APHRC Hosts Lancet Commission on Future of Health in Africa

INVESTING IN HEALTH

- Improves health infrastructure
- Moves towards universal healthcare

ENCOURAGES INDEPENDENT INCOME
- Generation

CREASES ECONOMIC GROWTH

IMPROVING HEALTH & NUTRITION

- Increases life expectancy
- Improves cognitive development

INCREASING ACCESS TO EDUCATION

- Maximizes job opportunities

CREATING AN EDUCATED YOUNG WORKFORCE

- Increases the number of health professionals
- Empowers women to access family planning services

How can we maximize opportunities for the largest group of young people in history?
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Fairy tales are usually not the subject of discussions at scientific research institutions. But on September 14, Richard Horton, editor-in-chief at The Lancet, brought up the subject in his opening remarks at the launch of the Lancet Commission report on the future of health in Africa.

“Sub-Saharan African countries have been described as a group of sleeping beauties, under the influence of a cruel fairy hoping for a Prince Charming,” he said in his keynote remarks at the APHRC campus. “However, the message of the report is one of hope: the continent can attain the same opportunities for health and long life as the rest of the world by 2030.”

The report, The path to longer and healthier lives for all Africans by 2030, is the culmination of four years of work by a group of health and policy experts, most of whom work on or are from the continent.

According to Horton, the timing of the report launch could not be better, as it followed the appointment of Tedros Gebreyesus of Ethiopia as the new head of the World Health Organization (WHO). To realize this vision, a radical shift in policy and practice is necessary, not just for African countries but also for organizations such as the WHO that work with governments in the region.

“Most money for research in Africa comes from outside the continent. Besides that, African research institutions barely collaborate with each other,” said Ezeh.

“Just 3% of research is done in partnership with other African institutions. Africans need to believe in themselves and their work and not just endorse work that is done by The Lancet or the London School of Hygiene and Tropical Medicine.”

The report’s focus on the future of Africa expands to a special interest in systems that are adaptive and responsive to the needs of young people. By 2050, sub-Saharan Africa will have an estimated 450 million people under age 25 years: the largest cohort of young people ever recorded on the continent.

Bright Simons, the Ghanaian founder of a medical supply start-up, noted that mitigation of the potential threats from a youth bulge such as crime and violence, will only happen when young people and innovators are at the heart of the development and execution of solutions.

There is much that aligns the future of health in Africa with the kind of targeted investments needed to help Africa trigger a demographic dividend – an economic boom that could accompany
a broad-based fertility decline. These are investments in health and wellbeing; education and skills development; employment and entrepreneurship; and in rights, government and empowerment.

These investments are necessary not only to maximize opportunities for youth but to trigger a virtuous cycle that could eventually wean the continent off dependence on foreign aid and begin to institutionalize homegrown solutions to the perennial challenges in health and economic development.

“This is a political moment for Africa. Medical knowledge on its own will not make a difference; political leadership and advocacy will.”

One such solution that will be tested in Kenya over the next five years is provision of universal health coverage through the National Hospital Insurance Fund (NHIF). During his inauguration speech in November 2017, the President pledged that all Kenyan households would benefit from medical coverage with NHIF over the next five years. This would mean dramatically increasing the number of people under NHIF cover from 6.8 million to 1 million.

Although this pledge is not directly attributable to the Lancet commission, it resonates with the report’s recommendation which calls on African countries to target universal health coverage. It also aligns with the call to ‘leave no one behind’ issued by WHO head Tedros on Universal Health Coverage Day, which was observed on December 12.

The report launch was co-chaired by The Lancet, APHRC and the London School of Hygiene and Tropical Medicine with the support of Unilever’s Social Mission office. This joint effort served as a model of how cross-sectoral collaboration may contribute to improved health outcomes across Africa.

Africans can have the same opportunities for health and long life as the rest of the world by 2030: this is no fairy tale. But as Horton made clear in his remarks, if governments do not make the necessary investments, innovation and political will, there will be no happily ever after.


INTERVIEW

Public Health Icon Peter Piot: Africa Can Do More!

By Lauren Gelfand, director of policy engagement and communications

Professor Peter Piot is a global public health legend. A microbiologist by training, Piot spent decades in Africa pursuing a greater understanding of two of the infectious diseases that have had catastrophic implications for the continent’s development.

He was part of a pioneering team that in the 1970s in Central Africa isolated the Ebola virus and investigated the first known Ebola epidemic. In the early 1980s, also in Central Africa, Piot led the groundbreaking Projet SIDA that has served as the foundation for global knowledge of the pathology, origins and transmission mechanisms for the human immunodeficiency virus, HIV – which causes AIDS.

In 1992, Piot joined the World Health Organization as the associate director of the WHO’s Global Program on AIDS. Just two years later, in 1994, he was named the first-ever executive director of UNAIDS in order to steward the global response to a disease that has claimed more than 35 million lives since the start of the epidemic that he was instrumental in identifying.

Since 2010, Piot has been the director of the London School of Hygiene and Tropical Medicine. It is in this context that he was asked to serve as a Commissioner by The Lancet for a four-year exhaustive interrogation of the future of health in sub-Saharan Africa, in order to develop a roadmap to longer and healthier lives for all Africans by 2030.

Piot was in Nairobi in September 2017 for the launch of the Lancet Commission’s report [see cover story] at APHRC. This interview has been lightly edited and condensed.

Q: You have been engaged in research about communicable diseases for decades, but the burden of disease in Africa, as elsewhere, is shifting to include a growing epidemic of non-communicable diseases. How should health systems adapt to that shift?

A: This shift is a shift in reality for health systems, and one of the main points of the report is the need for adaptability in health systems to help African countries confront these new challenges. But in a way that is different than elsewhere in the world, where the rise in NCDs is accompanied somewhat by a decline in infectious disease, Africa is still facing a sizeable burden of infectious disease – which makes it doubly hard for health systems to respond.

Ideally, [the rise in NCDs] would lead to universal health care, allowing people to be followed at the primary health care level and tested and so on, but the means currently are not there. One of the easiest ways to curb the epidemic is to keep smoking rates low; Africa still has the smallest proportion of
smokers globally, but that is under threat. I was recently in rural [Democratic Republic of Congo] and the cigarette promotion there was massive. Stronger tobacco control and regulation is the easiest and most effective prevention mechanism there is.

The other problem is that most countries don’t even know that they have an NCD problem – that is, the data are just not there. So alternative ways to respond are critical. One thing that is working well in Ghana is a program that works through chemists – small-scale pharmacies and dispensaries where staff are trained in taking blood pressure, for example. That goes beyond the regular medical care screenings and takes some of the pressure off health systems that are just not equipped for prevention.

Another big problem [contributing to NCDs] is salt – especially here in Kenya! I remember when I lived here [some 30 years ago] and everything was so salty. And that hasn’t changed. So we need regulations – but also education about salt and food.

“Africa still has the smallest proportion of smokers globally, but that is under threat. Stronger tobacco control and regulation is the easiest and most effective prevention mechanism there is.”

Promotion of exercise [as in Western countries as a deterrent to disease] is not really realistic in African contexts; people here walk so much already that to some extent that degree of prevention is built into all the cultural contexts. But then they are exposed to greater environmental pollution, which itself is a major health hazard.

Africa still has the smallest proportion of smokers globally, but that is under threat. I was recently in rural [Democratic Republic of Congo] and the cigarette promotion there was massive. Stronger tobacco control and regulation is the easiest and most effective prevention mechanism there is.

Q: As much as African health systems need to adapt to the changing disease burden, they also have to evolve their models of care; we see a lot of task shifting to lower cadres, especially outreach and education programs that are increasingly becoming the purview of community-based health workers who are not necessarily well-trained but who are well-grounded in their communities. Where are there opportunities in this model, and where are the risks?

A: We saw with the Ebola outbreak in West Africa in 2014 (in which more than 11,000 people lost their lives; more than five times the cumulative loss of life from all past Ebola outbreaks) the risks of uninformed health workers being on the front lines of responding to disease.

At the same time, it makes a lot of sense to get tasks shifted to the community health cadre of workers, and leaving the most qualified professionals to handle management and training and referrals. Quality assurance is a major, major component of public health and there are ways to ensure quality at all levels, especially with the leveraging of new technologies.

Q: What do you think is the biggest challenge that Africa’s rapid urbanization is presenting to the evolution of the burden of disease on the continent?

A: So of course there is the rise of chronic disease, but also greater numbers of accidents and injuries. And then of course with the rise of urban slums comes its own set of health challenges. Sanitation is a big issue.

But at the same time, concentrated populations provide a great opportunity [for public health mobilization and campaigns]; they are easier to reach, and while community cohesion may be less and resilience [to shock] may be less than in rural areas, there is still opportunity to reach larger populations and contain epidemics.

That’s really the research we need, to see how we can adapt our public health mobilization to the urban, and especially the slum, context. Traditional global health has focused on rural areas but with the majority of people living in cities now and in the future, we need a better understanding of what works – as well as in terms of urban planning and road infrastructure and so on.

Q: The London School of Hygiene and Tropical Medicine has a global reputation for excellence in research, but also for the way it draws people from around the world to collaborate. What tips would you share with APHRC to help us garner the same kind of profile?

A: We’re 120 years old, so we’ve had a lot longer to do this! But I will say that APHRC is one of those rare regional institutions, especially in Africa, with an enduring reputation for high quality work. You’ve got a diverse staff complement, including representatives from West Africa, and are doing great work in developing partnerships. Adopting new technologies can only lead to more opportunities – such as online learning.

The key is for you to have a vision – where do you want to be in the next 10 years? And work towards that while maintaining the same standards of quality and excellence.
TRIBUTE

Celebration of a Life Well-lived: Remembering Brian Njamwea

June 16 was a dark day for the APHRC community. We lost one of our own, Brian Gachuhi Njamwea.

Brian joined APHRC in July 2010 as a database programmer. Popularly known as “the solution provider,” his colleagues found him to be extremely personable, highly reliable, and hardworking. Brian earnestly believed in his abilities and seized challenges with glee. He went above and beyond, serving on committees including the IT, Health and Safety committees and volunteering as a fire marshal.

Brian earnestly believed in his abilities and seized challenges with glee. He went above and beyond, serving on committees including the IT, Health and Safety committees and volunteering as a fire marshal.

An active participant in staff meetings and sports events, Brian never refrained from giving his opinion on politics and global affairs, even as he always respected the views of others. He was nicknamed the ‘Government Spokesperson’ for his stand on local politics over lunchtime chats. Above all he was passionate about the things he loved: his wife, his son, his family, friends, Arsenal Football Club, and house music.

Brian met his wife, Akaco Ekirapa, at APHRC and together they were blessed with a son, Tesla Njamwea Gachuhi, on January 24, 2017. On June 15, Brian he went to work as usual, and actively participated in the meetings that he attended. Later that evening, after checking in on Akaco and Tesla, Brian met up with friends, and then returned home. Unfortunately, Brian Gachuhi, with no known ailments, rested in his sleep, succumbing to heart failure.

On June 18, APHRC held a memorial service for Brian’s friends and family. All who knew Brian will identify with the words of his friend and colleague Fred Wekesa, who wrote: “[Brian was] undoubtedly full of wit, charisma, and a zest for life. He believed in what is right, and never easily compromised.”

Brian embodied the very spirit of APHRC: committed, thoughtful, open, and close to the hearts of many. We have lost much more than a colleague; we have lost a friend, a brother. We remember Brian with deep fondness and gratitude.

NEWS

Harnessing data for Nairobi’s Slums: the Nairobi Urban Health and Demographic Surveillance System

By Marylene Wamukoya, data analyst

Though Africa is the least urbanized continent, it has the fastest rate of urbanization in the world. Take the example of Kenya. People continue to migrate from more rural areas to the capital city of Nairobi, which has long been the country’s economic powerhouse. The explosion of Nairobi is a visible manifestation of this trend; its total population grew from 350,000 in 1962, just before independence, to four million people today.

Urban growth brings different populations together, with different ideas and cultures and opportunities that can create a vibrant and thriving mix of people and possibilities. But without considered and thoughtful urban planning, these populations can crowd into teeming informal settlements, without access to systems that keep those vibrant populations healthy and productive.

Already in Nairobi, six in 10 urban residents lives in a slum environment, without access to basic needs for food and shelter, water, sanitation and schooling, safety and security and prevention of disease. To achieve its true urban potential, an integrated and innovative approach to slum-specific concerns is critical, requiring collaboration from city, county and national government agencies as well as from non-government and academic partners like APHRC.

Slum dwellers have worse health, social outcomes

An APHRC study from 2000 showed slum residents had the worst health and socioeconomic outcomes compared to people living elsewhere in Nairobi. They were more likely to experience violence and social unrest compared with any other group in Kenya. Their access to water, sanitation, education and employment was low, and there was a lack of the public sector and law enforcement agencies in slum communities. Further, slum residents had no legal claim over the land, a reality which continues today.

Meeting the need for localized data for decision-making

Until 17 years ago, health and socio-economic inequities between slum and non-slum residents of Kenya were masked by aggregated national data; no data existed to inform policy and budgetary decisions to improve conditions in slums.

In partnership with Nairobi City Council and community members, APHRC created the Nairobi Urban Health and Demographic Surveillance System (NUHDSS) in two slums-- Korogocho and Viwandani-- in 2002 to provide a platform to understand the link between living in a poor urban area and health and socio-economic outcomes. The resulting data and analysis, it was hoped, would help to drive investments in slum upgrading and other solutions.
The NUHDSS collects demographic information (births, deaths and migrations), health outcomes (sickness, disability, cause of death, child vaccination and nutrition) and socio-economic outcomes (marriage, educational attainment, livelihood, housing characteristics) twice a year. It also provides a platform for other specialized studies that focus on urbanization, population, education, family planning, reproductive and general health conditions of the urban poor.

“Until the NUDSS was created 17 years ago, no data existed to inform policy and budgetary decisions to improve conditions in slums.”

**Linkages with the Sustainable Development Goals**

NUHDSS was established a year and a half after the leaders of 189 countries signed the UN Millennium Declaration in 2000, which spelled out eight goals with measurable targets and a time frame up to 2015 to improve the lives of the poorest people in the world, such as the residents of Korogocho and Viwandani. Millennium Development Goal (MDG) #1 was to eradicate poverty and hunger. The NUHDSS provided useful evidence of the state of slum residents and monitored interventions in these slums to gauge their usefulness in reducing of poverty and hunger.

Following the conclusion of the MDGs period, the Sustainable Development Goals (SDGs) were adopted in September 2015, with a 2030 deadline. The SDGs build on lessons learned from MDGs and add in new priorities with an aim to improve life in a sustainable way for future generations. The NUHDSS is aligned with the SDG focus through its specialized intervention studies, prioritizing SDG 11 (target 1): end poverty.

With Sustainable Development Goal 11 on cities and human settlements, member states acknowledged the MDGs’ slum monitoring efforts and agreed to continue monitoring the proportion of people who live in slums/informal settlements or those facing inadequate housing for the next 15 years. This renewed mandate opens the window to improve how data on the populations living in slums can be collected and analyzed.

**Distinguishing Slums from Non-slum areas**

A recently published Lancet series summarizes the evidence on why urban poverty is an inadequate proxy for health in slums, as it ignores the neighborhood effects of shared physical and social environments.

For this reason, UNHabitat convened a meeting in November in Bellagio, Italy to improve the ways in which countries can distinguish slum from non-slum urban areas in national censuses and surveys. The group included Catherine Kyobutungi, APHRC’s executive director, and Alex Ezeh, executive director emeritus, among others from national statistical offices, UN agencies, donors and policymakers who developed a roadmap to move three key actions forward on international and local stages:

1. Identify techniques in use today to identify slum populations prospectively and retrospectively, analyzing the strengths and weaknesses of the various techniques;
2. Provide recommendations on how countries can integrate slum/non-slum urban designations in their censuses and surveys; and
3. Develop a global research agenda to understand which methods are most robust in identifying slum areas, including testing potential new techniques using geospatial data and machine learning.

These recommendations outline steps to change this problem, including that slum-specific data to be collected in national censuses and surveys. The steps are a call to action for the next generation of censuses to be designed such that the lowest levels of census enumeration areas are tagged as slums or non-slums for clusters located in urban areas.

Moving forward, the Bellagio group will work to elevate the importance of slum/non-slum designations in various global fora to marshal wide-ranging efforts to ensure that people who live in slums count. Ultimately, this group’s efforts will result in a guide that will be disseminated to national statistical agencies to apply step-by-step procedures to ensure that slum spaces are mapped and accounted for in the national sampling frames.

**Data-driven improvements**

Findings from the NUHDSS have been leading the way towards solutions for monitoring of the MDGs in Kenya, which today form the basis for monitoring the SDGs through 2030. Additionally, Nairobi County government has improved its focus on and investments in slum communities based on APHRC analysis. This demonstrates that APHRC is generating the kind of information that local policy-makers need for action.

As the NUHDSS enters its 18th year, APHRC is giving serious thought to what the future holds for its flagship demographic surveillance platform in terms of its untapped potential for additional research. The NUHDSS has matured profoundly from a monitoring and surveillance platform to a platform that is being used for implementation research with an aim to improve the wellbeing of the study communities. That’s good news for everyone involved.
**Experiences of Puberty in Nigeria and Kenya: A Cross-Cultural Comparison**

By Beatrice Maina, research officer

Puberty is a key marker of adolescent transition[1]. In early adolescence—the period from 10 – 14 years-- young people begin to experience physiological, social and psychological changes, [2] which can expose them to risks and opportunities likely to influence their future health and wellbeing[3]. It is a critical phase in human development, yet one of the least understood[4].

While biological processes are universal, the social contexts within which they occur vary considerably. During puberty, young people are expected to assume socially defined gender roles that shape their futures[5]. It is against this backdrop that the Global Early Adolescent Study (GEAS) (www.geastudy.org) was designed to understand the factors in early adolescence that predispose young people to sexual health risks, and, conversely, those that promote healthy sexuality.

Fifteen resource-poor urban sites (including Nairobi, Kenya and Ilı Ife, Nigeria) spread across five continents are included in the study, as they are home to a significant population of very young adolescents – a population that is growing exponentially, with potentially dramatic consequences for their health and wellbeing both now and in the future.

Study results could inform programs and services that target young people – but also, critically, might help contribute to how adults -- and young people themselves -- see where there are entry points to ensure young people are able to make informed choices about their sexuality, their gender roles and their ability to benefit from services availed to them.

APHRC researchers have completed the first phase of the study, using a mixed-methods approach to develop and test instruments for use among early adolescents that assess gender norms and sexuality. The second phase of the study, now under way, will examine longer-term findings.

Qualitative data collected in both Nigeria and Kenya are the basis for this article, which is adapted from a piece from the October special issue of the Journal of Adolescent Health that focuses on reactions to pubertal development [6]. It was jointly published by Caroline Kabiru, a former research scientist at APHRC now with the Kenya office of the Population Council, and our counterparts at the Ilı-Ifẹ, Nigeria study site.

Findings are drawn from conversations with adolescents aged 11 – 13 years and their parents, from both communities in Nigeria and Kenya. In Nairobi, adolescents and their parents were purposively selected from households in the Nairobi Urban Health and Demographic Surveillance System (see related article), a longitudinal research platform to assess the long-term socioeconomic and health effects of residences in urban poor settlements launched by APHRC in 2002.

**How do adolescents respond to puberty?**

A majority of adolescents had already started experiencing developmental changes; those who hadn’t were optimistic that they would happen soon and were aware of what to expect when that time came.

Adolescents’ reactions to puberty were based on a range of observations about their changing bodies; emotions and responsibilities including physiological changes that they observed or expected to see in themselves; and the changes in assigned responsibilities or the scope of responsibilities they were now taking on.

Many of the young people interviewed ascribed a greater maturity to themselves in adolescence, and a better approximation of what it meant to be an adult, for example in taking greater responsibility for younger siblings and household chores.

Survey respondents also said they were more concerned about their own privacy, particularly when it came to respecting their bodies as they develop. They voiced unease about taking a bath with pre-pubescent children, with adults around or in an open space. They also spoke of challenges both with peers as well as adults that emerged when it came to spending time with friends of the opposite sex.

Childhood games were no longer appropriate. Girls are seen as more vulnerable than boys, and in adolescence, even as they are embracing more adult roles, they are more restricted or monitored. Because of social stigma associated with pubertal development, some adolescents reacted by hiding any physiological changes that were happening to them. This resulted in anxiety, shame, and an increased desire for privacy, even while some expressed pride in the changes that were taking place.

Study results could help identify entry points to ensure young people make informed choices about sexuality, gender roles, and services.
Parents’ reactions and engagements with adolescents during pubertal development
Parents in both sites associated puberty with a desire for romantic and sexual exploration among adolescents – and expressed concerns about what changing bodies mean for changing relationships with the opposite sex. Many acknowledged that they are responding by monitoring their children’s behaviors and social interactions more closely.

Parents also identified a shift in the way their children behaved, thinking and expressing themselves in a more adult-like manner as they took up adult responsibilities. For some, this has resulted in greater autonomy and “adult-like” privileges accompanying an increase in responsibility. For a father of a Nigerian girl, he reports his daughter “wakes up even before the mother wakes up, she will begin to do [chores] like washing of plates, sweeping the frontage of the house and likewise the rooms” now that she has started puberty.

One Nairobi mother reported telling her daughter that “she might get cancer because... the moment you sleep with that boyfriend, it will enter your womb, cut it into pieces and then you die.”

As parents recognized the challenges and opportunities associated with puberty and the adolescence period, they acknowledged their role in providing sanitary towels for girls, training adolescents in handling processes relating to puberty, and counseling the adolescents on the challenges, implications, and expectations of their pubertal development. And although majority of the adolescents were living with both parents, mothers took up more responsibilities in monitoring the adolescents.

Study results demonstrated notable differences in the way boys and girls were treated by their parents as they entered adolescence. While boys were allowed greater independence, girls were more closely watched because of the risks they confront as they get older, beginning but not limited to increased risk of sexual activity and sexually predatory behavior from others in their communities.

Parents expressed deep concerns about their children’s sexual desires and whether – and how – they intended to act on them. They also reported discomfort in finding the right ways to approach the conversations about puberty and bodily change, and how that translated into sexual exploration and romantic behavior. Many parents reported staying with “safe” topics such as school and career prospects, and urging their youngsters to steer clear of romantic and sexual relations so as not to compromise their prospects for the future.

Some parents admitted to using scare tactics to deter their children from acting on their sexual desires; still others said they passed non-factual information to their adolescents as a way to delay them from engaging in early sexual activity.

One Nairobi mother reported telling her daughter that “she might get cancer because... the moment you sleep with that boyfriend, it will enter your womb, cut it into pieces and then you die.” Some parents, however, noted the importance of providing sound advice about safe sex as well as the consequences of early sexual relations such as unintended pregnancies, sexually transmitted infections. Finding youth-appropriate material, therefore, is of utmost importance and among the key recommendations emerging from these early findings.

Bringing young people and their parents together and providing frank, evidence-based information about sexuality, puberty and adolescence remains a top priority for APHRC as it continues its exploration of what works to reach adolescents and promote healthy behavior. Going forward into the next phase of the study that started in 2017 and will conclude in 2022.

References
**APHRC Researchers Share Wealth of Adolescent Research with Youth, Government Officials**

By Danielle Doughman, policy outreach manager

Adolescent health and education represent an important opportunity for APHRC’s research to influence policy, particularly in Kenya. The recent Kenya Adolescent Health Symposium, the second such forum for researchers, policy professionals and advocates to come together to share best practice and lessons learned about what works for reaching young people, was a great opportunity for APHRC to showcase its evidence-to-policy model. Beginning on 22 November with a youth-led, youth-driven pre-conference organized by Maisha Youth, hundreds of young people and their strongest champions in research and decision-making, as well as parents and teachers, discussed how to ensure young people live healthier lives – both now and in the future.

APHRC was a named partner for the symposium, alongside the Ministry of Health’s Division of Family Health, and played key roles in facilitating sessions bringing young people together for informed conversations.

The three days of workshops, plenary sessions and small group discussions offered something for everyone. APHRC research officer Beatrice Maina and Caroline Kabiru, formerly of APHRC and now with the Population Council, led focus groups with young adolescents aged 10-14 to discuss perceptions of puberty and adolescence alongside facilitators from Gertrude’s Children Hospital. This workshop aligned with the work APHRC is leading on conducting the Global Early Adolescent Study in Kenya (see article).

Using art as a tool for interactive and participatory research, workshop attendees were asked to depict the timeline of adolescence and puberty – from childhood to adulthood – marking the milestones and important events over that time period. Both girls and boys were asked to participate and at the end, the timelines were compared, in order to demonstrate both the differences and similarities in a boy or girl child’s journey through the often challenging period of adolescence.

In parallel, more than 200 older adolescents were invited by APHRC Communications Officer Carol Gatura to hear findings from a study released in April about sexuality education policies and how they are implemented in Kenya. More than 1,000 students and teachers from some 78 secondary schools in Nairobi, Homa Bay and Mombasa counties participated in the nationwide survey on the state of comprehensive sexuality education in Kenya’s schools.

Among the findings discussed during the seminar was that while three out of four surveyed teachers say they are teaching all the topics that constitute an internationally-agreed definition of comprehensive sexuality education curriculum only 2% of sampled students say they learned this material.

Among the discussants of the research findings were Evans Kasena, a project coordinator with Kwacha Afrika in Mombasa, and Robert Gonzi, a youth advocate working in Homa Bay. They also facilitated small group discussions of 15 young people to hear whether the study findings resonated with their own experiences. One group, in response to findings that show that nearly half (45%) of teachers are unprepared or uncomfortable teaching these topics reported that “sexuality education should be taught by well-informed people [such as healthcare professionals]; we don’t want to learn about this from our teachers, and they don’t want to teach it to us.”

“We were thrilled to engage a wide youth audience, which presented a unique opportunity to engage their thinking on issues affecting them directly,” Gatura said. APHRC shared resources throughout the symposium, including fact sheets produced in three languages (Kiswahili, Luo, and English) designed especially for young people to communicate the main study findings.

On the final day of the Symposium, APHRC post-doctoral fellow Yohannes Wado moderated an expert panel on how young people can be engaged in efforts to harness the demographic dividend to achieve economic growth and development. Panelists included Richmond Tiemoko, of the United Nations Population Fund, East and Southern Africa Regional Office; Joseph Wasikhongo from the National Gender and Equality Commission; Benson Muthendi of the Youth Enterprise Development Fund; and Bernard Onyango of AFIDEP.

Other APHRC contributions to the event included a presentation from Research Officer Shukri Mohamed, who led a panel on the implications of non-communicable diseases for Kenya’s youth.

The first-ever Kenya Adolescent Health Symposium was held in October 2015. The next event is tentatively planned for late 2019.

For links to the publications referenced, please visit [http://aphrc.org/post/8737](http://aphrc.org/post/8737).
Banking on “White Gold” to Save Newborns

By Eva Kamande-Monda, research officer; and Elizabeth Kimani-Murage, head of maternal & child wellbeing unit

A mother’s breastmilk is so important for the health and development of a newborn infant, so full of critical nutrients and valuable antibodies, that it is known as ‘white gold’. Optimal breastfeeding has the potential to prevent approximately 820,000 child deaths each year and is known to reduce the incidence of illness among children. World Health Organization recommendations suggest exclusive breastfeeding for an infant’s first six months and supplemental feeding for the first year of life.

For some babies, however, breastfeeding is impossible. Some of these babies enter the world too soon, born prematurely and at low birth weight. For others, it is because their mothers are unable to nurse, or they are separated too early from their mother for a variety of extenuating factors. These infants can suffer from nutrition deficits that lead to longer-term complications that require additional targeted treatment with proven, cost-effective interventions.

Formula, while engineered to be an adequate substitute, can be too expensive as a long-term solution for many. Animal milk fed too soon can bring further complications like allergies, feeding intolerances and infections. Donated breastmilk can be a viable alternative, and is recommended by WHO as a lifesaving measure for those babies who are most in need. Championing the needs of these fragile babies is at the core of a global campaign driven by WHO and its global partners to scale up the establishment of human milk banks (HMBs) in countries the world over, in order to provide and store safe donated human milk for those infants at risk and in need.

Some of the proven benefits of donated breastmilk are the improved ability to feed infants, less diseases for babies, and a reduction in healthcare costs including shorter hospital stays.

Human milk banking could bring tremendous opportunity to Kenya, which remains burdened by an unacceptably high rate of infant mortality and morbidity. Figures from the Kenyan Demographic and Health Survey in 2014 show that 22 of every 1,000 babies born in Kenya annually die during their first 28 days of life – some 40,000 lives cut too short, too soon. Prematurity and low birth weight also pose major, longer-term health challenges for Kenya’s population of infants: nearly 200,000 babies are born before 37 weeks gestation and 123,000 are born with a low birth weight (below 2500 grams), irrespective of gestational age.

A healthy start for every child begins with a fuller and more practical understanding of needs at the community level when it comes to antenatal services provided to expectant families, and a tailored approach to the specific needs in those communities related to nutrition during pregnancy and beyond, and the value of attended birth. The Every Newborn Action Plan (ENAP) global target of fewer than 10 deaths for every 1,000 live births before 2035 (even more ambitious than the 12 deaths per 1,000 births target of the Sustainable Development Goals) will require deliberate, concentrated action to fully implement the commitments that Kenya has endorsed.

The ENAP gives newborns a more prominent place on the global health agenda. It provides strategic actions for ending preventable newborn deaths and still births and contributing to reducing preventable maternal illness and deaths. It presents evidence-based solutions and sets out a clear path to 2020 with eight specific milestones in areas that need innovations to meet the mortality targets by 2035.

One of the proposed actions is to encourage nursing mothers to express milk for other babies in need and provide safe, hygienic facilities to store it, complemented by milk banks in facilities that care for preterm, sick, or small for gestational age babies. Helping Kenya to establish a network of human milk banks could be a first critical step toward delivering on this ambitious but achievable plan.

Working together with the Ministry of Health and PATH, APHRC has embarked on a feasibility study to determine what it will take to inaugurate Kenya’s own milk-banking initiative. A first step was to assess perceptions about donated breastmilk, among a network of stakeholders including mothers, fathers, community members, healthcare providers and policymakers across Nairobi County.

The assessment demonstrated highly positive perceptions among mothers about breastfeeding – a critically important demographic because they are both the targets for donation and for reception of donated breastmilk. Of the surveyed mothers, around eight in 10 of them said they would commit to donating their own excess breastmilk, while still more said they would consider it fine to feed children in need with donated breastmilk.

All perceptions were not uniformly positive however, amid concerns expressed by both mothers and healthcare providers about the human milk banking concept, arising from cultural and religious beliefs and practices. The most commonly cited concern related to the risk of disease transmission, especially HIV-AIDS, highlighting the need for awareness and education campaigns, as well as visible, demonstrable public policy that enumerates the type of protections and procedures that will be emplaced to guard against transmission of disease through donated breastmilk.
The below figure shows the process that donated milk goes through from donor to recipient to ensure its safety.

The study findings are promising as they point to potentially high acceptance of human milk banking in Kenya. The next phase of the feasibility study will turn from the perception to the practical, in order to unpack the mechanisms through which people might be able to donate milk, how it’s stored, and how others are able to access the donated milk.

Lessons learned from higher-income countries could help Kenya navigate its way toward establishing its first human milk bank. There is rich learning and demonstration of the successes a milk banking program can bring to a community; in Brazil, more than 220 milk banks are successfully established and have demonstrated savings of some US$540 million annually in healthcare costs, many of which are derived from avoiding the costs of treatment for newborn illness or conditions that are precipitated by a lack of breastmilk. Savings are also derived from shorter hospital stays and reduced use of expensive formula foods.

With the next phase of the feasibility study ramping up in 2018, Kenya could be putting itself on the road to banking ‘white gold’ and shoring up the futures of its most precious resource: its future.

Five minutes with Nancy Birdsall, APHRC’s newest Board Member

Nancy Birdsall is a senior fellow and president emeritus of the Center for Global Development, a US-based think tank and longtime thought partner of APHRC – including our agenda-setting work on what sub-Saharan Africa needs to do to deliver on the data revolution.

She joined the APHRC Board in January 2017 and will serve a three-year term. We caught up with Nancy during her first APHRC Board meeting in November, in Johannesburg, South Africa. The below has been lightly condensed.

On joining APHRC’s board:
I’ve been saying for years, including with donors, that there should be much more support for think tanks, especially in Africa, working on domestic or regional policy issues. I think that much of what donors do to support “capacity building” is misguided – whether it is a week of training in a [major European city] or daily per diems that are equivalent to a week of pay for a deputy minister.

As I have “returned” to work on family planning (modern contraception as the key technology to empower women and fuel global development) over the last few years, I see APHRC as a leader in this arena for the continent, as one of the best, if not the best, on independent and policy relevant research. So in the end, though I still worry about too many time commitments, I could not say no to (executive director emeritus) Alex [Ezeh] and (APHRC Board chair) Tamara [Fox].

On APHRC’s 2017-2021 Strategic Plan:
Perhaps most compelling is the priority APHRC gives to training African researchers to be true scholars — world-class. It exploits other “assets” of APHRC, most especially the fellows enrolled in the two fellowship programs, both the Consortium for Advanced Research Training in Africa (CARTA) as well as the support provided by the African Doctoral Dissertation Research Fellowship.

On APHRC taking its place among the global research/knowledge think tanks:
For Africa, there is a huge issue of the future of work/jobs, given the youth bulge and real justified fear that manufacturing, a la East Asia and Bangladesh, is not destined to absorb much labor.

There is a downside to the pursuit of harnessing a so-called demographic dividend, in the absence of coherent macro, social and labor market policies geared to fighting informality.

This article is based on the briefing paper Integrating Human Milk Banking with Breastfeeding Promotion and Newborn Care: is Kenya Ready? and the article Inside Kenya’s ambitious plan to build human milk banks.
I think becoming the think tank in the developing world on education/skills development should be a greater priority at APHRC – which probably means investing in building up expertise in order to get bigger funding. So I would invest some resources in exploring what would be needed to have a bigger critical mass on public sector education issues, which remains sclerotic even in the face of some healthy progress and change within the public health sector.

**How APHRC’s research can be truly transformative:**

Focus on quality, and give researchers and fellows the incentives – and time, space and resources – to be original, to publish in journals, and so on. My sense is this is already the tactic, if not the strategy.

On where APHRC should pursue a higher profile to help Africa achieve the SDGs by 2030:

The education sector needs more and better research on what works in order to give countries the best shot at achieving the SDGs.

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**Tips for Surviving the Formative Stages of Your PhD**

By Peter Ngure, program manager for the Consortium for Advanced Research Training in Africa (CARTA)

A Doctor of Philosophy, which most people know as a PhD, is the highest academic accolade. It demands a substantial investment of time, meticulous supervision and conscientiousness. Students enroll out of passion for their subject areas, better career opportunities, or both.

More and more students are registering for doctoral studies across Africa, which is a good thing. Exactly how many complete their PhD once enrolled is an open question, considering this data is incomplete or not available in most countries, according to SciDevNet. We know that globally, as in Africa, PhD completion rates are low. However, some find themselves ill-prepared to tackle their course work. To start to answer why, I’ve drawn from lessons learned while working with fellows in the Consortium for Advanced Research Training in Africa (CARTA) program.

CARTA is a doctoral fellowship that aims at producing research leaders and change agents in population and public health.

It is a consortium of nine African universities, four research centers and seven non-African partners. With 190 fellows currently enrolled in the program, pursuing PhDs in population and public health, their experiences and concerns may help others who are embarking on the tough, sometimes lonely journey to obtaining a PhD. A typical CARTA fellow is likely to be a full-time faculty member, usually an assistant lecturer or lecturer. They are talented, well-respected and have the potential to become real research leaders in addition to their contributions to generalizable knowledge.

Evaluations conducted among the latest cohort just beginning their PhD journey reveal that there are challenges that hinder them from starting their PhD work.

**Master's programs don't lay the groundwork for PhD research**

One of the problems lies with the structure of masters’ programs in Africa. These tend to last for two or three years. They’re traditionally assumed to be the foundation for career advancement in academia, but their focus tends to be on a strong component of course work, with limited opportunities for serious research. And research, of course, is the backbone of any PhD degree. When research is included in masters’ programs, too often the scope of the work is narrow and the quality of supervision is poor. Candidates are left to flounder in the dark alleys of research. In Kenya, where I am based, it is very rare for Master’s students to produce work that’s good enough to publish in peer-reviewed journals. Their work doesn’t influence policy- and decision-making. Masters’ graduates get a feather in their cap, but that’s really all.

CARTA fellows expressed frustration at their limited understanding of the philosophical underpinnings of their research topics. Fellows from “hard” science backgrounds such as biology or medicine indicated that they didn’t understand philosophy, nor see its value to research.

**Learning to think like a researcher**

Many PhD candidates have difficulty in identifying the research gap in their topic of interest and insist that the topic has not been studied in the geographical area they’re focusing on. We have also found that many PhD students don’t have the basic software skills needed to search databases and often haven’t heard of open-source software that might make their task easier and cheaper. Given that they do not undertake a critical appraisal of sources, the students battle to develop a workable research question.

**Focusing on the currency of research: strong writing**

As a result, a good number combine sentences derived from various journals conveniently to create what is submitted as the literature review. The write-up is illogical and incoherent, and is marked by high levels of plagiarism. One problem leads to another: most students struggle to understand and develop theoretical and conceptual frameworks for their proposed study.
One solution to jump-starting the journey to a PhD

CARTA has developed a month-long residential seminar during which new students are equipped with the necessary skills and competencies to kick off their doctoral journey. As a result, we’ve seen marked improvement in applying epistemology in defining their areas of research, ability to identify the research gap and develop researchable questions. This is the foundation for a good PhD.

Topics in the curriculum include knowledge philosophy; reading, writing and referencing; and how to develop a good research question and a conceptual framework. The seminars are learner-centered, with space for group work and one-on-one consultations. Since the seminars are residential, the fellows also get to spend lots of time with one another, sharing ideas and advice, and with mentors who have many years of experience in PhD supervision.

Feedback from previous seminars has suggested that this approach is really working. Fellows say that they find the sessions very helpful and this is obvious in the improved quality of their work. Some have even changed their PhD topics after realizing that the initial one had been over-researched. With a better grasp of their research ideas, fellows are comfortable defending them when they return to their institutions.

A version of this piece first appeared in Conversation Africa.

PROGRAM UPDATES

Evelyn Gitau takes the Helm as the new Director of Research Capacity Strengthening Division

APHRC welcomes Evelyn Gitau as the director of the Research Capacity Strengthening Division. Under Gitau’s direction, the division will continue to grow its signature fellowship program, the Consortium for the Advancement of Research Training in Africa (CARTA), and expand opportunities across the continent for African scholars to become great research leaders. She assumed the role on November 1 following the departure of the previous director, James Kisia.

Gitau earned her PhD in Life Sciences from the Open University/Liverpool School of Tropical Medicine in the UK, investigating neurological infections in children living in malaria-endemic areas. Gitau’s most recent role was as a program manager at the African Academy of Sciences, where she stewarded the Grand Challenges Africa at the Academy under the Alliance for Accelerating Excellence in Science in Africa (AESA) program. Prior to that, she was part of the team at the KEMRI-Wellcome Trust Program in Kilifi, Kenya, conducting research on developing biomarkers of disease among seriously ill children.

Alongside her more than 15 years of experience in medical research, Gitau has demonstrated strong commitment to mentoring and supervising students, believing that the next generation of research leaders in Africa must be at the forefront of the continent’s development agenda in order to shape decision-making and policy with evidence. Among her awards and accomplishments include a 2015 appointment as a fellow of the Next Einstein Forum, where she is the ambassador for the development of Science, Technology, Engineering and Mathematics in Africa.

CARTA Fellow and Team Win $3.6 million NIH Grant to Fight Blindness in Africa

Olusola Oluuyinka Olawoye, CARTA cohort 7 fellow, is part of a research team from the University of Ibadan (Nigeria) that has won the H3 Africa National Institutes of Health (NIH) research grant worth US$3.68 million.

The grant, for a collaborative research project titled Eyes of Africa: the genetics of blindness, will be carried out in Nigeria, Gambia, Malawi and South Africa for a five-year period.

The grant will study the genetics of blindness with a focus on Primary Open Angle Glaucoma (POAG) in Sub-Saharan Africa. POAG is one of the leading preventable causes of blindness in the world, it is a condition that leads to optic nerve damage and possible blindness. Progression of this optic nerve damage can usually be halted with treatment but cannot be reversed once the damage is done.

Olawoye will work on the project alongside six investigators: Adeyinka Ashaye (lead PI), Michael Hauser (PI key), Rand Allingham, Chimdi Chuka Okosa (site PI), Abba Hydara (site PI) and Aderonke Baiyeroju. Ashaye, the lead investigator, is a Professor of Ophthalmology College of Medicine, University of Ibadan.

“I thank CARTA for their support and encouragement all the way,” she said. Olawoye’s doctoral study is on pathways to care and hospital retention of glaucoma patients in South West Nigeria.

The Human Heredity and Health in Africa (H3Africa) Initiative aims to facilitate a contemporary research approach to the study of genomics and environmental determinants of common diseases with the goal of improving the health of African populations.
Muuo recognized for Best Oral Presentation by Young Researchers at International Forum

Sheru Muuo, research officer in the Population Dynamics and Sexual and Reproductive Health and Rights research unit, and Alys McAlpine, doctoral candidate at the London School of Hygiene and Tropical Medicine, received an award for being the best oral presenters in the young researchers’ category. They presented on “Challenges to Research in Refugee Camp Settings: Lessons from a Mixed Methods Evaluation in Dadaab, Kenya” at the Sexual Violence Research Initiative (SVRI) Forum in Rio de Janeiro, Brazil which was held between in September 2017.

The forum brought together over 500 researchers, gender activists, funders, policy makers, service providers, practitioners, and survivors working to understand, prevent and respond to sexual and intimate partner violence worldwide.

Their presentation is a part of a five-year study to assess an effective model of care for survivors of gender-based violence in Dadaab refugee camp in Kenya. The camp has a population of 238,000 as of October 2017 and was created in 1991 in response to people fleeing civil war in Somalia, according the UNHCR, the United Nations Refugee Agency. Another 130,000 refugees flowed to Dadaab in 2011 as a result of Somali drought and famine. APHRC partners with LSHTM, CARE International, and International Rescue Committee on the project.

APHRC was represented in both national and regional discussions on immunization and immunization programs’ planning. Through these interactions, APHRC gained a deeper understanding of the key players and progress made across the region—crucial insight as the Center prepares to roll out the second phase of the Immunization Advocacy Initiative that seeks to empower networks of civil society organizations with skills that will allow them to advocate for sustained national financing of immunization.

In November, Gaye Agesa, who leads APHRC’s Immunization Advocacy Initiative, delivered a presentation during Kenya’s Joint Appraisal, an annual meeting hosted by Gavi, the Vaccine Alliance, which brings key partners together to discuss successes of the past year and planning for the following year. Some of the priorities for 2018 include developing a transition plan that will fill an anticipated vacuum left by the end of significant multilateral financial support for the purchase of vaccine commodities. The discussions, led by the Ministry of Health’s National Vaccines and Immunization Program and Gavi, assessed gaps in the implementation program and made recommendations to support the strengthening and improved resilience of the national health system.

In December, Agesa and PEC Director Lauren Gelfand participated in the second regional immunization technical working group and the Regional Immunization Partners’ meeting, both held in Johannesburg, South Africa. APHRC is one of the key partners focused on advocacy and communications strategy as defined in the Addis Declaration on Immunization, a commitment by all African member states to guarantee equitable access to life-saving vaccines.
Towards Greater Collaboration in Education Research in East Africa

The Regional Education Learning Initiative (RELI) brings 40 education researchers together from Kenya, Uganda, Tanzania and the Democratic Republic of Congo to share learnings and insights from their work. The first stop for the RELI initiative was a meeting in Kampala that brought together grantees from Uganda to create synergies and chart a way forward on the areas of information sharing, collaboration and partnerships. Three thematic areas emerged: values and life skills; enabling teachers; and quality education for refugees, host children and girls. These thematic groups offer a learning platform for these grantees to work together for a common agenda centered on ensuring education for all children in Uganda.

RELI is a platform aimed to cluster partners (grantees) working within the education space to create synergies, ensure improved Monitoring, Evaluation and learning and targeted policy engagement.

A second country convening was held in November in Arusha, Tanzania. Themes reflected the different national context and included: inclusive education; teachers and quality of teaching; and values and life skills. Gift Kyando, the education officer in Arusha, reiterated the need to invest in education as the best way to get out of poverty in her remarks that framed the meeting.

The Kenya in-country convening marked the end of the first round of meetings with partners sharing progress made towards the goal of education for all. The meeting saw learning across the thematic areas of learner-centered teachers, equity, equality and inclusive education and policy engagement. A final convening is planned in DRC in early 2018.

From Research to Policy to Practice: Highlights from the WASH Learning Forum

Did you know that you can get more people to wash their hands if a pair of eyes is placed above the washbasins in public washrooms? It may sound creepy, but the feeling of being watched prompts people to do the right thing. This insight was shared during a presentation on applications of behavioral science in the Water, Sanitation and Hygiene (WASH) sector.

"Basically you are shaming the person into doing the right thing," Sharon Njavika from the Busara Center for Behavioral Economics explained, “and shame is a very powerful emotion.”

The presentation was one of several discussed at the Learning Forum hosted by APHRC and the Ministry of Health on October 18 in Nairobi.

Discussions at the Learning Forum were grouped into six clusters: Disease Prevention; School WASH; Menstrual Health Management; WASH and Nutrition; Urban Sanitation; and WASH Innovations. As part of the disease prevention cluster, Mohamed Karama from Umma University delivered a presentation on the cholera outbreak that has affected several parts of Kenya, including Nairobi.

The association of disease outbreaks with low-income neighborhoods highlights the need for safe, cost-effective water and sanitation interventions. APHRC research indicates that informal settlements in Africa’s rapidly urbanizing centers will continue to grow well into the 21st century. Ensuring that these populations are able to access safely managed water and sanitation systems requires innovative thinking and fresh ideas. This is one of the critical challenges of our times as diarrheal diseases are the second-leading cause of death for children under five years, even though they can largely be prevented through provision of safe water and sanitation systems (WHO, 2017).

Benjamin Murkomen from the WASH-Hub at the Ministry of Health urged researchers to consolidate their findings in an easily accessible platform to advance knowledge.

Keep an eye out for more details on the next WASH learning forum. Until then, remember to wash your hands -- even when no one is watching.
Elizabeth Kimani-Murage Awarded Wellcome Trust Public Engagement Fellowship

Elizabeth Kimani-Murage was awarded an international engagement fellowship from the Wellcome Trust in October. The fellowship, running from January 2018 to December 2019, will focus on public engagement on the right to food and nutrition in Kenya.

The aim of public engagement from the perspective of the Wellcome Trust is to help people connect with science and health in ways accessible and relevant to them, hence create a culture of public-informed research for greater public trust and acceptance. Public engagement with research and health concepts is an innovative tool for enhancing impact, hence critical to realizing APHRC’s vision of transforming lives in Africa.

Kimani-Murage’s objective for public engagement in her fellowship is to explore the nexus between the right to food and nutrition as stipulated in the Bill of Rights in the Kenyan Constitution and the lived experiences as evidenced by research, among vulnerable populations in Kenya, particularly the urban poor, and especially children. She will explore community understanding of the concepts of the right to food and nutrition and their degree of empowerment. She will then engage with law and policy makers to bridge the gap between the law/policy and lived experience.

Six Ways to Harness the Influence of Older Adults

- The creation of platforms for intergenerational mentoring and exchange
- The active inclusion of older adults as change agents for building the four demographic dividend pillars
- An expansion of adult, lifelong education opportunities
- An orientation of health systems to better respond to the needs of older persons
- An extension of social protection for older adults
- A development of long-term care systems that support family carers-while at the same time offering expanded opportunities for youth employment and enterprise as part of a care economy

Photo credit: Thomas S G Farnetti, Wellcome Trust
From left: Nabeel Petersen (South Africa), Elizabeth Kimani-Murage (Kenya), Sara Kenney (UK), and Anita Shervington (UK), four of the Trust’s new Engagement Fellows
Where in the World is APHRC?

Geneva, Switzerland
Abdhalah Ziraba
38th Global Fund to Fight AIDS, Tuberculosis and Malaria Board Meeting
November

Atlanta, Georgia, USA
Beatrice Maina
American Public Health Association
Conference Annual Meeting
November

New York City, USA
Blessing Mberu,
United Nations Expert Group Meeting on Sustainable Cities, Human Mobility and International Migration
September

Rio de Janeiro, Brazil
Sheru Muuo
Sexual Violence Research Initiative Forum 2017
September

Kampala, Uganda
Benta Abuya
2017 Global Grantee Convening hosted by the Partnership to Strengthen Innovation and Practice in Secondary Education
October

Accra, Ghana
Gaye Agesa
Expanded Program on Immunization Managers’ meeting for West African countries
September
The Final Word: Marking an Unforgettable Year

There is a saying that “a not so great beginning signals a beautiful ending” and this is how 2017 began for me! A change in my thesis defense date almost discouraged me. However on September 1, I successfully defended my PhD thesis, marking a beautiful ending to my graduate training!

This year brought crests and troughs. I witnessed my long-term mentor become the executive director of APHRC. However, 2017 also reminded me that life is fleeting. My lowest moment this year was the passing of our colleague, Brian. Months later, I still can’t deal with it.

I experienced tremendous growth in my role. One highlight was interacting with economic migrants from Tanzania living in Malawi. Karonga town in Malawi, as part of the Migration & SRHR study. Though the area is prone to earthquakes and floods, for them, it is a safe haven. It made me appreciate my home country Kenya more.

My year has been a mix of excitement and challenge since I became the NUHDSS project manager. Working more closely with the people in our study community has given the data I have been crunching greater depth and meaning. The experience of walking in Korogocho and Viwandani and inhaling the air can never be captured in numbers alone. I have made it my mission to ensure that our data inspire policymakers to action.