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IN THIS ISSUE

Malawi National Population and Development Conference sets country on new course for transformation

Malawi Minister of Finance, Economic Planning and Development, Hon. Goodall Gondwe cuts the ribbon as he officially launches the Malawi demographic dividend study report on 6th September 2016.

By Anthony Mugo & Diana Warira

High levels of poverty and inequality remain a major development challenge in Malawi. This challenge is grave in the rural areas where 85 percent of the country's population lives.

Government efforts to tackle poverty and inequality have seen Malawi's President, Arthur Mutharika, embrace the demographic dividend as a paradigm that can shift the country's socio-economic landscape. The demographic dividend is the economic benefit that arises from a significant increase in the ratio of working-age adults relative to young dependents that results from a decline in birth rates and death rates, if this population age structure is accompanied by human capital development and creation of quality jobs.

As part of furthering the President's commitment, in September 2016, the Ministry of Finance, Economic, Planning and Development (MoFEPD) and the Ministry of Health (Department of Reproductive Health) hosted a National Population and Development Conference in Lilongwe with the theme *Empowering, Educating and Employing Youth to Harness the Demographic Dividend and Achieve Sustainable Development in Malawi.* The conference explored how Malawi can tap into its large youthful population to reap a demographic dividend.

The 3-day event converged experts drawn from government departments, academia, research institutions, civil society, and the media. A key highlight of the Conference was the launch of a study report on Malawi's prospects for harnessing a sizeable demographic dividend. The report titled *Harnessing the Demographic Dividend to Accelerate Socio-economic*

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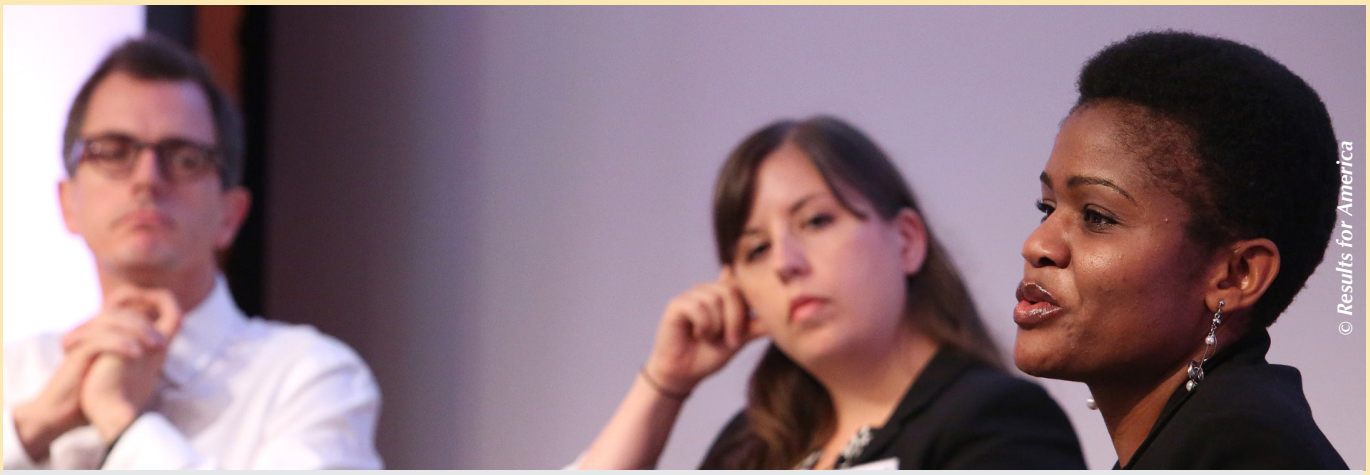
Editorial Team: Anthony Mugo | Bernard Onyango | Evans Chumo | Diana Warira | Joyce Ntaliwa | Marjory Githure | Martin Atela | Violet Murunga | Rose Oronje

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

Putting evidence at the heart of development: AFIDEP shares



Dr. Rose Oronje, Director, Science Communications and Evidence Uptake, speaks during a session at the What Works 2016 Global Summit in London.

By Diana Warira

The role of evidence in policymaking is increasingly becoming an integral part of global development conversations. AFIDEP experts have been part of these conversations, drawing from experiences and lessons learned from implementation of various programmes in African countries. Dr. Rose Oronje, Director, Science Communications and Evidence Uptake, and Dr. Abiba Longwe-Ngwira, Knowledge Translation Scientist, participated at the Evidence 2016 Conference organised by the Africa Evidence Network at the University of Johannesburg, South Africa. During the Conference, which took place on 20th to 22nd September 2016, Dr. Oronje shared lessons on how training could be made more effective as an intervention for building capacity for evidence use, drawing on experiences from Kenya and Malawi. Dr. Longwe-Ngwira, on the other hand, presented about the evidence-informed decision-making landscape in the health sector in Malawi and its implications for evidence use.

AFIDEP also had an opportunity to engage with other experts at the What Works Global Summit 2016, which took place from 26th to 28th September in London, United Kingdom.

The Summit brought together development experts, policymakers and researchers from around the

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Malawi National Population and Development Conference sets

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AFIDEP Executive Director, Dr. Eliya Zulu speaking during the Conference in September 2016.

Transformation and Economic Development in Malawi, detailed the findings of a study conducted by the government with technical support from AFIDEP and financial support from UNFPA Malawi.

In his keynote address, Dr. Eliya Zulu, AFIDEP's Executive Director, stated that Malawi's population is youthful, with young people aged below 35 years constituting 80 percent of the population.

According to Dr. Zulu, this scenario presents a unique opportunity to harness a demographic dividend and therefore potentially propel the country to upper middle-income status by 2054.

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lessons in global conversations

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world to share experiences about promoting policy uptake and measuring impact, knowledge translation, and uses of evidence.

Focusing on Kenya and Malawi, Dr. Oronje discussed the challenges poor countries in sub-Saharan Africa face in their attempts to translate research into evidence, and why these countries' efforts are bearing little results. Dr. Oronje also led a panel session entitled *Strengthening capacity to use research evidence in health policy decision-making: Lessons and reflections from Kenya and Malawi*. Other panelists included Dr. Damson Kathyola from the Malawi Ministry of Health and Hon. Dr. Susan Musyoka, a Kenyan Member of Parliament, and the Chairperson of the Kenya Parliamentary Caucus on Evidence-Informed Decision-Making (PC-EIDM), which advocates for the use of evidence in oversight and decision-making among the Members of Parliament and other arms of Government.

The Summit was organised by the Campbell Collaboration, International Initiative for Impact Evaluation (3ie), Sense about Science, and the Center for Evidence and Social Innovation.

In addition, AFIDEP's Executive Director, Dr. Eliya Zulu and Dr. Oronje participated as panelists on two different panels at the Evidence Works 2016: A Global Forum for Government held in London between 29th and 30th September.

The forum, organised by Results for All (an initiative of Results America) and Nesta (a UK-based charity foundation), presented an opportunity for senior government officials to engage in dialogue and exchange ideas on the practicality of evidence-informed policymaking. Dr. Oronje was a panelist on a session discussing lessons from sub-Saharan Africa on building a culture of evidence, while Dr. Zulu's session discussed efforts and lessons for better accountability and outcomes. During the meeting, policymakers discussed the policies and practices governments around the world are putting in place to promote the use of evidence and data in policymaking to improve outcomes for citizens and communities.

Poor countries need evidence more

Speaking at the sidelines of the Evidence Works forum, Dr. Zulu noted that evidence is important, more so for poor countries because it is critical to ensure the limited resources available are giving the best value for money. "Sometimes people tend to say that developing countries like [those] in Africa are too poor to invest in evidence and data. [On the contrary], the fact that African countries are poor, they cannot afford not to use data," he said.

Dr. Zulu went on to note that the use of evidence in making development decisions helps reduce subjectivity when setting development priorities. "[Evidence] helps you understand what are the most critical issues that you should focus on, and choose the right interventions," he concluded. This high-level gathering, which provided a forum for sharing country experiences of what works in promoting the use of evidence in decision-making, brought together senior leaders from governments, non-governmental organisations, and funding agencies from across the world to share examples of how governments are building capacity to support evidence-informed policymaking, and to encourage transnational collaborations.

country on new course for transformation

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Dr. Zulu, however, cautioned that earning a demographic dividend is not automatic. For this socio-economic transformation to be realised, Malawi has to make deliberate efforts through simultaneous investments in the five pillars or "wheels" of the demographic dividend namely: family planning, economic reforms and job creation, health, education and good governance. "As Malawi works to develop its next development strategy, it will be important that this strategy is aligned with the sustainable development goals (SGDs), particularly SGD 4, which not only emphasizes education for all, but education that is transformative, innovative and well-rounded to ensure learners acquire the skills needed to make them employable and productive adults," he said. Dr. Zulu added that the SDGs are indeed a 'demographic dividend framework.'

Speaking at the Conference opening, Malawi's Finance Minister, Goodall Gondwe, agreed that the country's high fertility rate, currently at about 4.4 births per woman, had derailed development efforts by overstretching public resources. During the Conference closing, Malawi's Health Minister, Dr. Peter Kumpalume, stated that the government is committed to increasing access to family planning services in order to address the existing unmet need particularly among young people, who constitute the majority of the population. Family planning became the centre of conversations throughout the Conference, largely due to the fact that high fertility and the consequent high population growth rate and high child dependency burden is a major impediment to Malawi's development.

The Conference ended with the adoption of a Communiqué that called for the establishment and equipping of a multi-disciplinary cross-sectoral National Population Council; the development and operationalisation of a Demographic Dividend Report Action Plan for the 2017 African Summit; and the extensive dissemination of findings of the demographic dividend report within Malawi.

It is hoped that with the findings of the demographic dividend study report and the establishment of a framework for implementation of the recommendations, Malawi will begin a new path towards socio-economic change that will pull millions of its people out of poverty.

Harmful traditional practices and their impact on adolescent sex


Ms. Violet Murunga

The negative effect of harmful traditional practices on the sexual and reproductive health and rights of girls and women is well documented. In Kenya, such practices include: early marriage, female genital mutilation (FGM), and sexual and gender-based violence. While there has been a reduction in the incidence of these practices, they are still widely practiced in some communities and remain major barriers to improving the health and wellbeing of girls and women in Kenya.

The 2014 Kenya Demographic and Health Survey (KDHS) reported that the national median age at first marriage among women aged 25-49 is 20 years. This means that half of women in Kenya marry by this age. However, in 13 of 47 counties, 1 in every 2 women marry before age 19 years. In addition, one in ten girls aged 15-19 in Kenya has undergone circumcision. However, 12 counties have higher rates of female circumcision ranging from 17 percent to 99 percent.

To further understand the nature of harmful traditional practices, their prevalence in Kenya and the interventions that have been implemented to curb their presence, we speak with Ms. Violet Murunga, a Senior Knowledge Translation Officer at AFIDEP.

By Evans Chumo

What are harmful traditional practices (in the context of sexual and reproductive health)?

These are activities stemming from deeply entrenched discriminatory views about the role and position of women and girls in society that result in unequal power relations between men and women, relegating women to an inferior position relative to men.

Other than what can be deduced from this definition, what is the larger concern about harmful traditional practices?

Harmful traditional practices legitimise and perpetuate various forms of violence against women including FGM, forced feeding of women to make them [visually] pleasing to men, early marriage, the various taboos or practices that prevent women from controlling their own fertility, son preference, female infanticide, early pregnancy and bride price, among others. The outcome is that women often fail to achieve their full potential as productive members of society because these discriminatory views and harmful practices result in their unequal access to education, healthcare, economic opportunities and leadership positions.

Which are the main forms of harmful traditional practices in Kenya?

FGM; early marriage, various taboos or practices which prevent women from controlling their own fertility, early pregnancy, son preference, and dowry price, although national advocacy efforts do not necessarily define all these practices as 'harmful' per se but rather obstacles to women's progression in society. FGM and early marriage are considered as 'harmful' alongside the emotional, sexual and physical abuse of women and girls, which are defined as sexual and gender-based violence. National advocacy efforts therefore mainly focus on eliminating FGM, early marriage and sexual and gender-based violence as well as promoting girls' and women's equal access to education, healthcare and economic opportunities, and promoting their sexual health and rights.

What is the prevalence of these practices and their effects in Kenya?

Reporting on harmful traditional practices is limited to FGM, early marriage and sexual and gender-based violence. According to the 2014 (KDHS), early marriage has declined over the past two decades. Between 1993 and 2014, the proportion of women who married at age 15 declined from 13 percent to 8 percent and those who married at age 18 declined from 41 percent to 29 percent. However, in a few counties, namely, Migori, Tana River and Homa Bay, marriage below age 18 is still common with half of women aged 25-49 years marrying by age 17. Similarly, despite a decline in FGM over the past two decades, still 1 in 10 (12 percent) girls aged 15-19 in Kenya have undergone circumcision with significant variations at sub-national level. FGM is rampant in some counties and not in others. Twelve counties have FGM rates above the national average and of these, FGM is nearly universal in three counties namely Nyamira (78 percent), Kisii (84 percent) and Garissa (99 percent). The 2014 KDHS also indicates that more girls than boys experience sexual violence (6.5 percent of girls compared to 2.7 percent of boys aged 15-19 years). While this signifies a decline of almost 50 percent from what was recorded in the 2008/09 KDHS, it remains a key issue of concern.

> "FGM is nearly universal in three counties namely Nyamira (78 percent), Kisii (84 percent) and Garissa (99 percent)."

What are the most effective interventions in curbing these harmful practices?

When you look at evidence on effective interventions for curbing harmful traditional practices, the strongest evidence suggests that integration of gender perspectives into education at all levels would have far reaching effects on reducing all kinds of harmful traditional practices.

In addition, it is likely to be cost-effective even though this aspect of the evidence unclear. But the fact that education as a social service is widely available in Kenya, it is safe to say that this is a low hanging fruit the country could easily leverage on. Notably, Kenya is in the process of reforming

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xual and reproductive health in Kenya: What's the way out?

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its basic education curriculum, which offers a great opportunity for this intervention to be incorporated. Interventions being implemented by groups such as Forum for African Women Educationalists (FAWE) are illustrating the benefits of improving access to gender-responsive education for girls from communities where FGM and early marriage are common.

In addition, there have been some targeted interventions for communities that practice FGM, which, while they have not yet been proven effective, show promise of effectiveness. Most of the promising interventions have largely engaged religious and community leaders, who are influential in shaping the beliefs and norms related to the practice, and some positive outcomes have been illustrated.

What difficulties have been experienced in the delivery of these interventions?

Deeply-rooted beliefs and norms are a major challenge and these need to be transformed in order for change to occur. Changing behavior is difficult. When behavior is rooted in a cultural belief it is nearly impossible to change, although, based on the evidence, improving access to gender-responsive education for girls and women from such communities is probably the most sustainable approach and the one that would have the greatest impact. In addition, educating religious leaders, boys and men in these communities on the need to eradicate harmful traditional practices is also critical for the success of these interventions.

What opportunities would you say the 2015 National Adolescent Sexual and Reproductive Health (ASRH) Policy presents in the fight against harmful traditional practices in Kenya?

The policy has five principles, the first of which is the respect for human rights and fundamental freedoms including the right to life, human dignity, equality and freedom from discrimination on the basis of gender, sex, age, disability, health status, geographical location or social, cultural and religious beliefs and practices. This offers a great basis with which to be able to intensify efforts to eliminate harmful traditional practices. Another key principle of the policy is to use evidence-based interventions and programming, which means that we can look forward to more effective interventions being adopted and scaled up. The policy also has five broad objectives, one of which aims to increase gender equity and equality in sexual and reproductive health amongst adolescents. Finally and most importantly, reduction of harmful traditional practices is one of the priority focus areas of the policy.

Implications of new WHO antenatal care guidelines on maternal mortality

Increasing antenatal care visits should be a welcome move in Kenya where maternal and neonatal deaths remain unacceptably high.

By Eunice Mueni

On 7th November 2016, the World Health Organization (WHO) released new guidelines on access to antenatal care for pregnant women. The revision was necessitated by the persistently high maternal deaths globally, particularly in developing countries, where deaths are still 14 times higher than in developed regions.

The WHO recommended increasing antenatal care visits from the current four to eight fundamental visits to ensure a continuum of care during pregnancy, labour and delivery, and also in the postnatal period.

The previous four-visit model (focused only on antenatal care) was adopted by WHO in 2002, and has been in use since then, providing goal-oriented and targeted care aimed at increasing the detection and management of complications during pregnancy.

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From humble beginnings to an agenda-setting African think tank

By Hleziwe Hara

At six years since inception, AFIDEP boasts a professionally diverse staff with offices in Kenya and Malawi. The story of how the Institute was born is best told by the Executive Director and founder, Dr. Eliya Zulu, "AFIDEP originally started in 2009, but it took about a year to get it registered, and this process was being [undertaken] from my garage. Yes, I turned my home garage into an office. The registration finally happened in August 2010, after which we moved to an office at the Royal Office Suites in Westlands, Nairobi, measuring 650 sq. feet and started hiring people."

Dr. Zulu notes that the office was so small and we still needed to have a conference room within this space, and so the conference room was even smaller! For about three years, we operated from this constraining space, until 2014 when an opportunity opened to expand our office space. We acquired more space within the same building, which enabled us to meet our staffing needs at the time. In two years, this space also proved to be inadequate and the Institute eventually relocated in late 2016 to the current office space of 5,100 sq. feet at Westcom Point in Westlands.

The Malawi office was opened in 2013, also in a considerably small office in Lilongwe. In 2016, the Malawi office also relocated to a bigger office space in Lilongwe.

The 2016 office moves for both Nairobi and Lilongwe offices is a major milestone for the Institute considering the humble beginnings. The new locations provide adequate space for the Institute's growth for the next 5-10 years. >> **Continued on pg. 7**

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Implications of new WHO antenatal care guidelines on maternal mortality

WHO's decision was informed by growing evidence that shows that a higher frequency of antenatal contacts with the health system is associated with a reduced likelihood of stillbirths. A minimum of eight contacts for antenatal care can reduce perinatal deaths by up to 8 per 1000 births when compared to a minimum of four visits.

Under the new guidelines, the first visit is recommended at 12 weeks of gestation, with subsequent visits at 20, 24, 28, 32, 36, 38 and 40 weeks of gestation. The new guidelines also provide details on the care that should be provided during each of the eight visits. Under the previous focused antenatal care model, the first visit was recommended at 16 weeks, the second at 24 to 28 weeks of gestation, and the 3rd and 4th visits were at 32 weeks and at 36 weeks of gestation.

The release of the new guidelines is a step towards implementation of the Sustainable Development Goals (SDGs). Goal three aims at reducing global maternal mortality ratio to less than 70 per 100,000 live births, and reducing neonatal mortality to at least as low as 12 per 1,000 live births by 2030.

Increasing antenatal care visits should thus be a welcome move in Kenya where maternal and neonatal deaths remain unacceptably high. Frequent visits provide a critical opportunity for health providers to deliver care, support and information to pregnant women, and identify and prevent adverse pregnancy outcomes.

According to the Kenya Demographic and Health Survey (KDHS) 2014, the average national maternal mortality ratio was 362 deaths per 100,000 live births, a decrease from 488 per 100,000 in 2008. In other words, for every 1,000 live births, approximately four women die during pregnancy, childbirth, or following childbirth.

In addition, the deaths that occur in the first month of life contribute to nearly half (42 percent) of all deaths occurring among children aged less than 5 years. The irony is that almost all these deaths are entirely preventable given proper medical surveillance and intervention.

However, Kenya and other developing countries have struggled to effectively implement the four-visit program. The question thus becomes: will the new

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Views from staff regarding the move

> I joined AFIDEP in October 2010, as a consultant and used to work from home as there was no formal office set up. I came in at a time when AFIDEP was looking to conduct systematic reviews which is my specialty. We were about five employees overall which is a great difference compared to the current number of about 22, in only 6 years. I found the commitment and dedication from the team to be encouraging and this shows how far the institution has come. The move to these new offices is therefore quite an achievement.
>
> Eunice Mueni
> Knowledge Translation Officer

> The new office provides a more conducive environment for staff and for our work. It also provides enhanced security since access to the office is controlled by finger imaging. We thank the Board [of Directors] for support in approving resources that facilitated this relocation.
>
> Alphonce Werah, Finance and Administration Manager and a member of AFIDEP's Senior Management Team

> The move is good, the new offices are more spacious and located in a good environment. When you look through the windows you get to enjoy the view.
>
> Abiba Longwe-Ngwira
> Knowledge Translation Scientist

> When I joined AFIDEP in early 2014, it was a very small organisation with a handful of employees. The growth to date has been phenomenal and has happened within a short period of time from 10 employees (both in Kenya and Malawi) to the current 22. That's double growth! There have been major developments in terms of the number of technical staff, as we started with only 4 PhD-holders and now we have about 8. Additionally, the projects and thematic focus of the organisation have grown immensely, which is indicative of visionary leadership. We are now in a bigger office space which provides a better working environment.
>
> Martin Atela
> Knowledge Translation Scientist

> I joined AFIDEP when the Institute had just set-up a small office at the Royal Offices in Westlands [Nairobi]. In my view, AFIDEP had a solid vision and mission that aligned perfectly with my career goals and that is what mattered most to me. The Institute offered me a platform to contribute to the science on the role of research evidence in decision-making processes and how to enhance it. From the time I joined AFIDEP, I have witnessed the Institute grow not only in terms of its physical space, institutional systems but also in its national, regional and international visibility in the research uptake and practice space. When I talk to people about AFIDEP and the work we focus on, they are often surprised at how quickly we have grown in terms of visibility given our relatively small staff size. Moving to the new location is the icing on the cake that builds upon many major milestones that AFIDEP has managed to achieve over the past 6 years.
>
> Violet Murunga
> Senior Knowledge Translation Officer

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eight-visit program be feasible? The 2014 KDHS showed that slightly more than half (58 percent) of pregnant women made four or more antenatal care visits during their pregnancy, an increase from 47 percent since the 2008-09 KDHS. In the North Eastern region, which has the highest maternal and neonatal mortality rates, only about one in every three women (37 percent) made four visits, compared with over 50 percent in the other regions. North Eastern counties recorded the highest maternal mortality ratios, at 3,795 deaths per 100,000 live births in Mandera, 1,683 in Wajir, 1,594 in Turkana and 1,127 in Marsabit. Indeed, 98.7 percent of the total maternal deaths in the country occur in only 15 out of 47 counties, most of them in the northern and coastal parts of the country. Increasing antenatal visits is bound to reduce maternal deaths, because it will increase contact between health workers and pregnant women. But what will make the eight-visit model work where the four-visit model has failed?

While there are obvious benefits of increasing antenatal visits, implementing the new guidelines is going to be much more difficult to achieve given current resource constraints. There is therefore need for careful considerations of the extra challenge the new guidelines pose and to understand the implications on the resources needed including among others: human resources, infrastructure, and equipment.

Given the sub-national disparity and inequity in access to critical health services and in health outcomes, it makes sense for the Kenyan government to prioritise the 15 counties accounting for most maternal deaths in implementing this new guideline.

PROGRAMME UPDATES

Furthering the demographic dividend agenda across Africa: AFIDEP's country engagements

In the last half of 2016, AFIDEP conducted workshops in Botswana, Namibia, Swaziland and Zimbabwe with country teams from the government and local universities to assess the countries' prospects for harnessing a demographic dividend.

By Diana Warira and Eunice Mueni

AFIDEP, in collaboration with the Development Policy Research Unit (DPRU) of the University of Cape Town, is providing technical support to demographic dividend studies in the Southern African region.

The studies, which are employing the National Transfer Accounts (NTA) approach, are being implemented in Botswana, Namibia, Swaziland and Zimbabwe with support from the respective UNFPA country offices and UNFPA East and Southern Africa Regional Office (ESARO). Government and UNFPA representatives in each country have indicated that the studies are happening at an opportune time to contribute to the countries' development planning, and results will be valuable in addressing the challenges facing the population, particularly the youth.

In the last half of 2016, AFIDEP conducted workshops in Botswana, Namibia, Swaziland and Zimbabwe with country teams from the government and local universities to assess the countries' prospects for harnessing a demographic dividend as well as identify priority policy and programme options that the countries should adopt to optimise their demographic dividend in line with their development aspirations.

In Botswana, the workshop was conducted on 22nd and 24th November 2016, and was attended by participants drawn from the National Statistical Office, the Ministries of Health, Labour, and Agriculture. In Namibia, the workshop took place on 13th to 16th December 2016, presided over by the Deputy Permanent Secretary, Ministry of Economic Planning, and attended by the UNFPA Country Representative for Namibia; representatives from Government ministries of health, labour and agriculture, education, youth, gender, trade, and officials drawn from National Statistical Office, Namibia University of Science and Technology, and University of Namibia.

In Swaziland, the workshop was conducted on 25th to 27th October 2016, and presided over by the Acting Principal Secretary, Ministry of Economic Planning and Development. Workshop participants were drawn from the National Statistical Office, Ministry of Health, Ministry of Education, Ministry of Labour, Ministry of Agriculture, and UNFPA.

In Zimbabwe, the workshop was conducted from 28th November to 2nd December 2016. The workshops were facilitated by AFIDEP's Dr. Bernard Onyango (Knowledge Translation Scientist), Dr. Grace Kumchulesi (Knowledge Translation Scientist), and Ms. Eunice Mueni (Knowledge Translation Officer), in collaboration with colleagues from the University of Cape Town.

AFIDEP initiates work to generate evidence for improvement of education in Africa

By Anthony Mugo and Jackline Nyerere

As part of implementation of its mandate along the broader theme of population change and sustainable development, AFIDEP initiated groundbreaking work in education and skills development in a number of African countries in 2016. The aim was to begin generating evidence to inform thinking and policies to incorporate 'transferable skills' into secondary schools and technical and vocational education training (TVET) institutions on one part, and to improve the quality of education from early childhood through to tertiary levels, on the other.

'Transferable skills' are higher order cognitive and non-cognitive skills that individuals can use to be successful across different situations in work and life. Examples include critical thinking, communication, problem solving, people and team skills.

Inculcation of transferable skills has been found to significantly boost the employability of young people, an outcome that is critically needed on a continent where the youth constitute the majority of the population, but experience unacceptably high levels of unemployment. Yet, having gainfully employed youth is vital in enabling countries to tap into their potential to generate wealth to levels that can boost national savings, while lowering the high dependency burden experienced across most sub-Saharan Africa countries. >> **Continued on pg. 10**

PROGRAMME UPDATES

Capacity-building for evidence uptake: Progress and updates

As the implementation of the SECURE Health (Strengthening Capacity to Use Research Evidence in Health Policy) programme draws to an end in January 2017, we share below some updates of programme activities. The SECURE Health programme, initiated in November 2013, sought to optimise individual and institutional capacity in accessing and utilising health research evidence in decision-making in Kenya and Malawi.

By Marjory Githure

Kenya and Malawi parliament staff share lessons with colleagues on mechanisms for improving evidence use

Four parliament staff from Kenya and Malawi, who benefited from a fellowship programme on better evidence use in the UK parliament through the Parliamentary Office of Science and Technology (POST), conducted learning workshops for colleagues upon their return. The workshops discussed some best practices learned from the UK in institutionalising the use of evidence in decision-making in their parliaments. These included, among others, the need for functional intranet or internal online platforms that enable real-time and better exchange of information among staff and members of parliament, and existence of peer-support in improving the quality of evidence briefs provided to members of parliament.

Studying the role of evidence in actual decision-making in the health sector in Kenya and Malawi

As part of strengthening capacity for evidence use, the programme also continued to implement a prospective policy analysis study to understand the role of evidence in ongoing policy development processes in Kenya and Malawi's the health ministries. This study is a follow-up to retrospective studies conducted in 2015 to understand the role of evidence in past policy development processes in the health ministries. The policy development processes being tracked in Kenya are the development of the Research for Health Policy and Priorities, and the Health Financing Strategy, and in Malawi are the development of the Sexual and Reproductive Health and Rights (SRHR) and Quality Management Policy. The findings of this study will be discussed by top officials of health ministries in both countries to provide lessons for enhancing and supporting better and increased use or consideration of evidence in health policy development.

Kenya and Malawi Ministries of Health and Parliament adopt Guidelines for Evidence Use in Decision-Making

In most of 2014 and 2015, the SECURE Health programme worked with the health ministries and parliaments in Kenya and Malawi to develop guidelines for evidence use. This was in response to the gap identified by these agencies on lacking guidance on evidence use. In late 2016, the four institutions adopted the developed guidelines, and committed to institutionalising these guidelines to ensure they ultimately improve the use of evidence within the decision-making processes within these institutions.

Graduation of Health Ministry and Parliament Staff Trained in Evidence-Informed Decision-Making in Kenya and Malawi

In 2014 and 2015, we developed a comprehensive training curriculum for evidence-informed decision-making and used it to train more than 80 technical staff in the health ministry and parliament in Kenya and Malawi. The training workshops, conducted in 2015, were then followed by a one-year on-the-job support and mentorship to each of the trained staff. One of the deliverables of the training and mentorship programme was development of a policy brief. The staff have now graduated in late 2016 and disseminated their policy briefs to the relevant top officials within their institutions.

Conducting end-line survey to assess the programme's impact

To assess the impact of the SECURE Health programme, we are currently conducting an end-line survey to compare with the results of the baseline survey conducted at the start of the programme.

September - December 2016 - In Pictures

Kenya Ministry of Health participants of the SECURE Health EIPM training programme pose after their graduation.

Dr. Ferdinand Okwaro and Hleziwe Hara cut the cake at AFIDEP's office warming party in November as Paul Mwendwa, the office Information Technology (IT) attaché, looks on.

Stakeholders during the revision of the Adolescent Sexual and Reproductive (ASRH) survey tool in October seeking to include information about 10-year-old girls.

AFIDEP Executive Director, Dr. Eliya Zulu (left) speaks during a visit by Sarah Lucas' (right) visit in October. Sarah is a Program Officer, Global Development and Population at the William and Flora Hewlett Foundation.

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AFIDEP initiates work to generate evidence for improvement of education in Africa

In 2016, AFIDEP conducted a four-country case study on Transferable Skills in Secondary and TVET education in sub-Saharan Africa. The case study, which focused on four countries, Rwanda, Nigeria, Kenya and Tanzania, established several clear benefits of integrating transferable skills into formal education and TVET, including: improved employability; increased propensity towards entrepreneurship (both trainers and trainees) as seen in the case of Rwanda; mindset change and; improved enrolment in TVET institutions as observed in the case of Kenya where demand for these programme was historically low. The MasterCard Foundation commissioned the study.

Still in 2016, AFIDEP conducted another study, which was a Field Scan on Education Sector Priorities and Initiatives to Improve Quality of Secondary Education in East and Southern Africa. This study was conducted in four countries, namely Kenya, Malawi, Tanzania, and Uganda. The scan established priority areas common in all the study countries as including: enhancing public prioritisation and funding of quality secondary education; enhancing coordination, regulation and oversight of public and non-public players in education; comprehensive reform and enhancement of the teaching workforce and teaching environment; review and operationalisation of quality oriented secondary school curriculums; and enhancing learning on "what works" to improve quality of secondary education. Both studies were commissioned by the MasterCard Foundation.

AFIDEP members of staff pose for a group picture with the AFIDEP Board of Directors. The Directors had made a visit to the new AFIDEP Nairobi office.

AFIDEP's Board of Directors in discussions during their last Board meeting for the year 2016 in Nairobi.

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Population stakeholders in Kenya reiterate value of investing in 10-year-old girls

Kenya has a raft of policies, but their implementation is limited

Like many other African countries, Kenya has a raft of policies, but their implementation is limited. The government needs to make deliberate investments in implementing existing policies. Stakeholders in population and development need to work collaboratively with the government in order to bridge the glaring policy-to-action gap.

According to Violet Murunga, AFIDEP's Senior Knowledge Translation Officer, studies show that certain interventions can be easily adopted and implemented in various counties across Kenya to curb challenges facing adolescents in general. For instance, cash transfers for poor families have been found to be an effective way of keeping girls in school. In addition, self-defense programmes and improvement of street lighting in slum areas have been found to be effective in reducing the incidence of sexual assault against girls. Further, Ms. Murunga alluded to the need for stakeholders to undertake longitudinal studies that can evaluate the impact of current interventions on the long-term wellbeing of girls in their adult life.

Ms. Murunga also pointed out other opportunities that exist for Kenya as including adopting the religious-based approach to dealing with FGM vice; a critical look at the comprehensive sexuality education (CSE) curriculum in order to ensure a wide range of gender issues are properly integrated; and formulation of effective strategies to deal with drug and substance abuse among adolescents. Ms. Murunga also called upon the government to ensure proper governance and accountability so funds set aside for programmes are well utilised. In addition, she noted that women need access to financial opportunities such as mortgages and education scholarships so tthey can take better care of themselves. This will have a trickle-down effect on the wellbeing of their children, particularly the girl child.

Population stakeholders in Kenya reiterate value of investing in 10-year-old girls

10-year-old girls from Mathare North Primary School perform a dance during the State of World Population Report launch in Nairobi on 1st November 2016.

By Diana Warira

On 1st November 2016, stakeholders in population and development convened at a forum to reflect on the health and wellbeing of the 10 year-old girl during the launch of the 2016 State of World Population Report. The launch, held at the Silver Springs Hotel in Nairobi, came at a time when Kenya is refocusing strategies to propel the country towards attainment of Vision 2030 and the sustainable development goals (SDGs). The launch was led by the National Council for Population and Development (NCPD) and the United Nations Population Fund (UNFPA) in collaboration with the African Institute for Development Policy (AFIDEP) and other stakeholders.

The launch was officiated by the Principal Secretary, the State Department for Planning and Statistics, Mr. Saitoti Torome. Mr. Torome noted that educating the girl child is critical in overcoming challenges facing adolescents and youth in Kenya. He noted that the government is making deliberate efforts to ensure women in vulnerable areas of the country are not left behind.

"Education empowers women and opens up opportunities for them to succeed in life. An educated woman is also better placed to make decisions regarding her household and children's upbringing," he said.

Further, Mr. Torome emphasised that the government is placing extra value on the use of statistics for planning. "When we use evidence for planning, then we make better decisions," he noted. Mr. Torome pointed that such a strategy would ensure the government singles out the counties where challenges facing adolescents are rife and therefore craft more effective county-specific programmes and interventions.

Dr. Josephine Kibaru-Mbae, the Director General of NCPD, reiterated the value of data in planning and the need to disaggregate data on children and adolescents. She noted that data on 10 year-olds is not available as it is often lumped with data covering 5-15-year-olds.

The girl at 10 is vulnerable

According to Gift Malunga, the UNFPA Deputy Country Representative, 10 years is a delicate age for girls as this marks transition to adulthood. Further, girls at this age are in a period of self-discovery. It is therefore critical that the government and other stakeholders in development collaborate to ensure girls stay in school to avoid harmful cultural practices such as early marriage, female genital mutilation (FGM), sexual exploitation, and child labour. "When we keep girls in school, we increase their potential for higher income and increased productivity, and they can invest in the economic development of their country," said Ms. Malunga.

Participants at the forum noted that girls continue to experience complications due to teenage pregnancy and forced abortion, among others. The teenage pregnancy burden is highest in Narok County, standing at 40 percent. Following closely are Homa Bay, West Pokot and Nyamira counties at 33 percent, 28 percent, and 27 percent respectively. The teenage pregnancy burden in these counties is higher than the national average, which stands at 18 percent. Other factors contributing to the vulnerability of adolescent girls are poor nutrition and poverty.

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