



African Population and
Health Research Center

NEWSLETTER



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Tackling NCDs one policy at a time

By Shukri Mohamed, Research Officer

Preventable risk factors such as physical inactivity, unhealthy diet, harmful alcohol consumption and tobacco use underlie most non-communicable diseases (NCDs) and are responsible for conditions such as obesity, and risky increases in blood sugar, leading to diabetes; blood pressure, which causes hypertension; and cholesterol, which contributes to heart disease.

Rapid economic growth and the attendant change in lifestyle that has accompanied that growth have contributed to a dangerous rise in the number of diagnosed NCDs across sub-Saharan Africa, and a commensurate increase in the number of deaths attributable to diseases including congestive heart failure, cancer and others. Unfortunately, at both the continental and national levels, there has yet to be a substantive change in the policy environment or in the way health systems are adapting to respond to the mounting epidemic.

Countries are now working to develop and update a series of preventative policies to reduce the risk of NCDs, including tobacco and alcohol controls. As part of a long-term, multi-country engagement, APHRC has examined a series of prevention policies and the extent to which a multi-sectoral approach was applied to both their design and their implementation.

The results from the studies conducted in Cameroon, Kenya, Malawi, Nigeria, South Africa, and Togo were collated and published in August in a special issue of the BMC Public Health Journal. They represent a historic first assessment of how sub-Saharan Africa is responding to recommendations by the World Health Organization, known as ‘best buys’, for how to prevent NCDs.

Tobacco, alcohol and other control policies at the national level were viewed through a multiplicity of lenses to understand whether there were any

WHO: Key chronic conditions and their NCD risk factors



commonalities in their development, design and implementation. They were also assessed as to how well different stakeholder groups - from across different sectors of government to civil society to the private sector - were engaged in the process of developing the policies as well as monitoring their implementation.

Among the recommendations that emerged from the study were:

- i)** A need for stronger governance and coordination structures across sectors to ensure that all relevant sectors are engaged in NCD prevention initiatives;
- ii)** Improved engagement by health actors with other sectors to identify opportunities for collaboration in prevention of NCDs, such as monitoring tax reforms and budgets;
- iii)** Establishment of sustainable joint financing mechanisms for effective implementation of prevention strategies; and
- iv)** Mechanisms to counter industry interference during the policymaking process.

New perspective on social pensions

By Hilda Owii, Research Officer



⤴ A Korogocho family, where grandparents are primary caregivers

Evidence suggests that social protection programs delivered through cash transfer can be effective mechanisms to lift people out of poverty. In the short term, they support access to basic commodities, while in the medium or longer term, cash may be used to generate income and eventually improve the socio-economic status of people and their families.

A cash transfer program funded by the Ministry of Labor and Social Protection established in 2007 in Kenya was predicated on this hypothesis. A pilot program in Thika, Nyando and Busia, known as the Older Persons Cash Transfer Program (OPCTP), gave a bi-monthly stipend of Ksh 1,200 (USD 12) to 300 people over age 65.

By 2015, the scheme had expanded to reach 325,000 older people around the country with a bi-monthly stipend of Ksh 2,000 (USD 40). As of April 2018, more than 500,000 people over age 70 were enrolled nationwide.

To assess whether the model is achieving its aims of contributing to a change in economic fortune and an improvement in wellbeing, APHRC's Aging and Development Unit, in partnership with the University of Southampton, UK, is conducting a two-year, mixed methods study in the Korogocho and Viwandani slums of Nairobi.

Qualitative interviews should reveal how beneficiaries are using subsidies to contribute to their livelihoods, and how they are sharing their cash, in order to understand the extent to which the stipends might be shaping relationships with family members, and alleviating poverty. It is hoped that the findings can be used as a lever to inform future programs that address structural deficiencies that contribute to poverty among older populations and seek to provide a degree of social protection to older people across sub-Saharan Africa.

With \$9 per person per year, sexual and reproductive health access could be covered for all of Africa

By Lauren Gelfand, Director of Policy Engagement and Communications

A PHRC's director emeritus, Dr. Alex Ezeh, was a keynote speaker at the May 9, 2018, launch of a comprehensive slate of recommendations from 23 global experts driving the need for a new, bold and comprehensive agenda to achieve sexual and reproductive health and rights for all.

"Nearly everyone of reproductive age, some 4.3 billion people worldwide, will lack at least one essential sexual or reproductive health service over the course of their lives," Dr. Ezeh told the audience assembled in Johannesburg, South Africa, for the global launch of the report by the Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights (SRHR).

"To make true progress [we are putting] forth a universal vision that recognizes that improving health depends on advancing rights: a right to have access over one's lifetime to the information, resources, services and support necessary to make decisions governing one's body and to

pursue a satisfying, safe and pleasurable sexual life."

The conclave of commissioners developed the methodology for evidence synthesis and interpretation over two years that culminated in recommendations for governments to spend some USD\$9 per person per year to cover the total cost of fully meeting the need for modern contraception, safe abortion, and maternal and newborn care in developing regions.

The commissioners noted that current levels of care are covered with about half that amount, requiring a doubling of domestic investment in the full slate of SRHR outreach and services for populations. This comprehensive SRHR package should also be a cornerstone of any country's efforts to draft and implement a universal health coverage strategy to reach its entire population, noted Ann Starrs, who with Dr. Ezeh was the commission's co-chair.

"What's more, these investments will yield enormous returns," Starrs said in her keynote address. "Evidence shows that sexual and reproductive health interventions save lives, improve health and wellbeing, promote gender equality, increase productivity and household income, and have multigenerational benefits by also improving children's health and wellbeing."

Access to SRHR is constrained by financial, traditional and social

GUTTMACHER-LANCET COMMISSION
ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

"Gaps in sexual and reproductive health and rights worldwide take an enormous toll on individuals, communities and economies.

We must not continue to tolerate this problem."

Dr. Alex Ezeh
Co-Chair, Guttmacher-Lancet Commission



barriers, and felt most acutely by sexual minorities and adolescents, as well as girls and women of childbearing age.

The Commission's report found that there were more than 200 million women globally who were sexually active but unable to access the modern methods of contraception they needed in order to avoid pregnancy.

Pregnancy prevention is not the only driver of needs to improve access

Nearly everyone of reproductive age, some 4.3 billion people worldwide, will lack at least one essential sexual or reproductive health service over the course of their lives

to contraception; nearly two million people are infected annually with HIV: among the more than 350 million people who are infected with preventable sexually transmitted infections.

"Ignoring these broader needs has a hugely detrimental impact on people's lives, on their wellbeing and ultimately on communities and countries," said Dr. Ezeh. "Around the world, we need to address the neglect of these needs, now."

Social transformation affects health in Africa

By Eunice Kilonzo, CARTA Communications Officer



📍 Kennedy Alatinga of Ghana's University of Development Studies speaks to participants at the first-ever African BIARI workshop

APHRC hosted the first-ever Brown International Advanced Research Institutes (BIARI) workshop convened in Africa at its campus in Nairobi, in June 2018. Participants from across Africa including ten CARTA fellows, secretariat staff and ADDRDF fellows were invited to explore topics related

to the social changes sweeping sub-Saharan Africa.

Anchored in the week-long workshop's theme of Health and Social Change in Africa, the discussions took place amid serious, rapid and at times overwhelming shifts in national fertility trends that are accompanied by rapid rural-to-urban migration and increased life expectancy - even as environmental changes threaten to upend traditional farming, animal husbandry, and fishing practices. The demographic transitions hitting most countries in sub-Saharan Africa are also contributing to increased

societal risks of non-communicable diseases (NCDs). How to respond to and mitigate such risks requires innovative and flexible approaches to adapting health systems to accommodate management and care of both communicable and non-communicable diseases.

Violent and resurgent conflict, the displacement of hundreds of thousands either because of conflict or a search for economic opportunities, and public health and infrastructural deficits such as poorly managed sanitation systems all contribute to, and reconfigure, the continent's burden of disease and any country's ability to handle the ensuing public health crisis.

BIARI took up these issues and more, with the aim of bringing together the nearly 50 scholars to learn about cutting-edge research and scholarship on the relationship between health and social change; develop participants' research capacities

to work productively on related questions; and build interdisciplinary professional networks of scholars.

Dr. Blessing Mberu, the convener of the workshop said the discussions in the workshop were critical because "epidemics or perceived health threats can trigger significant human responses that have effects beyond their impact on health."

He added: "Therefore, it is vital for capacity building for research and evidence to inform policy that will address social and health challenges."

The journey toward SDG 3

By Lynette Kamau - Policy and Communications Officer for the Innovations in Maternal and Child Health in Africa initiative

Africa, like the rest of the world, has just 12 years to achieve the targets outlined in the Sustainable Development Goals (SDGs), ensuring that no one is left behind in the ambitious agenda to markedly improve the health, wellbeing and socio-economic opportunities availed to all.

The health of all people is enshrined in SDG 3, which envisions improved individual and population health contributing to a stronger workforce, increased economic prosperity, lower poverty rates, and longer, healthier lives for everyone, regardless of who they are, where they are from or where they live.

As with the Millennium Development Goal agenda that preceded it, however, sub-Saharan Africa remains behind the curve - not just in achieving

the targets but in articulating strategies to pursue them.

Rapid urbanization, environmental pollution and an incremental but substantive shift in the way people live are also contributing to an increased burden of non-communicable diseases (NCDs).

They are straining health systems already stretched

by management and treatment of

communicable diseases like HIV,

tuberculosis, and malaria

that continue to plague

the continent. A lack of

human and financial

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A lack of human and financial resources persist even as new technologies seek to mitigate some of the challenges in the supply chain and data management.



For Africa to achieve the SDGs, investments in the following three areas are necessary.

Sustainable financing for health

Since committing to the Abuja Declaration's minimum requirement of at least 15% of their national budgets devoted to health, few governments in sub-Saharan Africa have managed to get even close.

The result is understaffed, understocked and under-resourced facilities across the region, which consequently limits the quality of care provided. Further, national immunization coverage rates have stagnated, declines in maternal and child mortality rates are minuscule, and there is a worrying drop off in adherence to, for example, the life-saving drugs needed to manage HIV.

Inequities abound within the health sector - between and among different ethnic

communities, geographies, and populations. These inequities threaten to rise as multilateral funding mechanisms such as the Global Financing Facility for maternal and child health, Global Fund to Fight AIDS, Tuberculosis and Malaria, and Gavi, the Vaccine Alliance begin to transition countries whose aggregate GDP per capita exceeds established thresholds.

Meeting in March in Arusha, Tanzania, for an annual conference by the East, Central, and Southern Africa Health Community (ECSA), representatives from the Ministries of Health from nine countries pledged to do more, and soon, to coordinate domestic resource mobilization for health. They also vowed to share findings and lessons learned from the most effective, and cost-effective, interventions that would bring them closer to achieving the health targets outlined in the SDGs.

This should include a more coordinated approach to working with development partners, specifically in terms of planning, implementation and monitoring both what services are being delivered and their impact on the health of communities.

It is hoped that this collaborative effort - which many consider to be long overdue - will help countries chart the course toward achieving universal health coverage, ensuring that all people have, at a bare minimum, access to essential health services.

Universal health coverage

Provision of quality health services is the government's obligation as articulated in several international treaties, declarations and national laws. African countries are therefore establishing structures to ensure people have access to basic quality and affordable health services. The World Health Organization states that countries that facilitate universal access to health care are more likely to attain health-related targets as well as the other SDGs.

Representatives from Ministries of Health committed to examining ways to sustainably and domestically mobilize resources, ultimately leading to a national health insurance scheme. They also committed to establishing systems to manage the process - what health services are covered, how they are funded, managed, and delivered - to ensure services are integrated and focused on the needs of people.

To successfully achieve this, they will need to address health system coverage, which heavily depends on the availability, accessibility, and capacity of health workers to deliver quality

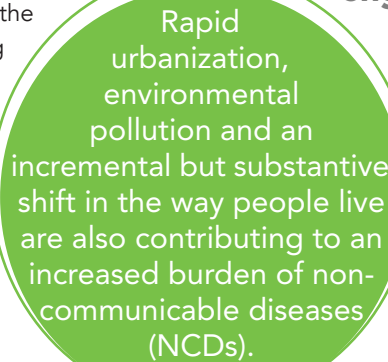
care. This will require a holistic approach and investments to enhance good governance, sound systems of procurement, consistent supplies of medicines, health technologies, and well-functioning health information systems in primary health care.

A multi-stakeholder engagement to health

The assembled executives and civil servants acknowledged that there is a need to engage more fully and thoughtfully with the private sector, both in the provision of health services and in the training, recruitment, and retention of health workers. Governments, too, need to do more to ensure that all actors in public, private and civil society are engaged in responding to public health challenges. For example, without engaging with the agriculture sector, it will be impossible to counter the twin threats of undernutrition as well as obesity, a major risk factor for any number of NCDs from diabetes to hypertension to some cancers.

To facilitate a strategic engagement, APHRC committed to working with ECSA to establish a framework that will enhance the tracking of progress in the implementation of health commitments passed during the Health Ministers conferences. The framework will strengthen ECSA's role as a regional body to support the reporting and overall accountability of member states on their progress towards achieving the SDG 3 targets and other global commitments.

By having sustainable access to human and financial resources, establishing accountability systems for universal health coverage and working with partners in the public and private sector, we have the potential to leave no one behind.



Rapid urbanization, environmental pollution and an incremental but substantive shift in the way people live are also contributing to an increased burden of non-communicable diseases (NCDs).



More than 50 representatives from across civil society participated in a three-day workshop to articulate health finance priorities in Kenya

Advocates come together to urge increased financing for health

By Gaye Agesa, Immunization Advocacy Initiative manager

Diarrrhea, pneumonia, tetanus: each of these diseases is vaccine-preventable yet still responsible for tens of thousands of deaths annually of children under age 5, most of whom live in sub-Saharan Africa.

Years of research, development and development partner-funded campaigns have made routine immunization the single most cost-effective health intervention there is: a \$44-return on investment globally, yielded in human capital as well as in offsetting the costs of treatment for disease.

Yet despite the value of routine immunization, coverage levels have stagnated, putting the lives of millions at risk. This risk is compounded by the declining global funding for immunization campaigns - including a decades-old polio vaccination effort that has systematically

eradicated the crippling disease in all but a handful of countries - as countries hit the minimum threshold for GDP that makes them ineligible for multilateral support.

Diminishing support for Gavi could mean rise in vaccine-preventable disease

Since 2002, Gavi, the Vaccine Alliance, has capitalized on pledges from governments, foundations and other development partners to pay for vaccines and vaccine-related commodities needed by the lowest-resourced countries in the world. Over the course of its existence, Gavi has evolved to also include investments in the strengthening of health systems: a result of repeated demonstrations of the value of investing in five of the six building blocks of health identified

by WHO: human resources, data management, supply chain management, infrastructure and governance.

The global appetite for continuing this massive multilateral investment, however, is dwindling, especially as the GDP of even the world's poorest countries increases without a commensurate increase in those countries' spending on basic healthcare for their populations.

In a bid to, hopefully, forestall any vacuum that would accompany the withdrawal of international funding for vaccines, Gavi has developed a co-financing model to begin to wean recipient countries away from reliance on outside support for their immunization needs.

This requires countries to meet a certain percentage of the total cost to run annual vaccination campaigns, including the human resource and supply chain costs. This status is referred to as "fully self-financing".

In 2018, Angola and the Republic of Congo achieved 'fully self-financing status' and are thus no longer eligible to receive Gavi financial support.

But despite their status as middle-income countries, the inequities in their societies are pronounced. Few domestic investments have been made in strengthening health systems and hiring the necessary staff to carry out immunization campaigns or improving their storage and transport facilities, and there is immense fear that their ill-preparedness for the transition away from external support could lead to huge drops in their coverage rates, making their populations more susceptible to disease pandemics.

At the same time, these concerns also demonstrate one of the inherent challenges with the Gavi model: that per capita GDP is the lone metric by which eligibility is calculated.

Countries preparing to transition from eligibility for Gavi support were assessed in five different domains to identify a tipping point for improved civil society participation in health - related decision making



For countries where the gaps between the haves and have-nots are yawning caverns, the fragility of the public health system is one of the most illustrative consequences.

These canaries in the coal mine of sustainable self-financing for immunization are prompting other rising economies such as Ethiopia and Nigeria to implore Gavi to hold them back and prevent them from graduating and becoming ineligible for support.

Other countries are using their predecessors' challenges as an incentive to plan earlier, and better. Kenya, for example, has committed to increasing its centralized domestic contributions to immunization campaigns by 15 percent per year over the next five years, to reach \$40 million by 2023.

How to ensure that there is demand from communities generated for these investments as well as high-level commitments from government officials to provide them remains a critically unanswered question that requires a collaborative approach from experts in health, social justice and finance.

In Côte d'Ivoire, Ghana and Kenya, APHRC convened a series of stakeholder meetings to begin to answer that question, as part of a new initiative that seeks to empower and enable civil society to play a significant role in mobilizing domestic resources to prevent the financing vacuum that will accompany transition from Gavi support.

The five-year Immunization Advocacy Initiative, led in consortium with the West Africa Civil Society Institute, brought more than 50 representatives from government, civil society, academia and professional bodies together in each of the three countries to validate an extensive secondary data-level analysis conducted in 2016 and 2017 by APHRC.

Assessing countries against indicators in five different domains -- political will; health sector; health finance; civil society space and immunization coverage -- we identified opportunities for evidence generation, capacity strengthening and advocacy to help guide governments toward developing Gavi transition plans.

All three of the validation meetings corroborated both our findings and the scope for the IAI to engage in a meaningful way to support improved coverage and equity of routine immunization campaigns, and stronger civil society voices in discussions about sustainable finance for the health sector.

And while each country presents its own unique circumstance, with different priorities, there were

a few key takeaways that resonated

across the region. First, is that civil society organizations need assistance in navigating the highly complicated process of making budgets at the national and sub-national level, and understanding where their voices on behalf of populations can be best brought to bear during that process. And second, is that both civil society and the decision-makers they are

trying to reach are well-aware that they are missing evidence that would help them be more effective in working together toward common goals of improved population health.

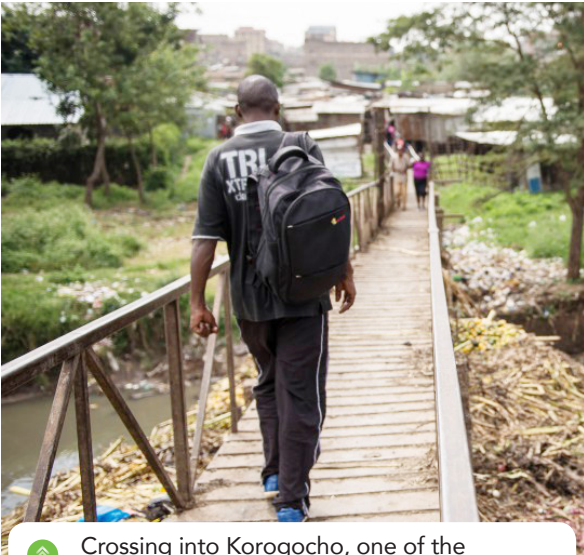
The project entered its second phase in August with a call for expressions of interest from civil society in each of the three countries to be considered for targeted financial and technical support to help them meet these and other challenges.




Kenya, for example, has committed to increasing its centralized domestic contributions to immunization campaigns by 15 percent per year over the next five years, to reach \$40 million by 2023

Lies we tell ourselves: debunking the myth of the urban advantage

Henry Owoko, Field Interviewer



 Crossing into Korogocho, one of the expanding slums in Nairobi

Among the most widely circulated myths in the field of international development is the notion of an urban advantage: the far-superior quality of life yielded by access to proper infrastructure, quality services, seemingly limitless opportunity. My name is Henry Owoko, and I live in Kariobangi. I can tell you from my own experience that the urban advantage is little more than an urban myth.

Charting my own course

I grew up in Siaya County, Kayombi village in Western Kenya. The closest town is Ugunja, home to 17,000 people. For most of us, Kenya's cosmopolitan capital, Nairobi, was the place to go: to "make it" and, with any luck, secure a white collar job.

So at age 23, I came to the city after a conversation with a friend from home who regaled me with tales of the fortunes of Nairobi. Stay away from farming, he said. Come seize the opportunities available for people like you. People like me, I

thought. So I packed my bags, got on a night bus and landed in Nairobi with no job prospects and one suitcase.

For the first four months, I lived with my sister and her two children, and slept on the chair: one of three pieces of furniture she owned, all crammed into her single-room house under a roof of corrugated iron. I stayed out late so as not to disturb her household, and began to encounter a whole host of opportunities - except none of them were the kind I was looking for.

In their research: "Rural-Urban Migration, Unemployment and Job Probabilities", Harris and Todaro liken migrants who come to cities to people playing the lottery. First prize? A job, with decent pay. For most of the rest? Intermittent employment, high exposure to risk, and the prospect of complete and utter destitution. From just watching my sister's neighbors, I already knew this deep down and didn't need any more evidence to convince me otherwise.

Of course there were people living around us who were living their lives with a relative degree of comfort. One neighbor, probably in his late fifties, sold cheap food to the people around him. His mud house was cemented, and his family of six occupied five rooms.

Others left little to admire, even if their fortunes were more considerable. Drug dealers, for one. Or thugs for hire. Was it possible for me to vow that no matter how bad things got, I would never be among them? I remember feeling that with every passing minute, a choice was being taken from me.

Reality sets in

I began to loiter near the bus stop among other idle young men, discussing the trivialities of our time with the weighty considerations of those who have nothing else to do. City life was always a hot topic, next to politics and football. I remember passionately arguing that we were better off than those we left behind in the village, we with our pizzas and our mobile phones, and our shopping malls, even as my own empty pockets and empty belly belied that notion.

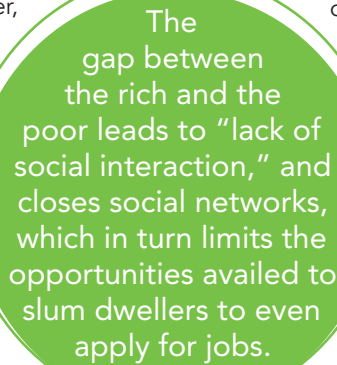
Our turn was just around the corner, I would think, even as I stumbled over sewage, threading my way through dark alleys back to my sister's place. But even as I made my way home it would strike me that I was living the myth of the urban advantage, a victim of the pervasive social, economic, political and cultural inequalities that embody the gap between rich and poor in the urban environment.

Those street corner chats and late night musings have found validation at the highest levels, including UN-Habitat's World Cities Report 2016.

For example, the gap between the rich and the poor leads to "lack of social interaction," and closes social networks, which in turn limits the opportunities availed to slum dwellers to even apply for jobs. No work means no wages -- and makes it harder to afford a decent place to live. So some, with no other options, turn to illegal activities, further compounding "social exclusion and marginalization" of the poorest.

The most ruinous element of the myth of the urban advantage, I think, is that notion of 'opportunity:' that somehow, there are more chances for success in the city because there are more services. Certainly as compared to some of the most remote rural areas, there are more schools, more shops, more clinics and dispensaries. But access for the most part to those services is contingent

on payment, since in the city, public services are overstretched and have been for a generation. The rapid growth of urban slums has pushed urban infrastructure beyond the breaking point. New research conducted by APHRC in partnership with the Nairobi County government has found that more than 60% of the fecal waste produced by Nairobi residents is uncontained. The city's sewer network only covers a fraction of the population, most of whom reside in middle-class neighborhoods. The rest of us? The rest of us suffer through cholera outbreaks every year due to exposure to pathogens in fecal matter.



The gap between the rich and the poor leads to "lack of social interaction," and closes social networks, which in turn limits the opportunities availed to slum dwellers to even apply for jobs.

This new work on fecal waste management is APHRC's latest contribution to the body of evidence debunking the myth of the urban advantage.

A study found that the urban poor do not have better access to services than the rural poor, despite their proximity to public offerings of primary education, health care and infrastructure. According to

APHRC's report Population and Health Dynamics in Nairobi's Informal Settlements (2014), slum residents had worse health and socio-economic outcomes than people living elsewhere in Nairobi. They were more likely to experience violence and social unrest compared to any other group in Kenya. Access to water, sanitation, education and employment was low, and there was limited presence of public sector or law enforcement agencies within slum areas. Further, slum residents had no legal claim on the land where they had settled. Little has changed in the last six years, except for the size of the slums dotting Nairobi.

My work with APHRC as a field researcher has, in some ways, lifted me into some degree of benefiting from the urban advantage. But that rise is a precarious one. Not until leaders take meaningful action to address systemic inequities plaguing urban slums will there truly be freedom of opportunity for "people like me."

Healthy communities in Western Kenya: from research to practice

By Carol Gatura, Communications Officer



APHRC convened a six-county meeting in Kisumu in June to discuss the state of Sexual and Reproductive Health care

Western Kenya is known for its breathtaking views of Lake Victoria, fresh fish, and warm people but also for slow progress to end unplanned pregnancies, high rates of HIV infection, and unsafe abortions. However, some county governments in this region have made slight but meaningful changes to this narrative.

APHRC brought together representative from six counties in Kisumu, Kenya's third-largest city, on 13 June to talk about the state of Sexual and Reproductive Health (SRH) care and awareness in the western region, to discuss what works and what is needed to ensure that every intervention is effective, cost-effective and appropriately addresses identified SRH needs from childhood into adulthood.

Improving access to family planning

Siaya and Busia counties have made remarkable progress in getting more men, women and adolescents to use long-acting contraceptives. From pills to injections to vasectomies, a network of community health volunteers offered education and awareness about the various methods available to prevent unplanned pregnancy and unwanted sexually transmitted infections. Over three years between 2012 and 2015, the project linked more than 46,000 people to family planning use for the first time through community-based distribution. Services targeting young people were especially successful, including youth-friendly health centers and free (telephone) hotline services.

These small-scale successes underscore the need for dedicated resources for family planning services and support; however, there has yet to be a push at county level to allocate a specific line to family planning in the health budget. A dedicated spending envelope for a specific set of activities is considered a key milestone in ensuring there are enough resources allocated to meet population needs, and family planning advocates have long pushed for such a commitment at the federal budget level. Now that health service delivery has been devolved, it requires a concerted and coordinated effort in each of the 47 counties as well as with the central government.

Yet even with a dedicated budget line, funding is not assured, as rarely do counties have enough resources to meet their entire range of health needs.

For fiscal 2017-2018, Busia County projected a budget of \$18 million. Its allocation of \$12 million from the central government meant that critical services for prevention, treatment and care were left unresourced.

Counties like Siaya confront different needs. Last year the county mobilized to develop a costed FP plan to submit to the national government for increased resource allocation, only to find that it had failed to spend all the money that it was already given. This could have consequences for health service delivery going forward.

Devolution of responsibility also provides opportunities for counties to domesticate national

policies to suit their needs. Homa Bay has tailored the national adolescent sexual and reproductive health policy to meet its specific needs.

County-specific policies on health

Health is a devolved function under the constitution, and counties are responsible for customizing national policies to their context. Homa Bay County has taken a lead on this and is working on domesticating the national Adolescent Sexual and Reproductive Health (ASRH) Policy. They have brought together different players, across the county's ministries, to develop a work plan that will focus on improving adolescent sexual and reproductive health outcomes.

Moving forward

Despite numerous investments by partners working in these counties, results of positive health indicators are minimal but promising. Counties expressed the need for evaluation of these interventions as well as research on county health priorities and funding challenges. Greater investment is also needed from national government coffers to increase overall county health allocations.

The conversations do not end here. This is another touch point along the path of a long-term relationship between APHRC and western Kenyan counties to work together to identify the research gaps as well as provided technical assistance in policy implementation.

Devolution of responsibility also provides opportunities for counties to domesticate national policies to suit their needs

Meet Board member Nalinee Sangrujee: a passionate champion of evidence-informed policymaking

Nalinee Sangrujee joined the APHRC Board in 2017, bringing with her extensive experience in the health sector, most recently as the associate director of health economics for the global HIV and TB division of the US Center for Disease Control and Prevention. Her interests in health policy and strategic use of data to improve accountability and performance of global health programs align with APHRC's mission of using research to be transformative. Nalinee has a PhD in Agricultural and Resource Economics from the University of California at Berkeley. Her work experience spans the health areas of HIV/AIDS (PEPFAR), maternal health, vaccine preventable diseases, child survival and avian influenza.

Carol Gatura caught up with her at the April meeting of the APHRC Board in Nairobi.

“ I thought this was a real opportunity to think about how a research organization could get more deeply involved in the policymaking world ”



APHRC Board member Nalinee Sangrujee

Q: Why did you say yes to the request to join the APHRC Board? What strengths and experiences do you bring to this role?

A: I had heard about APHRC and its great work from some of my colleagues. This is my first board assignment and I was excited by the opportunity [to serve on the board]. My professional experience has been in government and policymaking and I thought this was a real opportunity to think about how a research organization could get more deeply involved in the policymaking world.

Q: Where does APHRC need to invest more resources (either human or financial) in order to take its place among the global think tanks?

A: I think the hardest skill set to develop is the ability to know upcoming key policy issues, and being strategic enough to think about the research agenda that's going to inform those policies. It takes one to three years to generate evidence so you must have foresight. How do you engage with stakeholders to predict the strategic direction, define a research agenda that will still be relevant in a few years, and then translate the evidence in a way that is accessible to policymakers?

Q: How can APHRC research truly be transformative, cognizant of all of the contributing factors that might mitigate our impact [such as political and economic considerations, national priorities versus development priorities]?

A: APHRC does a good job of identifying key research directions. I think the difficult part is [that] the speed at which APHRC produces research is out of sync with the pace at which policy decisions are made, and programs change. For example, I work in the area of HIV/AIDS. Even though this is a decades-long research effort, the research and knowledge have changed over the years.

The ability to develop a research agenda that can quickly produce quality knowledge is probably one of the biggest challenges.

It calls for creativity on how one can produce information in different stages - synthesize information, research, and the longer-term impact evaluations. It takes three to five years to see any results. The main question is, how do you get people thinking and help them make decisions even when the research is not complete?

Q: Where should APHRC pursue a higher profile when it comes to developing strategies for Africa to achieve the Sustainable Development Goals (SDGs) by 2030?

A: APHRC is all about building the capacity of African researchers by Africans. So why not take it to the next level by building policies and policy priorities for Africa by Africans?

As APHRC becomes a leader, not just in research but translating that research, it should also empower Africans to set some priorities. There is conflict between development priorities, national priorities and where the funding comes from. How do they align?

Q: Any last thoughts?

A: What I love working on but found difficult was to translate and communicate the research to the broader community, whether to politicians, clinicians, civil society, or the general population. That is where impact happens. This is a skill that you cannot get in a formal institution, but that is incredibly valuable. From my personal experience, being recognized as an expert is also about being able to effectively communicate the knowledge.

Using brown-bags to promote dialogue and information sharing

By Lisa Omondi, Program Assistant, Research Capacity Strengthening

Since joining APHRC in May 2017, I have overseen 36 brown bag meetings that have become increasingly popular as months go by. The informal interactions that encourage learning and knowledge sharing are open to both internal and external participants and speakers.

Most sessions are facilitated by research officers and other staff before and after attending trainings, workshops or conferences to prepare them for presentations and provide them with much needed feedback on how to improve their presentations. The informal nature of the meetings provides presenters and the audience a conducive environment for learning and critiquing to clarify ideas. Students and post-doctoral fellows are encouraged to make at least one presentation a year.

Although sessions are held on alternate Wednesdays, 2018 has seen more and more people want to make presentations and the meetings are held every week. The hour-long sessions are so interactive that interns and visiting students are encouraged to attend and facilitate brown bag sessions at the end of their training period.



 Lisa Omondi

External collaborators, experts and partners whose agenda is in synergy with APHRC's goals and objectives are invited to lead sessions.

Whether the presenter is a member of staff or an external individual, the Center uses these sessions to identify potential areas of synergy with like-minded individuals or organizations such as a presentation from Alex Hinga, a PhD scholar at the KEMRI Wellcome Trust Research Program, who presented preliminary findings from his study on ethics of Verbal Autopsy in Health and Demographic Surveillance Systems (HDSS) within sub-Saharan Africa.

As the coordinator, I have introduced several sessions and in turn gained a lot of knowledge on issues around health, research and policy

engagement. Just recently, I got to understand and appreciate the Kenyan budgeting cycle through a presentation delivered by the International Budget Partnership (IBP). The presentation was made possible following a request by one of my colleagues, Emilly Juma, who was selected as a finalist for a nine-month, fully-funded training on budget facilitation.

Budget tracking is an invaluable element of policy engagement and critical in the policy change continuum as Catherine Kyobutungi, APHRC's executive director, once said. Therefore nurturing champions who can pass on skills in national budget tracking, from formulation, approval, implementation, audit and oversight, is a welcome effort by IBP, to keep governments accountable.

Generally, I have found brown bag sessions insightful and interesting as they help improve presentation skills, critical listening and engagement. Perhaps for me the most fascinating aspect is getting to interact with researchers, program leaders and experts from within and outside the Center as I schedule their presentations.

CARTA fellows equipped with skills to use data management software for research



⤴ CARTA fellows at a data management training workshop

Thirty-five CARTA fellows, cohorts seven and eight, joined an inaugural three-day regional Research Electronic Data Capture (REDCap) data management training workshop. The training from May 8-10 in Nairobi taught the students from across east and southern Africa how to use REDCap, the secure web application for building and managing online surveys and databases.

The software is a useful tool for students doing data collection and analysis of doctoral research. The three-day intensive training was led by CARTA Monitoring and

Evaluation Officer Emmanuel Otukpa, and was co-facilitated by an expert on the software, Mapule Nhlapho, from the University of the Witwatersrand Biomedical Informatics Center.

The fellows now have practical skills in longitudinal data collection along with advanced data management techniques. They were also taken through the entire lifecycle of a REDCap project – from initial setup to data entry and export.

CARTA Program Manager, Prof. Peter Ngure said the sessions also revolved around reporting and project management, data resolution workflow as well as use of the REDCap offline mobile app.”

The software is a useful tool for students doing data collection and analysis of doctoral research.

Countdown 2030 analysis workshop in Eastern and Southern Africa



Participants from across East and Southern Africa developed posters of national data about trends in maternal and child health

The Countdown to 2030 regional initiative for Eastern and Southern Africa convened its second data analysis workshop in Naivasha, Kenya, July 9-13. In total, 37 participants (senior analysts from Ministry of Health, public health institutions and Universities) from 17 countries across East and Southern Africa participated in an intense week of developing comprehensive regional, national, and sub-national health analyses related to maternal, newborn, and adolescent health inequities. APHRC led a facilitation delegation of experts from Johns Hopkins University, University of Manitoba, University of Pelotas, the World

Health Organization (WHO), UNICEF, and the Health Data Collaborative.

The countries conducted analyses that built on work begun during a first workshop held at APHRC in November 2017 that was enhanced in-country during the interim period. Our aim with this intensive training is to better equip countries to identify where more is needed to address sub-national inequities. In particular, the latest analyses focused on three major areas of inequity: wealth, urban-rural residence, and administrative area. Country teams, generally comprised of at least one person from the Ministry of

Health and one researcher from an academic or research institution, worked hand-in-hand to produce a comparative country RMNCH equity performance profile covering three major dimensions of inequality. As a result, participants strengthened their analytical skills and their ability to interpret, curate, and communicate the results.

Some 92% considered the workshop 'policy relevant' as some of the results may be used to address country policy gaps.

By the end of the workshop, country teams produced and interpreted research posters of levels and trends in inequalities in coverage and child mortality in their countries and the region.

The country posters were structured around three key dimensions of the continuum of care:

i) Inequities by wealth quintiles at national level;

ii) Subnational inequities related to health system performance;

iii) Disparities between urban and rural.

The country posters were assessed by all participants and facilitators and rated to identify the best two. Posters from Zambia and Tanzania were rated as the best, and their presenters were awarded a symbolic prize for their efforts.

The network is continuing to work on regional publications on equity and planning further analysis meetings on the generation of health statistics from health facility data and other topics. The next step is to support dissemination and knowledge translation of the evidence generated. It is hoped that the evidence will be used by government decision-makers to improve programming, and increase resource allocation to achieve the national and global targets to end preventable maternal, newborn, and child deaths.

Presentation on population policies and fertility transition in East Africa



 Tizta Tilahun

Tizta Tilahun attended and presented a paper at the Population Association of America annual meeting in Denver, Colorado on April 26-28. During the annual meeting, Tizta delivered a presentation on population policies and fertility transitions in East African countries and their implications for the demographic dividend.

The study reviewed population policies and fertility transitions in Ethiopia, Kenya, Rwanda, and Uganda, and examines the implications of fertility transitions and population policies on the prospects of the demographic dividend in these countries.

CARTA fellow appointed to Malawi's pharmacy board

CARTA Cohort Five fellow Felix Khuluza from the University of Malawi has been appointed by the state president of Malawi, Arthur Peter Mutharika, to the National Board of Directors of Pharmacy Medicines and Poisons Board (PMPB). His appointment, announced on July 13, means Khuluza and the other ten members of the policymaking institution will be involved in the registration of all pharmaceutical personnel. They will also assist in the promotion and improvement of the health of the population of Malawi mainly by controlling the registration and retention of medicines and allied substances.

Khuluza's name and skills in pharmacovigilance were also recognized in January this year when two of his published papers from his doctoral research on the quality of medicine available in his home country of Malawi were included in a new WHO global report on substandard and falsified medicines.

The report, 'Study on the public health and socioeconomic impact of substandard and



 Felix Khuluza

falsified medical products', is a systematic review of more than 100 papers released between 2007-2016 on the public health and socioeconomic impact of substandard and falsified medical products.

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