IPPF

From choice, a world of possibilities

Annual Performance Report
2010–2011

Welcome

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.

Acknowledgments
IPPF would like to express thanks to all who contributed to the Annual Performance Report 2010–2011. The production of the report was coordinated by the Organizational Learning and Evaluation unit and Advocacy and Communications unit.

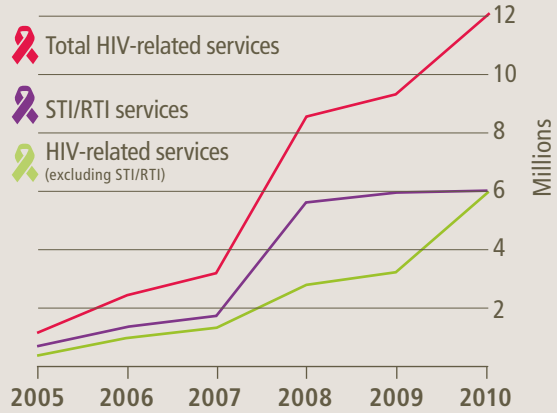
IPPF in 2010

$380m
IPPF's total income

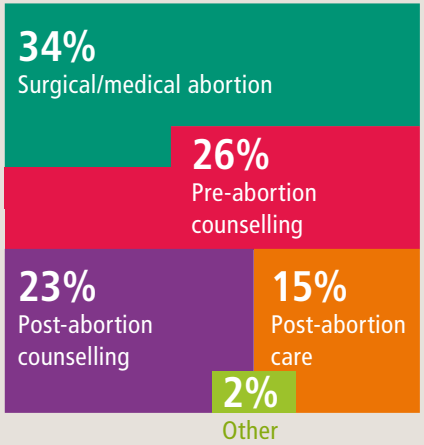
$96m of IPPF's income is unrestricted.

70%+ goes to countries with high maternal mortality rates.*

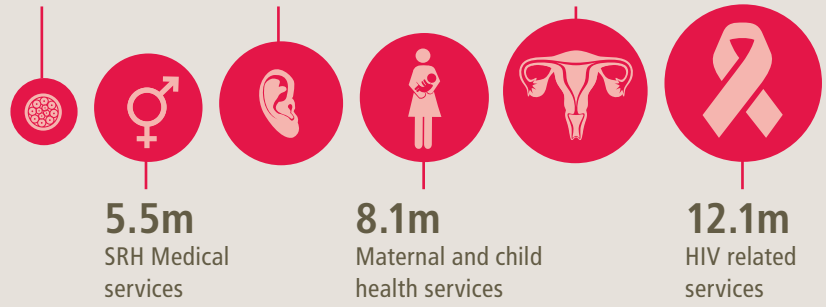
Number of HIV-related services provided, 2005–2010



624,000 Unsafe abortions averted

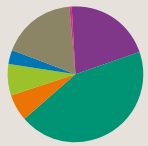


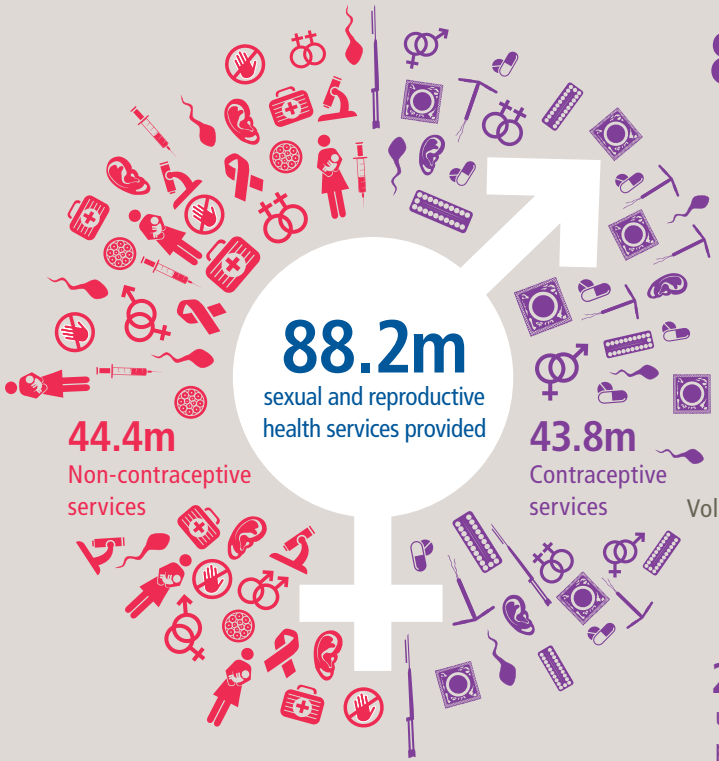
Non-contraceptive services



* Countries where 1–14 in every 1,000 women die in childbirth.

Inside





8.3m Couple years of protection,† by method, 2010

52% Long-acting		48% Short-acting	
5%	Implants	2%	Other❖
26%	Intra-uterine devices (IUDs)	12%	Injectibles
		15%	Oral contraceptive pills
21%	Voluntary surgical contraception (vasectomy & tubal ligation)	19%	Condoms

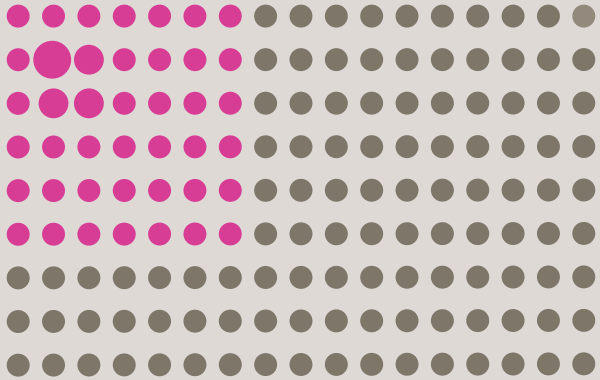
2.1m unintended pregnancies averted

190m condoms distributed

We provide comprehensive services to the most vulnerable groups.

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

42 Member Associations (MAs) contributed to **47** national legal or policy changes in 2010.



● MA whose advocacy achieved one or more legal/policy change(s)
● Other MAs

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

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

** Estimated figure of client numbers.

† 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 0.25 pregnancies averted for each couple year of protection, as recommended by the Guttmacher Institute in January 2011. The previous conversion factor was 0.57.

❖ Including emergency contraception.

Foreword

"I care deeply for those whose voices cannot be heard due to poverty, gender, stigma or vulnerability. IPPF's mission, and my passion, is to ensure that these millions are not forgotten..."

I am delighted to introduce the Annual Performance Report 2010–2011 in the very early days of my position as IPPF's Director-General, to have the opportunity to acknowledge the contributions made by my predecessor, Dr Gill Greer, and pay tribute to her for her unrelenting work on sexual rights and increasing people's access to sexual and reproductive health (SRH) services.

This report opens with a review of the status of the Millennium Development Goals most related to IPPF's work, and is followed by an analysis of IPPF's performance, which shows that between 2005 and 2010, the provision of SRH services has increased significantly, and the majority of our clients are poor or vulnerable, including substantial numbers of young people. These achievements would not be possible without funds going to the right places. Our financial strategy ensures that more money goes to countries that have the greatest needs, and evidence from an assessment on value for money confirms that the majority of Member Associations perform well, both in delivering IPPF's Strategic Framework 2005–2015 and in organizational effectiveness.

IPPF improves the health outcomes of millions of people by making a significant contribution to health systems strengthening around the world. We provide services where there are no government facilities, we train government health workers, react rapidly in emergency situations, and provide expertise and models of success that governments and others can learn from, replicate or scale up.

IPPF works tirelessly in advocating for changes to laws and policies in support of sexual and reproductive health and rights, and in opposing those that are harmful. Our global success is demonstrated by the 2010 achievements, and the geographical and thematic spread of our 330 advocacy successes from the last six years. As we look towards 2012, we will continue to focus on addressing the key challenges that threaten the sexual and reproductive health and rights of so many in the twenty-first century.

IPPF's global reach

IPPF is a unique organization with a worldwide presence of 153 nationally-owned Member Associations, who respond to local needs and provide a voice for the voiceless. These Member Associations work in close partnership with their communities, are supported by millions of volunteers, and are respected partners of government and other key stakeholders. They also hold governments accountable to promises made but not yet delivered, including commitments to the International Conference on Population and Development (ICPD) and the Millennium Development Goals, and of course, respond vociferously when the opposition and lack of political will threaten such hard won gains.

The work of Member Associations goes beyond the provision of SRH information, education and services to the work we do in supporting health systems strengthening, and to advocacy where we contribute to changes in policy and law that can make the greatest difference to the largest number of people. Overall, these three strategic approaches mean that more people are able to make informed decisions about having children, or not; have access to sexual and reproductive health information and services; are empowered and able to protect themselves from violence, stigma and discrimination; and can realize their right to happy and fulfilled sexual relationships. Moreover, it means that more people are active, able to care for their families, and contribute to society economically, politically and socially. This will have the greatest and most sustainable impact on human development and poverty reduction.

The achievements presented in this report result from the tireless efforts of IPPF's volunteers and staff, and I would like to take this opportunity to thank them for their commitment. I am equally committed, and will be working with you all, with governments and other stakeholders, to drive forward our common agenda for universal access to sexual and reproductive health and rights. ■

Tewodros Melesse,
Director-General, IPPF

IPPF's global reach

Advocating for policy and legislative change in support of sexual and reproductive health and rights

Supporting health systems strengthening

Providing integrated sexual and reproductive health information, education and services

Millions of volunteers

30,000+ staff

153 Member Associations – nationally-owned, volunteer-based, autonomous organizations

IPPF

Western Hemisphere
29
Member Associations

Arab World
15
Member Associations

Africa
37
Member Associations

South Asia
9
Member Associations

East & South East Asia and Oceania
22
Member Associations

European Network
41
Member Associations

Sexual and reproductive health and rights: a global overview

In 2000, the world committed to eight Millennium Development Goals (MDGs) to be achieved by 2015. IPPF's work directly relates to goals 3, 4, 5 and 6. Despite some progress in recent years, most are far from meeting their targets.

MDG 3 aims to promote gender equality and empower women. This is clearly part of IPPF's mandate since women will never be truly equal in society until they are able to take control over their own bodies and live free from the threat of violence and discrimination. The indicators used to measure this goal show signs of improvement, with increasing gender parity in education, especially at primary level, and some improvements in tertiary education. This is a good step forward, as educated women are more likely to access contraceptive services and less likely to experience maternal or child death. However, despite this progress, women remain poorer and less literate than men; they have fewer employment opportunities, a weaker political voice, and often experience discrimination, violence and ill health.

Gender-based violence is a significant human rights violation and impacts directly on sexual and reproductive health. In recent years, 125 countries have passed laws on domestic violence.[1] Evidence shows that where such laws are in place, prevalence is lower and fewer people think that gender-based violence is justifiable.[2] Nevertheless, many of these laws are not fully enforced and when it comes to sexual violence, progress is harder to assess. While almost all countries have laws against rape, they often define it narrowly and conviction rates remain extremely low the world over. Gender-based violence is both a cause and consequence of gender inequality, as well as HIV infection and maternal mortality.

Unequal power relations between women and men clearly put women at great risk and a long way from realizing their right to sexual and reproductive health. This inequality is reflected by research showing that, in a number of countries, high numbers of women are unable to ask their partners to use a condom.[3]

When it comes to MDG 4, which aims to decrease child mortality, there has been steady progress globally, with the mortality rate for children under five having declined by a third from 89 to 60 deaths per 1,000 live births between 1990 and 2009.[4] However, there is still another third to go if the goal of reducing child mortality by two thirds by 2015 is to be met. Investment in contraception can prevent ten per cent of child deaths,[5] and, with child mortality increasing by 60 per cent if the mother is under the age of 18,[6] it is clear that reducing early marriage and giving young people access to sexual and reproductive health care is vital if we are going to reduce child mortality further.

MDG 5, aimed at improving maternal health, is the goal most directly relevant to IPPF's work and is also the goal that is the furthest from meeting its target. Although most, if not all, of the MDGs are unachievable without access to sexual and reproductive health and rights, this was not recognized in the original framework. In 2007, IPPF and other organizations, were successful in addressing this omission, and another target, MDG 5b was introduced which aims to 'achieve by 2015, universal access to reproductive health'. However, this goal has had much less time than the others to make progress and is still a long way from meeting its target.

In 2008, it was estimated that 358,000 women died in pregnancy or childbirth, and currently only 14 countries are predicted to meet the MDG target of reducing the maternal mortality ratio by three quarters by 2015.[7] The reasons behind this are complex and wide ranging and can be linked to unmet need for contraception, poor access to maternal and reproductive health services, unsafe abortion, and early marriage followed by pregnancy at a young age.

One factor is a lack of appropriate and qualified medical practitioners. Even when they are available and not prohibitively expensive, the sensitive nature of sexual and reproductive health means that many women may be reluctant to visit a clinic if there are no female staff members available (Figure 1). It is therefore vital to support health systems strengthening to ensure that qualified and diverse health service practitioners are accessible to all, and that financial barriers are removed.

Unintended, closely-spaced pregnancies, or pregnancies in the very young, are particularly risky and therefore access to modern contraception plays a major role in reducing maternal mortality rates. However, worldwide there are still 120 million women aged 15 to 49 who have an unmet need for contraception.[9]

Figure 1: Barriers to women accessing health care, in selected countries with high rates of maternal mortality[8]

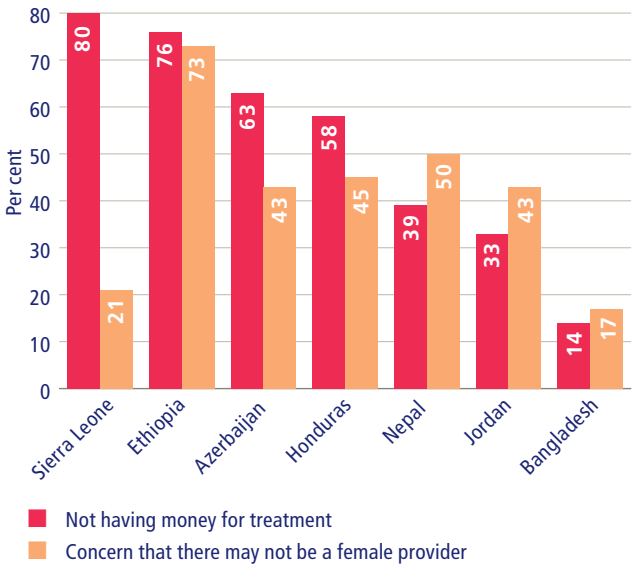
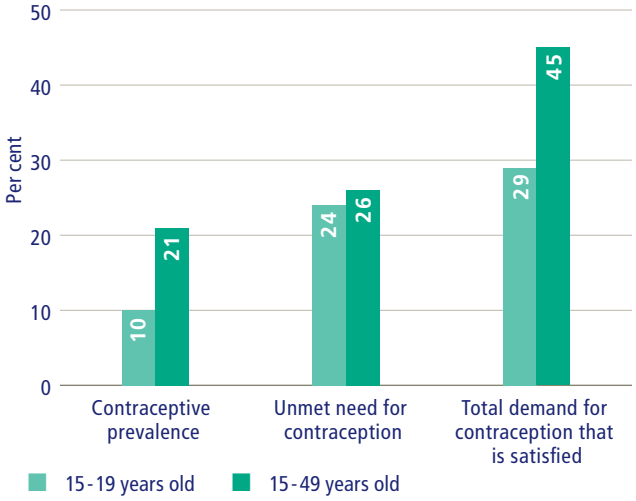


Figure 2: Contraceptive prevalence, unmet need for contraception, and total demand for contraception that is satisfied among women, by age group (sub-Saharan Africa)[11]

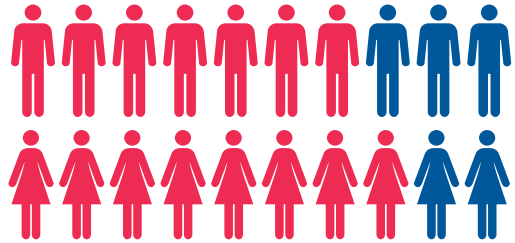


This has remained at the same level since 2000, reflecting the fact that international aid for contraception decreased in recipient countries from 11 per cent of total health care aid in 2001 to 3 per cent in 2009.[10] Despite the risks associated with early childbearing, evidence from sub-Saharan Africa shows that contraceptive use is lower for adolescents between 15 and 19 years of age, than for women aged 15 to 49 years, although there is a similar level of need (Figure 2).

Another factor that plays a big part in maternal mortality, leading to an estimated 47,000 maternal deaths per year, is unsafe abortion.[12] Currently 26 per cent of people live in countries where abortion is only permitted to save a woman's life or is prohibited altogether,[13] but there has been a relaxation of restrictions in some parts of the world, where laws have been revised to allow more women to access safe abortion. However, some of IPPF's recent advocacy achievements have been in fighting efforts to restrict access to abortion. This reflects a backlash against abortion rights and the anti-choice agenda gaining support in recent years.

MDG 6, aimed at combating HIV, has shown progress with the HIV incidence rate* declining steadily. In sub-Saharan Africa, in particular, it has fallen by nearly 25 per cent between 2001 and 2009.[14] However, rates have not fallen as dramatically elsewhere and, in Central Asia, the incidence rate has actually increased.

Understanding how HIV spreads is the first step to avoiding infection. However, only 33 per cent of young men and 20 per cent of young women in a number of developing countries have a comprehensive and correct knowledge of HIV.[15] This highlights the vital need for comprehensive sexuality education. On average, less than half of young men asked in a recent survey in sub-Saharan African countries had used condoms during their last high risk sexual activity,[16] highlighting the importance of working with men and boys as well as women on issues of sexual and reproductive health.



in developing regions lack a comprehensive and correct knowledge of HIV.

The criminalization and discrimination of people of diverse sexual orientations and gender identities is also related to HIV incidence rates. Same-sex sexual activity is criminalized in 40 per cent of countries,[17] and lesbian, gay, bisexual, transgender and intersex (LGBTI) people are particularly vulnerable to stigma and violence. This discrimination means that it is very difficult for LGBTI people to openly access HIV prevention, treatment, care and support services and puts them at risk of HIV infection. More, therefore, needs to be done to ensure that safe, stigma-free sexual and reproductive health services are accessible to all.

Overall, the world has seen some progress made in reaching the MDG targets. Nonetheless, there are disparities in progress between the goals, and even more so between regions and countries, as well as between urban and rural areas. It is clear that, despite the importance of sexual and reproductive health and rights to achieving the Millennium Development Goals, this has been the hardest area to address. Progress made has been unequal, and the needs of those most vulnerable are the furthest from being met. ■

* Number of new HIV infections per year, per hundred people, aged 15-49.

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.

IPPF saw impressive increases in service provision during 2010, continuing the trend seen since 2005, and reflecting our commitment to the delivery of a broad range of sexual and reproductive health services. By the end of 2010, 88.2 million services had been provided, an increase of more than 21.8 million from 2009 (Figure 3). IPPF's integrated approach includes prevention, diagnosis, care, treatment and support for all the key components of sexual and reproductive health. In line with the Strategic Framework, we are implementing programmes that provide both contraceptive and non-contraceptive services in equal numbers.

82% of IPPF's services are provided in countries with the greatest needs (UNDP Human Development Index).

We also ensure that IPPF's core investments result in sexual and reproductive health services being provided in countries of greatest need. A remarkable 82 per cent of IPPF's services are provided in countries defined by the UNDP Human Development Index (HDI) as having low or medium levels of human development. These are the places in the world with disproportionately high levels of sexual and reproductive ill health, including maternal mortality, HIV prevalence, infant mortality, and early marriage and childbearing. Many of these countries have the greatest numbers of people who are the poorest and the most vulnerable in the world.

Reaching the poor and vulnerable

Member Associations are often the only places that welcome the most marginalized, that do not discriminate, and that offer information, counselling and services in a safe and stigma-free environment. In many parts of the world, we are present where there is no other public or private health sector provider. Our record of reaching the poor and most vulnerable is unparalleled, with an estimated seven in every ten of our clients being identified as poor, marginalized, under-served and/or socially-excluded. This is a significant achievement which stems from IPPF's unwavering commitment to meeting the needs of the most vulnerable.

Over half of IPPF service delivery points are in rural or peri-urban locations. Mobile and outreach teams together with community-based distribution ensure that millions of otherwise under-served people can access services. Many different strategies are used to reach the poor and vulnerable: 74 per cent of Member Associations provide community based services; 70 per cent outreach and mobile services, 66 per cent subsidized services; and 59 per cent have specially adapted fee structures.

Figure 4 reveals the variation between different regions, with South Asia serving the greatest proportion of poor and vulnerable clients (82 per cent), followed by East and South East Asia and Oceania (77 per cent), and Africa (73 per cent).

Figure 3: Number of contraceptive and non-contraceptive sexual and reproductive health (SRH) services provided, 2005–2010

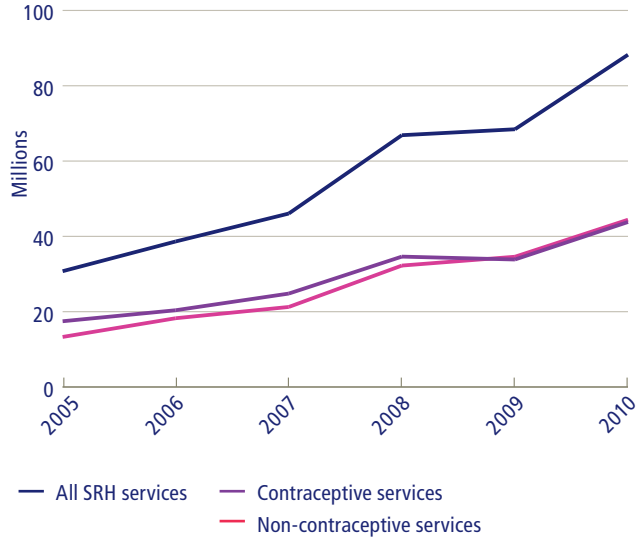


Figure 4: Estimated percentage of Member Association clients who are poor, marginalized, socially-excluded and/or under-served, by region, 2010

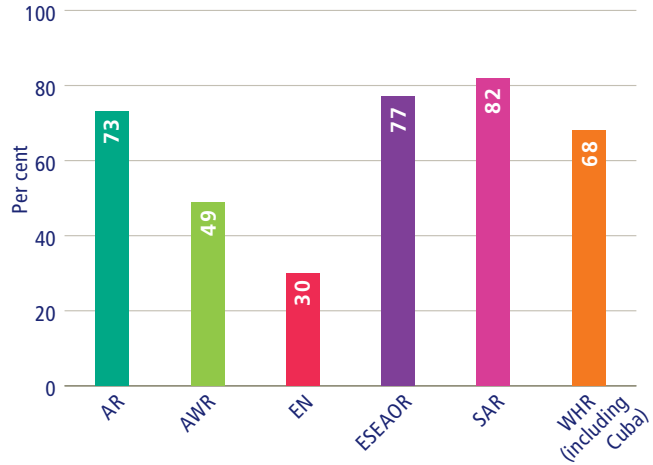


Figure 5: Number of SRH services provided to young people, by type, 2005–2010

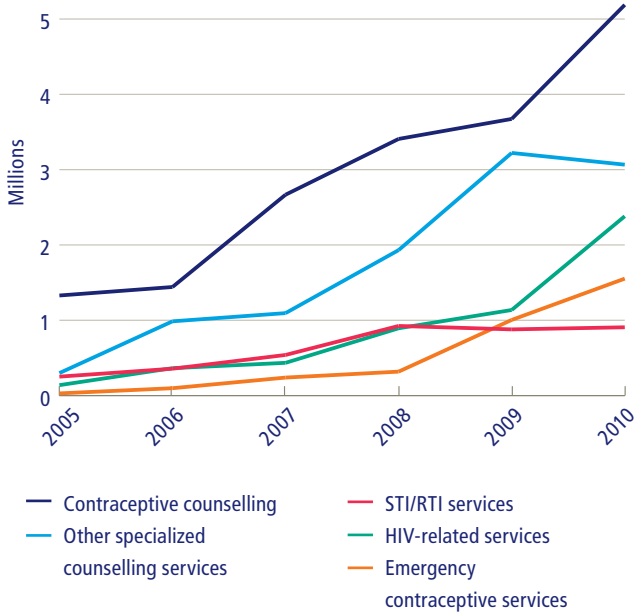
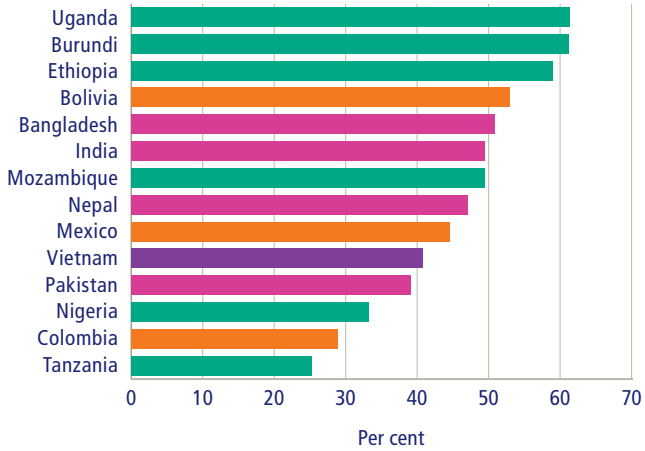


Figure 6: Proportion of SRH services provided to young people, selected countries, 2010



Providing services to young people

Just over 31 million sexual and reproductive health services were provided to young people in 2010, an increase of 6.4 million from 2009. Every year since 2005, more services reach young people, and a higher percentage of all IPPF's total services go to this client group; 35 per cent in 2010 in comparison to just 23 per cent in 2005.

Overall increases are seen in a range of different service types, with contraceptive counselling and HIV-related services showing the highest significant increases in 2010. Emergency contraception has also grown impressively from only 28,927 in 2005 to over 1.5 million in 2010 (Figure 5).

Figure 6 shows the proportion of services provided to young people for 14 Member Associations, indicating that they are particularly effective in attracting youth to their services and meeting young people's needs. In all of these countries, around one third of the population is under 25 years old. In both Burundi and Uganda, over 60 per cent of the Member Association's services are provided to young people, and many other Member Associations provide over 40 per cent of their services to youth. This work is vital in ensuring the largest ever generation of young people can access the services they need. IPPF's work in comprehensive sexuality education, youth participation and effective youth policies also supports the current generation of young people to be able to choose when, if and how many children they have, and to be able to protect their sexual and reproductive health.

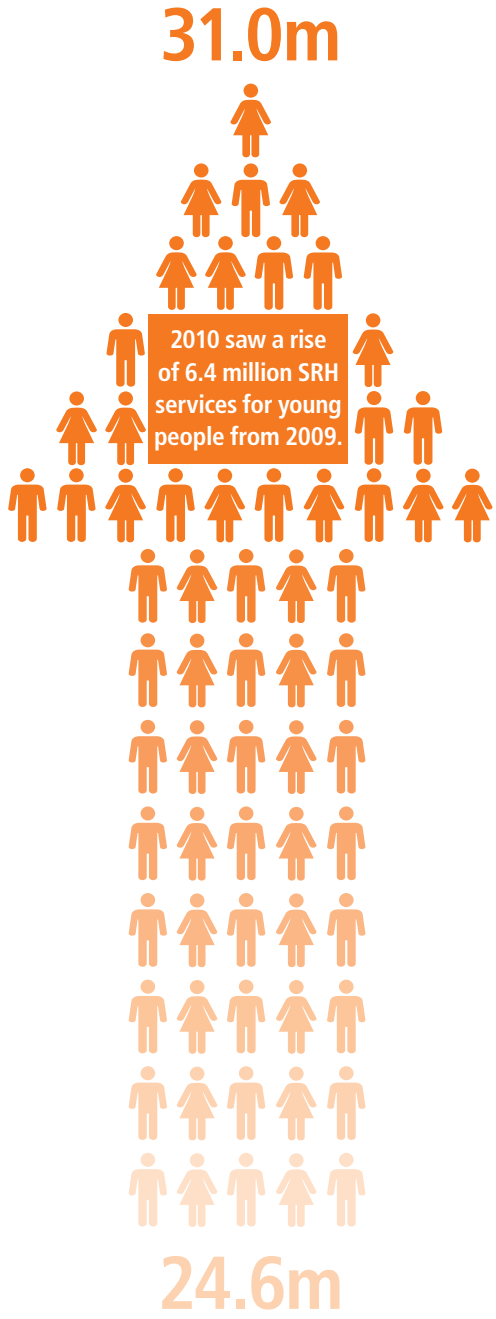


Figure 7: Global CYP, by method mix, 2010

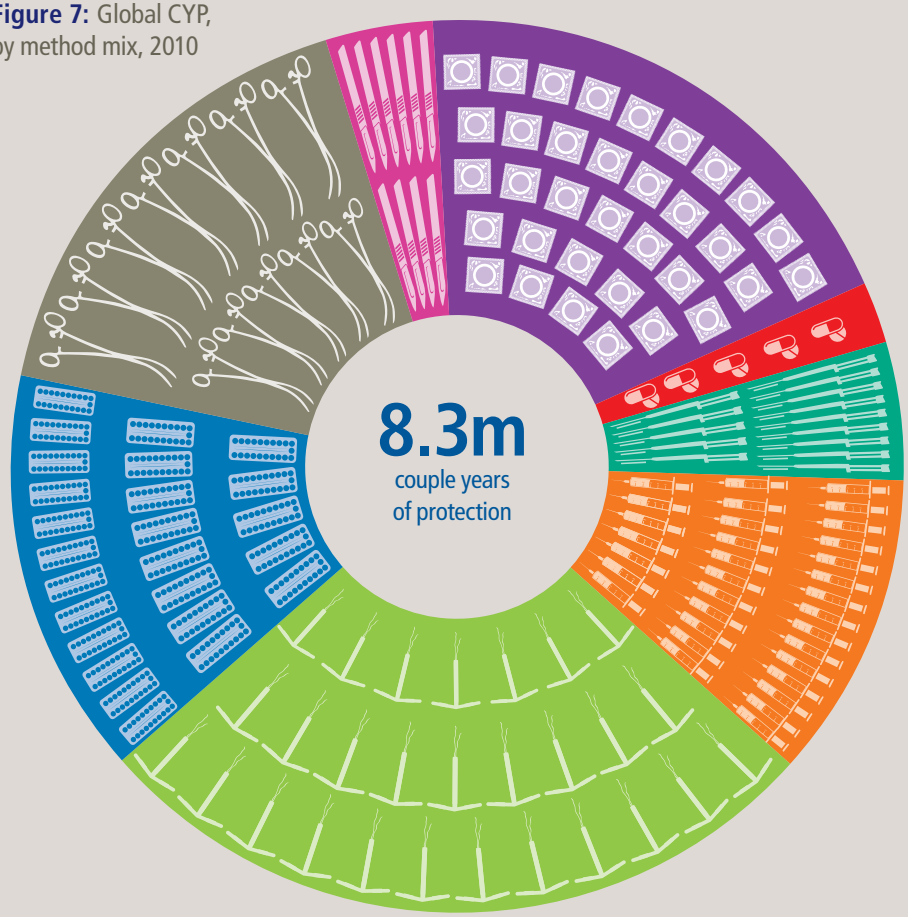
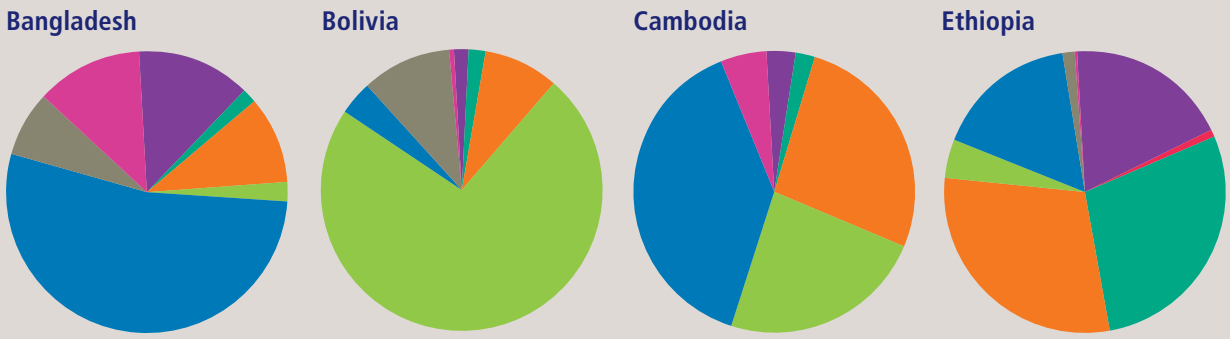


Figure 8: CYP by method mix, for selected countries, 2010



Couple Years of Protection (CYP)

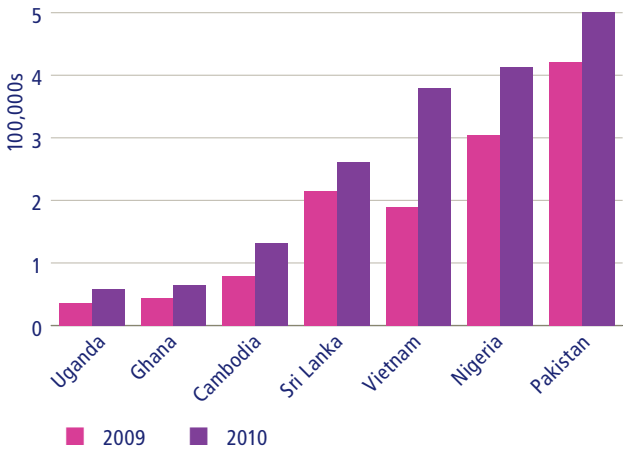
IPPF continues to provide clients with a broad range of contraceptive choices, including short-term, long-acting and permanent methods, to fully support decision making at all stages throughout the reproductive life cycle. Analysis of the method mix provided by IPPF shows little change since 2005; there are different method mixes provided in different countries, often related to client preferences and reproductive health commodity security. However, all IPPF Member Associations are committed to having both short- and long-acting methods available to enable individuals to exercise their reproductive rights (Figures 7 and 8).

Overall the number of contraceptive services provided increased significantly between 2009 and 2010, especially in services related to condoms, counselling, sterilization and emergency contraception. However, the number of couple years of protection (CYP) remained static during the same time period. This was mainly due to lower numbers of contraceptive items being provided by several larger Member Associations where there has been an increase in the provision of contraception by the government, or a decrease in funding. However, many other Member Associations showed significant increases in CYP (Figure 9), and in Africa and East and South East Asia and Oceania, CYP increased by 12 per cent and 44 per cent respectively.

In line with our commitment to serving the most vulnerable, IPPF support to Member Associations resulted in over 85 per cent of our CYP being provided in countries ranked by the Human Development Index as having high or highest needs (receiving 62 per cent and 23 per cent of IPPF's support respectively). It is in these countries that proportionately more women have an unmet need for contraception, and where fewer women can exercise their right to contraceptive method of choice. Women's reproductive ill health is the largest contributor to gender inequality throughout the world,[18] and far too many women are still denied access to services that could improve their sexual and reproductive health status, as well as reduce the disadvantages they face due to lower levels of educational, economic, social and political opportunities.

Overall, the number of contraceptive services provided increased significantly between 2009 and 2010.

Figure 9: CYP, selected countries, 2009–2010



IPPF provided 8.3 milllion couple years of protection in 2010.
IPPF/Peter Caton/Hong Kong

HIV-related services

Since 2005, there has been consistent progress in the number of HIV-related services being provided, with a recent increase of over 30 per cent between 2009 and 2010. The greatest increases are seen in the provision of STI/RTI services, voluntary counselling and testing, and HIV serostatus laboratory testing (Table 10).

The Africa region, in particular, has vastly increased the number of HIV-related services provided, from 254,814 in 2005 to over 3.7 million in 2010. Furthermore, half of those services go to young people, again a dramatic increase from just 85,000 in 2005 to over 1.8 million in 2010.

IPPF has been increasingly successful in integrating a number of HIV services into existing sexual and reproductive health service programmes. Facilitated by more targeted outreach efforts, this integration has enabled increased access to health services by key vulnerable groups as well as cost savings and other benefits.

Linking HIV and sexual and reproductive health services can ensure that clients receive comprehensive care and stigma-free services. The provision of HIV-related services along the prevention to care continuum has increased from 32 per cent of Member Associations in 2005 to 50 per cent in 2010, with at least six of the following nine services being provided by these Associations: 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.

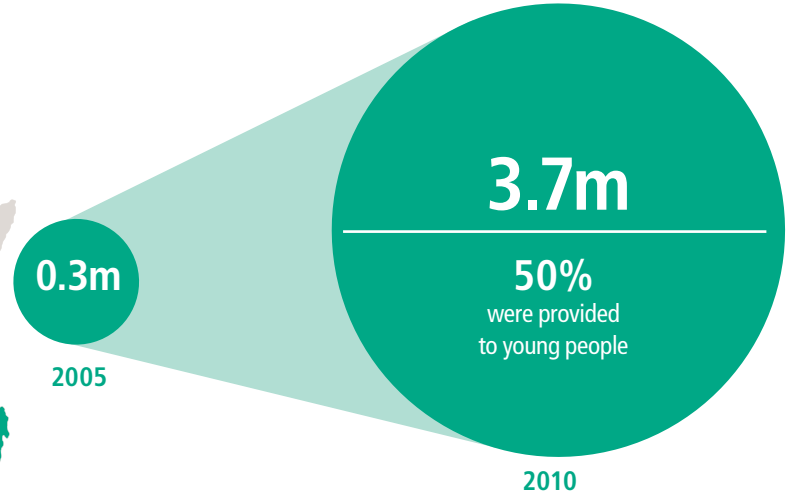
* Reclassification of 'Other HIV lab tests' into 'HIV serostatus lab tests' and better quality data explain this decrease in services reported between 2005 and 2010.

12.1m

HIV-related services were provided in 2010.

Table 10: Number of HIV-related services provided, by type, 2005 and 2010

Type of HIV-related services provided	Number of HIV-related services provided	
	2005	2010
STI/RTI services	818,550	6,053,551
HIV voluntary counselling and testing	76,221	2,810,524
HIV serostatus lab tests	42,524	1,782,159
HIV prevention counselling	221,294	1,210,230
HIV and AIDS home care treatment	4,848	68,888
HIV opportunistic infection treatment	40,954	60,748
Psychosocial support	859	37,943
Other HIV lab tests*	72,143	35,364
Antiretroviral treatment	565	23,687
All other HIV services	42,641	49,656
Total	1,320,599	**12,132,750**



The number of HIV-related services provided in the Africa region has grown by more than 3.4 million between 2005 and 2010 and half of these services were provided to young people.

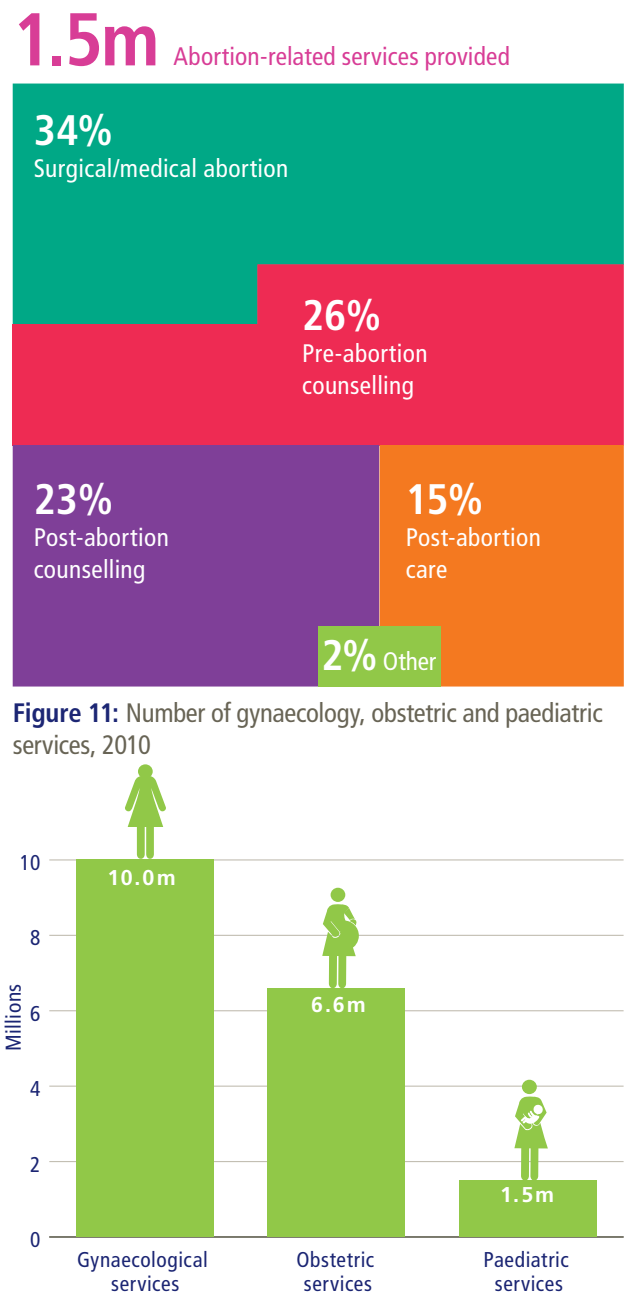


Figure 11: Number of gynaecology, obstetric and paediatric services, 2010

Abortion-related services

In 2010, 1.5 million abortion-related services were provided, a significant increase from 219,229 in 2005. The most common types of service are pre- and post-abortion counselling, and surgical/medical abortion.

One of the areas which has seen significant progress is the number of clients adopting post-abortion contraception, ranging from 76 per cent in Burkina Faso to 98 per cent in India. Another area of progress is the inclusion, for the first time, of medical abortion into the service package of Member Associations in Armenia, Burkina Faso, Kyrgyzstan and Nepal.

Focusing on the needs of women and girls

Many of the services provided by IPPF Member Associations are for women, who suffer disproportionately from sexual and reproductive ill health. Women and girls have been at the heart of IPPF's work for 59 years, and along with supporting a woman's right to use contraception, her right to end an unintended pregnancy, and her right to freedom from violence, much of IPPF's work focuses on the provision of gynaecological and obstetric services (Figure 11).

In 2010, 10.0 million gynaecological services were provided to women, the majority in diagnostics (examinations, biopsy, imaging), and for cancer screening (breast and cervical cancer). We also provided over 6.6 million obstetric services, including prenatal care (diagnostics, counselling and lab tests), pregnancy tests and post-natal care. Additionally more than 800,000 immunizations and over 300,000 baby/infant health checks were provided. ■

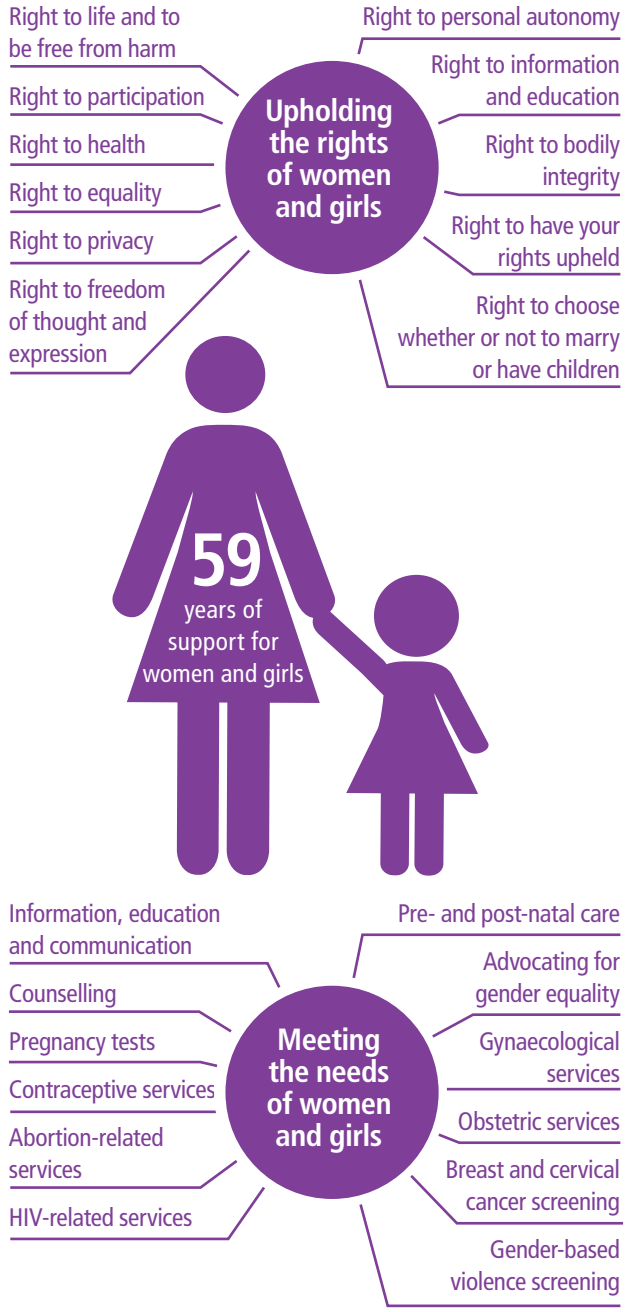


Table 12: Cumulative results by region, 2005–2010

Indicator	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of sexual and reproductive health services (including contraception) provided	76,487,898	10,840,962	8,627,700	35,344,580	65,256,881	142,449,149	339,007,170
Number of Couple Years of Protection (CYP)	4,889,758	1,481,802	253,324	3,414,624	10,391,447	25,790,032	46,220,987
Number of sexual and reproductive health services (including contraception) provided to young people under 25 years of age	30,183,298	2,280,789	3,334,068	6,987,718	29,742,626	38,378,235	110,906,734
Number of HIV-related services provided	9,253,966	787,084	1,313,027	4,665,281	5,163,610	15,969,113	37,152,081
Number of condoms distributed	128,425,963	5,374,908	5,255,696	86,291,108	162,720,411	423,029,417	811,097,503
Number of abortion-related services provided	460,795	173,375	435,609	692,045	1,374,801	2,265,070	5,401,695
Number of successful national 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	66	14	104	47	14	85	330

IPPF is achieving substantial results in each of the regions where it works (Tables 12 and 13). Table 12 highlights the six-year cumulative totals for the major types 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 the Member Associations' advocacy efforts have contributed. Table 13 focuses on results from 2010, with additional information on a number of key performance indicators, including the proportion of Member Associations that have a written HIV and AIDS workplace policy, the proportion that are providing the Essential Services Package, and the estimated number of clients who are poor, marginalized, socially-excluded and/or under-served.

IPPF/Kabir Singh/Austria

Table 13: Key results by region, 2010

Indicator	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of sexual and reproductive health services (including contraception) provided	29,968,031	1,930,746	1,506,577	9,493,922	14,664,943	30,668,160	88,232,379
Number of Couple Years of Protection (CYP)	1,059,149	213,531	34,677	789,432	1,791,570	4,420,067	8,308,427
Number of sexual and reproductive health services (including contraception) provided to young people under 25 years of age	11,317,560	424,714	779,239	2,382,796	6,882,495	9,214,640	31,001,444
Number of HIV-related services provided	3,742,379	280,621	203,157	1,337,781	1,525,087	5,043,725	12,132,750
Number of condoms distributed	31,436,362	629,677	1,873,529	44,166,189	37,345,747	74,643,144	190,094,648
Proportion of Member Associations with a written HIV and AIDS workplace policy	86.5%	76.9%	80.5%	59.1%	77.8%	82.8%	78.8%
Number of abortion-related services provided	132,580	38,401	101,222	149,821	333,630	793,465	1,549,119
Estimated percentage of Member Association clients who are poor, marginalized, socially-excluded and under-served	72.9%	48.9%	29.5%	76.6%	81.9%	67.9%	71.9%
Proportion of Member Associations providing Essential Services Package*	56.8%	66.7%	33.3%†	54.5%	87.5%	85.2%	62.0%
Number of successful national 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	9	2	12	8	2	14	47

* There are eight components in the Essential Services Package: contraception; emergency contraception; abortion; HIV; STI/RTI; gynaecology; obstetrics 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.

† For the majority of countries in the European Network, sexual and reproductive health services are provided by government and other private agencies, and in these cases, the Member Associations do not provide clinical services but focus on advocacy to ensure increased access to sexual and reproductive health services for all.

Investing for results

In order to improve effectiveness, IPPF directs funds to countries where the need is greatest, while also ensuring that controls and support are in place to make sure that these funds are well spent and provide good value for money.

IPPF income received from governments, foundations and other sources has increased in the last five years by 34 per cent. However, in 2010, IPPF income was US$124 million, a decrease of 11 per cent from 2009. Despite this fall in income, IPPF expenditure on grants to Member Associations and partner organizations only fell by four per cent to US$78 million. In addition to income from IPPF, Member Associations also raise funds from local and international sources. During the last five years, this income has grown significantly, from US$264 million in 2005 to US$360 million in 2010, an increase of 36 per cent.

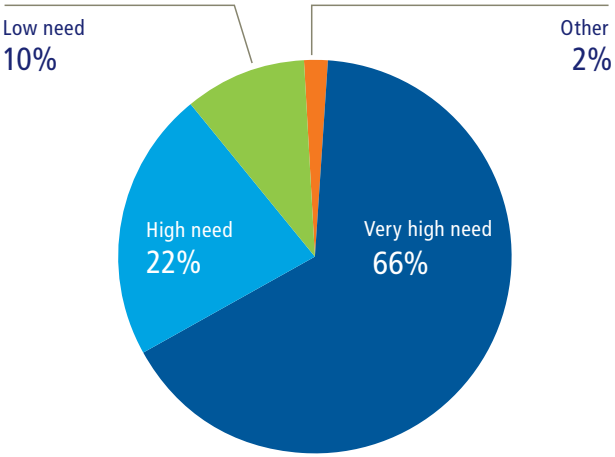
IPPF's financial strategy is to ensure that funds are directed to populations where the need is greatest, working with Member Associations to deliver both services and advocacy in the most effective and efficient way possible. In 2010, over 88 per cent of funds were delivered to Member Associations operating in countries classified by UNFPA as having high or very high needs with respect to sexual and reproductive health and only 10 per cent to those in low need countries (Figure 14).

A similar picture emerges when looking at UNDP's Human Development Index (HDI) ranking (Figure 15). Eighty-three per cent of IPPF unrestricted funding in 2010 went to countries with a low or medium level of human development. Only one per cent of IPPF unrestricted funds went to those countries with very high levels of human development.

Over the past five years, IPPF has been supporting Member Associations to develop income streams at a local level, thereby increasing their sustainability and enabling them to serve increasing numbers of poor, marginalized and under-served clients. The support provided by unrestricted funding, covering overhead costs and allowing for a more permanent presence, has enabled Member Associations to leverage other funds themselves. This has resulted in the income of Member Associations operating in high and very high need countries increasing by 50 per cent between 2005 and 2010, an annual growth rate of nine per cent. Of 116 Member Associations, 63 increased their income by more than 50 per cent and a further 26 showed positive income growth. Globally, Member Association income has grown considerably, by nearly US$120 million in this period and Figure 16 shows that the greatest increase in growth has occurred in those countries classified by UNFPA as of high or very high need.

A measure of the success of IPPF's strategy of building the capacity of Member Associations to be able to raise funds from other donors is the percentage of income that Member Associations obtain from sources other than IPPF. A minimum target of 25 per cent has been set for non-IPPF income and the number of grant-receiving Member Associations achieving this benchmark has risen from 72 per cent in 2005 to 85 per cent in 2010. By 2010, grant-receiving Member Associations were raising US$6 for every US$1 they received in unrestricted income from IPPF.

Figure 14: Percentage of IPPF unrestricted grants, by UNFPA classification, 2010



By 2010, grant-receiving Member Associations were raising US$6 for every US$1 they received in unrestricted income from IPPF.

Figure 15: Percentage of IPPF unrestricted grants, by HDI ranking, 2010

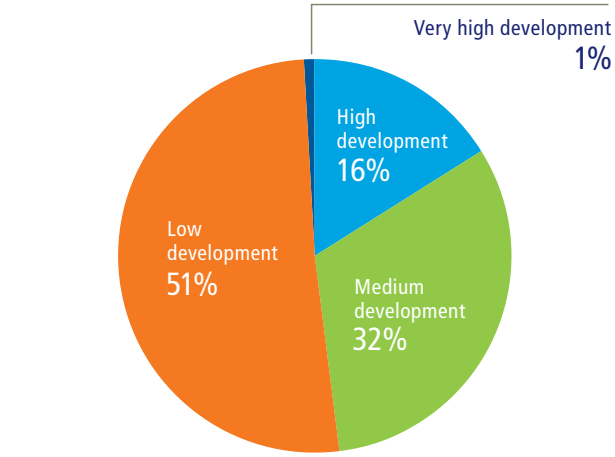
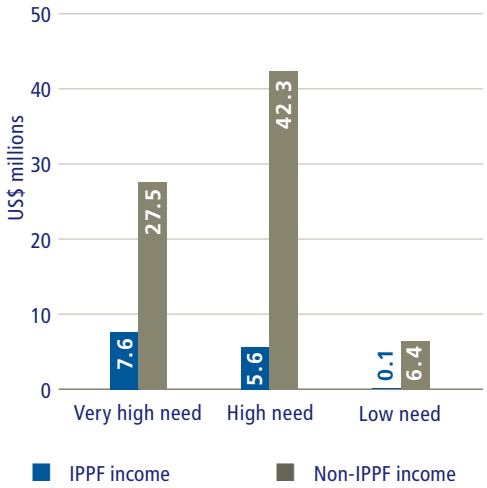


Figure 16: Growth in income, by UNFPA classification, 2005–2010



56%
of IPPF's money goes to countries where 1 in 20 children die before the age of five.

50%
of IPPF's funds go to countries where more than half of the population live on under US$2 per day.

Improving performance

As well as ensuring that funds are delivered to those who have the highest needs, IPPF is supporting Member Associations to continuously improve efficiency and performance, working on a number of initiatives including:

- the roll out of a clinic management information system to support clinics to improve management of client flow and utilization of data for decision-making purposes
- the development of a clinic performance tool that will allow Member Associations to understand the drivers of individual clinic performance and compare with internal and international benchmarks
- the development of a bespoke costing tool that will enable Member Associations to understand their cost structures, and make decisions on where to invest limited resources more effectively
- investing in the capacity building of Member Associations to raise and manage more funds at a local level and better support the communities they serve
- performance-based funding to further strengthen the linkage between funding and the performance of individual Member Associations (Box 17)

Box 17: Performance-based funding

IPPF is committed to supporting all Member Associations to make intelligent, data-driven decisions to improve performance. With a focus on achieving the priority objectives set out in the Federation's Strategic Framework 2005–2015, IPPF has been an early leader in establishing a strong performance culture, with the accreditation system, the global indicators and integrating Member Association performance into resource allocation decision making.

More recently, IPPF has piloted a performance-based funding system, the next essential step in promoting a performance culture throughout the Federation. The indicators used to assess performance are reflective of the broad areas of work undertaken by Member Associations, and include service provision, sexuality education, meeting the needs of the poorest and vulnerable, and contributing to advocacy success. The performance-based funding system creates incentives for performance by linking it to core grants awarded annually to Member Associations.

In 2011, the system was piloted in eight Member Associations: Albania; Barbados; Bolivia; Cambodia; Ghana; India; Palestine and Uganda. Each Association has analyzed branch-level data and is implementing branch-level budgetary reviews. All eight agreed that the new system strengthened the accountability of their work, supported better utilization of performance data, and increased transparency. As a result, concrete steps are now being taken by each of these Member Associations to improve performance.

In order for the performance-based funding system to deliver on its potential, it will be used to determine the level of core funding available to Member Associations; those with improved performance will receive increased core grants, and vice versa. This will ensure that IPPF funding supports those Associations with a proven track record of effectiveness, as well as providing incentives to poor performers to improve. Responding effectively to the incentives will depend on three key pillars: accurate data about clients and services, a complete picture of costs which will contribute to an understanding of value for money, and skilled managers who can interpret the data in order to identify opportunities to improve performance. All Member Associations will be eligible for technical assistance to support them in these areas if needed.

An evaluation of the performance-based funding pilot will be conducted in 2012. This marks a new stage in the evolution of IPPF's performance culture, and the system will be rolled out throughout the Federation.

Assessing value for money

There is currently no globally accepted definition of value for money, although there are two key elements that are frequently referred to as being important when assessing value for money. These are effectiveness, with a focus on what will be done and the achievement of objectives; and efficiency, how it will be done, at least cost and with the most efficient systems.

These two elements are captured in IPPF's focus on organizational effectiveness which means the ability of the Federation to fulfil its mission through a combination of sound management, good governance and a persistent dedication to achieving results. At all levels of the Federation, we have robust financial control systems, a set of standards and checks for internal financial control, internal and external audit, a rigorous annual programme budgeting and reporting process, and an annual risk management process. We also have an accreditation system which ensures all Member Associations are reviewed every five years. For accreditation, each Member Association is expected to uphold IPPF's ten membership principles* and comply with the standards associated with each principle, either at the time of review or within a 12-month period following post-review support. Failure to do so can lead to grant money being withheld, suspension or expulsion of the Association from the Federation. In addition to the strong accounting and accreditation review systems, annual review of Member Association performance is undertaken by Regional Offices to assess achievement of objectives, to identify where technical assistance is needed and for resource allocation purposes.


IPPF/Peter Caton/Bangladesh

In March 2011, the UK Department for International Development (DFID) published the 'Multilateral Aid Review – Ensuring maximum value for money for UK aid through multilateral organizations'.[19] This review compared 43 organizations and established two indices:

1. organizational strengths

2. contribution to UK development objectives

Following DFID's example, IPPF decided to undertake a similar assessment of Member Associations using a combination of the best available data, including accreditation review results (at time of review), global indicators, and financial information. The purpose of the analysis is for Member Associations and the Secretariat to use the results as a guide to action to make programmatic and organizational changes that will ensure value for money.

IPPF will continue to review and revise this model as more progress is made in our understanding of what value for money means, and how it can be assessed within and across the international aid community, including donors and non-governmental organizations, and in particular from IPPF's own perspective.

Methodology

Following DFID's lead on how to define 'value for money', we developed indices on:

1. delivering IPPF's Strategic Framework

2. organizational effectiveness

The first index focuses on the extent to which Member Associations are contributing to IPPF's strategic goals and objectives, specifically in the areas of young people, gender and rights, the poor and vulnerable, delivering results, quality service provision and having a progressive voice on sexual and reproductive health and rights.

The second index assesses key aspects of organizational effectiveness including management and governance, finance, partnerships, accountability, learning and evaluation. Table 18 lists the components of each index and summarizes the criteria used in scoring.

The most recently available (2010) performance and finance data were used in the analysis. The other main data source was the accreditation review results. At the time of publication, data from accreditation reviews in the 2009–2013 plan, were available for 31 Member Associations. This represents a fifth of IPPF Member Associations, with representation from all regions. It is important to note that a significant amount of data used to construct the two indices are from the results of each Member Association's accreditation review. These are undertaken at a specific point in time and if accreditation status is not immediately recommended, the Member Association has a 12-month period in which to comply with all standards. It is therefore very likely that, for many unaccredited Associations, their scores on a number of these indices will improve within a short period of time.

* 1. Open and democratic; 2. Well governed; 3. Strategic and progressive; 4. Transparent and accountable; 5. Well-managed; 6. Financially healthy; 7. Good employer; 8. Committed to results; 9. Committed to quality; 10. A leading SRHR organization.

Table 18: Framework used to assess value for money

Index 1: Delivering IPPF's Strategic Framework	
Components of delivering IPPF's Strategic Framework	**Key criteria reviewed**
Focus on young people	• has young people on governing board and as staff; acts on young people's feedback • provides a significant proportion of SRH services to young people
Provides quality services	• has a quality assurance system: effective logistics; is rights-based; guidelines and protocols in place • has procedures to take account of client feedback; has a client complaints system
Reaches the poor and vulnerable	• provides services in rural and peri-urban locations • proactive in advocating for, and provides high proportion of SRH services to, poor and vulnerable groups • ensures costs of services are not a barrier to access
Delivers results[Δ]	• high performance in contraceptive and non-contraceptive service provision (measured by reach and increasing trends) • contributes to policy/legislative change in support and defence of SRHR
Progressive in sexual and reproductive health and rights (SRHR)	• proactive in advocating for and providing services to the most marginalized groups • counteracts opposition to SRH • committed to IPPF's vision, mission and core values including gender equality, HIV, abortion and youth SRH
Focus on rights and gender equality	• implements IPPF's Declaration on Sexual Rights • promotes gender equality (policy, programmes)
Index 2: Organizational effectiveness	
Components of organizational effectiveness	**Key criteria reviewed**
Effectively managed and governed	• staff receive training, support and resources to perform effectively; annual appraisals conducted • has an organizational structure with clear accountability and reporting lines • Governing body focuses on strategic matters, Member Association performance and fulfilling governance responsibilities
Accountable and democratic	• information is freely available about mission, goals and objectives, governance, work programme etc; is clear on what information can be shared with public • constitution is clear on governance and election procedures • reports to donors submitted on time
Financially sustainable and cost-effective	• at least 25 per cent income from non-IPPF sources; has a resource mobilization plan • reviews cost-effectiveness of service provision • has written financial policies/procedures and an annual external audit
Learning and evaluation culture	• Governing body reviews performance in relation to strategic goals • data are collected, analyzed and utilized for decision-making; evaluation results are shared
Effective collaborator with partners	• is a member of consultative body to influence national policy/legislation on SRHR • partners with community groups and organizations to support SRHR • evidence from partner organizations of positive collaboration

Δ For Member Associations that do not provide significant numbers of sexual and reproductive health services, a combination of data on advocacy and provision of information (including information on where services can be obtained) were used.

At the Bangladeshi Member Association, women are shown the correct way to use a condom.
IPPF/Peter Caton/Bangladesh

Results

For the purpose of this report, the results are presented as an assessment of the overall value for money provided by IPPF (Figures 19 and 20). The average value for organizational effectiveness is slightly higher (84 per cent), than that of delivering IPPF's Strategic Framework (78 per cent). Both results indicate that, overall, IPPF and its donors can be assured that we are providing good value for money by having the structures, policies and systems in place to drive organizational performance, and in making progress toward the attainment of our strategic goals and objectives.

The overall picture masks some of the variability across the Member Associations in their results for each of the 11 components (with standard deviations between 8 and 24 per cent). The components with the greatest variability include quality of services; effective management and governance; financially sustainable; and learning and evaluation. Those with the least variance are effective partnerships; focus on youth; and being progressive in sexual and reproductive health and rights.

Individual results from each Member Association illustrate their own strengths and weaknesses, and there is variation within the dataset, as illustrated by Figure 21. With few exceptions, those Associations that score well in organizational effectiveness are also high performers in delivering IPPF's Strategic Framework, and vice versa. However, the results show that for organizational effectiveness, more Associations achieve scores of over 80 per cent (n=21) than on delivering the Framework (n=16). The standards set in this analysis were high, particularly on delivering the Framework, where every Association was assessed on performance in a broad range of sexual and reproductive health issues, gender, rights, reaching the poor, as well as on service delivery and advocacy. This, together with the inherent challenge of measuring some of these indicators, particularly in areas such as comprehensive sexuality education, poverty status and advocacy, will be taken into consideration when reviewing individual Member Association's current and future potential, value for money, and where support is needed most.

The results for organizational effectiveness and delivering IPPF's Strategic Framework for each of the 31 Member Associations have been shared with the Secretariat and Associations for discussion and action. There are four Associations that scored 70 per cent or less on both indices, indicating that they are in need of serious improvement, and we will be working closely to monitor progress and provide support where necessary. On the other hand, the majority of Associations performed well on both organizational effectiveness and delivering IPPF's Strategic Framework, with nearly half (n=14) scoring higher than 80 per cent in both indices, indicating that these are strong, high performing organizations, providing value for money and of which IPPF can be proud. ■

The majority of Associations performed well on both organizational effectiveness and delivering IPPF's Strategic Framework.

Figure 19: Delivering IPPF's Strategic Framework

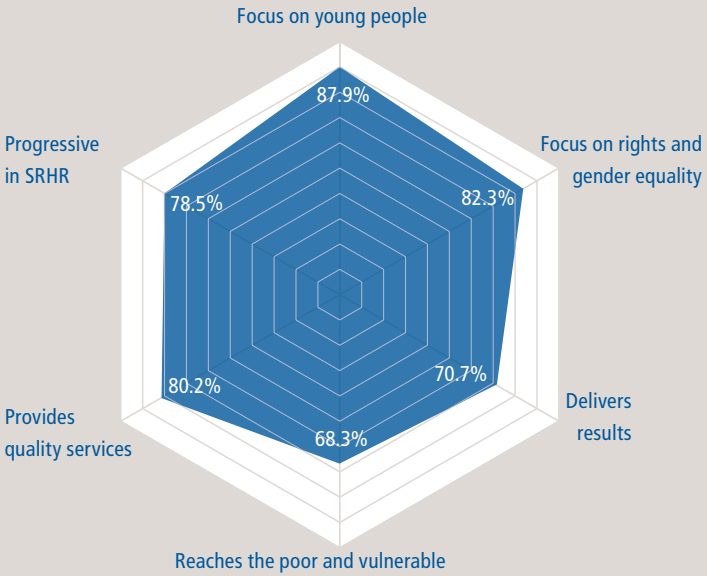


Figure 20: Organizational effectiveness

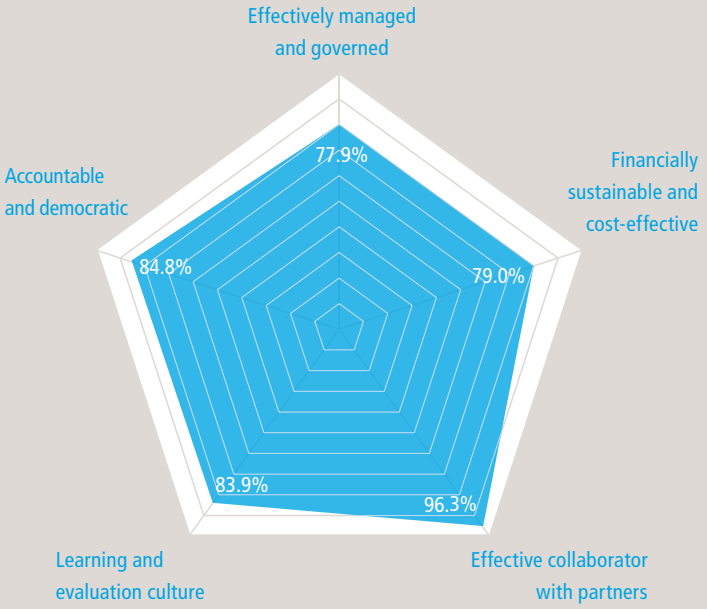
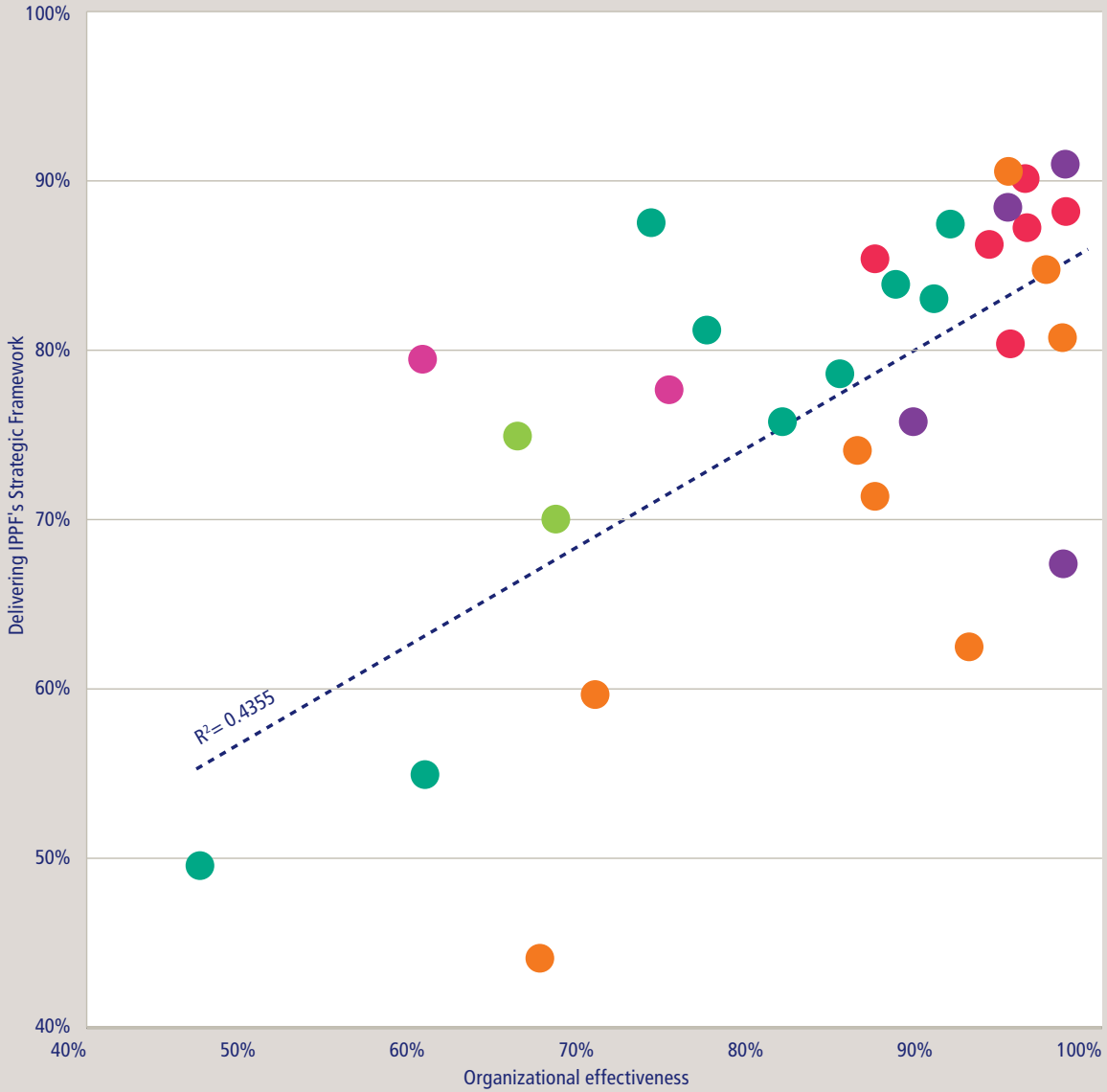


Figure 21: Percentage scores of value for money indices, by region*

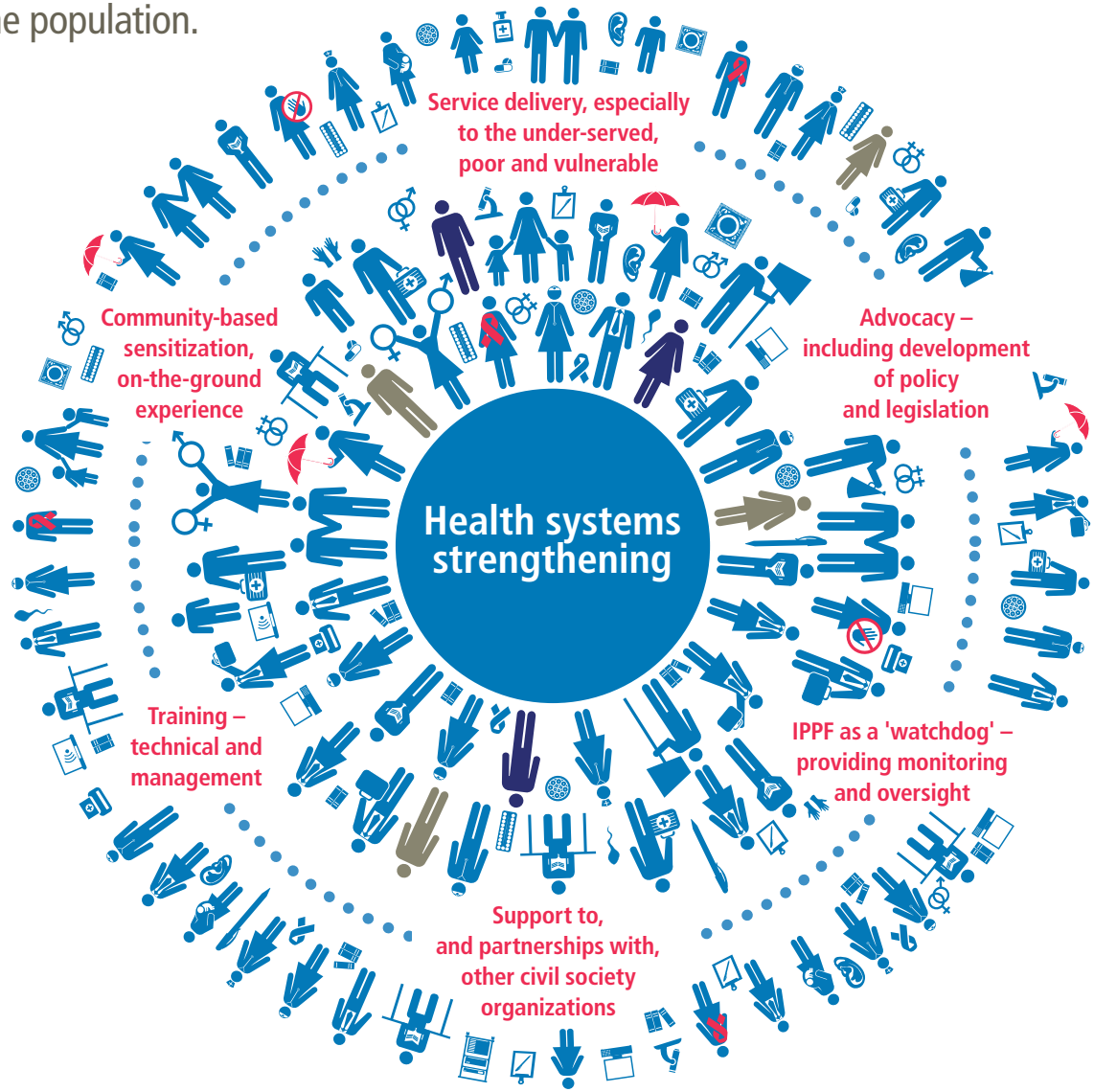


* Each dot represents a Member Association.

Health systems strengthening

In order for people to realize their rights to comprehensive sexual and reproductive health, systems must be in place, which are active, appropriate and accessible for all sectors of the population.

A health system includes organizations, institutions and resources devoted to ensuring and improving health. These health systems can be made up of various organizations both governmental and non-governmental. However, in many countries these systems are weak and under-resourced. IPPF works to strengthen health systems using a six-pronged approach (see opposite). Member Associations are helping to strengthen health systems through each of these approaches and specific examples of how, and where, Member Associations are providing support in each of these areas are highlighted in this section.



Service delivery, especially to the under-served, poor and vulnerable

Delivering effective, safe and quality services contributes to improved health and a good health system. However, many individuals and groups remain under-served, and their sexual and reproductive health needs are not met. IPPF plays a key role in ensuring services reach these people.

Working with vulnerable populations is one of IPPF's strategic goals and an estimated seven out of ten of the people Member Associations serve are poor, marginalized, socially-excluded and/or under-served, such as people living with HIV, people who have experienced gender-based violence and displaced populations (Box 22). Member Associations work with people who may not otherwise have

> "In any country, a 'well-performing' health workforce is one which is available, competent, responsive and productive."[20]
> World Health Organization

access to sexual and reproductive health services, including groups that governments may be particularly reluctant or unable to work with such as sex workers, people who use drugs, sexually diverse populations, men who have sex with men, and remote populations.

In many parts of the world, we are the only provider of sexual and reproductive health services and information. Member Associations use mobile clinics and outreach teams to reach under-served populations. Fifteen per cent of our clinic-based service delivery points are mobile clinics or outreach teams, examples of which can be found around the world:

- reaching the most isolated populations in **Mauritania** with the country's first-ever mobile clinics and teams of healthcare workers
- working in partnership with the government to provide sexual and reproductive health services to poor and marginalized populations in **Myanmar**
- delivering services to remote populations on the outer **Cook Islands**
- providing sex workers with sexual and reproductive health services and a safe place to meet in an extremely restricted area of northwest **Pakistan**
- providing much-needed sexual and reproductive health and HIV services and information for free to Burmese refugees in **Malaysia**

Box 22: Responding to humanitarian crises in 2011

A woman waits to receive treatment at an AIBEF camp clinic in Cote d'Ivoire.
IPPF/Nguyen-Toan Tran/Cote d'Ivoire

An estimated 65 million people worldwide are displaced due to conflict or natural/man-made disasters. IPPF's SPRINT initiative responds to humanitarian crises by providing life-saving sexual and reproductive health services to those affected, particularly women and girls.

During the recent conflict in **Côte d'Ivoire**, the Association Ivoirienne pour le Bien-être Familial (AIBEF) provided the following services (February to September 2011):

- 1,712 prenatal care
- 341 childbirth
- 174 STI treatment
- 25,361 condoms
- 1,352 contraceptives, including 110 implants and 46 IUDs
- 9 clinical management of rape

In **Tunisia**, the Association Tunisienne pour la Santé de la Reproduction responded to the influx of refugees from Libya by implementing the Minimum Initial Service Package for Reproductive Health in partnership with UNFPA in two camps near the Libyan border. During a two-month period in early 2011, the Association provided 9,063 services, these included sexual and reproductive health services, maternal and infant health services, psychosocial counselling, HIV testing and counselling and referrals to hospital for surgical procedures. Support and care for pregnant women and girls living in camps have been provided, including psychological support to help with difficulties caused by displacement.

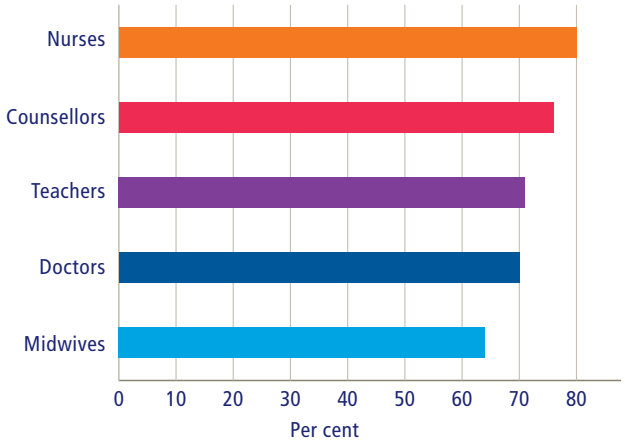
Training – technical and management

In many countries where IPPF works, there are shortages of trained health workers, especially those skilled in providing comprehensive sexual and reproductive health services. Member Associations are recognized for their expertise in sexual and reproductive health and rights. They play an important role, therefore, in helping strengthen the national health workforce to enable it to be more responsive and to deliver improved healthcare. Many Member Associations provide professional training and support to both public and private sector health workers, often at the request of the Ministry of Health (Figure 23).

Examples of how Member Associations provide this capacity building around the world include:

- running a nursing education course in **Hong Kong** that covers a wide range of sexual and reproductive health issues
- training public sector midwives from remote regions of **Senegal** on long-acting contraceptive methods
- training Ministry of Health employees in **Chad** on the Minimum Initial Service Package (MISP) for reproductive health in humanitarian situations
- training health professionals on the harm reduction model against unsafe abortion in **Argentina**
- training public hospital staff in **Ecuador** on the use of manual vacuum aspiration and pre- and post-abortion counselling

Figure 23: Proportion of Member Associations providing training, by profession, 2010



Community-based sensitization and on-the-ground experience

Member Associations use their expertise and experience at the grassroots level to work with community members and leaders to change attitudes and create a more supportive environment to enable access to sexual and reproductive health for all. The success of this community-based sensitization work is based on local expertise and is founded on human rights. Two examples of successful initiatives, funded by IPPF's Innovation Fund (Box 24), illustrate how results can only be achieved by having a presence on the ground, being close to the communities and inclusive and responsive to their needs, and finding ways to work in environments that are extremely hostile to the realization of sexual and reproductive health and rights.

In 2010, 70 per cent of Member Associations in Africa provided training for nurses and midwives, enabling them to deliver improved health care, especially to women in remote regions.

IPPF/Jane Mingay/Rwanda

"Extreme shortages of health workers exist in 57 countries; 36 of these are in Africa."[21]

World Health Organization

Cameroon National Association for Family Welfare (CAMNAFAW)

In Cameroon, same-sex sexual activity is punishable by up to five years imprisonment. Like many other countries in sub-Saharan Africa, social and religious values promote traditional gender roles and a rigid view of sexuality. Men who have sex with men, and, lesbians, gay men, bisexual, transgender and intersex (LGBTI) people face arrest, abuse and discrimination.

International estimates suggest that in low and middle income countries, men who have sex with men are 19 times more likely to be infected with HIV than the general population.[22] Yet despite this, sexual minorities in Cameroon rarely seek the medical support they need for fear of discrimination. Recognizing the urgent need to reach this group with specialized sexual and reproductive health information and services, CAMNAFAW set out, against the odds, to fill a critical gap in health care provision and sexuality education. This project presented both a big risk, as well as a huge opportunity.

The Association faced opposition at first, but by using their knowledge of the local environment, were able to respond to resistance from the government and the community in an effective and sensitive way. In communication with the government, they highlighted that Cameroon's constitution guarantees the right to health for all citizens. Through a series of sensitization and education sessions in bars and social venues, they increased young people's knowledge of sexual health and rights, dispelling myths and fears relating to gender identity and sexuality.

Another significant challenge was faced in reaching sexual minorities, who are unable to be open about their sexuality without fear of discrimination, and consequently are guarded against outsiders. Project staff identified and connected with a small number of leaders in the LGBTI community and recruited them to work as peer educators. They used personal networks to engage their peers and spread the word about the services and support being offered. This strategy was highly effective; within months, interest in both educational and clinical services rapidly increased and activities were scaled up to meet demand.

CAMNAFAW is now a trusted service provider among sexual minorities, and to date has provided over 4,000 confidential and non-discriminatory specialized health services. LGBTI people are also supported through a network of peer education groups to provide information on sexual and reproductive health issues and act as a forum to discuss experiences and share problems.

The success of this work has been recognized both regionally and internationally. CAMNAFAW has become a principle recipient of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and this is a clear indication of their expertise and increased capacity to provide specialized health services to at-risk, vulnerable populations.

> "I love the quality of the services provided and the warm welcome that we have at the clinic, where we are treated without being judged because of our sexual orientation."
>
> Project beneficiary

Box 24: The Innovation Fund

Ensuring universal access to sexual and reproductive health and rights in a world that is constantly changing requires innovative thinking and ground-breaking, in some cases, radical approaches. Through the Innovation Fund, IPPF has invested in many different types of interventions: addressing a sensitive issue for the first time; involving those affected by a problem in a fully participatory way; and taking risks that might result in failure, but nonetheless, contribute to the body of knowledge on what works and what doesn't work.

Since 2005, the Innovation Fund has tested approaches in response to both old and new problems in sexual and reproductive health and rights. Driving innovation from the ground up, Member Associations use their local, in-depth knowledge and expertise, and work in close partnerships with communities to design and implement new approaches that respond directly to unmet needs. They are also able to adapt quickly and incisively when progress is hampered. Many Innovation Fund projects focus on meeting the needs of the most vulnerable, and a key determinant of success has been the inclusive nature of engaging with the people they aim to serve.

the innovation fund

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

In Islamabad, a group of young women, their faces covered, sat before an audience of parliamentarians, policy makers and journalists. Each spoke courageously of their experience of Swara, the 'trading' of young women and girls as compensation for a crime committed by a family member. Used as a traditional dispute resolution mechanism in some areas of Pakistan, the practice is now illegal. However, informal tribal elders' councils, called Jirga, operating in parallel to the national legal systems, still consider Swara a legitimate form of justice.

The consequences for the girls and young women traded in the name of justice are serious. Most girls given in Swara are children, forced into marriage at an early age. They are vulnerable to sexual exploitation and early pregnancy, and consequently at a high-risk of maternal mortality, sexually transmitted infections and HIV. The girls have no autonomy and are unable to visit a doctor or nurse without permission.

Rahnuma-FPAP set out to challenge the acceptance of Swara and gender-based violence in the North-West Frontier Province of Pakistan, and provide access to services for survivors of these crimes. The strategies for intervention were designed in keeping with the tribal setting of the area, where Jirga law prevails. Rahnuma-FPAP recognized the need to work closely with Jirga members and religious leaders, as well as with mothers-in-law and female teachers. Mothers-in-law, who play an important role in decision making at the family and household level, were reached through sensitization programmes on a range of issues relating to gender equality and sexual health. A group of women activists have now become committed to reducing Swara and gender-based violence. This group has facilitated the provision of a comprehensive package of sexual and reproductive health services, information and counselling through mobile service units. In 2010, the project provided over 50,000 services and helped 211 Swara girls, 283 survivors of gender-based violence and 319 child brides.

A participatory approach involved Jirga members and religious leaders in project planning, ensuring full buy-in. Sensitization sessions and education materials based on Islamic teachings were used to inform religious leaders, Jirga members and 'Ulemas' (Islamic legal scholars) on gender-based violence, Swara, and sexual and reproductive health. The involvement of male community leaders was central to the project's success, and their endorsement made it possible to influence community attitudes and practice. Eighteen fatwas banning Swara have been issued by religious leaders of different ideologies, and 64 Jirga members now oppose Swara.

The forum in Islamabad enabled these young women to tell their stories for the first time, and the response from the audience was overwhelming, the practice of Swara must be stopped.

> "I was given in Swara when I was 14 years old. The man I was given to has married another woman. He has sold my daughters and beats me regularly for resisting prostitution."
>
> Participant at the forum in Islamabad

Support to, and partnership with, other civil society organizations

In addition to building the capacity of the health workforce, Member Associations are often called on to provide support to other civil society organizations working to promote sexual and reproductive health and rights. We also often become involved in partnerships which enable activities that would not be possible if done alone. One example is the 'People living with HIV Stigma Index' which was instigated by IPPF and other organizations,* and is an example of how working in partnerships can result in better health outcomes throughout a country.

The Index is a tool that monitors the degree of stigma experienced by people living with HIV, and each national study is led by a network of people living with HIV, in partnership with UNAIDS, a research institution and a Member Association.

- In **India**, a diverse group of people living with HIV were trained in research skills and they have gone on to document the experiences of other people living with HIV. United by a common research agenda, they now take on the role of watchdog to support universal access to HIV prevention, treatment, care and support.

- In **Sudan**, the results of the Stigma Index study are being used by the government to prioritize the sexual and reproductive health of people living with HIV in its five-year strategic plan.

* The International Community of Women Living with HIV/AIDS (ICW), UNAIDS and the Global Network of People living with HIV.

Another reason for working in partnership with other organizations when endeavoring to support health systems strengthening is that it is more efficient to work with already existing organizations rather than creating new ones when trying to reach a new target group. This has been particularly useful when working with hard-to-reach groups such as men who have sex with men (MSM) and other sexually diverse groups.

- A project in **China** that partnered with existing community groups for MSM, built the capacity of group leaders to act as champions, and established a network between the community groups for greater collaboration and the sharing of resources, tools and good practices.

- In **Venezuela**, partnering with existing groups that worked with sexual minorities ensured the efficient use of resources to reach as large a number of people as possible. This meant that people of diverse sexual orientations were able to gain access to a wide range of non-discriminatory sexual health services provided through a network of organizations.

IPPF as a 'watchdog' – providing monitoring and oversight

At the centre of an effective health system is good leadership and governance. Many Member Associations work with governments to strengthen their political will and commitment to sexual and reproductive health and rights. The Member Associations' credibility as experts enables them to act as 'watchdogs' to ensure that governments are held to account on their sexual and reproductive health commitments.

Examples of Member Associations taking on this role can be found across the world, and in the Western Hemisphere Region and the European Network, eleven Member Associations are holding their respective governments accountable for their commitments to achieve universal access to reproductive health (MDG 5b) through the five-year project 'Joining Forces for Accountability'. In **Albania**, the Member Association has pushed for the Ministry of Health to create a working group on sexuality education that includes representatives from the Ministry of Education, other civil society organizations and specialists in the field.

To expand this work on budget transparency and reproductive health even further, the Western Hemisphere Region is partnering with the International Budget Partnership (IBP) in five Latin American countries (**Costa Rica**, **El Salvador**, **Guatemala**, **Panama** and **Peru**) to assess the transparency of maternal health budgets through country-level partnerships between sexual and reproductive health organizations and budget groups. Together, these organizations first defined the actions that governments have committed to, then together with IPPF and the IBP, they identified which budget lines needed to be monitored to see whether or not governments were actually investing in those commitments.

To date, the main achievement has been that, in all countries, there was an improvement in terms of availability of information on the budget allocated to maternal health. The information gathered in the different countries allowed for the development of both general and specific recommendations in each country.

Advocacy

One area in which Member Associations support health systems strengthening is by advocating at a national level to achieve enabling environments and supportive legal frameworks for their countries' health systems to work within. This has led to 330 legislative and/or policy changes in the past six years, including blocking legislation that would be harmful to sexual and reproductive health and rights. More information on this can be found in the section on Advocacy on page 26.

In addition, many Member Associations take on the role of convening coalitions to work collectively with other organizations to bring about environments that support sexual and reproductive health and rights. For example, in **Palestine**, abortion is only legal when it endangers the life of the mother, but each case must be approved by a committee of seven doctors and one 'mufti' (Islamic scholar). The Palestinian Family Planning and Protection Association, in response, established a coalition that involved non-governmental and community-based organizations, as well as academics, to tackle the issue of unsafe abortion. The Association conducted intensive training with coalition members on post-abortion care and the legal framework in Palestine, to raise awareness of unsafe abortion. The coalition is also working to modify the national abortion legislation to allow for abortion in a wider variety of circumstances. ■

Member Associations advocate for new policies and laws; once in place, they monitor and provide training to ensure effective implementation.

Advocacy

Recognizing that "very few big societal changes happen without some form of advocacy,"[23] IPPF continues to advocate for increased commitment to sexual and reproductive health and rights.

Advocacy is a broad term for the many ways in which we build up political, public and financial support for universal access to sexual and reproductive health and rights. Whether it is at international meetings, through campaign events or encouraging public debate, by keeping our issues topical we aim to bring about social change.

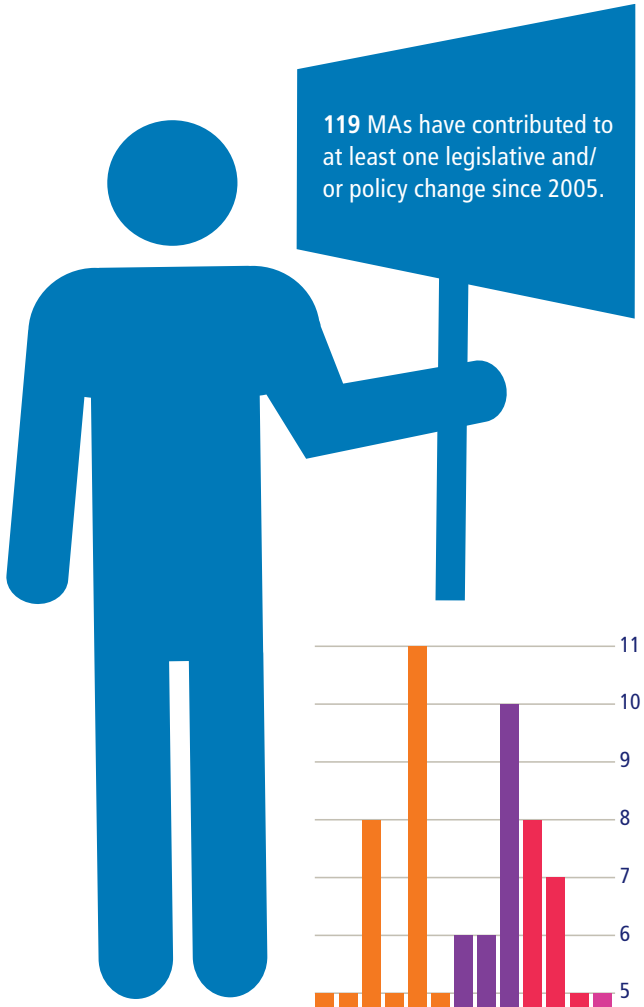
As advocates for health, choice and rights, IPPF offers a voice for those who so often go unheard. We believe that sexual and reproductive rights are human rights, and that they are indivisible, universal rights. Our advocacy work has resulted in a number of great successes. In 2010, Member Associations contributed to 47 policy or legislative changes in support of sexual and reproductive health, including defending previously hard-won positions. These changes resulted from partnerships with other organizations, and with support from the media, the sexual and reproductive health and rights movement, and the public. Over the last six years, Member Associations have contributed to legal and policy changes on a wide range of sexual and reproductive health issues (Table 25).

It is important to remember that successful advocacy efforts result from years or even decades of work in environments with vociferous and well-organized opposition forces, and only by standing resolute and indomitable in the face of setbacks are successes achieved. Not all Member Associations have contributed to a large number of advocacy successes in the past six years, measured as legal or policy change, but they continue to plan, persuade, invest and stand firm in their advocacy work focusing on changes that will make a significant difference to the sexual and reproductive health and lives of millions.

Table 25: Number of policy or legal changes on key themes, 2005–2010

Access to contraceptive services	37
Preventing gender-based violence	29
Access to safe and legal abortion	59
Support to people living with HIV	28
Education and services to young people	46
National budget allocations for sexual and reproductive health	21

"Most important has been learning how to do advocacy work as an organization. Now we're talking about making policy. Now we know how to deal with ministers, to consider them as our primary audience and use our energy to convince them. The Sexuality Education project opened the door for us to speak with the parliament."
Staff member, Nicaraguan MA



Since 2005, **13** Member Associations have contributed to five or more legislative and/or policy changes in support of sexual and reproductive health and rights, accounting for **86** of the **330** successful changes (**26** per cent).

Improving access to safe and legal abortion in the Ukraine

Through its active membership and coordination role on the Safe Abortion Working Group in Ukraine, Women Health and Family Planning (WHFP) successfully worked for three years to bring about a significant and positive change in the country's abortion law. In 2010, the Ministry of Health approved the working group's clinical protocol and guidelines on comprehensive care for unintended pregnancies, which focus on improved access to, and quality of, safe abortion – both of which were lacking in the previous legislation.

The rights-based protocol and guidelines ensure women have accurate information before and after abortion; access to counselling; increased access to manual vacuum aspiration, which is much cheaper than medical abortion in Ukraine; and the ability to undertake the second phase of medical abortion at home. The guidelines include detailed descriptions of procedures and equipment, and information on counselling, patients' rights and confidentiality.

These new rights-based components did not exist in the country's previous legislation, which instead focused on instilling fear in women who were considering abortion. This new legislation, therefore, will have a huge impact on the quality of abortion services provided and should dramatically increase women's and girls' access to these services.

Combating female genital mutilation in Uganda

In 2010, a law was passed in Uganda that allows for the conviction of people who carry out and/or promote female genital mutilation. Previously, there was no law in place to convict perpetrators, which made eradication of the practice difficult. Reproductive Health Uganda (RHU) played a vital role in supporting this important piece of legislation.

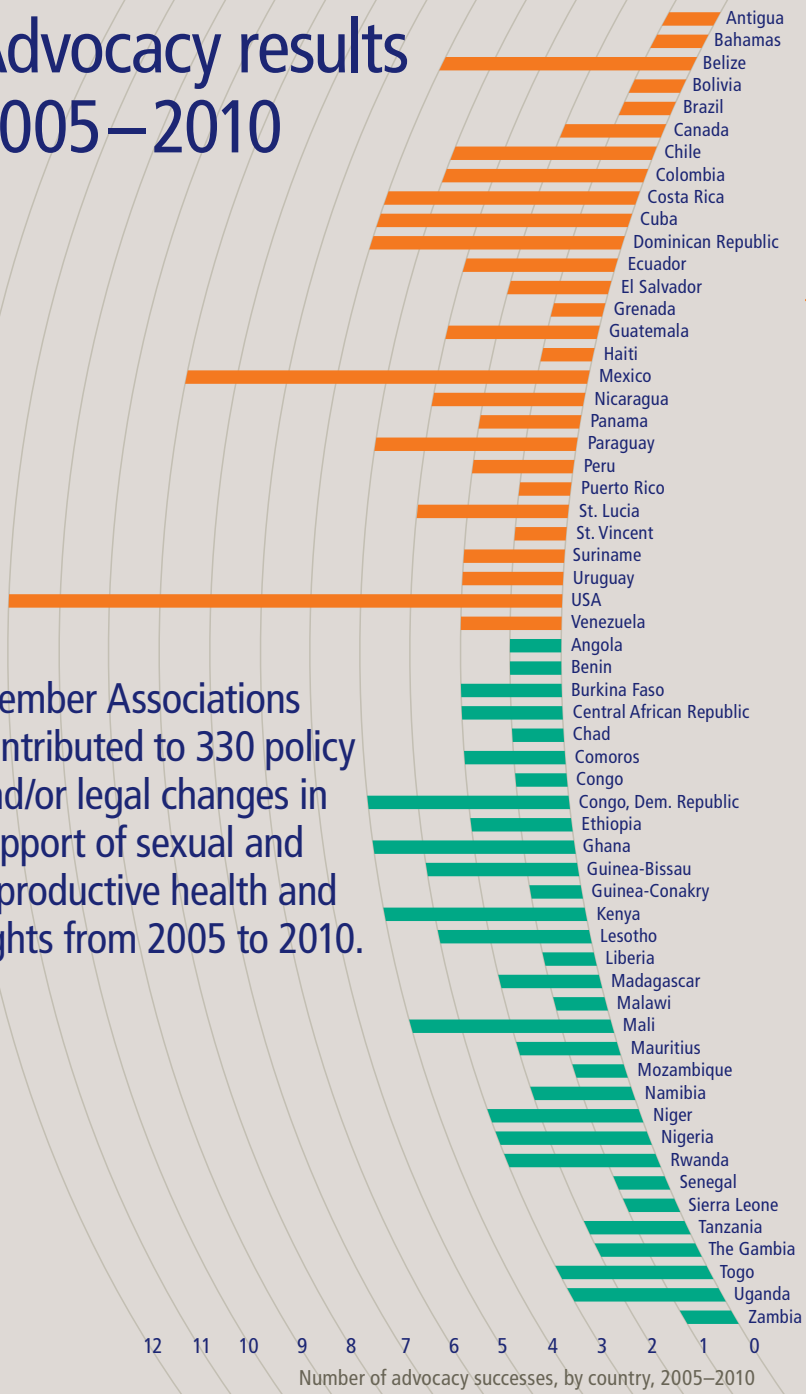
Working with other partners, RHU raised awareness of sexual and reproductive health and rights, mobilizing the local leadership of the district of Kapchorwa, where female genital mutilation was practised, to support a district council resolution calling for the enactment of a law prohibiting it. This involved three years of intensive community advocacy by the Member Association.

Working in partnership with the Network of Women Ministers and Parliamentarians, RHU also mobilized the support of members of Parliament to back a private members bill, tabled by an RHU volunteer on the prohibition of female genital mutilation, which resulted in the passing of the national law.

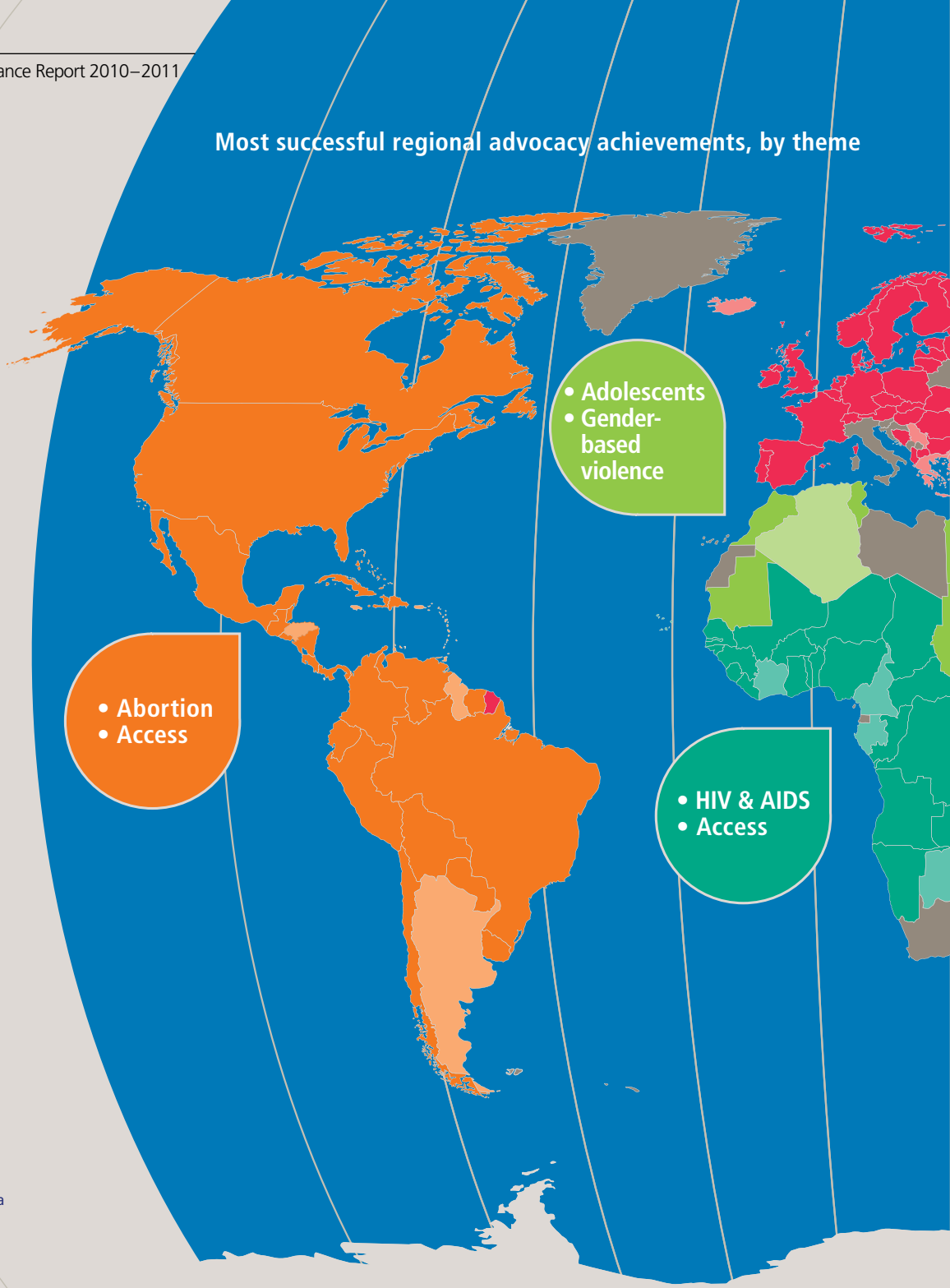
* 2005–2010.

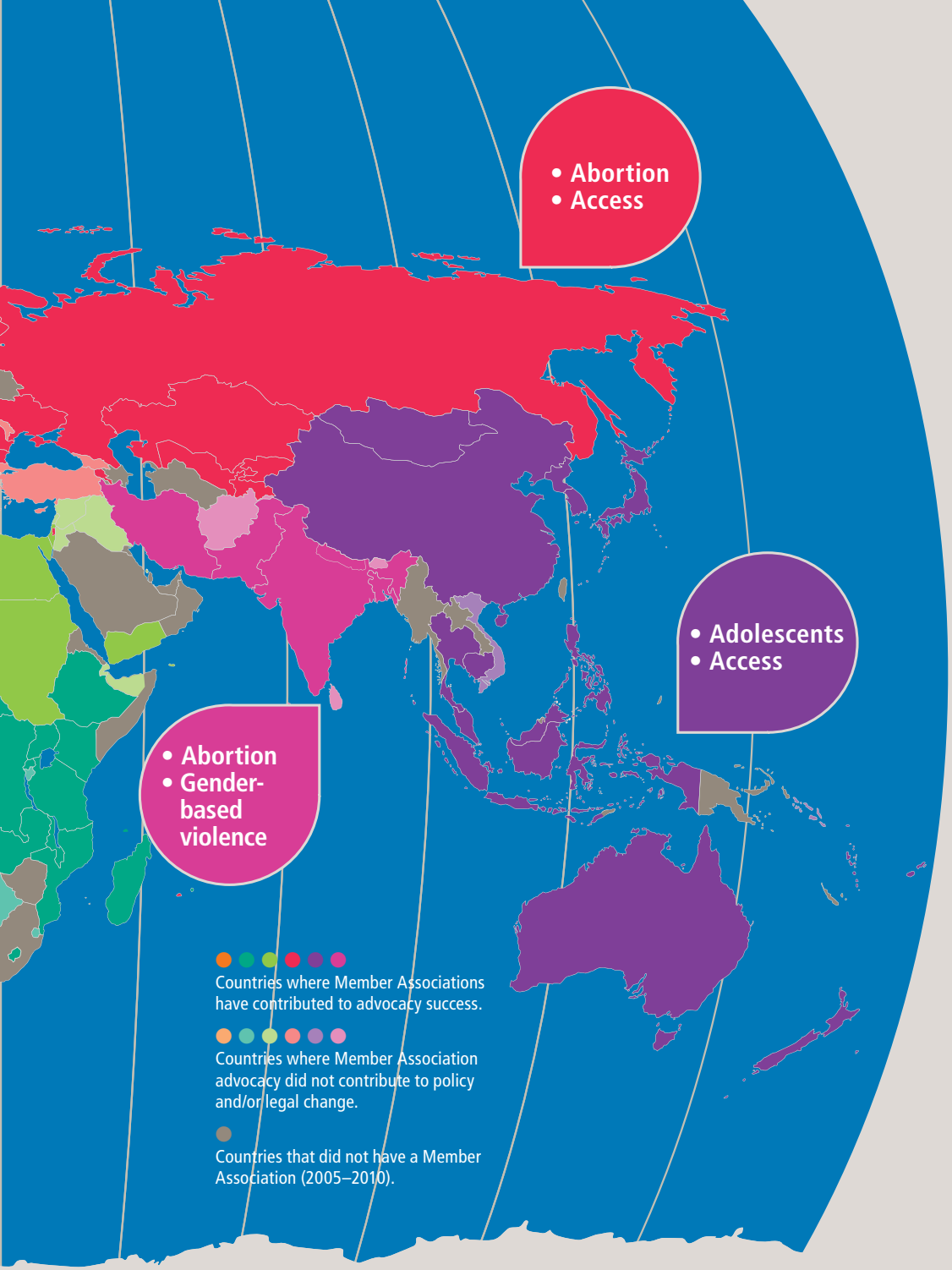
Advocacy results 2005–2010

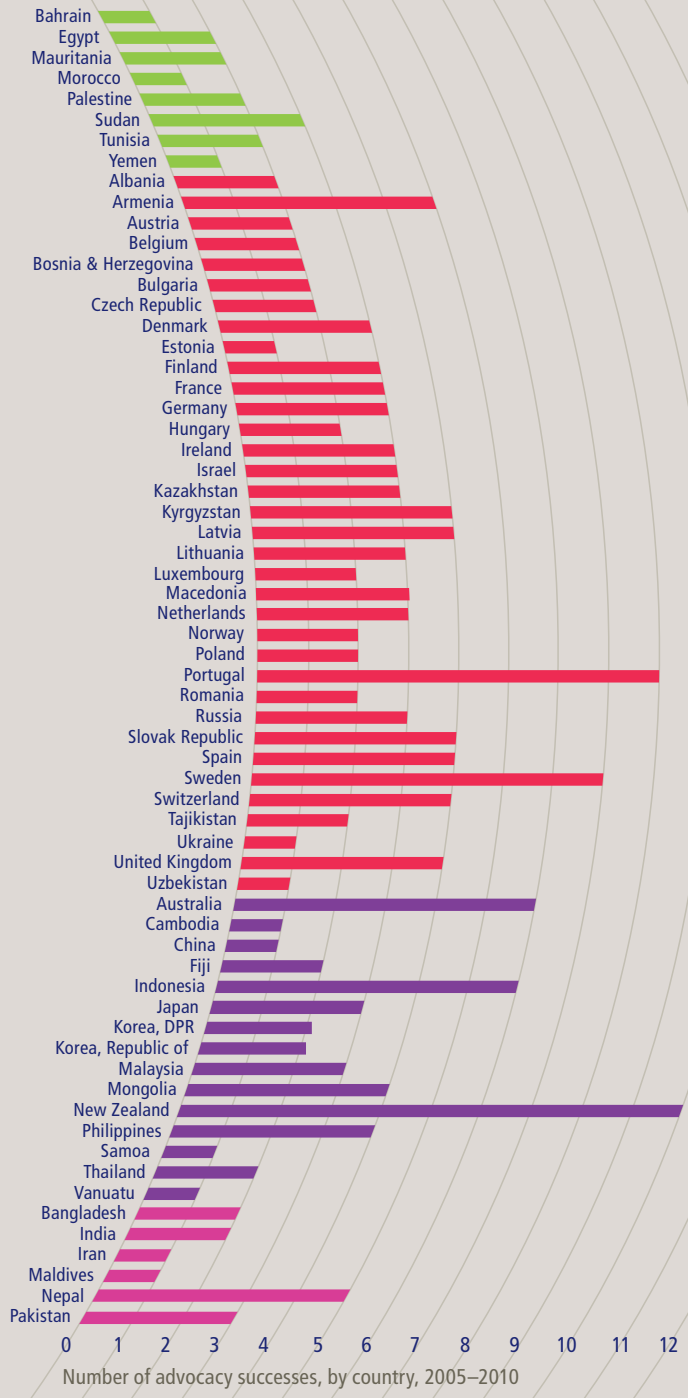
Member Associations contributed to 330 policy and/or legal changes in support of sexual and reproductive health and rights from 2005 to 2010.



Most successful regional advocacy achievements, by theme




• Abortion
• Access
• Adolescents
• Access
• Abortion
• Gender-based violence
Countries where Member Associations have contributed to advocacy success.
Countries where Member Association advocacy did not contribute to policy and/or legal change.
Countries that did not have a Member Association (2005–2010).


Bahrain
Egypt
Mauritania
Morocco
Palestine
Sudan
Tunisia
Yemen
Albania
Armenia
Austria
Belgium
Bosnia & Herzegovina
Bulgaria
Czech Republic
Denmark
Estonia
Finland
France
Germany
Hungary
Ireland
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Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Macedonia
Netherlands
Norway
Poland
Portugal
Romania
Russia
Slovak Republic
Spain
Sweden
Switzerland
Tajikistan
Ukraine
United Kingdom
Uzbekistan
Australia
Cambodia
China
Fiji
Indonesia
Japan
Korea, DPR
Korea, Republic of
Malaysia
Mongolia
New Zealand
Philippines
Samoa
Thailand
Vanuatu
Bangladesh
India
Iran
Maldives
Nepal
Pakistan
0 1 2 3 4 5 6 7 8 9 10 11 12
Number of advocacy successes, by country, 2005–2010

AS THIS REPORT HAS SHOWN, 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.

This young women's message about CIES (Centro de Investigación, Educación y Servicios – the Bolivian Member Association), "You are not alone, CIES is with you".

IPPF/Chloe Hall/Bolivia

Global indicators by region, results 2005–2010

Table A1: Online survey response rate

IPPF region	Year	Total number of Member Associations	Number of Member Association responses	Response rate (per cent)
Africa	2010	37	37	100
	2005	39	30	77
Arab World	2010	15	13	87
	2005	14	12	86
European Network	2010	41	41	100
	2005	40	31	78
East and South East Asia and Oceania	2010	22	22	100
	2005	20	17	85
South Asia	2010	9	9	100
	2005	8	8	100
Western Hemisphere*	2010	29	29	100
	2005	30	28	93
Total	**2010**	**153**	**151**	**99**
	2005	**151**	**126**	**83**

Table A2: Online service statistics module response rate

IPPF region	Year	Total number of Member Associations that provide services	Number of Member Associations providing data	Response rate (per cent)
Africa	2010	37	37	100
	2005	38	29	76
Arab World	2010	13	9	69
	2005	11	9	82
European Network	2010	22	18	82
	2005	33	2	6
East and South East Asia and Oceania	2010	22	22	100
	2005	19	14	74
South Asia	2010	8	8	100
	2005	8	8	100
Western Hemisphere*	2010	28	27	96
	2005	28	25	89
Total	**2010**	**130**	**121**	**93**
	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.

Table A3: Summary of adolescents indicators, 2005–2010

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	**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)**
		2009	73.0% (n=37)	45.5% (n=11)	35.0% (n=40)	50.0% (n=22)	44.4% (n=9)	59.3% (n=27)	52.7% (n=146)
		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	**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)**
		2009	4.1% (n=37)	5.3% (n=11)	3.5% (n=40)	9.1% (n=22)	5.5% (n=9)	4.9% (n=27)	5.4% (n=146)
		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	**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)**
		2009	97.3% (n=37)	63.6% (n=11)	90.0% (n=40)	95.5% (n=22)	77.8% (n=9)	96.3% (n=27)	91.1% (n=146)
		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*	**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)**
		2009	94.4% (n=36)	100.0% (n=9)	90.5% (n=21)	100.0% (n=22)	100.0% (n=8)	100.0% (n=26)	96.7% (n=122)
		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	**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)**
		2009	97.3% (n=37)	100.0% (n=11)	97.5% (n=40)	100.0% (n=22)	100.0% (n=9)	96.3% (n=27)	97.9% (n=146)
		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	**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)**
		2009	6,997,734 (n=36)	558,521 (n=9)	886,534 (n=21)	1,828,125 (n=22)	6,398,296 (n=8)	7,920,180 (n=26)	24,589,390 (n=122)
		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)

* The calculation of this indicator changed in 2010 and data for all other years were revised.

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

Table A4: Summary of HIV and AIDS indicators, 2005–2010

Indicator		Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
7	Proportion of Member Associations with a written HIV and AIDS workplace policy	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)
		2009	78.4% (n=37)	90.9% (n=11)	67.5% (n=40)	50.0% (n=22)	77.8% (n=9)	66.7% (n=27)	69.9% (n=146)
		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*	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)
		2009	70.3% (n=37)	18.2% (n=11)	10.0% (n=40)	36.4% (n=22)	55.6% (n=9)	55.6% (n=27)	41.1% (n=146)
		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)	31.0% (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	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)
		2009	81.1% (n=37)	45.5% (n=11)	47.5% (n=40)	59.1% (n=22)	55.6% (n=9)	55.6% (n=27)	59.6% (n=146)
		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	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)
		2009	94.6% (n=37)	72.7% (n=11)	65.0% (n=40)	81.8% (n=22)	100.0% (n=9)	77.8% (n=27)	80.1% (n=146)
		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	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)
		2009	97.3% (n=37)	63.6% (n=11)	47.5% (n=40)	68.2% (n=22)	88.9% (n=9)	74.1% (n=27)	71.9% (n=146)
		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	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)
		2009	1,842,362 (n=36)	243,089 (n=9)	257,734 (n=21)	1,287,806 (n=22)	1,240,324 (n=8)	4,440,585 (n=26)	9,311,900 (n=122)
		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	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)
		2009	29,563,740 (n=36)	788,493 (n=9)	1,495,101 (n=21)	7,885,122 (n=22)	31,554,421 (n=8)	81,110,317 (n=26)	152,397,194 (n=122)
		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 A5: Summary of abortion indicators, 2005–2010

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	**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)**
		2009	62.2% (n=37)	72.7% (n=11)	77.5% (n=40)	54.5% (n=22)	55.6% (n=9)	66.7% (n=27)	66.4% (n=146)
		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	**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)**
		2009	45.9% (n=37)	63.6% (n=11)	72.5% (n=40)	68.2% (n=22)	55.6% (n=9)	44.4% (n=27)	58.2% (n=146)
		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	**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)**
		2009	94.6% (n=37)	72.7% (n=11)	75.0% (n=40)	95.5% (n=22)	77.8% (n=9)	88.9% (n=27)	85.6% (n=146)
		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	**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)**
		2009	134,842 (n=36)	42,053 (n=9)	116,370 (n=21)	166,169 (n=22)	399,713 (n=8)	552,347 (n=26)	1,411,494 (n=122)
		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 A6: Summary of access indicators, 2005–2010

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	**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)**
		2009	100.0% (n=37)	81.8% (n=11)	82.5% (n=40)	95.5% (n=22)	100.0% (n=9)	92.6% (n=27)	91.8% (n=146)
		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	**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)**
		2009	67.8% (n=37)	43.0% (n=11)	35.0% (n=40)	75.1% (n=22)	80.6% (n=9)	63.6% (n=27)	68.6% (n=146)
		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)*	**2010**	**1,059,149 (n=37)**	**213,531 (n=9)**	**34,677 (n=18)**	**789,432 (n=22)**	**1,791,570 (n=8)**	**4,420,067 (n=27)**	**8,308,427 (n=121)**
		2009	947,633 (n=36)	194,560 (n=9)	34,330 (n=21)	547,989 (n=22)	1,738,252 (n=8)	4,848,736 (n=26)	8,311,500 (n=122)
		2005	510,891 (n=29)	318,963 (n=9)	4,809 (n=2)	460,076 (n=14)	1,789,096 (n=8)	3,097,667 (n=25)	6,181,502 (n=87)
21	Number of contraceptive services provided	**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)**
		2009	7,601,920 (n=36)	584,762 (n=9)	714,256 (n=21)	4,302,961 (n=22)	7,596,396 (n=8)	13,054,491 (n=26)	33,854,786 (n=122)
		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 to include emergency contraception.

Table A6: Summary of access indicators, 2005–2010 (continued)

Indicator		Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
22	Number of non-contraceptive sexual and reproductive health services provided	**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)**
		2009	6,739,116 (n=36)	1,164,508 (n=9)	1,340,377 (n=21)	3,840,778 (n=22)	5,843,298 (n=8)	15,662,364 (n=26)	34,590,441 (n=122)
		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*	**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)**
		2009	8,137 (n=36)	1,156 (n=9)	235 (n=21)	8,365 (n=22)	17,843 (n=8)	28,799 (n=26)	64,535 (n=122)
		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	**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)**
		2009	70.3% (n=37)	100.0% (n=11)	62.5% (n=40)	90.9% (n=22)	55.6% (n=9)	77.8% (n=27)	74.0% (n=146)
		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**	**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)**
		2009	91.9% (n=37)	87.5% (n=8)	64.3% (n=28)	90.9% (n=22)	77.8% (n=9)	88.0% (n=28)	83.7% (n=129)
		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 2010, these service delivery points included 8,219 clinic-based service delivery points and 55,470 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. 125 Associations reported to provide services in 2010).

Table A7: Summary of advocacy indicators, 2005–2010

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	**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)**
		2009	81.1% (n=37)	90.9% (n=11)	83.8% (n=40)	100.0% (n=22)	66.7% (n=9)	74.1% (n=27)	81.5% (n=146)
		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	**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)**
		2009	91.9% (n=37)	90.9% (n=11)	92.5% (n=40)	95.5% (n=22)	88.9% (n=9)	92.6% (n=27)	92.5% (n=146)
		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 national 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	**2010**	**9 (n=37)**	**2 (n=13)**	**12 (n=41)**	**8 (n=22)**	**2 (n=9)**	**14 (n=29)**	**47 (n=151)**
		2009	12 (n=37)	2 (n=11)	35 (n=40)	10 (n=22)	2 (n=9)	12 (n=27)	73 (n=146)
		2005	11 (n=30)	5 (n=12)	15 (n=31)	4 (n=17)	2 (n=8)	14 (n=28)	51 (n=126)
29	Proportion of Member Associations involved in counteracting opposition to sexual and reproductive health and rights	**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)**
		2009	91.9% (n=37)	81.8% (n=11)	90.0% (n=40)	77.3% (n=22)	88.9% (n=9)	81.5% (n=27)	86.3% (n=146)
		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	**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)**
		2009	94.6% (n=37)	81.8% (n=11)	80.0% (n=40)	90.9% (n=22)	55.6% (n=9)	77.8% (n=27)	83.6% (n=146)
		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 A8: Number of Couple Years of Protection (CYP) provided by region, method, 2005–2010

Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of responses	2010	(n=37)	(n=9)	(n=18)	(n=22)	(n=8)	(n=27)	**(n=121)**
	2009	(n=36)	(n=9)	(n=21)	(n=22)	(n=8)	(n=26)	(n=122)
	2005	(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	(n=87)
IUD	2010	182,672	179,001	8,075	167,591	440,129	1,224,150	**2,201,618**
	2009	195,598	155,096	14,578	224,595	396,120	1,793,761	2,779,748
	2005	116,991	260,117	3,115	209,969	422,618	920,189	1,932,999
Sterilization	2010	13,210	0	3,760	33,220	421,210	1,258,620	**1,730,020**
	2009	5,920	0	50	23,130	493,470	944,850	1,467,420
	2005	570	1,920	490	50,680	486,790	804,240	1,344,690
Oral contraceptives	2010	156,677	20,214	2,191	125,498	370,609	545,658	**1,220,847**
	2009	156,331	20,338	2,910	166,035	359,286	546,837	1,251,737
	2005	153,177	43,956	549	97,266	349,894	529,411	1,174,253
Condoms	2010	261,970	5,247	15,613	368,052	311,215	622,026	**1,584,123**
	2009	246,364	6,571	12,003	65,709	262,954	675,920	1,269,521
	2005	49,554	5,963	559	79,265	171,178	505,683	812,202
Injectables	2010	289,276	7,271	46	75,021	171,968	428,810	**972,392**
	2009	261,291	7,022	20	60,490	164,409	366,107	859,339
	2005	186,277	4,860	47	19,502	128,048	229,295	568,029
Implants	2010	144,210	385	3,475	17,299	14,616	216,247	**396,232**
	2009	63,408	4,235	3,003	5,195	10,633	342,551	429,025
	2005	460	154	0	1,778	202,755	72,714	277,861
Emergency contraception	2010	1,303	391	86	1,287	61,823	122,960	**187,850**
	2009	944	130	455	1,224	51,380	109,716	163,849
	2005	433	4	8	33	27,193	32,754	60,425
Other barrier methods	2010	9,816	1,022	1,432	1,374	0	907	**14,551**
	2009	17,757	1,168	1,302	1,597	0	66,630	88,454
	2005	3,429	1,989	37	1,583	620	1,139	8,797
Other hormonal methods	2010	15	0	0	90	0	689	**794**
	2009	20	0	9	14	0	2,364	2,407
	2005	0	0	4	0	0	2,242	2,246
Total	2010	1,059,149	213,531	34,678	789,432	1,791,570	4,420,067	8,308,427
	2009	947,633	194,560	34,330	547,989	1,738,252	4,848,736	8,311,500
	2005	510,891	318,963	4,809	460,076	1,789,096	3,097,667	6,181,502

Table A9: Number of sexual and reproductive health service provided (excluding contraceptive services) by region, by service type, 2005–2010

Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of responses	2010	(n=37)	(n=9)	(n=18)	(n=22)	(n=8)	(n=27)	**(n=121)**
	2009	(n=36)	(n=9)	(n=21)	(n=22)	(n=8)	(n=26)	(n=122)
	2005	(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	(n=87)
Gynaecological services	2010	450,223	381,383	88,872	1,115,931	900,651	7,023,958	**9,961,018**
	2009	343,265	282,125	130,822	1,087,132	697,667	6,863,782	9,404,793
	2005	40,251	186,848	19,574	268,416	307,972	4,495,533	5,318,594
Obstetric services	2010	847,062	294,653	20,794	871,826	1,679,951	2,841,509	**6,555,795**
	2009	448,979	216,447	231,230	694,239	1,590,360	2,244,005	5,425,260
	2005	90,330	234,384	8,376	208,030	778,263	1,466,688	2,786,071
Paediatric services	2010	261,267	35,891	230	77,559	856,439	277,427	**1,508,813**
	2009	401,197	44,966	903	5,492	774,812	301,601	1,528,971
	2005	115,399	117,808	0	149,644	285,503	276,682	945,036
Specialized counselling services	2010	3,082,671	223,702	753,106	914,430	867,061	802,455	**6,643,425**
	2009	2,907,778	257,718	595,784	302,734	663,423	739,302	5,466,739
	2005	20,237	31,591	4,859	45,446	264,425	552,064	918,622
STI/RTI services	2010	444,918	111,195	74,734	741,253	756,790	3,924,661	**6,053,551**
	2009	476,270	85,426	148,068	874,659	652,930	3,759,849	5,997,202
	2005	34,723	27,371	2,200	15,445	264,699	474,112	818,550
HIV-related services	2010	3,297,461	169,426	128,423	596,528	768,297	1,119,064	**6,079,199**
	2009	1,366,092	157,663	109,666	413,147	587,394	680,736	3,314,698
	2005	220,091	8,532	6,731	12,347	58,960	195,388	502,049
Abortion-related services	2010	132,580	38,401	101,222	149,821	333,630	793,465	**1,549,119**
	2009	134,842	42,053	116,370	166,169	399,713	552,347	1,411,494
	2005	25,044	3,333	339	39,797	137,142	13,574	219,229
Infertility services	2010	64,207	10,186	3,857	37,015	92,775	51,073	**259,113**
	2009	53,627	14,486	6,686	33,332	91,306	55,127	254,564
	2005	17,748	4,304	4,878	17,899	65,912	82,531	193,272
Urological services	2010	9,370	2,448	202	31,370	2,594	221,708	**267,692**
	2009	4,621	2,201	848	26,112	432	153,716	187,930
	2005	0	429	35	4,019	4,656	129,902	139,041
SRH medical services	2010	4,561,180	28,891	10,208	336,304	497,681	106,808	**5,541,072**
	2009	602,445	61,423	0	237,762	385,261	311,899	1,598,790
	2005	6,047	45,524	34	337,589	780,728	282,657	1,452,579
Total	2010	13,150,939	1,296,176	1,181,648	4,872,037	6,755,869	17,162,128	44,418,797
	2009	6,739,116	1,164,508	1,340,377	3,840,778	5,843,298	15,662,364	34,590,441
	2005	569,870	660,124	47,026	1,098,632	2,948,260	7,969,131	13,293,043

Table A10: Number of contraceptive services provided by region, by method, 2005–2010

Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of responses	2010	(n=37)	(n=9)	(n=18)	(n=22)	(n=8)	(n=27)	**(n=121)**
	2009	(n=36)	(n=9)	(n=21)	(n=22)	(n=8)	(n=26)	(n=122)
	2005	(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	(n=87)
Contraceptive counselling	2010	5,425,360	278,777	183,778	2,537,454	2,020,530	3,013,825	**13,459,724**
	2009	2,387,094	278,726	248,769	2,124,881	2,511,230	2,653,680	10,204,380
	2005	318,702	251,165	17,600	374,766	1,196,998	2,162,136	4,321,367
Oral contraceptives	2010	1,931,003	177,261	21,572	1,167,996	2,485,615	3,990,354	**9,773,801**
	2009	1,561,539	132,725	100,605	1,335,596	2,558,715	4,514,185	10,203,365
	2005	811,168	510,600	10,974	178,329	1,244,762	3,067,148	5,822,981
Condoms	2010	6,754,132	51,307	97,093	508,121	2,146,065	1,983,571	**11,540,289**
	2009	2,190,309	60,160	212,526	473,293	1,548,378	1,971,650	6,456,316
	2005	1,097,377	422	187	375,801	677,444	1,199,196	3,350,427
Injectables	2010	1,713,080	28,583	367	251,244	690,031	1,045,253	**3,728,558**
	2009	989,222	25,227	80,526	246,124	677,863	1,036,418	3,055,380
	2005	574,773	35,371	690	55,499	746,425	603,290	2,016,048
Emergency contraception	2010	449,990	29,352	11,748	34,140	248,313	2,214,773	**2,988,316**
	2009	26,980	2,328	7,302	7,086	29,995	1,564,430	1,638,121
	2005	28,855	1,084	155	667	3,886	38,173	72,820
IUD	2010	174,234	57,089	2,077	90,124	178,594	436,448	**938,566**
	2009	121,262	64,619	56,807	97,502	166,862	546,862	1,053,914
	2005	41,388	191,294	1,175	110,962	280,026	273,221	898,066
Voluntary surgical contraception (vasectomy and tubal ligation)	2010	1,352	0	411	4,895	82,493	348,020	**437,171**
	2009	1,639	52	5,583	3,851	81,554	205,633	298,312
	2005	147	592	268	14,705	131,697	139,282	286,691
Contraceptive referrals	2010	233,307	5,689	3,648	8,605	41,799	28,912	**321,960**
	2009	216,087	14,941	234	1,336	12,899	6,388	251,885
	2005	2,327	9,052	91	1,006	16,746	226,666	255,888
Implants	2010	92,199	709	233	10,532	15,634	165,424	**284,731**
	2009	58,185	1,695	120	4,204	8,893	222,647	295,744
	2005	16,137	381	9	1,633	82,517	56,090	156,767
Other hormonal methods	2010	184	0	2,200	901	0	244,279	**247,564**
	2009	206	0	124	286	0	249,667	250,283
	2005	0	0	114	0	0	3,304	3,418
Other barrier methods	2010	42,196	5,803	1,802	7,547	0	22,748	**80,096**
	2009	49,397	4,289	1,657	8,526	7	67,852	131,728
	2005	10	39,439	242	6,159	156	44,486	90,492
Awareness-based methods	2010	55	0	0	326	0	12,425	**12,806**
	2009	0	0	3	276	0	15,079	15,358
	2005	55,112	114,539	0	1,481	0	12,842	183,974
Total	2010	16,817,092	634,570	324,929	4,621,885	7,909,074	13,506,032	43,813,582
	2009	7,601,920	584,762	714,256	4,302,961	7,596,396	13,054,491	33,854,786
	2005	2,945,996	1,153,939	31,505	1,121,008	4,380,657	7,825,834	17,458,939

Table A11: Service results for consistently reporting Member Associations, 2005–2010

Type of service	2005 n = 72*	2010 n = 72*	Six-year percentage change	Six-year total (2005–2010)
Total sexual and reproductive health services (including contraception)	26,593,208	**63,202,670**	137.7%	**258,460,996**
Contraceptive services	14,564,995	**33,285,609**	128.5%	**139,869,853**
Non-contraceptive sexual and reproductive health services	12,009,022	**29,917,061**	149.1%	**118,591,143**
New users to modern methods of contraception	2,720,357	**4,147,466**	52.5%	**20,029,913**
HIV-related services	1,249,653	**6,129,159**	390.5%	**19,515,707**
Condoms distributed	94,842,803	**169,309,381**	78.5%	**740,921,622**
Abortion-related services	207,090	**608,146**	193.7%	**2,543,244**
Sexual and reproductive health services to young people	7,272,078	**24,273,964**	233.8%	**92,430,375**
Couple Years of Protection	5,886,922	**6,282,834**	6.7%	**36,787,072**
Number of pregnancies averted	1,471,731	**1,570,709**	6.7%	**9,196,768**

* Seventy two Member Associations have provided service data consistently for the six-year period 2005 to 2010. 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.

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Key abbreviations

AIBEF	Association Ivoirienne pour le Bien-être Familial
AIDS	Acquired immune deficiency syndrome
AR	Africa Region, IPPF
AWR	Arab World Region, IPPF
CAMNAFAW	Cameroon National Association for Family Welfare
CIES	Centro de Investigación, Educación y Servicios
CMIS	Clinic management information system
CSE	Comprehensive sexuality education
CYP	Couple years of protection
DFID	UK's Department for International Development
EN	European Network, IPPF
ESEAOR	East and South East Asia and Oceania Region, IPPF
FPAP	Family Planning Association of Pakistan
HDI	Human Development Index
HIV	Human immunodeficiency virus
IBP	International Budget Partnership
ICPD	International Conference on Population and Development
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MA	Member Association
MDG	Millennium Development Goal
MISP	Minimum Initial Service Package
MSM	Men who have sex with men
PEP	Post-exposure prophylaxis
RHU	Reproductive Health Uganda
SAR	South Asia Region, IPPF
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI/RTI	Sexually transmitted infection/Reproductive tract infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WHO	World Health Organization
WHR	Western Hemisphere Region, IPPF
WHFP	Women Health and Family Planning, Ukraine

Participants enjoy a lively discussion on sexual and reproductive health at the Palestinian Member Association.

IPPF/Steve Sabella/Palestinian Territories

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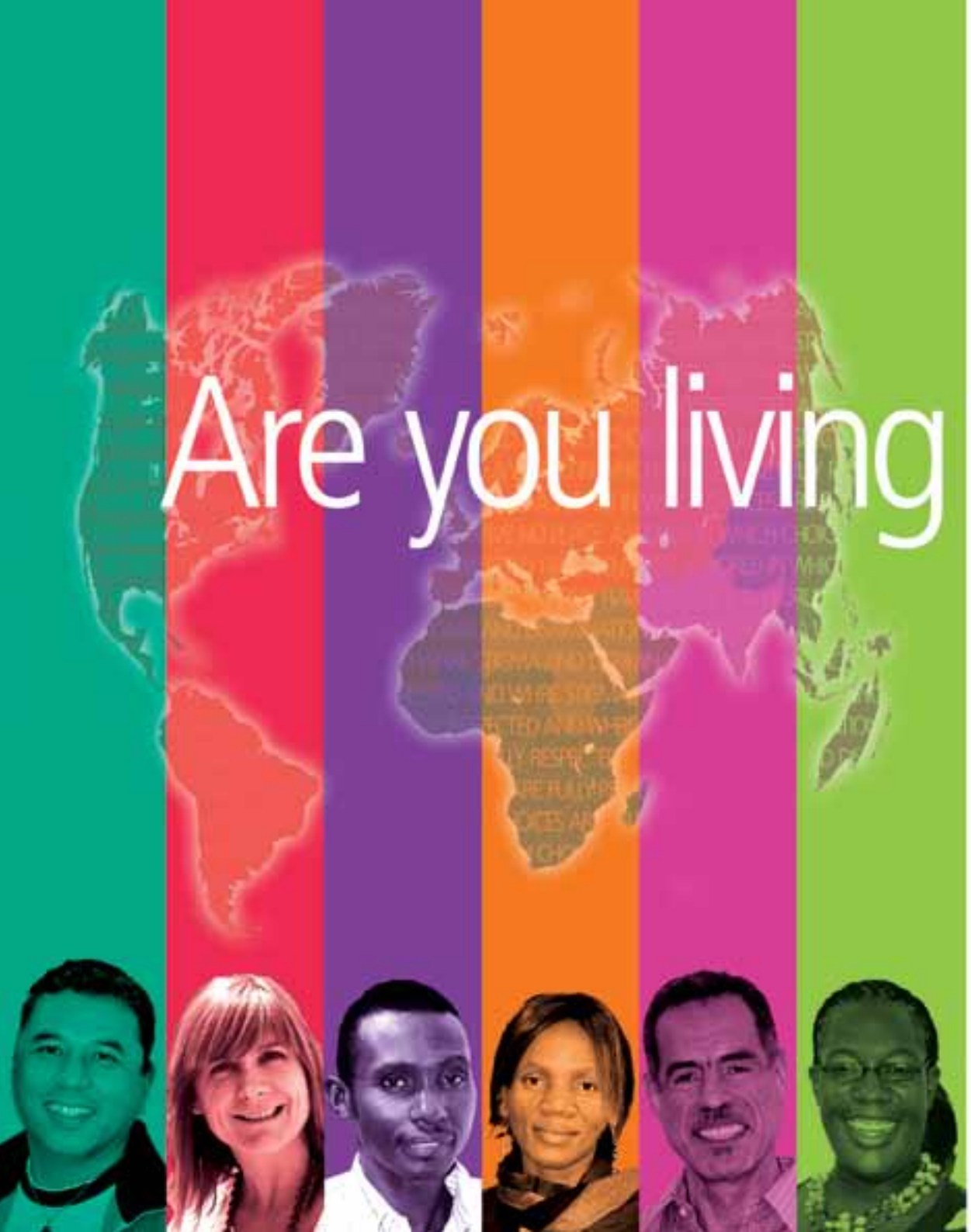

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IPPF+ is a growing group of people living with HIV who are working for and/or volunteering across the International Planned Parenthood Federation and its Member Associations. The group aims to provide a safe environment and support for all HIV positive volunteers and staff of the Federation.

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