for unstable countries as too many sources prefer to be anonymous in order to insulate themselves from any repercussions.

Censorship

Unsurprisingly, the best data on the AII project, are from the most democratic countries with high levels of open governance and public information on multiple platforms. The opposite is usually true in unstable countries where data is relatively scant as there are hardly any functional websites or repositories for public institutions. If they are available, the information is usually outdated or largely inadequate. Emergency legislation, necessitated by war, is generally used as a convenient scapegoat for withholding as much public information as possible. At the worst of times, especially during elections, the internet is jammed, and there are arrests and intimidation of journalists. For these reasons, researchers struggle to access the required data and have to go out of their way, sometimes putting themselves in harm's way, to access information. In countries like Libya with rival administrations, it is a big challenge to collect reliable data which is representative of the country.

Stigmatisation of Data From Unstable Countries

A novel yet under-acknowledged phenomenon regarding data from unstable countries is the stigma it suffers due to public perception and expectation. There is a massive expectation for unstable countries to score poorly on most, if not all, indicators. The AII project has proven over the years that this is not always the case as there are unstable countries that are exceptional. The best example from the AII project is Burkina Faso, which has consistently posted good scores across various indicators, contrary to widespread expectations. Burkina scores positively on some Elections indicators as well as in the Access and Openness indicators looking at citizen access to public information, declaration of assets for public officials and public finance. On several data dissemination platforms, the project management team has had to field questions on how countries like Burkina Faso have constantly performed better than many countries under seemingly stable civilian administrations.

Extra Quality Control Measures

Because of the myriad of challenges that come with data collection in unstable countries, they place an extra burden on the project management team. These countries tend to suffer from a high turnover as some researchers abandon the research midway because of these challenges. The team then has to find alternative solutions to either recruit new researchers or join the data collection process as time runs out. The quality control and peer review processes for these countries are also more taxing to ensure data integrity. Eventually, these countries tend to be the last countries to be completed, sometimes potentially jeopardising the project timelines.

Conclusion

The Africa Integrity Indicators project reflects AFIDEP's strong commitment to collecting credible governance data across all 54 African countries, including fragile states. Despite challenges such as insecurity and censorship, the project has upheld data integrity, inclusivity, and reliability—highlighting the vital role of evidence in shaping policy and driving change.

How Data is Building Resilient Health Systems in Africa

By Derick Ngaira

Africa's health systems face numerous obstacles, from a shortage of skilled health professionals and inadequate infrastructure to rising disease burdens and inefficient resource allocation and usage. These structural gaps are exacerbated by the frequent reliance on international aid, which, while necessary, often comes with its own challenges, including a lack of long-term sustainability.

In the face of these challenges, the need for data-driven decision-making has never been more pressing. It is in this regards that, through the Advance Domestic Health Financing (ADHF) project, African Institute for Development Policy (AFIDEP) and Partners in Population and Development Africa Regional Office (PPD–ARO), are supporting African governments to harness the power of data in identifying inefficiencies in healthcare spending and resource distribution, thereby leading to better allocation of domestic health financing.

Harnessing the Power of Data to Drive Efficient Health Systems

Data is an essential tool for improving the efficiency of health systems and ensuring the optimal use of available resources. By relying on accurate, timely data, African countries can make informed decisions about where and how to allocate resources most effectively, identify gaps in service delivery, and monitor the impact of health interventions. In nations where data has been strategically utilised, significant improvements in healthcare delivery have been achieved.

Zambia's healthcare system has embraced a data-driven approach to improve efficiency and accountability. Using platforms such as the Integrated Financial Management Information System (IFMIS) and the Electronic Logistics Management Information System (eLMIS), the country is able to effectively track healthcare expenditures and manage medical supplies.

These systems enable greater transparency in the use of healthcare resources, streamline supply chain operations with real-time stock level data, and support robust monitoring and evaluation to detect and address inefficiencies—such as discrepancies in billing and irregularities in medication or service usage. While challenges persist, including data quality issues, limited internet connectivity,


Photo: DC Studio

and inadequate ICT infrastructure, Zambia remains committed to strengthening data use for strategic planning and more effective health resource allocation.

In Malawi, effective data utilisation has driven significant improvements in the health sector. These include increased health budget allocations, a stronger focus on primary healthcare (PHC) for disease prevention, and enhanced fraud prevention through the use of IFMIS-generated local purchase orders.

The country has also made strides in monitoring and evaluation, alongside the development of Direct Facility Financing (DFF) guidelines to promote equitable resource distribution across districts. The DFF approach introduces an intra-district allocation formula to guide the fair distribution of health resources among community hospitals and health centres within each district. By adopting the unified framework of "one budget, one plan, and one monitoring and evaluation (M&E) system," the Ministry of Health (MoH) aims to strengthen budgeting processes through clear budget targets, expenditure tracking, and assessment of the impact of health investments.

In Kenya, the government has leveraged several key data sources—including the National Health Accounts, Public Expenditure Reviews, Out-of-Pocket Expenditure Estimates, and the Public Expenditure Tracking Survey—to identify and address inefficiencies in the healthcare system. Insights from these sources have been pivotal in informing strategies to advance universal health coverage (UHC), particularly by prioritising investments in primary healthcare (PHC). As a result, government expenditure on PHC has risen significantly, growing from KES 245.23 billion in the 2016/17 fiscal year to KES 284.91 billion in 2020/21.

> **The focus must shift towards strengthening national health systems that are data-informed, efficient, and sustainable**

At the same time, the Public Expenditure Tracking Survey in Kenya has been instrumental in uncovering resource leakages within the health sector. These findings led to the enactment of the Public Funding Financial Management Act, which sets clear guidelines for the effective use of healthcare funds—from the national treasury to individual health facilities. This legislation is designed to minimise bureaucratic inefficiencies and curb corruption-related losses, thereby enhancing accountability and ensuring optimal use of public resources.

In Uganda, multiple key data sources play a vital role in informing health policy and guiding resource allocation decisions. The National Health Accounts (NHA), for instance, track trends in domestic health financing across various sub-programmes. Over the past seven years (2017/18–2022/23), the NHA has reported a significant increase in healthcare investment—from UGX 1.827 trillion to UGX 3.685 trillion. This includes a rise in funding for medicines, which grew from UGX 396.17 billion in 2019 to UGX 513 billion in 2023. The data also reflects a strategic shift toward prioritising PHC over curative services, as demonstrated by the PHC grant increase from UGX 625.18 billion in 2020/21 to UGX 1,008.1 billion in 2023/24. Additionally, the Health Management Information System (HMIS) offers critical insights into disease patterns, demographics, and poverty indicators—data that are essential for equitable resource distribution and effective programme implementation. Collectively, these data-driven tools are strengthening Uganda's capacity to optimise health funding, improve service delivery, and address public health challenges more efficiently.

Way forward

The reduction in donors financing healthcare underscores the importance of building resilient, self-reliant health systems in Africa. By adopting data-driven decision-making, African governments can reduce inefficiencies, optimise resource use, and enhance domestic financing for health. This will not only improve health outcomes but also help ensure that countries can continue to meet the growing health needs of their populations, even in the face of external financial challenges.

As the global health landscape continues to evolve, the focus must shift towards strengthening national health systems that are data-informed, efficient, and sustainable. With the right investments in data systems, digital health technologies, and human capacity, Africa can reduce its dependence on external aid and build a stronger foundation for health financing and delivery.

Transforming Healthcare in Malawi Through Direct Facility Financing (DFF) Reform

By Godfrey Pumbwa and Mark Malema

The Government of Malawi has reinforced its commitment to achieving universal health coverage (UHC) through the Health Sector Strategic Plan III 2023-2030. A central pillar of this agenda is the adoption of Direct Facility Financing (DFF), a reform that grants primary health facilities autonomy over financial resources. This approach aims to address critical funding gaps, enhance local decision-making, and improve healthcare delivery, particularly at the community level, allowing people at the very first point of care to access the medical services without incurring financial hardship – a prerequisite for achieving UHC.

Why DFF is Necessary in Achieving UHC in Malawi

DFF represents a paradigm shift in health system management. Unlike traditional models that centralise resource allocation and decision-making at district or national levels, DFF reform allows primary health facilities to receive financial resources directly from the central level and to plan and implement healthcare services. This innovation offers several advantages in Malawi's journey toward UHC.

First, DFF ensures that financial resources are allocated more equitably. Historically, over 70% of Malawi's health expenditure has been concentrated on district hospitals which focus mainly on major surgeries, complicated births, diagnostics, and intensive care services, leaving primary healthcare facilities which focus on prevention, basic diagnostic and treatment, outreach, and common illness underfunded and unable to address local health care needs effectively. By channeling funds directly to these facilities, DFF addresses this funding imbalance, ensuring health facilities at PHC have adequate services and communities have greater access to essential healthcare services.

DFF also enhances responsiveness to local health needs. Centralised financing often results in a one-size-fits-all approach, which may not align with the specific priorities of individual communities. With DFF, facilities can identify their unique health challenges, prioritise interventions, and allocate resources where they are most needed, enabling a more tailored and effective response. .

DFF strengthens accountability and transparency. By decentralising financial decision-making, DFF fosters a sense of ownership and responsibility at the facility level.

Facility managers and health committees are directly involved in planning, monitoring, and reporting on expenditures, creating a more transparent system and less prone to inefficiencies or misuse of funds. .

Finally, DFF improves healthcare accessibility and quality. With direct control over their budgets, facilities can address gaps in infrastructure, procure essential medical supplies, and recruit additional personnel as needed. This improves the availability of services and enhances the quality of care provided, particularly for underserved populations such as women, children, and rural communities.

In the broader context of UHC, DFF aligns seamlessly with the principles of equity, accessibility, and quality. It enables the health system to become more community-focused and resource-efficient, ensuring no one is left behind.

AFIDEP's Role in Advancing DFF in Malawi

To operationalise DFF, Malawi's Ministry of Health (MoH) developed the Guidelines for Direct Facility Financing, which provide a robust framework for implementation. Through the Advancing Domestic Health Financing (ADHF) project, AFIDEP played a pivotal role in refining these guidelines. AFIDEP's contributions included streamlining funding flows, providing best practices from Kenya to strengthen regulatory frameworks in the long run, and enhancing governance structures for primary healthcare facilities.

Effective DFF implementation requires strong capacity-building efforts. AFIDEP partnered with the MoH to conduct comprehensive training sessions for facility staff and Health Centre Advisory Committees (HCAC) to ensure success. The training focused on building participants' understanding of DFF concepts, frameworks, and structures. The training has also developed skills in health facility planning, needs assessment, and resource prioritisation, providing practical guidance on procurement processes, financial reporting, and compliance. Additionally, the workshops have strengthened participants' knowledge of monitoring, supervision, and mentorship mechanisms critical for effective DFF management.

Looking Ahead

Malawi's MoH rolled out DFF in 13 districts in 2024, with an initial allocation of MK200 million to primary health facilities and the allocation increased to MK500 million in 2025 to cover the remaining districts. Malawi is taking a transformative step toward UHC by improving service availability through enhanced financial autonomy and capacity at PHC level. AFIDEP's leadership in capacity-building underscores the importance of shaping reforms that deliver tangible benefits to communities.

AFIDEP's contributions included streamlining funding flows, providing best practices from Kenya to strengthen regulatory frameworks in the long run, and enhancing governance structures for primary healthcare facilities

A section of community leaders during the DFF launch in Malawi

Strengthening Financing for Pandemic Preparedness in Africa: Zambia as a Case Study

By Nhlanhla Dhaka

The COVID-19 pandemic exposed a harsh reality: Many countries, especially in Africa, were unprepared for such a global health crisis. Despite early warnings and the virus' rapid spread, the pandemic highlighted significant gaps in health systems worldwide. African countries faced severe challenges due to limited healthcare infrastructure, inadequate funding, and a heavy reliance on external aid.

The COVID-19 Case Study

The World Health Organization (WHO) noted that many African countries struggled with insufficient testing capacities, limited access to medical supplies, and a shortage of healthcare workers. These challenges were exacerbated by the economic strain caused by the pandemic, which further limited the resources available for health interventions.

One of the critical lessons from COVID-19 is the importance of sustainable and robust health financing. The pandemic demonstrated that countries cannot effectively respond to health emergencies without adequate financial resources. This is particularly true for pandemic preparedness and response (PPR), which requires significant investment in surveillance systems, workforce development, and emergency response infrastructure.

The Need for Improved Domestic Financing

A major reason for the lack of preparedness is the insufficient financial allocation to prevent and curb pandemics. Many African countries rely heavily on donor funding, which, while crucial, is often unpredictable and inadequate to meet the comprehensive needs of PPR. For instance, Zambia's health sector depends on donor contributions for 49% of its total health expenditure. This reliance on external funding exposes the health system to volatility and sustainability risks. Funding from the Zambian government remains insufficient, constituting only 44% of overall health financing, with the remaining derived from out-of-pocket payments that burden households. In the specific area of PPR, the situation is even more precarious, with over 70% of PPR funding sourced from donors, highlighting critical vulnerabilities in Zambia's health security infrastructure.

There is a growing recognition of the need for improved domestic financing to address these challenges. By increasing domestic investments in health, countries can build more resilient health systems capable of responding to future pandemics. This approach not only ensures a more stable funding base but also promotes ownership and accountability in health financing.

Historical Commitments to Health Financing

African countries have long struggled with underfunded health systems, a challenge rooted in historical underinvestment, economic constraints, and competing national priorities. This chronic lack of resources has been further exacerbated by ongoing inefficiencies in health service delivery, poor financial management, and systemic waste in the use of limited health budgets. As a result, even the scarce funds that are available often fail to translate into meaningful improvements in healthcare access, quality, and outcomes, leaving millions without the essential services they need. Recognising this critical issue, African leaders have pledged to boost health investments over the years. Notable commitments include the 2001 Abuja Declaration and the 2019 African Leadership Meeting (ALM) Declaration. The ALM Declaration, endorsed by 52 Heads of State of the African Union (AU), has gained significant traction and momentum among member states, reflecting a collective effort to strengthen health systems across the continent.

The Learning Grant

The Financing Surveillance and Pandemics Preparedness and Response (SPPR) project, led by the African Institute for Development Policy (AFIDEP) in partnership with Globesolute, is a six-month learning grant that aims to generate rich insights on pandemic preparedness and readiness – what works, where it works, and how and why it works. This project informs the design and implementation of a longer-term initiative to increase country commitment to sustainable financing of surveillance and PPR. By focusing on evidence generation, high-level diplomacy, and regional engagement, the project builds momentum and support for robust health financing strategies.

As part of the project's interventions, a Health Financing and Pandemic Preparedness Stakeholder Dialogue was held in Zambia in December 2024. This dialogue brought together government representatives, development partners, private sector stakeholders, and civil society organisations to assess progress, identify gaps, and develop actionable health financing and PPR strategies.

Key outcomes included:

- **Commitment to a 10% Annual Budget Increase:** A significant resolution from the dialogue was the joint commitment by parliamentarians and the Ministry of Health (MoH) to a 10% annual progressive budget increase for PPR and surveillance activities, based on the current government allocation to these areas.This financial commitment reflects a shared understanding of the need to prioritise health financing as a cornerstone for building a resilient health system, particularly given that over 70% of PPR funding is presently sourced from donors.
- **Establishing a National Public Health Emergency Fund (NPHEF):** The dialogue underscored the need for a dedicated NPHEF to support PPR activities. This fund mobilises contributions from domestic and international sources, ensuring timely and sustainable financing for critical areas such as surveillance systems, workforce capacity, and emergency response infrastructure. Established robust accountability mechanisms ensure efficient use of resources and build public trust.
- **Technical Assistance Plan (TAP):** The TAP, developed by AFIDEP in collaboration with Globesolute and key national stakeholders, focuses on strengthening Zambia's health financing framework, with a specific emphasis on PPR. The TAP addresses critical gaps, including workforce capacity, supply chain management, and surveillance infrastructure, while ensuring resources are allocated efficiently and sustainably.
- **Enhancing Coordination and Capacity Building:** Stakeholders identified gaps in inter-ministerial collaboration, including poor coordination between the MoH, Ministry of Finance, and sub-national governments; weak communication channels; and the absence of regular multi-stakeholder engagement platforms to align priorities and decision-making. They also emphasised the need for targeted training programmes to strengthen technical expertise within the Ministry of Health and other agencies. This would enhance data collection, analysis, and reporting, enabling more informed and evidence-based decision-making.
- **Monitoring and Accountability:** The dialogue emphasised the importance of establishing robust review mechanisms to monitor progress, enhance accountability, and successfully implement Zambia's health financing and pandemic preparedness objectives. Structured reviews, including a mid-year check-in and an end-of-year evaluation, will allow the government and other stakeholders to track progress, address challenges, and refine strategies.

Charting the Course Ahead

AFIDEP's and Globesolute's SPPR project is a testament to countries' commitment to strengthening health financing and pandemic preparedness. The collaborative efforts among stakeholders are paving the way for sustainable health financing and robust PPR mechanisms. By prioritising surveillance, enhancing coordination, and ensuring accountability, African nations are well-positioned to address future public health challenges and achieve universal health coverage.

AFIDEP
African Institute for Development Policy

Why Africa Needs an Agenda for Gender Data Generation, Translation and Use

Gender data captures the influence of gender on various aspects of life, i.e. health, education, economic participation, and social behaviours. It constitutes sex-disaggregated data and captures the different experiences, roles, and needs of individuals based on gender. It includes both quantative and qualitative data.

African Union

Roadmap for achieving gender equality

1. Agenda 2063
2. Gender Equality and Women's Empowerment (GEWE) Strategy
3. Gender and Youth Observatory

> **Gender data** is critical for **informing priorities and equitable and inclusive policies, programmes and resource allocation decisions** that address gender disparities across various social and economic dimensions and for assessing progress towards gender equality.

In 2015

193 countries Ratified the 2030 Sustainable Development Goals (SDGs)

17 Goals

169 Targets

Key aspiration

- Leave no one behind
- Gender equality
- Social inclusion

As of 2024

Sub-Saharan Africa Progress

15 of the 17 SDGs have stagnated or declined

68.4% Gender gap closed

More than half of the countries in the region have closed **70%** of their gender gap

At the current pace, it will take sub-Saharan Africa 102 years to close the gender gap

To accelerate progress towards achieving the SDGs, **we need equitable and inclusive policies, programmes and investments** informed by the best available evidence including gender data.

However, **there is a lack of comprehensive gender data** needed for informing equitable and inclusive policies, programmes and investments due to systems, organisations and technical capacity constraints.

URGENT

Thus, the need to formulate an agenda for gender data generation, translation and use for Africa.

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Accelerating SDG 3: Proven Interventions for Stronger Maternal and Adolescent Health, Post COVID-19

By Charlotte Chisoni

The COVID-19 pandemic created unprecedented challenges for global health and development, exacerbating inequalities and intensifying vulnerable populations' difficulties. Women, adolescents, and children were disproportionately affected, with disruptions in education, healthcare, and social support systems threatening decades of progress. Although COVID-19 is no longer classified as a Public Health Emergency of International Concern (PHEIC), its impacts continue to be felt, especially in low- and middle-income countries (LMICs). Yet, amidst these challenges, hope emerge through innovative, evidence-informed interventions that can potentially transform lives on a large scale and regain the derailed progress toward achieving Sustainable Development Goals particularly SDG 3 on "Good Health and Well-being".

This article highlights proven strategies that address two critical public health challenges: unintended adolescent pregnancies and maternal mortality. Drawing on evidence from two systematic reviews published in the *BMC Public Health Journal* under the "Putting Countries Back on the Path to Achieving SDGs" project led by the African Institute for Development Policy (AFIDEP), the author explores interventions that have successfully enhanced adolescent and maternal health outcomes. From school-based education programmes that empower young people to make informed choices to community-driven maternal health initiatives that improve service uptake, these research-backed solutions provide a roadmap for policymakers, healthcare professionals, and advocates striving to create more equitable health systems.

Tackling Unintended Adolescent Pregnancies

Each year, an estimated 21 million pregnancies occur among adolescents aged 15–19 in LMICs, with approximately 50% of these being unintended. Many of these pregnancies result in unsafe abortions, while those who carry their pregnancies to term face increased risks of complications, poor maternal and child health outcomes, and economic hardship. Adolescent mothers are more likely to drop out of school, limiting their future opportunities and reinforcing cycles of poverty. Despite the urgent need for sexual and reproductive health (SRH) services, many adolescents struggle to access contraception and counselling due to stigma, discrimination, and restrictive policies.


Photo: Freepik

The COVID-19 pandemic further intensified these challenges by disrupting healthcare systems, restricting movement, and closing schools—one of the strongest protective factors against early pregnancies. The inability to access SRH services and the loss of structured education left many adolescent girls more vulnerable, contributing to increased rates of unintended pregnancies, child marriages, and school dropouts. Without effective interventions, adolescent girls remain at risk of poor health, economic insecurity, and social exclusion. However, research has identified strategies to mitigate these risks and support adolescent reproductive health.

Comprehensive sex education (CSE) is a widely used approach for preventing adolescent pregnancies, providing young people with factual, age-appropriate information on SRH including contraception, sexually transmitted infections (STI) prevention, and healthy relationships. While school-based CSE programmes play an important role in improving SRH knowledge, research highlights that curriculum-based education alone has limited effectiveness in reducing unintended pregnancies unless paired with contraceptive provision and accessible SRH services. To maximise its impact, national governments should integrate comprehensive sexuality education (CSE) into school curricula and ensure that adolescents have access to youth-friendly SRH services alongside education efforts.

Beyond education, skill-building initiatives have proven effective in reinforcing SRH programmes. These interventions, which include teacher-led SRH sessions, interactive learning approaches, and confidence-building exercises, have been associated with improved contraceptive use, delayed sexual initiation, and a stronger understanding of reproductive health. By integrating skill development into adolescent-focused programmes, interventions can become more impactful in reducing unintended pregnancies.

Peer-led interventions are another promising approach. Adolescents often respond more positively to their peers' messages than authority figures, making youth-led SRH education an effective tool. Trained peer educators provide SRH information in schools and communities, facilitating open discussions about contraception, safe sexual practices, and healthy relationships. Some programmes even incorporate peer referrals to youth-friendly health services, bridging knowledge and action gaps. To strengthen and expand these initiatives, community-based organisations (CBOs) and civil society organisations (CSOs) should scale up peer-led programmes, ensuring that adolescents are both the recipients and drivers of SRH knowledge within their communities.

While school-based interventions are essential, they must be complemented by community-based programmes to reach adolescents outside the education system. These initiatives involve parents, community leaders, and local organisations in promoting reproductive health, addressing cultural barriers to contraception, and creating a supportive environment for young people. When SRH education is paired with accessible contraceptive services, adolescents are more likely to make informed choices about their reproductive health.

However, information alone is not enough. Many adolescents face barriers to accessing contraceptives due to stigma, lack of confidentiality, or financial constraints. Programmes that integrate contraceptive access with SRH education are more effective in reducing unintended pregnancies. Ensuring these services are youth-friendly, non-judgmental, and easily accessible—whether through schools, community health centres, or mobile clinics—removes significant barriers to contraceptive uptake. Health ministries and education sectors must prioritise training teachers to deliver sexual and reproductive health education in ways that are accurate, engaging, and responsive to adolescents' needs.

Preventing unintended adolescent pregnancies requires a holistic approach that combines education, skill-building, peer-led programmes, and community support. Schools and health systems must work together to create an environment where adolescents can make informed choices about their reproductive health. Scaling up these proven interventions is key to reducing pregnancy rates and ensuring better health, education, and economic outcomes for young people.

Improving Maternal Health Through Enhanced Healthcare Service Uptake

Maternal mortality remains a major global health challenge, with over 295,000 women dying annually from preventable pregnancy-related complications. Most of these deaths occur in LMICs, where limited healthcare access, socio-economic barriers, and inadequate health infrastructure hinder maternal service utilisation. The COVID-19 pandemic further exacerbated these challenges, straining already fragile health systems and diverting resources away from maternal care. Lockdowns, economic hardship, and healthcare disruptions limited access to antenatal care (ANC), skilled birth attendance, and emergency obstetric services, reversing gains made in reducing maternal deaths. Evidence-informed interventions aimed at increasing healthcare engagement among pregnant women are essential for reducing maternal mortality and improving birth outcomes.

Mobile health interventions have emerged as a game-changer in improving maternal healthcare access, particularly in LMICs, where physical barriers often prevent pregnant women from attending regular ANC visits. Evidence from systematic reviews demonstrates that mobile-based interventions, such as SMS reminders and phone call follow-ups, have significantly improved service utilisation among pregnant women. For instance, evidence from a cluster-randomised controlled trial (cRCT) in Tanzania and Zanzibar found that pregnant women who received mobile health interventions were 2.39 times more likely to complete at least four ANC visits compared to those who did not receive reminders.

Another meta-analysis of three RCTs showed that pregnant women who received SMS reminders were 1.82 times more likely to have skilled birth attendance compared to those in control groups. Additionally, evidence shows that HIV-positive pregnant women who received text message reminders were 66% more likely to attend postnatal care after delivery than those who did not receive reminders. Recognising their success, governments and health ministries should expand mobile health (mHealth) platforms, ensuring that pregnant women receive timely reminders, remote consultations, and continuous support throughout pregnancy and postpartum periods.

Evidence shows that HIV-positive pregnant women who received text message reminders were

66%

more likely to attend postnatal care after delivery than those who did not receive reminders

Active engagement of male partners has also proven effective in improving maternal health outcomes. Programmes that involve men through targeted counselling and education increase their understanding of pregnancy-related risks and encourage them to provide financial and emotional support to their partners. Such involvement has been shown to boost skilled birth attendance (SBA) and retention in antiretroviral therapy (ART) programmes, highlighting the importance of inclusive healthcare approaches. However, passive involvement strategies, such as invitation letters for antenatal care visits, have been less effective, underscoring the need for active engagement of male partners. To fully harness this potential, policymakers should prioritise strategies that actively engage male partners, providing them with education and support to positively influence maternal health outcomes.

Facility-based interventions have played a pivotal role in addressing maternal health challenges, particularly among HIV-positive pregnant women. Integrating antenatal care and ART services within the same facility has removed access barriers, improving maternal ART uptake and retention. National governments and development partners must continue to strengthen integrated healthcare platforms, ensuring that ANC, ART, and maternal services are provided in cohesive, accessible ways to meet the diverse needs of pregnant women.

Similarly, community-based programmes have demonstrated success, with trained community health workers delivering essential antenatal and postnatal care, counselling for postpartum depression, and promoting good infant care practices such as exclusive breastfeeding and hygiene. To enhance the effectiveness of these initiatives, community health workers must be empowered and supported with the training, resources, and systems they need to deliver consistent maternal healthcare outreach, particularly in underserved rural settings.

The evidence underscores the importance of combining these interventions to achieve maximum impact. Mobile health initiatives, male partner engagement, service integration, and community-based efforts create a more supportive and accessible healthcare system for pregnant women throughout their maternal journey.

The findings from these systematic reviews reinforce the urgent need to scale up evidence-informed interventions that address adolescent pregnancies and improve maternal healthcare. As part of efforts to achieve SDG 3—ensuring healthy lives and promoting well-being for all—stakeholders must take decisive action to implement these proven strategies.

Read more in the published systematic reviews:

Mzembe, T., Chikwapulo, V., Kamninga, T. M., et al. (2023). Interventions to enhance healthcare utilisation among pregnant women to reduce maternal mortality in low- and middle-income countries: A review of systematic reviews. *BMC Public Health*, ***23(1)***, 1734. https://doi.org/10.1186/s12889-023-16558-y

Mohamed, S., Chipeta, M. G., Kamninga, T., et al. (2023). Interventions to prevent unintended pregnancies among adolescents: A rapid overview of systematic reviews. *Systematic Reviews*, ***12(1)***, 198. https://doi.org/10.1186/s13643-023-02361-8

Enhancing Maternal and Child Health: The Role of Midwifery in Low- and Middle-Income Countries

Photo: Jonathan Torgovnik/Getty Images/Images of Empowerment

By Ruckia Ibrahim-Nyirenda

Since the turn of the millennium, improving maternal and child health has been a global priority. Reductions in maternal and child mortality were central to the Millennium Development Goals (MDGs) for 2000–2015, and continue to be a key focus under the Sustainable Development Goals (SDGs) for 2015–2030. While significant progress was made between 2000 and 2015, with the global maternal mortality ratio (MMR) decreasing by a third, progress has since stagnated. Today, maternal and newborn deaths remain alarmingly high, with approximately 350,000 women dying annually from pregnancy-related complications—equating to 810 maternal deaths every day, one stillbirth every 16 seconds, and 2.4 million newborn deaths each year. Sub-Saharan Africa bears the highest burden, accounting for 99% of maternal deaths, with an MMR of 525 deaths per 100,000 live births and a neonatal mortality rate of 27 deaths per 1,000 live births.

Despite ongoing efforts, progress in reducing maternal and neonatal mortality has been slow primarily due to inadequate access to skilled healthcare professionals and well-equipped health facilities, especially in low- and middle-income countries (LMICs). Evidence shows that most maternal and newborn deaths could easily be prevented with timely, high-quality care and comprehensive sexual, reproductive, maternal, newborn, and adolescent health (SRMNAH) services. Yet almost one in five women gives birth without assistance from a skilled health provider, and an estimated 20 million women suffer from acute and chronic health complications following childbirth.

The Role of Midwifery in Healthcare Delivery

Midwifery plays a critical role in ensuring quality healthcare for mothers and their children. Evidence from the State of the World's Midwifery (SoWMy) 2021 report highlights that expanding midwife-led interventions could avert up to 40% of maternal and newborn deaths and 26% of stillbirths with just a 25% increase in coverage every five years. Achieving universal midwifery coverage could also prevent 65% of maternal and neonatal deaths, potentially saving 4.3 million lives annually by 2035. However, a significant global shortage persists, with a gap of 1.1 million 'dedicated SRMNAH-equivalent' (DSE) workers – with midwives accounting for 900,000 of this shortfall. To close this gap by 2030, 1.3 million new DSE worker posts—primarily midwives, especially in Africa—need to be created. At the current pace, however, only 0.3 million are expected to be filled, leaving a projected shortage of 1 million DSE workers, including 750,000 midwives, by 2030.

Research from high-income countries demonstrates that midwives play a fundamental role in delivering high-quality, comprehensive SRMNAH services. With their skills and expertise, midwives serve as essential points of contact within communities, providing services such as contraception, comprehensive abortion care, and screening for sexually transmitted infections, human papillomavirus, and intimate partner violence. They also assist with newborn resuscitation, promote breastfeeding, and support infant care. When trained according

to international standards set by the International Confederation of Midwives (ICM), midwives can provide up to 87% of essential childbirth services, significantly reducing maternal and neonatal deaths, stillbirths, and birth-related complications. If adequately trained, sufficiently numerous, and fully integrated into interdisciplinary healthcare teams, midwives could meet around 90% of the global demand for essential SRMNAH interventions.

A Cochrane Systematic Review found that women receiving care from midwives were 21% less likely to experience fetal loss before 24 weeks, 19% less likely to require regional analgesia, 14% less likely to need an instrumental delivery, and 18% less likely to undergo an episiotomy. With family planning included in the comprehensive package of midwifery care, 50–75% of maternal, fetal, and neonatal deaths could be prevented, with an additional 10–20% reduction in all deaths when linked to specialist care. Family planning alone could prevent 57% of all deaths due to reduced fertility and fewer pregnancies. When combined, the full package of midwifery care—incorporating both family planning and maternal and neonatal health interventions—could avert up to 83% of all maternal deaths, stillbirths, and newborn deaths.

The Key to Achieving Health Targets

Scaling up midwifery services, including family planning, as part of a comprehensive package of care could significantly reduce maternal, fetal, and neonatal mortality, especially in resource-constrained settings. The Lives Saved Tool (LiST) from The Lancet Midwifery Series estimated the impact of scaling up midwifery across 78 countries with varying Human Development Index (HDI) classifications. Modest (10%), substantial (25%), or universal (95%) increases in coverage were shown to reduce maternal deaths, stillbirths, and neonatal deaths by 2025 in all countries tested. The model also predicted that increasing coverage of midwifery services by 10% every 5 years could lead to significant reductions in mortality rates. In Group A countries (the lowest HDI), a 10% increase could reduce maternal deaths by 27.4%, while in Group C countries (moderate-to-high HDI), the reduction could reach 62.7%. Similar reductions were seen in stillbirths and neonatal deaths. Achieving 95% coverage could prevent up to 82% of maternal deaths, stillbirths, and neonatal deaths. Additionally, midwifery services can be successfully implemented at any stage of a country's transition to lower maternal and newborn mortality rates.

Despite the well-documented benefits of midwifery, several barriers continue to impede its effective scale-up, particularly in LMICs. An integrative review of midwifery care delivery in these settings highlighted the absence of a standardised model of care, leading to variations in training, certification, and practice standards, compromising service quality. Awareness of midwifery-led care remains low, with 54% of women and their families unable to distinguish midwives from nurses. Additionally, restrictive health policies, cultural norms, traditional birth practices, and financial constraints limit midwives' ability to provide their full scope of care. Overlapping roles among healthcare providers and resistance from medical professionals further challenge their integration into formal health systems.

Conclusion

As the world continues to grapple with high maternal and neonatal mortality rates, investing in midwifery care offers a practical and effective solution. Scaling up midwifery and services can help us move closer to achieving universal access to high-quality comprehensive SRMNAH services, ultimately ensuring that every mother and child has the chance to survive and thrive. In support of global efforts to enhance midwifery care, an ongoing research project on Midwifery Care Models in Kenya and Senegal—led by the African Institute for Development Policy (AFIDEP), Institute for Health Research - Epidemiological Surveillance and Training (IRESSEF), and Exemplars in Global Health programme—aims to identify key factors that can improve midwifery care. The project examines how midwife-led care models have been adapted to local needs and identifies the facilitators and barriers to their effectiveness in reducing maternal and child morbidity and mortality.

Approx.
350,000 women die from pregnancy-related complications

810 daily maternal deaths

1 stillbirths every 16 seconds

2.4 million newborn deaths every year

Photo: Freepik

Universal Health Coverage as a Game-Changer for Women's Economic Empowerment in Kenya

By Josephine Cherotich and Dr Magidu Nyende

Universal health coverage (UHC) represents a significant step forward in ensuring equitable access to quality healthcare for all individuals, without the financial burden that often accompanies medical expenses. In Kenya, where women face multiple socio-economic challenges, including the dual burden of caregiving and economic participation, UHC offers a transformative opportunity to empower women economically. By reducing healthcare costs, improving access to essential medical services, and alleviating the weight of caregiving responsibilities, UHC can unlock new opportunities for women to engage more actively and effectively in the workforce and contribute to the country's broader economic growth.

As in many other African countries, the informal sector remains a major source of employment for women in Kenya, and the absence of employer-sponsored health insurance exacerbates their vulnerability. The lack of comprehensive healthcare coverage means that women often shoulder the burden of out-of-pocket expenses, which compounds their financial instability. The informal sector's lack of social protection and the absence of healthcare benefits highlight the urgent need for inclusive policies that address the specific needs of women, especially in terms of healthcare.

The Economic Challenges Women Face in Healthcare Access

In Kenya, women are particularly vulnerable to economic instability due to limited access to healthcare and social protection. A large proportion of women work in the informal sector, where employment is often irregular, and access to employer-sponsored health insurance is virtually non-existent. In fact, nearly 80% of Kenyan women are employed in the informal sector, making them highly vulnerable to catastrophic healthcare expenditures. When an unexpected illness or health issue arises, the absence of insurance coverage means women must pay out-of-pocket, often depleting their limited resources. According to the World Bank Group, out-of-pocket health expenses account for about 22.77 % of current health expenditure in 2021 in Kenya, which can be a heavy burden on households, particularly those led by women.

Additionally, women in Kenya are typically the primary caregivers in households. They bear the responsibility of caring for sick family members, which often leads to missed economic opportunities and reduced work hours. This caregiving burden also has broader economic consequences, contributing to long-term financial

instability. The 2023 Kenya Time Use Survey reports that Kenyan women dedicate an average of 5 hours per day (18.7% of their time) to unpaid care work, while men spend just 1 hour daily (3.6%) on such tasks. The time spent on caregiving, coupled with the high financial cost of healthcare, limits women's ability to participate fully in the economy and achieve financial independence.

How UHC Empowers Women Economically

UHC can help mitigate the economic challenges women face in healthcare access by providing comprehensive healthcare services that reduce both the direct and indirect economic impacts of illness on their lives. By removing financial barriers and ensuring access to essential services, UHC empowers women to stay healthier, work more consistently, and contribute to their families' and communities' prosperity.

Reducing Financial Barriers to Healthcare

UHC minimises the out-of-pocket expenses associated with seeking medical care, which disproportionately affect women. Without UHC, women are more likely to forego treatment due to cost, exacerbating health conditions that may later demand more intensive and expensive care. By ensuring affordable access to healthcare, UHC reduces financial stress, enabling women to redirect their savings toward education, business investments, and other income-generating activities.

Alleviating Caregiving Burden and Unpaid Labour

In addition to directly improving health outcomes, UHC also addresses the gendered distribution of unpaid care work. In many Kenyan households, women are responsible for caregiving tasks that go uncompensated, whether it's caring for children, elderly parents, or sick family members. This unpaid labour consumes a significant amount of time, often preventing women from pursuing paid work or educational opportunities. UHC helps by ensuring that women can access medical services for their families without having to take on excessive caregiving responsibilities. For example, when family members are able to receive professional medical care, the caregiving load on women is reduced, allowing them more time to focus on their economic activities.

By alleviating the burden of caregiving, UHC can significantly contribute to women's economic independence and empowerment. With fewer caregiving responsibilities to shoulder, women can engage more fully in paid work, education, and entrepreneurial ventures, leading to improved economic outcomes for both individuals and communities.

Increasing Productivity and Workforce Participation

Access to healthcare improves women's overall health, allowing them to remain active participants in the workforce. Chronic illnesses, untreated conditions, or the inability to afford routine checkups often push women out of employment, especially in labour-intensive sectors like agriculture and manufacturing. UHC can reduce absenteeism, improve productivity, and create an environment where women can pursue career advancements, increasing their earning potential and enabling them to achieve long-term financial stability. Furthermore, healthier women are more likely to start businesses and take on leadership roles within organisations, contributing to economic growth.

Promoting Women-Owned Businesses

UHC also creates a safer economic environment for women entrepreneurs. Financial barriers to healthcare often deplete working capital, derail business plans, or force businesses to close when health-related emergencies arise. UHC acts as a safety net by ensuring that women can access healthcare without depleting their savings or causing financial strain on their businesses. By safeguarding their health and providing economic stability, UHC helps women maintain the sustainability and growth of their enterprises. Healthier populations also mean a healthier workforce, which directly benefits women-led businesses that employ others, contributing to both personal and community economic development.

Examples of UHC in Action for Women in Kenya

Kenya has made significant strides toward implementing UHC, with pilot programmes launched in counties such as Kisumu, Nyeri, Machakos, and Isiolo as part of the "Afya Care" initiative. These programmes have demonstrated that accessible and affordable healthcare can dramatically improve women's economic engagement. For example, improved access to maternal healthcare in these regions has eased the financial strain on families, allowing women to focus on income-generating activities, such as small-scale businesses or farming, post-delivery.

Photo: Freepik

In addition, the introduction of community health promoters under UHC programmes has created valuable job opportunities for women. These promoters, often women from local communities, are trained as health educators and service providers, contributing to the delivery of healthcare in rural and underserved areas. These roles not only enhance women's incomes but also elevate their status within their communities, empowering them as leaders and advocates for public health.

The Way Forward: Strengthening UHC for Women's Economic Empowerment

To maximise UHC's potential for women's economic empowerment in Kenya, several strategies need to be adopted:

Invest in Gender-Responsive Health Systems

Strengthening UHC begins with creating health systems that respond effectively to the specific needs of women and girls. This includes expanding access to maternal and reproductive healthcare services, prioritising mental health care tailored to women's experiences, and ensuring widespread availability of contraceptives and family planning services. Gender-sensitive training for healthcare providers can also help address biases and improve the quality of care for women.

Integrate Care Work into Health Policy

Recognising and addressing the link between unpaid care work and health is vital. Policies should integrate services such as childcare, eldercare, and community health programmes to reduce the care burden on women. Accessible and affordable health services can free up time for women, enabling them to participate more actively in the workforce and pursue economic opportunities.

Expand Financial Protections in Healthcare

To alleviate the economic burden of healthcare costs on women, UHC frameworks must include financial protection measures such as subsidies, insurance schemes, and cash transfer programmes targeting low-income households. Reducing out-of-pocket healthcare expenses ensures that women have access to necessary services without falling into financial hardship, thereby enhancing their financial stability.

Strengthen Data Systems for Gender-Sensitive Analysis

Reliable, disaggregated data is critical for designing effective health interventions. Governments and stakeholders should prioritise collecting and analysing gender-specific health data, including time use surveys and health outcomes. This evidence-based approach enables targeted resource allocation and ensures that UHC programmes effectively address women's unique challenges.

Promote Multisectoral Collaboration

Achieving gender-responsive UHC requires collaboration across sectors, including health, education, labour, and social protection. Partnerships between governments, private sector actors, and civil society organisations can drive innovation and resource mobilisation. For example, digital health technologies can improve access to care in remote areas, while vocational programmes can train women for employment in health-related sectors.

Enhance Community Engagement and Awareness

Encouraging women's participation in the design and implementation of health programmes ensures that services are aligned with their needs. Public awareness campaigns about the benefits of UHC, women's health rights, and available services can empower communities to advocate for better healthcare access and accountability.

Conclusion

The work of the African Institute for Development Policy (AFIDEP) on gender equality and equity across Africa, and in Kenya, highlights how gender disparities in healthcare access are deeply intertwined with broader economic challenges faced by women in Africa. Moreover, AFIDEP's research highlights how limited prioritisation of gender considerations within macroeconomic policy frameworks hinders progress toward achieving women's economic empowerment.

There is thus a need to integrate gender-responsive policies in healthcare and social protection frameworks to reduce the economic challenges women face. Gender-responsive healthcare policies are essential for ensuring that women's specific health needs, such as maternal care, are met without the added economic strain of high medical costs. Furthermore, AFIDEP emphasises the need for better data collection and monitoring to understand the gendered impacts of healthcare access and to ensure that policies are designed to address the unique barriers women encounter.

UHC is more than a healthcare initiative; it is a powerful tool for fostering women's economic empowerment. By alleviating financial burdens, improving productivity, reducing caregiving responsibilities, and supporting women entrepreneurs, UHC can unlock untapped potential within Kenya's female population and undoubtedly drive the nation's progress toward a healthier, wealthier, and more inclusive future.

The Human Rights Economy: A Pathway to Advancing Women's Economic Empowerment in Kenya

By Josephine Cherotich and Dr Magidu Nyende

In Kenya, women play a crucial role in the economy, actively contributing to various sectors, particularly agriculture and trade, and working largely in the informal economy. Despite their significant contributions, women face persistent challenges that impede their economic empowerment.

The World Economic Forum's Global Gender Gap Report 2024 ranks Kenya 75th globally with a score of 0.712 in women's economic empowerment, highlighting disparities in labour market participation, earnings, and access to opportunities. Additionally, for the many women work in the informal economy, where work is precarious, wages are low, and benefits like social protection and pensions are absent, their economic security is limited. Balancing domestic responsibilities with employment also reduces women's ability to fully engage in the labour market. These challenges collectively contribute to the gender pay gap and hinder women's ability to achieve economic independence and compete on equal terms with men.

To address these disparities, the Human Rights Economy (HRE) concept provides a promising pathway. The HRE concept emphasises embedding fundamental human rights principles such as equality, non-discrimination, and participation into economic policies and practices. By prioritising social protection, accessible childcare, equal pay, decent work, and expanded access to education and skills development, an HRE framework can create a more inclusive and equitable economic system. This approach would support women's full participation in the economy and help dismantle the structural inequalities that limit their opportunities. Through such measures, Kenya can move toward a more equitable economy, where women's contributions are valued, and their economic empowerment is fully realised.

Core Areas of Focus for Promoting Women's Economic Empowerment Through the Human Rights Economy

To effectively promote women's economic empowerment through the HRE, Kenya must take several actionable steps towards an inclusive and equitable economic system.

Photo: Canva

Social Protection

Social protection plays a critical role in improving women's economic security, especially those working in the informal sector or engaged in unpaid care work. According to Article 43(1e) of the Constitution of Kenya, every individual has the right to social security, obligating the government to extend social protection to vulnerable populations. However, a 2023 review by the International Center for Research on Women (ICRW) found that Kenya's current social protection policies have failed to adequately support informal workers, primarily due to its unregulated nature. Consequently, women working in the informal economy and those in rural areas remain largely marginalised, often lacking protection under labour laws, and are excluded from critical social benefits such as pensions, health insurance, and paid sick leave.

An HRE approach would advocate for comprehensive social security programmes that include unpaid caregivers and women in informal employment. This approach would call for the expansion of social protection systems to encompass more women, particularly those with irregular employment status or no formal contracts. Key measures would include extending unemployment benefits, pensions, and healthcare coverage to women in the informal sector and ensuring equitable access to social security services in all regions, including rural areas. Such interventions would help bridge the gap in access to essential services, improving women's economic resilience and fostering greater economic equality.

Unpaid Care and Domestic Work

A significant portion of care work, including childcare, eldercare, and household chores, is unpaid and remains invisible mainly within the formal economy. According to the 2023 Kenyan Time Use Survey, women spend an average of 277 minutes per day

on unpaid care work, while men spend only 54 minutes on the same tasks. This means that women perform five times more unpaid care work than men daily. Among working individuals, women dedicate about 4 hours per day to unpaid care tasks, compared to 1 hour for men. These disparities reflect deeply rooted gendered cultural norms, insufficient public services and infrastructure, and inadequate social protection policies.

An HRE approach would recognise care work as a vital economic activity contributing to national productivity. Kenya could implement policies such as paid parental leave, which would allow both parents to share childcare responsibilities, promoting gender equality in caregiving. Additionally, the establishment of affordable and accessible childcare services in both urban and rural areas would alleviate the burden on working parents, enabling women to participate more fully in the labour force without the worry of childcare costs or availability. Furthermore, increased investment in the care sector would not only meet essential social needs and create employment opportunities for women, supporting both gender equality and economic growth.

Equal Pay and Decent Work

Women continue to earn less than men for similar work, with the pay gap being particularly pronounced in the informal labour market. A 2023 UN Women report found that women earn 17.7% less than men on an hourly basis and 31.3% less every month. On average, for every KSH100 a man earns, a woman earns only KSH82. Despite efforts to reduce gender inequality, many women still have limited access to decent work, which the International Labour Organization (ILO) defines work that provides fair wages, job security, and a safe working environment.

An HRE approach would advocate for the implementing of fair wage policies to ensure women receive equal pay for equal work. In addition, policies should focus on providing decent work for women in the formal sector by improving job security, offering health benefits, and guaranteeing safe working conditions. Addressing gender-based discrimination in recruitment, promotions, and career development is crucial to ensuring that women have equal access to high-paying jobs and career advancement opportunities. By prioritising workplace gender equality initiatives, Kenya can eliminate systemic barriers that hinder women's career progression and foster a more inclusive and equitable labour market.

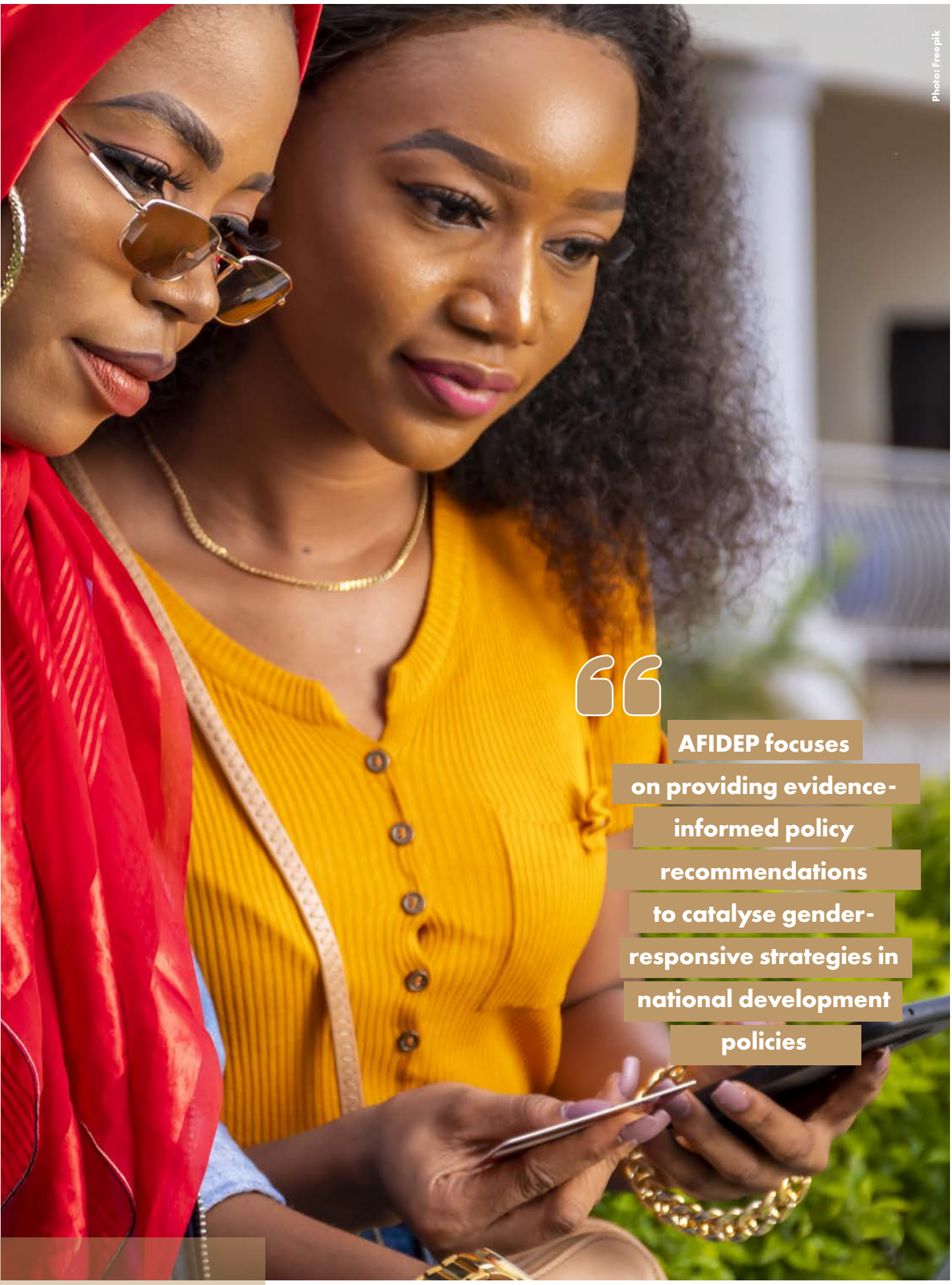
Education and Skills Development

Significant gender disparities persist in education, particularly in access to higher education and vocational training. According to the 2020 statistics by UNICEF, while girls' access to primary education has improved with 84% of girls completing primary school compared to 88% of boys, the gap widens at the secondary education level. Only 42% of girls complete secondary school, while 46% of boys do. Despite progress in gender parity at the primary level, many girls face challenges transitioning to secondary school, especially in rural areas where traditional gender norms, early marriages, and economic constraints limit their educational opportunities. Furthermore, women remain significantly underrepresented in technical and vocational education (TVET) and Science, Technology, Engineering, and Mathematics (STEM) fields. TVET enrolment in Kenya has grown, but women account for only 16% of students in STEM fields. This underrepresentation limits women's access to high-paying and rapidly growing sectors, contributing to persistent gendered economic inequalities.

An HRE approach would address these disparities by prioritising gender-responsive educational policies that ensure equal access to skills development opportunities for both girls and women. HRE would emphasise the importance of STEM education, encouraging girls to pursue careers in high-growth, well-paying industries through initiatives such as targeted scholarships, mentorship programmes, and community outreach. Additionally, an HRE would advocate for expanding vocational training programmes that are affordable, accessible, and tailored to meet the specific needs of women in both urban and rural areas. By tackling barriers such as cultural biases and limited infrastructure, an HRE would ensure that women have the necessary skills and opportunities to enter high-demand sectors, helping close the gender gap in education and economic participation.

Conclusion

An HRE approach offers a robust framework for advancing women's economic empowerment in Kenya by addressing the systemic barriers that women face. AFIDEP focuses on providing evidence-informed policy recommendations to catalyse gender-responsive strategies in national development policies. By focusing on social protection, childcare, equal pay and decent work, and education and skill development, Kenya can create an inclusive economic environment where women can fully participate and thrive. While progress has been made through various government initiatives and policies, much work remains to be done. To achieve true economic empowerment for women, Kenya must continue to prioritise gender equality in all economic policies and ensure that the principles of human rights are fully integrated into the economic fabric of the nation. Moving forward, it is essential to build on existing programmes, expand their reach, and ensure that women, particularly those in the informal economy and rural areas, have the opportunities and protections they need to succeed.



> **AFIDEP focuses on providing evidence-informed policy recommendations to catalyse gender-responsive strategies in national development policies**

Paving New Paths to Women's Empowerment: A Collaborative Approach for Lasting Change

By Charlotte Chisoni

Women's empowerment has long been a focus of major development institutions, such as the United Nations (UN), the World Bank, and the World Health Organization. The UN 2030 Agenda for Sustainable Development prioritises gender equality and women's empowerment as key pathways to promoting human well-being. Women's empowerment broadly refers to expanding women's freedom of choice and action by increasing their control over resources and enhancing their agency in decision-making. This empowerment leads to significant development outcomes, such as improved human capital, poverty reduction, and enhanced self-sufficiency. Despite its central role in the global development agenda, operationalising and evaluating women's empowerment remains a persistent challenge.

While women and girls have made notable social, political, and economic progress, they continue to face systemic marginalisation in homes and communities. Global estimates indicate that 15 million primary school-aged girls are out of school, and women hold only 25 percent of parliamentary seats worldwide. Limited access to education, healthcare, and property exacerbates the risk of poverty for women, making them more reliant on public sector support and more vulnerable to crises such as climate change.

Globally, women are disproportionately affected by poverty. Today, 1 in every 10 women (10.3 percent) is living in extreme poverty. If current trends continue, by 2030 an estimated 342.4 million women and girls—or 8 percent of the global female population—will still be surviving on less than $2.15 a day. The majority of these women, approximately 220.9 million, will reside in sub-Saharan Africa. This stark projection underscores the urgent need for targeted, gender-responsive interventions that address the structural barriers women face and create pathways toward economic independence and well-being.

Crucially, the COVID-19 pandemic has had a profound impact on women's economic empowerment across Africa. Women experienced the greatest share of job losses in hard-hit sectors like hospitality, education, and informal trade—areas where they are overrepresented. According to the Africa Gender Index, women's economic status declined more sharply than men's during the pandemic, exacerbating existing inequalities in income and employment. The economic aftershocks of the pandemic have had lasting consequences, pushing millions of women further into poverty and reducing their resilience to future crises.

Moreover, unpaid care and domestic work remain some of the most significant, yet invisible, barriers to women's economic empowerment. In Africa, women perform nearly three times more unpaid care work than men—a burden that restricts their participation in formal employment, entrepreneurship, and education.

The lack of public investment in care infrastructure, such as childcare and eldercare, further reinforces these inequalities. As long as care work remains undervalued and disproportionately shouldered by women, efforts to close gender gaps in labour markets, leadership, and economic participation will fall short. Recognising, redistributing, and reducing unpaid care work is essential to unlocking women's full economic potential.

Additionally, gender-based violence (GBV) continues to undermine women's rights and economic empowerment. Its effects ripple across women's lives, from deterring girls from completing their education to limiting women's ability to pursue work or start a business. It creates fear, instability, and dependence, undermining women's autonomy and reinforcing cycles of poverty. When women are unable to access education, engage in paid work, or control financial resources due to violence or the threat of it, their potential to contribute to and benefit from economic development is severely constrained. This not only affects individual women but also slows broader progress toward inclusive and sustainable growth.

It is also essential to recognise that women's experience of poverty is not uniform. Many women face additional layers of discrimination due to race, ethnicity, disability, or migration status, a concept known as intersectionality. For example, Indigenous women often face legal and cultural barriers to owning land or accessing formal employment, making it difficult to break the cycle of poverty. Disabled women face additional challenges in accessing healthcare, education, and employment opportunities. Addressing the intersectionality of poverty ensures that empowerment efforts reach women from all backgrounds and effectively address their unique challenges.

Child marriage remains a barrier to women's economic mobility and independence. Although the global rate of child marriage has decreased, it will take until 2092 to completely eradicate the practice at the current pace, perpetuating the cycle of poverty for generations. Early and forced marriages limit girls' access to education and curtail their economic potential, making it harder for them to escape poverty.

Addressing these disparities is not only a moral imperative but also an economic necessity. Women's economic empowerment is essential for achieving the SDGs and fostering sustainable development worldwide. For instance, empowering women farmers in sub-Saharan Africa with equal access to resources could boost agricultural productivity and alleviate food insecurity, benefiting entire communities. Furthermore, closing the gender gap in labour force participation could add as much as $28 trillion to global GDP by 2025.

These efforts also align with SDG 16, which calls for peaceful and inclusive societies by ensuring access to justice and building accountable institutions. In many regions, particularly sub-Saharan Africa, women face a lack of legal protection, weak judicial systems, and exploitative economic practices that perpetuate cycles of poverty and marginalisation. Dismantling these barriers is crucial for achieving gender equality and empowering women to thrive.

Many women face additional layers of discrimination due to race, ethnicity, disability, or migration status, a concept known as intersectionality

Eradicating poverty requires more than economic interventions—it demands a fundamental shift in how institutions operate and how societies perceive those in poverty. The African Programme on Women's Empowerment Research (POWER), administered by the Human Capital Initiative (HCI) at the Boston University's Global Development Policy Center (GDP Center) was founded to facilitate collaborative partnerships across multiple institutions that work on a range of issues related to women's empowerment and well-being in selected countries. Other core partners and member institutions of the POWER consortium include the African Institute of Development Policy (AFIDEP), IDInsight, EconInsight Center for Development Research, and AidData.

POWER conducts rigorous, interdisciplinary research to explore the factors driving women's empowerment and its effects on human well-being. The programme intends to build a body of evidence within three core areas: health and human capital, mobility and access, and sustainable social and economic empowerment. Through this work, POWER aims to establish a foundation of knowledge essential for designing effective empowerment strategies.

The African POWER Consortium will advance these goals across sub-Saharan Africa by fostering collaborative partnerships among institutions focused on women's empowerment, gender equity, and human well-being. The consortium plans to support the formation of new partnerships and strengthen existing ones with organisations working at the forefront of research, policy, and advocacy in the region.

Addressing key challenges in women's empowerment requires multisectoral approaches and engagements that are costly to facilitate within a single institution or organisation. By consolidating efforts across these sectors, the African POWER Consortium will enhance its ability to influence policies and programmes directly, translating research insights into actionable strategies alongside stakeholders.

African Institute for Development Policy
@Afidep
African Institute for Development Policy
AFIDEP
afidep_org

Malawi Office:
3rd Floor, Public Service Pension Fund Building,
Presidential Way, City Centre,
P.O. Box 31024, Lilongwe
Phone: +265 995 495 143

Kenya Office:
6th Floor (Block A), Westcom Point Building,
Mahiga Mairu Avenue, Off Waiyaki Way, Westlands,
P.O. Box 14688-00800, Nairobi
Phone: +254 20 203 9510 | +254 716 002 059

www.afidep.org