IPPF

From choice, a world of possibilities

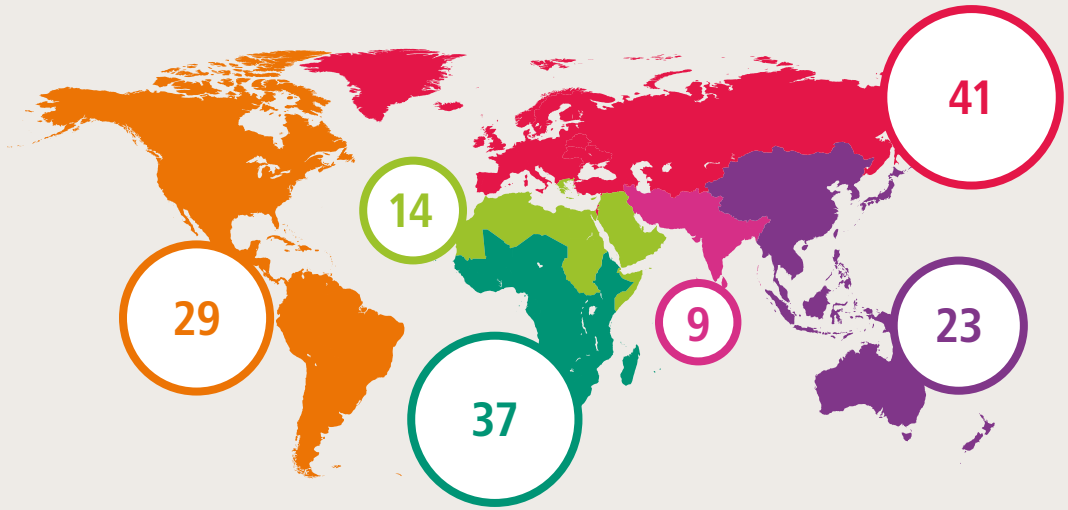
60 IPPF 1952 – 2012

Annual Performance Report

2011–2012

Who we are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.



153 Member Associations

Millions of volunteers

30,000+ staff

85% of Member Associations have at least one young person on their Governing board.

69% of Member Associations have at least one staff member who is under 25 years old.

48% of Member Associations have volunteers and/or staff openly living with HIV.

Acknowledgements

We would like to express thanks to Member Association, Regional Office and Central Office volunteers and staff who have contributed to this report. We are especially grateful to the clients of Member Associations who gave us their time and voices during participatory research on IPPF's work with vulnerable groups. Special thanks to Mahua Sen and James Newton for data analysis.

Editorial

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IPPF's results in 2011

Advocacy successes, by theme

65 Member Associations contributed to

116 policy and/or legal changes in support of sexual and reproductive health and rights.

- **30** Education and services to young people
- **27** Access to SRH services
- **19** Prevention of gender-based violence
- **17** National budget allocations for SRH
- **12** Access to safe and legal abortion
- **07** Support for people living with HIV
- **02** Access to emergency contraception
- **02** Access to Human papillomavirus vaccine

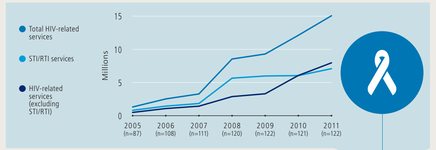
169m Condoms distributed

33m people received services from IPPF

7 out of 10 people we serve are poor, marginalized, socially-excluded and/or under-served.

We provide comprehensive services to the most vulnerable groups.

People who use drugs · Sex workers · People living with HIV · Displaced populations · Sexually diverse groups · Men who have sex with men · Survivors of gender-based violence · People with disabilities



9.1m Couple years of protection,* by method

- 2% Others**
- 11% Injectables
- 15% Oral contraceptive pill
- 16% Condoms
- 31% Intrauterine devices (IUDs)
- 21% Voluntary surgical contraception (vasectomy and tubal ligation)
- 5% Implants

43% Short-acting methods

57% Long-acting and permanent methods

42.5m Contraceptive services provided

89.6m Sexual and reproductive health (SRH) services provided

47.1m Non-contraceptive services provided

- **0.2m** Urological
- **0.3m** Infertility
- **1.6m** Abortion-related
- **2.3m** SRH medical

- **7.8m** Specialized counselling
- **9.2m** Maternal and child health
- **10.5m** Gynaecological
- **15.1m** HIV-related

2.6m unintended pregnancies averted*

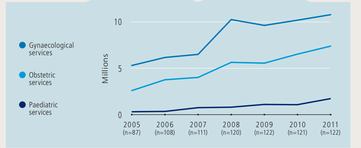
710,000 unsafe abortions averted

* Couple years of protection refers to the total number of years of contraceptive protection provided to a couple. The number of unintended pregnancies averted is based on a conversion factor of 0.288 pregnancies averted for each couple year of protection.

** Including emergency contraception

4 out of 10 of our services are provided to young people under 25 years old.

Location of our 65,000 service delivery points



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Foreword

I want to reclaim the language from the self-proclaimed pro-life movement. For those of us working in sexual and reproductive health and rights, we are the ones who are pro-life because we care about life – the lives of women, children and families.

In the year that marks IPPF's 60th anniversary, I am delighted to introduce the Annual Performance Report 2011–2012 which demonstrates progress achieved in implementing our Strategic Framework 2005–2015. At 60 years old, IPPF remains as passionate, brave and angry as ever before, proud of our past achievements and steadfast in our commitment to what still needs to be done to achieve sexual and reproductive health and rights for all.

This report opens with an overview of external challenges that threaten sexual and reproductive health and rights around the world with a focus on opposition, funding, the availability of health workers, conflict and natural disasters, and health information systems. Despite these challenges, IPPF continues to deliver impressive results. In 2011, Member Association advocacy contributed to an unprecedented 116 policy and/or legislative changes in support or defence of sexual and reproductive health and rights. This is more than double the number of changes from the previous year and a record annual result since we began collecting data in 2005. Successful advocacy for legal and policy changes can take years – and even decades – of tireless work by Member Associations, but the nature of these changes makes a difference to the sexual and reproductive health and lives of millions of people when accompanied by public, political and financial support.

An analysis of IPPF's key global results shows our ongoing and unwavering commitment to ensuring access to sexual and reproductive health and rights through the provision of information, education and services. For the seventh year running, IPPF provided more sexual and reproductive health services (89.6 million) in 2011 than in the previous year. We also continued to serve those whose sexual and reproductive needs are neglected by others: an unparalleled seven in ten of IPPF clients are poor and vulnerable, and four in ten are under 25 years old. We provide services where there are neither government nor private providers, and through our national teams, we respond to humanitarian crises. We provide services to those that others may be reluctant or unable to work with, including sexually diverse populations, sex workers, young people, remote populations and those who cannot pay. In the current political and economic climate, and with ambitious targets to achieve, it is vital that IPPF is supported by robust business systems and processes to ensure that money is invested where it is most needed, and that resources are spent efficiently. The majority of our funding goes to countries with the lowest levels of human development. This investment builds capacity to provide a much higher level of financial return and long-term development.

Our impact is made sustainable by our nationally-owned Member Associations, all of whom are governed and staffed by local people responding to local needs, building capacity and providing a voice for the voiceless. In partnership with donors, governments and civil society organizations at global, regional and national levels, our advocacy work results in enabling environments that recognize sexual and reproductive rights as human rights, which must be guaranteed everywhere, and for everyone.

IPPF Change Goals

As we celebrate our six decades of success, we are working with renewed energy to ensure sexual and reproductive health and rights have an indisputable place on the post-2015 development agenda. We will be guided by the IPPF Change Goals – Unite, Deliver and Perform – that build on IPPF's Strategic Framework 2005–2015. The Change Goals provide us with focus and priority in order to achieve accelerated results by 2015. They reflect IPPF's zero-tolerance to human rights violations, and they ensure accountability to our partners and donors, to the public and to ourselves. Ultimately, being guided by the Change Goals will help us maximize impact for those people with the greatest unmet needs for sexual and reproductive health and rights.

I would like to take this opportunity to thank IPPF's volunteers and staff around the world. Without their determined efforts and commitment, we would not have achieved the results that are presented in this report. I look forward to working together as a Federation and with governments and other stakeholders in our collective movement towards universal access to sexual and reproductive health and rights.

Tewodros Melesse,
Director-General, IPPF

IPPF's Change Goals 2012–2015

Challenges to sexual and reproductive health and rights

Numerous challenges to sexual and reproductive health and rights continue to jeopardize women's and young people's ability to access information, education and services. Progress in achieving equity for the poorest and most vulnerable remains uneven.

IPPF's global movement of sexual and reproductive health and rights advocates and service providers makes a difference to the lives of millions of people, especially women and girls. However, our collective and tireless efforts toward achieving universal access for all are threatened by several external challenges, including opposition to sexual and reproductive health and rights; funding availability; a shortage of health personnel; conflict and natural disasters; and inadequate health information systems.

Opposition to sexual and reproductive health and rights

Opposition to sexual and reproductive health and rights continues to be driven by conservative political, religious, cultural and social forces. Anti-choice groups are unrelenting and vocal, and their aim is to threaten IPPF's vision of "a world where women, men and young people have access to the information and services they need; a world in which sexuality is recognized both as a natural and precious aspect of life and as a fundamental human right; a world in which choices are fully respected and where stigma and discrimination have no place".[1] In politics, religion and the media, some of the most prominent debates focus on sexual and reproductive health and rights issues, particularly abortion, women's rights, contraception, young people, homosexuality, sexual rights and the criminalization of HIV.

In many countries, even where access to safe abortion has fewer legal restrictions, attempts by the anti-choice movement to increase restrictions are persistent. Sexual rights and young people also remain a key focus of anti-choice groups. At United Nations (UN) meetings recently, anti-choice groups made spurious claims about abortion, contraception and homosexuality. The response from the sexual and reproductive health movement, however, was robust and UN Member States issued a bold resolution in complete support of young people's sexual and reproductive health and human rights.

Many young people are still denied access to sexual and reproductive health information, education and services, and their lives are deeply affected by the views of older generations – including parents, teachers and service providers – and cultural and religious taboos regarding young people's sexuality. Anti-choice groups promote abstinence-only approaches, and aim to prohibit the provision of comprehensive sexuality education to young people. The results are that more young people experience unintended pregnancy, unsafe abortion, sexual abuse and sexually transmitted infections, including HIV. Anti-choice groups also support punitive laws and policies that obstruct access to HIV information and services, including condoms, which are proven to be the most effective way to prevent sexual transmission of HIV. The criminalization of HIV exposure and transmission contradicts the very essence of HIV prevention, undermines efforts to support the most vulnerable groups in seeking help, and puts women in the highest risk category, as both perpetrator and victim.[2]

Groups opposed to sexual and reproductive health and rights work at national, regional and global levels to advance their anti-choice agendas. Some are moderate, others fanatical. They are driven by religious conviction, patriarchy, conservatism, conventionality and/or authoritarian orientation, and they use a variety of tactics. We believe that with strong political, financial, legislative and popular support for sexual and reproductive health and rights, and with reduction in stigma and discrimination, anti-choice groups will be increasingly marginalized.

Funding for sexual and reproductive health and rights

Global financial investment in sexual and reproductive health and rights is affected by numerous variables. The global financial crisis, which began in 2007, continues to influence prospects for potential growth and poverty reduction. In many countries, austerity measures mean that health and education spending is reduced, and this may particularly be the case for the most controversial issues, such as sexual and reproductive health. At times of economic crisis, investment in international development is usually one of the first areas to be affected, resulting in lower prioritization and reduced funding levels by donor countries. Since 2007, progress has not been made in the proportion of national income committed to official development assistance (ODA), with only five out of 23 Development Assistance Committee country donors meeting the internationally recognized target of 0.7 per cent.[3] Furthermore, in 2011, total ODA dropped for the first time since 1997,[4] and it is feared that this decline could continue with those countries most at risk being hardest hit.

> The fall of ODA is a source of concern, coming at a time when developing countries have been hit by the knock-on effect of the crisis and need it most.
> **OECD Secretary-General Angel Gurría[5]**

Sexual and reproductive health competes for priority in development budgets with numerous global development issues including climate change, education, food security, other health priorities, humanitarian response, water and sanitation, and democracy building. Global development initiatives, such as the Millennium Development Goals, give prominence to certain issues which means resources are diverted from others. A finite amount of funding, from public, donor and/or private sources, means that resources are directed at issues that are favoured at a certain time, leaving others with less funding.

Governments are accountable to their electorate and need to consider public opinion when making budgetary decisions. Alongside the financial crisis, there is public scepticism about the effectiveness of international aid, which has led to a focus on results, cost effectiveness and value for money. This presents both opportunity and risk – opportunity to prove the effectiveness of sexual and reproductive health and rights programmes, and the risk that value for money is defined so narrowly that it does not take into account the importance of empowerment and social change. The cost of working with the poorest and hardest-to-reach populations can be much higher than reaching urban middle-income populations, and interpreting results for effectiveness rather than equity-focused aims could threaten IPPF's mandate of working with the most vulnerable, including young people. As a result, inequity in sexual and reproductive health and rights may increase further.

Availability of health workers

A lack of available, well trained health staff is a major challenge for the global health sector. It is also difficult to attract and place staff in remote areas where those with some of the greatest unmet health needs live. About half of the world's population live in rural areas, but most health workers reside in cities; this is the case in most countries, but the impact is most severe in low-income countries.[6] Furthermore, the sensitive nature of sexual and reproductive health can also act as a barrier to service uptake if there are no female staff available. Evidence shows that this, alongside inability to pay for services, is one of the most common concerns and reasons for not attending health care facilities.[7]

> A shortage of qualified health workers in remote and rural areas impedes access to health care services for a significant percentage of the population, slows progress towards attaining the Millennium Development Goals and challenges the aspirations of achieving health for all.
> **World Health Organization[8]**

Conflict and natural disasters

Conflict and natural disasters have devastating effects on people, the environment, infrastructure and the economy, and the ensuing fragility in states makes it difficult to deliver effective health services. The statistics remain alarming in terms of how many people are affected, with 10.5 million refugees and 27.5 million internally displaced people worldwide.[9] Women and children are more likely to die than men during natural disasters,[10] and they are particularly vulnerable to sexual violence, especially in armed conflict. Sexual and reproductive health services are increasingly recognized as a key component of disaster relief efforts; however, the challenge is that they are not prioritized. Conflict and disasters can cause disruption that lasts for weeks, months or over many years. Access to services, including gender-based violence screening and counselling, sexually transmitted infection treatment, HIV-related services, contraception, sanitary protection and pre-natal and maternity care, is critical to prevent increased morbidity and mortality during any crisis.

Health information systems

There remains a lack of effective health information systems in many developing countries, with huge variance in quality and coverage. In some countries, even vital statistics systems are weak, with low levels of birth and death registration. For sexual and reproductive health and rights, this poses a challenge in terms of planning, monitoring progress, investment decisions, logistics (personnel and commodities), coordination between agencies and measuring progress. The contentious and sensitive nature of certain sexual and reproductive health issues makes data collection even more challenging. Data on rates of unsafe abortion, HIV prevalence, sexual behaviour and gender-based violence are notoriously difficult to capture accurately, despite being critical for budgetary and planning purposes.

IPPF's response

Despite facing these ongoing and new challenges, IPPF continues to be resilient and adaptive, and brave enough to work on some of the world's most controversial issues. As a Federation, our structure is based on common purpose and objectives, on representation of the local communities we serve, on national ownership and on democracy. We are united in pursuing our agenda and are responsive, innovative and results-focused. We also engage with those outside the sexual and reproductive health movement, not only on what we do and the contribution we make, but on the value of sexual and reproductive health and rights and its importance to human and economic development. Only then will political and financial support follow so that international commitments are enacted to transform the lives of millions of people.

Advocating for changes in policy and legislation

In 2011, Member Associations contributed to a record 116 policy and/or legal changes in favour of sexual and reproductive health and rights in 65 countries. The results illustrate a growing recognition that these rights are human rights, fundamental and indivisible.

Through our advocacy work, we garner public, political and financial support for universal access to sexual and reproductive health and rights. We are often the first to raise awareness and change attitudes on the most sensitive and controversial issues, even when facing extreme hostility, including threats of violence and arrest.

Member Association advocacy results

2011 was an extremely successful year with Member Associations contributing to an unprecedented 116 policy and/or legislative changes on a wide range of sexual and reproductive health and rights issues (Figure 1). These included the introduction of new laws and policies as well as defending against changes that would be harmful to sexual and reproductive health and rights. Eleven of the advocacy successes involved opposing proposed funding cuts and attempts to restrict access to abortion. For example, in Colombia, where abortion is permitted in cases of rape, foetal malformation, incest and to preserve a woman's health, Profamilia and partners stopped a bill from being passed that would have banned abortion under all circumstances.

Creating an enabling environment for sexual and reproductive health and rights involves significant effort, resources and expertise. Advocacy activities include: intensive research; political mapping and analysis; raising awareness and creating space for dialogue; political and public debate; strengthening capacity of civil society; inspiring stakeholders, including citizens, to engage in political processes and participate in campaigns; and acting as a watchdog to hold governments to account on promises made. IPPF is like no other organization in having such a long and successful history of promoting sexual and reproductive health and rights through an extensive global network that advocates at local, national, regional and international levels. Our work is all the more powerful due to the involvement of civil society and bringing grassroots voices to the table.

Figure 1: Number of policy and/or legislative changes by theme, 2011

IPPF has contributed to changing policies and laws in support of sexual and reproductive health and rights from 2005–2011 in

130 countries.

The following examples describe advocacy successes achieved in Pakistan, Ecuador, Uganda and Slovakia. The first two involve changes that support women and young people; the third relates to securing additional budgetary support for contraception; and the fourth to preventing calls to restrict access to abortion. The final example, from the Philippines, describes work being done in an extremely hostile environment where it is likely to take years before policy or legal change occurs.

Combating gender-based violence

Pakistan Rahnuma – Family Planning Association of Pakistan (Rahnuma-FPAP)

Rahnuma – Family Planning Association of Pakistan (Rahnuma-FPAP) contributed to four major policy changes in 2011, overcoming strong opposition to women's empowerment. The Prevention of Anti-Women Practices Bill outlaws forced marriage and depriving women of inheritance. The Acid Control and Acid Crime Prevention Bill ensures a 14-year to life sentence and fine for those convicted of acid throwing, a form of gender-based violence that has become more common in recent years.

At a sub-national level, Rahnuma-FPAP drafted a resolution that calls for the inclusion of sexual and reproductive health education in the school curriculum and acknowledges young people's sexual and reproductive rights. Despite widespread opposition, it was passed in the Punjab Assembly. With strong support from the Netherlands Member Association, Rutgers WPF, a new resolution based on the Human Rights Council resolution on preventable maternal mortality and morbidity also passed in three regional parliaments. Rahnuma-FPAP achieved these changes by working in partnership with civil society organizations, convening meetings between parliamentarians and survivors of forced marriage, providing technical support in the writing of bills, and advising key parliamentarians who then went on to table the bills.

Comprehensive sexuality education and youth friendly services

Ecuador Centro Ecuatoriano para la Promoción y Acción de la Mujer (CEPAM)

Through coordinated advocacy efforts and with the participation of young people, the Member Association in Ecuador, Centro Ecuatoriano para la Promoción y Acción de la Mujer (CEPAM), contributed to a new Intercultural Education Act which requires compulsory comprehensive sexuality education in all public schools, and the implementation of a new national strategy on family planning, which incorporates the sexual rights of adolescents and ensures access to youth friendly sexual and reproductive health services.

These achievements follow on from advocacy work by CEPAM and others in the Western Hemisphere region to ensure that Ministers of Health and Education ratified the Mexico City Declaration on Sex Education in Latin America and the Caribbean in 2008. The Declaration committed countries to roll out HIV and sexuality education programmes and to recognize the critical importance of providing both education and health services.

Young people in Guayaquil, Ecuador, campaign for their rights.
CEPAM/Ecuador

By mobilizing young people, building and strengthening youth networks, partnering with other organizations and establishing alliances with key political actors, CEPAM was able to get young people's rights onto the public agenda, despite strong opposition from conservative forces in Ecuador.

Securing financial commitment

Uganda Reproductive Health Uganda (RHU)

Reproductive Health Uganda (RHU) has been advocating for increased budgetary commitment for contraceptive supplies for a number of years. In 2011, they made a significant breakthrough, convincing the Ministry of Finance to increase the national budget allocation for contraception from US$600,000 to US$3.2 million. Through the Advanced Family Planning Project, RHU and other civil society partners presented persuasive economic and development arguments and supported parliamentary champions to push the issue forward. Advocacy by Member Associations in Benin, Senegal and Tanzania also led to increased budgetary allocations for contraception, and all these successes indicate a growing recognition that reproductive health is critical to achieving development goals and reducing poverty.

Blocking further abortion restrictions

Slovakia Slovak Family Planning Association (SFPA)

The Slovak Family Planning Association (SFPA) successfully blocked changes that would have had a negative effect on women's health and rights. For years, conservative forces have been pushing to restrict access to abortion and had introduced a policy that allowed for objection by medical professionals based on conscience. In 2011, there were calls for a clause in the objection of conscience law that would have enabled hospitals to automatically extend the objection of conscience to all of its employees, regardless of their actual religious or moral beliefs. This would have caused substantial restrictions to the provision of abortion services in Slovakia and would have had a hugely negative impact on the sexual and reproductive health and rights of women throughout the country. In response, SFPA identified the key issues concerning objection of conscience that related particularly to young people and their health. They developed a factsheet and website on the issue, held seminars, lobbied parliamentarians and worked with the media to ensure that the problems with the proposed changes were recognized.

SFPA successfully drew attention to the clause in the objection of conscience policy being called for, gaining support from the public and some politicians. Despite facing an intensive media campaign from anti-choice organizations, religious communities and political pressure from the Ministry of Health, no policy change was made.

Fighting for access to reproductive health care for all

Philippines Family Planning Organization of the Philippines (FPOP)

The Philippines is an example of where, despite strong advocacy activities and good progress, the national situation makes it very hard to actually achieve a change in the law in support of sexual and reproductive health. In the Philippines, reproductive health policies are decided at municipality or province level as there is no national policy. Local political will, therefore, influences whether contraception is included in local government budgets; in practice, this means that the young, poor and vulnerable are often unable to access a chosen method of contraception to avert unintended pregnancy.

Since 2001, the Family Planning Organization of the Philippines (FPOP), as an active member of the Reproductive Health Advocacy Network, has been advocating for a reproductive health bill that would make sexual and reproductive health services accessible to the poor and under-served. This advocacy effort has faced a great deal of opposition from conservative forces, including the Catholic Church. Despite not having changed the reproductive health law, FPOP continued to make incremental gains in 2011. Larger and more frequent mobilizations of supporters took place and commitment was gathered from influential people. The President showed his increasing support by including the bill in his list of priority measures. Unlike at previous congresses, the Reproductive Health Bill was 'alive' in the senate and house debates.

FPOP's high level advocacy was also successful in blocking the passage of the Protection of the Unborn Bill, which would have imposed even more severe penalties for abortion.

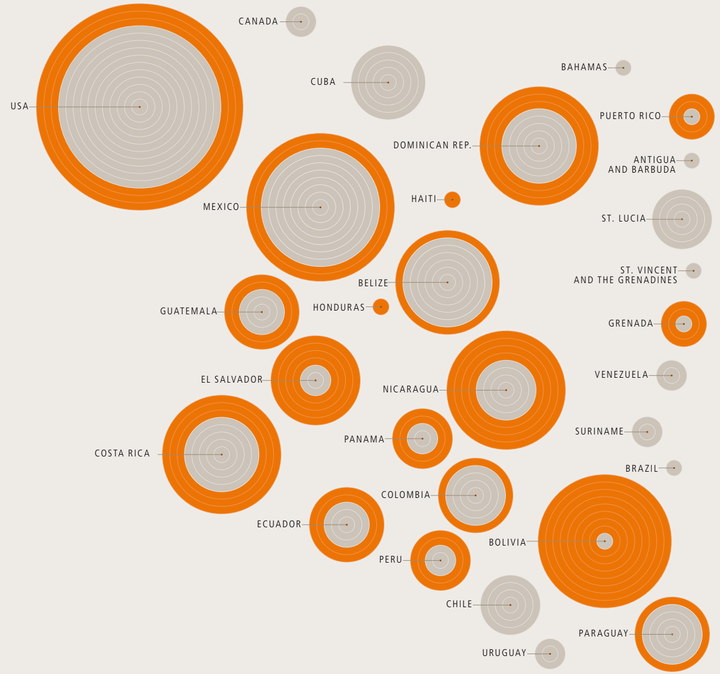
Advocacy results, 2005–2011

From 2005 to 2011, Member Associations contributed to

451 policy and/or legislative changes

in support of sexual and reproductive health and rights in

130 countries.



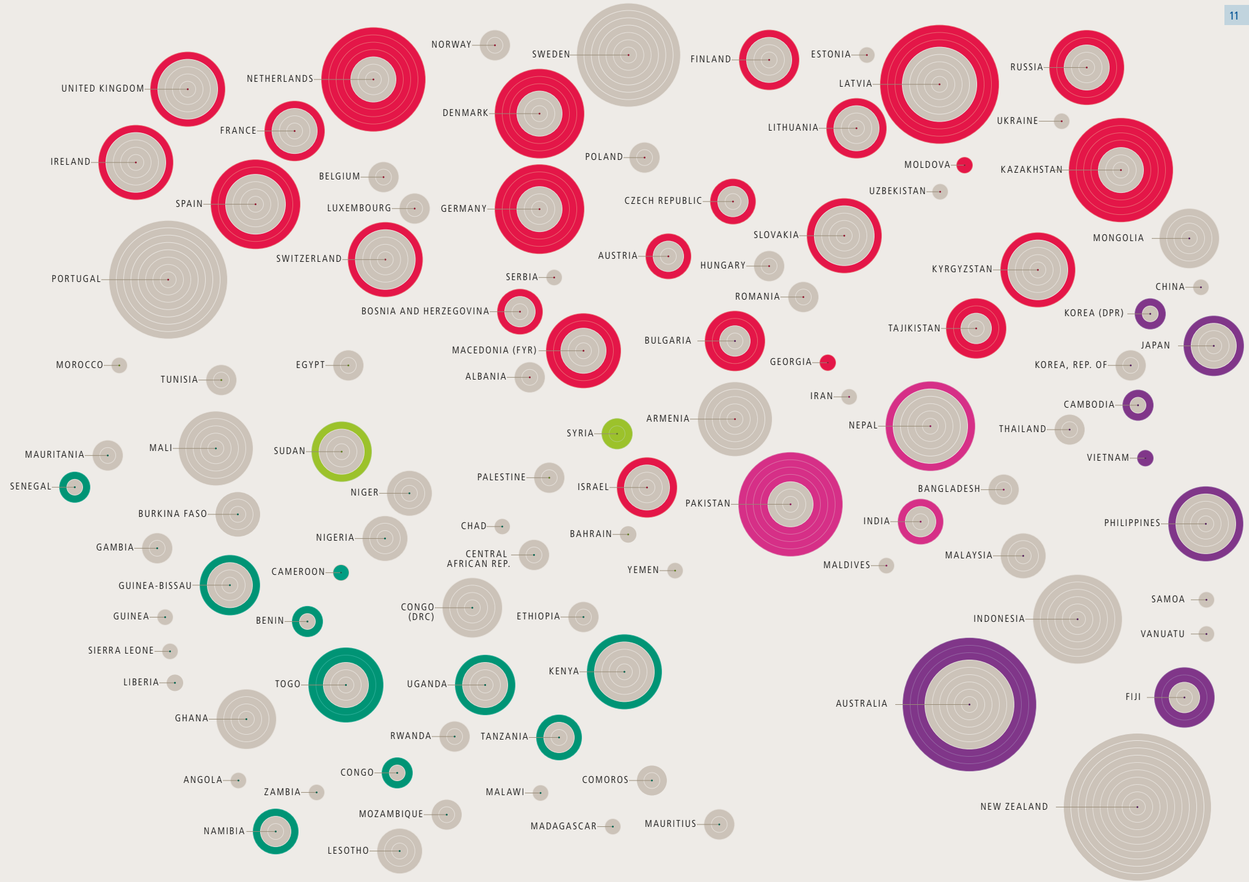
Key

IPPF regions

- Africa
- Arab World
- East and South East Asia and Oceania
- European Network
- South Asia
- Western Hemisphere

Year of policy and/or legislative change

Number of policy and/or legislative changes



Global advocacy on sexual and reproductive rights

IPPF's global advocacy work benefits from our extensive network of Member Associations, from their expertise, and from their ability to mobilize partners (politicians, decision makers and civil society organizations) in support of sexual and reproductive health and rights. Working with IPPF's Secretariat, Member Associations are involved in regional and global advocacy initiatives to ensure that sexual and reproductive health and rights are included in development frameworks, agendas and commitments. In 2011, these included holding the World Bank to account on its commitment to reproductive health, ensuring progressive language was included in various UN documents, and using the Universal Periodic Review as a mechanism to improve policies and laws on sexual and reproductive rights.

Watchdog on the World Bank

The World Bank's Reproductive Health Action Plan 2010–2015 describes the Bank's commitment to sexual and reproductive health, with a focus on reducing high fertility, improving pregnancy outcomes, and reducing sexually transmitted infections, including HIV. IPPF, working with the Bank's Health, Nutrition and Population division, developed a scorecard to assess implementation of the Plan, at both national and global levels. The scorecard is used as a tool for civil society advocates, including Member Associations, to hold the Bank accountable to its commitments, and for those within the Bank itself to champion the issue of sexual and reproductive health and to ensure adequate funding is made available. It is also used on an annual basis by both civil society and World Bank staff, including Directors, to assess progress prior to the Bank's annual review of the Action Plan.

IPPF also advocated for the linkages between reproductive health, women's empowerment and economic growth to be strongly articulated in the World Bank's publication, the World Development Report 2012. An initial draft of the publication lacked sufficient reference to the importance of sexual and reproductive health for human development, and Member Associations, together with the African Women Leaders Network, contacted the World Bank to express their concerns. As a result, the Bank amended the report to emphasize the linkages between sexual and reproductive health, women's empowerment and human development.

UN: where language makes a difference

In 2011, IPPF successfully advocated for progressive language to be included in various UN documents. These included the outcome documents from the Annual Ministerial Review, the Commission on the Status of Women and the Commission on Population and Development (CPD) which had fertility, reproductive health and development as its theme. IPPF and UNFPA also organized a joint side event at CPD entitled 'Putting Girls First' which focused on adolescent health and fertility and young women's sexual and reproductive health and rights. More recently, at the 2012 CPD, IPPF supported youth advocates from Africa, Asia, Europe and Latin America to help facilitate a pre-conference strategy session and to advocate with their national governments for supportive policies and programmes. IPPF also held several events on the importance of comprehensive sexuality education and youth rights. As a result, UN Member States delivered a bold resolution in support of young people's sexual and reproductive health and rights. By ensuring that these issues are prominent and supported at such a high level, the rights of young people and sexual minorities will continue to be included in future commitments on sexual and reproductive health.

Leading up to the Rio+20 UN Conference on Sustainable Development, IPPF Secretariat and Member Associations, in collaboration with the Population and Climate Change Alliance, called for sexual and reproductive health and rights to be included in international development commitments. Written submissions focused on recognizing that sexual and reproductive health and rights and gender equality are essential components of sustainable development. The importance of young people's access to comprehensive sexuality education was also highlighted.

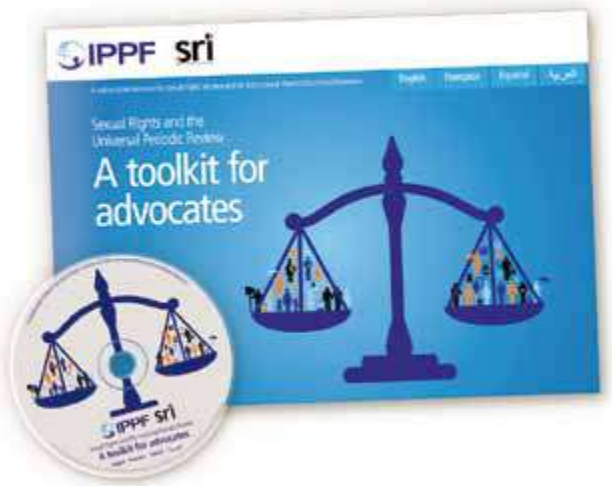
Throughout negotiations during the Rio+20 conference, IPPF highlighted the importance of including sexual and reproductive health and rights in the outcome document and kept sustained pressure on participants who had influence on the language. IPPF also organized a well-attended side event to discuss population, women and rights. As a result, and for the first time in this forum, sexual and reproductive health and the promotion and protection of human rights in this context were included in the outcome document. This serves as a mandate for advocates to ensure sexual and reproductive health and rights are included in the post-2015 sustainable development goals, and IPPF's Declaration of Sexual Rights can be used to call for the recognition of sexual rights as universal human rights.

IPPF also partnered with other organizations to convince many UN Member States to sign up to the Human Rights Council landmark resolution on preventable maternal mortality and morbidity. IPPF forwarded urgent action alerts to Member Associations, who in turn advocated to their own governments. To date, over 90 Member States have signed up to the resolution, out of a total of 193 countries, acknowledging that a rights-based approach is needed to protect the health of women, including young women, during pregnancy and childbirth to reduce maternal mortality and morbidity rates.

Universal Periodic Review: highlighting human rights violations

The Universal Periodic Review is a UN process whereby all UN Member States have their human rights records reviewed by peers from other countries. Recommendations are then made as to how a country's human rights record could be improved to increase compliance with international human rights standards established by the Human Rights Council. This Review provides a unique opportunity for sexual rights advocates to engage with the UN system, their government and other countries to highlight human rights violations in an international forum, and to follow up on the recommendations made to improve policy and legislation that deny sexual rights.

In 2011, four countries were reviewed at the Universal Periodic Review: Ireland, Lithuania, Thailand and Trinidad and Tobago. IPPF and the Sexual Rights Initiative provided training for staff from IPPF's Regional Offices and the four Member Associations whose countries' human rights records were to be reviewed. The Member Associations then submitted information to the Office of the High Commissioner for Human Rights on violations specifically related to sexual and reproductive health and rights in their countries. The Irish Family Planning Association (IFPA) highlighted the ways in which criminalization of abortion in Ireland violates women's and girls' rights to health, privacy, life, freedom from cruel and degrading treatment and non-discrimination. The Family Planning and Sexual Health Association of Lithuania emphasized the need to respect, protect and fulfil the rights of young people to sexual and reproductive health, including comprehensive sexuality education and access to health services. The submissions in Thailand and in Trinidad and Tobago focused on a wide range of sexual rights issues, including the rights of sex workers in Thailand, and of lesbian, gay, bisexual and transgender people in Trinidad and Tobago. All these submissions, along with intensive advocacy efforts by the Member Associations, resulted in very strong recommendations from UN Member States, with many being accepted by the respective governments (Box 1). Unfortunately, the government of Ireland, despite receiving six strong recommendations on abortion, did not accept the recommendations. The three Member Associations followed up on the recommendations that were accepted to ensure implementation at country level in Lithuania, Thailand and Trinidad and Tobago; and all four continue to highlight the rights violations related to those recommendations that were deferred.



Box 1: Three governments accepted recommendations made by UN Member States

Key recommendations that were accepted by governments included:

Lithuania

- make a comprehensive range of modern and affordable contraceptives more widely available

Thailand

- increase efforts to address the human rights challenges faced by all sex workers
- provide sexual and reproductive health services to all people, including sex workers, their clients and clients' spouses and partners, without discrimination
- give sex workers the option of voluntarily joining the Social Security Scheme

Trinidad and Tobago

- undertake proactive policies to promote the rights of individuals, especially with regard to their sexual orientation and HIV status
- continue promoting equality, participation and empowerment of women in public policy making
- strengthen legislation and policy measures aimed at preventing and addressing violence against women
- increase measures to ensure that violence and discrimination against members of vulnerable groups, such as women and lesbian, gay, bisexual, and transgender people, are both prevented and prosecuted

IPPF and the Sexual Rights Initiative will continue to use the Universal Periodic Review process to advocate for greater recognition of sexual and reproductive rights. In 2012, the human rights records of Argentina, Finland, Indonesia, the Netherlands, Pakistan, Peru, the Philippines, Switzerland and the United Kingdom will be reviewed, and Member Associations in these countries will make written submissions to the UN Human Rights Council and advocate strongly for sexual and reproductive rights violations to be highlighted in the recommendations.

Civil society's contribution recognized

IPPF was part of a group of health organizations that successfully advocated for the role of civil society to be recognized at the Fourth High Level Forum on Aid Effectiveness in Busan, a meeting to review progress on implementing the Paris Declaration principles. The resulting Busan Partnership for Effective Development Cooperation established for the first time a broader and more inclusive framework for cooperation that includes donors – both old and new – civil society organizations, private funders and others.

> "Civil society organisations play a vital role in enabling people to claim their rights, in promoting rights-based approaches, in shaping development policies and partnerships, and in overseeing their implementation. They also provide services in areas that are complementary to those provided by states.[11]

Key global results

IPPF provides sexual and reproductive health services that enable people to make choices, to protect themselves from ill health, violence and death, and to enjoy happy, healthy and fulfilled sexual lives.

For the seventh year running, the number of sexual and reproductive health services provided by IPPF has increased, from 88.2 million in 2010 to 89.6 million in 2011. Contraceptive and non-contraceptive sexual and reproductive health services were provided in almost equal numbers to fulfil our mission of providing a service package focused on prevention, diagnosis, care, treatment and support for all the key components of sexual and reproductive health (gynaecology, obstetrics, contraception, HIV, abortion-related services and specialized counselling). These services are provided via a range of service delivery mechanisms, in static clinics, by mobile outreach teams or community-based distributors, in private pharmacies, through social franchises, in government facilities or social marketing outlets, in urban, peri-urban and rural locations.

Our service provision focuses on those with the greatest unmet needs, with seven in ten of our clients being poor, marginalized, socially-excluded and/or under-served, and four in ten under 25 years old. In its 60th year, IPPF continues to pay attention to the needs of women and girls, with the majority of our work bringing better health outcomes, an improved chance of survival for women and their children, increased opportunity, and a better quality of life. In 2011, the majority of our core investments went to countries with low or medium levels of development, as defined by the UNDP Human Development Index. These countries have disproportionately high levels of maternal and child morbidity and mortality, HIV prevalence, early marriage and childbearing. They are also countries where it is less likely that governments invest sufficient resources in health and education, especially in relation to sexual and reproductive health and rights, to meet the needs of all, including those hardest to reach and least able to pay.

Providing services to young people

In 2011, 37.4 million sexual and reproductive health services were provided to young people, a rise of over 6.4 million from 2010, with HIV-related services and specialized counselling services showing the highest significant increases (Figure 2). More sexual and reproductive health services are reaching young people, and in 2011 a higher percentage of all IPPF's services were provided to youth – in 2005, this was 26 per cent, compared to 35 per cent in 2010, and 42 per cent in 2011 (Figure 3).

This work is critical to ensure the realization of the sexual and reproductive health and rights of the largest ever generation of young people. It is particularly important where young people face stigma and discrimination, and where they have no voice and little recourse to information, education and services. Young people who visit Member Association service delivery points do so confident in the knowledge that they will receive high quality, youth friendly and non-judgemental services. Figure 4 illustrates the proportion of services provided to young people for 16 Member Associations that were particularly effective in meeting young people's sexual and reproductive health needs in 2011. Globally, one-third of Member Associations provided more than half of their services to those aged under 25.

Figure 2: Number of SRH services provided to young people, by type, 2005–2011

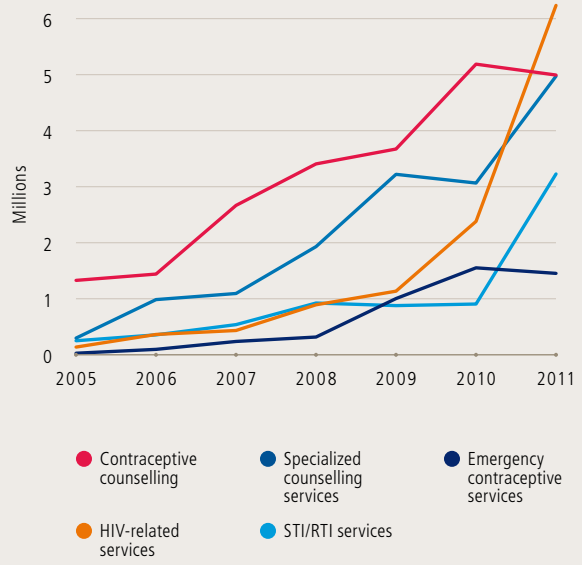


Figure 3: Percentage and number of SRH services provided to young people, 2005–2011

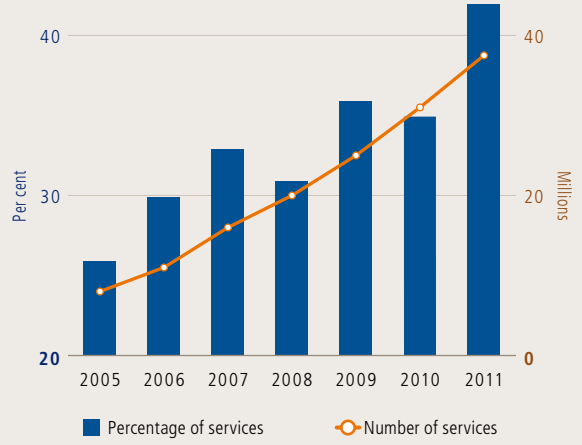


Figure 4: Percentage of SRH services provided to young people, selected countries, 2011

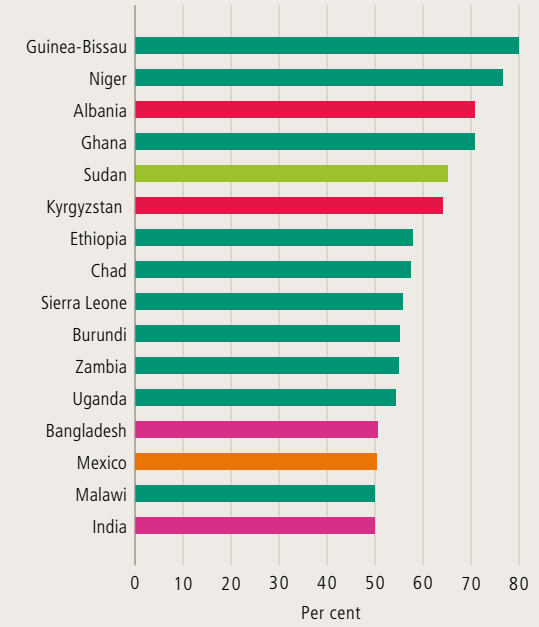
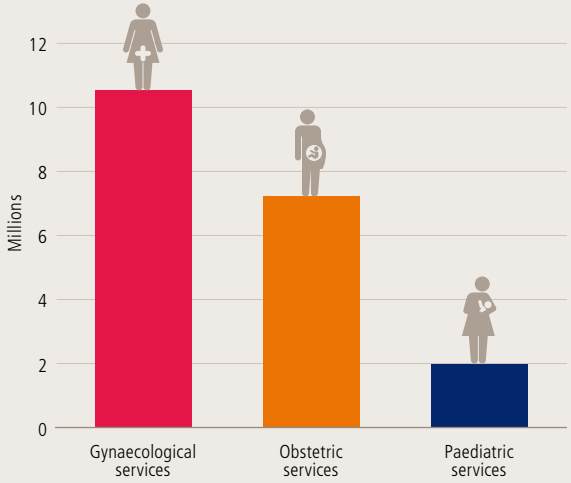


Figure 5: Number of gynaecological, obstetric and paediatric services provided, 2011



Focusing on the needs of women and girls

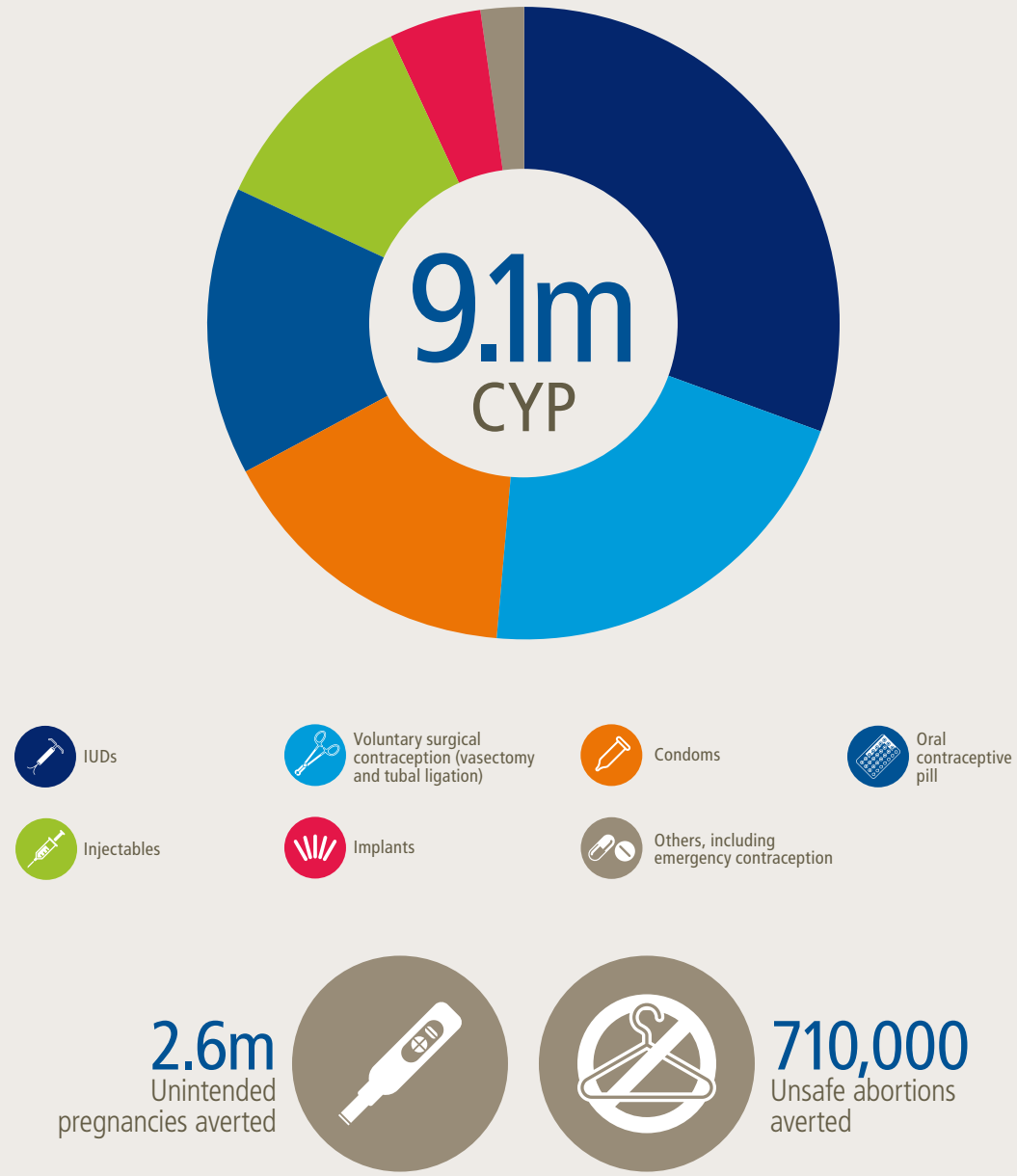
Morbidity and mortality related to sexual and reproductive health and rights disproportionately affect women and girls. Ingrained gender-based power inequalities between men and women mean that despite some progress having been made in recent years, millions of women and girls still experience discrimination in many forms. Women are more likely to be poor and illiterate than men and less likely to be able to benefit from economic opportunities. Women's lack of power means that their voices often go unheard, with only 20 per cent of all members of national parliaments being women.[12] All this means that, when it comes to sexual and reproductive health, women are more at risk and they are often denied the right to choose when, if and how many children they bear. In many parts of the world, women are prevented from ending an unintended pregnancy because of legal restriction, financial constraints, and/or a lack of access to safe abortion. Women and girls are also at greater risk of violence, trafficking and sexual exploitation.

For 60 years, IPPF has worked to reduce some of these inequalities, providing information, education and services, as well as advocating and raising awareness of the rights of women and girls. In addition to contraceptive and abortion-related services, we provided more than 10.5 million gynaecological services to women (examinations, biopsy, imaging and cancer screening), and over 7.2 million obstetric services (pre- and post-natal care, pregnancy testing and deliveries). In terms of child health, nearly 2.0 million paediatric services were provided, including more than one million immunizations and over 380,000 baby/infant health checks and neonatal screening services (Figure 5). Since 2005, these figures have increased on an annual basis, validating our ongoing and deep commitment to women and girls.

In 2011, we provided 9.2 million maternal and child health services.

IPPF/Nguyen-Toan Tran/Côte d'Ivoire

Figure 6: Global couple years of protection (CYP), by method mix, 2011



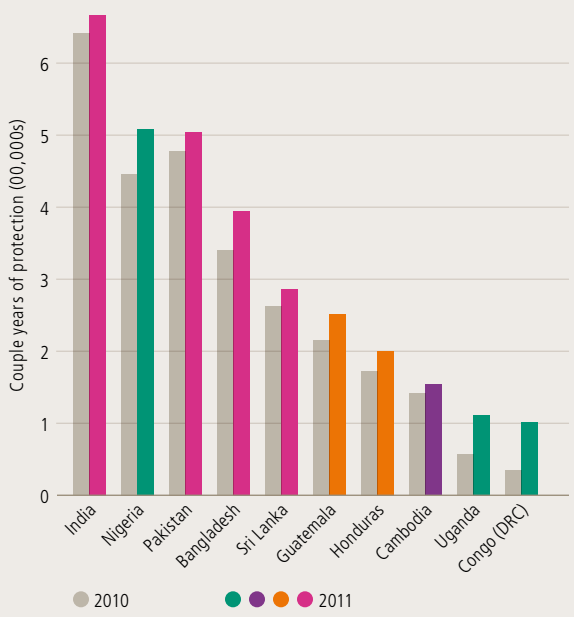
Couple years of protection (CYP)

IPPF provides contraceptive counselling to millions of women and couples to ensure that they are empowered to make informed decisions about when, if and how many children they want. Contraceptive counselling includes choice of method and their advantages and disadvantages; a client's medical history and other circumstances are also discussed to ensure that the chosen method is appropriate and safe. This is a fundamental primary health care service; it supports a shift toward the use of more reliable contraceptive methods, dispels myths and can reduce barriers to the uptake of contraception, including religious and cultural resistance.

IPPF offers a broad range of contraceptive methods in all types of service delivery points, including long- and short-acting and permanent methods wherever possible. Figure 6 shows the method mix of IPPF's couple years of protection (CYP): 36 per cent of CYP was provided by long-acting; 43 per cent by short-acting; and 21 per cent by permanent methods. IPPF's rights-based approach to ensuring choice fully supports women in their decision-making throughout the duration of their reproductive lives.

The global trend for the number of CYP provided by IPPF showed a two per cent increase in 2011, from 8.9 million in 2010 to 9.1 in 2011. Using impact estimation models, this means that 2.6 million unintended pregnancies and 710,000 unsafe abortions were averted. Despite the majority of Member Associations providing greater CYP in 2011 than in 2010, one-third saw a decline. More significantly, three of IPPF's largest CYP providers, Brazil, Colombia and Vietnam, showed decreases between 2010 and 2011, totalling nearly half a million. For Brazil and Vietnam, much of the drop in CYP resulted from lack of access to condoms (due to increased cost and/or unavailability of condoms from the government/other private suppliers). Despite increases in injectables, emergency contraception and condoms in Colombia, the overall decline in CYP resulted primarily from providing

Figure 7: CYP, selected countries, 2010–2011



Family Guidance Association of Ethiopia's clinic brings a great difference to my life... After one birth I started using family planning... If I hadn't, I would have had another birth and I couldn't continue with my education. This would make it difficult for me to earn money. I would have so many difficulties throughout my life if I didn't continue my education.

30-year old client, Ethiopia

fewer intrauterine devices (IUDs) and tubal ligations. The impact of these decreases on IPPF's global figure masks the progress made by many other Member Associations (Figure 7), including a substantial increase in the Africa region of 28 per cent, and an increase in the South Asia region of 6 per cent.

Abortion-related services

In 2011, 1.6 million abortion-related services were provided, with the most common types of services including pre- and post-abortion counselling, and surgical/medical abortion. IPPF also provided support to strengthen health systems in the provision of abortion-related services, and to ensure quality of care (Box 2).

As part of a comprehensive abortion care package, emphasis continues to be placed on post-abortion contraceptive service provision. In 2011, the proportion of clients adopting a post-abortion contraceptive method averaged 88 per cent among the 12 Member Associations participating in the Global Comprehensive Abortion Care Initiative. The Cameroon and Sudan Member Associations were particularly successful in providing this service, achieving 100 per cent and 99 per cent respectively. Member Associations have adopted a range of strategies for establishing themselves as providers of comprehensive abortion care and increasing the number of clients served. Some activities undertaken have been:

- training community health workers and young peer educators to provide information on, and referrals for, safe abortion and contraceptive services
- using radio programmes to highlight the range of services available at clinics
- operating open days during which services are provided free of charge
- increasing clinic opening hours
- reducing user fees in conjunction with a 'no refusal policy'
- disseminating information materials with accurate messages about safe abortion and contraception
- developing referral partnerships with local organizations

IPPF is increasingly focused on providing treatment for incomplete abortion using manual vacuum aspiration. This is an abortion-related service that is rarely regulated by stringent laws, and which reduces maternal morbidity and mortality. We also develop the skills of providers in the event that opportunities for scaling up safe abortion services arise following the liberalization of national laws and policies. To ensure access to medical methods of safe abortion, IPPF has continued to work with the Concept Foundation to pilot test and eventually register Medabon®* in Burkina Faso, Cameroon, Ghana and Kenya. As a result of Member Association advocacy, Medabon® has recently been registered in Benin and Mozambique, and registrations in the other countries are expected to follow soon.

Box 2: Abortion-related services in Kyrgyzstan

Kyrgyzstan Reproductive Health Alliance of Kyrgyzstan (RHAK)

In 2011, the Reproductive Health Alliance of Kyrgyzstan trained 97 medical specialists in government clinics and other health care organizations in pre- and post-abortion counselling, medical abortion and manual vacuum aspiration. These procedures improved client safety in comparison to the outdated method of dilatation and curettage previously used by the clinics before the training. The support provided by RHAK also led to improved quality of care in the clinics, which now have new separate recovery rooms and comfortable, private rooms for pre- and post-abortion counselling.

* Medabon® is a combination therapy for medical abortion. Medical abortion refers to the process of taking medications to end a pregnancy, rather than through surgical intervention (such as manual vacuum aspiration or dilatation and curettage). The most effective and safest medical abortion regimen requires the use of two medications, mifepristone and misoprostol. Medabon® is the first product to package and license these two medications together.

HIV-related services

IPPF has made impressive progress in the number of HIV-related services provided, with the most recent annual increase of 24 per cent from 2010 to 2011 (12.1 million to 15.1 million). The greatest increases were seen in the provision of STI/RTI services, voluntary counselling and testing and HIV serostatus laboratory testing (Table 1). Also, more Member Associations than ever before provided at least six of the nine services along the prevention-to-care continuum, from 50 per cent in 2010 to 58 per cent in 2011.*

The Africa region in particular significantly increased the number of HIV-related services provided. Over 5.2 million services were provided in 2011, a 39 per cent increase on the 3.7 million services provided in 2010. Over 2.2 million of these HIV-related services went to young people, one of the groups most at risk from HIV infection. Whether educating young people about modes of HIV transmission, preventing transmission from a young woman to her child, or reducing stigma and discrimination faced by young people living with HIV, focusing on youth is crucial to determine future attitudes towards HIV, prevent HIV transmission and promote the rights of all people living with HIV.

Scaling up the linking of sexual and reproductive health and HIV provides an unparalleled opportunity to expand access to a wide range of sexual and reproductive health services, including contraception and HIV services. The Integra initiative, one of IPPF's major research projects that is run in collaboration with the London School of Hygiene and Tropical Medicine and the Population Council, is strengthening the evidence base for integrating HIV and sexual and reproductive health services. Since 2008, Integra has implemented and evaluated four different models of integrating sexual and reproductive health and HIV services in Kenya, Malawi and Swaziland. One of the research aspects of the programme is to investigate whether sexual and reproductive health and HIV integration is a more efficient way to use resources. Early findings suggest that economic gains can be made, but also that a number of variables can influence the outcome. For instance, in Malawi, the cost of integrated services for young people varies depending on the availability of supplies and the workload of staff. If supplies are low, this affects patient volume, and staff can be under-utilized leading to increased cost per client.

> "There is no blue print for integration – costs and savings are context specific. Integration is about using what you have that is scarce in a better way.[13]

Table 1: Number of HIV-related services provided, by type, 2010 and 2011

Type of service provided	2010	2011
STI/RTI services	6,053,551	7,101,681
HIV voluntary counselling and testing	2,810,524	3,385,802
HIV serostatus lab tests	1,782,159	2,353,660
HIV prevention counselling	1,210,230	1,924,961
HIV and AIDS home care treatment	68,888	86,682
HIV opportunistic infection treatment	60,748	52,411
Psychosocial support	37,943	62,938
Other HIV lab tests**	35,364	18,588
Antiretroviral treatment	23,687	27,836
All other HIV services	49,656	69,615
Total	**12,132,750**	**15,084,174**

Reaching the poor and vulnerable

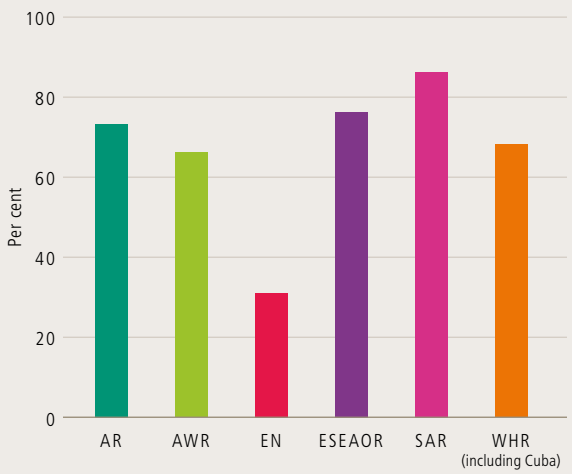
IPPF's record of reaching and serving the poorest and most vulnerable continues unabated and unparalleled, with over seven in every ten of our clients being identified as poor, marginalized, socially-excluded and/or under-served. This results from the significant proportion, 78 per cent, of our services being provided in countries with the greatest needs, and our steadfast commitment to meeting the needs of the most vulnerable. Over half of IPPF's service delivery points are in peri-urban and rural areas (54 per cent), serving those who are more likely than others to experience barriers to health care due to physical isolation and a lack of alternative health providers. IPPF's approach to service provision in urban centres is to provide health care to the most vulnerable, for whom access remains extremely challenging due to a variety of economic, cultural and religious barriers. Figure 8 shows the variation between different regions, with South Asia serving the greatest proportion of poor and vulnerable clients (86 per cent), followed by East and South East Asia and Oceania (76 per cent) and Africa (73 per cent).

In many parts of the world, IPPF is the only place that welcomes the marginalized; provides a safe, non-judgemental and stigma-free environment; does not discriminate; and upholds the rights of the most disenfranchised. IPPF serves people that governments and other providers are reluctant to work with, or unable to provide specialized services for. Particularly hard-to-reach groups include sex workers, people who use drugs, sexually diverse populations, prisoners, men who have sex with men, people with disabilities, survivors of sexual and gender-based violence, and people who have been trafficked. Often, the public and private sectors do not adequately address the specific needs of young people and may be resistant to serving youth due to their age and/or unmarried status. Many people would agree that it is the role of government to ensure a minimum level of health care to all, regardless of their ability to pay. Yet, with

* The nine services include: behaviour change communication, condom distribution, management and treatment of sexually transmitted infections, voluntary counselling and testing, psychosocial support, prevention of mother-to-child transmission, treatment of opportunistic infection, antiretroviral treatment and palliative care.

** Reclassification of 'Other HIV lab tests' into 'HIV serostatus lab tests' and better quality data explain the decrease in services reported between 2010 and 2011.

Figure 8: Estimated percentage of Member Association clients who are poor, marginalized, socially-excluded and/or under-served, by region, 2011



limited resources and increased pressure to be sustainable, many government services actually disproportionately benefit wealthy and middle-income clients, rather than the poor, and the result is greater inequity in health.

IPPF has begun to roll out a methodology which assesses the proportion of clients who are poor and/or vulnerable. This is based on Poverty Scorecards,[14] a tool that uses regression analysis of national survey questions to estimate the probability of a client being poor, with additional questions relating to sexual and reproductive health vulnerability. All questions are country context specific. The data enable Member Associations to identify the clients they serve, ensure access to the most marginalized groups, and reduce inequity in sexual and reproductive health outcomes (Box 3).

Box 3: Data demand and utilization to increase equity

Bolivia Centro de Investigación, Educación y Servicios (CIES)

In Bolivia, large disparities in sexual and reproductive health outcomes exist. These relate to economic status, educational attainment, ethnicity, gender and other social attributes. Implementing an equity approach to programming necessitates gathering data that measure the extent to which programmes reach the poor and vulnerable, and using that information to improve access to those most in need.

The Bolivian Member Association, Centro de Investigación, Educación y Servicios (CIES), conducted surveys to measure the proportion of clients who are poor and vulnerable and recognized the utility of these data very quickly. CIES decided to include the number of vulnerable clients served by a clinic in their core set of clinic monitoring indicators, and they set goals for each site based on actual performance, an analysis of the clinics' catchment area, and the current strategies in place to balance sustainability with their commitment to reaching vulnerable populations. Each month, a team gathers to review these data and to make decisions for improvement if targets are not being met. Knowing who their clients are has supported CIES to feed this information into its programmes in a variety of ways, such as developing new promotional strategies when the number of vulnerable clients drops, or modifying the services themselves. Analysis of the average price of a service, the percentage of poor clients and the total service volume showed that in one site there was low volume but a high proportion of poor clients. Cost analysis revealed that it was possible to reduce prices, and this resulted in an overall higher volume at this clinic as well as increased utilization by poor and vulnerable clients.

Having transparent, reliable data on its service provision to vulnerable populations has also been important in CIES's collaboration with the Ministry of Health, establishing legitimacy and helping to align their strategies to best meet the needs of the population. It has been important in communicating to staff internally about the strength of CIES's social commitment, and in raising their profile with donors. Finally, it has helped CIES to take on the challenges of sustainability and equity together, informing new strategies for cross-subsidizing services to ensure provision to the poorest and most vulnerable.

Key results by region

IPPF is achieving impressive results in all of its six regions (Tables 2 and 3). Table 2 highlights the seven-year cumulative totals for the major categories of sexual and reproductive health services, as well as the number of policy and/or legislative changes in support of sexual and reproductive health to which Member Associations' advocacy efforts have contributed. Table 3 focuses on results from 2011, with additional information on a number of key performance indicators.

Table 2: Cumulative results by region, 2005–2011

Indicator	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of sexual and reproductive health services (including contraception) provided	103,992,423	13,100,902	10,141,791	47,678,312	80,642,983	173,067,211	**428,623,622**
Number of couple years of protection (CYP)	6,482,026	2,034,997	335,645	4,403,140	13,135,163	32,719,819	**59,110,790**
Number of sexual and reproductive health services (including contraception) provided to young people under 25 years of age	43,014,019	3,213,585	4,118,209	9,725,821	36,800,924	51,458,512	**148,331,070**
Number of HIV-related services provided	14,459,093	1,132,852	1,478,448	6,699,418	6,877,895	21,588,549	**52,236,255**
Number of condoms distributed	169,286,471	5,951,084	6,922,394	125,236,144	196,602,772	475,927,433	**979,926,298**
Number of abortion-related services provided	694,575	218,805	532,940	865,303	1,629,219	3,075,979	**7,016,821**
Number of successful policy initiatives and/or positive legislative changes in support of sexual and reproductive health and rights to which the Member Association's advocacy efforts have contributed	78	17	148	57	20	131	**451**


We provided 37.4 million
SRH services to young people in 2011.
IPPF/Jane Mingay/Rwanda

Table 3: Results by region, 2011

Indicator	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of sexual and reproductive health services (including contraception) provided	27,504,525	2,259,940	1,514,091	12,333,732	15,386,102	30,618,062	**89,616,452**
Number of couple years of protection (CYP)	1,406,890	246,417	37,238	822,688	2,019,072	4,530,351	**9,062,656**
Number of sexual and reproductive health services (including contraception) provided to young people under 25 years of age	12,830,721	932,796	784,141	2,738,103	7,058,298	13,080,277	**37,424,336**
Number of HIV-related services provided	5,205,127	345,768	165,421	2,034,137	1,714,285	5,619,436	**15,084,174**
Number of condoms distributed	40,860,508	576,176	1,666,698	38,945,036	33,882,361	52,898,016	**168,828,795**
Proportion of Member Associations with a written HIV and AIDS workplace policy	89.2%	84.6%	80.0%	65.2%	88.9%	93.1%	**83.4%**
Number of abortion-related services provided	233,780	45,430	97,331	173,258	254,418	810,909	**1,615,126**
Estimated percentage of Member Association clients who are poor, marginalized, socially-excluded and/or under-served	73.2%	65.7%	30.8%	76.3%	85.5%	67.9%	**73.2%**
Proportion of Member Associations providing Essential Services Package*	70.3%	77.8%	36.8%**	78.3%	85.7%	88.2%	**72.1%**
Number of successful policy initiatives and/or positive legislative changes in support of sexual and reproductive health and rights to which the Member Association's advocacy efforts have contributed	11	3	42	10	6	44	**116**

* There are eight components in the Essential Services Package: contraception, abortion, HIV, STI/RTI, gynaecology, obstetrics, sexuality counselling and gender-based violence. A 25 per cent margin is included in this calculation to allow for different sizes, budgets and staffing of Member Associations, and the country context in which they work.
** In the European Network, governments and private agencies provide a range of sexual and reproductive health services, explaining the lower result for Member Associations in this region, many of whom invest more in advocacy work.

The following two qualitative studies describe the remarkable work that Member Associations do to support the sexual and reproductive health and rights of two of the most vulnerable and disenfranchised groups, people with disabilities and survivors of sexual and gender-based violence.

Sexuality and disability: the last taboo?

Israel Israel Family Planning Association (IFPA)

The sexual and reproductive health and rights of people with disabilities are ignored and overlooked in many countries. A common myth is that they are unable to experience sexual pleasure, and do not have reproductive and sexual health needs. This results in a lack of specialized sexual and reproductive health information, education and services which denies people with disabilities the freedom to explore their sexuality, without fear of abuse or discrimination.

> “Disabled populations are not viewed as acceptable candidates for reproduction or even capable of sex for pleasure. We are viewed as childlike and in need of protection.[15]

By focusing on the sexual and reproductive health and rights of people with disabilities, the Israel Family Planning Association (IFPA) is leading the way in this neglected and controversial area. IPFA’s three-year Innovation Fund project supports people with disabilities to make responsible choices regarding their sexual and reproductive health and rights. The programme is the first of its kind in Israel and uses a three-pronged approach of sexuality education, service delivery and advocacy.

The two-year sexuality education programme was designed for people living with both sensory and physical disabilities. It has increased their knowledge and understanding of a range of subjects, including sexual and reproductive health and rights and has improved communication skills. Once graduated, the participants are qualified to provide sexuality education to other young people, both with and without disabilities. Taking part in the project has profoundly changed the participants’ lives; they are able to talk about sexuality-related issues for the first time, understanding and recognizing that their sexuality and sexual rights are an entitlement. Previously, participants believed that they were non-sexual and without the same sexual rights as people without disabilities. The programme requires them to draw on their personal experiences, and for some, this means relating to their disability in a way they have not done before. As well as accepting their sexuality, the programme has also helped them accept their disability.

With increased confidence and self-esteem, many participants are now working as peer educators, and acting as positive role models for others. IFPA’s innovative support to people living with disabilities is an example of how IPPF works with the most marginalized groups, who not only have difficulty accessing sexual and reproductive health information, education and services,

> Until now, no one had ever spoken to me about sexuality in such a clear and concentrated manner. This work helped me dig into myself and find my sexual self, to attempt to understand it, listen to it, be complete with it, to love it.
>
> **Project participant**

> Through the programme, I learned to forgive myself and that it is OK to be hurt and angry. I... accept my disability now. I have more peace within myself.
>
> **Project participant**

> For many years after I was paralyzed, I repeatedly told everyone else that I didn’t want to have a boyfriend, even though secretly I wished I had one. But through my participation in the course, I discovered my sexuality, as well as my femininity. I have altered my appearance... and today I feel beautiful and attractive.
>
> **Project participant**

I understand that sexuality is related to every aspect of life. Sexuality is not just intercourse or the body's physiological appearance – there are also a lot of psychological, cultural and social aspects of sexuality.

Project participant

but who also suffer from low self-esteem due to stigma and discrimination, and whose sexuality is denied.

As a taboo topic in Israel, sexuality and disability have previously been absent from public and private discourse, and ignored by parents, doctors, therapists and others who play a key role in the lives of people with disabilities. One of the main achievements of the project is the increased profile and attention given to the issue, and conferences that focus on either disability or sexual and reproductive health are now more likely to include sessions integrating both topics. Increasing awareness on sexuality and disability has been supported by the participation and leadership of people with disabilities, several of whom have become excellent public speakers and advocates. IFPA's work has transformed the lives of many people living with disabilities; it has empowered them to make informed decisions, feel proud and perhaps most importantly, take pleasure in their sexuality.

Combating violence against women and girls

Kenya Family Health Options Kenya (FHOK)

In Kenya, 20 per cent of 15-49 year old women have reported having experienced sexual violence.[16] Data further show that 37 per cent of ever-married women have experienced physical violence, 30 per cent emotional violence and 17 per cent sexual violence from their husbands.[17] Despite these statistics and the fact that violence against women and girls is so common in Kenya, it remains hidden, unmentionable and many believe, immutable. It affects large numbers of women and girls, including many young girls who are still in primary school.

Sexual and gender-based violence is an extreme violation of human rights and can have many effects, including physical and psychological trauma, ill health and girls dropping out of school. For fear of stigma and/or lack of funds, those affected often remain silent and are unable to pursue legal proceedings. Many women and girls lack knowledge of their rights and/or opportunities to gain assistance. Survivors of sexual and gender-based violence are often expected to accept their fate. Many of them feel ashamed, violated, guilty or somehow responsible. Remaining silent means these women and girls do not get the medical care they need. This can increase their chances of experiencing unwanted pregnancy, unsafe abortion, acute and/or chronic ill health, and even death.

> Anyone who has been subjected to a sexual assault – as either a child or an adult, male or female – needs support and help, most often involving medical, psychological, social and legal aid. Awareness of this is growing all over the world.[18]

Family Health Options Kenya (FHOK) is working at the community level to address and eradicate sexual and gender-based violence in slum and rural areas. FHOK provides free medical care – such as testing for pregnancy, sexually transmitted infections and HIV; and gynaecological examinations to determine injury – and counselling to women and girls who have experienced sexual and gender-based violence. Telephone hotlines are operated by trained counsellors for survivors and their parents. These hotlines provide much needed and free access to counselling in the local language, and are particularly important to those living in remote areas.

FHOK refers clients to a clinic that operates in a government hospital for services that FHOK does not provide so that survivors can obtain official medical evidence of sexual and gender-based violence. Under Kenyan law, only government hospitals are recognized in the provision of medical evidence for the prosecution of sexual and gender-based violence cases, which contributes significantly to low conviction rates.

After months of being in the support group I felt protected; I felt that someone else understood and cared about me. I gained the courage to confront my step-father; I told him that he could never touch or hurt me again. I feel that my healing process has begun and I finally found a reason to live and see my dreams through.

Teenage girl who was raped by her step-father at seven years old

Some of us were ignorant before about sexual and gender-based violence issues. The workshop has made us understand the real issues of sexual and gender-based violence and the need to pay serious attention to uproot them from society.

Village chief

We were alarmed at the revelations at the workshop. All of us agreed to treat sexual and gender-based violence as an urgent issue and integrate it into our programme.

FHOK Reproductive Health Coordinator

FHOK has also set up support groups for survivors and their parents. These groups provide a safe space and opportunity to restore hope and confidence. The group members are trained in team-building, communication skills, assertiveness and psychosocial counselling. The members of the group offer peer-to-peer support and participate in community education campaigns to reduce stigma, advocate for the rights of survivors and raise awareness about sexual and gender-based violence. Many people no longer think that such violence should remain hidden, and have started to discuss it openly with support from various sensitization programmes.

Another major achievement of the project is that it has helped girl survivors of sexual and gender-based violence return to school. This has been done by providing financial support to pay for medical care – especially important when the girl survivor is HIV positive – as well as registration fees, school uniforms and other materials needed for school. Survivors of sexual and gender-based violence and their families are also benefitting from microfinance schemes and income-generation activities.

In addition to providing support and services, a significant aspect of FHOK's project is prevention. These activities are largely carried out in communities and schools so that they can take a lead in the fight against sexual and gender-based violence. Programmes are organized to educate young people about human rights and national legal frameworks to enable them to become effective advocates. The project also works closely with community leaders, other service providers and the wider community to raise awareness and remove stigma associated with surviving sexual and gender-based violence. In school health clubs, students learn about and discuss the subject, as well as other issues such as HIV, abortion and unwanted pregnancy. There have been observed positive behaviour changes among members of these clubs, and some students have asked for support with issues that they are facing, including sexual violence.

FHOK is creating the space for people to talk openly about sexual and gender-based violence where this has not happened before, and for the sexual and reproductive health and rights of this neglected group of women and girls to be increasingly realized.

Increasing impact through partnerships

Member Associations forge strategic partnerships with each other, as well as with other government and non-governmental organizations, to maximize the impact they have as service providers and advocates of sexual and reproductive health and rights. These partnerships are a more effective way of working to achieve common objectives, and they are mutually beneficial: Member Associations and their partners can make better use of limited resources, have a more powerful impact in advocacy campaigns, and make the most of respective expertise and comparative advantages. The end result is that sexual and reproductive health information and services are available to an increasing number of people. IPPF often makes technical contributions to other agencies and organizations working on sexual and reproductive health and rights; likewise, we build on learning that comes from outside the Federation to continuously improve our own programmes.

The collective wealth of expertise within the Federation provides huge potential for learning and technical assistance between Member Associations around the world. Member Associations work in partnership with one another to share experiences and learn from each other on a range of issues, both organizational and programmatic (Box 4). IPPF also works with United Nations agencies on policy dialogue, advocacy, mobilizing funds, convening meetings and sharing information and learning. We hold formalized strategic partnerships with FIGO, UNAIDS, UNFPA and WHO. We also collaborate with the World Bank, bringing the voice of civil society to policy consultations on sexual and reproductive health. Member Associations that worked in partnerships on their most important advocacy initiatives in 2011 played the role of convener (59 per cent), lead or chair of the initiative (56 per cent) or technical experts (72 per cent). Many Associations are also involved in partnerships to influence national funding mechanisms, for example, Country Coordinating Mechanisms, Poverty Reduction Strategy Papers, Medium Term Expenditure Frameworks and National Development Plans.

Box 4: South-to-South learning in Latin America

IPPF Western Hemisphere Regional Office has developed a South-to-South technical assistance programme that draws on the experience and technical expertise in both the northern and southern parts of that region. The programme is structured around two main strategies: technical assistance visits and online training. The exchange visit element of the South-to-South programme is a proven mechanism for increasing learning between Member Associations and reducing training costs. It strengthens skills and systems throughout the region for delivering high quality sexual and reproductive health information and services.

The technical assistance visits generally consist of personalized exchanges during which a delegation or representative from one Association travels to another Association to receive training on a specific issue. These visits have covered a range of topics and in 2011 included, among others, the provision of youth friendly services, using mobile health units to reach marginalized populations, cost analysis and marketing of products, and the provision of abortion-related services. These visits have produced concrete results, improving the quality of services and increasing organizational effectiveness in the Member Associations involved.

For example, after an exchange visit to Profamilia **Colombia** to learn about their youth friendly services model, the Association in **El Salvador**, Asociación Demográfica Salvadoreña (ADS), has strengthened its youth programme. ADS now trains all of its service providers in youth friendly services and promotes the services it offers to young people through different mechanisms including radio, television and community workshops. ADS has also modified all of its educational materials to make them more youth friendly and their website is being updated to include more detailed information on the types of services available to young people. In addition to improving the quality of its youth services, ADS significantly increased the number of services it provided to young people, from 98,869 in 2010 to 192,458 in 2011.

Another example involved Profamilia in the **Dominican Republic**, where the Member Association received technical assistance from the **Bolivian** Member Association (CIES) in the area of cost analysis and information management systems. As a result, Profamilia adopted a new business management system, which allows for better integration of institutional data, more efficient management and, through the adoption of a clinic management information system, an improvement in the quality of care provided.

In 2011, ADS increased its total services to youth by **95%**

Partnering with government agencies is an important strategy that many Member Associations use to provide clients with sexual and reproductive health services. The following two examples illustrate how Member Associations partner with governments to provide clients, especially the poor, marginalized, socially-excluded and under-served, with information and services.

Through a partnership with a government agency, the Family Planning Organization of the **Philippines** (FPOP) provides free sexual and reproductive health services to the poorest and most vulnerable people in the region of Mindanao. In the Philippines, a national health insurance programme provides health coverage through the agency PhilHealth, which partners with qualified health care providers. One of FPOP's clinics has received PhilHealth accreditation for its childbirth services and is now an important partner in the national scheme.

While the programme benefits from FPOP's facilities, equipment and technical expertise, the clinic also gains from the partnership. The FPOP clinic has significantly increased the number of services it provides, particularly to those belonging to PhilHealth's 'sponsored' category, the poorest and most vulnerable. This partnership also ensures that the FPOP clinic provides quality services. With PhilHealth's strict monitoring of compliance to quality of care standards, the clinic has benefited from guidance and support on how to provide quality services to adhere to the standards set.

IPPF's collaborating partner, the **Myanmar** Maternal and Child Welfare Association (MMCWA), works with the Ministry of Health to provide maternal and child health services to poor and marginalized people, including those in remote and under-served areas. Through this important partnership, MMCWA provides community services in 133 maternity homes throughout the country. MMCWA operates and funds these homes, which are run by midwives and trained birth attendants. Volunteer doctors from local health departments are also on call to handle emergency cases.

In addition to working in partnership on advocacy initiatives to change and defend policies and/or laws in support of sexual and reproductive health and rights, and with government agencies to increase provision of sexual and reproductive health services, Member Associations are involved in many other types of partnerships with both the public and private sectors (Figure 9) and through social franchising networks (Box 5).

Figure 9: Member Associations in partnership

76% of Member Associations have partnerships with national networks of people living with HIV.

34% of Member Associations have partnerships with private sector providers to increase access to safe abortion services.

50% of Member Associations have partnerships with public and private sector providers to increase access to SRH services by the poor and vulnerable.

Member Associations provide SRH services in partnership with **4,360** private physicians.

Box 5: Social franchising

Social franchising is a service delivery mechanism that aims to increase the quantity and quality of services in a cost-effective way. A social franchise is a network of private health providers linked through contracts to provide socially beneficial services under a common brand. In 2011, 23 per cent of Member Associations provided sexual and reproductive health services through social franchising networks.

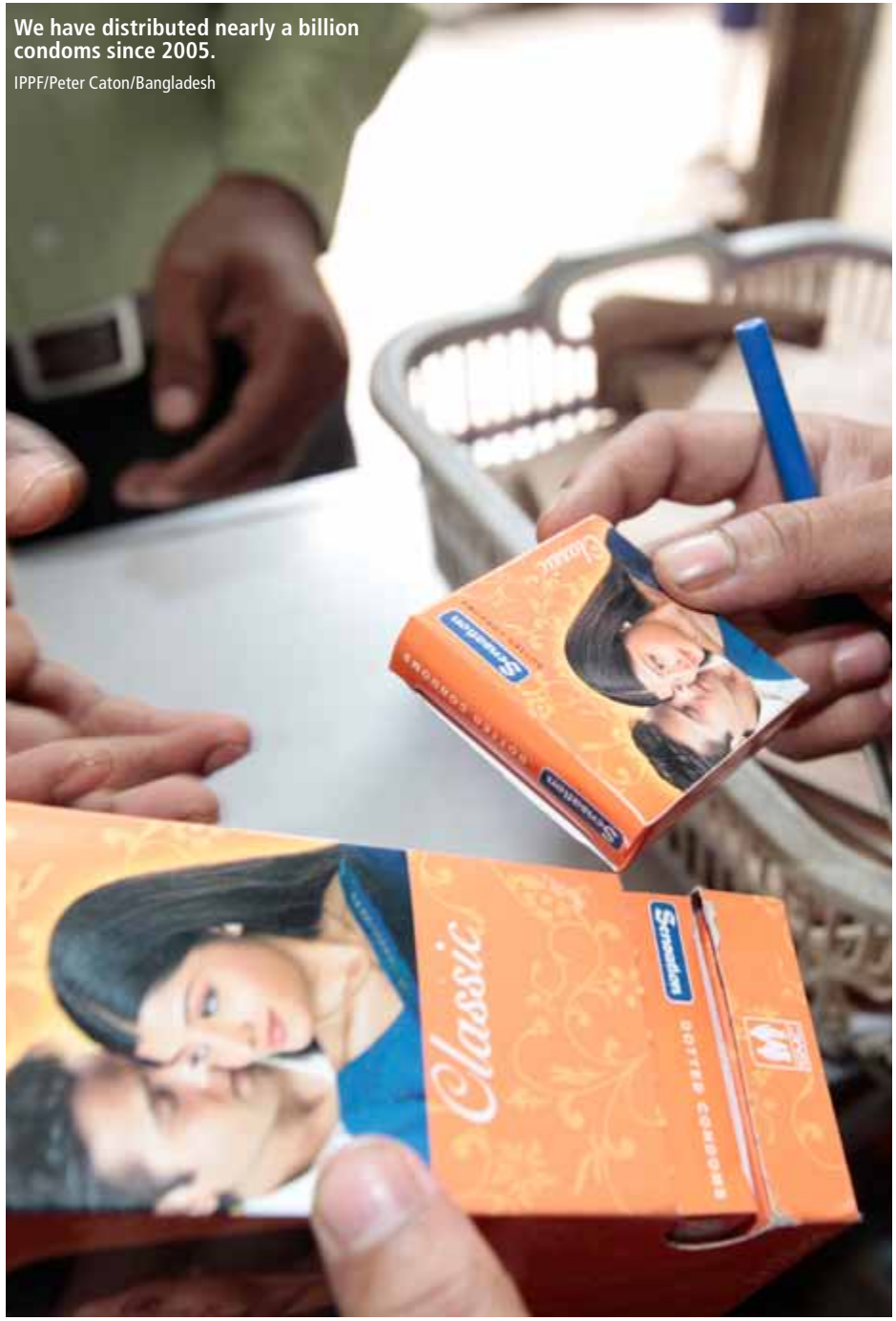
The Member Association in **Peru,** Instituto Peruano de Paternidad Responsable (INPPARES), for example, supports and administers RedPlan Salud, a network of affiliated health professionals who provide reproductive health care in private offices. They provide contraceptive and non-contraceptive services including HIV testing, cervical cancer screening and post-abortion care to low-income populations. RedPlan Salud recruits and trains midwives and physicians who sign a one-year contract and agree to sell contraceptives at a recommended price. In return, they receive commercial brand contraceptives at social marketing prices, as well as free training on service provision and quality of care. In 2011, RedPlan Salud provided nearly 700,000 services through 1,723 network members, which accounted for 60 per cent of all INPPARES' services.

In addition to increasing access to low-cost services for women in low-income areas, the RedPlan Salud franchise also ensures improvement in the quality of these services. Quality assurance follow-up has reduced waiting times and promotional campaigns have increased demand for services.

The Member Association in **Pakistan**, Rahnuma-FPAP, works with private health care providers from their own community-based facilities and has significantly increased access to quality sexual and reproductive health services. In 2011, Rahnuma-FPAP established relationships with providers who delivered nearly 558,000 sexual and reproductive health services, a fifth of all Rhanuma-FPAP's services. The majority of these services went to people who were poor and vulnerable and who otherwise would not have had access to services. Rahnuma-FPAP's social franchising programme provides training, technical support and commodities, and monitors performance, including quality of care.

23%

of Member Associations provided services through social franchising networks.



We have distributed nearly a billion condoms since 2005.

IPPF/Peter Caton/Bangladesh

Investing for results

IPPF is committed to delivering long-term sustainable development by directing funds to where the needs are greatest, having controls and support in place to ensure that funds are used efficiently, and implementing programmes that achieve maximum results.

Over the past 60 years, IPPF's role as a global service provider and a leading advocate of sexual and reproductive health and rights has been supported by strong partnerships with our donors and other stakeholders. We receive a substantial amount of funding through multi-year unrestricted agreements. This investment ensures that we can support a truly global sexual and reproductive health movement, with 153 nationally-owned Member Associations that are governed and staffed by local people who are affected by similar issues and experiences as their clients, and whose contribution to their communities will be sustainable. This approach is essential if local expertise, organizations and management systems are to be strengthened, ultimately providing a much higher level of financial return, and resulting in long-term development.

Growing investment in IPPF

Despite the continuing global economic difficulties in 2011, IPPF's total income from governments, foundations and other sources rose by US$3.4 million between 2010 and 2011, an increase of 3 per cent, to US$127.6 million. This comprised a rise of US$4.1 million in restricted income (9 per cent), and a fall in unrestricted income of US$0.7 million (1 per cent). Over the past five years, total income from governments, foundations and other sources has increased by 19 per cent, and grants to Member Associations have increased by 25 per cent.

Nearly 80 per cent (US$60.7 million) of IPPF's unrestricted funding is invested in country programmes designed to deliver sustained impact. Of the direct grants to Member Associations, 78 per cent went to those working in countries identified as having low or medium levels of human development, according to the UNDP's Human Development Index (HDI), confirming that the majority of IPPF's unrestricted funding supports Member Associations working in areas of highest unmet need (Figure 10). IPPF income is used by Member Associations to provide sexual and reproductive health information, education and services, especially to poor and vulnerable people, and to advocate for sexual and reproductive rights to be recognized as fundamental human rights. The Secretariat uses its income to provide technical support to Member Associations and to conduct regional and global advocacy initiatives. Across all levels of IPPF, income is used to support effective management, including finance, human resources, evaluation, accreditation and governance, and to mobilize resources.

In response to changes in the development aid architecture, it is critical that Member Associations are able to raise resources themselves by developing infrastructure and capacity to identify and secure further funding from both local and international sources. This enables Member Associations to increase their financial resources, diversify their income base, build sustainability and improve performance. With technical assistance and targeted investment from the Secretariat, Member Associations have had considerable success in raising additional funding, gaining support from both government donors and foundations, and in a number of instances, becoming the primary recipient for the Global Fund to Fight AIDS, Tuberculosis and Malaria. Over the past five years, overall income for grant-receiving Member Associations has increased by 47 per cent compared to an increase in grants from IPPF of 14 per cent*, demonstrating how Member Associations are becoming less dependent on IPPF income. We consider that growing the financial independence of

Figure 10: Percentage of IPPF unrestricted grants, by HDI ranking, 2011

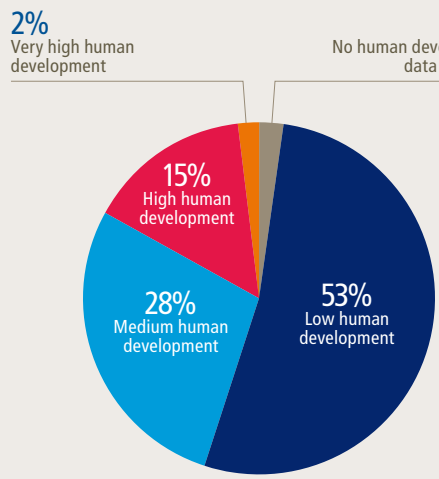
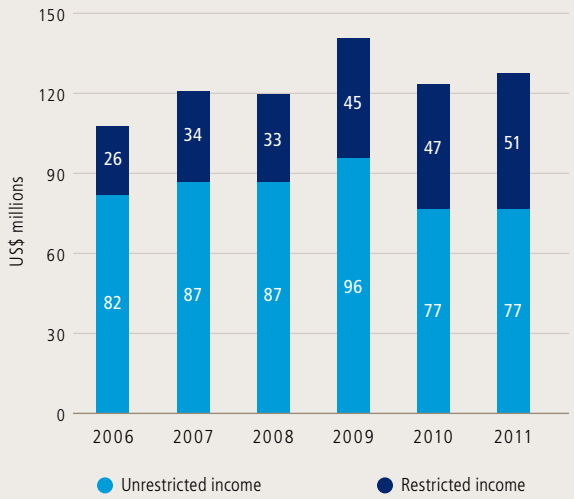


Figure 11: Total unrestricted and restricted income, 2006–2011



Member Associations is fundamental to increasing the Federation's overall capacity to reach areas of highest need, and to ensuring the sustainability of our programmes on the ground.

The importance of unrestricted income to IPPF cannot be understated. Resources can be allocated quickly and responsively; long-term plans, so important for sustainable development, can be made and implemented; high start-up and shut-down costs are avoided; and the presence of a permanent local civil society organization working on sexual and reproductive health and rights means that governments and other stakeholders can invest in productive and long-term partnerships. However, in recent years, restricted funding has provided most of IPPF's income growth and now represents 40 per cent of IPPF's total income, compared to 24 per cent in 2006 (Figure 11). This reflects an increasing trend of donor support focusing on defined project areas and/or priority countries. Restricted funding provides IPPF with important opportunities to deliver specific interventions and to drive implementation in key priority areas of the Strategic Framework. The costs of restricted projects can be significant in terms of the investment needed in their management, systems, support, and monitoring and evaluation. It is vital, therefore, for the performance and sustainability of restricted projects that comprehensive provision for critical management functions is included during the planning and funding stages.

The majority of our funding supports Member Associations working in countries with the greatest needs.

IPPF/Chloe Hall/Mauritania

* In 2011, Member Associations raised 81 per cent of their funding from locally generated income and other international sources. Total Member Association income in 2011 was US$386 million.

IPPF's Governing Council is responsible for allocating unrestricted funding across each of the Federation's six regions. The highest priority regions for IPPF are Africa and South Asia, receiving 45 per cent and 16 per cent of unrestricted funding respectively. Regional Offices make decisions on grants awarded to Member Associations according to resource allocation criteria, including performance-based funding. In 2011, 86 per cent of grants to Member Associations were invested in projects across the five priority areas of the Strategic Framework 2005–2015, and a further 14 per cent were invested in the four supporting strategies (Figure 12).

Financial control

IPPF's goal of serving the poorest and most vulnerable means that work is often undertaken in challenging conditions in which the maintenance of strong systems of internal control is fundamental to the performance of our programmes. IPPF prioritizes the application of good principles of financial management in its funding regulations, and regional financial advisors work with all Member Associations to develop and maintain robust financial systems and reporting arrangements.

Central and Regional Offices regularly receive independent external audits. Grants are only made to Member Associations for whom an audited set of financial statements has been received, and who have been assessed as meeting the IPPF Accreditation standards. Teams of technical financial advisors work with Member Associations to ensure that systems and processes are in place to deliver audited financial accounts. Any issues that are reported by audit teams are addressed as a matter of priority. Furthermore, IPPF has rolled out a new programme of financial control evaluation that requires external auditors to undertake and report on a detailed set of tests to guarantee that financial systems and controls are operating adequately. By the end of 2012, 21 Member Associations will have undertaken this exercise, with a further 49 scheduled for 2013. This programme has already helped to identify areas for improvement in financial performance, procurement and risk management for a number of Member Associations.

The Federation takes a zero tolerance approach to fraud and, in line with the UK Bribery Act, has strengthened its policies and procedures designed to prevent, identify and manage fraudulent activity. IPPF will continue to strengthen the control environment across the Federation in 2012 and beyond as part of its core capacity building work. We are committed to further developing the robust systems and processes that are already in place to ensure that every grant, donation and contract awarded to IPPF will be invested in improving the sexual and reproductive health and rights of the poorest and most vulnerable.

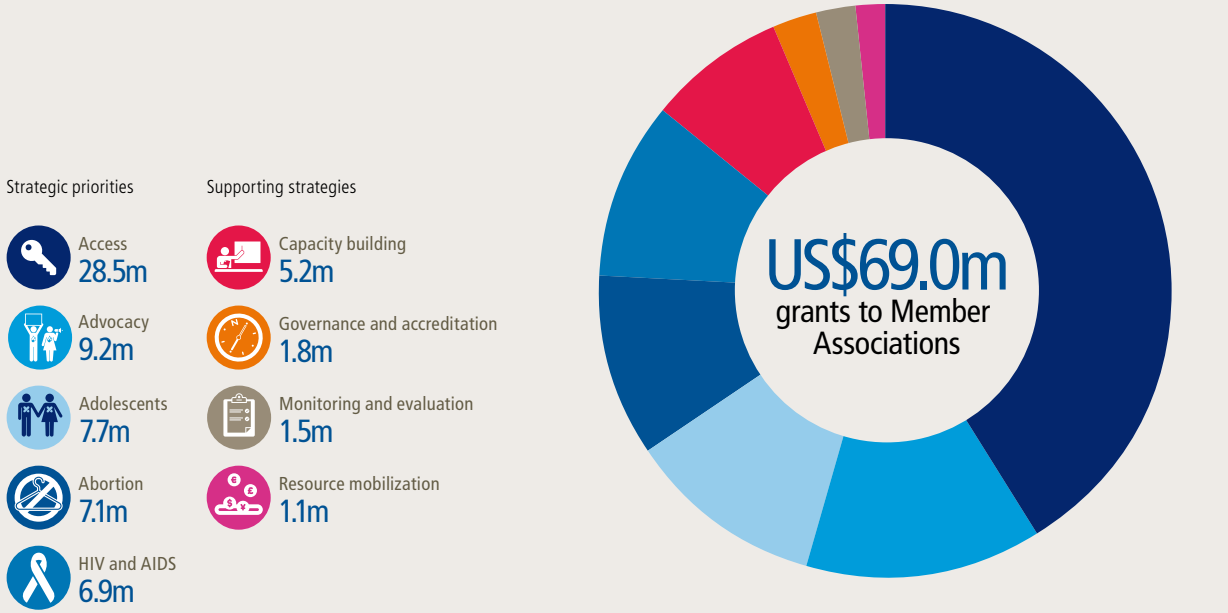
Spending resources efficiently

Investment in IPPF yields results in terms of advancing sexual and reproductive health and rights, and IPPF has developed business systems and processes to ensure that principles of economy, efficiency, effectiveness and equity are adhered to. These management systems are the foundation for ensuring value for money and promoting a performance culture throughout the Federation.

Business systems

IPPF has robust procurement policies in place to manage costs, both in the Secretariat and in grant-receiving Member Associations. Expenditure against budget is closely monitored to ensure that costs remain in line with expectations as part of comprehensive management accounting processes. Efficiency is achieved through IPPF's technical and financial work planning cycle, for which

Figure 12: Grants to Member Associations, by IPPF strategic priorities and supporting strategies, 2011



all grant-receiving Member Associations are required to submit detailed budgets and activity plans for the year ahead. These are reviewed jointly by Member Association management teams and the Secretariat to ensure that effective systems and structures are in place to deliver results, and that the costs of inputs are competitive. We are also investigating costing models that can be used to give Member Associations a better understanding of their cost base, and build this into their planning cycle.

Accreditation

Every five years, Member Associations undergo an accreditation review which monitors adherence to a set of ten membership principles: open and democratic; well-governed; strategic and progressive; transparent and accountable; well managed; financially healthy; good employer; committed to results; committed to quality; and a leading sexual and reproductive health and rights organization. This review ensures that Member Associations are committed to organizational effectiveness and accountability.

Staffing costs

At the Secretariat level, staff costs are benchmarked to industry standards (both for-profit and not-for-profit) to ensure costs are in line with those of similar organizations. Across the IPPF global network, Member Associations are staffed only by nationals. This means that there are no costly expatriate contracts at the country level, and few at the Regional Office level. This model means that IPPF is investing in local capacity, training staff who gain experience and expertise to develop professionally and who then invest in their own countries. It also ensures that costs are kept low, in comparison to international expatriate postings.

Linking resources to performance

IPPF is introducing performance-based funding across the Federation, using ten indicators related to sexual and reproductive health service provision, comprehensive sexuality education and advocacy. The performance-based funding system strengthens the link between grants awarded to Member Associations and performance. Those Associations whose performance improves receive an increase in IPPF unrestricted funding; those who perform poorly see a reduction in their grant. During the annual review process, reflective discussions between peers about performance, income, unmet need and demographic context provide learning opportunities and the chance to exchange expertise and ideas.

We invest in local people who make a sustainable contribution to their communities.

IPPF/Chloe Hall/Ethiopia

Assessing clinic performance

The Branch Performance Tool supports Member Associations to capture data on the performance of individual service delivery points (static clinics and outreach) to compare between facilities, and use the information to guide performance improvements. Efficiency scores use a variety of data including:

- clients per staff per day
- service/couple year of protection (CYP) provided per client
- cost per service/CYP
- overhead as a per cent of total cost

Using the Branch Performance Tool in a select number of Member Associations in 2011 resulted in identifying efficiency improvements estimated to increase the overall service output by nearly 50 per cent.

Next steps

IPPF's Change Goals – Unite, Deliver and Perform – will guide us in focusing limited time and resources to achieve accelerated results between now and 2015.

IPPF's work is based on the fundamental belief that sexual and reproductive rights are human rights, to which we are all equally entitled. Our efforts focus on reducing unjust inequity for the millions who still do not have access to sexual and reproductive health services. In the last seven years since IPPF first began implementing its Strategic Framework 2005–2015, our achievements have been impressive. Service coverage has increased across the globe, reaching proportionately more clients who are poor and vulnerable. IPPF has also contributed to hundreds of policy and/or legal changes in support of sexual and reproductive health and rights, creating an enabling environment upheld by public, political and financial support. In the last year alone, 89.6 million sexual and reproductive health services were provided, 9.1 million couples were protected from unintended pregnancies, and 116 progressive policy and/or legal changes resulted from Member Association advocacy.

In the next three years, we will pursue our work with greater focus and ambition and be guided by our three Change Goals.

Unite By uniting with our partners, we will continue to actively push for sexual and reproductive health and rights to be reflected in future policy development, especially in the post-2015 development framework. This must go beyond rhetorical speechmaking, and we will be pushing for sufficient resources to be allocated to sexual and reproductive health, without which there will be limited progress.

IPPF is nurturing new champions for sexual and reproductive health and rights. We are working with the BRIC countries (Brazil, Russia, India and China), Islamic leaders and the G20. Through the Rio+20 UN Conference on Sustainable Development, we have built new relationships with other sectors of development. All of this is to help decision-makers and power brokers who will be negotiating the next development framework to prioritize sexual and reproductive health and rights. We are also developing a Manifesto which will set out IPPF's position for the ICPD+20 and the post-MDG development framework. This Manifesto will call on governments to recognize the linkages between sexual and reproductive health and rights and poverty reduction.

Deliver By delivering sexual and reproductive health services through our own network of service delivery facilities and by supporting government and private providers, we can reduce unmet need. We will focus our efforts on providing a rights-based integrated service package through a range of service delivery points to those who would otherwise have little access to local facilities in impoverished areas where they are needed most. While we can improve our effectiveness, we will also align this with the aim of reducing inequities and bridging the ever expanding health gap that exists between the wealthiest and the poorest.

Our recent commitment to doubling the number of sexual and reproductive health services provided by 2015 is only likely to be accomplished alongside increased global commitment to funding, public and political will, and commodity security. Through our advocacy work, we will continue to call on governments and other stakeholders to make sufficient resources available to ensure universal access to sexual and reproductive health and rights, including contraception.

Perform As leaders in sexual and reproductive health and rights, we will maintain a high level of performance, remain relevant and hold unwavering positions on controversial topics, despite threats from the opposition. IPPF is committed to a strong performance culture and we are investing in data capture tools to increase data quality and utilization. We are accountable to the promises we made in our Strategic Framework 2005–2015, progress against which is monitored annually. We are accountable to our donors and partners to ensure that their investment in us yields significant results. Most importantly, we are accountable to the clients we serve so that they can choose parenthood or not, pursue healthy and fulfilled sexual lives, and be free from violence, stigma and discrimination.

IPPF is a diverse yet unified Federation, with nationally-owned Member Associations supported by millions of volunteers and thousands of staff who are experts on the needs of their communities, having similar experiences and local knowledge. Strengthening capacity and management systems at the local level will provide a higher level of financial return and result in long-term human and economic development.

IPPF plays a vital role in international development, by providing sexual and reproductive health information and services, supporting health systems strengthening, holding governments accountable to the promises they have made, and ensuring that sexual and reproductive health and rights remain a priority for human development and poverty reduction.

Our work will continue to focus on improving the health and ensuring the rights of millions of people to make decisions free from coercion about when, if and how many children to have; to be sexually fulfilled; to be free from violence, stigma and discrimination; to pursue an education; to have a voice, and to be heard.

Our work is founded on the belief that these are indivisible human rights, which must be guaranteed – everywhere in the world, and regardless of age, gender, sexuality or religion. Only by realizing these rights will people be able to invest in their futures with skills, hopes and ambition, and live longer, healthier and happier lives.

Annex A: Global indicators by region, results 2005–2011

Table A.1: Online survey response rate

IPPF region	Year	Total number of Member Associations **	Number of Member Association responses	Response rate (per cent)
Africa	2011	37	37	100
	2005	39	30	77
Arab World	2011	14	13	93
	2005	14	12	86
European Network	2011	41	40	98
	2005	40	31	78
East and South East Asia and Oceania	2011	23	23	100
	2005	20	17	85
South Asia	2011	9	9	100
	2005	8	8	100
Western Hemisphere*	2011	29	29	100
	2005	30	28	93
Total	**2011**	**153**	**151**	**99**
	2005	151	126	83

Table A.2: Online service statistics module response rate

IPPF region	Year	Total number of Member Associations that provide services**	Number of Member Association responses	Response rate (per cent)
Africa	2011	37	37	100
	2005	38	29	76
Arab World	2011	12	9	75
	2005	11	9	82
European Network	2011	22	19	86
	2005	33	2	6
East and South East Asia and Oceania	2011	23	23	100
	2005	19	14	74
South Asia	2011	8	7	88
	2005	8	8	100
Western Hemisphere*	2011	28	27	96
	2005	28	25	89
Total	**2011**	**130**	**122**	**94**
	2005	137	87	64

* Cuba is a Member Association of IPPF. It is not currently assigned to any region but receives technical support from the Western Hemisphere region (WHR). Cuba has been included with WHR's data since 2006 for the purposes of this analysis due to its geographical location. In 2005, data from Cuba were not available. This is the same for all the following tables.

** Membership at end of reporting year

Table A.3: Adolescents – summary of indicators, 2005–2011

Indicator		Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
1	Proportion of Member Associations with 20 per cent or more young people under 25 years of age on their governing board	**2011**	**75.7%** (n=37)	**38.5%** (n=13)	**45.0%** (n=40)	**65.2%** (n=23)	**44.4%** (n=9)	**62.1%** (n=29)	**58.3%** (n=151)
		2010	73.0% (n=37)	38.5% (n=13)	41.5% (n=41)	59.1% (n=22)	44.4% (n=9)	69.0% (n=29)	57.0% (n=151)
		2005	33.3% (n=30)	25.0% (n=12)	38.7% (n=31)	23.5% (n=17)	0.0% (n=8)	39.3% (n=28)	31.7% (n=126)
2	Percentage of Member Association staff who are under 25 years of age	**2011**	**3.3%** (n=37)	**7.7%** (n=13)	**5.6%** (n=40)	**9.3%** (n=23)	**6.4%** (n=9)	**8.5%** (n=29)	**7.6%** (n=151)
		2010	3.3% (n=37)	9.1% (n=13)	4.3% (n=41)	8.6% (n=22)	9.2% (n=9)	4.5% (n=29)	5.6% (n=151)
		2005	4.1% (n=30)	4.3% (n=12)	3.1% (n=31)	8.1% (n=17)	4.6% (n=8)	3.3% (n=28)	4.0% (n=126)
3	Proportion of Member Associations providing sexuality information and education to young people	**2011**	**91.9%** (n=37)	**76.9%** (n=13)	**90.0%** (n=40)	**95.7%** (n=23)	**77.8%** (n=9)	**96.6%** (n=29)	**90.7%** (n=151)
		2010	94.6% (n=37)	69.2% (n=13)	92.7% (n=41)	95.5% (n=22)	88.9% (n=9)	96.6% (n=29)	92.1% (n=151)
		2005	93.3% (n=30)	83.3% (n=12)	96.8% (n=31)	100.0% (n=17)	87.5% (n=8)	100.0% (n=28)	95.2% (n=126)
4	Proportion of Member Associations providing sexual and reproductive health services to young people	**2011**	**100.0%** (n=37)	**100.0%** (n=9)	**94.7%** (n=19)	**100.0%** (n=23)	**100.0%** (n=7)	**100.0%** (n=27)	**99.2%** (n=122)
		2010	100.0% (n=37)	88.9% (n=9)	94.4% (n=18)	95.5% (n=22)	100.0% (n=8)	100.0% (n=27)	97.5% (n=121)
		2005	82.8% (n=29)	44.4% (n=9)	50.0% (n=2)	28.6% (n=14)	75.0% (n=8)	64.0% (n=25)	63.2% (n=87)
5	Proportion of Member Associations advocating for improved access to services for young people	**2011**	**97.3%** (n=37)	**84.6%** (n=13)	**95.0%** (n=40)	**100.0%** (n=23)	**100.0%** (n=9)	**100.0%** (n=29)	**96.7%** (n=151)
		2010	94.6% (n=37)	84.6% (n=13)	100.0% (n=41)	100.0% (n=22)	100.0% (n=9)	96.6% (n=29)	96.7% (n=151)
		2005	100.0% (n=30)	91.7% (n=12)	96.8% (n=31)	100.0% (n=17)	100.0% (n=8)	100.0% (n=28)	98.4% (n=126)
6	Number of sexual and reproductive health services (including contraception) provided to young people under 25 years of age	**2011**	**12,830,721** (n=37)	**932,796** (n=9)	**784,141** (n=19)	**2,738,103** (n=23)	**7,058,298** (n=7)	**13,080,277** (n=27)	**37,424,336** (n=122)
		2010	11,317,560 (n=37)	424,714 (n=9)	779,239 (n=18)	2,382,796 (n=22)	6,882,495 (n=8)	9,214,640 (n=27)	31,001,444 (n=121)
		2005	379,922 (n=29)	74,947 (n=9)	7,582 (n=2)	253,787 (n=14)	3,075,344 (n=8)	4,077,749 (n=25)	7,869,331 (n=87)

n=number of Member Associations that provided data; this applies to all annex tables.

Table A.4: HIV and AIDS – summary of indicators, 2005–2011

Indicator		Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
7	Proportion of Member Associations with a written HIV and AIDS workplace policy	**2011**	**89.2%** (n=37)	**84.6%** (n=13)	**80.0%** (n=40)	**65.2%** (n=23)	**88.9%** (n=9)	**93.1%** (n=29)	**83.4%** (n=151)
		2010	86.5% (n=37)	76.9% (n=13)	80.5% (n=41)	59.1% (n=22)	77.8% (n=9)	82.8% (n=29)	78.8% (n=151)
		2005	40.0% (n=30)	41.7% (n=12)	22.6% (n=31)	23.5% (n=17)	12.5% (n=8)	35.7% (n=28)	31.0% (n=126)
8	Proportion of Member Associations providing HIV-related services along the prevention to care continuum*	**2011**	**89.2%** (n=37)	**46.2%** (n=13)	**30.0%** (n=40)	**47.8%** (n=23)	**66.7%** (n=9)	**69.0%** (n=29)	**58.3%** (n=151)
		2010	81.1% (n=37)	46.2% (n=13)	26.8% (n=41)	31.8% (n=22)	66.7% (n=9)	51.7% (n=29)	49.7% (n=151)
		2005	63.3% (n=30)	8.3% (n=12)	9.7% (n=31)	29.4% (n=17)	25.0% (n=8)	35.7% (n=28)	31.7% (n=126)
9	Proportion of Member Associations advocating for increased access to HIV and AIDS prevention, treatment and care and reduced discriminatory policies and practices for those affected by HIV and AIDS	**2011**	**89.2%** (n=37)	**61.5%** (n=13)	**62.5%** (n=40)	**78.3%** (n=23)	**66.7%** (n=9)	**69.0%** (n=29)	**72.8%** (n=151)
		2010	91.9% (n=37)	92.3% (n=13)	58.5% (n=41)	63.6% (n=22)	55.6% (n=9)	72.4% (n=29)	72.8% (n=151)
		2005	63.3% (n=30)	33.3% (n=12)	48.4% (n=31)	41.2% (n=17)	62.5% (n=8)	50.0% (n=28)	50.8% (n=126)
10	Proportion of Member Associations with strategies to reach people particularly vulnerable to HIV infection	**2011**	**100.0%** (n=37)	**76.9%** (n=13)	**85.0%** (n=40)	**91.3%** (n=23)	**100.0%** (n=9)	**93.1%** (n=29)	**91.4%** (n=151)
		2010	97.3% (n=37)	76.9% (n=13)	78.0% (n=41)	90.9% (n=22)	100.0% (n=9)	89.7% (n=29)	88.1% (n=151)
		2005	93.3% (n=30)	58.3% (n=12)	64.5% (n=31)	64.7% (n=17)	75.0% (n=8)	57.1% (n=28)	69.8% (n=126)
11	Proportion of Member Associations conducting behaviour change communication activities to reduce stigma and promote health-seeking behaviours	**2011**	**100.0%** (n=37)	**76.9%** (n=13)	**67.5%** (n=40)	**91.3%** (n=23)	**100.0%** (n=9)	**96.6%** (n=29)	**87.4%** (n=151)
		2010	100.0% (n=37)	84.6% (n=13)	80.5% (n=41)	95.5% (n=22)	100.0% (n=9)	89.7% (n=29)	90.7% (n=151)
		2005	96.7% (n=30)	58.3% (n=12)	58.1% (n=31)	58.8% (n=17)	75.0% (n=8)	50.0% (n=28)	66.7% (n=126)
12	Number of HIV-related services provided	**2011**	**5,205,127** (n=37)	**345,768** (n=9)	**165,421** (n=19)	**2,034,137** (n=23)	**1,714,285** (n=7)	**5,619,436** (n=27)	**15,084,174** (n=122)
		2010	3,742,379 (n=37)	280,621 (n=9)	203,157 (n=18)	1,337,781 (n=22)	1,525,087 (n=8)	5,043,725 (n=27)	12,132,750 (n=121)
		2005	254,814 (n=29)	35,903 (n=9)	8,931 (n=2)	27,792 (n=14)	323,659 (n=8)	669,500 (n=25)	1,320,599 (n=87)
13	Number of condoms distributed	**2011**	**40,860,508** (n=37)	**576,176** (n=9)	**1,666,698** (n=19)	**38,945,036** (n=23)	**33,882,361** (n=7)	**52,898,016** (n=27)	**168,828,795** (n=122)
		2010	31,436,362 (n=37)	629,677 (n=9)	1,873,529 (n=18)	44,166,189 (n=22)	37,345,747 (n=8)	74,643,144 (n=27)	190,094,648 (n=121
		2005	5,970,411 (n=29)	718,437 (n=9)	67,370 (n=2)	9,549,970 (n=14)	20,623,889 (n=8)	60,925,614 (n=25)	97,855,691 (n=87)

* Prevention to care continuum includes behaviour change communication, condom distribution, management and treatment of sexually transmitted infections, voluntary counselling and testing, psychosocial support, prevention of mother-to-child transmission, treatment of opportunistic infection, antiretroviral treatment and palliative care.

Table A.5: Abortion – summary of indicators, 2005–2011

Indicator		Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
14	Proportion of Member Associations advocating for reduced restrictions and/or increased access to safe legal abortion	**2011**	**62.2%** (n=37)	**69.2%** (n=13)	**72.5%** (n=40)	**56.5%** (n=23)	**55.6%** (n=9)	**69.0%** (n=29)	**65.6%** (n=151)
		2010	75.7% (n=37)	69.2% (n=13)	78.0% (n=41)	50.0% (n=22)	77.8% (n=9)	69.0% (n=29)	70.9% (n=151)
		2005	60.0% (n=30)	41.7% (n=12)	67.7% (n=31)	47.1% (n=17)	37.5% (n=8)	42.9% (n=28)	53.2% (n=126)
15	Proportion of Member Associations conducting IEC/ education activities on (un)safe abortion, the legal status of abortion and the availability of legal abortion services	**2011**	**48.6%** (n=37)	**53.8%** (n=13)	**82.5%** (n=40)	**56.5%** (n=23)	**55.6%** (n=9)	**48.3%** (n=29)	**59.6%** (n=151)
		2010	56.8% (n=37)	61.5% (n=13)	78.0% (n=41)	63.6% (n=22)	55.6% (n=9)	41.4% (n=29)	60.9% (n=151)
		2005	36.7% (n=30)	16.7% (n=12)	67.7% (n=31)	52.9% (n=17)	37.5% (n=8)	32.1% (n=28)	43.7% (n=126)
16	Proportion of Member Associations providing abortion-related services	**2011**	**97.3%** (n=37)	**69.2%** (n=13)	**67.5%** (n=40)	**100.0%** (n=23)	**100.0%** (n=9)	**93.1%** (n=29)	**86.8%** (n=151)
		2010	97.3% (n=37)	77.8% (n=13)	70.7% (n=41)	95.5% (n=22)	100.0% (n=9)	89.7% (n=29)	84.8% (n=151)
		2005	90.0% (n=30)	75.0% (n=12)	83.9% (n=31)	88.2% (n=17)	87.5% (n=8)	71.4% (n=28)	82.5% (n=126)
17	Number of abortion-related services provided	**2011**	**233,780** (n=37)	**45,430** (n=9)	**97,331** (n=19)	**173,258** (n=23)	**254,418** (n=7)	**810,909** (n=27)	**1,615,126** (n=122)
		2010	132,580 (n=37)	38,401 (n=9)	101,222 (n=18)	149,821 (n=22)	333,630 (n=8)	793,465 (n=27)	1,549,119 (n=121)
		2005	25,044 (n=29)	3,333 (n=9)	339 (n=2)	39,797 (n=14)	137,142 (n=8)	13,574 (n=25)	219,229 (n=87)

Table A.6: Access – summary of indicators, 2005–2011

Indicator		Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
18	Proportion of Member Associations conducting programmes aimed at increased access to sexual and reproductive health services by poor, marginalized, socially-excluded and/or under-served groups	**2011**	**100.0%** (n=37)	**76.9%** (n=13)	**77.5%** (n=40)	**95.7%** (n=23)	**100.0%** (n=9)	**89.7%** (n=29)	**89.4%** (n=151)
		2010	100.0% (n=37)	61.5% (n=13)	85.4% (n=41)	95.5% (n=22)	100.0% (n=9)	89.7% (n=29)	90.1% (n=151)
		2005	86.7% (n=30)	75.0% (n=12)	67.7% (n=31)	82.4% (n=17)	100.0% (n=8)	75.0% (n=28)	78.6 % (n=126)
19	Estimated percentage of Member Association clients who are poor, marginalized, socially excluded and/or under-served	**2011**	**73.2%** (n=37)	**65.7%** (n=13)	**30.8%** (n=40)	**76.3%** (n=23)	**85.5%** (n=9)	**67.9%** (n=29)	**73.2%** (n=151)
		2010	72.9% (n=37)	48.9% (n=13)	29.5% (n=41)	76.6% (n=22)	81.9% (n=9)	67.9% (n=29)	71.9% (n=151)
		2005	71.9% (n=30)	76.8% (n=12)	24.1% (n=31)	26.7% (n=17)	81.3% (n=8)	52.7% (n=28)	56.6% (n=126)
20	Number of couple years of protection (CYP)*	**2011**	**1,406,890** (n=37)	**246,417** (n=9)	**37,238** (n=19)	**822,688** (n=23)	**2,019,072** (n=7)	**4,530,351** (n=27)	**9,062,656** (n=122)
		2010	1,102,342 (n=37)	269,789 (n=9)	36,136 (n=18)	834,726 (n=22)	1,903,573 (n=8)	4,781,999 (n=27)	8,928,609 (n=121)
		2005	550,262 (n=29)	379,437 (n=9)	5,664 (n=2)	452,985 (n=14)	1,924,125 (n=8)	3,363,448 (n=25)	6,675,921 (n=87)
21	Number of contraceptive services provided	**2011**	**15,854,386** (n=37)	**802,635** (n=9)	**298,389** (n=19)	**5,134,421** (n=23)	**7,702,355** (n=7)	**12,701,170** (n=27)	**42,493,356** (n=122)
		2010	16,817,092 (n=37)	634,570 (n=9)	324,929 (n=18)	4,621,885 (n=22)	7,909,074 (n=8)	13,506,032 (n=27)	43,813,582 (n=121)
		2005	2,945,996 (n=29)	1,153,939 (n=9)	31,505 (n=2)	1,121,008 (n=14)	4,380,657 (n=8)	7,825,834 (n=25)	17,458,939 (n=87)

* Couple years of protection (CYP) refers to the total number of years of contraceptive protection provided to a couple by method. The values have been revised for IUD and sterilization for all years following the 2011 revision of the CYP conversion factors.[19]

Table A.6: Access – summary of indicators, 2005–2011 (continued)

Indicator		Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
22	Number of non-contraceptive sexual and reproductive health services provided	**2011**	**11,650,139** (n=37)	**1,457,305** (n=9)	**1,215,702** (n=19)	**7,199,311** (n=23)	**7,683,747** (n=7)	17,916,892 (n=27)	**47,123,096** (n=122)
		2010	13,150,939 (n=37)	1,296,176 (n=9)	1,181,648 (n=18)	4,872,037 (n=22)	6,755,869 (n=8)	17,162,128 (n=27)	44,418,797 (n=121)
		2005	569,870 (n=29)	660,124 (n=9)	47,026 (n=2)	1,098,632 (n=17)	2,948,260 (n=8)	7,969,131 (n=25)	13,293,043 (n=87)
23	Number of service delivery points*	**2011**	**11,384** (n=37)	**1,191** (n=9)	**389** (n=19)	**8,298** (n=23)	**18,707** (n=7)	**25,059** (n=27)	**65,028** (n=122)
		2010	6,951 (n=37)	1,323 (n=9)	348 (n=18)	10,320 (n=22)	18,674 (n=8)	26,073 (n=27)	63,689 (n=121)
		2005	2,329 (n=29)	1,591 (n=9)	16 (n=2)	2,689 (n=14)	30,118 (n=8)	21,727 (n=25)	58,470 (n=87)
24	Proportion of Member Associations with gender-focused policies and programmes	**2011**	**67.6%** (n=37)	**84.6%** (n=13)	**75.0%** (n=40)	**78.3%** (n=23)	**77.8%** (n=9)	**79.3%** (n=29)	**75.5%** (n=151)
		2010	81.1% (n=37)	84.6% (n=13)	70.7% (n=41)	81.8% (n=22)	66.7% (n=9)	65.5% (n=29)	74.8% (n=151)
		2005	63.3% (n=30)	91.7% (n=12)	71.0% (n=31)	82.4% (n=17)	75.0% (n=8)	67.9% (n=28)	72.2% (n=126)
25	Proportion of Member Associations with quality of care assurance systems, using a rights-based approach**	**2011**	**94.6%** (n=37)	**87.5%** (n=8)	**87.0%** (n=23)	**95.7%** (n=23)	**100.0%** (n=8)	**92.6%** (n=27)	**92.9%** (n=126)
		2010	91.9% (n=37)	87.5% (n=8)	78.3% (n=23)	95.5% (n=22)	87.5% (n=8)	85.2% (n=27)	87.3% (n=125)
		2005	66.7% (n=30)	66.7% (n=12)	48.4% (n=31)	64.7% (n=17)	62.5% (n=8)	82.1% (n=28)	65.0% (n=126)

* In 2011, these service delivery points included 9,443 clinic-based service delivery points and 55,585 non-clinic based service delivery points, which include community-based volunteers, social marketing outlets, private physicians, pharmacies, government clinics and other agencies.
** This analysis is based on the number of Member Associations that provide clinical services (e.g. 126 Associations reported having provided services in 2011).

Table A.7: Advocacy – summary of indicators, 2005–2011

Indicator		Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
26	Proportion of Member Associations involved in influencing public opinion on sexual and reproductive health and rights	**2011**	**75.7%** (n=37)	**92.3%** (n=13)	**85.0%** (n=40)	**95.7%** (n=23)	**88.9%** (n=9)	**89.7%** (n=29)	**86.1%** (n=151)
		2010	75.7% (n=37)	84.6% (n=13)	100.0% (n=41)	95.5% (n=22)	88.9% (n=9)	79.3% (n=29)	87.4% (n=151)
		2005	60.0% (n=30)	91.7% (n=12)	80.6% (n=31)	70.6% (n=17)	62.5% (n=8)	67.9% (n=28)	71.4% (n=126)
27	Proportion of Member Associations involved in advancing national policy and legislation on sexual and reproductive health and rights	**2011**	**94.6%** (n=37)	**92.3%** (n=13)	**95.0%** (n=40)	**91.3%** (n=23)	**88.9%** (n=9)	**96.6%** (n=29)	**94.0%** (n=151)
		2010	94.6% (n=37)	84.6% (n=13)	95.1% (n=41)	90.9% (n=22)	100.0% (n=9)	93.1% (n=29)	93.4% (n=151)
		2005	86.2% (n=30)	100.0% (n=12)	93.5% (n=31)	94.1% (n=17)	87.5% (n=8)	85.7% (n=28)	90.4% (n=126)
28	Number of successful policy initiatives and/or positive legislative changes in support of sexual and reproductive health and rights to which the Member Association's advocacy efforts have contributed	**2011**	**11** (n=37)	**3** (n=13)	**42** (n=40)	**10** (n=23)	**6** (n=9)	**44** (n=29)	**116** (n=151)
		2010	9 (n=37)	2 (n=13)	12 (n=41)	8 (n=22)	2 (n=9)	14 (n=29)	47 (n=151)
		2005	11 (n=30)	5 (n=12)	17 (n=31)	4 (n=17)	2 (n=8)	16 (n=28)	55 (n=126)
29	Proportion of Member Associations involved in counteracting opposition to sexual and reproductive health and rights	**2011**	**91.9%** (n=37)	**92.3%** (n=13)	**92.5%** (n=40)	**78.3%** (n=23)	**66.7%** (n=9)	**82.8%** (n=29)	**86.8%** (n=151)
		2010	91.9% (n=37)	69.2% (n=13)	90.2% (n=41)	77.3% (n=22)	100.0% (n=9)	82.8% (n=29)	86.1% (n=151)
		2005	83.3% (n=30)	66.7% (n=12)	87.1% (n=31)	82.4% (n=17)	87.5% (n=8)	71.4% (n=28)	80.2% (n=126)
30	Proportion of Member Associations advocating for national governments to commit more financial resources to sexual and reproductive health and rights	**2011**	**91.9%** (n=37)	**61.5%** (n=13)	**87.5%** (n=40)	**78.3%** (n=23)	**55.6%** (n=9)	**82.8%** (n=29)	**82.1%** (n=151)
		2010	94.6% (n=37)	69.2% (n=13)	87.8% (n=41)	86.4% (n=22)	55.6% (n=9)	82.8% (n=29)	84.8% (n=151)
		2005	93.3% (n=30)	66.7% (n=12)	90.3% (n=31)	94.1% (n=17)	75.0% (n=8)	82.1% (n=28)	86.5% (n=126)

Table A.8: Number of couple years of protection (CYP)* provided by region and method, 2005–2011

Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of responses	2011	(n=37)	(n=9)	(n=19)	(n=23)	(n=7)	(n=27)	**(n=122)**
	2010	(n=37)	(n=9)	(n=18)	(n=22)	(n=8)	(n=27)	**(n=121)**
	2005	(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	**(n=87)**
IUD	**2011**	**272,214**	**208,784**	**11,700**	**241,687**	**501,765**	**1,572,064**	**2,808,214**
	2010	236,998	235,258	9,531	213,573	443,213	1,604,423	2,742,996
	2005	154,836	320,563	3,969	202,541	420,844	1,191,450	2,294,202
Voluntary surgical contraception (vasectomy and tubal ligation)	**2011**	**17,310**	0	**3,890**	**41,200**	**575,342**	**1,265,840**	**1,903,582**
	2010	13,210	0	3,760	33,220	530,833	1,258,620	1,839,643
	2005	570	1,920	490	50,780	606,214	804,240	1,464,214
Oral contraceptive pill	**2011**	**291,872**	**21,401**	**2,464**	**115,002**	**400,429**	**497,912**	**1,329,079**
	2010	156,677	20,214	2,191	125,498	370,609	545,658	1,220,887
	2005	153,758	43,956	549	97,283	349,894	529,411	1,174,851
Condoms	**2011**	**340,504**	**4,801**	**13,889**	**324,542**	**282,354**	**440,817**	**1,406,907**
	2010	261,970	5,247	15,613	368,052	311,215	622,026	1,584,122
	2005	50,318	5,963	559	79,356	171,178	505,683	813,057
Injectables	**2011**	**290,822**	**7,569**	**4**	**70,486**	**171,025**	**454,571**	**994,477**
	2010	289,276	7,271	46	75,021	171,968	428,810	972,398
	2005	186,455	4,860	47	19,531	128,048	229,295	568,236
Implants	**2011**	**182,683**	**3,370**	**4,453**	**24,331**	**18,899**	**177,227**	**410,961**
	2010	133,076	385	3,477	16,610	13,911	197,905	365,363
	2005	463	167	0	1,878	220,134	67,542	290,183
Emergency contraception	**2011**	**1,428**	**8**	**67**	**1,199**	**69,258**	**119,873**	**191,833**
	2010	1,303	391	86	1,287	61,825	122,960	187,852
	2005	433	19	8	33	27,193	32,754	60,440
Other barrier methods	**2011**	**10,051**	**485**	**753**	**4,150**	0	**1,183**	**16,622**
	2010	9,816	1,022	1,434	1,375	0	907	14,553
	2005	3,429	1,989	37	1,583	620	1,139	8,798
Other hormonal methods	**2011**	**6**	**0**	**19**	**90**	0	**865**	**980**
	2010	15	0	0	90	0	689	794
	2005	0	0	4	0	0	1,935	1,939
Total	**2011**	**1,406,890**	**246,417**	**37,238**	**822,688**	**2,019,072**	**4,530,351**	**9,062,656**
	2010	1,102,342	269,789	36,136	834,726	1,903,573	4,781,999	8,928,609
	2005	550,262	379,437	5,664	452,985	1,924,125	3,363,448	6,675,921

* Data for IUD and sterilization have been revised for all years following the 2011 revision of the CYP conversion factors.[20]

Table A.9: Number of sexual and reproductive health services provided by region, by service type, 2005–2011

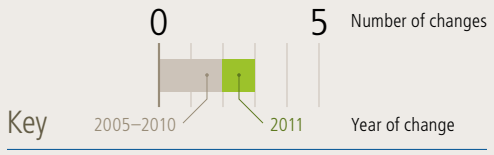
Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of responses	2011	(n=37)	(n=9)	(n=19)	(n=23)	(n=7)	(n=27)	(n=122)
	2010	(n=37)	(n=9)	(n=18)	(n=22)	(n=8)	(n=27)	(n=121)
	2005	(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	(n=87)
Contraceptive (including counselling)	2011	15,854,386	802,635	298,389	5,134,421	7,702,355	12,701,170	42,493,356
	2010	16,817,092	634,570	324,929	4,621,885	7,909,074	13,506,032	43,813,582
	2005	2,945,996	1,153,939	31,505	1,121,008	4,380,657	7,825,834	17,458,939
Gynaecological	2011	522,276	336,207	61,332	1,445,092	1,209,347	6,958,108	10,532,362
	2010	450,223	381,383	88,872	1,115,931	900,651	7,023,958	9,961,018
	2005	40,251	186,848	19,574	268,416	307,972	4,495,533	5,318,594
Obstetric	2011	760,462	223,126	23,250	1,621,893	1,783,262	2,805,643	7,217,636
	2010	847,062	294,653	20,794	871,826	1,679,951	2,841,509	6,555,795
	2005	90,330	234,384	8,376	208,030	778,263	1,466,688	2,786,071
SRH medical	2011	1,111,955	69,248	10,708	344,731	623,174	165,679	2,325,495
	2010	4,561,180	28,891	10,208	336,304	497,681	106,808	5,541,072
	2005	6,047	45,524	34	337,589	780,728	282,657	1,452,579
Paediatric	2011	349,599	29,967	78	120,932	1,198,333	291,133	1,990,042
	2010	261,267	35,891	230	77,559	856,439	277,427	1,508,813
	2005	115,399	117,808	0	149,644	285,503	276,682	945,036
Specialized counselling	2011	3,366,313	390,644	852,574	1,399,468	799,614	1,012,258	7,820,871
	2010	3,082,671	223,702	753,106	914,430	867,061	802,455	6,643,425
	2005	20,237	31,591	4,859	45,446	264,425	552,064	918,622
STI/RTI	2011	577,848	100,620	67,271	1,174,531	756,085	4,425,326	7,101,681
	2010	444,918	111,195	74,734	741,253	756,790	3,924,661	6,053,551
	2005	34,723	27,371	2,200	15,445	264,699	474,112	818,550
HIV-related (excluding STI/RTI)	2011	4,627,279	245,148	98,150	859,606	958,200	1,194,110	7,982,493
	2010	3,297,461	169,426	128,423	596,528	768,297	1,119,064	6,079,199
	2005	220,091	8,532	6,731	12,347	58,960	195,388	502,049
Abortion-related	2011	233,780	45,430	97,331	173,258	254,418	810,909	1,615,126
	2010	132,580	38,401	101,222	149,821	333,630	793,465	1,549,119
	2005	25,044	3,333	339	39,797	137,142	13,574	219,229
Infertility	2011	96,108	14,189	4,923	49,817	95,216	59,992	320,245
	2010	64,207	10,186	3,857	37,015	92,775	51,073	259,113
	2005	17,748	4,304	4,878	17,899	65,912	82,531	193,272
Urological	2011	4,519	2,726	85	9,983	6,098	193,734	217,145
	2010	9,370	2,448	202	31,370	2,594	221,708	267,692
	2005	0	429	35	4,019	4,656	129,902	139,041
Total	2011	27,504,525	2,259,940	1,514,091	12,333,732	15,386,102	30,618,062	89,616,452
	2010	29,968,031	1,930,746	1,506,577	9,493,922	14,664,943	30,668,160	88,232,379
	2005	3,515,866	1,814,063	78,531	2,219,640	7,328,917	15,794,965	30,751,982

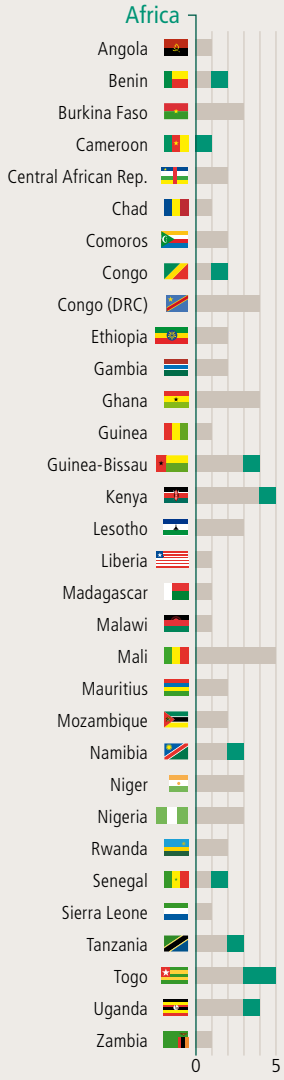
Table A.10: Results for consistently reporting Member Associations 2005–2011

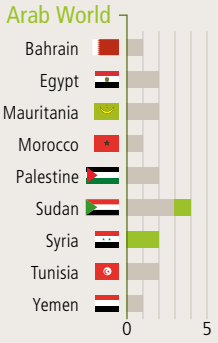
Indicator	2005 (n=72*)	2011 (n=72*)	Seven-year percentage change	Seven-year total (2005–2011)
Sexual and reproductive health services (including contraception) provided	26,574,017	**63,552,455**	139.2%	**322,010,748**
Non-contraceptive sexual and reproductive health services provided	12,009,022	**30,849,762**	156.9%	**149,439,318**
New users to modern methods of contraception	2,720,357	**4,967,853**	82.6%	**24,997,731**
HIV-related services (including STI/RTI services) provided	1,249,653	**8,333,193**	566.8%	**27,847,849**
Condoms distributed	94,842,803	**146,387,927**	54.3%	**887,309,549**
Abortion-related services provided	199,246	**692,258**	247.4%	**3,234,966**
Sexual and reproductive health services provided to young people	7,111,036	**26,978,499**	279.4%	**119,648,063**
Couple years of protection provided	6,313,457	**6,786,757**	7.5%	**45,983,471**
Number of pregnancies averted	1,818,276	**1,954,586**	7.5%	**13,243,240**

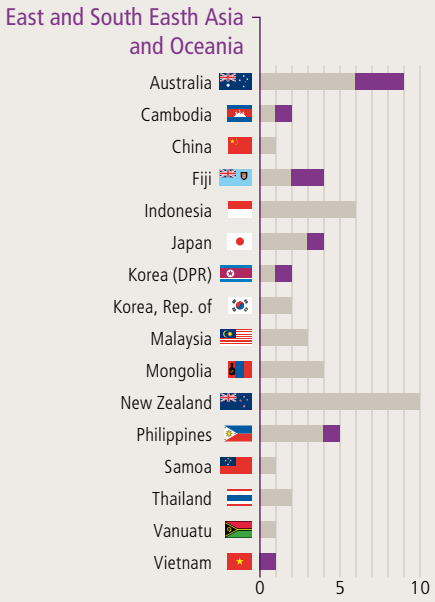
* Seventy-two Member Associations have provided service data consistently for the seven-year period 2005 to 2011. These data differ from the global data set as the number of Member Associations reporting global indicator results changes from year to year. The results for the consistent countries provide evidence of significant growth in all service categories.

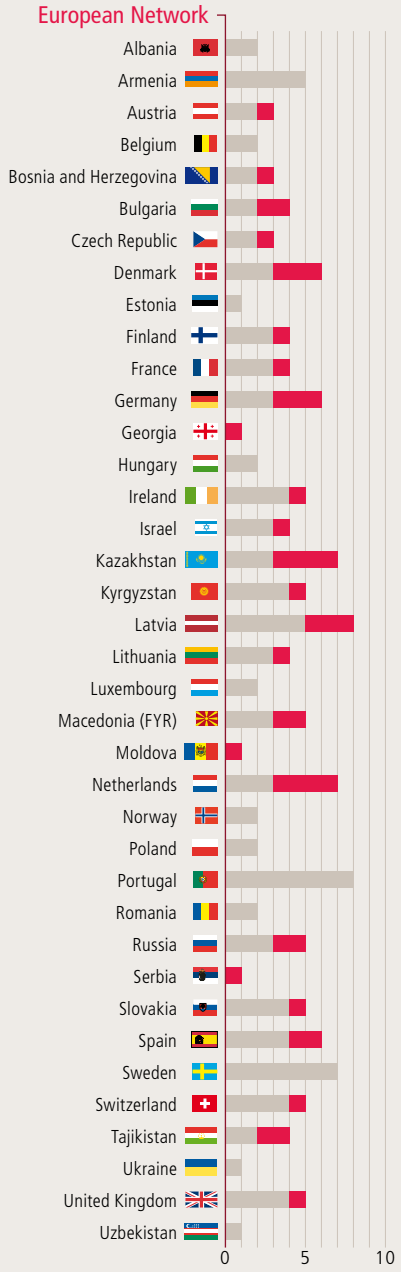
Annex B: Number of policy and/or legal changes, by country, 2005–2011

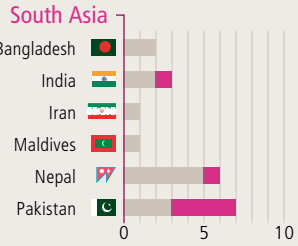


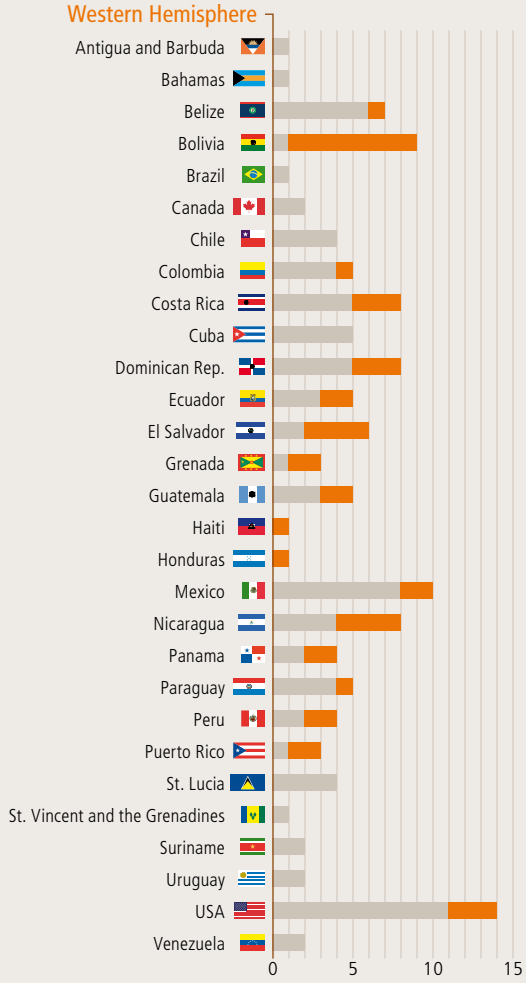












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Key abbreviations

ADS	Asociación Demográfica Salvadoreña
AIDS	Acquired immune deficiency syndrome
AR	Africa region, IPPF
AWR	Arab World region, IPPF
CEPAM	Centro Ecuatoriano para la Promoción y Acción de la Mujer
CIES	Centro de Investigación, Educación y Servicios
CPD	Commission on Population and Development
CYP	Couple years of protection
EN	European Network, IPPF
ESEAOR	East and South East Asia and Oceania region, IPPF
FHOK	Family Health Options Kenya
FIGO	International Federation of Gynecology and Obstetrics
FPAP	Family Planning Association of Pakistan
FPOP	Family Planning Organization of the Philippines
HDI	Human Development Index
HIV	Human immunodeficiency virus
IEC	Information, education and communication
IFPA	Irish Family Planning Association
IFPA	Israel Family Planning Association
INPPARES	Instituto Peruano de Paternidad Responsable
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
MMCWA	Myanmar Maternal and Child Welfare Association
ODA	Official development assistance
OECD	Organisation for Economic Co-operation and Development
RHAK	Reproductive Health Alliance of Kyrgyzstan
RHU	Reproductive Health Uganda
RTI	Reproductive tract infection
SAR	South Asia region, IPPF
SFPA	Slovak Family Planning Association
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organization
WHR	Western Hemisphere region, IPPF

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Government of Thailand
Government of United Kingdom
Herbert Smith (in memory of David Kato)
John Hopkins University (Advanced Family Planning)
Libra Foundation
John D & Catherine T MacArthur Foundation
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Nirvana Manana Institute Foundation
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