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International Planned Parenthood Federation

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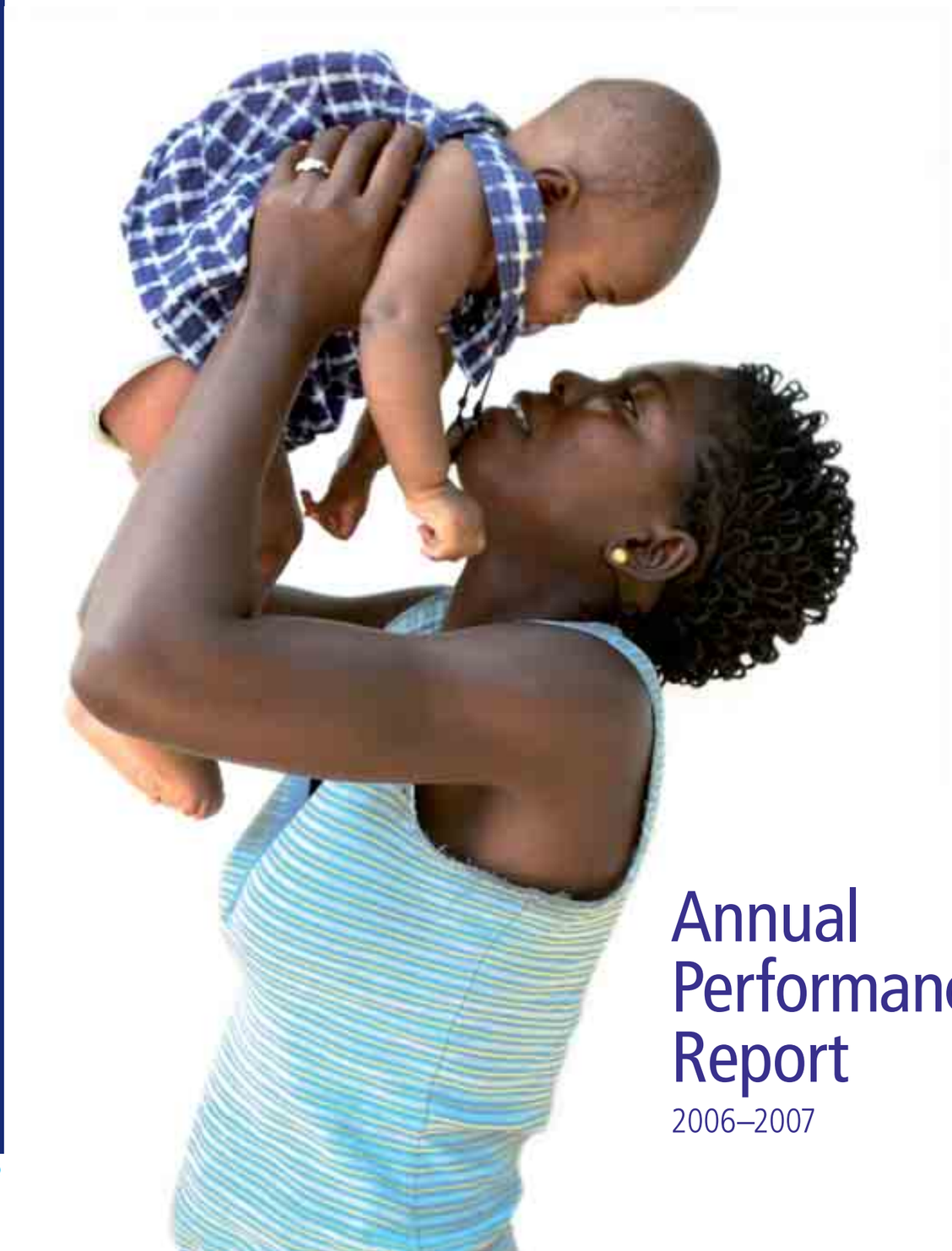
ANNUAL PERFORMANCE REPORT 2006–2007

IPPF

From choice, a world of possibilities



Annual Performance Report

2006–2007

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.

IPPF works towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

Acknowledgments

IPPF would like to express thanks to all who contributed to the Annual Performance Report 2006–2007. We are especially grateful to staff in our Member Associations and Regional Offices who provided the information used to document IPPF's important work in the field. The production of the Annual Performance Report 2006–2007 was coordinated by the Organizational Learning and Evaluation unit and Advocacy and Communications unit.

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Foreword by the Director-General

Sexual and reproductive ill health causes over one-third of the global burden of disease among women of childbearing age and without IPPF, this burden would be even greater.

Sexual and reproductive health issues, together with women's rights and empowerment, always challenge people's perceptions and call into question societies' stereotypes and structures.

I remain concerned about the strength of the opposition to sexual and reproductive health and rights around the world – particularly those people and groups opposed to the new Millennium Development Goals' target on universal access to reproductive health. There is an extraordinary lack of logic among those who fail to see that sex precedes reproduction, and that sexual and reproductive health and HIV and AIDS are part of a continuum of comprehensive care that must be planned for and funded accordingly.

During 2006, IPPF has continued to work tirelessly at the global level to help others recognize the ICPD goal of universal access to reproductive health in the Millennium Development Goals framework, with some success at UN meetings. IPPF has also played a lead role with partners in developing the Maputo Plan of Action which will, among other things, address the public health pandemic resulting from unsafe abortion in Africa.

IPPF responds to new demands for services every year, and in 2006 we pushed forward with our drive to integrate sexual and reproductive health and HIV and AIDS. Without this, we cannot hope to halt the pandemic, nor its increasing feminization and impact on young people and children.

This past year we have noted an increased demand for work with internally displaced people. Their heightened risk of violence, sexual abuse and rape, together with limited access to safe childbirth facilities and commodities to prevent unplanned pregnancies, sexually transmitted infections and HIV, make them extremely vulnerable. Member Associations are part of their communities and continue, even in times of conflict, to support them.

Often the critical role that civil society and non-governmental organizations, like our Member Associations, play is overlooked, both in delivery of services and in advocacy. They can go where governments cannot, and speak on behalf of those who cannot.

I am pleased to note that this year's Annual Performance Report reflects a higher response rate for our global indicators data across the Federation than last year. As an organization committed to continuous learning and improvement, we will continue to refine the indicators and improve the data. We have been happy to share the systems with non-governmental organizations who wish to adapt them, and to work with donors to incorporate them in agreements.

We recognize that IPPF's proud history does not create an entitlement to donors' funding. Rather we must be increasingly committed to making a difference to the lives of those we serve – the most vulnerable and marginalized. And we must develop better systems to monitor and evaluate our work, so we can plan and implement accordingly.

To achieve our mission, IPPF requires strong partners and donors. Our shared vision of a better world enables us to continue to be brave and angry but also increasingly effective and accountable. I thank them for this, and hope they will be with us for the even greater challenges ahead.

Dr Gill Greer
Director-General, IPPF

Executive summary

Many promises have been made to fulfil the unmet sexual and reproductive health needs of millions of women, men and young people around the world. The IPPF Strategic Framework was created to ensure that these promises translate from rhetoric to reality.

Introduction

IPPF's Annual Performance Report provides an overview of our performance during 2006. In the first chapter, six case studies are presented that highlight key programmatic achievements for the Five A's; adolescents, HIV and AIDS, abortion, access and advocacy. In chapter two, our global indicators results from 2006 are compared to the baseline indicators from 2005 to highlight where progress has been made. In chapter three, key initiatives undertaken throughout 2006 in the area of our four supporting strategies, governance and accreditation, resource mobilization, capacity building, and monitoring and evaluation, are presented.

Chapter one: Key achievements and lessons learned from the field

IPPF's Strategic Framework highlights the five priority areas that the Federation is focusing on between 2005 and 2015, and commits us to monitor our performance and the effects we have on people's lives. In this chapter, one case study from each of our six regions is highlighted. These are examples of some of our key programmatic achievements from 2006, and of the work that is taking place at grassroots level in partnership with communities and with other key stakeholders. The first case study on adolescents comes from the Burundi Member Association, and describes a project that addresses the complex needs of young survivors of sexual violence. The second case study describes an initiative to alleviate the negative impacts of HIV and AIDS in the Golden Triangle with Member Associations and partners from China, Thailand and the Lao People's Democratic Republic (Lao PDR) addressing the needs of young mobile populations and sex workers.

The third and fourth case studies examine work from two regions to address unsafe abortion. In the European Network, the capacity of Member Associations in Armenia, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan was strengthened to provide the Associations with the necessary skills and tools to improve the quality of abortion-related services in their own or their partner clinics. In the Arab World region, the Palestine Family Planning and Protection Association implemented a project in its clinics to raise awareness about the dangers of unsafe abortion and how to minimize its incidence, and to inform women of the instances when abortion is legally permitted.

In Bangladesh, the Member Association has increased maternal health services for poor women in rural areas through community development centres and reproductive health clinics which provide a comprehensive range of sexual and reproductive health services. Finally, the case study on advocacy illustrates how the Peruvian Member Association participated in an inter-institutional alliance to advocate for the development and implementation of comprehensive sexuality education guidelines within the Ministry of Education's national plan to improve the sexual and reproductive health of young people.

Chapter two: Global performance indicators

IPPF's thirty global indicators are used by the Federation to monitor progress in implementing its Strategic Framework 2005–2015, and to identify areas where investment needs to be focused in future years in pursuit of the Federation's strategic goals and objectives. The results are presented each year to IPPF's decision makers on Governing Council and on each Regional Council. The data also provide key information which is used by Member Associations to improve their own programmes, and by Regional Offices to identify where Member Associations most need technical support.

Global indicators data are collected annually from all of IPPF's Member Associations to measure the Federation's performance in implementing its Strategic Framework 2005–2015. Collection of these data across the Federation involves a major collaborative effort between Member Associations, both grant receivers and non-grant receivers, Regional Offices and the Central Office. All Member Associations are asked to complete an online survey, and those Member Associations that provide sexual and reproductive health services, are also asked to complete a service statistics module. These data are then reviewed and checked by the Regional Offices and again by Central Office before regional and global analyses are conducted. In 2006, 96 per cent of Member Associations completed the online survey (145 out of 151 Member Associations), an increase of 12 per cent from 2005. Of those Associations that provide sexual and reproductive health services, 80 per cent completed the online service statistics module (108 out of 135 Member Associations). This is an increase of 16 per cent from 2005, or 21 more Member Associations reporting in 2006 than in 2005.

In chapter two, the data from 2006 are compared with those from 2005 to indicate progress as well as highlighting areas where further investment may be needed. The results from 2006 confirm IPPF's position as a powerful global voice that advocates for improved sexual and reproductive health and rights, and as a major provider of high quality services that meet the needs of millions of poor, marginalized, socially-excluded and/or under-served people around the world.

Chapter three: IPPF's four supporting strategies

IPPF's Strategic Framework focuses on the Five A's and is supported by the four supporting strategies of governance and accreditation, resource mobilization, capacity building, and monitoring and evaluation, including knowledge management. Chapter three provides updates on key initiatives and developments from 2006 in these areas, as well as a financial review.

These management systems ensure that the goals and objectives in IPPF's Strategic Framework will be achieved by improving organizational effectiveness and increasing accountability. The first strategy supports strong governance and a global network of Member Associations that comply with essential standards. The second ensures that we raise the resources needed for our work. The third supporting strategy is concerned with building the capacity of our Member Associations to implement their programmes effectively. The fourth strategy ensures that we monitor, evaluate and learn from our work, and benefit from the experience and expertise that exists through the Federation's global network.

Chapter four: Next steps

The final chapter highlights some of the key areas that IPPF will focus on in the future.

Annex A: Global indicators by region

In Annex A, the results of IPPF's 2006 global indicators are summarized, and regional breakdowns for each indicator are presented.

Annex B: IPPF's income by region

Annex B presents an analysis of IPPF's income by region in 2006, according to the three sources of funding to Member Associations; IPPF, local and international income.

"IPPF will continue to be brave and angry, to challenge injustice, poverty and the denial of sexual and reproductive rights at every level."

Dr Gill Greer, Director-General, IPPF

Chapter 1

Key achievements and lessons learned from the field

IPPF's Strategic Framework highlights the five priority areas that the Federation is focusing on between 2005 and 2015, and commits us to monitor our performance and the effects we have on people's lives. In this chapter, six case studies, one from each region, are presented. These are examples of some of our key programmatic achievements from 2006, and of the work that is taking place at grassroots level in partnership with communities and with other key stakeholders. These programmes have been selected to illustrate our work in the five priority goals of adolescents, HIV and AIDS, abortion, access and advocacy.

Adolescents and young people

Goal: All adolescents and young people are aware of their sexual and reproductive rights, are empowered to make informed choices and decisions regarding their sexual and reproductive health, and are able to act on them.

Addressing the sexual and reproductive health needs of young girls who are survivors of sexual violence

Association Burundaise pour le Bien-Être Familial (ABUBEF), Burundi

Since 1993, Burundi has witnessed an unprecedented political crisis that has resulted in the loss of many lives, the degradation of the country's economy, and an erosion of the sense of solidarity that has traditionally been highly valued among the Burundi people. Many orphans, especially those children orphaned by war or by parents dying of AIDS-related illnesses, receive no financial assistance and are forced to live on the street. Other vulnerable groups such as widows, those who have physical disabilities and those affected by HIV and AIDS, are often discriminated against and do not receive support from the state. Of all the groups affected by the crisis in Burundi, women and children are the most affected.

This is particularly significant because Burundi culture promotes female dependence: young girls are raised to rely on their parents from an early age, and this trend continues when they become adults as married women rely on their husbands economically. Often, this dependence confines women to a life lived in the shadow of men; it puts women and girls at risk of sexual abuse and violence and prevents them from seeking help.

The political crisis in Burundi has also resulted in increased sexual abuse and violence against girls and young women, often by soldiers deployed throughout the country or by armed resistance groups.

Many of the survivors of sexual violence are under the age of 25, and as a consequence, the number of young women seeking abortions, young mothers, fatherless children and street children has increased drastically in recent years. Young female survivors face the shame, stigma and social rejection that is a consequence of sexual abuse in Burundi. Some of these young women move to urban areas in search of employment and a better life. However, roles such as domestic work may leave them even more vulnerable to further abuse and violence.

The IPPF Member Association in Burundi, Association Burundaise pour le Bien-Être Familial (ABUBEF), has been working to address the complex needs of young survivors of sexual violence in two sites, Bujumbura City and the Kayanza province. In Bujumbura City, the target areas were peripheral settlements most affected by attacks and destruction during the conflict. These densely populated areas serve as the preferred shelter for many rural exodus migrants. The Kayanza province was selected as an intervention site as it was also severely affected by war and violence. In addition, the nearby Ikibira forest served as a hiding place for former rebels, and Kayanza is a highly populated province, with more than 350 inhabitants per square kilometre.

The Member Association in Burundi collaborated with four other specialist organizations to implement the project ensuring a comprehensive approach, and providing technical expertise on sexual and reproductive health and rights, socio-economic and legal issues, advocacy and girls' leadership.

The two main objectives associated with addressing the sexual and reproductive health and rights of survivors of violence was to support 400 young girls affected by violence, inform them of their rights and establish mechanisms to protect these rights. ABUBEF also sought to raise awareness among community leaders on the issue of violence against young girls and empower the community to extend care to survivors of violence.

ABUBEF conducted and coordinated training with survivors of sexual violence on sexual and reproductive health issues, including prevention of HIV and sexually transmitted infections, and on life skills. The Association also trained community leaders, educators, administrative authorities and parents to help create a supportive environment for survivors and an overall reduction of cases of sexual violence. This training emphasized the importance of psychosocial care and legal counselling for survivors of sexual violence. Counselling and rehabilitation sessions were conducted with the survivors and home-based monitoring was undertaken to ensure that a supportive environment prevails in their daily lives. ABUBEF also established referral mechanisms to other service providers on issues such as legal advice and economic assistance.

Achievements

As a result of ABUBEF's participation in the project, 413 girls across both sites received trauma counselling and sexual and reproductive health services and education, including information about sexually transmitted infections and HIV. The project emphasized the importance of sexual and reproductive health information and served as a primary response to young survivors of violence and conflict. Sessions were held for the young women suffering from post-traumatic stress on a quarterly basis, and were supplemented by personalized counselling and psychological monitoring for cases of serious trauma.

In total, 320 victims received home visits from a counsellor or psychologist to assist with their psychosocial needs. Following the sessions, and the work done with parents and communities in supporting these young women and accepting them back into the community, most of the girls grew in confidence and were better informed to make decisions on important issues in their lives.

The girls who were identified as those most in need of professional training received training in jobs that matched their skills and interests including sewing, auto-mechanics, hairdressing, embroidery and catering. In total, 221 girls received professional training, and of these, many have used their skills to open workshops and implement small scale income-raising initiatives. As well as increasing economic independence, this type of training has restored the girls' assertiveness and self-esteem; many now enjoy more respect from their families and neighbourhood, and they are also able to meet the primary needs of their children.

The results achieved by the project can be illustrated and understood through the life of a 21-year old young woman from Bujumbura. Now a mother of a six-year old child, she was sexually abused by one of her teachers when she was in her ninth year of high school. After she became pregnant, she was expelled from school, ostracized by her neighbours and community, and evicted by her family. She was eventually taken in by a friend but during her pregnancy did not receive any antenatal care. She was looked after by a traditional birth attendant at home until it was clear that she was suffering complications during delivery. The birth attendant took her to the public hospital and left her at the gates knowing that the young woman would be unable to pay her hospital fees. The hospital did treat her and performed an emergency caesarean delivery, advising her that her body was not yet mature enough to be able to endure a natural delivery. The baby was born healthy; however, once the woman had recovered she was held in custody by the hospital for insolvency and only finally released two months later when a charity agreed to settle her hospital bills. When ABUBEF began to identify girls and young women who were survivors of sexual violence in Bujumbura, they included her in their project. ABUBEF provided counselling and worked with her family to sensitize them to their daughter's situation. She came back into her own family, received training in micro-credit, and is now supporting herself financially.

The project's legal counselling component has assisted 250 girls, and lawyers have counselled a further 79 girls. As a result of this legal advice, most young mothers have now registered their children at the Registry Office and cases of paternity search and alimony claims have been settled either amicably or in court. Others engaged in consensual marriage have started legalizing their marriage. The legal aspect of this project also plays a preventative role, as the availability of legal counsel to survivors deters potential perpetrators of sexual violence and abuse. This increased level of awareness was reflected in the participation of project partners in the 16-day long activism campaign to combat violence against women in Burundi during December 2006.

Sensitization and awareness sessions on violence against women and young girls were held in both provinces for community leaders, including 180 elected officers and religious leaders, 150 education officers, 33 administrative authorities, parents and traditional birth attendants. Administrative authorities recognized the urgency of preventing sexual violence and abuse and the importance of supporting survivors of violence. These leaders now address issues of sexual violence and abuse, as well as the psychosocial stress and economic situation of survivors, in weekly security meetings in each of their administrative districts.

Lessons learned

Despite the overall success of the project and a gradual decrease in the number of incidents of violence, coordinators recognized that there are a higher number of survivors in need of services than initially predicted. ABUBEF also realized that survivors of sexual violence and abuse are understandably more interested in material and financial support than their sexual and reproductive health and rights. However, this project has proven to be flexible enough to cover both aspects. Moreover, the importance of raising awareness of sexual rights and gender issues, as well as strengthening and encouraging leadership among young girls, has been highlighted by the project as key focus areas for the future.

In addition, counsellors lacked regular transportation to remote parts of the Kayanza province, and it was more difficult to support and work with girls in rural regions to build their skills and independence. Given the scarcity of land and the reluctance of parents or brothers to surrender their plots of land, young women are often prevented from farming to generate their own source of income. This illustrates the need to work with men in order to properly address the needs and rights of women, and to address the root causes of gender inequality and violence against women.

HIV and AIDS

Goal: Reduction in the global incidence of HIV and AIDS and the full protection of the rights of people infected and affected by HIV and AIDS.

Reducing transmission of sexually transmitted infections and HIV in the Golden Triangle

China Family Planning Association (CFPA), China

Planned Parenthood Association of Thailand (PPAT), Thailand

Lao Project Office, Lao People's Democratic Republic (Lao PDR)

The Golden Triangle is a part of the Greater Mekong region shared among the People's Republic of China, Lao People's Democratic Republic, Myanmar and Thailand. Injecting drug use is a significant problem in the area and many people move between the countries in search of improved economic opportunities. These factors contribute to a booming sex industry in the urban and border areas and to the high prevalence of HIV. The Mekong region currently accounts for around 1 million of the 6.6 million people living with HIV (PLHIV) reported in Asia and the Pacific,[1] and the region has many health-related, social and developmental challenges, the greatest of which is the HIV epidemic. The population has little access to HIV education, voluntary counselling and testing services, condoms or treatment for sexually transmitted infections. In addition, highly mobile groups may experience social exclusion and/or low levels of participation in the host community, a lack of health and support networks, and other cultural and linguistic barriers which result in reduced access to services.

To respond to the urgent need to alleviate the negative impacts of HIV and AIDS in the Golden Triangle, Member Associations have been working together to address the growing rates of sexually transmitted infections, including HIV. The China Family Planning Association (CFPA), the Planned Parenthood Association of Thailand (PPAT) and IPPF's partner in the Lao People's Democratic Republic (Lao PDR) implemented a comprehensive model of intervention involving HIV prevention and treatment of sexually transmitted infections. The project, named 'Dawn at Golden Triangle', targeted young mobile populations and sex workers in border provinces of the Golden Triangle; both groups having been identified as particularly vulnerable to HIV infection. Despite these groups indicating multiple risk factors for sexually transmitted infections and HIV transmission, they lack access to information and/or services that enable safer sex practices. The intervention aims to reduce HIV prevalence and stigma at the same time as promoting health seeking practices among these vulnerable groups.

Prior to the start of the project, a survey with the target populations was conducted to gauge HIV knowledge. The survey revealed that many young people perceived their individual risk for sexually transmitted infections and HIV to be low, despite a relatively high level of knowledge of HIV and AIDS among those interviewed. The survey also indicated a high level of misunderstanding of how HIV is transmitted, especially among people in the border provinces of China, Lao PDR and Myanmar. Many of those surveyed reported that they do not seek sexual and reproductive health services because of inadequate information about the services available, cost of services, long waiting times at service delivery points and discomfort in discussing sexual health issues. The survey also indicated that the leading causes of unsafe sex include influences from the media, peer pressure, and a level of personal risk that is perceived to be low.

The survey revealed that the most common sources of HIV-related information among the project's target populations were television, radio, government offices and peers. The project was therefore designed to utilize mass media and to adopt a social marketing approach for its information, education and communication (IEC) component.

The project established community committees comprised of representatives from the target groups, including migrants, sex workers and young people. These community committees worked together with community leaders and local service providers to increase awareness of HIV and AIDS, and to integrate sexually transmitted infection and HIV prevention programmes into existing systems linked to local authorities and institutions. Life skills training and comprehensive sexual education programmes were implemented to reduce prevalence rates of sexually transmitted infections and HIV among young people. Condom promotion campaigns directed at men and women were conducted to emphasize the dual benefits of condom use – infection prevention and contraception. A publicity campaign was also conducted involving mass media, (electronic and print) together with the distribution of other IEC materials on the types of services available at youth friendly centres to encourage the use of these centres.

Achievements

Increased awareness and sensitization

To increase awareness among targeted groups in the Golden Triangle, information, education and behaviour change communication interventions were hosted at service delivery points, and outreach activities were organized in border region communities. These efforts resulted in an

increased level of awareness of sexually transmitted infections and HIV and AIDS in all project sites. In China, the knowledge of HIV among community leaders and community committee members increased from 29.2 per cent to 95.6 per cent, and from 57.8 per cent to 68.4 per cent in Thailand. The Nanning project site in China documented similar success with a post-intervention survey among the employees of entertainment establishments showing an increase of HIV knowledge from 48.5 per cent to 90.1 per cent.

The project organized workshops for community committee members and community leaders to increase their knowledge of and sensitivity to HIV and AIDS-related issues, and hosted HIV and AIDS education workshops in the workplace for migrants and service women. The project also encouraged dialogue on male involvement in sexual and reproductive health issues by hosting a 'Man to man talk' for youth and community members in Lao PDR.

Through these activities, participants acquired a factual understanding of HIV and AIDS, and their opinions about issues related to HIV and AIDS shifted to reveal a positive change. Results in Thailand were particularly encouraging with 85.0 per cent of community leaders disseminating information on sexually transmitted infection and HIV prevention to people in their community, and another 56.0 per cent referred clients for voluntary counselling and testing (VCT) services.

Strengthened capacity

Project organizers developed courses and curricula to train service providers on sexually transmitted infection management, advocacy, behaviour change communication and voluntary counselling and testing. Training courses were also organized for community committee members on project management, advocacy and peer education. These training sessions involved project managers, service providers, peer educators, provincial and community leaders and members, hotline counsellors and village broadcasters. Project sites in China trained nearly 1,700 people, while Lao PDR and Thailand trained over 200 each.

Increased access

The project addressed the need for increased access to sexual and reproductive health services by increasing the number of outreach services available to target populations in the Golden Triangle, as well as offering counselling services. In Thailand, over 2,700 clients received care through the project's outreach services. Project staff advocated for integration of these services with existing health service systems and existing community institutions by hosting advocacy workshops and developing advocacy action plans.

Mobile clinics were encouraged to provide primary, as well as sexual and reproductive, health care to clients. This was a successful initiative as many migrants do not attend government clinics or hospitals due to linguistic, cultural, financial and/or legal barriers. In Lao PDR, the success of the project was reflected in the increased number of referrals to sexual and reproductive health service delivery points.

In China, owners of entertainment establishments were encouraged to support the objectives of the project by installing condom vending machines on site. To achieve this, project coordinators collaborated with the condom industry and the Department of Commerce to effectively market the condoms and install an initial ten vending machines. As a result of the success of this project, the Chinese government installed a further 380 condom vending machines in the city of Nanning. In these entertainment establishments, the use of condoms increased from 36.3 per cent to 89.0 per cent.

The project provided services in a friendly and non-intimidating environment. An outreach worker in China reported an incident where a woman who had been working in an entertainment establishment in Tengchong Tianhong suspected that she had a sexually transmitted infection. When she went to visit the hospital, she found the attitude of the doctor to be very judgemental so she self-medicated instead. Several months later she had still not recovered but did not dare to visit the hospital again. In April 2006, she heard about the Golden Triangle project when outreach staff in China visited her place of work. The staff arranged a health check up and she received the correct treatment. This woman now works as a volunteer conducting outreach and peer education in the district where she lives. "Your project has helped me know how to protect myself and taught me a lot about AIDS prevention; your services have made me well again." (Volunteer, Tengchong, Yunnan Province, China).

Challenges and lessons learned

There were many difficulties associated with trying to target a highly mobile population. These included difficulty in carrying out baseline and follow up assessments. The language barriers and literacy rates of the beneficiaries were also a huge challenge for the project. However, the cross-regional collaboration did help with overcoming language difficulties. Similarly, an innovative and creative approach to using many different forms of mass media in public communication

meant that the target groups were able to access information without relying on written or printed material.

The participating countries were involved in the project after the initial concept was finalized. In such a complex cross-border environment, the involvement of the countries at an earlier stage would have been ideal and provided a clearer perspective of the beneficiaries' point of view. For example, based on their observations in the field, the team from China would have placed more emphasis on the use of condoms and their information, education and communication outreach activities would have focused primarily on prevention.

Addressing the sensitive issues of HIV in China, Lao PDR and Thailand, choosing to target migrants, sex workers and young people and to implement the project in the Golden Triangle cross-border region, in a multi-national, multi-cultural and migratory environment, was a courageous initiative. The project provided access to sexual and reproductive health information and services for people who previously were not able or willing to access such services, either because they did not exist or due to a lack of confidentiality, perceived or real.

Drawing from pre-project survey results that indicated the importance of mass media in reaching mobile populations in the Golden Triangle, project organizers focused on developing creative communication materials that would engage the target audience. Pamphlets, radio broadcasts and audio tapes were recorded in different languages, a 24-hour telephone hotline was set-up and publicized, a World AIDS Day campaign increased awareness of HIV and AIDS, and sports activities were organized to get young people involved.

Those who collaborated on this project demonstrated a strong commitment to its success which was then reflected in the level of participation and support of local, district and provincial authorities, including both local and state level government agencies and unions, and other partner organizations. This involvement contributed significantly to the success of the project by encouraging stakeholders at all levels to increase their involvement in the project.

Many different organizations worked together with the Member Associations from China and Thailand and IPPF's partner organization in Lao PDR, including the Women's Federation, Youth League, Health Bureau and the Trade Union. These partnerships, collaborating so closely and capitalizing on their combined knowledge, experience and contacts, is an excellent example of the strength of teamwork and mutual learning. Despite the language barriers, the cultural, educational and professional differences, and the diversity of their backgrounds, the partners were able to combine forces and achieve shared objectives, and this has laid a solid foundation for future cross-border projects in the region.

"I live with HIV. I disclosed myself in Siangsaen, Thailand, and I also used the services there as I was not confident to reveal my status in Lao. Fortunately, one day the project mobile team came and visited me and explained how to get the services confidentially in Lao. I now attend and also participate in the group of people living with HIV there."

Client, 28 years old, Lao PDR

Abortion

Goal: A universal recognition of a woman's right to choose and have access to safe abortion, and a reduction in the incidence of unsafe abortion.

Promoting safe abortion in Central and Eastern Europe and Central Asia

'For Family and Health' Pan-Armenian Association (PAFHA), Armenia

Association HERA XXI, Georgia

Reproductive Health Alliance of Kyrgyzstan (RHAK), Kyrgyzstan

Tajik Family Planning Alliance (TFPA), Tajikistan

Uzbek Association on Reproductive Health (UARH), Uzbekistan

The project 'Promoting safe abortion in Central and Eastern Europe and Central Asia' is a regional five-country abortion initiative which began at the end of 2005.

Since the end of World War Two, women in these countries have had easy access to abortion paid for by social security. Liberal abortion laws remain in place in most of these countries and recognize a woman's right to abortion without restriction up to at least twelve weeks of pregnancy. However, the quality of abortion services in the region is a major concern and there is an unacceptable rate of morbidity and mortality associated with legal abortion. Widespread shortages of equipment and medications, crowded facilities, poor hygienic conditions, lack of training, use of outdated abortion technologies, inadequate standards and guidelines, and the fact that post-abortion contraception is often not provided, combine to create an unnecessarily low standard of care.

Despite the poor quality of abortion services there is a high abortion rate, very low use of modern contraceptive methods and declining fertility rates. The low income levels, the unmet need and high cost of contraception (rendering unsafe abortions a less expensive alternative), the acceptance of reliance on abortion for fertility control, and the attitudes of gynaecologists who view abortion as a good source of income, has led to abortion rates that are the highest in the world.

The aim of the project was to provide the Member Associations with the necessary skills and tools to perform needs assessments and to develop action plans for improving the quality of services among their partner clinics. The project builds the capacity of the Member Associations that do not have their own clinics, and they in turn work with their partner clinics in order to improve the quality of abortion services provided. As a result of this initiative, the IPPF European Network Regional Office and several of its Member Associations have developed and tested tools for assessing the quality of the abortion services provided in partner clinics.

Three regional workshops were conducted with Member Associations from Armenia, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan. The goal of these workshops was to ensure that the Member Associations and their partner clinics are able to act as national resources for promoting access to high quality, affordable safe abortion services.

The initial workshop was held in Kyrgyzstan and there were representative participants from all five countries involved. The workshop was attended by one Member Association staff, a medical doctor, a health manager, and a young female community worker – either a social worker or a woman involved with a women's organization – to represent the client perspective. The aim of the workshop was to improve the ability of the Member Associations to conduct a rapid assessment of the quality of available abortion services. Participants discussed what comprehensive high quality abortion services and care should look like and what tools could be used for rapid assessment on the quality of the abortion services provided. Training on organizing and facilitating focus group discussions was also conducted.

Participants in the workshop discussed the need for providing good quality abortion services in their countries, including tailoring care to each woman's individual needs, providing accurate, appropriate information and counselling, offering post-abortion contraceptive services, including emergency contraception, referring to or providing reproductive and other health services, and ensuring confidentiality, privacy, respect and positive interactions between women and health care staff. The final day of the workshop was devoted to finalizing the first draft of the tools, and agreeing on the next steps to be taken by the Member Associations. These steps included conducting a pilot assessment in a partner clinic in their respective countries to test the assessment tools and process.

Following the workshop, between February and March 2006, the five Member Associations conducted pilot assessments in their respective countries. A follow up workshop was then held in Armenia in March. The purpose of this workshop was to review the results of the assessment exercise in each of the countries, draw lessons from their experiences, and refine the tools and methodology based on these lessons. Following the completion of further assessments with partner clinics, including

meetings with local communities, a final follow up workshop was conducted in Brussels in October. This was attended by the Executive Directors of the five Member Associations involved in the project. At this meeting, the participants updated the group on the results from the rapid assessments and the plans of action for the partner clinics.

Achievements

The five Member Associations involved in this regional initiative have conducted assessments in several of their partner clinics. All of the five Member Associations have clear action plans to improve services offered through these partner clinics which reflect the feedback they have received from the communities they work with. In addition, Armenia, Kyrgyzstan and Tajikistan have decided to establish their own abortion clinics.

There is now a complete set of tools to aid Member Associations in assessing the quality of abortion services, including a user guide available in English and Russian. The participatory approach used in the development of these tools allowed the Member Associations to be involved in the process from the very beginning, getting their input and ensuring that each country's particular needs are met. In addition, the development of focus group discussions with clients of partner clinics, as well as the local surrounding communities, provided an opportunity to understand how the communities view the current services and what their needs are. The results of the assessments can be used as evidence-based advocacy tools both at the management level of the clinics as well as within local municipalities. The whole process provided the Member Associations with an entry point into the area of safe abortion and should help them to attract other donors and stakeholders to focus on the issues surrounding safe abortion. Furthermore, tools and lessons learnt from the IPPF Quality of Care initiative, which includes comprehensive service delivery guidelines, will be used to uphold the rights of the clients and the needs of the providers in the clinics that provide safe abortion services.

Educating women in Palestine on unsafe abortion

Palestinian Family Planning and Protection Association (PFPPA), Palestine

Abortion is severely restricted in the Occupied Palestinian Territories and viewed as being in contradiction with the prevailing religious strictures and policies in place. The termination of a pregnancy is only allowed if it constitutes a risk to the life of the pregnant woman or in cases of major fetal impairment. If a physician determines that abortion is the best option, the procedure must be performed in accordance with certain medical directives and under governmental supervision.

To overcome the prevailing restrictions around abortion, many women with unwanted pregnancies turn to private clinics to seek abortion services, or they resort to traditional methods at home. The restrictions on reproductive health awareness programmes mean that women do not have access to the information needed to make informed decisions about abortion or on their contraceptive options.

"Medical staff at our clinic increased their knowledge, especially on issues regarding modern methods of contraception and manual vacuum aspiration during the last workshop, organized by UARH. Specialists from Ipas offered their knowledge and experience. In practice, we have had the opportunity to use this method of safe abortion, especially in the early stages of pregnancy."

Doctor of UARH partner clinic – Center of Reproductive Health, Uzbekistan

This lack of access to adequate information, coupled with limited access to contraceptive methods, contributes to increasing rates of unsafe abortion in Palestine, especially in refugee camps where socio-economic conditions are generally poor.

Since abortions are severely restricted and performed either through private contacts or at home using traditional methods, data are largely unavailable. This makes it extremely difficult to track the current numbers of abortions, the conditions under which they are performed, and the impact on women's health. In addition, the Ministry of Health excludes private sector abortion-related data in its reports, and this means that the quality of the information available to service providers and to women seeking information on abortion is limited.

As a result, it can be extremely difficult for service providers to address abortion-related issues and develop educational programmes on unsafe abortion. For these reasons, the Palestinian Family Planning and Protection Association (PFPPA) implemented a project in its clinics to raise awareness about the dangers of unsafe abortion and how to minimize its incidence, and to inform women of the circumstances under which abortion is legally permitted. The project was integrated into the clinics' broader sexual and reproductive health education programmes that educate women on how to avoid unwanted pregnancies. The project also offered post-abortion counselling to inform women who have had abortions about the types of contraceptive methods available to them to avoid unwanted pregnancies in the future.

PFPPA conducted field visits to its clinics in different regions of Palestine, and after reviewing the data collected from community outreach sessions, they identified a lack of information on abortion-related issues among women throughout Palestine. Due to the sensitive nature of abortion in Palestine, PFPPA recognized the need to produce materials that address abortion-related issues through an approachable medium from which all women, regardless of socioeconomic status, could benefit. The result was a videocassette that includes interviews with women, and provides information on the physiological implications and complications of unsafe abortion.

To develop appropriate content for the video, PFPPA collected data from its clinics on the post-abortion services provided. Project organizers also identified two women who were willing to speak, albeit anonymously, about their individual experiences of having an unsafe abortion. The first woman discussed how her economic status affected her decision to attempt an abortion through traditional methods because she could not afford to attend a private clinic. To induce an abortion, she placed a heavy metal gas bottle on her abdomen and asked her children to jump on it. This resulted in bleeding and complications.

The second woman explained that she did not use contraceptive methods as she believed they caused infections and bleeding. Because of her reluctance to use contraception, she frequently became pregnant and aborted repeatedly using unsafe methods. Although she had learned during an awareness session that PFPPA talked to the community about contraceptive methods and emergency contraception, she was only convinced to visit a PFPPA clinic when one of her abortions resulted in illness, weakness and bleeding. She received post-abortion care and post-abortion counselling from PFPPA. After this counselling, she decided to have an IUD fitted and became a regular PFPPA client.

PFPPA's staff worked with Bethlehem Television to prepare the material for the video. In addition to the real-life client testimonies, the tape featured discussions with the Member Association's health educator, legal advisor and counsellor about abortion from their perspectives (legal, medical and psychological). The health educator offered a brief description of how a safe abortion is performed, and the legal counsellor reviewed the legal dimensions of abortion, as interpreted by the Ministry of Health and Palestinian law. The social worker discussed the importance of supporting post-abortion clients psychosocially through individual counselling sessions. The twenty-minute video concluded with a discussion of various contraceptive methods and emergency contraception.

Upon its completion in 2006, the video was distributed to PFPPA clinics and refugee camps to be used during awareness sessions. It was also provided to other organizations, both governmental and non-governmental, to be used in community awareness sessions, training sessions, meetings with decision makers, and religious leaders to increase advocacy for women's access to reproductive health information and services.

Achievements

PFPPA organized twelve workshop sessions in refugee camps to address the dangers of unsafe abortion and pregnancy prevention methods; the video was used in these workshops to supplement the curriculum and spark discussion among participants. In total, the video was shown to 265 women, aged 17 to 50 years. Workshop attendees responded well to the video and reported that they learned a great deal from the real-life cases featured in the film. Because abortion is such a sensitive issue in Palestine, participants felt that the video provided an important educational opportunity to learn about and discuss unsafe abortion and its implications. Nearly all of the women who attended the workshops valued this approach, especially as many knew someone close to them who had been affected by an unsafe abortion. A 33-year old woman who watched the video was married at 15 years old, and due to a lack of information about, and access to, contraceptive methods, she had undergone recurrent unsafe abortions. Her reaction after watching the video was that she would ensure that her own daughter would not be in the same situation, saying "Nobody prepared me for this life or gave me information about marriage, children, contraceptive methods and how to avoid pregnancy. I will now talk to my daughter and raise her awareness on this issue."

In addition to affecting individual women's perceptions about unsafe abortion, the video workshops helped PFPPA's project team to recognize where there was a greatest need for abortion-related education. For instance, the project team noted an increased demand for the workshops in the northern refugee camps and people in these camps requested that PFPPA host additional screenings. In the southern refugee camps, project organizers noted that attendees were more familiar with the topics, most likely due to the fact that PFPPA had more clinics and greater outreach in the south than in the north. However, attendees appreciated the new way this information was presented and felt that the video offered an effective way to spread information between communities in the region.

During these workshop sessions, field coordinators gathered detailed information about attendance, recorded the responses of attendees, and interviewed participants to ask about their feelings after viewing the video. Researchers also asked attendees about their perceived benefits from the film so that PFPPA could assess the effectiveness of the video as a learning tool. PFPPA now intends to produce another film that includes this material for use as an advocacy tool.

Challenges and lessons learned

Although it was difficult finding women who were willing to discuss their experience of abortion, the project and film conveyed the importance of educating and informing women on unsafe abortion, how to effectively utilize contraceptive methods to prevent unwanted pregnancies, and to be aware of how and when they are able to access safe abortion services if needed. In the future, PFPPA intends to collaborate with the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) to educate women in refugee camps about the dangers of unsafe abortion.

Despite the many taboos surrounding abortion in Palestine, the women involved in the project valued the increased information and accessibility of being able to hear other women's experiences by watching the video. A 30-year old woman living in a refugee camp in the north of the country said "I will now talk about this problem with every woman I know. I believed that this was only my problem and did not know that other women had the same experience. I now realize that it's a big problem and it is very important to spread this valuable information within my community." Similarly a 29-year old woman involved in the project who watched the video said "The size of the problem is big, but we don't talk about it."

In the future, interventions on abortion will focus more on providing accurate information on safe abortion, and on the support and care required for women seeking abortion. Comprehensive information will also be provided on the dangers of unsafe abortion, on how to minimize its incidence, and on the instances when abortion is legally permitted. In this way, the agenda can gradually move from concerns over morbidity and mortality to increasing access to high quality services and the protection of fundamental human rights.

Access

Goal: All people, particularly the poor, marginalized, the socially-excluded, and under-served are able to exercise their rights, to make free and informed choices about their sexual and reproductive health, and have access to sexual and reproductive health information, sexuality education, and high quality services including family planning.

Safe motherhood project: Increasing access to maternal health services for poor women in rural Bangladesh

Family Planning Association of Bangladesh (FPAB), Bangladesh

Bangladesh has one of the highest maternal mortality rates in the world, with 320 women in every one hundred thousand live births dying every year due to causes related to pregnancy and childbirth.[2] The high rates of maternal deaths in Bangladesh are caused by social, cultural and economic factors that severely limit access to sexual and reproductive health services for many women, and especially in rural areas.

A knowledge, attitude and practice survey was completed in March 2006 by the Human Development Research Centre. The survey entitled 'Increasing access to maternal health services for poor women in rural Bangladesh' was conducted in six sub-districts of Bangladesh, in the areas of Rangamati Sadar, Kaptai, Naniachar, Sylhet Sadar, Dharmapasha and Noakhali Sadar. The study identified the critical need for the provision and expansion of sexual and reproductive health services where several constraints relating to accessibility of services were identified. These constraints included a general lack of health facilities, women having to travel long distances to access services, lack of skilled health providers, a lack of knowledge among women regarding their health and low levels of knowledge and/or involvement of men in maternal and child health. Gender-based violence, a disregard for women's rights and little decision making capacity of women were some of the social issues affecting women's health and fertility that were highlighted in the study.

The key findings of this survey were used as baseline data for the FPAB project which aims to reduce the maternal mortality rates of poor and disadvantaged women in rural areas through increased access to sexual and reproductive health services. The survey highlighted low levels of knowledge both among the service users as well as the service providers, and a lack of services to poor women in these rural areas. Over 50 per cent of women of reproductive age in the project area did not have any information about modes of HIV transmission. Nearly one third of the service providers in the project area were not aware of the various components of sexual and reproductive health services and how to prevent unsafe abortion. Forty per cent of women with a history of gynaecological complications had to go to an unqualified provider to seek services. Fifty per cent of women of reproductive age believed that having a 'talisman' could cure a couple suffering from infertility and the same was true regarding misconceptions around sexually transmitted infections. In the project area, 95 per cent of deliveries took place at home.

In addition to low levels of knowledge and a lack of services, the survey identified a lack of knowledge around rights, and a pervasive abuse of women's rights. While menstrual regulation is quite an acceptable practice in Bangladesh, the study revealed that service providers are mistreating women who go for menstrual regulation services. Seventy per cent of women reported being subjected to gender-based violence. Ninety nine per cent of women did not know of any services for survivors of gender-based violence, and more than 50 per cent of women felt that their husbands were responsible for the delay in calling a provider for an obstetric emergency.

Achievements

There have been considerable achievements in the expansion of health services in the project area. Since the launch of the project in February 2006, 67 community development centres have been established and are fully functional. Over 20 skilled birth attendants have been recruited and trained on safe motherhood services by the National Institute for Population Research and Training. Six reproductive health clinics have been established, and are fully operational. The services provided at these six clinics include ante- and post-natal care, general curative health, counselling and advice on nutrition, hygiene, immunization, family planning, menstrual regulation, management of sexually transmitted infections and laboratory testing. In addition, 24-hour safe delivery services have also been started in three of the clinics at Noakhali, Sylhet and Rangamati Sadar. As Rangamati is within close proximity to Kaptai and Naniachar, the project has made transportation arrangements for clients residing in these areas to access safe delivery services and instrumental interventions such as caesarean sections, episiotomy and extraction of placenta at the Rangamati clinic.

The Family Planning Association of Bangladesh is providing maternal and child health services to the poor free of charge, and has improved access and quality for those whose main constraint is not necessarily financial. The project is using the IPPF and World Health Organization service delivery guidelines to guide service provision in all the clinics to ensure the highest quality of care. This is also the first time that comprehensive emergency contraception is being provided as part of sexual and reproductive health services in Bangladesh.

A pre-paid healthcare financing model to increase the accessibility of services by poor and marginalized rural women was developed and piloted in selected project sites. The majority of respondents (68 per cent) agreed to pay between 26 and 50 per cent of the costs of ante- and post-natal care. Twenty three per cent were willing to pay a quarter or less of the delivery cost, and a small proportion (5 per cent), were willing to pay between 51 to 75 per cent and above of the costs. This highlights the fact that accessibility is not solely an issue of economic status and money, but about availability and the manner in which the services are provided. The pre-paid healthcare financing model ensures that services are available and accessible by all women, regardless of their financial status by using a sliding scale voucher system. The poor clients therefore receive subsidized treatment, and the system also ensures that marginalized clients receive the same quality of care as other clients who may be making a financial contribution.

Challenges

The main challenge encountered by the project in the first year was the retention of service providers. These included medical officers, unit managers, obstetricians, gynaecologists and anaesthetists who are critical to the provision of emergency obstetric care. The high turnover was attributed to the remoteness of the clinic locations, and as a result, FPAB introduced flexible working hours and a special remuneration package for clinic staff to try to reduce the high turnover of technical staff.

To ensure the availability of emergency contraceptive services to all the six project locations, FPAB also undertook a mapping exercise to prepare a list of obstetricians and gynaecologists currently registered and available in the project areas. This was followed by one-to-one consultative meetings to ascertain their willingness and availability to provide reproductive health services in the project clinics. This process resulted in a formal understanding between FPAB and the gynaecologists for the provision of emergency contraceptive services in all clinics.

Lessons learned

The project invested heavily in creating community groups, changing the minds of local leaders, providing training to reproductive health promoters and in the establishment of community development centres. This has ensured project ownership by the local community and will contribute to its long term sustainability. The results of the participation are evident in terms of infrastructure support for establishing community development centres, increased attendance in the clinics, community spaces for organizing outreach sessions and management of community transport.

The project has also begun to work more closely with husbands and other male relatives of women. This is a direct result of seeing how many more women access the services if they have support from their husbands. Renu is 30-years old and has been married for 16 years. During the first five years of her marriage, Renu gave birth three times. Her first child was delivered with no complications. However, the second was stillborn and the third died within a few days of birth. Renu then gave birth to her fourth child at a hospital in Dhaka through caesarean section. As they were very poor, the family could not pay the hospital fees and had to sell the baby to settle the bill. A few months later, Renu again conceived and this time she used antenatal care provided by the clinic under the safe motherhood project. The clinic treated her free of cost as she was very poor. However, when the labour pains started, her husband did not take her to the clinic and she gave birth at home. Due to lack of proper medical care her condition was critical, but nevertheless she survived.

When the safe motherhood project staff learned about this incident, and others of a similar nature, they started holding awareness programmes for the husbands in the community about the benefits of accessing the clinics and the importance of medical help for their families. In the first session, 42 men attended, and these awareness raising programmes are slowly resulting in increased maternity care to the mothers in the community and in changed attitudes of the husbands towards the clinics, and towards their wives' health.

Advocacy

Goal: Strong public, political and financial commitment to and support for sexual and reproductive health and rights at the national and international level.

¡Sí Podemos!: Advocating for comprehensive sexuality education in Peru

Instituto Peruano de Paternidad Responsable (INPPARES), Peru

In Peru, national statistics on the sexual and reproductive health of young people, especially adolescent girls, indicate a deteriorating situation. Adolescent pregnancy rates are increasing rapidly, with nearly 13 per cent of all adolescent girls currently pregnant or already mothers, and 27.9 per cent of pregnancies in Peru occurring among girls and young women under the age of 20.[3] Adolescent girls account for 15 per cent of all pregnancy-related deaths,[4] and girls and young women between the ages of 15 and 29 account for 39 per cent of all HIV and AIDS cases registered in Peru.[5] A further 10 per cent of adolescents who are in their fourth or fifth year of secondary school are victims of sexual abuse, with a ratio of two girls for every boy abused.[6]

In the past, presidential statements in Peru have supported sexuality education but this has not translated into concrete action. The Catholic Church plays an important role in the debate surrounding sexual and reproductive health and rights, and several conservative personalities hold key positions in public administration. These factors have all contributed to a decline in the quality of comprehensive sexuality education in schools.

While the Ministry of Education has a national education framework that mentions sexuality education and adopts a rights-based approach, this national education framework lacks a comprehensive sexuality education component, is under-funded, and has limited implementation. These all contribute to the declining sexual and reproductive health of young people in Peru.

In response to the declining sexual and reproductive health of young people and the absence of a comprehensive sexuality education programme, the Member Association in Peru, Instituto Peruano de Paternidad Responsable (INPPARES), launched an advocacy initiative: the '¡Sí Podemos!' ('Yes we can!') project. ¡Sí Podemos! advocates for the development and implementation of comprehensive sexuality education guidelines within the Ministry of Education's national plan. The project implemented three advocacy-related activities:

- **strengthening civil society** by working in an inter-institutional alliance and improving collective advocacy capacities
- **strengthening the technical capacity of the Ministry of Education** to enhance its comprehensive sexuality education programme with appropriately developed approaches and content, and well-qualified staff
- **increasing political will** among key officials and decision makers to support and strengthen support for comprehensive sexuality education

Achievements and lessons learned

Although the project contributed positively to the implementation of sexuality education in Peru, INPPARES identified lessons learned that should be remembered for future advocacy efforts.

Alliance building

One of the initial activities of the project was to create an inter-institutional alliance for comprehensive sexuality education. This alliance comprised of 25 diverse organizations and youth networks and included members of movements that INPPARES does not often have the opportunity to partner with, such as the Afro-Peruvian movement and the human rights movement. INPPARES hopes that the alliance will continue to inspire and implement advocacy projects within the sexual and reproductive health and rights community in the future.

Although INPPARES sometimes found working within the alliance challenging because it required 'sacrificing' overall control of the project, it created a new space for dialogue and consensus building and the achievements of the alliance outweighed the difficulties. INPPARES also found it difficult to ensure consistency due to the irregular participation of members at key events and meetings. The alliance decided to divide their work into three areas to be more efficient: advocacy, community mobilization, and capacity building.

Political mapping

The project constructed a comprehensive political map, which was compiled during a project planning workshop. Originally, this was to provide historical, socio-demographic and political analysis, thus enabling an accurate review of the instruments and political processes that influence comprehensive sexuality education. However, this map was so useful that the INPPARES team decided to expand it by including a historic framework and the existing protocols and norms related to comprehensive sexuality education in Peru. The map was printed and now serves as a reference for all the coalition members, as well as an important advocacy tool for INPPARES.

Youth participation

One of the central objectives of the project was to strengthen youth capacity and to support youth to be effective advocates. Youth participated in all stages of this project, including planning, decision making, implementation and monitoring. As a result, there is now a strong advocacy youth group working on an issue that directly affects young people. Young people also participated in two youth-related activities; a national conference on comprehensive sexuality education for teachers and students, and a national seminar on priority issues for young people.

Monitoring application of comprehensive sexuality education

The project monitored agreements made with the Ministry of Education and other officials, particularly the application of comprehensive sexuality education guidelines. This was supplemented by a comprehensive media strategy that included training and sensitizing journalists on the importance of implementing and tracking a comprehensive sexuality education policy. The goal was to help build a media base (electronically and written) that would monitor sexuality education-related issues. Initially, INPPARES found working with the media and journalists challenging because of the amount of time and energy required to address the media; it was able to overcome this issue by hiring a coordinator to manage all inquiries from the media.

The project also launched the '100 roses for 100 hearts' campaign on Valentine's Day (14 February) to raise public support for sexual and reproductive rights. This event targeted public officials and decision makers and was held in the National Congress with the support of legislators.

Public policy achievements

As a result of INPPARES's efforts, a number of public policies relating to the sexual and reproductive rights of Peru's adolescents have been adopted: the National Youth Programme, Guidelines for Adolescent Health, an HIV and AIDS strategy, and the incorporation of a sexual and reproductive health curriculum within the National Health Programme.

The project has also led the Ministry of Education to develop a comprehensive sexuality education proposal, and it has asked for input and participation from ¡Sí Podemos! with its revision and adoption. INPPARES supported the ¡Sí Podemos! alliance to advocate for the government to adopt a framework that requires comprehensive sexuality education to be recognized and coordinated by all Ministries, implemented nationwide and backed by civil society. The alliance also encouraged the government to prioritize the framework in the education system, to issue clear and permanent guidelines, and to provide adequate resources to enable implementation at all educational levels.

Through the advocacy efforts of the ¡Sí Podemos! project, INPPARES and its partners made great progress in advocating for the development and implementation of comprehensive sexuality education guidelines within the Ministry of Education's national plan.

"The contribution of youth is highly valued in this project because we have a vision that is experience-based and, in many cases, more objective about the situation. Having the opportunity to work in confronting this problem allows me to gain personal and professional development and to share this learning with other people."

Carlos Macazana Quispe,
youth activist, Peru

Chapter 2

Global performance indicators

IPPF's thirty global indicators are used by the Federation to monitor progress in implementing its Strategic Framework 2005–2015, and to identify areas where investment needs to be focused in future years in the pursuit of the Federation's strategic goals and objectives. Results from 2005 and 2006 are presented in this chapter and in Annex A where regional breakdowns are available. Areas where progress has been made since 2005 are discussed.

Global indicators results 2006

Access to sexual and reproductive health information and services remains beyond the grasp of hundreds of millions of people, especially those in the developing world.

Collecting our performance data

The global indicator results are presented each year to IPPF's decision makers on Governing Council and each Regional Council. The thirty global indicators are divided between the Five A's: adolescents, HIV and AIDS, abortion, access and advocacy. The data also provide key information that is used by Member Associations' governance and staff to improve their own programmes, and by Regional Offices to identify where Member Associations most need technical support.

These global performance indicators results confirm IPPF's vital role as a voice advocating for sexual and reproductive health and rights for all, and as a provider of millions of sexual and reproductive health services, especially for poor, marginalized, socially-excluded and under-served groups.

Global indicators data are collected annually from all of IPPF's Member Associations. Collection of these data involves a major collaborative effort between Member Associations, both grant receivers and non-grant receivers, Regional Offices and the Central Office. All Member Associations are asked to complete an online survey, and those Member Associations that provide sexual and reproductive health services, are also asked to complete a service statistics module. These data are then reviewed and checked by the Regional Offices and again by Central Office before regional and global analyses are conducted.

Baseline data were collected in 2005, and the results from 2006 presented in this chapter are compared with 2005 data. It should be noted, however, that due to differences in response rates between the years, the two data sets are not directly comparable. In 2006, 96 per cent of Member Associations completed the online survey (145 out of 151 Member Associations), an increase of 12 per cent from 2005 (Table 2.1). Of those Associations that provide sexual and reproductive health services, 80 per cent completed the online service statistics module (108 out of 135 Member Associations). This is an increase of 16 per cent from 2005, or 21 more Member Associations reporting in 2006 than in 2005 (Table 2.2).

IPPF recognizes the importance of learning from its own experiences and those of others, reflecting on its achievements and using this knowledge to better achieve the Strategic Framework goals and objectives.

Table 2.1: **Online survey response rate**

IPPF region	Year	Total number of Member Associations	Number of Member Associations responses	Response rate (per cent)
Africa	**2006**	**39**	**38**	**97**
	2005	39	30	77
Arab World	**2006**	**13**	**12**	**92**
	2005	14	12	86
European Network	**2006**	**41**	**38**	**93**
	2005	40	31	78
East and South East Asia and Oceania	**2006**	**21**	**21**	**100**
	2005	20	17	85
South Asia	**2006**	**8**	**8**	**100**
	2005	8	8	100
Western Hemisphere*	**2006**	**29**	**28**	**97**
	2005	30	28	97
Total	**2006**	**151**	**145**	**96**
	2005	151	126	84

Table 2.2: **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	**2006**	**38**	**37**	**97**
	2005	38	29	76
Arab World	**2006**	**11**	**10**	**91**
	2005	11	9	82
European Network	**2006**	**31**	**10**	**32**
	2005	33	2	6
East and South East Asia and Oceania	**2006**	**20**	**17**	**85**
	2005	19	14	74
South Asia	**2006**	**8**	**8**	**100**
	2005	8	8	100
Western Hemisphere*	**2006**	**27**	**26**	**96**
	2005	28	25	89
Total	**2006**	**135**	**108**	**80**
	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. Cuba has been included with the Western Hemisphere Region's data for the purposes of this analysis due to its geographical location.

Adolescents – results

Table 2.3: **Adolescents indicators**

(n=number of Member Associations that provided data)

	Indicator	2005	2006
1	Proportion of Member Associations with 20 per cent or more young people under 25 years of age on their governing board	16.7%	17.2%
		(n=126)	(n=145)
2	Percentage of Member Association staff who are under 25 years of age	4.0%	4.7%
		(n=126)	(n=145)
3	Proportion of Member Associations providing sexuality information and education to young people	95.2%	100%
		(n=126)	(n=145)
4	Proportion of Member Associations providing sexual and reproductive health services to young people	93.7%	97.2%
		(n=126)	(n=145)
5	Proportion of Member Associations advocating for improved access to services for young people	98.4%	98.6%
		(n=126)	(n=145)
6	Number of sexual and reproductive health services (including contraception) provided to young people under 25 years of age	7,869,331	11,514,850
		(n=87)	(n=108)

Youth participation

IPPF's youth policy strongly recommends that at least 20 per cent of Member Associations' governing board members should be under the age of 25 years. In 2006, 17.2 per cent of Member Associations had at least a 20 per cent membership of young people on their governing board. This is a slight increase from 16.7 per cent in 2005 and indicates a need for IPPF to renew its commitment to achieving this part of the IPPF policy on young people. Progress is being made however, and twenty Member Associations had between 15 and 20 per cent of young people on their governing boards in 2006. The Africa region is currently strongest in implementing the policy having 34.2 per cent of its Associations with 20 per cent of young people on their governing boards. Overall, five per cent of governing board members were young women, and four per cent were young men. Eighteen Member Associations had at least one young person on their governing board for the first time in 2006.

The percentage of Member Association staff under 25 years was 4.7 per cent, a slight increase from 4.0 per cent in 2005. Regional differences are minor with the Arab World region having the highest proportion of young staff (10.2 per cent), and the Western Hemisphere region the lowest proportion (3.4 per cent) in 2006. There were slightly more young female staff (3.3 per cent) than young male staff (1.4 per cent). Overall, 64.8 per cent of IPPF's Member Associations had at least one staff member under the age of 25 years, and the roles and responsibilities of staff under 25 varied from community educators, accountants and library assistants to nurses, provincial officers and project coordinators.

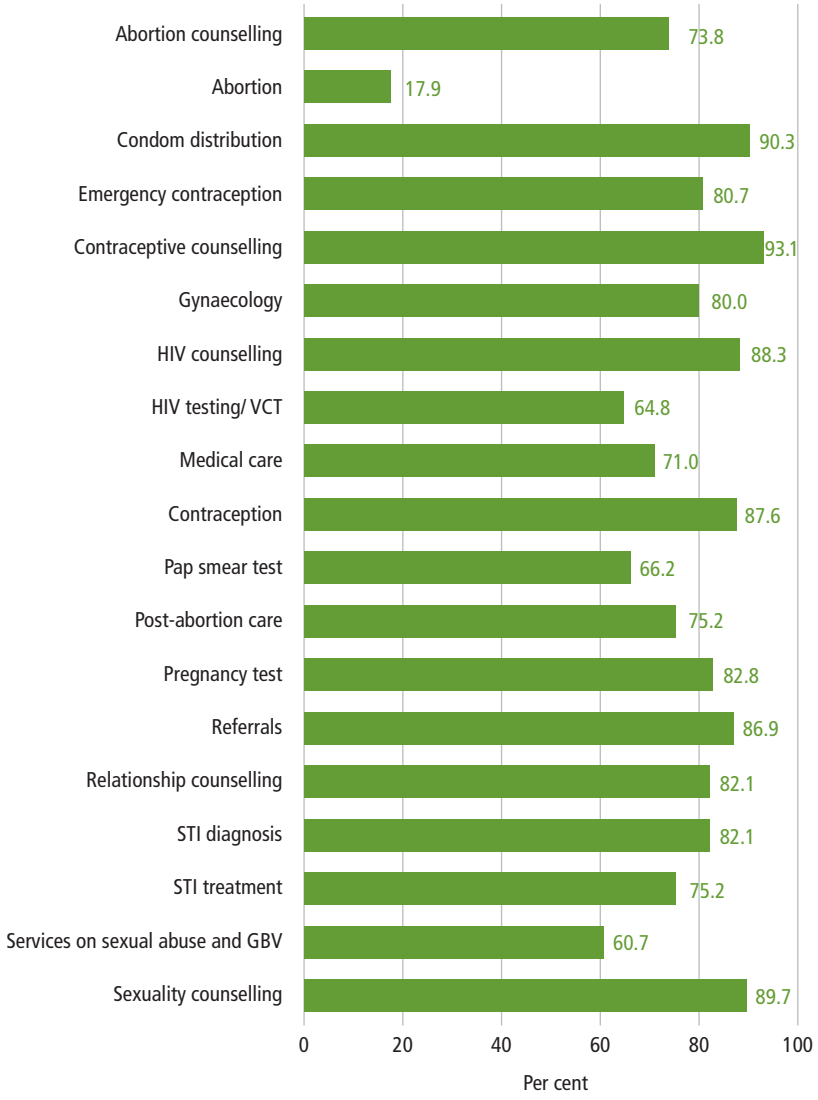
Information and education on sexuality for adolescents

Results for 2006 indicate that all Member Associations provided sexuality information and education specifically designed for young people, an increase from 95.2 per cent in 2005. Over 90 per cent of these programmes targeted young people who were in and out-of-school and unmarried young people. Slightly fewer programmes targeted married youth (86.9 per cent). Other groups included the very young, under 12 years of age (58.6 per cent), young people living with HIV and AIDS (63.4 per cent), gay, lesbian and bisexual youth (40.7 per cent), and marginalized or socially-excluded groups of youth (71.0 per cent). For all target groups, slightly more sexuality information programmes were conducted than sexuality education, although the differences were minor.

Advocating for increased access for youth

All Member Associations in Africa, the Arab World, East and South East Asia and Oceania, and the Western Hemisphere advocated for improved access to services for young people, and the global figure was 98.6 per cent. The main target groups for this advocacy work included teachers and parents (91.7 per cent), government decision makers (93.1 per cent), the media (88.3 per cent), and lawyers or legal bodies (43.4 per cent).

Figure 2.4: **Percentage of Member Associations providing sexual and reproductive health services to young people**



Providing sexual and reproductive health services to young people

In 2006, 97.2 per cent of IPPF's Member Associations provided sexual and reproductive health services to young people, an increase from 93.7 per cent in 2005. Figure 2.4 illustrates the wide range of sexual and reproductive health services provided, including contraception, HIV-related services, abortion-related services, pregnancy tests, sexually transmitted infection diagnosis and treatment, gynaecological services, counselling, and special services on sexual abuse and gender-based violence (GBV).

In 2006, 11,514,850 sexual and reproductive health services were provided to young people, a significant increase of over 46 per cent since 2005 when 7,869,331 services were provided. Table 2.5 illustrates the breakdown of sexual and reproductive health services provided to young people by type. More Associations provided services to urban youth (93.8 per cent) than to young people in rural areas (84.0 per cent). Fewer of the services provided reached socially-excluded youth (67.4 per cent) and youth with special needs (59.0 per cent). Overall, these figures on provision of sexual and reproductive health services to specific target groups of young people, indicate a small increase on the results from 2005.

Table 2.5: **Number of services provided to young people, by type**

Type of service provided	Number of services provided to young people 2005	2006
All contraceptive services (including contraceptive counselling)	4,507,646	**6,151,415**
Abortion-related services	60,102	**139,441**
Gynaecological services	956,945	**1,140,511**
Maternal and child health services*	1,236,701	**1,994,563**
Infertility services	33,458	**36,822**
HIV-related services	135,080	**356,896**
Sexually transmitted and reproductive tract infection services	251,229	**354,859**
Other sexual and reproductive health counselling services	304,474	**933,779**
Urological services	33,194	**33,308**
Other sexual and reproductive health medical services	350,502	**373,256**
Total	**7,869,331**	**11,514,850**

* Includes obstetrics and paediatrics services

HIV and AIDS – results

Table 2.6: **HIV and AIDS indicators**

(n=number of Member Associations that provided data)

	Indicator	2005	2006
7	Proportion of Member Associations with a written HIV and AIDS workplace policy*	31.0% (n=126)	40.7% (n=145)
8	Proportion of Member Associations providing HIV-related services along the prevention to care continuum*	31.7% (n=126)	32.4% (n=145)
9	Proportion of Member Associations advocating for increased access to HIV prevention, treatment and care and reduced discriminatory policies and practices for those affected by HIV and AIDS	50.8% (n=126)	57.9% (n=145)
10	Proportion of Member Associations with strategies to reach people particularly vulnerable to HIV infection	69.8% (n=126)	75.9% (n=145)
11	Proportion of Member Associations conducting behaviour change communication activities to reduce stigma and promote health-seeking behaviours	66.7% (n=126)	79.3% (n=145)
12	Number of HIV-related services provided	1,320,599 (n=87)	2,539,629 (n=108)
13	Number of condoms distributed	97,855,691 (n=87)	105,336,066 (n=108)

* Note: this indicator has been revised in 2006, and data from 2005 were re-analyzed to provide a figure for comparative purposes.

Increasing access to HIV-related services

The prevention to care continuum reflects a mixture of elements that IPPF considers appropriate for Member Associations to be emphasizing in their HIV programmes. These include information, education and communication/behaviour change communication (IEC/BCC), condom distribution, sexually transmitted infection management and treatment, voluntary counselling and testing (VCT), psychosocial support, prevention of mother to child transmission (PMTCT+), treatment of opportunistic infection, antiretroviral treatment and palliative care. In 2006, 32.4 per cent of IPPF's Member Associations provided at least six of these nine services in comparison to 31.7 per cent in 2005. Africa was the strongest region with 63.2 per cent of its Member Associations providing at least six of these service elements along the prevention to care continuum.

Nearly twice the number of HIV-related services were provided in 2006 in comparison to 2005, a significant increase from 1.3 million to 2.5 million, and Table 2.7 illustrates the breakdown of these services by type. In 2006, over 105.3 million condoms were distributed globally by IPPF's Member Associations, a significant rise of 7.6 per cent from 2005 (97.8 million condoms). The majority of condoms are distributed by the Western Hemisphere region (over 63 million), followed by South Asia (nearly 21 million) and Africa (over 15 million).

The initial strategy in integrating sexual and reproductive health and HIV has been in prevention, and this is reflected in the data, although IPPF is now working with a number of priority countries to establish models of integration focusing on a full continuum of services.

The most common types of services provided in 2006 were IEC/BCC (81.9 per cent of Member Associations), condom distribution (88.9 per cent), sexually transmitted infection management and treatment (72.9 per cent) and VCT (70.1 per cent). Psychosocial support was provided by 52.1 per cent of Associations, 39.6 per cent provided treatment of opportunistic infections, and 18.1 per cent provided PMTCT+. The proportion of Member Associations providing palliative care was 13.9 per cent and for antiretroviral treatment, it was 4.9 per cent (Figure 2.8). IPPF is now focusing on providing the evidence that supports linking sexual and reproductive health and HIV through a number of programmatic entry points. For some of these entry points, IPPF already has a strong track record, for example, condom distribution and management and treatment of sexually transmitted infections, and so in the future, we will be focusing more on PMTCT+ and the delivery of antiretroviral treatment within a sexual and reproductive health setting.

Working with vulnerable groups

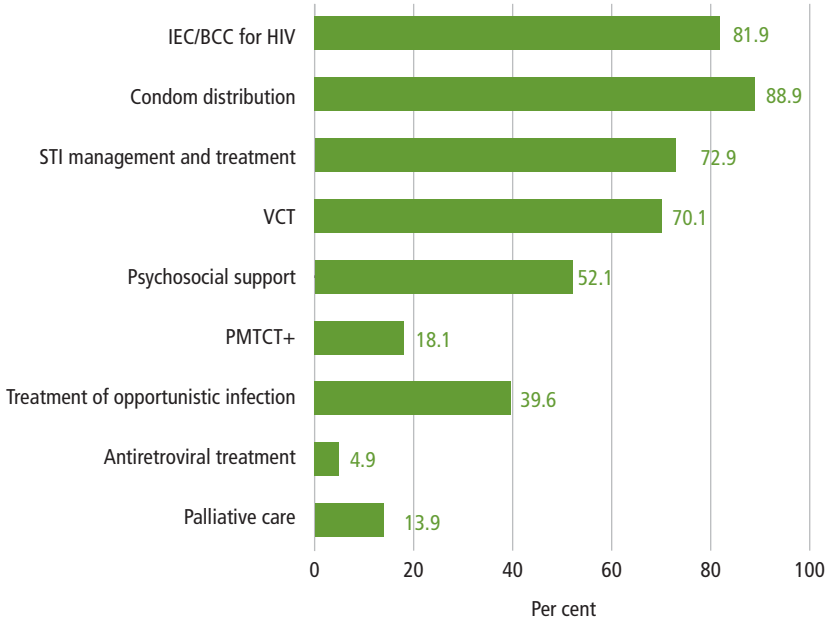
Groups that may be particularly vulnerable to HIV infection include people living with HIV (PLHIV), sex workers, men having sex with men, gay and bisexual men, injecting drug users, newly married women, migrants and internally displaced persons. Member Associations implement a variety of different strategies to reach such vulnerable groups including mobile clinics, VCT for specific populations, participation of PLHIV in governance and advisory capacities, and partnerships with other organizations working with vulnerable groups.

Table 2.7: **Number of HIV-related services provided, by type**

Type of HIV-related service provided	Number of HIV-related services provided 2005	2006
HIV prevention counselling	221,294	**263,793**
HIV voluntary counselling (pre and post test)	76,221	**346,723**
HIV sero status lab tests	42,524	**193,805**
Antiretroviral treatment	565	**2,955**
Opportunistic infection treatment	40,954	**7,349**
HIV psychosocial support and post-exposure prophylaxis (PEP)	859	**23,238**
AIDS home care treatment	4,848	**174,699**
Other HIV treatment	8,935	**5,469**
Other HIV lab tests	72,143	**16,157**
Sexually transmitted and reproductive tract infection services	818,550	**1,453,250**
All other HIV and AIDS services*	33,706	–
Total	**1,320,599**	**2,539,629**

* Some Member Assocations were unable to provide the breakdown of services by type for 2005, so these services were included in 'all other HIV and AIDS services'.

Figure 2.8: **Percentage of Member Associations that provide HIV and AIDS services along the prevention to care continuum**



In 2006, the proportion of Member Associations with strategies to reach at least one group of people vulnerable to HIV infection was 75.9 per cent, an increase from 69.8 per cent in 2005 with the highest increases in the South Asia and Western Hemisphere regions. More Member Associations had strategies to reach sex workers (51.0 per cent) and people living with HIV (50.3 per cent), followed by newly married women (39.3 per cent) and migrants (35.9 per cent). Fewer Associations implemented strategies to reach men having sex with men (29.7 per cent), gay and bisexual men (26.2 per cent), internally displaced persons (22.1 per cent), and injecting drug users (16.6 per cent).

The proportion of Member Associations conducting behaviour change communication activities both to reduce the stigma associated with HIV and AIDS and to promote health-seeking behaviour amongst vulnerable groups rose from 66.7 per cent in 2005 to 79.3 per cent in 2006. Promotion of health-seeking behaviour was most common with PLHIV (49.0 per cent), sex workers (47.6 per cent), newly married women (42.1 per cent), and migrants (35.9 per cent). Other target groups included men having sex with men (29.0 per cent), gay and bisexual men (25.5 per cent), internally displaced persons (25.5 per cent), and injecting drug users (19.3 per cent). These figures represent a substantial rise in the numbers of programmes targeting PLHIV (up by 6.1 per cent), sex workers (up by 6.3 per cent) and men having sex with men (up by 10.7 per cent) since 2005.

Promoting the rights of people living with HIV and AIDS

More Member Associations advocated for increased access to HIV prevention, treatment and care, and reduced discriminatory policies and practices for those affected by HIV and AIDS than ever before. In 2006, 57.9 per cent of Associations advocated on HIV and AIDS in comparison to 50.8 per cent in 2005, with the highest increases in the Africa, Arab World and East and South East Asia and Oceania regions.

In 2006, the proportion of Member Associations that had a written HIV and AIDS workplace policy in place was 40.7 per cent, a significant increase from 31.0 per cent in 2005. The South Asia region made the most progress in this area with an increase from 12.5 per cent of its Member Associations in 2005 to 87.5 per cent in 2006.

Abortion – results

Table 2.9: **Abortion indicators**

(n=number of Member Associations that provided data)

	Indicator	2005	2006
14	Proportion of Member Associations advocating for reduced restrictions and/or increased access to safe legal abortion*	53.2% (n=126)	54.5% (n=145)
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	43.7% (n=126)	48.3% (n=145)
16	Proportion of Member Associations providing abortion-related services	82.5% (n=126)	85.5% (n=145)
17	Number of abortion-related services provided	219,229 (n=87)	435,294 (n=108)

* Note: this indicator has been revised in 2006 and data from 2005 were re-analyzed to provide a figure for comparative purposes.

Strengthening the right to choose and to have access to safe abortion

The proportion of Member Associations advocating for reduced restrictions and/or increased access to safe legal abortion increased slightly, from 53.2 per cent in 2005, to 54.5 per cent in 2006. The results of Member Associations' advocacy work in 2006 are illustrated by successful national policy or legislative changes in support of safe abortion in which the Member Associations played a key role. A selection of examples from Ethiopia, Colombia, France, Kyrgyzstan and Russia, are described in detail on page 34.

Indicator 15 is a composite indicator made up of three components: IEC activities on (un)safe abortion, on the legal status of abortion and on the availability of legal abortion services. The data show that more Member Associations were involved in providing IEC activities on (un)safe abortion (78.6 per cent) and on the legal status of abortion (70.3 per cent), than on the availability of legal abortion services (58.6 per cent). The proportion of Member Associations conducting IEC on all three components was 48.3 per cent in 2006, a slight increase from 43.7 per cent in 2005.

Also, 6.8 per cent more Member Associations were involved in IEC activities on the legal status of abortion in 2006 than in 2005. The key target groups for these IEC activities on abortion included young people, men, women's groups, community groups, parents, community leaders and health professionals.

Increasing access to abortion-related services

In 2006, the proportion of Member Associations providing abortion-related services was 85.5 per cent, and the proportion of Associations providing surgical and/or medical abortion was 20.7 per cent. Figure 2.10 illustrates the different types of services provided by IPPF's Member Associations. The most common services provided were post-abortion care (70.3 per cent), pre-abortion counselling (62.1 per cent), referrals to external abortion services (61.4 per cent), and management of abortion-related complications and incomplete abortion (43.4 per cent). The proportion of Member Associations providing surgical abortion (vacuum aspiration) was 17.2 per cent, medical abortion was 12.4 per cent, and finally surgical abortion (D&C and D&E) was 10.3 per cent.

The total number of abortion-related services provided by Member Associations in 2006 was 435,294, almost twice the number of services provided in 2005 (219,229). The most common types of abortion-related services provided were post-abortion counselling, pre-abortion counselling, and induced/surgical abortion (Table 2.11). The biggest increase in abortion-related services since 2005 was in induced/surgical abortion services (from 16,964 in 2005 to 105,330 in 2006).

Figure 2.10: **Percentage of Member Associations providing abortion-related services**

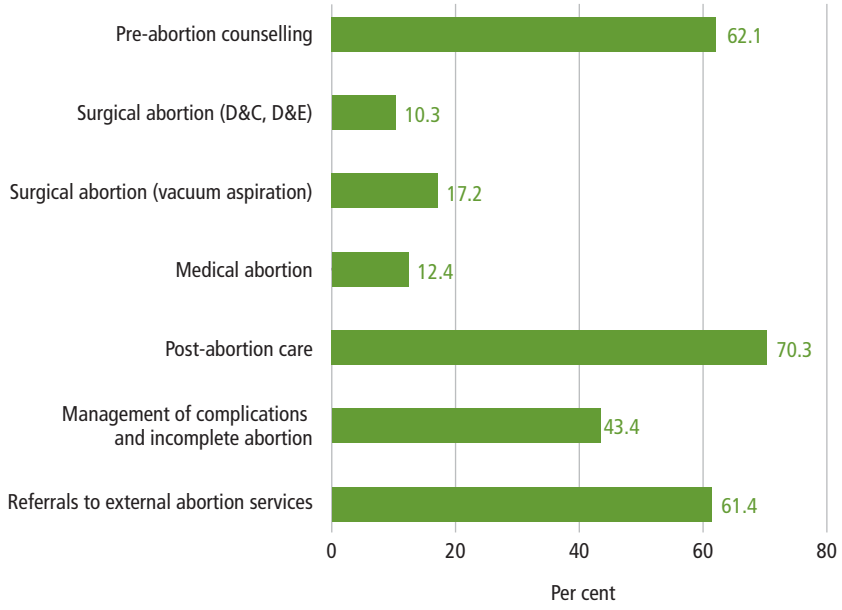


Table 2.11: **Number of abortion-related services provided, by type**

Type of abortion-related service provided	Number of abortion-related services provided 2005	2006
Pre-abortion counselling	53,707	**113,004**
Abortion – consultation/diagnostic	13,684	**3,939**
Induced/surgical abortion	16,964	**105,330**
Medical abortion	13,047	**14,523**
Post-abortion care	9,651	**19,113**
Post-abortion counselling	109,638	**157,574**
Referrals to external abortion services	2,538	**21,811**
Total	**219,229**	**435,294**

Access – results

Table 2.12: **Access indicators**

(n=number of Member Associations that provided data)

	Indicator	2005	2006
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	78.6 % (n=126)	81.4% (n=145)
19	Estimated percentage of Member Association clients who are poor, marginalized, socially-excluded and/or under-served	56.6 % (n=126)	59.3% (n=145)
20	Number of Couple Years of Protection (CYP)	6,121,077 (n=87)	7,800,073 (n=108)
21	Number of contraceptive services provided	17,335,608 (n=87)	20,384,904 (n=108)
22	Number of non-contraceptive sexual and reproductive health services provided	13,416,374 (n=87)	18,261,652 (n=108)
23	Number of service delivery points	58,470 (n=87)	55,911 (n=108)
24	Proportion of Member Associations with gender-focused policies and programmes	72.2 % (n=126)	71.0% (n=145)
25	Proportion of Member Associations with quality of care assurance systems, using a rights-based approach*	65.0 % (n=126)	72.1% (n=129)

* This analysis is based on the 129 Member Associations that responded to the quality of care questions on the online survey.

Increasing access for the poor, marginalized, socially-excluded and/or under-served

Indicator 18 is made up of two different components, implementing programmes and advocating for improved sexual and reproductive health for the poor, marginalized, socially-excluded and/or under-served. The proportion of Member Associations both implementing programmes and conducting advocacy was 81.4 per cent.

IPPF employed many different strategies to increase access to services by poor and marginalized groups including community-based services (73.8 per cent), subsidized services (69.0 per cent), outreach and mobile services (60.7 per cent), and finally by having specially adapted fee structures (52.4 per cent).

In line with the wider concept of poverty of opportunity, indicator 19 is an estimate of the percentage of Member Association clients that are poor, marginalized, socially-excluded and/or under-served. For the different categories of client groups, the following definitions are applied, although these are not mutually exclusive:

- **poor:** people living on less than US$2 per day
- **marginalized:** people who, for reasons of poverty, geographical inaccessibility, culture, language, religion, gender, migrant status or otherwise, have not benefited from health, education and employment opportunities, and whose sexual and reproductive health needs remain largely unsatisfied
- **socially-excluded:** people who are wholly or partially excluded from full participation in the society in which they live
- **under-served:** people who are not normally or adequately served by established sexual and reproductive health service delivery programmes due to a lack of capacity and/or political will; for example, people living in rural or remote areas, young people, people with a low socio economic status or unmarried people

Figure 2.13: **Number of Couple Years of Protection (CYP) provided by Members Associations, by method**

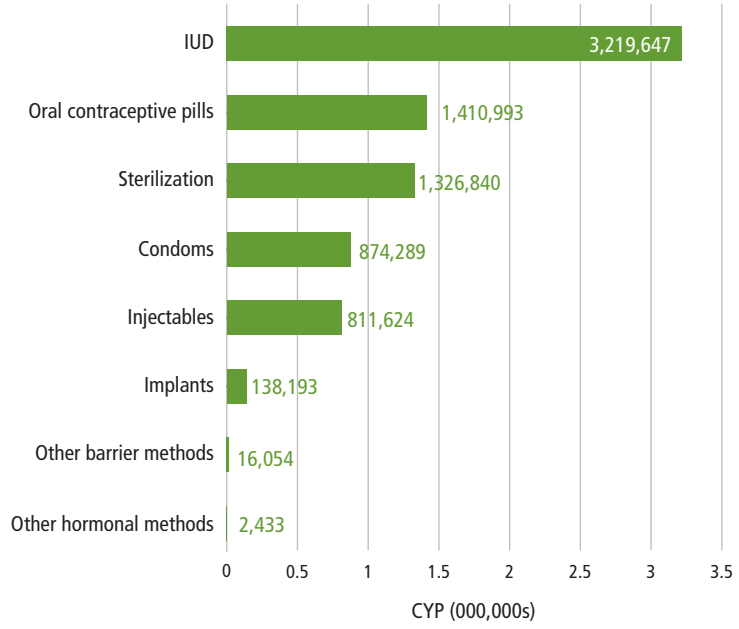
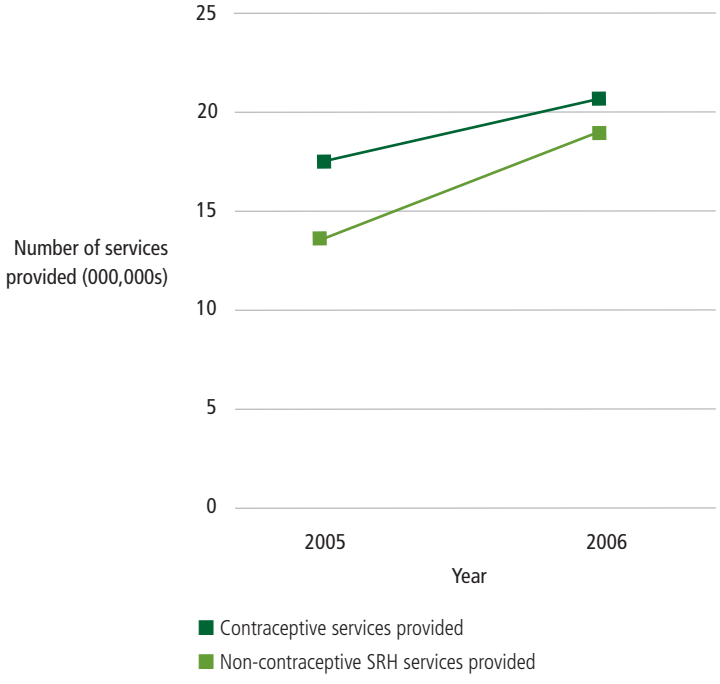


Figure 2.14: **Number of contraceptive and non-contraceptive SRH services provided, 2005–2006**



The accurate collection of these data is particularly difficult. Member Associations are advised to be guided by these definitions of the categories but to bear in mind that in the different national and local contexts in which they work, there will be a variety of alternative ways of identifying clients who are poor, marginalized, socially-excluded and/or under-served. For example, in the majority of countries, sex workers will be socially-excluded; all mobile health units will be providing services to under-served groups; and women in many parts of the world remain marginalized and cannot access sexual and reproductive health services.

In 2006, the estimated number of clients served by Member Associations was 27,817,129. The estimated proportion of clients who were poor, marginalized, socially-excluded and/or under-served was 59.3 per cent. In the South Asia region, the proportion of clients who were poor, marginalized, socially-excluded and/or under-served was 84.3 per cent. In Africa, it was 77.0 per cent, and in the Arab World, it was 64.3 per cent. In countries with a low human development index (HDI) ranking, this percentage of poor, marginalized, socially-excluded and/or under-served clients was 76.6 per cent.

Providing sexual and reproductive health services

In 2006, the global couple years of protection (CYP) provided by IPPF's Member Associations was 7,800,073, a significant increase of 27.4 per cent from 2005. Figure 2.13 illustrates the breakdown of CYP values for different methods of contraception. Compared to 2005, most of the rise in CYP was contributed by the IUD which increased by 66.6 per cent. There was also an increase of 43 per cent in CYP for injectables, and all other methods increased slightly.

Figure 2.14 illustrates the increases in number of contraceptive and non-contraceptive sexual and reproductive health services provided between 2005 and 2006.

Figure 2.15: **Number of contraceptive services provided, by type**

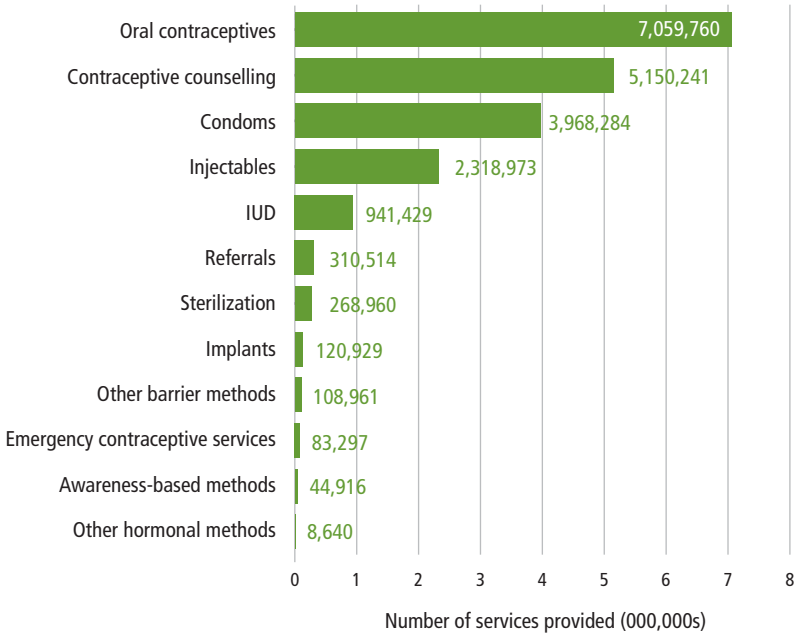
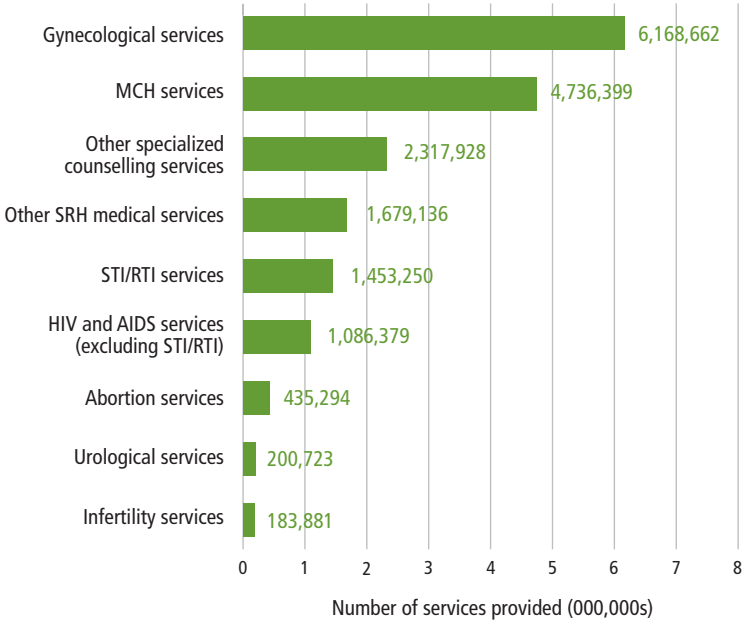


Figure 2.16: **Number of non-contraceptive SRH services provided, by type**



In 2006, the number of contraceptive services provided was 20,384,904, an increase of 17.6 per cent from 2005 (Figure 2.14). Figure 2.15 illustrates the numbers of contraceptive services provided, by type.

In 2006, the total number of sexual and reproductive health services provided, excluding contraceptive services, was 18,261,652, an increase of 36.1 per cent from 2005 (Figure 2.14). Figure 2.16 illustrates the numbers of sexual and reproductive health services provided by Member Associations by type of service.

IPPF provides sexual and reproductive health services through both clinical and non-clinical service delivery points. A clinic-based service delivery point may be static or mobile and provides clinic-based sexual and reproductive health services. A non-clinical service delivery point is a channel of distribution that does not provide clinic-based sexual and reproductive health services, but distributes contraceptives and other commodities. These include community based distribution, social marketing, government channels of distribution and private physicians. Globally, the number of service delivery points dropped significantly from 58,470 in 2005 to 55,911 in 2006, of which 5,733 were clinical, and 50,178 were non-clinical. The number of clinic-based service delivery points increased in all regions except the Western Hemisphere Region; the number of non-clinical service delivery points increased in all regions except the European Network and South Asia.

Table 2.17: **Percentage of Member Associations with quality of care standards in place, by type of standard**

Quality of care standards	Percentage of Member Associations with standards in place
Written standards/protocols/norms consistent with IPPF's 'Medical and Service Delivery Guidelines' in all service delivery points	93.0
Procedures to ensure clients' perceptions on service provision are taken into account	62.0
Orientation and ongoing training provided to staff in all service delivery points	92.2
Mechanisms to regularly assess technical competence of service providers	84.5
Implements strategies/approaches to assess quality of care provided	83.7
All service delivery points have the right conditions to deliver sexual and reproductive health services	95.3

Promoting gender equity and equality

Indicator 24 requires Member Associations to have both a gender equity policy in place and to be implementing at least one gender-focused programme. The proportion of Member Associations with both gender-focused policies and programmes in 2006 was 71.0 per cent. More than 73.0 per cent of Associations had a gender equity policy in place, and many more (92.4 per cent) were implementing gender-focused programmes. These programmes included women's empowerment (73.8 per cent), women's participation (78.6 per cent), women's rights in clinics (73.1 per cent), men's needs (69.7 per cent), gender-based violence (64.8 per cent), gender capacity building (68.3 per cent), and monitoring and evaluation of gender programmes (46.9 per cent). Information on the gender of Member Associations' governing board members and of staff in management positions also illustrates IPPF's commitment to gender equity and equality. The proportion of Member Associations with more than 50 per cent of their governing board members being female was 66.9 per cent, and the proportion of women on IPPF's governing boards globally was 54.1 per cent. In terms of staff in management positions, over 72 per cent were women.

Ensuring high quality of care

Indicator 25 is a composite indicator requiring six quality of care standards to be adhered to for the indicator to be positive. The proportion of Member Associations adhering to all six components in 2006 was 72.1 per cent, an increase from 65.0 per cent in 2005, and Table 2.17 illustrates the proportion of Member Associations with the different quality of care standards in place.

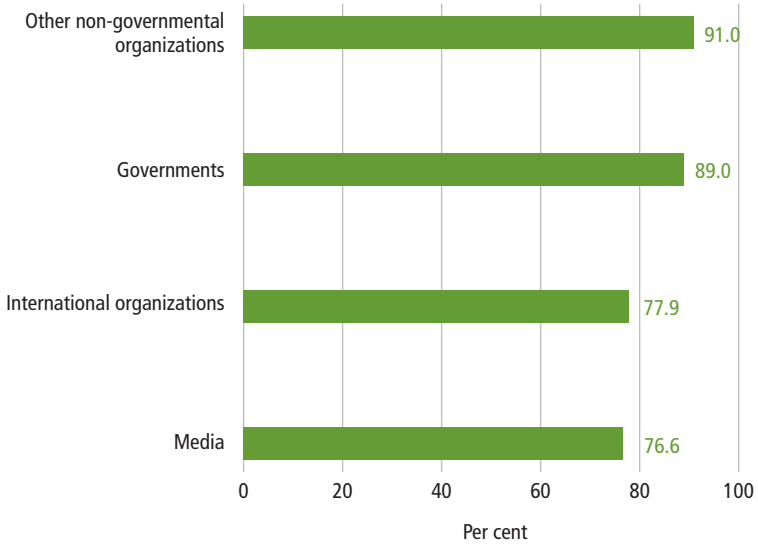
Advocacy – results

Table 2.18: **Advocacy indicators**

(n=number of Member Associations that provided data)

	Indicator	2005	2006
26	Proportion of Member Associations involved in influencing public opinion on sexual and reproductive health and rights	71.4% (n=126)	73.1% (n=145)
27	Proportion of Member Associations involved in advancing national policy and legislation on sexual and reproductive health and rights	90.4% (n=126)	91.0% (n=145)
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	51 (n=126)	56 (n=145)
29	Proportion of Member Associations involved in counteracting opposition to sexual and reproductive health and rights	80.2% (n=126)	82.8% (n=145)
30	Proportion of Member Associations advocating for national governments to commit more financial resources to sexual and reproductive health and rights	86.5% (n=126)	84.8% (n=145)

Figure 2.19: **Percentage of Member Associations participating in coalitions**



Influencing public opinion

Indicator 26 requires Member Associations to implement initiatives to influence public opinion on sexual and reproductive health and rights to support favourable policies and legislation as well as having a communications strategy to influence public opinion on sexual and reproductive health and rights. The proportion of Member Associations with both components in place in 2006 was 73.1 per cent.

Advancing national policy and legislation

In 2006, the proportion of Member Associations conducting advocacy activities to advance national policy and legislation on sexual and reproductive health and rights was 91.0 per cent. The key activities that Associations implement in their campaigns included public education (83.4 per cent), working with the media (83.4 per cent), and informing policy makers (76.6 per cent). The target groups for advocacy activities for policy and legislation on sexual and reproductive health and rights included government decision makers (86.9 per cent), mass media (84.1 per cent), the general public (80.7 per cent), and community and religious leaders (68.3 per cent).

Working in partnerships with other organizations to advance sexual and reproductive health and rights is vital, and IPPF's Member Associations collaborated with other non-governmental organizations (91.0 per cent), governments (89.0 per cent), international organizations (77.9 per cent), and also with mass media (76.6 per cent), to increase pressure to effect positive change (Figure 2.19).

The results of Member Associations' advocacy work are illustrated by the successful national policy initiatives and/or positive legislative changes in support of sexual and reproductive health and rights in which the Associations played a key role. In 2006, there were 56 policy or legislative changes, and Box 2.20 provides a selection of some of these changes.

Box 2.20: Examples of successful national policy and legislative changes in support of sexual and reproductive health and rights to which the Member Associations' advocacy efforts have contributed in 2006

Adolescents

The government of **Armenia** adopted a 'Youth Health Strategy' in 2006 after vigorous advocacy by the Member Association. The strategy prioritizes youth health, development and protection, and promotes youth friendly services in clinics providing sexual and reproductive health services.

In **Palestine**, the Member Association worked with UNFPA to integrate sexual and reproductive health education into the school curriculum for fourth and ninth grades, and contributed substantially to the content of the curricula. In **Mauritius**, family life education was recently integrated into the school curriculum, and the Member Association was a member on the Family Life Education Committee.

HIV and AIDS

The Member Association in **Fiji**, in collaboration with the Fiji National AIDS Council, was successful in advocating for a new national HIV and AIDS policy.

In **Guinea-Conakry** for the first time in 2006, the parliament voted for a new law to protect people living with and affected by HIV. The Member Association in Guinea-Conakry contributed to the development of this new law.

Abortion

The Member Association in **France** organized an information campaign, and mobilized civil society in public demonstrations against a proposal to amend the law which would provide legal status to a fetus.

The Member Association in **Russia** fought successfully to repeal a proposed new law requiring a husband's consent to be given before an abortion.

The Member Association in **Kyrgyzstan** was the leading organization counteracting the attempt by the government's ombudsman to criminalize abortion after 12 weeks. The Association brought together key stakeholders, including civil sector, government, international organizations and medical professionals to successfully defend a woman's right to abortion after 12 weeks.

Prior to 2006, the law in **Ethiopia** permitted abortion only when the pregnancy posed a threat to a woman's life. Today, as a result of advocacy by the Member Association together with other partners, abortions can be performed when the pregnancy is a result of rape or incest, when the life of the woman or fetus is in jeopardy, when the fetus has severe abnormalities, when the woman has physical or mental disabilities, or when a minor is physically or psychologically unprepared to raise a child.

The Member Association in **Colombia** campaigned with other organizations for abortion to be permitted in cases of rape or incest, fetal malformation incompatible with life, risk of woman's health, and forced pregnancy. In 2006, the Constitutional Court approved this law, and later, the Ministry of Public Health issued binding guidelines for all health institutions to provide these services.

Access

The Member Association of the **Philippines** and other networks were able to defend the allocation of funds to local governments to ensure access to a stable supply of contraceptives. The Philippines Association also counteracted opposition by anti-choice groups and was successful in convincing the Department of Health not to issue new policy guidelines to ban IUDs.

The Member Association in **Chile** participated in the drafting of the Fertility Regulation Norms including a chapter on male contraception, and another on access to emergency contraception for young people from the age of 14 years without parental consent. The norms were in place by 2006, and the Member Association and others have since fought hard against challenges by conservative parties and the Constitutional Tribunal, resulting in a presidential decree supporting the norms.

The Member Association in **Niger** played a key role in advocating and advising on new laws on contraception and reproductive health. Likewise, in **Rwanda**, contraception was not a priority for the government, but following advocacy for the promotion of contraception with parliamentarians by the Member Association, the law on family planning was widely disseminated. In **Zambia**, the Member Association advocated on the registration of Jadelle (a contraceptive implant) and emergency contraception, and the revised national family planning policy was adopted.

Emergency contraception

The Member Associations in **Australia** and the **United States of America** have successfully advocated for legislative change to enable the purchase of emergency contraception over the counter. In **Peru**, the Member Association campaigned for the unrestricted use of emergency contraception and this was approved by the Constitutional Court in 2006.

Gender-based violence

The Member Association in **Pakistan** launched a successful campaign with other partners against the 'Hudood' laws of 1979. As a result, these 'Hudood' laws were amended in 2006 so that women who have been sexually abused can no longer be accused of extra-marital sexual relations.

The Member Association in **Albania** was a key participant in a non-governmental organization network that drafted a law against domestic violence. The Member Association conducted research on the issue, submitted recommendations to government and participated in roundtable meetings with police and the judiciary. The network conducted a campaign which resulted in 20,000 Albanians signing the draft law which was approved in November 2006.

Advocacy

The Member Association in the **Slovak Republic** successfully opposed a proposed treaty on the 'Right to Exercise the Objection of Conscience with the Holy See' which would have restricted access to sexual and reproductive health services.

Counteracting opposition

The proportion of Member Associations counteracting opposition to sexual and reproductive health and rights was 82.8 per cent. The main opposition strategies that Associations were counteracting included misinformation or misrepresentation of sexual and reproductive health and rights (76.6 per cent), de-funding or cutting funds to sexual and reproductive health and rights (43.4 per cent), undermining existing policy or legislation (45.5 per cent), and blocking or opposing new policy and legislation (37.9 per cent).

Increasing financial resources for sexual and reproductive health

The proportion of Member Associations advocating for national governments to commit more financial resources to sexual and reproductive health and rights was 84.8 per cent. Slightly more Member Associations were advocating governments for specific financial commitment in their national budget lines on sexual and reproductive health (72.4 per cent) than were advocating governments to meet financial commitments under international agreements such as Cairo (66.9 per cent).

Key highlights from 2006

This chapter has presented IPPF's global indicators results from 2006 and compared them with results from 2005. More Member Associations provided data in 2006 than in 2005, an increase of 12 per cent on the survey, and 16 per cent for service statistics with a number of Member Associations providing data for the first time.

The numbers of sexual and reproductive health services provided in 2006 have increased dramatically, for example, the number of condoms distributed has risen from nearly 98 million in 2005 to over 105 million in 2006. Almost double the numbers of sexual and reproductive health services were provided to young people in 2006, and the global couple years of protection (CYP) rose from 6.1 million to 7.8 million in 2006. The estimated proportion of IPPF's clients that were poor, marginalized, socially-excluded and/or under-served in 2006 was nearly 60 per cent, with the highest proportions in the South Asia (84 per cent) and Africa (77 per cent) regions. The number of Associations with HIV workplace policies in place increased by ten per cent, and the proportion of Associations with quality of care assurance systems went up by seven per cent in 2006. There were 56 important national policy or legislative changes that Member Associations contributed to in 2006, changes that will dramatically improve sexual and reproductive health and rights for millions around the world.

The global performance indicators provide IPPF with information to measure progress in implementing its Strategic Framework 2005–2015. The data are also important for each Member Association in highlighting strengths and weaknesses in programmes, governance and management, and for Regional Offices to identify where technical support needs to be directed. IPPF's global achievements in 2006 demonstrate the importance of the Federation as a global voice advocating for sexual and reproductive health and rights, and as a service provider, implementing strategies to reach the poor, marginalized, socially-excluded and under-served groups.

Chapter 3

IPPF's four supporting strategies

IPPF's Strategic Framework focuses on five thematic areas of adolescents, HIV and AIDS, abortion, access and advocacy. It is supported by four supporting strategies that are committed to (1) good governance and accreditation to ensure quality, effectiveness and accountability; (2) resource mobilization essential to fund IPPF's work; (3) capacity building to support Member Associations; and (4) monitoring, evaluation and learning to capture and utilize knowledge and expertise within the Federation.

This chapter reviews work undertaken in the areas of these four supporting strategies throughout 2006. A financial review for 2006 is also presented.

Governance and accreditation

Goal: IPPF practices good governance throughout the Federation and is made up of effective and democratic Member Associations.

Governance

During 2006, the Governing Council discussed how to increase youth participation in the regional governing bodies of IPPF. It has set a target to ensure that every Regional Council be composed of at least 20 per cent young people by 2008. In 2006, IPPF's Governing Council also established a task force on governance and volunteerism to identify ways in which the work of the IPPF's governing bodies at all levels can be improved. The task force has also been asked to make recommendations on the measures IPPF and its Member Associations can take to remain a vibrant sexual and reproductive health and rights volunteer movement in the 21st century. The task force will present its work and recommendations to Governing Council in May 2008.

In 2006, a number of key regional initiatives were undertaken to support Member Associations in the area of governance. The East and South East Asia and Oceania Regional Office initiated a series of workshops to strengthen the capacity of the governing bodies of Member Associations in the Pacific. A regional task force also met to agree on strategies needed to achieve the 20 per cent target of young people on all governing bodies in this region.

Senior governing body volunteers and senior management from all of South Asia's Member Associations worked together in a participatory process to develop a code of conduct to be applied by all Members. This code of conduct is intended to strengthen commitment to high standards, to generate greater transparency between volunteers and staff, and to improve clarity of roles.

The Western Hemisphere Regional Office prepared case studies on Member Associations whose governing bodies had developed strengths in key areas including advocacy (Trinidad and Tobago), resource mobilization (Mexico), board diversity (Puerto Rico), youth participation (Peru) and good relations between boards and chief executives (Colombia). These case studies provide valuable lessons on how to improve the work of IPPF's governing boards, and during 2006, were used as a basis for workshops with boards of Member Associations where action plans to strengthen their governance were developed and financially supported. Furthermore, the bylaws of the Western Hemisphere region were modified to ensure a 33 per cent representation of young people at its Regional Council.

Accreditation

Member Associations in Algeria, Bangladesh, Belize, Benin, Brazil, China, Colombia, Costa Rica, Cyprus, Estonia, Finland, Germany, Guinea Conakry, Israel, Cote d'Ivoire, Jordan, Latvia, Lithuania, Mali, Mauritius, Mexico, Nicaragua, Niger, Nigeria, Panama, Romania, Sudan, Swaziland, Thailand, and the UK all underwent an accreditation review in 2006. Despite a difficult country situation, the Arab World Regional Office conducted an accreditation review of the Palestinian Member Association, which was completed in 2007. Bem-Estar Familiar (Brazil), the China Family Planning Association and Fundación Mexicana para la Planeación Familiar (Mexico) complied fully with all 65 IPPF Membership Standards at the time of the review, bringing the number of Associations complying with all standards at the actual time of review since 2003 to five.

A number of international non-governmental organizations who are developing their own accreditation systems have consulted with IPPF to learn from our experiences from the past five years.

Post-accreditation follow-up support

Thirteen grants were approved for the period 2006-2007 to assist Member Associations in addressing areas for improvement identified during their accreditation review. In Costa Rica, Israel and Italy, funds were used to develop strategic plans, including funding strategic planning workshops in Israel and Italy. A capacity building workshop was held in Panama, and consultative meetings were held in Cyprus to formulate an advocacy strategy and to develop financial regulations, and in Bangladesh and India to formalize constitutional amendments. Staff from the Arab World Regional Office provided technical assistance to Member Associations in Jordan, Sudan and Syria to address governance and management standards, and the European Network Regional Office assisted Member Associations in Finland, Hungary and Turkey on the translation of key documents.

IPPF's Regional Offices continued to provide follow-up support to Member Associations throughout 2006. For example, the East and South East Asia and Oceania Regional Office provided training on logistics management, and assisted the Member Association in the Philippines to restructure its organization and set up an internal control framework.

Associations accredited

The Associations in Algeria, Bosnia, Brazil, Greece, Honduras, Iran, Jamaica, Kazakhstan, Kenya, Democratic People's Republic of Korea, Maldives, Mexico, Nepal, Paraguay, Philippines, Sri Lanka, Suriname and Syria were accredited in 2006. By the end of 2006, a total of 103 accreditation reviews had taken place, and a total of 41 Member Associations had been accredited.

Current projections are that a further 35 Associations will be recommended for accreditation during 2007.

Inter-regional initiatives

In October and December 2006, two inter-regional accreditation review visits were conducted during which the accreditation focal points from different regions worked together. These visits were intended to promote learning between IPPF's regions and to provide reassurance that there are no major regional variations in how accreditation reviews are conducted or in how the membership standards are interpreted and applied.

Another initiative involved collaboration between the Africa and Western Hemisphere regions to ensure that the five Member Associations in Lusophone countries on the African continent received support and training by staff from the Member Association in Brazil (BEMFAM) and the Western Hemisphere Regional Office to prepare them for their upcoming accreditation reviews.

Evaluation of the accreditation process

The objectives of the evaluation of IPPF's accreditation process were to determine, based on the first five years of experience, to what extent IPPF has benefited from the introduction of Member Association accreditation, and to identify improvements to the system. The results of the evaluation will provide information on how to make the review system more effective in ensuring Member Association compliance with the Federation's essential standards and responsibilities of membership.

The evaluation of the accreditation process began in 2006 when an external consultant was contracted to undertake a number of visits to Member Associations. The purpose of the visits was to review the value of undergoing accreditation and to gather the views of volunteers and staff on the accreditation process. All other Associations which were not visited were invited to provide their feedback through structured questionnaires sent to Executive Directors and Presidents.

In addition to the evaluation, a number of other sources of information will be used to inform the review of the accreditation system. Throughout 2006, a number of international organizations and agencies involved in certification processes were consulted to see how the IPPF system of accreditation compares to other initiatives and procedures. Discussions with these organizations will continue in 2007 to ensure that the planned revisions of the current system are in line with good international practice. Furthermore, in October 2006, the European Network gathered together a number of volunteers who had participated in accreditation teams in the region to discuss the benefits and weaknesses of the current accreditation system. The outcome of the review will provide critical guidance on how to make the accreditation system more effective.

"Once we get accreditation we will be in a very strong position to tell everyone we have credibility, we are here, we can deliver…"

"The accreditation team listened to our points of view. What was good was that it had a member from another Association, and it was useful to have other volunteers – they share experience."

Interviewees from the evaluation of the accreditation process

Resource mobilization

Goal: IPPF has a sustainable and diversified income at all levels.

In recent years, the structure of official development assistance (ODA) has begun to shift dramatically across all areas of international aid. Donors and recipient countries are reforming the aid system by putting in place measurable objectives and indicators and a new management framework. These changes were spearheaded at a number of international conferences, notably the Millennium Summit (2000), the International Conference on Financing for Development (2002), and the High Level Forum on Aid Effectiveness (2005).

The funding structure that is emerging will have a substantial impact on developing countries and grassroots civil society organizations, and will fundamentally change the environment in which IPPF works. It requires a Federation-wide response that capitalizes on the scope and reach of its network, and involves a paradigm shift that alters the way that we think about, and undertake, resource mobilization activities. As a result, the Secretariat and many of our Member Associations are investing resources and energy in advocating for financial and political support for sexual and reproductive health and rights at the national level.

Setting the agenda at the Millennium Summit

In 2000, the international community committed itself, via the Millennium Declaration, to the Millennium Development Goals (MDGs). The Millennium Development Goals are clear and coherent priorities that all nations should work on to help the world's poorest people achieve a better quality of life by 2015. Sexual and reproductive health and rights, including the goals of the International Conference on Population and Development, were initially excluded from the Millennium Development Goals, and the reorientation of donor and recipient country programmes to the Millennium Development Goals resulted in sexual and reproductive health and rights becoming increasingly marginalized.

As a result, IPPF and its partner organizations have brought renewed vigour to and raised the profile of sexual and reproductive health and rights issues. This has led to resurgence in donor confidence. We are also making progress in the policy arena where there is increasing understanding and support for the connections between HIV and AIDS and sexual and reproductive health and rights. Following the 2005 World Summit, the outcome document explicitly incorporated 'the achievement of universal access to reproductive health by 2015' and 'universal access to treatment for HIV and AIDS by 2010 for all who need it.' This has contributed to the development of two new targets for the Millennium Development Goals five and six, reworded by the Secretary General of the UN in 2006.

The Millennium Development framework has resulted in a number of donor countries reorganizing their internal structures for development cooperation, developing new missions to align themselves with the Millennium Development Goals and laying out new national policies on international development and aid.

The Monterrey Conference: An opportunity for sexual and reproductive health and rights?

Since 2000, the donor-recipient country partnership has moved from policy formation to funding, from defining what the priorities are, to how they will be supported. The Monterrey Consensus, resulting from the UN International Conference on Financing for Development in 2002, lays out six financing solutions for development. All countries that have ratified the agreement are responsible for implementing the necessary reforms. The Monterrey Consensus has increased pressure on donors to meet the long-standing 0.7 per cent of gross national income (GNI) funding commitment. However, although the international donor community committed to achieving 0.7 per cent of gross national income in ODA in 1970, to date only Denmark, Luxemburg, the Netherlands, Norway and Sweden[7] have met or surpassed this target.

In the new funding architecture, decisions relating to the allocation of development assistance are made at the country level to increase country ownership and leadership. As a result, IPPF anticipates that funding for civil society organizations, particularly as sub-contractors for public services, could increase. In this environment, donor governments will also look to civil society organizations to utilize their skills and experiences to implement evidence-based advocacy initiatives and inform policy debates. In particular, donor agencies will look to civil society organizations and local non-governmental organizations to advocate for policies to include the needs and rights of poor and marginalized communities. They will also look to them to advocate for national policies to address

more politically sensitive issues such as sexual and reproductive health and rights to ensure they do not become an even lower priority. In 2006, IPPF took on this role by managing the Safe Abortion Action Fund. In 2006, the UK government requested IPPF to act as secretariat for the Safe Abortion Action Fund, a $US11.1 million programme which supports 45 projects to reduce unsafe abortion worldwide. Donors will continue to rely on non-governmental organizations and multilaterals in fragile states, where the national government does not have the capacity to effectively mobilize or manage aid money.

Being aware of how donor countries are spending their official development assistance is vital. Even though non-governmental organizations may not be able to influence spending allocations of donor countries, tracking official development assistance spending will enable them to prepare for and take advantage of opportunities as they arise. By increasing their awareness of national spending on health and sexual and reproductive health and rights, IPPF's Member Associations will be able to position themselves as an appropriate investment prospect if and when funding becomes available.

The Paris Declaration and aid harmonization: a threat to sexual and reproductive health and rights?

When international donor countries pledged to increase official development assistance, there were also questions raised as to the effectiveness of the present system of providing aid. The Paris Declaration on Aid Effectiveness, ratified in March 2005 by over one hundred donor and recipient countries as well as multilateral institutions, is reforming the way donors and developing countries do business. With a set of measurable indicators and targets, the declaration is a commitment to monitoring the success of aid and to continually improving the aid system.

Successful and effective aid makes the greatest impact on poverty reduction. Donors recognize that the complexity of the aid system has hindered progress in reducing poverty. The Paris Declaration will increase effectiveness by improving aid coordination among donors, aligning aid with nationally-owned strategies, reducing unnecessary expenditure, and eliminating duplication and competition.

Unveiling proposals for closer coordination of national aid projects, the EU Development Commissioner Louis Michel said: "(It is) a question of making it better and more effective… Too many donors are concentrating on the same countries and the same sector."[8] With donors focusing aid on the more promising developing countries, the neediest countries become aid orphans, with few or no benefactors. Similarly, donors are focusing on a handful of sectors, for instance, infrastructure or education, while others go unsupported. Particularly as bilateral funding increases, these imbalances reveal a need for donors to coordinate among themselves so that aid is reaching all of those who need it. Civil society organizations also need to increase their watchdog function and call on donor governments to meet commitments they have made if and when this fails to occur.

Mechanisms to monitor accountability are vital for aid to be effective. Currently, a lack of accountability and a high level of corruption in many developing country governments prevent poor people from benefiting from official development assistance. The Paris Declaration aims to solve these problems by creating a new agreement on mutual accountability. The declaration specifies a greater role for civil society organizations in the aid process. Civil society organizations are in a unique position with the media and national stakeholders to monitor government expenditure and programme implementation against plans, budgets and strategies.

As independent watchdogs, civil society organizations play an invaluable role in ensuring that citizens' voices are heard and in holding their governments to account. However, despite recognition of this role, the Paris Declaration has the potential to inadvertently sideline civil society. The Commission on Population and Development has noted that the sexual and reproductive health (and population) sector is heavily dependent on population assistance from non-governmental organizations for the services and advocacy it finances.[9] As such, if non-governmental

organizations in this sector are excluded from the aid process, the ramifications for sexual and reproductive health and rights could be quite serious.

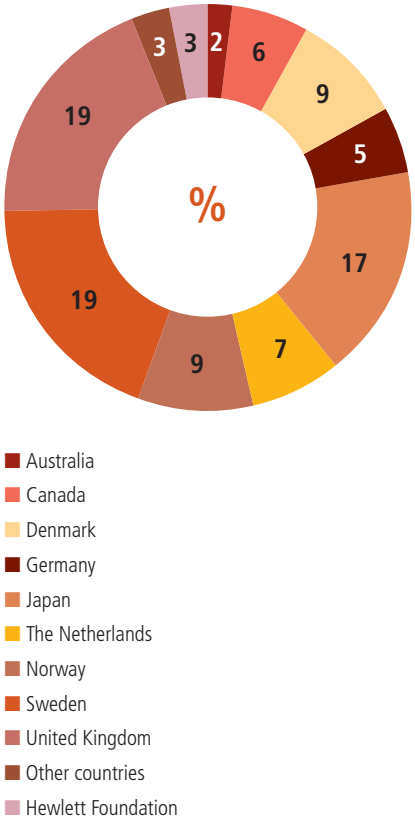
In 2006, overall income to IPPF reached a 12-year high at US$107.4 million. This was primarily due to increased unrestricted contributions from the governments of Canada, Finland, Sweden and the United Kingdom alongside an increasingly successful individual giving programme in IPPF's Western Hemisphere region. IPPF also gained increased funding from the UNFPA, demonstrating the continued strong collaborative working relationship between the two agencies.

The sustainability of IPPF's unrestricted income has increased, with many donors now providing multi-year commitments and no single donor contributing more than 25 per cent of funding. (Figure 3.1)

Many of IPPF's Member Associations have continued to increase their local income. In 2006, local income received by grant receiving Member Associations reached US$170 million.

This represents a considerable achievement on behalf of many Member Associations to increase their sustainability. However, income from international sources to Member Associations continued to be at a level well below that received in 2002. As the Paris Declaration on Aid Effectiveness increasingly sees decisions on international funding decentralized, it is vitally important that we strengthen our efforts to make the case for funding from international sources, and to build capacity among volunteers and staff in resource mobilization. Dedicated staff with responsibility for a broad range of resource mobilization activities are based within IPPF's Secretariat Offices and in a number of Member Associations. Their responsibilities involve stimulating demand to fund sexual and reproductive health and rights, and directly undertaking resource mobilization to fund their own activities or those of Member Associations. Strengthening resource mobilization at every level of the Federation will be a key priority.

Figure 3.1: **Unrestricted contribution per donor, 2006**



Capacity building

Goal: IPPF has the capacity to effectively implement the Strategic Framework.

Capacity building is critical to IPPF's mission to implement the Five A's and in its work to ensure strong governance, management, evaluation and accountability. Investment in capacity building for Member Associations enhances the Federation's ability to achieve the objectives of its Strategic Framework. IPPF has decades of experience in providing this type of support to Member Associations through its Regional Offices. Equally, within the Member Associations, there exists a vast wealth of skills and experience that is the Federation's most valuable asset.

IPPF views capacity building as a vital means of building the skills required to implement the Five A's and develop strong effective Member Associations. Capacity building may also involve changing the way an organization works by implementing new systems, encouraging different practices, and reorienting resources to increase effectiveness. The following section provides a selective summary of programmatic interventions carried out in 2006 to build capacity across the Federation by providing support from the Central Office to the Regional Offices and Member Associations, from Regional Offices to the Member Associations and also support between Member Associations. This capacity building between Member Associations is highly effective in increasing understanding through the exchange of experiences, lessons learned and good practice, reducing duplication of work and avoiding reinventing the wheel.

Capacity building for HIV and AIDS, abortion and adolescents

Central to IPPF's HIV strategy is targeted support provided to HIV-focus country Member Associations and Regional Offices. We work closely with these selected countries to build capacity and develop successful models for other Member Associations to learn from and replicate. Examples of these models include an HIV prevention outreach project with men who have sex with men in Colombia, which has been adapted and implemented in India, and an innovative approach to HIV treatment in clinics in the Dominican Republic and Kenya which is now being replicated in Sudan.

Technical support is also provided to Member Associations on specific issues. For example, in 2006, workshops on positive prevention were held in Kenya to support people living with HIV avoid contracting other sexually transmitted infections, delay HIV progression and avoid passing HIV to others. A central fixture of IPPF's HIV capacity building efforts each year is the competencies workshop, covering the latest developments in the HIV field and allowing staff to share ideas and experiences. Each year, the workshop systematically addresses the four areas of IPPF's HIV strategic plan: HIV prevention; treatment, care and support; stigma reduction; and supporting the linkages between HIV and sexual and reproductive health. In 2006, IPPF held their competencies workshop in Toronto, Canada, to link to the International AIDS Conference. This enabled workshop participants to learn about the latest programme and policy development from the international HIV and AIDS community. IPPF was invited to present its work in 18 different sessions covering a wide variety of programmatic areas including stigma reduction, the integration of HIV and AIDS into sexual and reproductive health programmes, and working with marginalized and vulnerable groups such as men having sex with men. This clearly indicates the interest in and success of the Federation's work.

In 2006, a regional safe abortion workshop was held in Hanoi, Vietnam to build the capacity of service providers from the Member Associations of the Democratic Republic of Korea, Malaysia, Thailand and Vietnam, and partner organizations in Myanmar and the People's Democratic Republic of Lao. The East and South East Asia and Oceania Regional Office facilitated the workshop jointly with Ipas. Service providers were trained on pre- and post-abortion counselling to support women to explore their decisions, to understand the abortion procedure, and to discuss any other concerns, including preventing any future unintended pregnancies. The service providers received hands-on training on the use of manual vacuum aspiration for safe abortion, and discussions were held on the issue of medical abortion including procurement, benefits, efficacy, safety and acceptability, to investigate whether providing medical abortion would be feasible in this region in the future. The service providers that received the training in Hanoi returned to their organizations to train other providers on counselling and the use of manual vacuum aspiration.

Working in partnership with Ipas proved to be a key factor in the success of the workshop, and it is envisaged that this relationship will continue to be built upon for future abortion-related activities in the region.

IPPF promotes a supportive partnership between staff, volunteers and young people, and empowers young people to be equal and active partners in programme implementation and decision making. In November 2006, the Member Association in Russia and the IPPF European Network conducted a training of trainers on advocacy for youth sexual and reproductive health and rights. The aim of this initiative was to involve more young people in the advocacy activities of the project and to develop a resource pool of youth advocates. Eleven young volunteers and regional coordinators worked together over five days to explore issues regarding young people's sexuality and reproductive health and rights, to identify areas that they wish to advocate on and to develop basic advocacy techniques and skills. Since completing the training, the group has provided similar trainings, conducted small scale youth-led advocacy activities, created opportunities to explore sensitive issues with their peers, and developed a youth declaration on sexual and reproductive health which was presented at a national sexual and reproductive health and rights conference in 2007.

In 2006, the Africa Regional Office, in collaboration with the Central Office Youth Team, developed a framework to build the capacity of Member Associations to integrate HIV into adolescent sexual and reproductive health and rights programmes in the region. The team met in January 2006 and established a pool of staff and young volunteers with the skills to adopt a rights-based approach to integrating HIV into adolescent sexual and reproductive health programmes. The meeting also improved the understanding of capacity building among the participating staff and young people, and demonstrated that planning and implementing a capacity building initiative cannot be done without the commitment of the various stakeholders and young people from the Member Associations. Collaboration between young people, staff from the Member Associations and the Regional Office is fundamental for the development of an innovative agenda for regional and local capacity building. One important lesson learned from the meeting is that promoting ideas of inclusion and partnership, using experiential and participatory learning methods, has a positive effect on creative thinking and joint decision making.

Support for restricted funded projects

Complying with the requirements of restricted funding can present a challenge to some Member Associations, and additional support may be needed. Capacity building is therefore a key component for the ten projects funded by a €10 million grant in the Republic of Congo, the Dominican Republic, the Gambia, Haiti, Lesotho, Madagascar, Mauritania, Rwanda, Sudan and Tuvalu. Strategies for improving programme management and performance include:

- support provided to the country projects through regular technical assistance visits by Regional Office staff
- training conducted by the project staff themselves and by IPPF
- activities to help ensure the sustainability of projects

Throughout 2006, technical assistance was provided by Regional Office programmatic and finance staff. The primary role of these visits was to monitor programme implementation and work with the projects to enable them to meet their objectives and deliver expected outputs. A number of technical assistance visits focused on the implementation of recommendations made during previous mid-term reviews. Others were related to specific issues (such as sustainability, quality of care assessment and negotiations for the purchase of clinic buildings). Financial capacity building and support was also provided to improve the financial reporting skills of Member Associations. Trip reports were prepared following each of these visits providing detailed information of activities implemented during the visits, observations, recommendations and follow-up action required. The reports are shared across IPPF.

Training to raise capacity is also an integral part of all ten projects. In 2006, a total of 63 staff members and 530 project volunteers received training. Two kinds of training took place. Firstly, training conducted in-house by the Member Association itself on the continuous upgrading of service provider skills, refresher training in counselling and the provision of quality services, training of peer educators, and training of religious leaders and policy makers on the sexual and reproductive health needs of young people. Secondly, training was conducted by other IPPF staff including support provided by

other Member Associations. For example, in Rwanda, training on management information systems was provided by the Madagascar Member Association, and in Lesotho, training on sustainability was provided by the Ghanaian Member Association. In Madagascar, 16 staff were trained on the Cost Revenue Analysis tool by two staff from the Africa and Arab World Regional Offices, and in Mauritania, project service providers (one doctor and four midwives) were trained in Tunisia for five days on techniques for cervical cancer screening (including pap smear, counselling, referral and management). Finally, training was given to the Association in Tuvalu on the use and application of the IPPF eIMS system in order to improve data collection and analysis.

Capacity building should be viewed as an ongoing process that is systematically planned and implemented. The Regional Offices are undoubtedly the best placed to implement capacity building activities, in particular the sustained follow-up that our experience has shown is essential for bringing about change and consolidating learned skills. Central Office in turn plays a coordinating and facilitating role, and ensures that experience and knowledge is shared cross-regionally.

As illustrated in some of the examples above, the promotion of experience sharing and technical assistance between Member Associations has been a successful strategy for many Regional Offices, and one which IPPF is keen to encourage. This approach uses the experiences and skills of strong Member Associations to build skills in other Associations both intra- and inter-regionally.

IPPF is also striving to make greater use of its volunteer structure and the substantial resource that volunteers provide. Targeted training, orientation and support of volunteers can considerably increase the manpower and expertise available to Member Associations to undertake certain key tasks. IPPF's Member Associations, Regional Offices and Central Office combined provide the Federation with a vast range of skills and experience in the areas needed to build capacity and achieve the objectives of our Strategic Framework, and the strategies we are using to ensure that these skills and experiences are shared across the regions have been harnessed throughout 2006 to continue to build a strong and successful Federation.

Within Member Associations, there exists a vast wealth of skills and experience that is the Federation's most valuable asset.

Monitoring and evaluation, including knowledge management

Goal: IPPF has a knowledge culture and infrastructure which identifies, creates, captures, shares and uses information and experiences.

Monitoring, evaluation and learning

IPPF's Monitoring and Evaluation Policy was revised for the first time since 1990 and approved by the Governing Council in May 2006. The new policy highlights the importance of monitoring, evaluation and learning as integral to organizational effectiveness. Monitoring and evaluation provide the information needed to analyze and reflect upon the process that led to results, both positive and negative, in ways which enable continuous improvement. Monitoring, evaluation and learning also increase our accountability both to those we serve and to those who support our work.

The policy commits IPPF to increase the evaluation skills of volunteers and staff, to report results on the implementation of the Federation's Strategic Framework, and to implement a participatory approach to monitoring and evaluation in which key people who have a concern and interest in a project are actively and meaningfully involved in its evaluation.

Measuring progress in implementing IPPF's Strategic Framework

The global indicators results from 2005 provided IPPF with baseline data against which it now measures progress in implementing the Federation's Strategic Framework. Throughout 2006, the 2005 global indicators results were shared with IPPF's Governing Council and Regional Councils to provide them with the evidence they need to monitor our work in relation to strategic and operational plans. The results were shared with IPPF's donors at the annual donors' meeting in 2006. They were published in detail in the 'Annual Performance Report 2005', and also in 'IPPF At a glance' which presents key facts and figures about IPPF's performance, and is translated into five other languages – Arabic, French, Japanese, Russian and Spanish.

Increasing the evaluation capacity of Member Associations

IPPF's Regional Offices continue to provide technical support to Member Associations to build their capacity in monitoring, evaluation and learning, and to ensure that IPPF's policy on monitoring and evaluation is implemented.

The Arab World and Western Hemisphere Regional Offices conducted workshops throughout 2006 to train their Associations on service statistics data collection and analysis. The Africa Regional Office conducted monitoring, evaluation and planning workshops, and an assessment of the impact of sexual and reproductive health services provided by Member Associations in four countries. The European Network trained Regional Office colleagues in monitoring and evaluation to build capacity in the Regional Office. This ensures that technical assistance on monitoring and evaluation can be provided in addition to other support when visiting Member Associations.

The East and South East Asia and Oceania Regional Office held an evaluation workshop attended by 11 Member Associations. Results-based management workshops were conducted in Malaysia and Thailand, and the Regional Office also provided training on evaluation to assist the Vietnam Member Association on their end-of-project evaluation for an adolescent sexual and reproductive health project. The South Asia Regional Office provided support to five Member Associations to build their capacity in using tools to conduct facility surveys, mapping of services, exit interviews and focus group discussions with providers and users of sexual and reproductive health services.

The electronic Integrated Management System (eIMS)

The results-based electronic Integrated Management System (eIMS) has continued to evolve during 2006. Most notable are the significant improvements made in the data analysis areas, now allowing easy access to the systems-wide range of user-friendly reports. The latter are now being used by Regional Offices and Central Office staff to analyze Member Associations' programme performance data including the global indicators data. The information can be aggregated from the clinical level to provide IPPF with national, regional and global overviews. In addition, the forecasting module now allows us to compare service data against all commodities issued, including contraceptives. Following the implementation of new, sophisticated reporting software, IPPF can produce information dashboards that show projects, programme and in depth service data on one single page. IPPF's future planning is greatly enhanced by the systems' ability to facilitate analysis of projects and programmes.

With the implementation of a range of new functionalities such as commodities management, the travel module and service statistics, the eIMS is now complete. It does however constantly need to be adapted and enhanced to meet new users' needs and the technical requirements of the ever evolving IT world. To guarantee sustainability, the Knowledge Information Systems unit has established a network of international charitable organisations, the Non Profit Knowledge Initiative (NPOKI), that is working together to develop tools similar

to the eIMS that meet the specific needs of development organizations. Several organizations, including donors, met in September 2006 and succeeded in developing tools that are generic enough to be used by all organizations. The development of the eIMS has largely been a success and encouraged other non-governmental organizations to join the NPOKI initiative.

The set of tools available on the eIMS is currently being expanded to provide much-needed clinical management facilities in the field. The new clinical system will allow the tracking of patient records, management of patient flow, point of sale and inventory. A shortlist of possible candidate Member Associations suitable to test this new clinical management facility has been drawn up and testing began in 2007. The system will integrate with the eIMS and enhance the collection of tools that are available to Federation members.

Integration between the eIMS and IPPF's website was key in the implementation of the new website in 2006. A key advantage is the ability to pull data directly from the eIMS. The Knowledge Information Systems unit supported the Communications unit in designing the website and in developing a long-awaited resource bank CD-ROM that will soon be available on IPPF's website. Users can directly access various IPPF publications and information about consultants from this CD-ROM.

In summary, 2006 could be described as the final breakthrough in fully integrating all of IPPF's information systems, allowing the organization to focus on long-term sustainability and clinical solutions at the service delivery point level.

Organizational learning

A scoping exercise on organizational learning was undertaken in 2006 by a consultant working with a number of Central and Regional Office staff, including members of IPPF's Senior Management Team. The review identified examples of good practice in IPPF and also made specific recommendations to increase IPPF's capacity for organizational learning.

The review concluded that there is a positive attitude to learning within the Federation with the senior management leadership and support necessary to give organizational learning a strategic profile and to allocate sufficient resources.

Some of the key areas of good practice in organizational learning currently being implemented include:

- focal point meetings in accreditation, communication, electronic Integrated Management System, evaluation and learning, and finance, with a strong emphasis on shared problem-solving and mutual learning
- travel bans to ensure staff are present for important meetings and sharing experience and knowledge
- end-of-project meetings for restricted projects to share lessons learned
- exchange visits, twinning arrangements and annual meetings that bring together Member Associations to provide opportunities for mutual learning, the provision of technical support and sharing of expertise
- policy development being informed by research, systematic analysis and collaboration between experts
- participation in national and international networks, conferences and other high-profile events, and sharing of experiences with other organizations
- prioritized focus countries for specific capacity building to provide models for scaling up
- human resource initiatives that recognize the importance of learning in annual performance appraisals, personal objectives and development plans
- a redesigned website and the introduction of Sharepoint, a document management system to increase sharing of information, including documentation, calendar of activities and discussion forums
- the production of various publications for both internal and external audiences, for example, newsletters, toolkits, guidance manuals and technical publications
- the development and review of new proposals by multidisciplinary teams with a broad range of experience and knowledge
- annual retreats to focus on planning, collaboration and the developmental aspects of team work

Following on from the scoping exercise, a strategy was developed, 'Be brave, angry and smart,' to support a more systematic approach to organizational learning throughout the Federation. Our aim is for IPPF to become a leading learning organization in the non-governmental sector, and we have begun a participatory process to build the necessary commitment to implement this strategy across all levels of the Federation.

Financial review

Table 3.2: **Summary of income 2004–2006**

	2004 US $'000	2005 US $'000	2006 US $'000
Unrestricted:			
Government	68,542	64,994	71,421
Multilaterals etc	8,489	6,448	5,157
Other	4,737	2,233	5,233
Restricted:			
Government	2,609	4,006	5,798
Multilaterals etc	11,786	14,615	19,569
Other	239	227	257
Total	**96,402**	**92,523**	**107,435**

Source: IPPF Financial Statements 2004, 2005, 2006.

Table 3.3: **Summary of expenditure 2004–2006**

	2004 US $'000	2005 US $'000	2006 US $'000
Grants to Member Associations and partners	45,226	56,358	61,288
Programme activities	20,612	18,856	20,397
Support costs	10,652	13,483	9,981
Fundraising	2,257	2,558	2,758
Governance	1,610	2,285	2,251
Trading company	1,900	1,897	1,577
Total	**82,257**	**95,437**	**98,252**

Source: IPPF Financial Statements 2004, 2005, 2006.

Full details of IPPF's 2006 financial results are provided in a separate document entitled 'IPPF Financial Statements 2006.' These were prepared according to UK accounting standards and are in compliance with the UK Charity Commission accounting requirements. The financial statements were audited by KPMG LLP who provided an unqualified audit opinion (clean opinion) on 12 May 2007. The IPPF financial results do not include the income and expenditure of the individual Member Associations.

IPPF's income

The overall income received by IPPF in 2006 was US$107.4 million. Compared with the previous year, there was an increase of 16 per cent (Table 3.2), and since 2001, our income has increased by 34 per cent from US$80.2 million.

IPPF's main source of funding is unrestricted government contributions which accounted for 66 per cent of the total incoming resources in 2006. Unrestricted government grants showed an increase of 10 per cent or US$6.4 million since 2005.

Table 3.4: **IPPF grant funding per region, 2004–2006**

Region	2004 US $'000	2005 US $'000	2006 US $'000
Africa	16,989	20,790	21,685
Arab World	4,370	5,343	4,998
East and South East Asia and Oceania	6,121	6,781	6,574
Europe	1,627	3,946	5,294
South Asia	6,598	8,850	9,129
Western Hemisphere	9,521	10,648	13,608
Total	**45,226**	**56,358**	**61,288**

Source: IPPF Financial Statements 2004, 2005, 2006.

Table 3.5: **Commodity grants by type, 2006**

	US $
Oral contraceptives	1,620,489
Diaphragms	5,848
Condoms	1,445,990
Spermicides	65,738
IUDs	181,582
Injectable contraceptives	1,461,525
Emergency contraceptives	17,125
Implantable contraceptives	222,846
Medical and clinical equipment and consumables	349,098
Audio-visual equipment	143,407
Office equipment	36,634
Vehicles	702,183
Freight, handling, etc.	414,419
Total	**6,666,884**

Restricted government grants amounted to US$5.8 million, up from US$4.0 million in 2005. Grants from multilaterals and other income sources amounted to US$24.7 million compared with US$21.0 million in the previous year. The support of a number of US Foundations who provide unrestricted funding, along with support from the European Commission, the UK Big Lottery Fund, UNFPA and income raised by the IPPF private sector fundraising programme from the general public, has allowed IPPF to diversify funding and provide support to a number of innovative projects.

IPPF's expenditure

The overall expenditure in 2006 was US$98.3 million (Table 3.3). This compared with US$95.4 million in the previous year. Grants to Member Associations increased by 9 per cent to US$61.3 million (Table 3.4). This was due to an increase in unrestricted grants which went up by 7 per cent from $43.1 million to U$46.2 million. Restricted grant expenditure increased to $15.0 million.

IPPF provided nearly US$6.7 million in commodities to Member Associations as part of their grant allocations (Table 3.5 and Figure 3.6).

Figure 3.6: **Commodity grant by type, 2006**

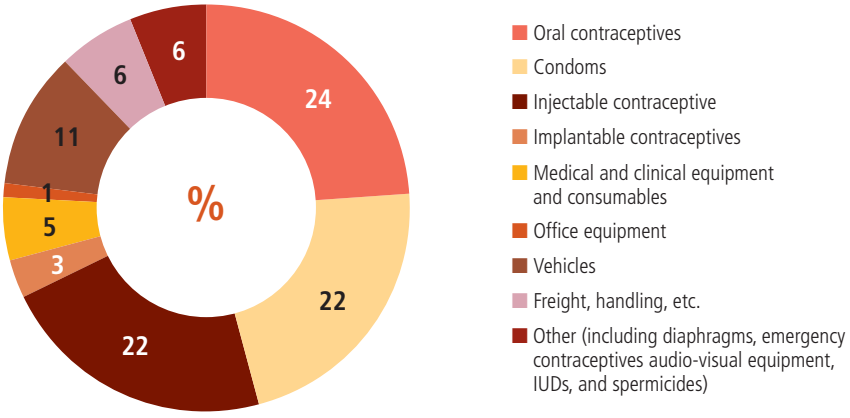


Table 3.7: **Percentage of unrestricted resource allocation to Member Associations by UNFPA category, 2004–2006**

Country classification	2004	2005	2006
A – Highest need	62.9	63.9	60.4
B – High need	25.4	25.3	25.2
C – Low need	7.3	6.0	8.2
O – Other	4.4	4.8	6.2
Total	**100**	**100**	**100**

Grants to Member Associations and partners can be classified according to the UNFPA country methodology to asses the resources which are being allocated to countries with the greatest sexual and reproductive health and rights needs. In 2006, IPPF allocated 85.6 per cent of unrestricted funding to category A and B countries (Table 3.7).

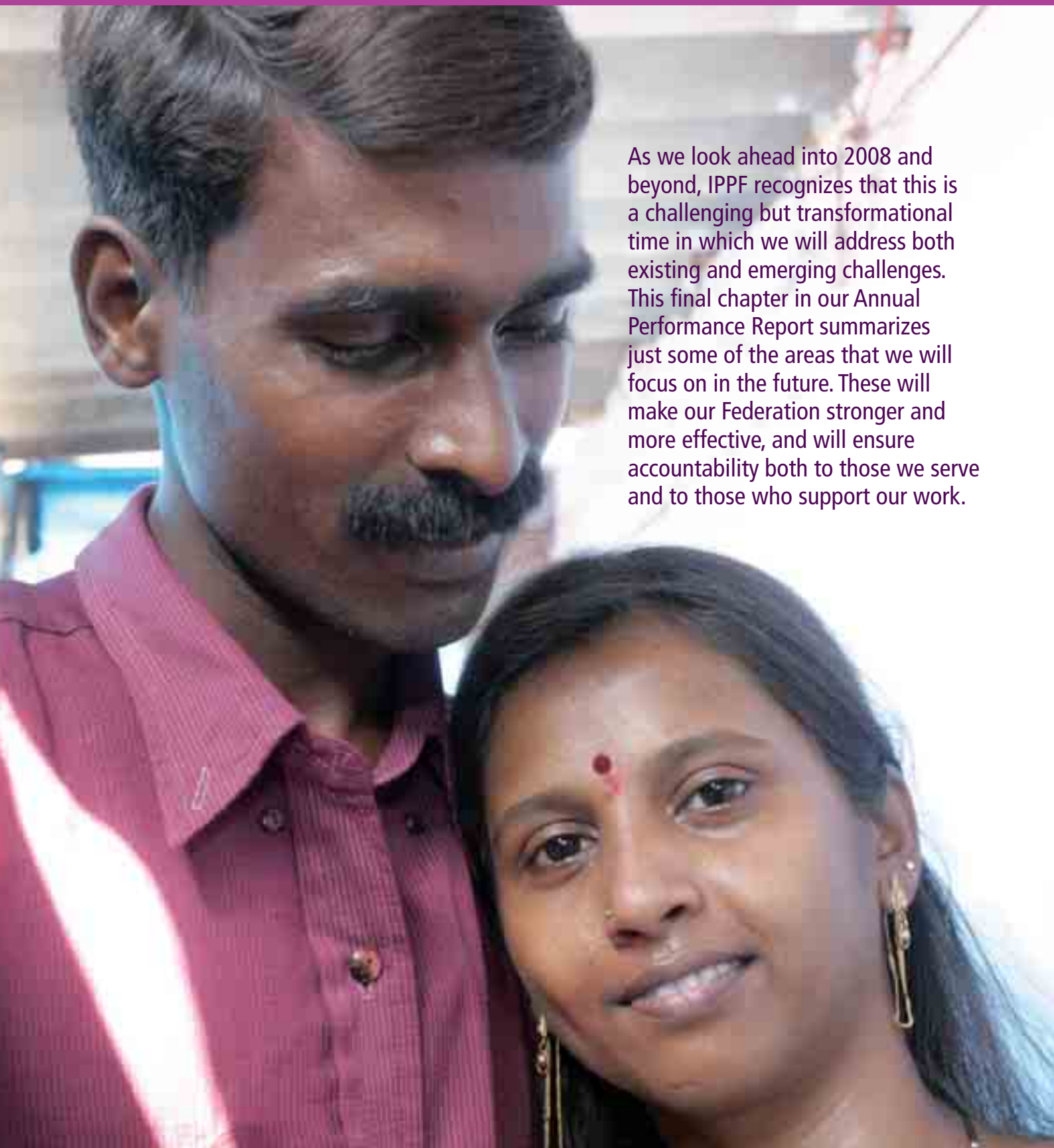
Member Association income

IPPF conducts analyses on the overall funding received by the grant receiving Member Associations. Annex B presents a summary of grant receiving Member Association income comprising IPPF, local and international sources. IPPF's total income has increased over the last five years from US$207.6 million to US$262.7 million, or by 26.5 per cent.

Regional comparisons show considerable differences among Member Associations in terms of relying on IPPF for the majority of their funding. IPPF encourages self-sufficiency and diversity of income sources but also recognizes that in meeting the needs of the poorest of the poor and in working with marginalized groups, it is not always possible to achieve this whilst providing services for free or which do not fully cover costs.

Chapter 4

Next steps



As we look ahead into 2008 and beyond, IPPF recognizes that this is a challenging but transformational time in which we will address both existing and emerging challenges. This final chapter in our Annual Performance Report summarizes just some of the areas that we will focus on in the future. These will make our Federation stronger and more effective, and will ensure accountability both to those we serve and to those who support our work.

Looking ahead...

IPPF will concentrate and focus efforts to make the greatest gains for sexual and reproductive health and rights for all, both globally and locally.

Improving quality

A major focus for IPPF in the near future is to strengthen our capacity, ensuring that we deliver comprehensive and high quality services which contribute to a reduction in morbidity and mortality, and make a real difference in people's lives.

We will continue to deliver on the promises made in our Strategic Framework and to demonstrate progress through improved monitoring and evaluation and a commitment to continuous learning. Following an independent external evaluation, we will also implement a revised accreditation system that will ensure that Member Associations adhere to essential standards that increase quality, effectiveness and accountability.

Increasing advocacy and resource mobilization

Another major priority is to strengthen our advocacy and resource mobilization at the local, regional and global levels to ensure that sexual and reproductive health and rights, and the critical role of civil society, are not forgotten in a competitive and complex world of new development aid architecture. We will also work hard to ensure that the new Millennium Development Goal target of universal reproductive health and the Maputo Plan are realized.

Significant initiatives

In May 2008, following 18 months of study and consultation, a Governing Council Task Force will make a series of recommendations to improve the governance of the Federation to maintain IPPF as an effective sexual and reproductive health and rights volunteer movement for the next ten years.

A draft Bill of Sexual Rights has been developed by a panel made up of IPPF representatives from the regions, as well as external representatives. This bill will be submitted to Governing Council for approval in late 2007, and will provide direction on IPPF future policy and programming to promote a strong focus on sexual rights and gender issues in both service delivery and advocacy.

Integrating sexual and reproductive health and rights and HIV and AIDS

IPPF will continue to improve services for the prevention and treatment of sexually transmitted infections including HIV. Efforts will also continue to focus on more effective integration of sexual and reproductive health and HIV services across the continuum of care, including condom distribution, VCT, prevention of mother-to-child transmission, treatment of opportunistic infection, antiretroviral treatment and palliative care. Equally important, IPPF will continue to work with other partners and communities to fight stigma and discrimination.

Commodity distribution

ICON contributes to IPPF's mission through the provision of products, including contraceptives. It is a social enterprise that provides integrated marketing and supply chain expertise across the reproductive and sexual health market. Working together with Member Associations, ICON will add new products to its range, and work with even more partners across the globe to ensure that people can increasingly exercise their choice of contraception, as well as protect themselves from sexually transmitted infections, HIV and cervical cancer.

Building networks

IPPF has a unique and extensive global reach and diversity and we recognize the importance of learning from our own experiences and from others. We will continue to strengthen partnerships at all levels, and especially between Associations, both within and across regions. Our work with other strategic partners is also of critical importance and this will continue to be prioritized in the future.

Annex A: Global indicators by region[Δ]

Table A.1: **Summary of adolescents indicators, 2005–2006**

(n=number of Member Associations that provided data)*

	Indicator	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Overall
1	Proportion of Member Associations with 20 per cent or more young people under 25 years of age on their governing board	**2006**	**34.2%**	**0.0%**	**18.4%**	**4.8%**	**0.0%**	**14.3%**	**17.2%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	23.3%	16.7%	16.1%	17.6%	0.0%	14.3%	16.7%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
2	Percentage of Member Association staff who are under 25 years of age	**2006**	**5.3%**	**10.2%**	**6.3%**	**7.6%**	**6.1%**	**3.4%**	**4.7%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	4.1%	4.3%	3.1%	8.1%	4.6%	3.3%	4.0%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
3	Proportion of Member Associations providing sexuality information and education to young people	**2006**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	93.3%	83.3%	96.8%	100.0%	87.5%	100.0%	95.2%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
4	Proportion of Member Associations providing sexual and reproductive health services to young people	**2006**	**100%**	**100%**	**94.7%**	**100%**	**100%**	**92.9%**	**97.2%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	93.3%	83.3%	93.5%	100.0%	100.0%	92.9%	93.7%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
5	Proportion of Member Associations advocating for improved access to services for young people	**2006**	**100%**	**100%**	**97.4%**	**100%**	**87.5%**	**100%**	**98.6%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	100.0%	91.7%	96.8%	100.0%	100.0%	100.0%	98.4%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
6	Number of sexual and reproductive health services (including contraception) provided to young people	**2006**	**2,623,538**	**358,566**	**249,186**	**317,804**	**3,103,582**	**4,862,174**	**11,514,850**
			(n=37)	**(n=10)**	**(n=10)**	**(n=17)**	**(n=8)**	**(n=26)**	**(n=108)**
		2005	379,922	74,947	7,582	253,787	3,075,344	4,077,749	7,869,331
			(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	(n=87)

Δ Cuba is a Member Association of IPPF. It is not currently assigned to any region but receives technical support from WHR. Cuba has been included with WHR's data in 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.

* Refer to tables 2.1 and 2.2 on page 22 for a summary of Member Association response rates.

Table A.2: **Summary of HIV and AIDS indicators, 2005–2006**

(n=number of Member Associations that provided data)*

	Indicator	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Overall
7	Proportion of Member Associations with a written HIV and AIDS workplace policy ▲	**2006**	**39.5%**	**33.3%**	**32.4%**	**33.3%**	**87.5%**	**50.0%**	**40.7%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	40.0%	41.7%	22.6%	23.5%	12.5%	35.7%	31.0%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
8	Proportion of Member Associations providing HIV-related services along the prevention to care continuum ▲+	**2006**	**63.2%**	**8.3%**	**7.9%**	**28.6%**	**37.5%**	**35.7%**	**32.4%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	63.3%	8.3%	9.7%	29.4%	25.0%	35.7%	31.7%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(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	**2006**	**73.7%**	**66.7%**	**39.5%**	**61.9%**	**62.5%**	**53.6%**	**57.9%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	63.3%	33.3%	48.4%	41.2%	62.5%	50.0%	50.8%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
10	Proportion of Member Associations with strategies to reach people particularly vulnerable to HIV infection	**2006**	**92.1%**	**66.7%**	**65.8%**	**71.4%**	**87.5%**	**71.4%**	**75.9%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	93.3%	58.3%	64.5%	64.7%	75.0%	57.1%	69.8%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
11	Proportion of Member Associations conducting behaviour change communication activities to reduce stigma and promote health-seeking behaviour	**2006**	**94.7%**	**83.3%**	**68.4%**	**66.7%**	**87.5%**	**78.6%**	**79.3%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	96.7%	58.3%	58.1%	58.8%	75.0%	50.0%	66.7%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
12	Number of HIV-related services provided	**2006**	**726,593**	**59,820**	**75,619**	**515,852**	**369,740**	**792,005**	**2,539,629**
			(n=37)	**(n=10)**	**(n=10)**	**(n=17)**	**(n=8)**	**(n=26)**	**(n=108)**
		2005	254,814	35,903	8,931	27,792	323,659	669,500	1,320,599
			(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	(n=87)
13	Number of condoms distributed	**2006**	**15,275,326**	**2,084,864**	**205,342**	**3,580,187**	**20,955,100**	**63,235,247**	**105,336,066**
			(n=37)	**(n=10)**	**(n=10)**	**(n=17)**	**(n=8)**	**(n=26)**	**(n=108)**
		2005	5,970,411	718,437	67,370	9,549,970	20,623,889	60,925,614	97,855,691
			(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	(n=87)

* Refer to tables 2.1 and 2.2 on page 22 for a summary of Member Association response rates.

▲ This indicator has been revised in 2006 and data from 2005 were re-analyzed to provide a figure for comparative purposes.

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

Table A.3: **Summary of abortion indicators, 2005–2006**

(n=number of Member Associations that provided data)*

	Indicator	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Overall
14	Proportion of Member Associations advocating for reduced restrictions and/or increased access to safe legal abortion ▲	**2006**	**60.5%**	**58.3%**	**60.5%**	**38.1%**	**50.0%**	**50.0%**	**54.5%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	60.0%	41.7%	67.7%	47.1%	37.5%	42.9%	53.2%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(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	**2006**	**39.5%**	**50.0%**	**63.2%**	**61.9%**	**25.0%**	**35.7%**	**48.3%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	36.7%	16.7%	67.7%	52.9%	37.5%	32.1%	43.7%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
16	Proportion of Member Associations providing abortion-related services	**2006**	**92.1%**	**66.7%**	**86.8%**	**90.5%**	**87.5%**	**78.6%**	**85.5%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	90.0%	75.0%	83.9%	88.2%	87.5%	71.4%	82.5%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
17	Number of abortion-related services provided	**2006**	**36,315**	**11,175**	**3,694**	**75,509**	**104,810**	**203,791**	**435,294**
			(n=37)	**(n=10)**	**(n=10)**	**(n=17)**	**(n=8)**	**(n=26)**	**(n=108)**
		2005	25,044	3,333	339	39,797	137,142	13,574	219,229
			(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	(n=87)

* Refer to tables 2.1 and 2.2 on page 22 for a summary of Member Association response rates.

▲ This indicator has been revised in 2006 and data from 2005 were re-analyzed to provide a figure for comparative purposes.

Table A.4: **Summary of access indicators, 2005–2006**

(n=number of Member Associations that provided data)*

	Indicator	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Overall
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	**2006**	**89.5%**	**75.0%**	**76.3%**	**81.0%**	**87.5%**	**78.6%**	**81.4%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	86.7%	75.0%	67.7%	82.4%	100.0%	75.0%	78.6%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
19	Estimated percentage of Member Association clients who are poor, marginalized, socially-excluded and/or under-served	**2006**	**77.0%**	**64.3%**	**47.1%**	**18.8%**	**84.3%**	**60.0%**	**59.3%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	71.9%	76.8%	24.1%	26.7%	81.3%	52.7%	56.6%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
20	Number of Couple Years of Protection (CYP)	**2006**	**695,416**	**362,946**	**16,170**	**613,547**	**1,664,203**	**4,447,791**	**7,800,073**
			(n=37)	**(n=10)**	**(n=10)**	**(n=17)**	**(n=8)**	**(n=26)**	**(n=108)**
		2005	510,458	318,959	4,801	460,043	1,761,903	3,064,913	6,121,077
			(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	(n=87)
21	Number of contraceptive services provided	**2006**	**3,280,159**	**1,578,506**	**116,411**	**1,839,720**	**4,172,932**	**9,397,176**	**20,384,904**
			(n=37)	**(n=10)**	**(n=10)**	**(n=17)**	**(n=8)**	**(n=26)**	**(n=108)**
		2005	2,917,141	1,152,855	31,350	1,120,341	4,376,771	7,737,150	17,335,608
			(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	(n=87)
22	Number of non-contraceptive sexual and reproductive health services provided	**2006**	**3,722,421**	**701,990**	**203,847**	**1,988,337**	**2,959,273**	**8,685,784**	**18,261,652**
			(n=37)	**(n=10)**	**(n=10)**	**(n=17)**	**(n=8)**	**(n=26)**	**(n=108)**
		2005	598,725	662,208	47,181	1,099,299	2,952,146	8,057,815	13,416,374
			(n=29)	(n=9)	(n=2)	(n=17)	(n=8)	(n=25)	(n=87)
23	Number of service delivery points	**2006**	**2,644**	**1,684**	**157**	**7,169**	**20,945**	**23,312**	**55,911▲**
			(n=37)	**(n=10)**	**(n=10)**	**(n=17)**	**(n=8)**	**(n=26)**	**(n=108)**
		2005	2,329	1,591	16	2,689	30,118	21,727	58,470
			(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	(n=87)
24	Proportion of Member Associations with gender-focused policies and programmes	**2006**	**81.6%**	**100%**	**57.9%**	**71.4%**	**50.0%**	**67.9%**	**71.0%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	63.3%	91.7%	71.0%	82.4%	75.0%	67.9%	72.2%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
25	Proportion of Member Associations with quality of care assurance systems, using a rights-based approach+	**2006**	**70.3%**	**80.0%**	**60.7%**	**65.0%**	**75.0%**	**88.5%**	**72.1%**
			(n=37)	**(n=10)**	**(n=28)**	**(n=20)**	**(n=8)**	**(n=26)**	**(n=129)**
		2005	66.7%	66.7%	48.4%	64.7%	62.5%	82.1%	65.0%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)

* Refer to tables 2.1 and 2.2 on page 22 for a summary of Member Association response rates.

▲ 5,733 clinic based service delivery points and 50,178 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 129 Member Associations that responded to the quality of care questions on the online survey.

Table A.5: **Summary of advocacy indicators, 2005–2006**

(n=number of Member Associations that provided data)*

	Indicator	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Overall
26	Proportion of Member Associations involved in influencing public opinion on sexual and reproductive health and rights	**2006**	**63.2%**	**91.7%**	**81.6%**	**90.5%**	**50.0%**	**60.7%**	**73.1%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	60.0%	91.7%	80.6%	70.6%	62.5%	67.9%	71.4%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
27	Proportion of Member Associations involved in advancing national policy and legislation on sexual and reproductive health and rights	**2006**	**86.8%**	**91.7%**	**97.4%**	**90.5%**	**75.0%**	**92.9%**	**91.0%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	86.2%	100.0%	93.5%	94.1%	87.5%	85.7%	90.4%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(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	**2006**	**15**	**1**	**14**	**10**	**4**	**12**	**56**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	11	5	15	4	2	14	51
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
29	Proportion of Member Associations involved in counteracting opposition to sexual and reproductive health and rights	**2006**	**89.5%**	**83.3%**	**81.6%**	**66.7%**	**87.5%**	**85.7%**	**82.8%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	83.3%	66.7%	87.1%	82.4%	87.5%	71.4%	80.2%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)
30	Proportion of Member Associations advocating for national governments to commit more financial resources to sexual and reproductive health and rights	**2006**	**78.9%**	**91.7%**	**86.8%**	**85.7%**	**62.5%**	**92.9%**	**84.8%**
			(n=38)	**(n=12)**	**(n=38)**	**(n=21)**	**(n=8)**	**(n=28)**	**(n=145)**
		2005	93.3%	66.7%	90.3%	94.1%	75.0%	82.1%	86.5%
			(n=30)	(n=12)	(n=31)	(n=17)	(n=8)	(n=28)	(n=126)

* Refer to tables 2.1 and 2.2 on page 22 for a summary of Member Association response rates.

Table A.6: **Number of sexual and reproductive health services provided (excluding contraceptive services) by region and by service type, 2005–2006**

Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of Member Associations that provided data*	**2006**	**37**	**10**	**10**	**17**	**8**	**26**	**108**
	2005	29	9	2	14	8	25	87
Gynaecological services	**2006**	**228,253**	**256,295**	**42,554**	**682,785**	**302,310**	**4,656,465**	**6,168,662**
	2005	40,251	186,848	19,574	268,416	307,972	4,495,533	5,318,594
Other specialized counselling services	**2006**	**1,174,921**	**58,149**	**73,931**	**248,420**	**267,603**	**494,904**	**2,317,928**
	2005	20,237	31,591	4,859	45,446	264,425	552,064	918,622
Other SRH medical services	**2006**	**467,568**	**98,659**	**566**	**241,077**	**331,914**	**539,352**	**1,679,136**
	2005	6,047	45,524	34	337,589	780,728	282,657	1,452,579
STI/RTI services	**2006**	**155,014**	**26,258**	**51,252**	**388,151**	**257,833**	**574,742**	**1,453,250**
	2005	34,723	27,371	2,200	15,445	264,699	474,112	818,550
HIV and AIDS services	**2006**	**571,579**	**33,562**	**24,367**	**127,701**	**111,907**	**217,263**	**1,086,379**
	2005	220,091	8,532	6,731	12,347	58,960	195,388	502,049
Abortion-related services	**2006**	**36,315**	**11,175**	**3,694**	**75,509**	**104,810**	**203,791**	**435,294**
	2005	25,044	3,333	339	39,797	137,142	13,574	219,229
Urological services	**2006**	**10,855**	**5,542**	**321**	**21,293**	**5,697**	**157,015**	**200,723**
	2005	0	429	35	4,019	4,656	129,902	139,041
Infertility services	**2006**	**34,214**	**13,075**	**724**	**27,006**	**55,166**	**53,696**	**183,881**
	2005	17,748	4,304	4,878	17,899	65,912	82,531	193,272
Obstetrics services	**2006**	**806,446**	**154,639**	**6,319**	**170,479**	**1,130,694**	**1,494,051**	**3,762,628**
	2005	90,330	234,384	8,376	208,030	778,263	1,466,688	2,786,071
Paediatrics services	**2006**	**237,256**	**44,636**	**119**	**5,916**	**391,339**	**294,505**	**973,771**
	2005	115,399	117,808	0	149,644	285,503	276,682	945,036
Total	**2006**	**3,722,421**	**701,990**	**203,847**	**1,988,337**	**2,959,273**	**8,685,784**	**18,261,652**
	2005	**598,725**	**661,208**	**47,181**	**1,099,299**	**2,952,146**	**8,057,815**	**13,416,374**

* Refer to table 2.2 on page 22 for a summary of Member Association response rates.

Table A.7: **Number of contraceptive services provided by region and by service type, 2005–2006**

Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of Member Associations that provided data*	**2006**	**37**	**10**	**10**	**17**	**8**	**26**	**108**
	2005	29	9	2	14	8	25	87
Oral contraceptives	**2006**	**466,685**	**531,024**	**16,810**	**935,289**	**1,790,499**	**3,349,453**	**7,089,760**
	2005	811,168	510,600	10,974	178,329	1,244,762	3,067,148	5,822,981
Contraceptive counselling	**2006**	**739,062**	**323,973**	**48,536**	**403,202**	**717,307**	**2,858,963**	**5,091,043**
	2005	318,702	251,165	17,600	374,766	1,196,998	2,111,625	4,270,856
Condoms	**2006**	**780,277**	**519,507**	**49,958**	**242,484**	**653,130**	**1,690,245**	**3,935,601**
	2005	1,097,377	422	187	375,801	677,444	1,199,196	3,350,427
Injectables	**2006**	**899,878**	**55,941**	**32**	**85,183**	**654,027**	**623,912**	**2,318,973**
	2005	574,773	35,371	690	55,499	746,425	603,290	2,016,048
IUD	**2006**	**56,707**	**128,183**	**580**	**143,035**	**149,215**	**463,709**	**941,429**
	2005	41,388	191,294	1,175	110,962	280,026	273,221	898,066
Sterilization	**2006**	**2,118**	**291**	**2**	**7,137**	**128,330**	**128,962**	**266,840**
	2005	147	592	268	14,705	131,697	139,282	286,691
Contraceptive referrals	**2006**	**249,427**	**14,577**	**168**	**1,805**	**27,781**	**16,756**	**310,514**
	2005	2,327	9,052	91	1,006	16,746	226,666	255,888
Implants	**2006**	**27,258**	**253**	**0**	**1,721**	**49,273**	**42,424**	**120,929**
	2005	16,137	381	9	1,633	82,517	56,090	156,767
Other barrier methods	**2006**	**14,579**	**4,725**	**216**	**8,764**	**50**	**80,711**	**109,045**
	2005	10	39,439	242	6,159	156	44,486	90,492
Emergency contraceptive services	**2006**	**18,382**	**32**	**19**	**4,935**	**2,721**	**121,125**	**147,214**
	2005	28,855	1,084	155	667	3,886	88,684	123,331
Awareness-based methods	**2006**	**25,786**	**0**	**55**	**6,165**	**599**	**12,311**	**44,916**
	2005	55,112	114,539	0	1,481	0	12,842	183,974
Other hormonal methods	**2006**	**0**	**0**	**35**	**0**	**0**	**8,605**	**8,640**
	2005	0	0	114	0	0	3,304	3,418
Total	**2006**	**3,280,159**	**1,578,506**	**116,411**	**1,839,720**	**4,172,932**	**9,397,176**	**20,384,904**
	2005	**2,917,141**	**1,152,855**	**31,350**	**1,120,341**	**4,376,771**	**7,737,150**	**17,335,608**

* Refer to table 2.2 on page 22 for a summary of Member Association response rates.

Table A.8: **Number of Couple Years of Protection (CYP) provided by region and method, 2005–2006**

CYP by method	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of Member Associations that provided data*	**2006**	**37**	**10**	**10**	**17**	**8**	**26**	**108**
	2005	29	9	2	14	8	25	87
IUD	**2006**	**104,937**	**257,464**	**1,705**	**405,836**	**331,314**	**2,118,393**	**3,219,649**
	2005	116,991	260,117	3,115	209,969	422,618	920,189	1,932,999
Sterilization	**2006**	**18,510**	**260**	**5,170**	**14,600**	**498,070**	**789,530**	**1,326,140**
	2005	570	1,920	490	50,680	486,790	804,240	1,344,690
Oral contraceptives	**2006**	**175,567**	**64,905**	**1,247**	**124,988**	**406,183**	**638,103**	**1,410,993**
	2005	153,177	43,956	549	97,266	349,894	529,411	1,174,253
Condoms	**2006**	**126,785**	**17,304**	**1,704**	**28,603**	**173,927**	**524,854**	**873,177**
	2005	49,554	5,963	559	79,265	171,178	505,683	812,202
Injectables	**2006**	**217,834**	**22,230**	**6,309**	**32,306**	**244,992**	**287,953**	**811,624**
	2005	186,277	4,860	47	19,502	128,048	229,295	568,029
Implants	**2006**	**45,782**	**102**	**0**	**3,448**	**9,566**	**79,295**	**138,193**
	2005	460	154	0	1,778	202,755	72,714	277,861
Other barrier methods	**2006**	**6,001**	**681**	**33**	**3,766**	**151**	**7,232**	**17,864**
	2005	3,429	1,989	37	1,583	620	1,139	8,797
Other hormonal methods	**2006**	**0**	**0**	**2**	**0**	**0**	**2,431**	**2,433**
	2005	0	0	4	0	0	2,242	2,246
Total	**2006**	**695,416**	**362,946**	**16,170**	**613,547**	**1,664,203**	**4,447,791**	**7,800,073**
	2005	**510,458**	**318,959**	**4,801**	**460,043**	**1,761,903**	**3,064,913**	**6,121,077**

* Refer to table 2.2 on page 22 for a summary of Member Association response rates.

Annex B: IPPF's income by region

Table B.1: **Total Member Association income by region: 2005-2006**

Region	IPPF total income $000's	Increase/ (Decrease)	Local income $000's	Increase/ (Decrease)	International income $000's	Increase/ (Decrease)	Grand total $000's	Increase/ (Decrease)
Africa								
2005	20,789		4,606		11,649		**37,044**	
2006	21,685	4.3%	5,163	12.1%	11,294	-3.1%	**38,142**	**3.0%**
Arab World								
2005	5,343		4,051		808		**10,202**	
2006	4,998	-6.5%	2,019	-50.2%	714	-11.6%	**7,731**	**-24.2%**
East and South East Asia and Oceania								
2005	6,781		51,275		7,864		**65,920**	
2006	6,573	-3.1%	54,507	6.3%	3,636	-53.8%	**64,716**	**-1.8%**
European Network								
2005	3,947		226		1,644		**5,817**	
2006	5,294	34.1%	334	47.8%	331	-79.9%	**5,959**	**2.4%**
South Asia								
2005	8,850		4,551		3,497		**16,898**	
2006	9,129	3.2%	6,029	32.5%	2,886	-17.5%	**18,044**	**6.8%**
Western Hemisphere								
2005	10,647		101,277		16,559		**128,483**	
2006	13,609	27.8%	101,972	0.7%	12,519	-24.4%	**128,100**	**-0.3%**
Total								
2005	**56,357**		**165,986**		**42,021**		**264,364**	
2006	**61,288**	**8.7%**	**170,024**	**2.4%**	**31,380**	**-25.3%**	**262,692**	**-0.6%**

Table B.2: **Total income for grant-receiving Member Associations: 2002–2006**

Year	IPPF total income $000's	Increase/ (Decrease) 2002 as base year	Local income $000's	Increase/ (Decrease) 2002 as base year	International income $000's	Increase/ (Decrease) 2002 as base year	Grand total $000's	Increase/ (Decrease) 2002 as base year
2002	44,563		120,258		42,774		**207,595**	
	21.5%		57.9%		20.6%		**100.0%**	
2003	41,773	-6.3%	123,555	2.7%	41,662	-2.6%	**206,990**	**-0.3%**
	20.2%		59.7%		20.1%		**100.0%**	
2004	45,226	1.5%	140,229	16.6%	50,373	17.8%	**235,828**	**13.6%**
	19.1%		59.5%		21.4%		**100.0%**	
2005	56,357	26.5%	165,986	38.0%	42,021	-1.8%	**264,364**	**27.4%**
	21.3%		62.8%		15.9%		**100.0%**	
2006	61,288	37.5%	170,024	41.4%	31,380	-26.6%	**262,692**	**26.5%**
	23.3%		64.7%		12.0%		**100.0%**	

Table B3: **Africa region: Sources of funding (2006 actual)**

Figure 1: Local income $000's

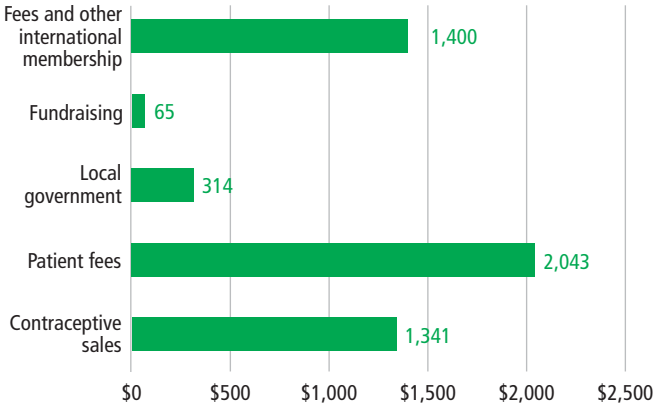


Figure 2: International income $000's

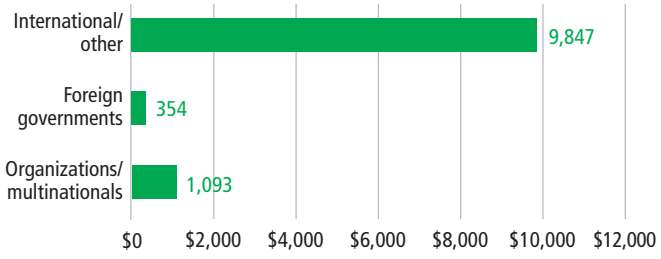


Figure 3: IPPF total income $000's

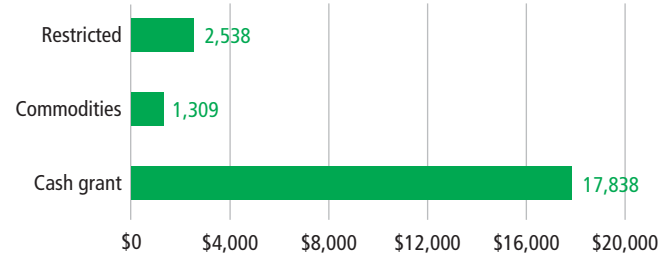
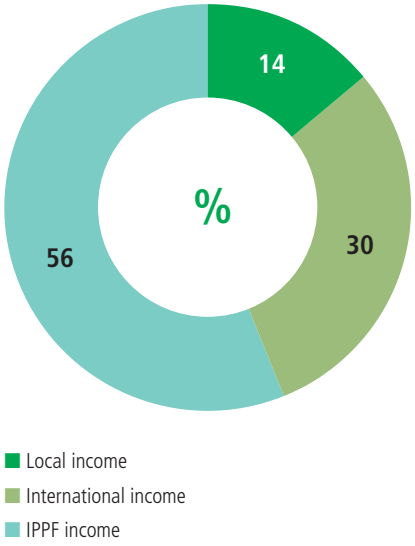


Figure 4: Income $000's



Key trends for the Africa region

Total income for the Africa region in 2006 amounted to US$38.1 million – an increase of 3 per cent from 2005.

Local income increased by 12 per cent but international income reduced by 3 per cent.

IPPF income increased by 4 per cent representing greater funding available at IPPF level.

IPPF income represented 67 per cent in 2002, reducing to 56 per cent in 2006, indicating less reliance on IPPF as the main funding mechanism.

Table B4: **Arab World region: Sources of funding (2006 actual)**

Figure 1: Local income $000's

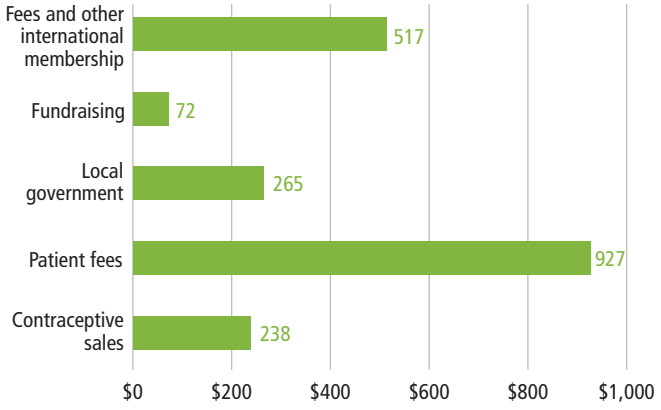


Figure 2: International income $000's

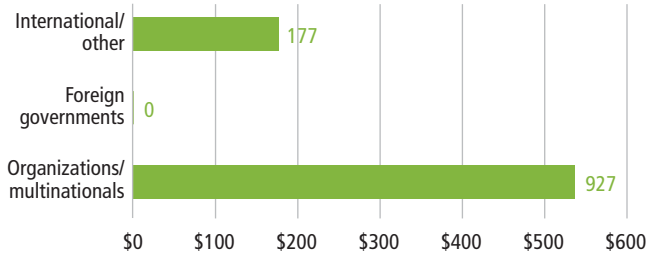


Figure 3: IPPF total income $000's

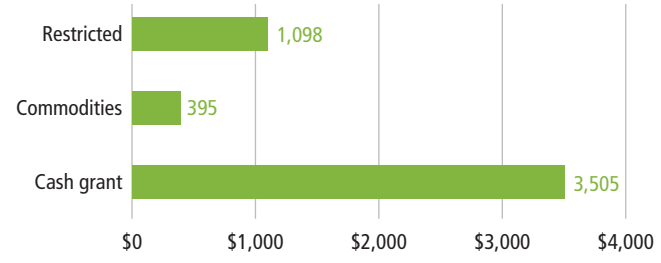
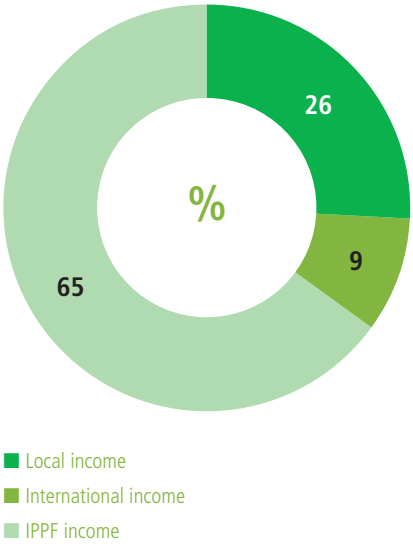


Figure 4: Income $000's



Key trends for the Arab World region

Total income for the Arab World region in 2006 amounted to US$7.7 million – a decrease of 24 per cent from 2005. The main reason for the decrease is the structure of the Egyptian Member Association with independent branches being introduced.

Local income decreased by 50 per cent and international income fell by 11 per cent.

IPPF income reduced by 6 per cent representing less restricted funding being available than in 2005.

IPPF income represented 41 per cent in 2002, increasing to 65 per cent in 2006, indicating more reliance on IPPF as the main funding mechanism.

Table B5: **East and South East Asia and Oceania region: Sources of funding (2006 actual)**

Figure 1: Local income $000's

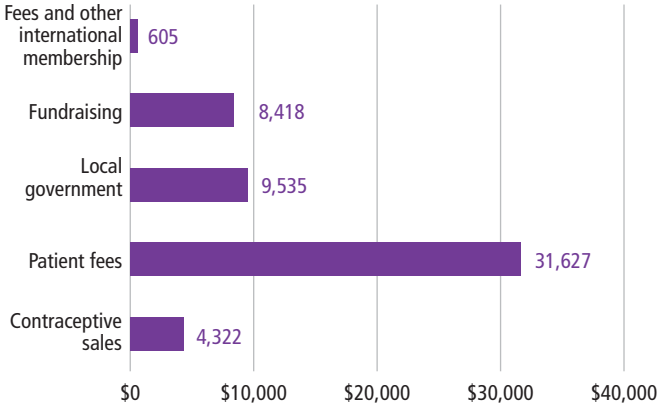


Figure 2: International income $000's

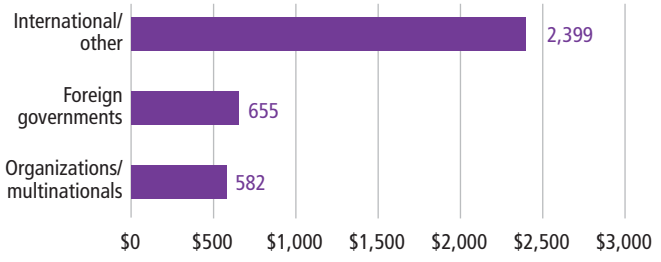


Figure 3: IPPF total income $000's

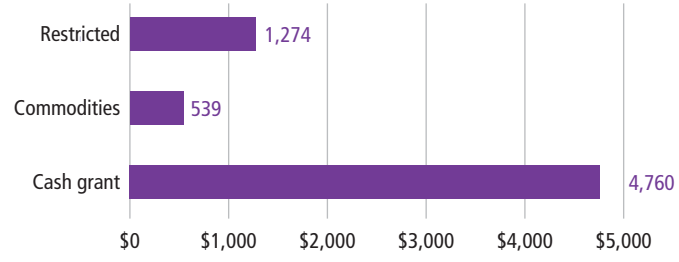
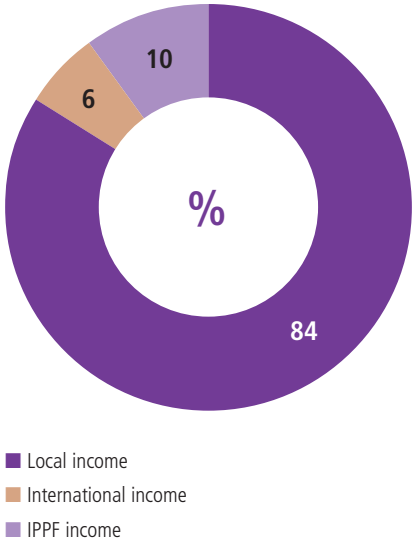


Figure 4: Income $000's



Key trends for the East and South East Asia and Oceania region

Total income for the East and South East Asia and Oceania region in 2006 amounted to US$64.7 million – a decrease of 2 per cent from 2005.

Local income increased by 6 per cent but international income reduced by 54 per cent. This was due to Cambodia being suspended from funding and China receiving less international funding in 2006.

IPPF income decreased by 3 per cent representing less restricted funding being available.

IPPF income represented 7 per cent in 2002, increasing to 10 per cent in 2006, indicating an overall diversified source of funding beyond IPPF.

Table B6: **European Network: Sources of funding (2006 actual)**

Figure 1: Local income $000's

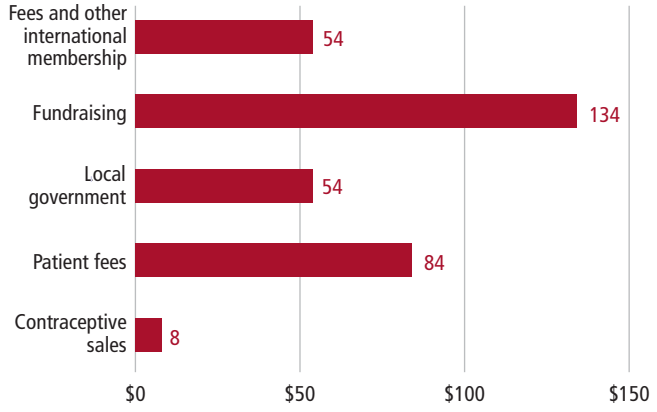


Figure 2: International income $000's

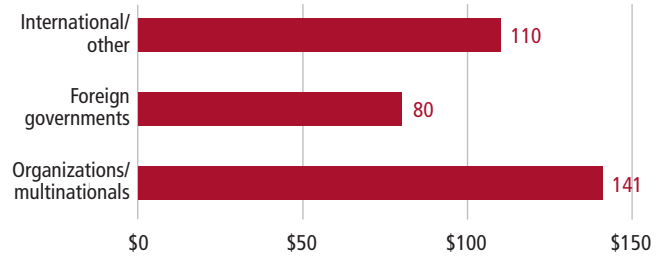


Figure 3: IPPF total income $000's

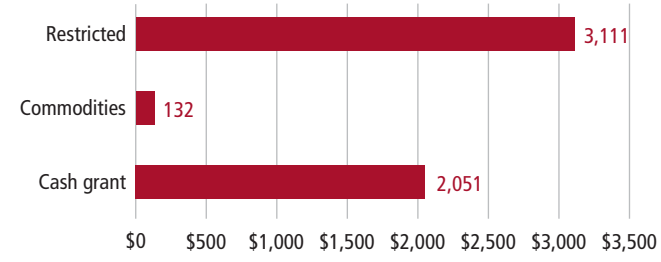
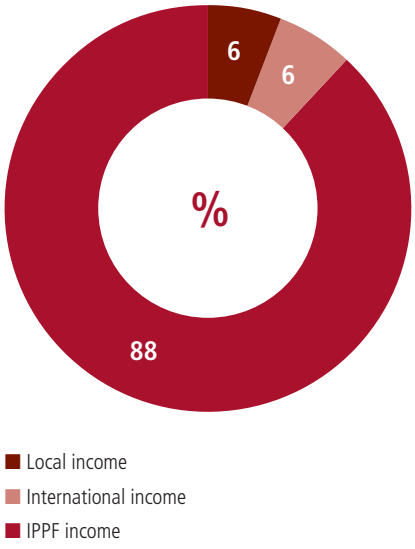


Figure 4: Income $000's



Key trends for the European Network

Total income for the European Network in 2006 amounted to US$5.9 million – an increase of 2 per cent from 2005.

Local income increased by 47 per cent whilst international income decreased by 80 per cent.

IPPF income increased by 34 per cent representing greater funding available at the IPPF level and a revision to the Resource Allocation System which recognizes the needs within the eastern European countries.

IPPF income represented 28 per cent in 2002, increasing to 88 per cent in 2006, indicating more reliance on IPPF as a source of funding as finding other donors willing to support countries within this region becomes more difficult.

Table B7: **South Asia region: Sources of funding (2006 actual)**

Figure 1: Local income $000's

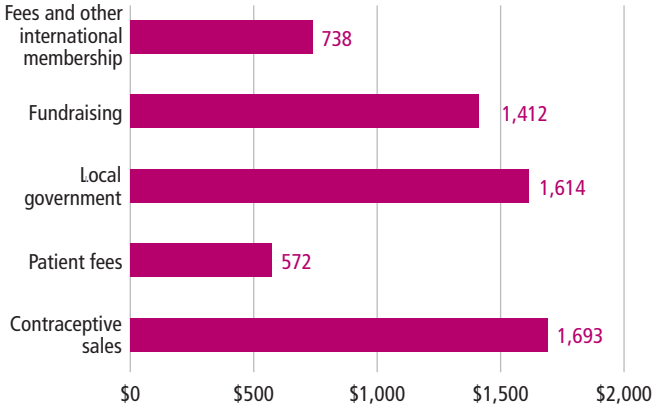


Figure 2: International income $000's

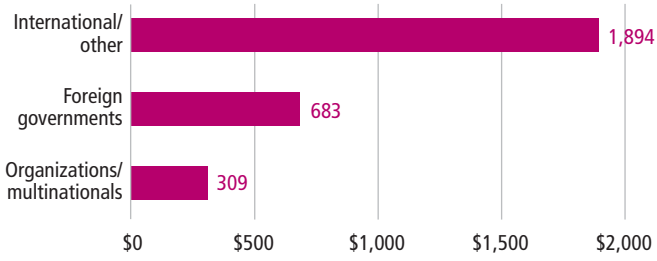


Figure 3: IPPF total income $000's

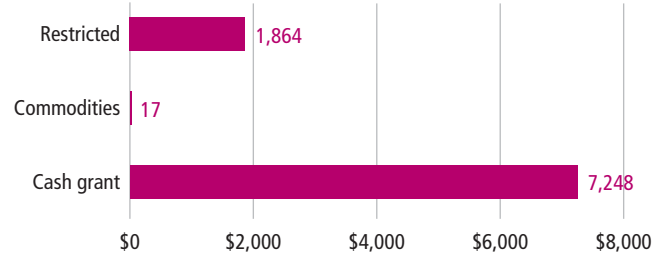
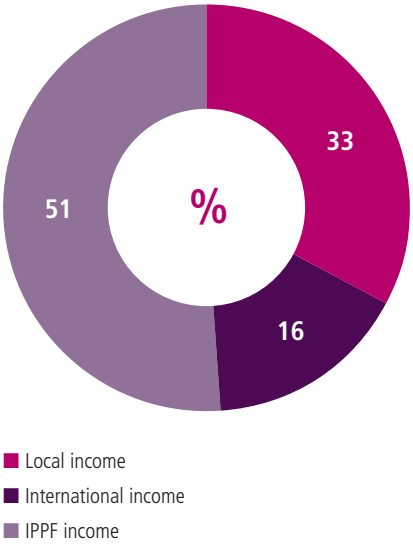


Figure 4: Income $000's



Key trends for the South Asia region

Total income for the South Asia region in 2006 amounted to US$18 million – an increase of 7 per cent from 2005.

Local income increased by 32 per cent whilst international income decreased by 17 per cent.

IPPF income increased by 3 per cent representing greater funding available at IPPF level.

IPPF income represented 48 per cent in 2002, increasing slightly to 51 per cent in 2006, indicating some progress in developing diversified sources of funding beyond IPPF, however still with progress to be made.

Table B8: **Western Hemisphere region: Sources of funding (2006 actual)**

Figure 1: Local income $000's

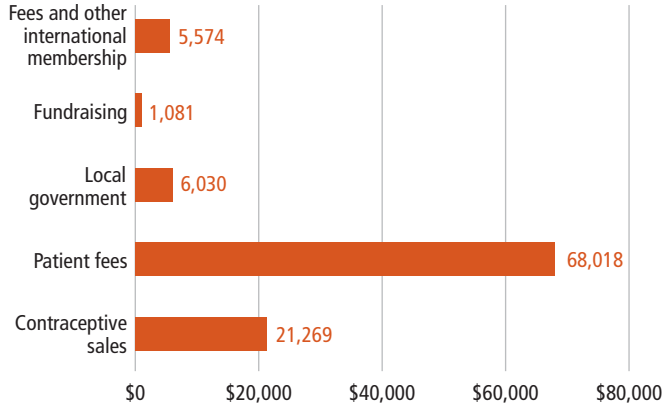


Figure 2: International income $000's

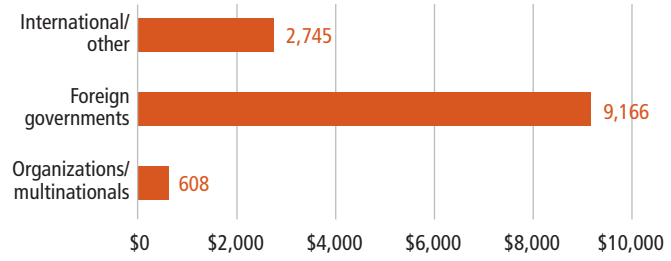


Figure 3: IPPF total income $000's

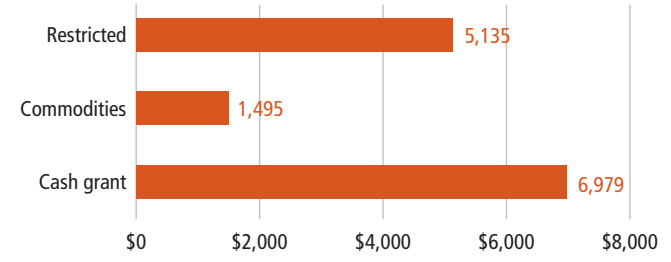
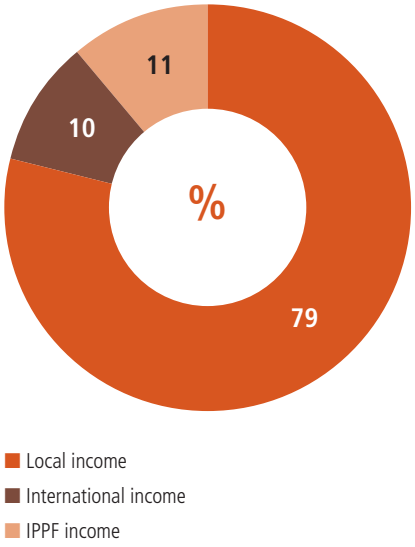


Figure 4: Income $000's



Key trends for the Western Hemisphere region

Total income for the Western Hemisphere region in 2006 amounted to US$128.1 million – the same level as 2005.

Local income remained static whilst international income decreased by 24 per cent.

IPPF income increased by 28 per cent representing greater restricted funding available at the IPPF level.

IPPF income represented 5 per cent in 2002, but has increased to 11 per cent in 2006, however the region continues to have well diversified source of funding beyond IPPF.

References

Chapter 1

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3 Perú: Encuesta Demográfica y de Salud Familiar (ENDES contínua). Informe Principal. Instituto Nacional de Estadística e Informática, Lima. 2004.

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5 Ibid.

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Chapter 3

7 2006 Development Co-Operation Report (2007) Volume 8, No. 1. OECD. Page 130.

8 'EU States Urged to Pool Aid Policies' (28 February 2007) Reuters. http://today.reuters.com/News/CrisesArticle.aspx?storyId=L2814993 (Accessed 10 March 2007)

9 The 36th Session of the UN Commission on Population and Development noted (in the sessional report) that non-governmental organizations dominate service delivery in this field: "In 2000, over half of all population assistance went through the non-governmental channel, while bilateral programmes and multilateral organizations each accounted for 23 per cent of funds. Provisional figures for 2001 show that this has remained unchanged, with the non-governmental channel continuing to dominate the flow of final expenditures."

Key abbreviations

ABUBEF	Association Burundaise pour le Bien-Être Familial
AIDS	Acquired Immune Deficiency Syndrome
AR	Africa Region, IPPF
AWR	Arab World Region, IPPF
BCC	Behaviour Change Communication
BEMFAM	Bem-Estar Familiar No Brasil
CBN	Cross Border Network for HIV Prevention
CFPA	China Family Planning Association
CYP	Couple Years of Protection
DFID	Department for International Development
eIMS	electronic Integrated Management System
EN	European Network, IPPF
ESEAOR	East and South East Asia and Oceania Region, IPPF
EU	European Union
FPAB	Family Planning Association of Bangladesh
GNI	Gross National Income
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
INPPARES	Instituto Peruano de Paternidad Responsable
IOM	International Organisation for Migration
IPPF	International Planned Parenthood Federation
IT	Information Technology
IUD	Intrauterine Device
MDG	Millennium Development Goals
NGO	Non-Governmental Organization
NPOKI	Non-Profit Organization Knowledge Initiative
ODA	Official Development Assistance
OPT	Occupied Palestinian Territories
PAFHA	For Family and Health Pan-Armenian Association, Armenia
PCCA	Provincial Committee for Control of AIDS
PDR	People's Democratic Republic
PFPPA	Palestine Family Planning and Protection Association
PLHIV	People Living with HIV
PMTCT+	Prevention of Mother To Child Transmission
PPAT	Planned Parenthood Association of Thailand
RHAK	Reproductive Health Alliance of Kyrgyzstan
RTI	Reproductive Tract Infection
SAR	South Asia Region, IPPF
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TFPA	Tajik Family Planning Alliance
UARH	Uzbek Association on Reproductive Health
UN	United Nations
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WHR	Western Hemisphere Region, IPPF