

Genesis of the Strategic Plan

IPPFAR plays a key role in promoting sexual and reproductive health in sub-Saharan Africa (SSA) through its network of Member Associations (MAs) in 44 countries, and their associated 38,000 local volunteers who are the backbone of programme implementation.

Membership in the global Federation enables the regional office to adhere to policies and standards that give it the credibility to leverage for additional resources outside the IPPF family to achieve its goals, while its regional character allows it to form partnerships with international, regional and subregional institutions to tackle the continent's growing reproductive health challenges.

Where We Started

To build on its region wide achievements, and grow into the millennium, IPPFAR knew it had to strengthen not only its MAs, but also its own institutional capacity.

In early 2002 the regional office launched a process of redefining its own objectives and functions and those of the network. Two workshops held early that year brought together representatives of all 44 Member Associations in brainstorming and soul searching sessions that began the process of redefinition. The draft strategic plan developed in this process was approved by the regional Executive Committee in April and reviewed and adopted by the

Regional Council by the end of the year. Subsequently, to ensure its alignment with the outlook of the IPPF at the global level, the Africa Region took up the planning process again and in early 2004 revisited and refined the strategic plan to sharpen its perspective and

extend its outlook over the five years from 2005 to 2009. What you see here is a condensed version of the revised plan and work programme that emanated from that process.

The plan required a total restructuring of the Africa regional office, on the one hand, so as to provide more effective technical assistance to the Member Associations, on the other hand, mainly to support their institutional development and knowledge infrastructure. These steps recognize the pivotal role the Member Associations play in providing a wide range of specialized skills and capabilities to facilitate effective implementation of new programmes.

The Context

The sexual and reproductive health status in sub-Saharan Africa requires urgent solutions. According to UNAIDS (2002) estimates, the region has the world's highest HIV/AIDS rates: of the 42 million people globally living with HIV, 29.4 million (71 per cent) are in SSA; of these 58 per cent are women of childbearing age. Maternal and infant mortality rates are also the highest in SSA, on average 830 per

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100,000 live births and 91 per 1,000 births, respectively. Life expectancy is 51 years, compared with the global life expectancy of 67 years and North America's 77 years.

The lifetime risk of maternal death is 1 in 20 for a woman who lives in SSA, compared with 1 in 110 for Asia, 1 in 2,000 for Europe and 1 in 3,500 for North America. SSA also has the lowest contraceptive prevalence rates, an average of 19 per cent compared with a global rate of 61 per cent. In addition, the region has a high incidence of teenage pregnancies and early marriages and high population growth rates (IPPFAR, 2004).

The Millennium Development Goals (MDGs) adopted by world leaders in 2001 have as their primary objective to cut in half the proportion of people living in poverty by 2015.

The critical role of SRH in poverty reduction is highlighted in the MDGs that specifically address maternal health, child mortality, empowerment of women and HIV/AIDS. In addition to these and other sector-specific concerns, the goals incorporate the development of a global partnership for development.

IPPFAR's objectives are aligned with the MDGs. As one of the leading players in sexual and reproductive health in the continent, IPPFAR appreciates the importance of the sector-wide approach implied by the MDGs. Poverty is one of the primary causes of the dismal SRH picture painted above, and improving the picture requires efforts from many directions. For this reason IPPFAR understands that no one can work in isolation. There is need to harmonize and coordinate the efforts of all concerned. IPPFAR's intent is to be a strong and reliable partner to those efforts.

IPPFAR's New Strategic Direction

The new strategy sets out IPPFAR's approach within six specific programmatic areas – adolescents, AIDS, access to family planning, advocacy, abortion and safe motherhood – as the basis of its operations.

This is a shift from the past where the regional office organized its assistance to MAs by grouping them on the basis of language (francophone, anglophone, lusophone) or subregion (east, south, west, central) without focusing on the specific needs of the population.

IPPFAR's Guiding Principles

The implementation of the IPPFAR strategy will be guided by the following principles:

- Ownership and leadership by the African Member Associations
- Gender sensitivity in all programmes
- A focus on youth as future leaders
- Effective and strategic partnerships with key stakeholders, including beneficiaries
- A participatory process of designing comprehensive service packages
- Ethical considerations and cultural sensitivity
- Good governance, peace and security – IPPFAR will strive to set an example of harmony and to do whatever it can to promote peace

Under the new approach, countries facing similar problems should be able to make maximum use of resources by collaborating to address common issues.

Family planning is and will continue to be the core business of IPPFAR and its Member Associations for the foreseeable future. But the structure of the new regional strategy will permit IPPFAR to reach more widely to ensure that its vision and mission are realized. The grouping of countries (through the tabulation of variables and statistical values) provides the basis for planning appropriate programmatic responses.

The two key variables are HIV/AIDS prevalence rates and contraceptive prevalence rates: HIV/AIDS because of its socio-economic impact on society, and contraceptive prevalence because it reflects the extent to which modern family planning methods are used in the various countries and is an indicator of awareness of wider reproductive health issues and rights.

Other variables, including literacy levels, urbanization, displacement and maternal mortality rates, also enter the equations as important elements for developing detailed and appropriate programmatic responses.

Critical Programme Needs

From this analysis, four groups of countries were identified on the basis of their identified

critical programme needs. The following four programmatic clusters emerged:

- **Countries with high demand for HIV/AIDS interventions:** These are countries with high HIV/AIDS infection rates. The interventions will focus on providing targeted services such as community-based care in rural areas with low literacy. Culturally sensitive audiovisual materials in local languages (e.g., puppetry, community criers, local concert/folk theatre, etc.) will be used to foster behaviour change. Home-based care and social marketing of condoms will be promoted in urban and peri-urban areas. Information, education and communication (IEC) using print and electronic media will be promoted through state-of-the-art communication, e.g., help-lines.
- **Countries with high need for family planning services:** Many sub-Saharan African countries have low rates of contraceptive use and high fertility and birth rates. The interventions will focus on clinical services and social marketing through the electronic and print media in urban areas, while community-based services (CBS) will be promoted in the rural areas through culturally acceptable audiovisual materials in local languages.
- **Countries with high maternal mortality rates:** In urban areas, the interventions will emphasize service provision through health

clinics, interpersonal communications and mass media. In the rural areas with low literacy levels, community-based services will be provided through traditional birth attendants and CBS agents as well as culturally sensitive audiovisual materials in local languages.

- **Countries with high need for technical assistance in institutional capacity building:** This cluster brings together countries with high need for technical assistance and capacity building, and includes most of the new MAs. Here IPPFAR will provide technical assistance to strengthen new and weak MAs to enable them to provide effective services to their clients and to become credible, results-based organizations.

Institutional development will be achieved by improving the infrastructure of the MAs to ensure they reach more rural areas with services and information. The levels of literacy will direct the use of media/methodology for training health workers: a visual/practical approach will be used in areas with low literacy, while conventional methodologies will be used where literacy is high. The capacity in countries with high urbanization will focus on upgrading their facilities to offer quality care modelled on best practice, while partnerships with the private sector will be promoted in countries with low urbanization.

Figure 1 shows the four country clusters by programme area, while Table 1 arranges the clusters according to literacy and urbanization variables, which also have programmatic implications for the new IPPFAR strategic direction.

Target Groups

The new strategic focus will be on marginalized and underserved groups in Africa, including the youth, women and displaced people.

Youth. IPPFAR's focus on youth is more than lip service. Young people make up more than half the population of most countries in the continent. They face sexual and reproductive health challenges that threaten their individual and collective survival. Yet they are Africa's

The Millennium Development Goals

- Halve the proportion of people in poverty by 2015
- Eradicate extreme poverty and hunger
- Achieve universal primary education
- Promote gender equality and empower women
- Reduce child mortality
- Improve maternal health
- Combat HIV/AIDS, malaria and other diseases
- Ensure environmental sustainability
- Develop a global partnership for development

In all phases of this strategic plan, and within all other target groups, young people are the primary focus.

future. As a group they represent the next generation of the economic base of the continent. Keeping them healthy is therefore essential to Africa's future economic growth. IPPFAR will help secure that future by providing this strategic group with the tools it needs to make informed, responsible choices. In all phases of this strategic plan, and within all other target groups, the focus on youth is paramount.

Displaced people. There are over 4 million displaced people in Africa, including the internally displaced, who have been forced to flee their homes following armed conflicts, natural disasters, large-scale development projects or other human rights violations (UNHCR database, 2004).

Reproductive health needs of displaced people are generally not adequately addressed, as assistance usually deals with relief rather

than long-term provision of services. IPPF has experience in providing services and information to this marginalized group worldwide and IPPFAR will explicitly respond to the needs of the displaced groups in the region.

The approach will encompass advocating for the problem to be recognized in the wider relief and support community, working with these organizations to integrate reproductive health services into their programmes, identifying and training peer workers within the displaced populations themselves, and preparing a package of interventions that is flexible enough to allow for response to changing populations.

Women – and men. Gender is a cross-cutting issue that will be addressed by each of the four strategic programmes to ensure its mainstreaming at all levels by increasing gender awareness, providing services and changing attitudes related to gender concerns. The “neglected” target group here depends largely on the type of programme under consideration. Women are often limited in their decision making power on issues related to their own

Figure 1 IPPFAR country clusters for priority programme focus (adolescent and advocacy issues cut across all other programmatic areas)

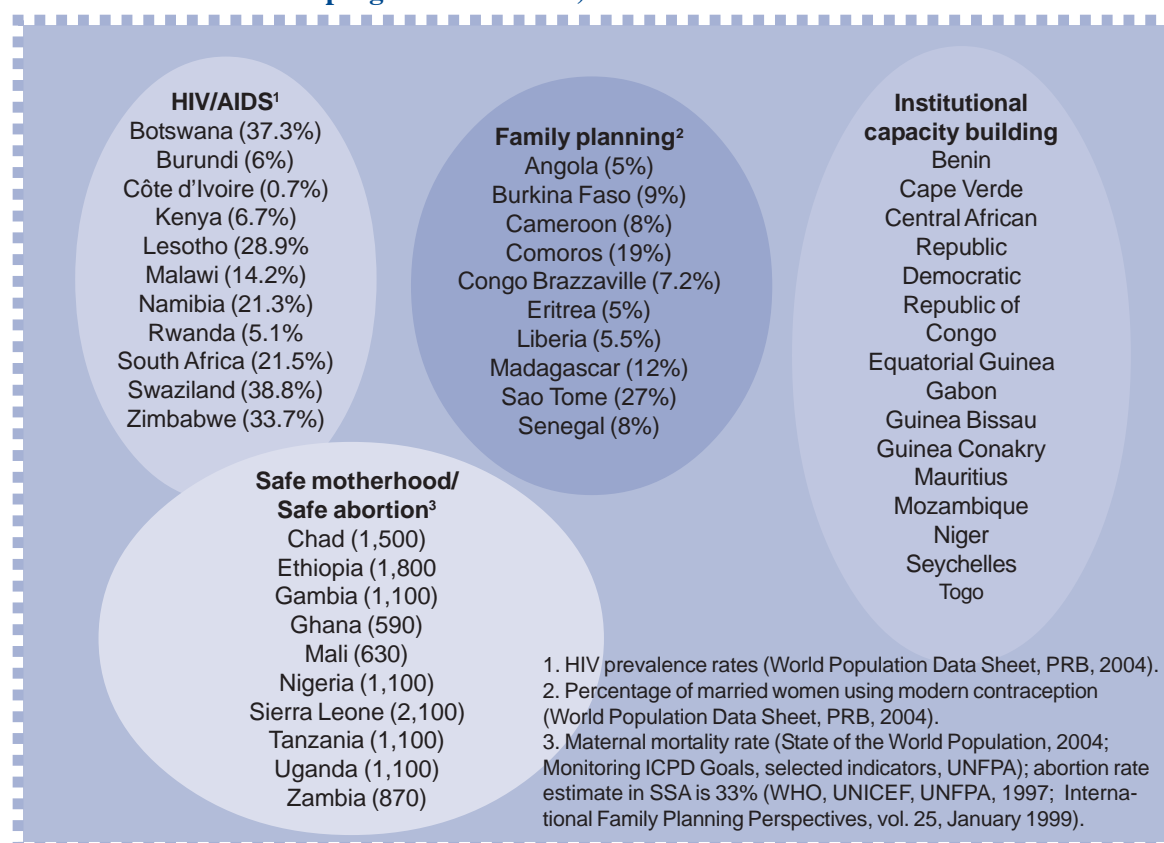


Table 1 Country clusters showing literacy¹ and urbanization² variables

STI/HIV/AIDS	Family planning	Safe motherhood/ Safe abortion	Institutional development
High literacy: Botswana (75%) Kenya (79%) Lesotho (82%) Malawi (57%) Namibia (80%) Rwanda (62%) South Africa (84%) Swaziland (78%) Zimbabwe (86%)	High literacy: Cameroon (72%) Congo Brazzaville (77%) Eritrea (63.2%) Madagascar (78%) Sao Tome (77.8%)	High literacy: Ghana (68%) Nigeria (60%) Tanzania (73%) Uganda (64%) Zambia (75%)	High literacy: Cape Verde 74.5%) Democratic Republic of Congo (DRC; 77.3%) Equatorial Guinea (80 %) Gabon (66%) Mauritius (83%) Seychelles (82%)
Low literacy: Burundi (45%) Côte d’Ivoire (43%)	Low literacy: Angola (42.5%) Burkina Faso (21%) Comoros (58%) Liberia (47%) Senegal (35%)	Low literacy: Chad (48.1%) Ethiopia (35%) Gambia (34%) Mali (36%) Sierra Leone (33%)	Low literacy: Benin (36%) Central African Republic (43%) Guinea Bissau (36%) Guinea Conakry (38%) Mozambique (41%) Niger (14%) Togo (54%)
High urbanization: Botswana (49%) Côte d’Ivoire (46%) South Africa (54%)	High urbanization: Cameroon (48%) Congo Brazzaville (41%) Liberia (45%) Sao Tome (44%) Senegal (43%)	High urbanization: No countries	High urbanization: Cape Verde (53%) Gabon (73%) Mauritius (43%) Seychelles (63%)
Low urbanization: Burundi (8%) Kenya (20%) Lesotho (16%) Malawi (20%) Namibia (27%) Rwanda (5%) Swaziland (25%) Zimbabwe (32%)	Low urbanization: Angola (32%) Burkina Faso (15%) Comoros (29%) Eritrea (16%) Madagascar (22%)	Low urbanization: Chad (21%) Ethiopia (15%) Gambia (37%) Ghana (37%) Mali (26%) Nigeria (36%) Sierra Leone (37%) Tanzania (22%) Uganda (16%) Zambia (38%)	Low urbanization: Benin (42%) Central African Republic (39%) DRC (29%) Equatorial Guinea (37%) Guinea Bissau (22%) Guinea Conakry (26%) Mozambique (28%) Niger (17%) Togo (31%)

Notes: 1. Overall adult literacy rate, 2002 (Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections, UNAIDS/ UNICEF/WHO).
2. Proportion of the population living in urban centres, 2002 (World Population Data Sheet, PRB).

health, sexuality, or access to protection against disease or pregnancy. The health, social and economic consequences of unwanted pregnancies and the transmission of HIV/STIs are serious for women, and are worsened by the inequalities they face in society. Men, meanwhile, are often not viewed as equal partners in outreach for family planning and sexual and reproductive health information and communication programmes. Young men are particularly sidelined when it comes to services and counselling programmes.

Under this strategic plan IPPFAR acknowledges that “gender” is not just another word for women. IPPFAR will ensure that both genders are involved. Women will be trained

and empowered to participate in their communities, while male participation and acceptance of changing gender roles will be made an integral part of the process.

“Gender” is not just another word for women.

Information, services and counselling programmes will be made available to both men and women. Gender-based violence will be addressed through training law enforcement officers, police and community leaders for better management of sexual violence cases. The emphasis will be on a rights-based approach to promote equity and fairness.

Africa Regional Office Organization Structure

A new organization structure has been formulated to provide IPPFAR with the operational capacity to carry out its new strategy components effectively. To be phased in as resources become available, the structure (depicted in Figure 2) reflects the main components of the new strategy through its programmes, partnerships, and finance and administration departments.

Programmes Department

The Programmes Department will ultimately be organized into six specialized components: three content programmes, one services programme and two specialist units. The content areas are: STIs/HIV/AIDS, safe motherhood and safe abortion, and family planning.

The work of these programmes is underpinned by the work of the fourth, institutional development, which will deliver services and promote quality assurance, externally, to the MAs and internally to the three content programmes. Specialization will be evident also in the work of the special services unit, which covers gender, youth, displaced persons and rights, and the information, education and communication/

behaviour change communication (IEC/BCC) unit, both of which will report to the director of programmes and work in tandem with the programmes.

Partnerships Department

The Partnerships Department will provide a new focus and professionalism to the external communications function to promote IPPFAR's leadership in the region. In particular, it will seek partnerships based on the comparative advantages of IPPFAR and other African institutions in reproductive health care in areas of collaboration. Central to this role are advocacy, resource mobilization and publications production.

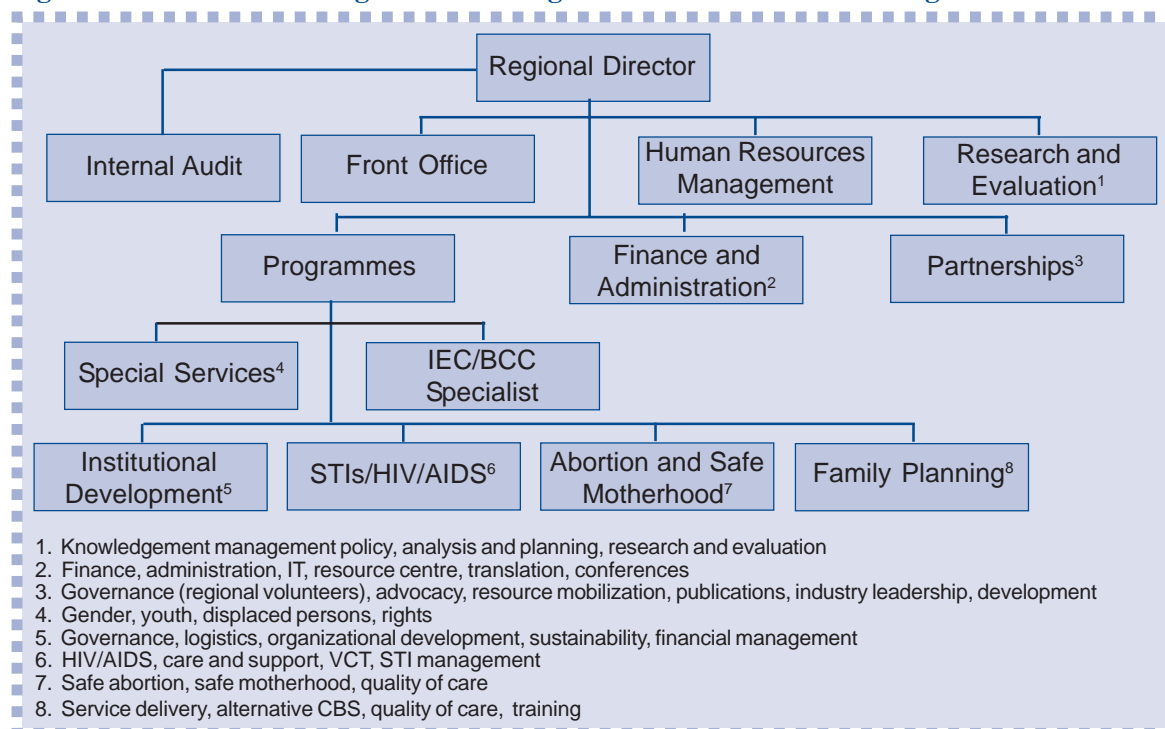
Finance and Administration Department

The Finance and Administration Department will include information technology, translation capacity (given the multilingual nature of IPPFAR's work), and the development of a resource centre for the staff. Within the regional office it will provide support to the other departments/units to enable them to perform effectively.

Other Operational Units

Reporting to the regional director in addition to the three department directors are the internal auditor, the human resources manager, and the

Figure 2 IPPF Africa Regional Office organizational structure – Strategic Plan 2005–2009



1. Knowledge management policy, analysis and planning, research and evaluation
2. Finance, administration, IT, resource centre, translation, conferences
3. Governance (regional volunteers), advocacy, resource mobilization, publications, industry leadership, development
4. Gender, youth, displaced persons, rights
5. Governance, logistics, organizational development, sustainability, financial management
6. HIV/AIDS, care and support, VCT, STI management
7. Safe abortion, safe motherhood, quality of care
8. Service delivery, alternative CBS, quality of care, training

ADVOCACY

underlines everything we do – that is, people have a *right* to service and to quality service.

manager of the research and evaluation unit. The latter will address policy analysis and planning and the new knowledge management function for the region that will inform its work especially sharing of best practices and regional advocacy.

The Role of the Africa Regional Office

In implementing the strategy, the regional office will undertake an array of activities:

- Resource allocation and mobilization
- Technical assistance, including development of tools and policies
- Performance monitoring, assessment, reporting and feedback
- Monitoring and evaluation of resource utilization
- Developing strategic interventions for improving programme performance
- Institutional capacity building
- Partnership development and advocacy
- Quality assurance and accreditation

The role of the IPPF Africa Regional Office (ARO) will be catalytic. ARO will show the way within the context of limited resources, operating as a partner to MAs and striving to build the capacity of the membership. ARO will provide technical assistance in all operations, from financial and information systems management to service delivery and quality accreditation. ARO will also spearhead the drive to cement partnerships with regional bodies, governments and other entities to address SRH needs in sub-Saharan Africa.

The Partnership Factor

IPPFAR is fortunate to enjoy the respect and partnership of a number of the leading players in the development and SRH arena. For example, we go into this strategic plan with memorandums of understanding and cooperative agreements with UNFPA, UNAIDS and the African Union.

Since the needs and demands of the network of MAs outstrip the available resources and capacity, IPPFAR will rely on networking and partnerships to facilitate those MAs with capabilities and expertise in specific areas to transfer or share such skills with their counterparts that lack them. This could range from sharing best practices to out-sourcing technical support through consultancies, or collaborating with universities and other institutions of learning, including the use of expertise within the pool of IPPFAR volunteers.

Among the national and continental level partners IPPFAR will seek out are the Girl Guides, Boy Scouts, Young Men's/Women's Christian Associations and the Forum for African Women Educationalists (FAWE).

The IPPF Family

Partnerships will include backwards, forwards and lateral linkages within the IPPF family. Just as ARO's mandate is to build the capacity of its MAs, the regional office will seek the assistance of the central office in areas ranging from advocacy at the international level to help with specific activities such as advocacy tools, including film and video development. A key element in the relationship will be information sharing and the development of South to South linkages and exchange of expertise.

New Partnership for Africa's Development (NEPAD)

IPPFAR subscribes to the goals and objectives defined in the New Partnership for Africa's Development (NEPAD), the economic recovery programme recently initiated by African heads of state. NEPAD's health objectives, which emphasize the need to empower African peoples to improve their health and to reduce the burden of disease on the poor, are in line with IPPFAR's strategic approach.

Stakeholders

IPPFAR will ensure that the values, needs, aspirations and perspectives of key stakeholders are taken into account when rolling out the strategy. The stakeholders include donors, collaborators, affiliates, coalition partners and regional staff. Others are academics, local leaders, the private sector, advocacy groups, professional associations, and national and regional reproductive health organizations.

Adolescents/Youth Programme Strategy

Adolescence and youth should be one of the healthiest stages of life. When young people live in supportive environments and have access to programmes designed specifically to reach and serve them, they can and do make healthy decisions about their sexual and reproductive lives and become productive citizens.

IPPFAR intends to ensure that young people are informed, educated and served through clinics, youth centres and outreach services to enable them to make responsible choices to protect themselves against unwanted pregnancies and STIs, including HIV/AIDS. This group is, in fact, so important in the Africa region that IPPFAR has prepared a separate strategic plan focusing specifically on young people and all MAs in the region are developing their own targeted youth strategies.

Programme and Service Issues Concerning Adolescents

In many parts of sub-Saharan Africa, young people lack the information they need to make responsible decisions about their sexual behaviour and to use safe methods to protect themselves from STIs and HIV. Adolescents especially need information that promotes and encourages responsible sexual behaviour now and when they are grown. Too often “adult” society looks the other way, trying to convince itself that adolescents are not sexual beings and therefore have no need of sexual and

reproductive health information, services and counselling.

Yet more than 90 per cent of those aged 15 to 24 are sexually active (IPPFAR, 2004). The

SRH problems they face are enormous – unwanted pregnancy, STIs including HIV/AIDS, female genital mutilation (FGM),

Half the population of SSA is under 20, and 90 per cent of 15–25-year-olds are sexually active.

gender-based violence, drug abuse. They are also adversely affected by other forms of exploitation arising from social problems such as conflict, high unemployment rates and the increasing number of children involved in the informal labour market and in commercial sex.

Within this group girls and young women are particularly at risk, as they face socio-cultural, economic and political pressures, practices, and barriers that disproportionately affect them. Yet, young men are often neglected in the wider sexual and reproductive health and rights agenda. It is, furthermore, important to remember that regardless of gender, adolescents are not a homogeneous group, but have a variety of needs depending on their age, social status, and political and economic circumstances.

Rolling Out the Regional Adolescent Strategy

IPPFAR will implement a holistic youth development agenda by promoting an integrated, multi-sector approach to address

issues related to the youth at all levels, with interventions and activities conducted by recognized stakeholders such as youth themselves, parents, key community leaders, church leaders, etc., in close collaboration with existing community associations. The approach is designed to maximize resources and to have visible impact.

Priority Objectives

In implementing its strategic operations plan for reaching young people, IPPFAR will apply a combination of innovation and best practices in four major cross cutting areas:

- Involvement of young people themselves in SRH programming.
- Advocacy to reduce cultural barriers to the provision of SRH services to youth.
- Access to high quality, youth-friendly, gender-sensitive services and information.
- Use of a holistic development approach to youth programming.

Key Interventions

Within those four objectives, IPPFAR will among others implement activities for:

- Creating forums for youth from MAs to participate in and influence policy and governance actions.
- Documenting both vertical and integrated youth participation models across the region and sharing results.
- Promoting and facilitating exchange programmes and internships.
- Advocating with national governments to review legal and regulatory barriers that prevent young people from accessing SRH information and services.
- Advocating with religious leaders, traditional leaders and communities to secure favourable attitudes towards youth SRH information and services and to change detrimental cultural practices and attitudes, including gender-based violence, child marriage and FGM.
- Promoting a rights-based approach in programmes for young people.
- Providing life skills education and enterprise-development training.
- Promoting strategic social franchising partnerships with youth-serving, public sector, private sector, non-government and

religious organizations to incorporate adolescent and youth SRH programmes and services into their agendas.

- Expanding services for youth to difficult-to-reach and under-served areas.

Expected Outcomes

- Reduced incidence of HIV/AIDS, early pregnancy and abortion among young people in SSA.
- Increased number of young people receiving appropriate SRH services.
- Increased number of governments, NGOs and other youth-friendly organizations working together to address the myriad SRH needs of youth.
- Increased number and variety of adolescent/youth SRH activities in MA programmes.
- Increased number of young people involved in policy, governance, advocacy, resource development and programmes at MA level.
- Increased number of MAs implementing existing ASRH policies in countries where the policies exist.
- Involvement of religious and traditional leaders in adolescent and youth SRH policy reforms and other activities.
- Better environment for adolescent and youth SRH in MA countries.
- Increased number of MAs reaching under-served areas with information and services for young people.
- Government funding for youth SRH activities increased.

Partners, Players and Stakeholders

- Youth organizations – YMCAs/YWCAs, Scouts, Girl Guides, student groups
- Education and training institutions
- Governments, including ministries of education, agriculture, sports and others
- Regional bodies such as AU, NEPAD, etc.
- Traditional leaders
- Sports figures – both men and women – and other popular personalities
- NGOs, CBOs, faith-based groups
- Private sector
- Media
- National youth councils, youth parliamentarians

HIV/AIDS Programme Strategy

HIV prevalence rates vary widely among countries and regions across the continent. The prevalence rates are generally low, under 3 per cent, in West Africa. However in Nigeria, Africa's most populated country, over 5 per cent of adults are HIV positive, while Côte d'Ivoire is one of the 15 worst affected countries in the world. Infection rates in eastern Africa, once the highest in the continent, have now been exceeded by southern Africa. At least one in five adults is HIV positive in several southern African countries.

More women than men are affected (56 per cent overall), largely as a result of sexual violence, women's greater physical vulnerability and their inability to control their sexuality. Adolescent girls, moreover, are 2–6 times more likely to be infected than their male agetmates, largely because of pressure from older men.

Young people in Africa are in general particularly vulnerable to contracting HIV, for reasons relating to life style, poverty, violence and other factors. In a region where over half the population is below 25 years and where the highest rates of sexually transmitted infections are among the youth aged 20–24, the HIV/AIDS epidemic must be addressed urgently.

Impact of HIV/AIDS

In 1999 the World Bank described the HIV/AIDS pandemic as the biggest threat to sub-Saharan Africa's development. The situation has only gotten worse since then. The epidemic

Of the 42 million adults and children estimated to be living with HIV world wide, over 29 million are in sub-Saharan Africa

is not only a health disaster of enormous proportions, it is a socio-economic disaster as well. Its impacts are many, varied and severe.

Demographic Impact

The pandemic has changed the structure of Africa's population to one in which the very young, the upper middle-aged and the elderly increasingly dominate the population structure. The result is a growing rate of dependency on cadres who are not able to provide support. The situation is further characterized by dramatic declines in life expectancy, which are expected to drop from 51 years to 45 years in the next decade. In countries like Zimbabwe, life expectancy will fall from 61 years to 33 years (World Bank, 2002).

Social-Economic Impact

HIV/AIDS has negatively affected the well-being and livelihoods of many millions of Africans, aggravating already severe poverty.

The economies of many African countries have suffered setbacks in productivity because of absenteeism, ill health and deaths, sending them further into decline.

It is estimated that 3 per cent of Africa's gross domestic product (GDP) is spent on HIV/AIDS related cases. The epidemic has increased demand for care in already overstretched public health services and diverts resources from other human development needs: Caring for one AIDS patient can cost as much as educating ten primary school children (World Bank, 2000).

The education sector is among the worst affected. The pandemic is reducing the available and qualified teaching force, thus severely eroding the quality of education. Zambia, for example, loses some 1,300 teachers a year, which is almost equal to those being trained. In 1998 two-thirds of Zambia's newly trained teachers died. Kenya loses about 40 teachers a month. Across the continent, an estimated 860,000 children lost teachers to AIDS in 1999 (Kelly, 1999).

Agricultural and industrial sectors are similarly affected. Agricultural production has declined due to reduction in the agricultural labour force caused by ill-health or deaths, or by reduced output occasioned by the need to care for the ill. In industry, firms face multiple losses as a result of absenteeism, high health care costs for employees, low productivity from employees in ill health, and high costs related to funeral and terminal benefits.

Programme and Service Issues in HIV/AIDS

To deal comprehensively with the HIV/AIDS pandemic, the following issues must be addressed:

- Political commitment and leadership
- Prevention through:
 - ▶ Practice of safer sex by increasing condom use
 - ▶ Reduction of numbers of sexual partners
 - ▶ Emphasis on HIV testing and counselling
 - ▶ Reduction of cultural influences and norms
 - ▶ Special focus on adolescents and young adults, and involving young PLWHAs
 - ▶ Investment in behaviour change processes
 - ▶ Management of STIs
 - ▶ Reduction of mother to child transmission

- Care and support, especially through:
 - ▶ Increased access to antiretroviral therapy
 - ▶ Provision of support to PLWHAs
 - ▶ Management of opportunistic infections

Rolling Out the Regional AIDS Strategy

To address the HIV/AIDS pandemic, IPPFAR will assist its 44 MAs to integrate HIV/AIDS into their comprehensive sexual and reproductive health programmes. IPPFAR will also use its extensive experience in dealing with reproductive health issues in developing participatory approaches at the grassroots level.

Priority Objectives

The following priority objectives have been identified for the HIV/AIDS programme operations:

- To increase access to interventions for prevention of HIV/AIDS through integrated, gender-sensitive, rights-based SRH services, with special emphasis on young people.
- To reduce religious, economic and political barriers that contribute to stigma and discrimination.
- To increase access to care, support and treatment for people infected by and providing support for people affected by HIV/AIDS.

Key Interventions

IPPFAR's strategy will be characterized by:

- **Prevention:** Assisting MAs in promoting behaviour change among young people as the primary target group, facilitating provision of and access to male and female condoms for dual protection (in particular HIV infection prevention), addressing issues of sexual violence and vulnerability that increase the risk of women and girls, promoting voluntary counselling and testing (VCT) for HIV/AIDS, and improving STI treatment and management within their service outlets.
- **Advocacy:** Developing strategies that will increase the visibility of IPPFAR as a regional body and key partner in the HIV/AIDS arena and collaborating with key regional HIV/AIDS serving organizations.

- **Care and support:** Supporting the efforts of MAs in their care and support initiatives for people living with HIV/AIDS, including the provision of anti-retroviral (ARV) drugs and home-based care.

Underlying these will be capacity building assistance from ARO to ensure that MAs are able to integrate the proposed interventions into their programmes through collection and management of HIV/AIDS specific information, project development, and monitoring and evaluation.

Expected Outcomes

- Increased access to interventions for prevention of HIV/AIDS through integrated gender-sensitive rights based SRH services.

- Reduced religious, economic and political barriers that contribute to stigma and discrimination.
- Increased access to care, support and treatment for people infected by and support for people affected by HIV/AIDS.
- Neonatal and childhood morbidity and mortality from HIV/AIDS reduced.
- Replication and scaling up across the region of interventions that work through enhanced South-to-South sharing of experiences.

Partners, Players and Stakeholders

The various organizations expected to partner in the implementation of the HIV/AIDS strategy are summarized in Table 2, by category of intervention.

Table 2 HIV/AIDS partners, players and stakeholders

Abortion Programme Strategy

Throughout most of sub-Saharan Africa abortion remains illegal in all but the most circumscribed situations, usually defined as when the mother's life is endangered. This does not stop women from seeking abortion services. What it does is either push the cost of the service far out of reach of most women or consign abortion largely to back street providers whose services are often dangerous, even fatal. The result is that abortion related maternal mortality and morbidity has become a major public health concern.

Programme and Service Issues in Safe Abortion

Between 60 and 80 per cent of the recorded maternal deaths in African cities are caused by abortion complications and over half of admissions in gynaecological wards in African cities are a result of such complications.

The impacts of unsafe abortion include:

- High maternal morbidity and mortality rates
- Pelvic infections that can lead to infertility
- Psychological trauma
- Over burdening of already overstretched health systems

Unsafe abortions occur because of the following reasons:

- Lack of safe abortion services
- High cost of safe abortion services
- Legal barriers to safe abortion
- Negative attitudes among service providers
- Moral or religious conflict

IPPFAR will always strive to work within the framework of the existing law and advocate for change and safety.

A woman's decision to have an abortion may be influenced by various factors, but fundamentally it usually stems from the desperation that accompanies an unintended and unwanted pregnancy. This may arise because of the woman's social and emotional status. She may be, for example, unmarried, in an abusive relationship, a victim of sexual assault, a student, too poor to cope with a child, unable to visualize any other options for her life. The pregnancy may have occurred as a result of:

- Lack of or limited access to contraceptives
- Policy and other restrictions to easy access to contraceptives
- Lack of or limited information and knowledge about family planning
- Failure of contraceptive method
- Sexual violence, e.g., rape, incest, etc.

Rolling Out the Regional Strategy for Abortion

IPPFAR regards access to safe abortion services as both a right of individual women and a means for saving many lives. IPPFAR will therefore work to promote the provision of safe abortion services and lobby for liberalizing

Globally, a woman dies every minute from complications related to pregnancy, childbirth or unsafe abortion. Most are in developing countries.

restrictive abortion laws. For these activities, IPPFAR will always strive to work within the framework of the existing law and advocate for change and safety. In addition, post-abortion care and contraceptive services will form an integral part of sexual and reproductive health service delivery.

Priority Objectives

On the side of safe abortion, IPPFAR intends to take action in two broad areas:

- Increased access to abortion related services, including post-abortion care (PAC), as an integral part of SRH.
- Advocacy to secure the support of government, development partners, civil society, and communities to protect and promote the right to safe abortion and to increased access to post-abortion care.

Key Interventions

To accomplish these objectives, IPPFAR will facilitate:

- Training MA staff in use of manual vacuum aspiration (MVA).
- Providing equipment and supplies for post-abortion care services.
- Reorganizing clinics/facilities for provision of post-abortion care services.
- Developing/adapting/disseminating guidelines on management of abortion/abortion complications.

- Establishing referral systems to address management of abortion complications.
- Developing country specific abortion and post-abortion care action plans.
- Sensitizing and mobilizing communities on abortion, its complications and available services.
- Collecting/collating data, case studies, information and research findings on abortion laws, policies and magnitude of abortion related problems, and sharing these with the IPPF central office and MAs.
- Developing partnerships with NGOs, parliamentarians, pressure groups (women lawyers, youth, etc.) to advocate for review of abortion laws and policies.
- Facilitating South-to-South exchange of experience and information among MAs.
- Developing proposals for funding for use by ARO and MAs.

Expected Outcomes

- MA capacity to provide post-abortion care strengthened.
- Guidelines on management of abortion complications in place.
- Action plan for abortion and post-abortion care in place with selected MAs.
- Referral systems in place at MAs.
- Better understanding of the impact of abortion laws.
- Wider support from members of parliament, women and youth pressure groups for review of abortion laws and policies.
- Resources mobilized for abortion/post-abortion care.
- Advocacy guidelines and tools in place to facilitate the review of laws.
- Improved environment for access to safe abortion.
- Fund raising proposals in place.

Partners, Players and Stakeholders

Institutions

- Ministries of Health
- WHO
- INTRAH
- Engender Health
- IPAS
- Allan Guttmacher Institute
- POLICY Project
- Marie Stopes Internat'l

Areas of collaboration

- Post-abortion care
 - Post-abortion care
 - Training in safe abortion and post-abortion care
 - Training in safe abortion and post-abortion care
 - Provision of manual vacuum aspiration (MVA) equipment and training
 - Research on legal barriers to SRH and on the magnitude of unsafe abortion and other factors associated with unsafe abortion
 - Post-abortion care and safe abortion service delivery
-

Safe Motherhood Programme Strategy

UNFPA estimates that about 511,000 women die every year from complications related to pregnancy, childbirth or abortions done in unhygienic environments. This translates to approximately one death per minute. In Africa it amounts to an average maternal mortality rate of 870 deaths per 100,000 live births (UNFPA website, 2004).

Programme and Service Issues in Safe Motherhood

Maternal mortality is defined by WHO as: “Death of women during pregnancy or within 42 days after pregnancy, whatever the duration or the place of pregnancy, for whatever reason related to pregnancy and its management or made worse by the latter.”

Causes of Maternal Mortality

The main causes of maternal mortality are:

- Cervical dystosis
- Severe blood loss
- Infections of the reproductive tract
- Severe hypertension in pregnancy
- Complications of diseases like malaria and diabetes, or conditions related to female genital mutilation

These are often aggravated by such socio-economic, cultural and environmental factors as:

- Poverty
- Malnutrition
- Overwork or fatigue
- Compromised hygiene conditions

Maternal deaths, regional comparison

Region	Maternal Deaths/Year
World	529,000
Industrialized countries	2,500
All developing countries	527,000
Africa	251,000

Number of maternal deaths per 100,000 live births (maternal mortality ratio MMR)

World	400
Industrialized countries	20
Developing countries	440
Africa	830
North America	11

Lifetime risk of maternal death

World	1 in 74
Industrialized countries	1 in 2,800
Developing countries	1 in 61
Africa	1 in 20
North America	1 in 3,500

www.unfpa.org/mothers/statsbycountry.htm

- Illiteracy
- Gender imbalance in decision making and reproductive choices
- Lack of and poor access to reproductive health information and services
- High premium on having many children, especially boys
- Competition in polygamous marriages
- HIV-positive women being forced to carry pregnancies
- Others, including early pregnancies, multiple births, deliveries in old age, unsafe abortion, high cost of medical care

Contribution of the Health Infrastructure

Inadequate health facilities and frameworks for

service provision play a big role. Some of the problems related to the health infrastructure are:

- Small percentage of the national budget being allocated to health
- Poor health coverage
- Poor access to services due to geographical reasons, finances and cultural inhibitions
- Poor referral systems
- Insufficient or lack of access to specialized obstetrical care

Rolling Out the Regional Strategy for Safe Motherhood

The IPPFAR strategy recognizes that the prompt recognition and management of pregnancy and delivery complications is the key to addressing safe motherhood issues.

Priority Objectives

Safe motherhood interventions will include both the mother and her young children, to be broadly based on:

- Ensuring the commitment of national governments and development partners to increase resource allocation for safe motherhood programmes.
- Increasing access to and utilization of maternal and child health services.

Key Interventions

Sub-Saharan Africa faces a myriad of socio-economic, cultural and political problems, which all exacerbate the high maternal and infant mortality rates. Therefore, any interventions to reduce the rates must of necessity take place at a variety of levels and consider a range of issues:

- **IEC/BCC and community mobilization:** Media partnerships; national data banks on safe motherhood issues and programmes; advocacy support materials such as videos and brochures; sensitizing and mobilizing

couples, families and communities on safe motherhood and their roles in ensuring use of MCH services in qualified facilities.

- **Advocacy:** Mobilizing policy and decision makers, advocacy coalitions and networks on safe motherhood, lobby meetings with international, regional, national and sub-national governments and non-governmental bodies, lobbying for commemoration of annual safe motherhood day.
- **Capacity building and resource mobilization for MAs:** Strengthening technical skills of selected MAs in provision of emergency obstetric care and life saving skills; improving the infrastructure, equipment and supplies needed by MAs to provide safe motherhood services.
- **Service delivery:** Community education in MCH services; effective integration of traditional birth attendants into the health care system; integration of SRH services into MCH services; provision of MCH services through static clinic and community outreach services; promotion of community resource persons and systems for improving MCH services.

Expected Outcomes

- Strong public, religious and political support mobilized/galvanized for safe motherhood and increased access to safe motherhood services
- Increased resource commitment for safe motherhood programmes at international, regional, national and sub-national levels
- Strengthened capacities of ARO and MAs to implement safe motherhood programmes
- Increased utilization of maternal-child health services in MAs and other facilities
- Increased availability of MCH services, including emergency obstetric care.

Partners, Players and Stakeholders

Access Programme Strategy

Sub-Saharan Africa has the lowest rate of contraceptive use (19 per cent) in the world. According to estimates, the potential demand for family planning in Africa is 38.9 per cent, current users (met need) are 15.6 per cent and unmet need is 23 per cent. By comparison, the potential demand in Asia is 60.8 per cent, while current users amount to 46.7 per cent (CDC, 2002).

Among the factors that have contributed to this situation are:

- Increasing numbers of sexually active people, especially the youth, who are not using contraceptives.
- Growing numbers of people who want to use contraceptives to space births.
- Unsafe sex and lack of male involvement in and support for family planning.
- Poor access to contraceptive services.
- Lack of authoritative family planning information.
- Poverty, affecting affordability of family planning services.
- High value placed on large families.

It is for these reasons that the primary focus of IPPFAR's access strategy is on increasing access to and utilization of family planning services as the major component of broader sexual and reproductive health services.

Impact of Unmet Family Planning Needs

The impact of unmet family planning needs has three elements that cut across demographic, socio-economic and health issues:

- **Demographic impact:** The average total fertility rate (TFR) in the continent is high, at 5.6 children per woman, which has contributed to the overall high population growth rate estimated at 3 per cent. This dynamic involves a doubling of the population every 25 years. Life expectancy is low, at 51 years, compared with 71 years in the industrialized nations (PRB, 2003).
- **Socio-economic impact:** Economic development is not keeping pace with the population dynamic, increasing the level of poverty.
- **Health impact:** Some of the effects of lack of access to family planning information and services are large numbers of unwanted and high-risk pregnancies, high abortion rates, and high maternal and infant mortality rates. At the individual level, women who bear children "too early, too late and too often" also frequently suffer adverse health consequences.



Displaced persons have the same basic reproductive health needs as anyone, but these are often sidelined in the provision of basic humanitarian relief services.

Programme and Service Issues in Access to Family Planning

The scope of family planning needs can be summarized as follows:

- In most sub-Saharan countries, young people aged 10 to 24 constitute about 45 per cent of the population. A very large segment of this population is sexually active (up to 90 per cent in some countries), but most lack access to family planning information and services.
- There are also growing numbers of the fecund population (15-49 years) who are not practising family planning, while those who want to use contraceptives to space births lack information and access to services.
- Sub-Saharan Africa has the largest population of displaced persons in the world – an estimated 4.3 million across the continent (UNHCR, 2004). This huge group has the same basic reproductive health needs as anyone – and some that stem urgently from their precarious status – but these are often sidelined in the provision of basic humanitarian relief services.
- Unsafe sex practices, often arising from lack of male involvement in, commitment to and support for family planning, have brought about gender imbalance in the acceptance of family planning – and contribute directly to the spread of HIV.

Rolling Out the Regional Access Strategy

Priorities will be based on the severity of unmet needs and will focus on disadvantaged and underserved groups, particularly young people (including street children), men, refugees and displaced people. Rural and urban variables will be used to determine the priorities within each group.

Priority Objectives

The following are the main objectives of the proposed regional strategy in access:

- To promote quality family planning services in order to expand access to and utilization of SRH services across sub-Saharan Africa.
- To increase access to SRH information and services to displaced persons within SSA.
- To secure support of national governments and humanitarian agencies to protect and promote SRH services for displaced persons.
- To develop and put in place appropriate IEC/BCC strategies tailored for the displaced.
- To mobilize appropriate service packages for displaced persons.

There will of necessity be important links with the advocacy component of the plan as IPPFAR presses for overcoming social, political, religious, cultural and legal barriers to family planning. Critical to all efforts will be the establishment and nurturing of partnerships in an effort to learn from best practice, broaden the resource base and increase efficiency.

Key Interventions

The strategic approaches to achieve these objectives will include the following:

- **Promotion of quality family planning services and information in order to expand access to and utilization of SRH services:** innovative approaches to increase coverage and measures to address legal and socio-cultural impediments to use, including those constraining the involvement of men; promotion of social franchises of clinics for operation in urban areas, intensified social marketing to reach those with limited access, and increased collaboration with public and private-for-profit sectors. Rural outreach will include enhanced community-based family planning services.
- **Provision of services to displaced persons:** IPPFAR will support the efforts of MAs that have response programmes to the SRH needs of some of the nearly 14 million displaced persons in the region where feasible in formats developed by the MAs in the countries of conflict with a view to supplementing the existing emergency interventions by the UNHCR and other organizations.

Expected Outcomes

- Expanded access to and utilization of SRH services across sub-Saharan Africa.
- Increased access to SRH information and services to displaced persons within SSA.
- Support of national governments and humanitarian agencies to protect and promote SRH services for displaced persons in SSA.
- Appropriate IEC/BCC strategies tailored for displaced persons developed and in place.
- Appropriate service packages for displaced persons mobilized.
- Increased participation of men in MA's SRH programmes.
- Strategic Partnership Platform for emergency response established.

- MAs that are able to provide authoritative information and quality services to reduce unwanted pregnancies and unsafe sex, especially among young people.
- Increased use of family planning and other SRH services throughout SSA.

Partners, Players and Stakeholders

Building national and international partnerships is critical to this programme area, particularly concerning support to displaced persons. But the full range of potential partners is wide, from local midwives associations to the United Nations. The possibilities are summarized in Table 3.

Table 3 Potential partnerships to improve access

Key players and stakeholders	Programme focus and responses	Gaps/IPPFAR's niche
<ul style="list-style-type: none"> ▪ Government institutions and private NGOs (national and international) ▪ Midwives associations ▪ Religious organizations ▪ Armed forces ▪ Traditional leaders (chiefs and elders) ▪ Labour unions ▪ Youth organizations ▪ Private sector: business community ▪ Training institutions: African and international, e.g., Centre for African Family Studies ▪ International organizations sponsorship and support: WHO, UNFPA, UNICEF, UNHCR, UNESCO, Pathfinder, PATH, Population Council, World Bank, CEDPA, JOICFP 	<ul style="list-style-type: none"> ▪ Advocacy for FP/RH rights ▪ Authoritative FP information ▪ Provision of clinic-based FP services ▪ Expansion of FP community services including social marketing/commercial distribution of contraceptive services ▪ Gender integration and synergy in acceptance and practice of FP, especially male commitment and support ▪ Research support to contraceptive technology and trials 	<ul style="list-style-type: none"> ▪ Provision of authoritative IEC/BCC audio-visual materials for enhancement of FP knowledge to empower people to make informed decisions and choices to accept and practice FP ▪ Capacity building/training in basic counselling skills to be integrated into FP for service providers at all levels of service delivery ▪ Provision of easily accessible and affordable FP services especially to the youth in rural areas with low literacy and poverty ▪ Promotion/introduction of new FP products ▪ Advocacy for change of policies and obsolete laws and traditional customs that are barriers to FP ▪ Promotion of quality FP services and creation of platforms for learning and best practices ▪ Documentation of best practices in FP and sharing of experiences with other partners ▪ Capacity building/training in community mobilization and CBS approaches

Advocacy Programme Strategy

Partnership is the cornerstone of IPPFAR's strategic vision of advocacy. The ARO will build partnerships at the regional level with organizations such as the African Union, New Partnership for Africa's Development, Common Market of Eastern and Southern Africa, and others, while the Member Associations will be encouraged to forge similar relationships at the national level.

Programme and Service Issues in Advocacy

Three of the Millennium Development Goals relate directly to sexual and reproductive health issues, and indirectly to all the others, but the links with poverty are not always fully recognized (UNFPA, 2004). Collaboration with agents from governments to families, churches to workplaces to peers is essential for addressing Africa's still largely patriarchal, largely traditional and frequently authoritarian leadership structures so as to overcome negative attitudes towards sexual and reproductive health and rights issues.

It is all the more urgent in this era of constrained resources and attention to a variety of other pressing issues, and measures must be taken to demonstrate the relationships between

Advocacy underlines all aspects of the IPPFAR programme in sub-Saharan Africa

If the Millennium Development Goals are to be achieved, it is essential to demonstrate the relationships between lack of focus on sexual and reproductive health and the HIV/AIDS epidemic, for example, or between SRH and rising poverty.

lack of focus on SRH and the HIV/AIDS epidemic, for example, or between SRH and rising poverty. This understanding is essential if the Millennium Development Goals and the action plan of the International Conference on Population and Development (ICPD) are to be realized.

Rolling Out the Regional Strategy for Advocacy

Advocacy in fact underlines virtually all aspects of the IPPFAR programme in sub-Saharan Africa – advocacy to change laws, adjust attitudes, promote behaviour change. A variety of advocacy techniques will be used to build partnerships, raise funds, raise awareness and reduce risk.

Priority Objectives

In the Africa region, IPPFAR's advocacy initiatives will attempt to:

- Galvanize greater support for, commitment to and financial support for sexual and reproductive health and rights (SRHR) in Africa.

- Advocate for an enabling policy and programme environment to address pressing sexual and reproductive health and rights challenges.
- Promote the image and visibility of IPPFAR and MAs in the region.
- Increase the contribution of MAs to regional publications.

Key Interventions

- Building capacity in advocacy skills for IPPFAR and MA staff.
- Building alliances with key stakeholders and strategic partners, including governments and civil society to articulate a common position on SRH issues.
- Developing advocacy strategy and tools.
- Developing media relations to increase coverage of sexual and reproductive health and rights.
- Convincing governments and other key actors of the linkages between SRHR, MDGs and poverty reduction.
- Advocating for training of law enforcement officers, police, military and community leaders for better management of sexual violence cases.
- Addressing gender-based violence, child marriage, FGM and other harmful practices that affect women's sexual and reproductive health and their economic and social capability.
- Lending support to efforts to improve the education and literacy of girls and women to reduce their sexual, reproductive and economic vulnerability.
- Developing a marketing strategy for IPPFAR and the MAs.
- Using print and electronic media to promote the activities and achievements of IPPFAR and MAs, including a regional website and contributions to central office publications.
- Identifying focal points for publications in the MAs.
- Developing guidelines on articles for publication.

Expected Outcomes

- Africa's SRHR position developed in collaboration with partners such as AU, UNFPA, civil society, etc., resulting in increased financial support.

- Comprehensive SRHR component developed and integrated into the NEPAD framework and AU institutions.
- Greater support of, commitment to and financial support for SRHR in Africa.
- An enabling policy and programme environment to address pressing SRHR challenges.
- SRHR issues on Africa's development agenda.
- Enhanced image and visibility of IPPFAR and MAs in the region.
- Increased contribution of MAs to regional publications.
- Increased funding and policy support from governments for SRHR programmes.
- MA staff and volunteers engaging effectively in advocacy at the country level.
- Continental SRHR network/lobby to promote ICPD programme of action formed.
- Policy reform in support of SRHR.
- Stakeholders engaging in SRH policy dialogue.
- SRHR messages and tools developed and widely disseminated.
- Public events around ICPD programme of action.
- IPPFAR and MA achievements widely disseminated in Africa through publications and internet.
- Website for MAs to share information and experiences.
- Increased coverage of MAs' activities in regional publications.
- Regular and high quality articles submitted for publication.

Partners, Players and Stakeholders

- Governments, including ministries of health, education, agriculture, sports and others
- National AIDS control councils
- Regional bodies such as AU, NEPAD, etc.
- Parliamentarians and other political leaders
- Traditional leaders
- Sports figures – both men and women – and other popular personalities
- NGOs, CBOs and civil society organizations
- Professional associations
- Private sector
- Faith-based groups
- Media

Supporting Strategies: Resource Mobilization

Nothing can happen if the resources are not available to make it happen. In an era of increasingly constrained resource availability, special attention must be given to exploring ways of generating and multiplying resources. Perhaps nowhere else is this more true than in sub-Saharan Africa, where needs are so great, poverty so pervasive and limited resources stretched to breaking.

Rolling Out the Resource Mobilization Strategy

A key element of the role of the IPPF Africa Regional Office (ARO) will be to build the capacity of Member Associations in resource mobilization. In order to meet the goals set herein – reaching their communities with more effective messages and higher quality services, and of building networks and local partnerships that will enhance and extend their outreach – the Member Associations have the formidable task of achieving financial viability in this era of dwindling resources.

Priority Objectives

The MAs and the ARO recognize that in order to build and maintain the quality of their programme delivery they must put in place solid frameworks for ensuring financial sustainability. Over the next five years IPPFAR will:

- Redouble efforts to diversify and strengthen the national and regional funding base for IPPFAR and MAs.
- Lobby governments to increase their contributions, and put similar pressure on

local and international donors to support IPPFAR and MAs programmes and activities.

- Develop mechanisms for improving staff and volunteers' skills in resource mobilization.

Key Interventions

- Meeting government officials and donors to acquaint them with IPPFAR and MA programmes and activities.
- Conducting advocacy missions for resource mobilization.
- Articulating a resource mobilization strategy for IPPFAR and MAs.
- Strengthening capacity of MAs in resource mobilization.

Expected Outcomes

- Formalized memorandums of understanding with governments and donors committing financial and in-kind contribution to IPPFAR and MAs.
- Increased funding for IPPFAR and MA programmes and activities.
- Increased involvement of MAs and volunteers in resource mobilization.
- MAs with capacity to mobilize own resources.

Partners, Players and Stakeholders

- Governments, including ministries of health, education, agriculture, sports and others
- International and regional bodies such as World Bank, UNAIDS, AU, NEPAD, etc.
- Private sector
- Media

Supporting Strategies: Institutional Development

IPPFAR's core business is to build a strong, effective and sustainable network of affiliates that will make a significant contribution to improving sexual and reproductive health in sub-Saharan Africa. This involves providing support to MAs in the region to increase their capacity to deliver and sustain high quality, youth focused and gender sensitive services.

In this endeavour IPPFAR assists MAs to:

- Increase their capacity to develop innovative and sustainable programmes.
- Enhance effective leadership, governance and viability.
- Strengthen their management information services.
- Build capacity in programme development and management, research and evaluation
- Develop effective strategies for resource development/mobilization and sustainability.

The regional office has provided support to MAs in various ways, including multi-disciplinary technical assistance teams from ARO staff and volunteers, as well as overall programme evaluation and management audits, programme and institutional reviews, and

In 2001, a survey of all 44 Member Associations found that their performance had not improved sufficiently to enable them to respond to the challenges they face.

sourcing expertise from external consultants and partnership agencies, among others.

Programme Issues in Institutional Development

Despite these efforts, according to an institutional and programmatic survey IPPFAR conducted of all 44 MAs in 2001, their performance had not improved sufficiently to enable them to respond to the emerging challenges they face. The survey showed that three-quarters of MAs would benefit from greater support to strengthen their institutional capacity and improve their performance, particularly in management and communication skills.

While some MAs have moved radically from the provision of traditional family planning services to concentrate more on the sexual and reproductive health needs of young people, others continue to provide traditional family planning services with women of reproductive age as the major clientele. The involvement of local leaders in the governance of MAs is a major strength of the IPPF system, and some MAs in the Africa region attracted high calibre volunteers to their governing boards. However, this system also presents challenges in terms of ensuring well defined roles for, and teamwork between, volunteers and staff.

Building the institutional capacity of the MAs requires first and foremost attention to the development of management and governance capability. Furthermore, like all NGOs in the region, MAs are directly affected by the decline

in funding as donors shift their interests and priorities. Their clients, who are generally among underserved groups, usually do not have the ability to pay for services or can afford only nominal fees.

The decline in external support is occurring in the context of increasing unmet need, which means that services and products must be heavily subsidized, presenting challenges for cost recovery measures. This in turn calls for attention to procurement systems, sustainability issues, cost-effectiveness of service delivery and mechanisms for covering costs.

Quite apart from these issues relating to the functions of MAs themselves, there is the issue of the MAs' interaction with and impact on the environment in which they operate. In Africa a major characteristic of that environment is pervasive poverty. MAs have an important potential role to play in poverty alleviation efforts because SRH and poverty are inextricably intertwined. The magnitude of the HIV/AIDS epidemic on the continent is very much a function of poverty. Reducing poverty therefore must of necessity involve improving the SRH status of Africans, and especially youth and women.

An SRH contribution to poverty reduction through girls' education

Education of mothers is a key pointer to family well-being. Keeping girls in school is therefore an economic imperative. In Africa, too many girls slip out of the education system because they miss classes regularly for no more reason than that their schools lack the basic hygiene facilities – decent latrines and a water supply – for them to manage their menstrual periods. MAs could sensitize school heads to provide these “amenities”.

Rolling Out the Regional Institutional Development Strategy

The assessment showed clearly that considerable additional effort was required to enable the MAs to respond adequately to the identified priorities in IPPFAR's work in the next four

years. This strategic plan thus incorporates a range of additional technical assistance to the MAs in order to address their institutional weaknesses and enable them to become results-based and sustainable organizations.

From the other direction, it is anticipated that the region will require some support from the IPPF central office in this endeavour, particularly in the design of training tools for systems, commodity and logistics management, compliance with IPPF regulations, and other areas.

Priority Objectives

- To provide support to MAs in the region to increase their capacity to deliver and sustain high quality SRH services.
- To increase the capacity of MAs to develop innovative and sustainable programmes, enhancing leadership, governance and viability.
- To strengthen MA management information systems.
- To build capacity in programme development and management, research and evaluation.
- To develop effective strategies for resource development, resource mobilization and sustainability.

Specifically over the next five years ARO will work with MAs in nine major areas:

- Financial management
- Governance
- Accreditation
- Strategic planning
- Mainstreaming gender
- Sustainability
- Institutional development and structure
- Commodities and logistics

Key Interventions

IPPFAR will provide assistance to MAs in:

- **Financial management:** MA debt management; attracting and retaining financial/accounting staff; strengthening the Federation for financial sustainability by 2008; strengthening logistics management.
- **Governance:** Improving governance systems within the region – MAs and ARO.
- **Accreditation:** Enhancing compliance with IPPF regulations.
- **Strategic planning:** Ensuring all MAs have strategic plans, IEC/BCC strategic plans,

and strategies related to the full participation of the community in project development and management.

- **Gender:** Mainstreaming gender in all aspects at ARO and MAs; strengthening collaboration and linkages in gender and development in IPPFAR.
- **Sustainability:** Improving the overall institutional sustainability of MAs and ARO; to improve sustainability of restricted projects; strengthening financial sustainability of the Federation.
- **TA:** Enhancing south–south technical assistance.
- **Institutional development and structure:** Enhancing organizational management of MAs and ARO; collaborating with other agencies; assisting MAs to develop and strengthen resource mobilization strategies; increasing resources of ARO and MAs.
- **Commodities and logistics:** Securing resources to meet MAs’ growing demand for safe and effective SRH commodities.

Expected Outcomes

- Enhanced financial and commodity management systems in place at all MAs.
- Systems in place for effective governance and management within MAs and ARO.
- MAs in compliance with IPPF regulations
- Strategic plans in place within all MAs focusing on the Five A’s.
- Gender mainstreamed into programmes and operations at ARO and MA level.
- All MAs with sustainability plans.

Leadership Development

In a bid to develop the capacity of potential partners, IPPFAR intends to start a leadership development initiative to prepare young people for leadership roles. An annual internship programme, which will aim to develop accountable and responsible professionals, will train and mentor young people and give them an opportunity to participate in IPPF activities.

MA Training and Technical Assistance Needs

The Africa Regional Office will work closely with the MAs in all six areas of focus – adolescents, AIDS, access, advocacy, abortion and safe motherhood – to provide or arrange technical assistance tailored to the needs of the individual MA. The type of training needed by the MAs will depend on the environment in which they are operating, but it is anticipated to range widely, from the development of management skills to computer operations and leadership training. Training in advocacy, community mobilization, youth-friendly service delivery, communications, and monitoring, evaluation and documentation – among others – is also likely to be needed

It should be noted that activities in most programmatic areas will cut across sub-Saharan Africa, while the HIV/AIDS interventions will be targeted more according to the stage of the epidemic in the respective countries.

Partners, Players and Stakeholders

- Governments
- International and regional bodies
- International agencies – UNAIDS, World Bank, UNESCO, UNICEF
- International and regional NGOs – CAFS, PATH, Population Council, CEDPA
- Training and technical institutions
- Faith-based groups
- Media institutions and practitioners
- Youth serving organizations and institutions

Supporting Strategies: Research, Monitoring & Evaluation

Evaluation built on sound research is a key component of this strategic framework. IPPFAR's evaluation policy has three main strategic objectives: to promote accountability by ensuring that the 44 MAs in the Africa region adhere to IPPF standards, norms, policies and responsibilities of membership; to facilitate the use of state-of-the-art information for policy and programme development; and to disseminate best practice findings for improved programme performance by affiliates and other stakeholders.

A Web-Based Management System

Information sharing is critical to the success of this strategic plan. IPPFAR's region-wide management information and data base systems facilitate information exchange and sharing of programme/project outcomes and best practice.

Known as the eIMS, this web-based system is designed in such a way that evaluation is an integral part of a programme right from the planning stage. The eIMS allows all identified users of the system to consult the details of any project (except financial ones).

Rolling Out the Regional Research, Monitoring and Evaluation Strategy

The strategic plan will be implemented through annual programmes developed by the ARO and the MAs according to the structure provided in

Timely access to reliable information is critical to the success of this strategic plan.

this five-year plan. Research results arising from the monitoring and evaluation framework described here will assist both the ARO and the MAs to assess progress and take remedial action, where necessary, to achieve proposed objectives. The framework is based on the premise that appropriate information, provided in a timely way, is the basis of effective decision making.

Priority Objectives

Specifically over the next five years the research and M&E support will aim for:

- Strengthened research, monitoring, and evaluation capacity of MAs and ARO.
- Better documentation/record keeping for best practice in IEC/BCC among all MAs.

Key Interventions

- Institutionalizing research and evaluation.
- Conducting research/studies and evaluation.
- Providing TA in research and evaluation.
- Developing performance indicators.
- Disseminating research and evaluation findings.
- Promoting the use of reliable information for decision making.
- Cataloguing and disseminating IEC/BCC document material at MA and ARO.
- Integrating RM&E into IEC/BCC

Evaluation results will be used to improve both current activities and future programming, document lessons learnt, and provide a rationale for scaling up where appropriate.

programmes at MA and ARO levels.

- Providing TA to each MA to develop effective RM&E tools to measure actual behaviour change.

Expected Outcomes

- Improved research and evaluation within MAs and ARO.
- Effective TA and project/programme performance.
- Effective utilization of research/studies and evaluation findings for programme development and management.
- More informed decisions leading to better management – and more effective service delivery.
- Better, more timely reports.
- ARO and individual IEC/BCC database available for easy access via eIMS and other channels.
- MAs and ARO able to assess impact of IEC/BCC activities.
- Member Association's IEC/BCC-specific RM&E plan in place and implemented.
- Basic standardized RM&E tools developed for IEC/BCC.
- Regular and effective monitoring implemented by MAs.

Monitoring

Monitoring will consist of a periodic oversight of the implementation of the activities to establish the extent to which input deliveries, work schedules, other required actions and targeted outputs are proceeding according to plan, so that timely action can be taken to correct deficiencies.

The Programme Director is responsible for the overall implementation of the plan. The Unit Leaders are charged with achieving each goal and objective of their respective programme.

The Research and Evaluation Unit will monitor the implementation of the plan and provide results to management for decision making.

The status of the implementation, including progress toward each of the overall strategic goals, will be reported on a quarterly basis.

Evaluation

Evaluation will attempt to determine as systematically and objectively as possible the relevance, effectiveness, efficiency and impact of activities of the strategic plan in the light of specified objectives for improving both current activities and future programming, documenting lessons learnt, and providing a rationale for scaling up where appropriate.

Two types of evaluation will be carried out during the implementation of the strategic plan, a midterm evaluation and a final evaluation. The midterm evaluation will be to verify that the plan is on the right track and provide information to correct any observed deficiencies, including the revision of objectives, strategies or activities. The final evaluation will assess the achievement of the activities of the plan and identify and document the success or failure.

Monitoring and Evaluation Indicators

The eIMS makes available the information necessary for monitoring and evaluating activities. Expected results/outcomes, how to verify them and how frequently are all part of the information that is plugged in at the planning phase.

During implementation only a simple review of current (actual) results is required to determine performance. The results and conclusions will also help identify whether resources are being used properly.

Table 4 summarizes the type of information that will be fed into the eIMS – the monitoring and evaluation indicators that will be critical to the success of this strategic plan. The table lists the expected outcomes as detailed in the preceding chapters, along with a selection of illustrative indicators for gauging the success of programmatic activities.

Table 4 Summary of programme outcomes and illustrative indicators

Programme focus	Expected outcomes	Sample indicators
Adolescents	<ul style="list-style-type: none"> ▪ Meaningful involvement of young people in programme design, implementation, governance and advocacy actions ▪ Reduction in the social-cultural barriers and practices and the legal and regulatory barriers that affect the reproductive health of young people ▪ Increased access for young people to comprehensive, youth-friendly and gender sensitive information, education and services ▪ A developmental approach adopted for addressing the SRH needs of adolescents and young people 	<ul style="list-style-type: none"> ▪ Number of young people involved in policy, governance, advocacy, programmes and resource development at MA level ▪ Adolescent and youth SRH rights agenda in place in MA countries ▪ Number and categories of young people receiving SRH information and services at the MA level ▪ Number of governments, NGOs and other youth-friendly organizations working together to address the myriad SRH needs of youth
AIDS	<ul style="list-style-type: none"> ▪ Increased access to interventions for prevention of HIV/AIDS through integrated gender-sensitive rights based SRH services ▪ Reduced religious, economic and political barriers that contribute to stigma and discrimination ▪ Increased access to care, support and treatment for people infected by and support for people affected by HIV/AIDS 	<ul style="list-style-type: none"> ▪ Number of MAs with integrated HIV/AIDS services ▪ Number of HIV-related services provided by type of service ▪ Number of condoms distributed ▪ Number of MAs advocating for policy change to increase access to treatment and reduce discriminatory policies and practices ▪ Number of MAs providing care services along the continuum: prevention, referrals, psychosocial support, opportunistic infection treatment, ARV treatment
Abortion	<ul style="list-style-type: none"> ▪ Increased access to abortion related services, including post-abortion care, as an integral part of SRH ▪ Governments, development partners, civil society and communities committed to protect and promote the right to safe abortion and to increased access to post-abortion care 	<ul style="list-style-type: none"> ▪ Number of beneficiaries of abortion-related services by type of service ▪ Number of MAs advocating for policy change in order to reduce restrictions and/or improve access to safe abortion ▪ Number of policy changes related to legislation or liberalization of abortion occurring in a given year to which IPPFAR/MAs advocacy contributed
Access	<ul style="list-style-type: none"> ▪ Expanded access to and utilization of SRH services across sub-Saharan Africa ▪ Increased access to SRH information and services to displaced persons within SSA ▪ Support of national governments and humanitarian agencies to protect and promote SRH services for displaced persons in SSA ▪ Appropriate IEC/BCC strategies tailored for displaced persons developed and in place ▪ Appropriate service packages for displaced persons mobilized 	<ul style="list-style-type: none"> ▪ Number of CYP by method ▪ Number of beneficiaries for other SRH services by type of service ▪ Number of MAs implementing strategies specifically targeting the poor, marginalized, displaced, socially excluded and/or underserved by type of strategy and group ▪ Number of national governments funding SRH services for displaced persons ▪ Appropriateness of IEC/BCC strategies and service packages to the psychological, environmental and social conditions of displaced persons

Continued

Table 4, continued

Programme focus	Expected outcomes	Sample indicators
Safe Motherhood	<ul style="list-style-type: none"> ▪ National governments and development partners committed to increase resource allocation for safe motherhood programmes ▪ Increased access to and utilization of maternal and child health services 	<ul style="list-style-type: none"> ▪ Amount of resources from national government to support safe motherhood programmes ▪ Number of policy changes related to promotion of safe motherhood programmes occurring in a given year to which IPPFAR/MAs advocacy contributed ▪ Number of beneficiaries of safe motherhood-related services by type of service
Resource Mobilization	<ul style="list-style-type: none"> ▪ Diversified and strengthened funding base for IPPFAR and MAs ▪ Governments increase their contributions, and putting similar pressure on local and international donors to support IPPFAR and MAs programmes and activities ▪ Improved staff and volunteer skills in resource mobilization 	<ul style="list-style-type: none"> ▪ Existence of formalized memorandums of understanding with governments and donors committing financial and in-kind contribution to IPPFAR and MAs ▪ Amount of financial resources from governments for IPPFAR and MA programmes and activities
Institutional Development	<ul style="list-style-type: none"> ▪ Financial management: MA debts under control; competent financial/accounting staff on board; logistics management capacity enhanced ▪ Governance: governance systems within MAs and ARO ▪ Accreditation: Compliance with IPPF regulations enhanced ▪ Strategic planning: All MAs have strategic plans; all MAs have IEC/BCC strategic plans in five years; strategies in place for full participation of the community in project development and management ▪ Gender: Gender mainstreamed in all aspects at ARO and MAs; collaboration and linkages in gender and development in IPPFAR strengthened ▪ Sustainability: Overall institutional sustainability of MAs and ARO improved; sustainability of restricted projects improved; financial sustainability of the Federation strengthened ▪ TA: South-south TA in place ▪ Institutional development and structure: Organizational management of MAs and ARO enhanced; collaboration with other agencies expanded; MAs with resource mobilization strategies; ARO and MAs have increased resources ▪ Commodities and logistics: Resources available to meet the growing demand for safe and effective SRH commodities among the 44 MAs 	<ul style="list-style-type: none"> ▪ Existence of financial and commodity management systems at MAs level ▪ Existence of systems for effective governance within MAs and ARO ▪ Extent of compliance with IPPF regulations ▪ Availability of strategy plans at the MA level focusing on the 5 As ▪ Existence of gender-sensitive programmes and operations at ARO and MA level ▪ Existence of sustainability plans at MA level ▪ Existence of organization management systems at ARO and MA levels

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