

**MEMBER ASSOCIATIONS
IN THEIR NATIONAL SETTING:
A STUDY OF IPPF AFRICA REGION**

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By

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ACCRONYMS

CEDPA	Centre for Development and Population Activities
DANIDA	Danish International Development Agency
DR Congo	Democratic Republic of Congo
FHI/IMPACT	Family Health International
GDP	Gross Domestic Product
GNP	Gross National Product
GTZ	German Technical Development Agency
FP	Family Planning
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IPPF	International Planned Parenthood Federation
IPPFAR	International Planned Parenthood Federation–Africa Region
JSI	John Snow International
MA	Member Association(s) of IPPF
MIS	Management Information Systems
NGO	Non-Governmental Organization
PATH	Programme for Appropriate Technology in Health
PLWA	Person/People Living with AIDS
SDP	Service Delivery Points
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
UNAIDS	United Nations AIDS Agency
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children’s Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organization

IPPF AFRICA REGION



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1. ACKNOWLEDGEMENTS

A thorough knowledge of how Member Associations operate in their setting is an important resource in the technical assistance planning process. It enables the IPPF Africa Regional Office to target its interventions to suit its affiliates as far as capacity building is concerned and as a result, there is better use of scarce financial, human and material resources for the benefit of communities. Strengthening the capacity of Associations, based on a knowledge of the socio-economic and health environment, will contribute to the achievement of IPPF Africa Region's Vision, namely to build an African society where every child is a wanted child, every person enjoys good health, and men, women and youth live free from HIV/AIDS.

Several individuals and associations provided information that enabled the research team to conduct its study. We would therefore like to sincerely acknowledge the following;

- The IPPF Africa Region Management team for its support during the entire study process ;
- Focal persons of the Regional Office Member Associations for the reminders they sent to their Associations to submit completed questionnaires ;
- Member associations who spared no effort to provide basic information ;
- Ms. Pauline Magawi, Temporary Research Assistant for her support in validating information provided by member associations;
- Mr. Charles Onoka, Evaluation Officer, FPAK who spared no effort to read and suggest corrections.

We express our deep gratitude to all those persons both near and far, who contributed to the study. This work will go a long way in transforming our Regional Office and Member Associations into strong organizations.

2. EXECUTIVE SUMMARY

In 2004, IPPFAR conducted a study of its member associations to determine present levels of capacity with a view to targeting interventions to suit individual members' strengths. The objectives of the study were to:

- Determine the position held by IPPFAR Member Associations (MAs) in their national context;
- Have a better understanding of Member Associations' working environment;
- Improve planning for technical assistance in programmatic interventions for Member Associations.

Thirty eight out of the forty four (86.3%) member associations responded to a self-administered questionnaire. The questionnaire was designed to collect data and information on the following areas:

- The Socio-Demographic Context of Member Associations
- Population and SRH Policies in the Africa Region
- Profile of Member Associations
- Programmes
- Strategic Direction of Member Associations
- Public and Private Sector Partnerships
- Funding Mechanisms
- Institutional Capacity of Member Associations

The data was analysed using EPI Info and was further verified through field visits. The following are the key findings and recommendations of the study.

The Socio-Demographic Context of Member Associations

On average, 40% of the population in the region is poor (62.5% in Niger compared to 11.3% in Mauritius)¹. Only Liberia, Togo and DR Congo have no poverty reduction strategy or policy.

All indicators for SRH in the region fall far below global levels: maternal mortality is at 848 per 100,000 live births compared to 23/100,000 in the developed world. Seventy percent of HIV infections occur in this region as compared to the rest of the world. Modern contraceptive practices are at 16% compared to 57% in the developed world.

Recommendations:

IPPFAR - *Coordinate and facilitate the development of policies in countries where there are none.*

MAs - *Integrate poverty reduction strategies and activities into on-going programmes.*

Population and SRH Policies in the Africa Region

Most countries in the Africa Region have a National Population Policy that sets out principles and strategic orientations.

¹ UNDP, 2002 Human Development Report 2002.

The major challenges for most countries in the Africa Region are: maternal mortality, HIV/AIDS, low contraceptive prevalence, close or unwanted pregnancies and unsafe abortion.

Gender, adolescent/youth and HIV/AIDS policies are more recent and were developed in the 1990s. Some countries such as Burundi and the Comoros do not yet have Gender and Youth policies; the Comoros and Mauritius have no policy on HIV/AIDS. They do not consider HIV/AIDS as a serious problem since the prevalence rate is lower than 1%.

In the IPPF Africa Region, it is only South Africa and Cape-Verde that have a clear and pro-abortion policy. In other countries, abortion is illegal and only permitted under the following conditions: where the mother's life is in danger, foetal risk and treatment of incomplete abortions.

In most countries, poverty reduction strategies include components such as family planning, HIV/AIDS, maternal mortality, and close or unwanted pregnancies.

Few MAs play a pivotal role in national policy-making bodies. Most MAs have consultative roles in their respective countries' technical committees.

Recommendations:

IPPFAR

Build capacity and communication skills of MAs in advocacy, lobbying and networking.

Influence national policy making bodies to utilize staff of MAs who are trained in policy development and advocacy.

Disseminate IPPF's new strategic framework which includes abortion-related issues.

Commit resources for training staff in MAs in policy development and advocacy.

MAs

Advocate with national authorities to adopt population, gender, youth, SRH (family planning, safe motherhood, HIV/AIDS) and poverty reduction policies in countries where such policies are lacking.

MAs should campaign aggressively in order to be included in national policy-making bodies and to leverage funding for such activities.

Profile of the Member Associations

IPPFAR has three categories of Member Associations: large MAs with more than 100 employees, 10 Service Delivery Points (SDPs) and 7 branches/sections; medium size MAs that have staff members numbering between 50 and 100, 6 branches/sections and 7 SDPs; and small MAs have less than 50 employees, 6 branches/chapters and 7 SDPs.

The data revealed that out of a total number of 2,759 employees of the 38 Member Associations, 51% are women whereas 49% are men.

Associations employ staff with a wide range of professional qualifications.

Youth below 25 years are still under-represented at the MAs staff level.

Recommendations:

IPPFAR

MAs must recruit staff with skills and capacity in:

- *Organizational and corporate management;*
- *Finance and accounting;*
- *Programme management;*
- *Advocacy, negotiation and resource mobilisation;*
- *Monitoring and evaluation and marketing.*

MAs

Need to hire qualified young people under the age of 25 years.

Need to recruit volunteers, representing the diversity of their society, who:

- *Can perform and go beyond material survival issues ;*
- *Have a vision to serve communities to improve their well-being;*
- *Understand their roles and responsibilities and comply with them.*

Programmes

A total number of 2,759 staff and 32,000 volunteers were involved in programme activities. More than 3.7 million people were served by these programmes.

High risk and vulnerable populations and men are especially difficult groups to target since they do not take advantage of services offered by the Member Associations.

Abortion and Advocacy have not been considered yet many of the associations.

Recommendations

IPPFAR

Development/review² of MAs strategic plan to align them with the 5As will help to integrate unsafe abortion and advocacy programmes.

MAs

Programmes should be expanded to include unsafe abortion and advocacy initiatives.

MAs should reach out and target vulnerable populations and men with new interventions.

² During 2004 about 23 Associations developed or reviewed their strategic plans to align them with the 5As. There are 21 Associations that need to embark on the process of reviewing their strategic plans.

Strategic Direction of Member Associations

Some member associations do not have a strategic plan in place. The associations that have strategic plans do not emphasise on abortion and advocacy issues. Moreover, they are not in harmony with the Federation's new Strategic Framework³.

The most common elements of MA programmes are: Family Planning, HIV/AIDS, institutional capacity building, IEC/BCC, and Youth SRH.

Stationary Clinics, youth centres/clinics, peer education, community based services (CBS) and outreach strategies are common approaches used by MAs in order to provide SRH services.

Very few MAs use innovative service provision approaches such as social marketing of condoms, market places for SRH services, workplace programmes, or home based care for HIV/AIDS.

Recommendations

IPPFAR

The Regional Office should provide technical assistance to help MAs draw up strategic plans based on the Federation's new strategic framework.

The Regional Office should provide technical assistance to MAs to restructure their programmes according to the five themes of the Federation's new strategic directions, namely: Access, Adolescents, AIDS, Advocacy and Abortion.

MAs

MAs should think in terms of diversifying their approaches to service provision and being more innovative.

Public and Private Sector Partnerships

Few Member Associations have developed good working partnerships with the public and private sectors in the region; they nor do they work closely either with embassies or research institutions.

The private sector promotes SRH by providing either material or financial support to organizations and/or implements its own SRH activities within its corporate health structure.

Recommendations

IPPFAR

Strengthen advocacy and negotiation capacities of Executive Directors and volunteers to enable them to forge partnerships with government agencies as well as embassies.

Strengthen MAs capacities to develop and market proposals and fundable projects.

Aggressively expand networks with the public and private sectors.

³ When the study was launched in March 2003, some associations had not yet developed a strategic plan. Starting from the second half of 2004, Burundi, Comoros, DR Congo and Namibia associations have a strategic plan drawn from the Federation's new Strategic Framework based on the 5As.

Conduct studies and research to determine the best way for member associations to obtain funds from the private sector.

MAAs

Develop and market strategies, proposals and plans targeting government agencies, research institutions and embassies that outline corporate MAAs strengths and capabilities.

Actively collaborate on SRH, HIV/AIDS and related activities with government, other NGOs, and the private sector.

Use current research findings to educate and sensitise members of parliament, policy makers, and the private sector about MAAs contribution to society.

Establish monthly/quarterly fora where public and private sector professionals can network and share experiences and promising and/or best practices on SRH.

Funding Mechanisms

Since 2001, the budgetary trends of the MAAs have generally shown a reduction of the core grant and restricted funds from IPPF. However, this reduction has been offset by funds from national and international sources.

For almost all the associations, the major local source of income is consultation fees and the sale of medicine/contraceptives.

Recommendations

IPPFAR

The Regional Office should provide technical assistance to MAAs in the area of resource mobilization to facilitate access to existing funding opportunities at the national and international levels.

MAAs

MAAs that do not benefit from public funds should lobby to obtain such assistance from their governments.

In addition, marketing the expertise of associations can constitute an important national funding source that can be explored.

Institutional Capacity of Member Associations

Various institutional evaluations conducted in 2003 showed that more than twenty associations⁴ are experiencing governance and/or management difficulties.

Many associations used to occupy a leading position in family planning issues during the launching phase and part of the growth phase but are now currently declining.

Many associations have been unable to successfully adapt to a competitive environment that goes beyond family planning and integrates other SRH components such HIV/AIDS and abortion into their ongoing programmes,

⁴ Status of Regional Office support to MAAs with special needs, ARO Report, October 15, 2004.

There is a degree of non-compliance to the codes of practice with regard to governance and management.

Recommendations

IPPFAR

The Regional Office should assist MAs to establish efficient Management Information Systems.

The Research and Evaluation Unit must ensure that the database is regularly updated so that reliable information is available on time for informed decision-making at the managerial level.

The Regional Office should take the lead to disseminate state of the art SRH practices and ensure that MAs remain competitive in the sexual and reproductive health market.

The Regional Office should provide technical assistance to the MAs to ensure they are self-sustaining and result-oriented organizations.

MAs

MAs should review their strategic directions, programmes, organizational structures and establishing management systems in order to be on the cutting edge in business.

Member Associations require systems and tools that enable them to collect, analyze and disseminate information in a timely manner at all levels.

« Appropriate information, provided in a timely manner, assists in assessing progress and taking remedial action, if necessary, to achieve the proposed objectives of having performing and sustainable Member Associations and Regional Office ».
IPPFAR Research and Evaluation Unit

3. BACKGROUND AND OBJECTIVES OF THE STUDY

In the Africa region, the current socio-economic environment is characterized by massive upheavals in the socio-political and financial sectors, armed conflicts, poverty, corruption, endemic diseases, HIV/AIDS, and competition for scarce resources, among other challenges.

In this context, the scarcity of resources has led to a considerable reduction in financial support from donors to development activities. Thus, the health sector, and in particular, reproductive health programmes, continues to experience great financial difficulties as it struggles to provide basic health care and services. Indeed, the issues of maternal death, abortion, unmet family planning needs and the spread of HIV/AIDS weigh heavily on the development world in general and in Sub-Saharan Africa in particular.

The levels at which these scourges stand as far as the health sector in Sub-Saharan African is concerned are quite terrifying. In fact, on average, more than a thousand women die during delivery; the average contraceptive prevalence is less than 20%, and 70% of the people infected with HIV live in Sub-Saharan Africa.

It is in this context that IPPF Africa Region decided to redirect its actions in 2002 by defining a new strategic framework aimed at achieving tangible results in the following three programmatic areas: Family Planning, Safe Motherhood and Abortion, and HIV/AIDS. These three areas are supported by institutional development actions. The strategic framework was revised in 2003 to align it to the Federation strategic framework in order to accommodate the 5As: Access, Adolescents/Youth, AIDS, Abortion and Advocacy.

Within this framework, the forty-four Member Associations' (MAs) mission is to implement the new strategic framework with IPPF Regional Office financial and technical assistance. However, MAs require enhanced skills and capacity to seize opportunities, document and disseminate best practices, and to position themselves and maintain their position. Furthermore, poor management style as practiced by some MAs does not foster such a change.

A combination of three factors, namely: scarce resources, current major challenges, and inadequate institutional capacities provided a rationale for the Regional Office to support MAs to ensure optimal performance and quality services. Therefore, MAs are required to avail and provide timely and reliable information on the challenges they encounter, the advantages and means they have, their position in their context, their relationship with partners and other stakeholders, as well as their strengths and weaknesses. It is for these reasons that this study was conducted. The information from this study therefore, will serve as a benchmark from which MAs can undertake targeted actions with the support of the Regional Office.

OBJECTIVES

The study had the following three objectives:

- Determine the position held by IPPFAR Member Associations in their national context;
- Have an in-depth understanding of Member Associations' working environment;
- Improve planning for technical assistance for Member Associations programmatic interventions.

4. METHODOLOGY

4.1 Sample

IPPF Africa Region provides technical and financial assistance to 44 MAs. The study involved all the 44 MAs.

4.2 Data Collection

A self administered questionnaire was used to gather the information from each MA. The responses were checked for accuracy by the Monitoring and Research unit and MA focal points during technical field visits. To this end, a briefing on the rationale, objectives and expected results from the study as well how to complete the questionnaire were done with the focal points of MA at the Regional Office.

The questionnaire contained the following parts:

1. The country's socio-demographic context of Member Associations: data was collected on social and demographic indicators, and major challenges in terms of population (size, distribution by age, etc.), infant mortality, maternal mortality, fertility level, contraceptive prevalence, HIV/AIDS prevalence, literacy, urbanization, armed conflict, refugees, internally displaced persons, GNP, GDP per capita; how the government perceives these challenges and policies in those areas: actions taken by the government and other agencies or NGOs. This information will be used to develop a clearer understanding of the social and health environment in which the MA operates.
2. Population and SRH Policies in the Africa Region: this part of the study captured information on the existence of population, SRH, HIV/AIDS, poverty reduction policies and the translation of such policies into programmes. This will enable the Regional Office to gauge the Government's efforts to deal with the challenges facing the country and to appreciate the conduciveness of the environment in which MAs operate.
3. A profile of the MA: this part of the study elicited information on the name, size (number of staff, volunteers, number of sections/branches and service delivery points) of each MA.
4. Programmes: data and information was collected on the innovative aspects of the programmes/projects the MA currently implements and the approached used, and who the beneficiaries are. Questions were also asked about the MA's advocacy strategy. This information was intended to highlight the relevance of the MA programmes in relation to the major challenges the country is facing, the Federation's mission, vision and the beneficiaries' needs.
5. Strategic Direction of Member Associations: information was gathered on the MAs' strategic framework in terms of its vision, mission and strategies and possible ways to establish and/or strengthen links with the regional office and the major challenges of the country.
6. Public and Private Sector Partnerships: Information was gathered on the relationships between the MA and Government bodies (Ministries of: Health, Social Development, Women/Children, Youth; the National Assembly or Parliament, etc), International Development Organisations (UNFPA, UNICEF, WHO, USAID and its cooperating agencies), national NGOs working in the same field and other development NGOs and the role and contribution of the private sector in fighting against HIV/AIDS and the relationship between this sector and the MAs. This information would be useful in appreciating the image, credibility and position of the MA at the national level with respect to developing advocacy actions as well as the possible funding opportunities that exist within the country and which may be able to contribute to sustaining the activities of the MAs.

7. Funding Mechanisms: The MAs were asked to provide information on their internal and external funding sources, including funds from IPPF and the amounts over a five year period. The information would yield the spectrum of the MAs' donors and allows for an assessment of fundraising capacities. In addition, information was gathered on available equipment and materials such as vehicles and computers, and their source.

8. Institutional Capacity of MAs: Information was captured on the organisational structure and capacities of each MA. Questions were focused around the organization's own staff training and training for other institutions, their capacity to do monitoring and evaluation and the quality and functioning of a management information system.

4.3 Data Analysis

The data collected was processed and analysed using EPI INFO application software. This programme made it possible to generate frequency tables and to carry out descriptive qualitative and quantitative analysis from the created database.

Then, a consolidated analysis was conducted from the comprehensive data of the 44 MAs in order to draw out major trends on certain issues. This consolidated analysis will provide a basis for the development of an advocacy strategy and materials for IPPF Africa Region's leaders.

Furthermore, each Officer in the Regional Office shall develop a targeted technical assistance plan for each MA under his/her direction.

4.4 Dissemination and Use of Study Findings

A study can only be of value if it is disseminated and action is taken from the results. With this in mind, this report shall be circulated among the senior management team in the Regional office and MAs in the Africa Region, other Regional Offices of the Federation and among partners. The results shall also be included in the IPPAR website currently under development.

The results will be used by Regional Office professionals to develop interventions, activities, strategies and programmes in order to provide targeted assistance to MAs. IPPFAR managers (volunteers, Regional Director and others) will also use the findings as a basis for advocacy and resource mobilisation on behalf of the Regional Office and MAs.

Additionally, the established database will serve as a basis for Regional Office staff to conduct annual reviews. The database will make it possible to better appreciate the quality, timeliness and relevance of programmes submitted by MAs with respect to major challenges at the national level and within each MA.

MAs will also use the findings to develop their annual programmes and to conduct subsequent advocacy activities.

The database developed in this study framework supplements the objectives of the integrated management system which all MAs will soon have access to with regard to information on the context and the programmes of each MA.

5. MAJOR FINDINGS

At the time the analysis was done, only 38 out of 44 MAs or 86.3% had submitted the completed questionnaire. This report therefore takes into account only the information from these MAs. Appendix 1 lists the countries that responded and those that didn't respond to the questionnaire.

5.1 THE SOCIO-DEMOGRAPHIC CONTEXT OF MEMBER ASSOCIATIONS

Sub-Saharan Africa has the highest maternal mortality and HIV/AIDS rates and the lowest rates when it comes to the use of modern contraceptives⁵. In fact, the socio-demographic data collected in the course of this study showed that maternal mortality is at 848 per 100,000 live births within the region compared to 23/100,000 in the developed world. Seventy percent of HIV infections take place in this region as compared to the rest of the world; modern contraceptive practices are at 16% compared to 57% in the developed world. Poor contraceptive practices have led to unwanted pregnancies that, in most cases, end up in induced abortions carried out in unhealthy conditions and close-spaced pregnancies that affect women's reproductive health.

This observation is further confirmed by the fact that almost all of the 38 MAs that responded to the questions on major SRH challenges in their countries affirmed that maternal mortality; HIV/AIDS; unwanted pregnancies; close-spaced pregnancies and unsafe abortions constitute the major challenges for their respective countries. For MAs such as Namibia, Mauritius and the Comoros, close pregnancies are not at the level of major SRH problems.

Maternal mortality, HIV/AIDS, unwanted pregnancies, close pregnancies and unsafe abortion are not just reproductive health issues. Responses from MAs show that governments perceive these as serious development problems.

5.1.1 Population and SRH Policies in the Africa Region

It was promising to note that most MAs confirmed that their countries have a population policy. For any given country, a population policy provides general guidelines on population, health, culture, and social matters, as well as programme themes that need to be developed in order to improve the living conditions and welfare of the population. The dates of these policies range from 1989 (Sierra Leone) to 2002 (Gambia). Some of these policies have recently been reviewed. These policies create a conducive environment for the implementation of health programmes including SRH. Some countries such as Eritrea, Congo Brazzaville, DR Congo, Swaziland, Mauritius and the Comoros do not yet have a national population policy.

5.1.2 Policies on Gender

Gender policies in countries within the IPPFAR were first developed in the early 1990s. Out of the 38 responses, only 14 (36.8%) IPPFAR countries have already developed a gender policy. They are: Ghana, Sierra Leone, Cameroon, Ethiopia, Eritrea, Rwanda, Zambia, Namibia, Guinea Conakry, Gambia, Mali, Malawi, Côte d'Ivoire and Central African Republic.

Many countries in the Region, specifically, Burundi, the Comoros, Swaziland, DR Congo, and Togo have not yet defined a clear gender policy. In view of the importance IPPF attaches to gender concerns, MAs in countries that have not yet defined a policy on gender issues should conduct advocacy actions to influence their governments to establish a clear policy.

⁵ See annex table on socio-demographic and health data

5.1.3 Policies on Adolescent/Youth Health

Adolescent/Youth SRH is one of the five priority areas of the Federation and especially in the Africa Region. The emphasis in this area is justified by the fact that youths below 25 years represent the greatest proportion of the sub-Saharan population (64%); youth between 10-24 years account for 31% of the population. The youth are the most vulnerable to problems of early and unwanted pregnancies, abortions, sexually transmitted infections and HIV/AIDS.

Out of 38 responses, only 13 countries (34.2%) including Ghana, Sierra Leone, Cameroon, Ethiopia, Eritrea, Rwanda, Benin, Guinea Conakry, Burkina Faso, Congo Brazzaville, Mali, Malawi and Côte d'Ivoire, have developed a specific youth policy. These policies are recent and go only back to the late 1990s.

Countries that do not currently have an adolescent/youth SRH policy such as Burundi, Comoros, Swaziland, DR Congo, Togo, Liberia, and others, should make an effort to adapt policies that can enable young people to fully enjoy their rights to access SRH information and services.

5.1.4 Policies on HIV/AIDS

Since HIV/AIDS is one of the deadliest diseases in Africa especially South of the Sahara accounting for 70% of the world's infections. According to respondents, most governments in the region have developed policies for HIV/AIDS prevention, care and support. The majority of these policies were developed towards the end of the 1990s and early 2000. The existence of these policies demonstrates the political will of leaders in these countries to fight the pandemic and thus creates a conducive environment for the implementation of preventive and care and support activities. In addition, the study revealed that 69% of respondent MAs affirm that their countries offer antiretroviral therapy to those who are HIV positive.

In most countries, HIV/AIDS prevention is included in the curriculum of the national education system, starting from the fifth year in primary school right through university. This demonstrates the governments' commitment to control the scourge. Countries with high HIV prevalence rates such as Zambia, Kenya, Burundi, DR Congo, and others, should advocate for the integration of HIV prevention activities into the school curriculum from the 3rd and 4th years in primary.

Some countries like Mauritius and the Comoros with very low HIV/AIDS prevalence rates do not yet have HIV/AIDS policies.

5.1.5 Sexual and Reproductive Health Policies (SRH)

SRH serves as the pillar of population programmes in most IPPFAR countries. SRH is composed of several components of which family planning, safe motherhood, and unsafe abortion control are the major ones. Several countries of the region have family planning and/or safe motherhood as components of the national population policy; others have separate policies for family planning and/or safe motherhood. Some countries have had family planning policies in place for quite some time. These include Kenya (1967), Mali (1972), and Burkina Faso (1985). The most recent policies were developed between 2000-2002 for Francophone countries such as Burundi (2002), Togo (2001) and Guinea Conakry (2000). Namibia and Zambia have no specific policy on safe motherhood. It is incorporated in their national population policy.

5.1.6 Policies on Abortion Issues

Only two countries in the Region- South Africa and Cape-Verde have a clear pro-abortion policy. For all other countries in the region, abortion is illegal and in most cases can only be practiced under the following conditions:

- To save the mother's life;
- Foetal impairment
- Management of incomplete abortion

In some countries such as Cameroon, Ethiopia, Rwanda, the Gambia, Mali, Togo, Madagascar, Mauritius, Côte d'Ivoire, Chad, Central African Republic and Burundi abortion is not allowed even in the case of rape or incest. In addition, unwanted pregnancies do not constitute part of the cases allowing for abortion in the two countries where abortion is legalized. Illegal abortion poses a great challenge to IPPF and its affiliate associations.

5.1.7 Policies on Poverty Reduction

The study found that poverty is widespread in the Africa Region. Populations living below the poverty line range from 62.5% in Niger to 11.3% in Mauritius, with an average of 40% for the Region. In response to such levels of poverty in the Region, most countries have developed a poverty reduction strategy or policy. However, the data revealed that Liberia, Togo and DR Congo are among countries that have not yet defined a poverty reduction strategy or policy.

It was interesting to note that in most countries, poverty reduction strategies include components such as family planning, HIV/AIDS, maternal mortality, and close or unwanted pregnancies. However, unsafe abortion practices are not clearly spelt out. In addition, in most cases, policies on poverty reduction have been translated into programmes, although Rwanda and Zambia have not yet done so. Few Associations play an active role either in national committees for poverty alleviation or in implementing poverty reduction programmes.

The 1994 International Conference on Population and Development affirmed that universal access to quality reproductive health services is a determinant in the reduction of poverty, maternal and infant mortality and the spread of HIV/AIDS⁶. This statement clearly shows the relation between poverty and reproductive health. Consequently, Member Associations in countries that lack policies really need to conduct vigorous advocacy actions so that government leaders develop clear poverty reduction strategies supported by action programmes that are actually implemented.

5.1.8 Role of MAs in Defining Policies

The data revealed that 73% of the countries of the Region have at least a population, gender, youth, FP, HIV/AIDS or poverty policy. However, very few Member Associations play an important role within national policy-making bodies. Their roles are rather limited to consultations within technical committees. This role should now go beyond technical committees to extend to central decision-making bodies. This is where volunteers and executive directors need to make full use of their abilities to assert themselves so as to make their associations more visible at the national level.

5.2 PROFILE OF MEMBER ASSOCIATIONS

Human resources constitute one of the most critical factors for proper management of Member Associations and the implementation of their programmes and activities.

5.2.1 Size of Member Associations

Based on the data collected from the MAs, IPPFAR is comprised of Member Associations that could be grouped into three main categories:

⁶ 2004 UNFPA State of the World Population

- Large MAs with more than 100 employees, 10 SDPs and 7 branches/sections. These include South Africa, Ethiopia, Ghana, Kenya, Nigeria, Uganda and Tanzania.
- Average MAs that have staff members numbering between 50 and 100, 6 branches/sections and 7 SDPs. This includes: Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Gambia, Madagascar, Mali, Mozambique, Senegal, Togo and Zambia.
- Small MAs have less than 50 employees, 6 branches/chapters and 7 SDPs. MAs included in this category are: Botswana, Burundi, Cape Verde, Central African Republic, Comoros, Congo Brazzaville, Eritrea, Guinea Bissau, Guinea Conakry, Equatorial Guinea, Mauritius, Malawi, Namibia, Liberia, DR Congo, Rwanda, Sao Tome, Sierra Leone, Swaziland and Chad.

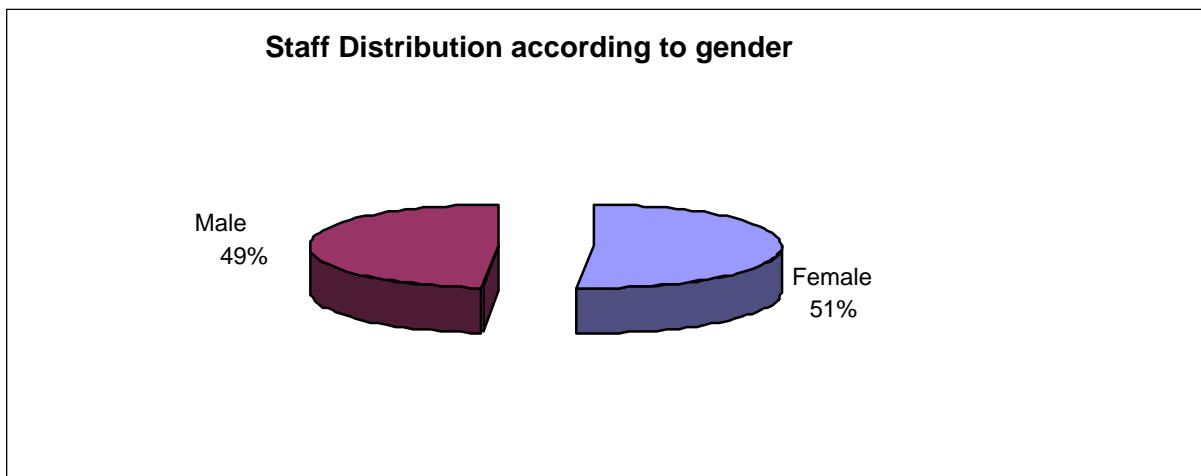
The distribution of these associations by size is shown in the following pie chart:

**Distribution of MAs according to Size
(N=38)**

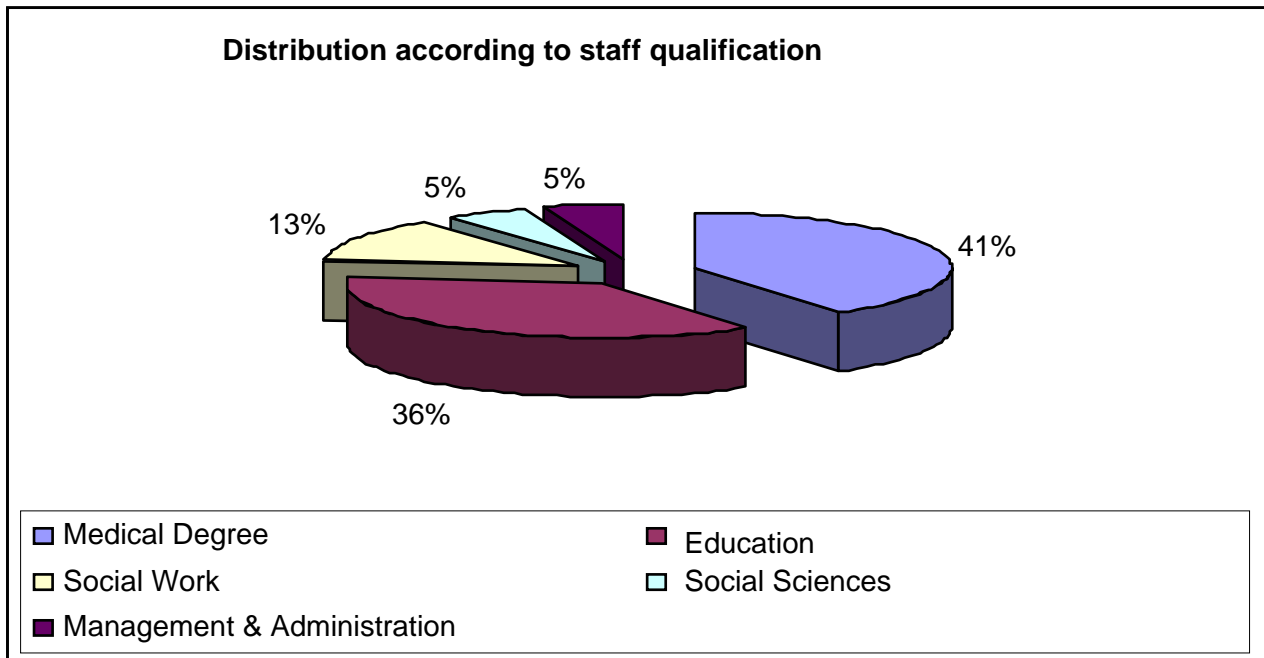


5.2.2 Gender Balance among the Staff

Staff distribution according to gender gives a slight advantage to women. The data revealed that out of a total number of 2,759 employees of the 38 Member Associations, 51% are women whereas 49% are men.



Associations employ staff with a wide range of professional qualifications. This is shown in the following pie chart.



5.2.3 Representation of Youth below 25 Years in the Workforce

One of IPPF’s target priorities in programme implementation is youth below 25 years. This priority is translated in the Federation’s new strategic framework in which Adolescents occupy the same position in the 5As as Access, AIDS, Abortion and Advocacy.

Youth below 25 years are still under-represented at the MAs staff level. In 18 of the 38 Associations that responded, the findings showed that youth below 25 years represent only 4.9% of Association’s staff members.

5.3 PROGRAMMES

5.3.1 Programme Components

Eighty-eight percent of the Associations have programmes in the following areas:

- Family Planning;
- STIs/HIV/AIDS;
- Adolescent/Youth SRH;
- Capacity building;
- IEC/BCC.

Safe motherhood (Namibia, Malawi and South Africa), advocacy (Comoros and Equatorial Guinea), sustainability (Eritrea and Comoros) and gender (Comoros) are not included in programmes.

5.3.2 Service Delivery Approaches

In terms of service delivery, MAs reported that they use a wide range of approaches to provide services to the beneficiaries. These include:

- static clinic approaches (except in Namibia, Equatorial Guinea);
- youth centres with or without a clinic unit (except in Namibia, Central African Republic, Guinea Bissau, Equatorial Guinea);
- peer education (except Equatorial Guinea);
- community based services (except in Eritrea, Namibia, Burundi, Guinea Bissau, Equatorial Guinea) ;
- outreach strategy (except in Sierra Leone, Eritrea, Guinea Conakry, Burkina Faso, Liberia, Comoros, Central African Republic, Burundi).

In all, 78% of the Associations use at least one of the above-listed service delivery approaches. Other approaches such as condom social marketing (as in DR Congo and Sierra Leone), market places or home-based care for HIV/AIDS patients (as in Mozambique) are hardly used by member associations

5.3.3 Programme Beneficiaries

Respondents were asked who the beneficiaries of the programmes that MAs implement are. There was a wide range of responses. They all reported that women of childbearing age, (except South Africa) and pregnant women and youth are beneficiaries, although, it was disappointing to note that not all categories of people are beneficiaries of the programmes run by the Member Associations. For example:

- men are excluded as beneficiaries in DR Congo, Comoros, South Africa and Mozambique programmes.
- people living with HIV/AIDS are excluded (except in Liberia, DR Congo, Malawi, Mauritius, Côte d'Ivoire, South Africa) ;
- sex workers are excluded (except in Namibia, Malawi, Mauritius, Comoros, Central African Republic, Burundi, Mozambique) ;
- displaced persons (except in Rwanda, Zambia, Kenya, Togo, Madagascar, Malawi, Maurice, Comoros, Central African Republic, Burundi, Equatorial Guinea, Mozambique) are excluded from programmes and services offered by the MAs.

In total, 79% of the Associations provide services to one of the above-mentioned beneficiaries. In addition, about 12 Associations provide services to the elderly. They include Ghana, Ethiopia, Burkina Faso and Senegal, among others.

It should be pointed out that the current MA programme is closely linked to the major SRH challenges facing the countries. It meets the priorities set for the Region. Furthermore, it perfectly conforms to three of the five strategies at the Federation's strategic plan level, namely: Access, Adolescents and AIDS. Abortion and Advocacy have not been considered yet by 11 and 14 associations respectively out of the 38 MAs that responded to the questionnaire. The MAs are implementing programmes and activities in the 5As as follows:

<u>ADOLESCENTS</u>	<u>ACCESS</u>	<u>ADVOCACY</u>
<p><u>ABORTION</u></p> <p>ETHIOPIA ERITREA CONGO GAMBIA TANZANIA SOUTH AFRICA</p>	<p><u>AIDS</u></p> <p>SAO TOME GUINEA BISSAU CAPE VERDE BENIN ETHIOPIA ERITREA RWANDA GUINEA CONAKRY CAMEROON BURKINA FASO CONGO GAMBIA</p> <p>TANZANIA SOUTH AFRICA TOGO BURUNDI SENEGAL NAMIBIA MOZAMBIQUE ZAMBIA KENYA SIERRA LEONE LIBERIA MADAGASCAR SWAZILAND</p> <p>DR CONGO MALAWI MAURITIUS COTE D'IVOIRE CHAD COMOROS MALI CENTRAL AFRICAN REPUBLIC BOTSWANA UGANDA GHANA</p>	<p>ETHIOPIA BURKINA FASO CONGO GAMBIA TANZANIA SOUTH AFRICA KENYA SWAZILAND MALAWI MAURITIUS COTE D'IVOIRE MALI UGANDA GHANA</p>
<p>SAO TOME GUINEA BISSAU NIGERIA CAPE VERDE BENIN ETHIOPIA ERITREA RWANDA GUINEA CONAKRY CAMEROON BURKINA FASO CONGO DR CONGO GAMBIA</p> <p>TANZANIA SOUTH AFRICA TOGO BURUNDI SENEGAL EQUITORIAL GUINEA NAMIBIA MOZAMBIQUE ZAMBIA KENYA SIERRA LEONE LIBERIA MADAGASCAR</p> <p>SWAZILAND MALAWI MAURITIUS COTE D'IVOIRE CHAD COMOROS MALI CENTRAL AFRICAN REPUBLIC BOTSWANA UGANDA GHANA</p>	<p>SAO TOME GUINEA BISSAU NIGERIA CAPE VERDE BENIN ETHIOPIA ERITREA RWANDA GUINEA CONAKRY CAMEROON BURKINA FASO CONGO GAMBIA SOUTH AFRICA</p> <p>TANZANIA TOGO BURUNDI SENEGAL MOZAMBIQUE ZAMBIA KENYA SIERRA LEONE LIBERIA MADAGASCAR DR CONGO</p> <p>SWAZILAND MALAWI MAURITIUS COTE D'IVOIRE CHAD COMOROS MALI CENTRAL AFRICAN REPUBLIC BOTSWANA UGANDA GHANA</p>	

REGION MAS CURRENT PROGRAMMEMATIC FRAMEWORK

The diagram of the Region Member Associations Programmatic Framework is as follows:



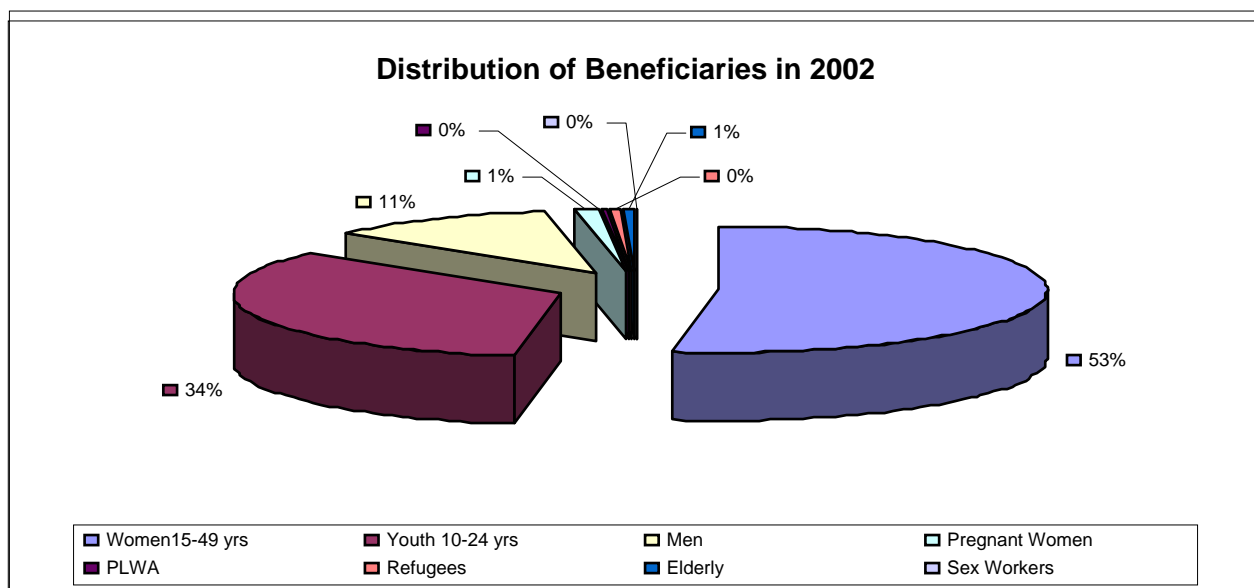
* By order of importance. (cf. Graph "Distribution of Beneficiaries in 2002")

5.3.4 Results attained by Member Associations

The survey revealed that a total number of 2,759 MAs staff members and 32,000 volunteers were involved in the operations and programmes during the period under review. About 1,816 service delivery points and 538 VCT centres for HIV management served 1,958,104 women of childbearing age; 44,485 expectant mothers; 14,088 people living with HIV; 13,876 refugees; 1,260,976 youth; 428,303 men and 21,534 elderly persons; giving a total of 3.7 million people during the same period.

This data is slightly underestimated in as far as information management systems in some MAs are still manual; on the other hand, the data presented was from only 38 out of 44 member associations. In spite of these inadequacies the data that was made available gives an indication of the effort made by member associations during the preceding period, in terms of safeguarding life, preventing unwanted pregnancies and unsafe abortion, and curbing the spread of HIV/AIDS.

Furthermore, the data confirms the predominance of target groups: women of childbearing ages between 15-49 years (53%), youth (34%) and men (11%). This is to the detriment of people living with HIV, refugees, expectant mothers, commercial sex workers and the elderly, as indicated in the graph below:



5.4 STRATEGIC DIRECTIONS

The data suggests that most MAs have developed a strategic plan that integrates their strategic orientations. All MAs in the Region aspire for a society in which youth, women and men fully enjoy SRH rights and benefit from quality services. To attain this vision, MAs have adopted a mission of promoting SRH and its rights by providing information and services focusing on family planning and HIV/AIDS as well as safe motherhood. Therefore, the strategic objectives focus mainly on access to FP, safe motherhood, HIV/AIDS prevention, youth and institutional capacity building. These strategic directions are relevant as long as they provide a framework for the greater part of SRH challenges that the countries are encountering.

5.5 PUBLIC AND PRIVATE SECTOR PARTNERSHIPS

Few Member Associations have developed good working partnerships with the public and private sector.

5.5.1 Partnerships between MAs and Government

There are various government agencies that coordinate SRH activities at the national level. They range from family health departments to National AIDS Control Committees/programmes, working through national population councils/commissions. These bodies are mostly attached to the Ministry of Health. Others are under the umbrella of the Office of the President or Prime Minister. They define the national SRH policy; provide programme coordination, monitoring and evaluation. Some bodies directly carry out activities but most have decentralized/devolved structures that implement activities at the grassroots.

Member Associations reported that they play an important role in facilitating the deliberations of the technical committees of these bodies. Some MAs sit in these bodies to participate in defining national policies and priorities. Such is the case of Malawi, Burundi, Central African Republic, Côte d'Ivoire, Liberia, and Guinea-Conakry.

Other MAs such as Cameroon, Ethiopia, Eritrea, Rwanda, Namibia, Benin, Congo Brazzaville, Gambia, Mali, and Togo collaborate with these government bodies and/or implement some of their programmes/activities.

With regard to National AIDS and Poverty Alleviation Committees, it has been noted that very few Associations have working relations that would enable them to benefit from funding.

Other policy-making government bodies such as Parliaments or National Assemblies, Customs and Excise departments maintain good working relationships with some MAs. MAs in countries such as Cameroon, Benin, Burkina Faso, Congo Brazzaville, Gambia, Mali, Togo, Côte d'Ivoire and Chad have strong working relations in the area of advocacy to overcome obstacles for SRH. This is evidenced by the advocacy actions carried out by parliamentarians and MAs in the above-mentioned francophone countries to lobby for the abrogation of the 1920 French Birth-Control Law.

Some MAs such as Gambia, Togo, DR, Côte d'Ivoire, Burkina Faso and Congo Brazzaville have signed agreements with Customs and Excise Departments in their countries in order to benefit from tax reductions and exemptions on imports of contraceptive products and other materials used in their SRH programmes.

5.5.2 Partnerships between MAs and International Agencies

Besides Government agencies for the promotion of SRH, some MAs enjoy working relations with several agencies such as:

- UNFPA: UNFPA provides contraceptive supplies and medicine to MAs in Eritrea, Rwanda, Benin, Burkina, Congo Brazzaville, Gambia, Mali, Liberia, Togo, Madagascar, DR Congo, Mauritius, Namibia, Côte d'Ivoire, Chad, Comoros, Central Africa, Burundi and Uganda. UNFPA also partners with MAs in HIV/AIDS interventions, training community staff and workers, providing SRH services for refugees/displaced persons, and audio-visual equipment and material.
- UNICEF: MAs in Cameroon, Burkina Faso, Congo Brazzaville, RD Congo and Comoros enjoy good working relationships with their UNICEF country office and work together on the implementation of some projects. They also collaborate on child welfare and safe motherhood activities.
- Other agencies such as the World Bank, UN agencies (WHO, UNHCR WFP) work with MAs in Côte D'Ivoire, Congo Brazzaville, Central Africa and Burundi) either in the area of institutional support or the humanitarian field.

- GTZ: GTZ provides support to Cameroon and Madagascar for capacity building and support to community based services.
- Respondents reported that American agencies such as Plan International, Pathfinder International, Engender Health, Family Health International, Impact, Africare, FPIA, PSI, JSI, Population Council, Peace Corps provide funding and support for capacity building, SRH community based service delivery, promoting condom use, and HIV/AIDS prevention. MAs in countries including, Ethiopia, Rwanda, Benin, Guinea Conakry, Mali, Liberia, Togo, Uganda and Côte d'Ivoire have benefited from this support. However, relations with some American agencies have weakened since the current American administration re-instated the Mexico City Policy (known as the Gag Rule) which suspends all funding to organizations that promote abortion.
- Respondents in Eritrea, Burkina Faso, Mauritius and Chad reported having received financial support from the Embassies of Netherlands, Great Britain, Denmark, Japan, and USA for the implementation of projects to curb female genital mutilation and for SRH service provision.
- MAs in Liberia, Mauritius, Gambia, Benin, Côte d'Ivoire and Namibia reported they have forged relations with their national university or research institutes at the local level to conduct research activities on community based services, STI control, training on research techniques, and training student interns.

5.5.3 Partnerships between MAs and National SRH Networks

There are a wide variety and numerous networks within the countries in the region which promote SRH. The most popular are, among others, Health NGOs networks, women lawyers associations, women doctors associations, youth networks, networks of advocates for behaviour change, safe motherhood associations, networks of people living with HIV/AIDS, parliamentarians network for population and development, HIV/AIDS control network, network of women ministers and parliamentarians. Most MAs in the Region reported that they enjoy good relations with these networks and associations for the implementation of programmes/projects of common interest and/or information sharing.

In some cases MAs are founding members of these networks or have a role in managing them; for instance African Youth Network (coordinated by ABPF-Benin) HIV/AIDS Forum (Chaired by ABEF/ND-DR Congo), SRH NGO network (founding member FPAM-Malawi), NGO network for HIV/AIDS Prevention-COSCI (vice-chair AIBEF-Côte d'Ivoire), network for promotion of SRH among youth in Chad (Founding member ASTBEF-Chad).

5.5.4 Partnership between MAs and the Private Sector

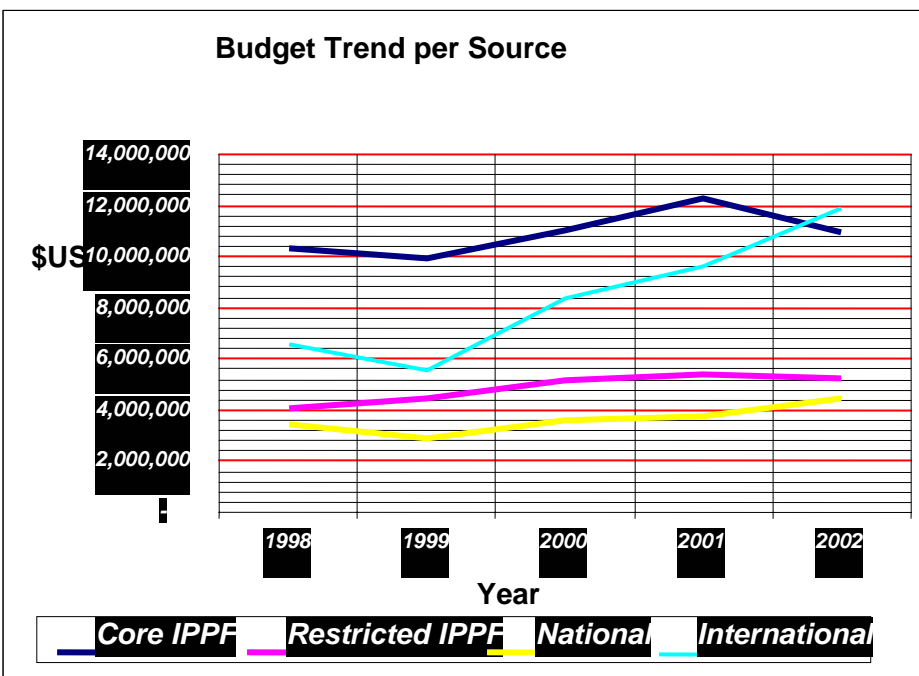
The private sector provides support for the promotion of SRH and HIV/AIDS prevention within the countries in the Region. This support is provided financially both to Ministries of Health, MAs and other agencies and to health facilities of the private companies.

MAs in South Africa, Cameroon, Gambia, Mauritius Namibia, Nigeria, Togo, DR Congo, Senegal, and Zambia report having benefited from private sector funding in their respective countries either to buy medical supplies or to implement activities for the prevention of HIV/AIDS or FP activities. It should be noted that few associations establish relations to enable them to work with the private sector.

Some Associations have taken the initiative to introduce SRH programmes within the private sector of their respective countries: these are Côte d'Ivoire, Ethiopia, Ghana, Lesotho, Malawi, Mali, Kenya, and Swaziland.

5.6 FUNDING MECHANISMS

Since 2001, the budget trend of the MAs has generally shown a reduction of the core grant and restricted funds from IPPF. These funds declined from 12.2 to 10.9 and from 5.4 to 5.2 million US dollars from 2001 to 2002 respectively. However, this reduction has been offset by funds from national and international sources. In fact, since 1999, it can be noted that there has been a regular increase of funds from international and national sources. Funding increased from 2.9 to 4.5 and from 5.6 to 11.9 million US dollars from 1999 to 2002 respectively.



It should be noted though that the positive evolution of funds from national donors benefits only a minority of MAs that also mobilise more money at the international level (Ghana, Kenya, South Africa and Tanzania) or at the national level (Côte d'Ivoire, Ghana and Kenya).

5.6.1 IPPF

IPPF is the main source of consistent funding for the Associations. All MAs get annual grants according to criteria⁷ linked to the countries' SRH needs, the Association's performances and their ability to help other associations.

Besides this basic grant, most MAs received restricted funds from the Japanese Trust Fund, Netherlands Trust Fund, Vision 2000 Fund, Bill Gates Fund, European Commission Fund, etc. Association like those in: South Africa, Botswana, Côte d'Ivoire, Ethiopia, Ghana, Gambia, Guinea Conakry, Kenya, Nigeria, Senegal, Sierra Leone, Swaziland, and Togo, have also benefited from large sums of money from IPPF restricted funds after they submitted satisfactory proposals. Equatorial Guinea and Sao Tome are the only ones who have not yet submitted their project proposals so as to benefit from the restricted funds.

During the period 1998-2002, funds released by IPPF for these basic and restricted grants represented 39% and 18% respectively of the total grants received by the Associations. The combination of these two funds made IPPF the main funding source of member associations during that period, with funds representing 57% of the total funding received by the associations. (Cf. pie chart on page 34).

5.6.2 Local Income or National Sources

Local revenue is derived from the sale of medicine/contraceptives, consultation fees, membership fees, members' contribution, interests on accounts, government and local company grants.

⁷ Criteria derived from IPPFAR resource allocation system

For almost all the associations, the major local source of income is consultation fees and the sale of medicine/contraceptives. The only MAs that do not yet provide clinic services and do not generate service-linked revenue are those of Equatorial Guinea and Namibia.

Governments of countries like Chad, Congo Brazzaville, Côte d'Ivoire, Gambia, Liberia, Mali, Mauritius, Nigeria, South Africa and Swaziland give funds directly and offer facilities to MAs in their countries through the Ministry of Health or the Ministry of Social Affairs for the implementation of their programmes. Assistance is in the form of tax rebate on importation of contraceptives/medicines and equipments.

Between 1998 and 2002, national sources represented 13% of the funds received by Associations. Funds received by MAs from these sources are the lowest. The study found that Member Associations need to tap into national sources in order to lessen their dependence on IPPF and other international funding sources.

5.6.3 International Sources

Between 1998 and 2002, funds received from international sources represented 30% of the total funds received by the associations. Different international sources are offered to Associations depending on their capacity to submit fundable projects. Institutions such as UNFPA, DANIDA, Engender Health, Rockefeller Foundation, European Union, Johns Hopkins University, FHI/IMPACT, JSI, GTZ, USAID, CEDPA, UNAIDS, UNICEF, Plan International, UNIFEM, Pathfinder International, World Bank, Population Concern, PATH, CTB/Belgium, Netherlands Embassy, JICA, FDCI-Canada, British Council, Japanese Embassy, Ford Foundation, FPIA, Future Group, Policy Project, CECI Canada, UNDP, FAO, Action Aid, DFID, Compton Foundation, Kaiser Family Foundation, UNHCR, and PSI, were able to give financial support to MAs for project implementation.

Respondents reported that funding opportunities vary from country to country. In fact countries such as South Africa, Senegal, Nigeria, Mauritius, Madagascar, Mali, Kenya, Guinea Conakry, Ghana, Gambia, Eritrea, Cameroon, Burkina Faso, Rwanda, Tanzania and Uganda have a good working relation with a multitude of international donors whereas Burundi, Chad, Côte d'Ivoire, and Togo are experiencing the effects of donor shortage. Internal armed conflict and governance problems at national level are some of the factors that keep donors away.

5.7. INSTITUTIONAL CAPACITY OF MEMBER ASSOCIATIONS

5.7.1 Status of Member Association Constitutions

All 38 respondent Associations operate within a statutory framework as stipulated in constitutions and by-laws adopted by their General Assembly. Sixteen of these MAs reviewed their constitutions between 1997 and 2001. These are Mauritius (1997), Ethiopia, Central African Republic and Zambia (1999), Tanzania (2000), and Togo (2001).

5.7.2 Organizational Structure

The study tried to determine whether associations have an organisational chart with clearly defined roles. The results indicate that all the Associations except four have an organisational chart at the time the study was conducted. The Associations that do not have an organisation chart are: Botswana, Cape Verde, Côte d'Ivoire and Equatorial Guinea. Among the associations with organisation charts, two feel that the roles are not clearly defined and this could lead to overlapping in roles.

The typical organisational structure is composed of an executive management, a programme management/department and an administration and finance department. This basic organisational structure is under the leadership of the governing body of volunteers. The latter's role is to define policies and to act as guarantors for the Association. Different services, depending on the programme's size, spring from this basic structure.

5.7.3 Systems in place

The study took interest in checking whether associations have functioning systems used for monitoring, evaluation and information which are able to furnish needed information for managing their activities. The results show that 50% of the Associations lack the necessary functioning systems for monitoring and evaluation. These are Benin, Botswana, Burkina Faso, Cape Verde, Central African Republic, Chad, DR Congo, Eritrea, Equatorial Guinea, Guinea Bissau, Mozambique, Namibia, Rwanda, Sao Tome, Senegal, Tanzania, Togo and Zambia. Therefore, capacity building should focus on:

- conceptual modelling and logical frameworks (for developing projects and marketing for resource mobilisation);
- integrating monitoring and evaluation in programme development;
- using data analysis software such as SPSS, EPI INFO;
- management of databases and MIS;
- design operation research projects and implementing them following the perspective of moving vertical FP services into integrated SRH services in line with the 5As;
- developing data collection tools;
- data analysis, interpretation and use.

In terms of accessibility to the Internet and e-mail services, all Associations in the Region have access at their headquarters apart from Congo and DR Congo who still use cyber-café. However, as far as local area networks are concerned, only 29% of the associations have been able to install network that provides access to internet facilities as well in their head office. Most associations (71%) lack this facility that could ease the search and use of information.

5.8 PIONEER POSITION IN FP/SRH MATTERS

It is evident from the preceding analysis that the majority of the Member Associations in the region are currently implementing changes within a well-defined statutory framework and with the support of national policies. A number of these MAs were pioneers in introducing family planning and some of SRH components in their countries, particularly in francophone countries. The hard work carried out in the field, at times in a context where government FP and SRH policies were not clearly defined, earned most MAs the status of national public utility association. Cameroon and the Comoros can be quoted as examples. This appreciation is manifested by the involvement of Associations in the development and implementation of development policies and programmes related to sexual and reproductive health or population.

This pioneering role, however, has not automatically developed the Associations' capacities to be prepared to work in an environment that is increasingly becoming more competitive with other NGOs conducting similar activities. Thus, MAs have not always seized funding opportunities provided by government bodies fighting against AIDS, poverty, customs and excise departments and the private sector. MAs often do not appeal to accredited embassies in their countries to fund some of their activities. This situation limits the growth of a number of associations and puts them in a state of dependency on their regular IPPF donor.

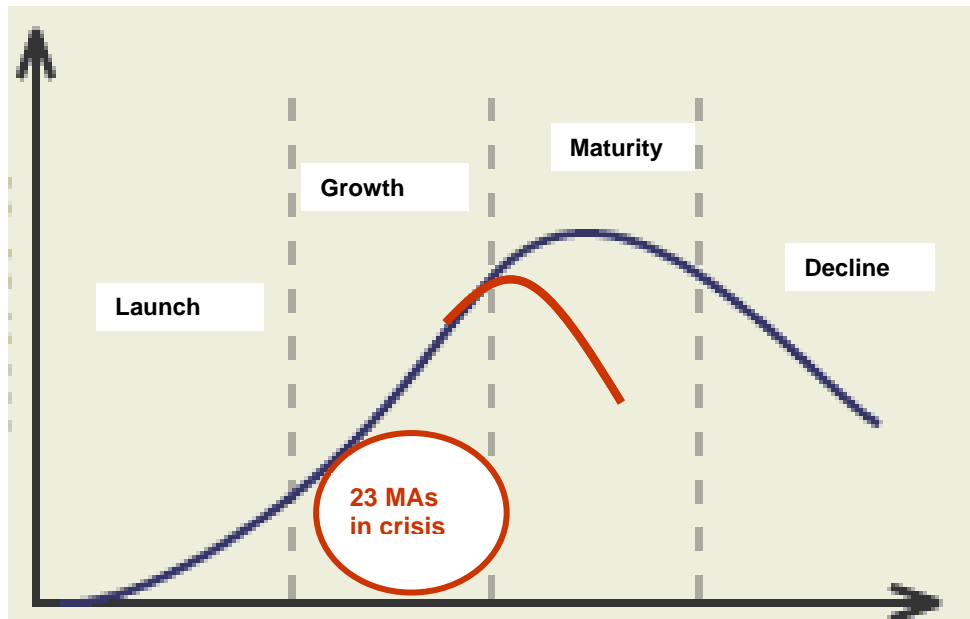
Distribution of MA Budget by Source: 1998-2002



In general, Member Association resource mobilization capacities should constitute one of the areas in which IPPF needs to provide technical assistance with the aim of helping them to seize existing funding opportunities both at the national and international level.

5.9 GROWTH CRISIS

Various institutional evaluations that were conducted in 2003 show that more than around twenty⁸ associations are experiencing governance and/or management difficulties. Among them, 12 are in a critical situation, namely: Equatorial Guinea, Liberia, Sierra Leone, Senegal, Benin, Burundi, Angola, Nigeria, Niger, Zambia, Gabon and Seychelles.



Those in a moderate state are 11, and these are: Mozambique, Mauritius, Kenya, Central Africa, Cameroon, Tanzania, Togo, Comoros, South Africa, Namibia and Chad.

These Associations are experiencing a growth crisis because, whereas the social, technical and technological (knowledge, ability) have changed, management and governance leaderships have not been able to keep abreast or cope with such changes.

⁸ Status of Regional Office support to MAs with special needs, ARO Report, October 15, 2004.

Conflicts in different structures (volunteers/staff) due to a lack of awareness of roles, the inability to distinguish between policy issues and management professionalism, and the inability to anticipate eventual problems and their solutions before associations are plunged into crisis has resulted in a staggered growth pattern, and in some cases, no growth at all.

After more than twenty years in existence, it is sad and frustrating to note that the associations are still unable to consistently defend their leadership position in order to be more visible and indispensable within a competitive environment. By this time, MAs should be focusing on innovative programmes and quality service delivery that would distinguish them from their competitors. They should ensure their own promotion and those of services provided through research, monitoring and evaluation to document and guide the implementation of activities and market their services to enhance programme sustainability and their credibility in the Region.

Possible Solutions

IPPF Africa Regional Office has made a lot of efforts to try and solve this crisis. Examples of actions undertaken in this direction include:

- institutional evaluations which exposed the problems and subsequent development of recovery plans;
- availing an administrator with well-defined terms of reference over a period of three to six months;
- building governance and management capacities of volunteers and staff
- Appointment of an advisor to the Regional Director to take care of Associations in crisis.

In addition to all the above-mentioned solutions, other complementary solutions have been recommended in the recommendation section.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

The data from this study has revealed that the MA environment at country level is conducive for SRH programme implementation. It has also shown that the capacity of Executive Directors in advocacy and negotiation, as well as management professionalism, needs to be strengthened to enable them to advocate and/or partner with government agency circles such as AIDS Control Councils, Poverty Reduction Committees, Customs and Excise Departments, Parliament, the Private Sector and Embassies. As a matter of urgency, MAs need to restructure their programmes in order to cover the five themes of the Federation's new strategic plan, and to begin implementing more innovative service delivery approaches including social marketing, work place programmes, home based care, and health insurance schemes.

The efforts of IPPFAR to turn the Associations into result-oriented organizations so as to ensure their sustainability must be supported by the MAs themselves. To this end, volunteers and staff, with IPPF support, should fully assume their respective roles within the confines of the current policies of the federation. Volunteers and managerial staff should seek funding opportunities and extend their partnership networks with a view to better capitalise on opportunities for implementation of innovative result-oriented programmes.

It should be noted from the data that the MAs and Regional Office are experiencing several weaknesses. The major ones that need immediate attention and are thus, opportunities for action are the followings:

At the Regional level

The reluctance to fill the gap between the support and encouragement provided to MAs to restructure their programmes in line with the strategic direction of the region and the needs in this area.

The inadequacy of the technical assistance and support provided to MAs from the Regional Office in Advocacy, fundraising, Monitoring and Evaluation, Management Information Systems and programme development.

The Inadequacy between the technical assistance in general and the needs expressed or identified of the MAs

At the Member Associations' level

The fact that there is very little funding or support in general from the private sector shows that MAs are not reaching out to the latter despite the opportunities that exist.

MAs lack the ability to attract and retain more staff and volunteers who are committed to the welfare of the community. The diversity of skills and background of the volunteers of MAs are not always representative of the range of potential skills in the society.

The MAs, in general, don't have a culture of building and working with coalitions and partnerships with other stakeholders to have a bigger impact on the life of the population.

There is a clear lack of capacity in Advocacy or advocacy not being a priority.

There is also a lack of willingness to be associated with any abortion related issue.

In conclusion, the final outcome of the crisis that associations are currently experiencing does not solely depend on IPPF. Associations are the focal point of this outcome. In order to do this, they should accept the current volunteer perspective to end up with a volunteer service where the motto 'give more than you get' is practiced. Management professionalism should take precedence over self-centred politics of small groups of individuals who feel they are indispensable to the survival of the associations. That is the sacrifice that has to be made in order to transform these associations into sustainable organisations.

6.2 Recommendations

The following recommendations are presented for two levels: the Regional Office of IPPFAAR and the Member Associations. They are also presented according to the following themes of the study:

- The Socio-Demographic Context of Member Associations
- Population and SRH Policies in the Africa Region
- Profile of the Member Associations
- Programmes
- Strategic Direction of Member Associations
- Public and Private Sector Partnerships
- Funding Mechanisms
- Institutional Capacity of Member Associations

The Socio-Demographic Context of Member Associations

IPPFAR

Coordinate and facilitate the development of policies in countries where there are none.

MAs

Integrate poverty reduction strategies and activities into on-going programmes.

Population and SRH Policies in Member Countries

IPPFAR

Build capacity and communication skills of MAs in advocacy, lobbying and networking.

Influence national policy making bodies to utilize staff of MAs who are trained in policy development and advocacy.

Disseminate IPPF's new strategic framework which includes abortion-related issues.

Commit resources for training staff in MAs in policy development and advocacy.

MAs

Advocate with national authorities to adopt population, gender, youth, SRH (family planning, safe motherhood, HIV/AIDS) and poverty reduction policies in countries where such policies are lacking.

Campaign aggressively to be included in national policy-making bodies and to leverage funding for such activities.

Profile of the Member Associations

IPPFAR

MAAs must recruit staff with skills and capacity in:

- *Organizational and corporate management;*
- *Finance and accounting;*
- *Programme management;*
- *Advocacy, negotiation and resource mobilisation;*
- *Monitoring and evaluation and marketing.*

MAAs

Need to hire qualified young people under the age of 25 years.

Need to recruit volunteers, representing the diversity of their society, who:

- *Can perform and go beyond material survival issues ;*
- *Have a vision to serve communities to improve their well-being;*
- *Understand their roles and responsibilities and comply with them.*

Programmes

IPPFAR

Development/review of MAAs strategic plan to align them with the 5AAs will help to integrate unsafe abortion and advocacy programmes.

MAAs

Programmes should be expanded to include unsafe abortion and advocacy initiatives.

MAAs should reach out and target vulnerable populations and men with new interventions.

Strategic thrust of Member Associations

IPPFAR

The Regional Office should provide technical assistance to help MAAs draw up strategic plans based on the Federation's new strategic framework.

The Regional Office should provide technical assistance to MAAs to restructure their programmes according to the five themes of the Federation's new strategic directions, namely: Access, Adolescents, AIDS, Advocacy and Abortion.

MAAs

MAAs should think in terms of diversifying their approaches to service provision and being more innovative.

Public and Private Sector Partnerships

IPPFAR

Strengthen advocacy and negotiation capacities of Executive Directors and volunteers to enable them to forge partnerships with government agencies as well as embassies.

Strengthen MAs capacities to develop and market proposals and fundable projects.

Aggressively expand networks with the public and private sectors.

Conduct studies and research to determine the best way for member associations to obtain funds from the private sector.

MAs

Develop and market strategies, proposals and plans targeting government agencies, research institutions and embassies that outline corporate MAs strengths and capabilities.

Actively collaborate on SRH, HIV/AIDS and related activities with government, other NGOs, and the private sector.

Use current research findings to educate and sensitise members of parliament, policy makers, and the private sector about MAs contribution to society.

Establish monthly/quarterly fora where public and private sector professionals can network and share experiences and promising and/or best practices on SRH.

Funding Mechanisms

IPPFAR

The Regional Office should provide technical assistance to MAs in the area of resource mobilization to facilitate access to existing funding opportunities at the national and international level.

MAs

MAs that do not benefit from public funds should lobby to obtain such assistance from their governments.

In addition, marketing the expertise of associations can constitute an important national funding source that can be explored.

Institutional Capacity of Member Associations

IPPFAR

The Regional Office should assist MAs to establish efficient Management Information Systems.

The Research and Evaluation Unit must ensure that the database is regularly updated so that reliable information is available on time for informed decision-making at the managerial level.

The Regional Office should take the lead to disseminate state of the art SRH practices and ensure that MAs remain competitive in the sexual and reproductive health market.

The Regional Office should provide technical assistance to the MAs to ensure they are self-sustaining and result-oriented organizations.

MAs

MAs should review their strategic directions, programmes, organizational structures and establishing management systems in order to be on the cutting edge in business.

Member Associations require systems and tools that enable them to collect analyse and disseminate information in a timely manner at all levels.

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ANNEXES

Country	Population mid-2003 (millions)	TFR	GDP (USD) (billion)	%POOR	MMR /100000	CPR (%)	HIV/AIDS PREV. (%)	% BIRTHS ATTENDED SKILLED HEALTH PRO.	ACCESS ESSENTIAL DRUGS	NUMBER OF PHYSICIANS / 100,000 P
ANGOLA	13.1	6.8	8.8	-	1500	4	5.5	22	very low	8
BENIN	7.0	5.6	2.2	46.8	990	7	3.6	60	low	6
BOTSWANA	1.6	3.6	5.3	28.3	250	42	38.8	98	medium	24
BURKINA FASO	13.2	6.5	2.2	45.3	930	5	6.5	31	low	3
BURUNDI	6.1	6.3	0.7	46.1	1300	7	8.3	25	very low	-
CAMEROON	15.7	4.9	8.9	30.7	550	8	11.8	56	low	7
CAPE VERD	0.5	3.9	0.6	20.8	190	46	1	53	medium	17
CENTRAL AFRICA	3.7	5.1	1	45.2	700	3	1.4	44	low	4
CHAD	9.3	6.6	1.4	50.2	1500	22	3.6	16	very low	3
COMOROS	0.6	6.8	0.2	31.9	950	2	0.1	62	medium	7
CONGO BRAZZA	3.7	6.3	3.2	30	890	2	7.2	-	low	25
COTE D'IVOIRE	17.0	5.2	9.4	42.3	810	7	9.7	47	medium	9
DR CONGO	56.6	6.9	5.6	39.7	870	2	4.9	70	<i>not available</i>	7
ETHIOPIA	70.7	5.9	6.4	56.5	1400	6	2.8	10	low	-
ERITREA	4.4	5.9	0.6	42.9	1400	4	11.8	21	low	3
EQUATORIAL GUINEA	0.5	4.9	1.3	29.2	820	3	3.4	-	very low	25
GABON	1.3	4.3	4.9	-	500	12	4.2	86	very low	-
THE GAMBIA	1.5	5.8	0.4	60	1100	9	1.6	51	medium	4
GHANA	20.5	4.2	5.2	28.7	740	13	3	44	very low	6
GUINEA BISSAU	1.3	6.0	0.9	49.3	910	4	2.8	35	very low	17
GUINEA CKRY	9.0	6.0	3	50	1600	4	1.5	35	medium	13
KENYA	31.6	4.4	10.4	31.9	650	32	15	44	very low	13
LESOTHO	1.8	4.4	0.9	25.7	610	30	31	60	medium	5
LIBERIA	3.3	6.6	Not avail.	Not avail.	560	5	2.8	Not avail.	<i>not available</i>	<i>not avail.</i>
MADAGASCAR	17.0	5.8	3.9	36.7	490	10	0.3	47	low	11
MALAWI	11.7	6.5	1.7	42.5	560	26	15	56	very low	-
MALI	11.6	7.0	2.3	47.3	1200	6	1.7	24	low	5
MAURITIUS	1.2	1.9	4.4	11.3	120	49	0.1	91	good	85
MOZAMBIQUE	17.5	5.1	3.8	47.9	1500	5	13	44	low	-
NAMIBIA	1.9	4.9	3.5	34.5	370	26	22.5	76	medium	30
NIGER	12.1	8.0	1.8	62.5	1200	4	1.4	16	low	4
NIGERIA	133.9	5.8	41.1	34.9	1000	9	5.8	42	very low	18
RWANDA	8.3	5.8	1.8	44.3	1071	4	8.9	31	very low	-
SAO TOME	0.2	6.1	0.17	33	131	15.5	0.07	63	very low	47
SENEGAL	10.6	5.2	4.4	45.2	1200	8	0.5	50	low	8
SEYCHELLES	0.1	2.1	0.6	16	67	59	0.1	-	medium	132
SIERRA LEONE	5.7	6.2	0.6	59.2	1800	4	7	42	very low	7
SOUTH AFRICA	44.0	2.8	125.9	20.2	230	55	20.1	84	medium	56
SWAZILAND	1.2	5.9	1.5	27.3	560	19	33.4	67	good	15
TANZANIA	35.4	5.3	9	32.7	770	17	7.8	36	low	4
TOGO	5.4	5.5	1.2	37.9	640	7	6	50	low	8
UGANDA	25.3	6.9	6.2	40.8	1200	18	5	38	low	-
ZAMBIA	10.9	5.9	2.9	40	870	23	15.6	46	low	7
ZIMBABWE	12.6	4.0	7.4	36.1	610	50	33.7	72	low	14

MA_s RESPONSE TO THE STUDY QUESTIONNAIRE

COUNTRY	RESPONDED TO QUESTIONNAIRE
ANGOLA	NO
BENIN	YES
BOTSWANA	YES
BURKINA FASO	YES
BURUNDI	YES
CAMEROON	YES
CAPE VERDE	YES
CENTRAL AFRICA	YES
CHAD	YES
COMORES	YES
CONGO BRAZZA	YES
COTE D'IVOIRE	YES
DR CONGO	YES
ETHIOPIA	YES
ERITREA	YES
EQUATORIAL GUINEA	YES
GABON	NO
THE GAMBIA	YES
GHANA	YES
GUINEA BISSAU	YES
GUINEA CKRY	YES
KENYA	YES
LESOTHO	NO
LIBERIA	YES
MADAGASCAR	YES
MALAWI	YES
MALI	YES
MAURITIUS	YES
MOZAMBIQUE	YES
NAMIBIA	YES
NIGER	NO
NIGERIA	YES
RWANDA	YES
SAO TOME	YES
SENEGAL	YES
SEYCHELLES	NO
SIERRA LEONE	YES
SOUTH AFRICA	YES
SWAZILAND	YES
TANZANIA	YES
TOGO	YES
UGANDA	YES
ZAMBIA	YES
ZIMBABWE	NO

TABLE: MA SIZE IN 2003

Country	Total Staff	Female Staff	Male Staff	Youth Staff	No. Office/ Branch	No of Member	SDP	VCT Centres
GHANA	182	89	93	2	12	519	17	117
SIERRA LEONE	47	22	25	2	4	262	4	1
CAMEROON	36	16	20	1	19	671	10	1
ETHIOPIA	368	166	202	32	7	2649	933	17
ERITREA	45	28	17	3	5	1271	4	0
RWANDA	47	24	23	1	1	2938	4	4
ZAMBIA	65	26	39	0	48	Missing	17	2
NAMIBIA	8	6	2	0	13	Missing	0	0
BENIN	84	47	37	1	6	600	30	1
KENYA	114	49	65	2	54	4181	14	200
GUINEA CKRY	47	20	27	0	5	1275	7	1
BURKINA FASO	89	44	45	0	4	685	8	0
CONGO BRAZZA	34	18	16	0	12	850	5	0
GAMBIA	92	37	55	3	7	837	7	0
MALI	52	18	34	1	6	426	20	1
LIBERIA	23	9	14	Missing	11	535	6	0
TOGO	65	20	45	0	7	450	235	2
MADAGASCAR	104	58	46	Missing	6	77	Missing	18
DR CONGO	21	5	16	Missing	3	241	Missing	Missing
SWAZILAND	54	38	16	20	Missing	280	Missing	5
MALAWI	29	10	19	3	3	371	18	0
MAURITIUS	28	20	8	1	2	600	137	0
COTE D'IVOIRE	50	31	19	0	7	Missing	92	1
CHAD	19	13	6	0	11	1496	5	3
COMORES	22	8	14	0	3	Missing	4	1
C. A. REPUBLIC	17	9	8	0	2	587	3	0
BURUNDI	57	25	32	0	4	334	5	3
NIGERIA	214	128	86	1	34	4000	43	0
GUINEA BISSAU	22	10	12	0	2	600	1	0
EQUAT GUINEA	12	3	9	1	1	300	1	0
MOZAMBIQUE	75	46	29	17	6	1012	5	0
TANZANIA	132	65	67	0	11	100	21	6
CAPE VERDE	18	9	9	0	3	230	3	0
SOUTH AFRICA	294	191	103	58	9	Missing	147	474
SENEGAL	51	30	21	0	8	509	7	3
SAO TOME	14	4	10	4	0	80	3	0
BOTSWANA	13	11	2	0	5	106	5	5
UGANDA	115	63	52	1	29	2900	15	8
TOTAL	2759	1416	1343	154	370	31972	1836	874