IPPF

From choice, a world of possibilities

Annual Performance Report

2007–2008

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 2007–2008. 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 2007–2008 was coordinated by the Organizational Learning and Evaluation unit and Advocacy and Communications unit.

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Foreword by the Director-General

This Annual Performance Report demonstrates yet again the difference that IPPF Member Associations are making to people's lives across the globe. It also confirms IPPF's unique outreach, enabling us to advocate at community, national, regional and global levels in order that promises become reality.

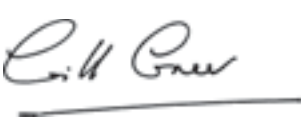
More Member Associations contributed their global indicators data in 2007 than in previous years, and these data demonstrate improved performance in a number of vital areas of our work, for example, in the delivery of HIV-related services and abortion-related advocacy. Overall, these results indicate our commitment to a comprehensive approach to sexual and reproductive health, while retaining a central core of work committed to family planning. Nevertheless, there remain areas where we need to make further progress, including the greater involvement of young people and reaching the most vulnerable groups.

Discussing these results with staff, volunteers and other stakeholders, it is clear that more needs to be done to convince civil society and governments that sexual and reproductive health and rights are critical to sustainable social and economic development, as well as to individual health and well-being. Yet for some governments, these basic rights to health and development rate low in priority in comparison with infrastructure development, and in particular, there is much to do to increase commitment to improving maternal health by increasing access to emergency obstetric care, skilled birth attendants and family planning.

More also needs to be done to challenge those who oppose our vision where everyone has access to good sexual and reproductive health. These powerful groups continue to ignore the realities in people's lives, where women, men, and young people are denied the most basic of rights; where unjust, inequitable levels of maternal mortality and morbidity devastate the lives of women, particularly in developing countries; and where over 200 million women cannot access contraceptive services. Despite such opposition, in 2006, the United Nations General Assembly agreed on target 5b of the Millennium Development Goals (MDGs), universal access to reproductive health by 2015, and accepted the revised MDG monitoring framework on MDG indicators including 5.3 contraceptive prevalence rate; 5.4 adolescent birth rate; 5.5 antenatal care coverage; and 5.6 unmet need for family planning. This revised framework will now be used to assess the implementation of the Millennium Declaration. As such it provides an opportunity for IPPF and its partners to monitor accountability and actions, and for Member Associations to seek to be active partners through national and community strategies.

The number of Member Associations involved in the Country Coordinating Mechanisms for the Global Fund on HIV, Tuberculosis and Malaria has grown to 72 in just a few years. This demonstrates the key role that many Member Associations are playing in civil society and in partnership with governments. Other Member Associations are leading the integration of sexual and reproductive health and HIV and AIDS prevention, care and treatment.

While 2007 has seen an increase in funding, we recognize that the impact of increasing fuel prices, food shortages, a global economic slowdown, together with changing systems of funding, mean that IPPF must continue not only to deliver services that genuinely make a difference, but to demonstrate that this is so. With the continued support and commitment of our partners, stakeholders and donors, with innovation and hard work, and an increased commitment to accountability and effectiveness, we will be able to build on this year's work to ensure that the right to sexual and reproductive health becomes a universal reality.



Dr Gill Greer
Director-General, IPPF

Executive summary

IPPF's Annual Performance Report provides an overview of our performance during 2007 with case studies highlighting achievements in the Five 'A's, our global indicators results, and key initiatives in the four supporting strategies of governance and accreditation, resource mobilization, capacity building, and monitoring and evaluation.

Chapter one: Key achievements

IPPF's Strategic Framework highlights the five priority areas of adolescents, HIV and AIDS, abortion, access and advocacy, that the Federation is focusing on between 2005 and 2015. The Framework commits us to monitoring 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. The first two case studies are from the South Asia region and the Western Hemisphere region and examine IPPF's work to address young people's sexual and reproductive health and rights. The third case study from the Arab World region presents work in Sudan to integrate HIV and AIDS into sexual and reproductive health services. The fourth, from the East and South East Asia and Oceania region, illustrates Indonesia's efforts to provide safe abortion-related services. The fifth case study from the European Network presents work in Bosnia-Herzegovina on human trafficking for sexual exploitation. The sixth case study illustrates how the Africa region advocated for the implementation of the Maputo Plan of Action, and finally, an overview of IPPF's global advocacy work is presented.

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. The data also provide key information that 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. In 2007, 97 per cent of Member Associations completed the online survey, an increase of 14 per cent from 2005. Of those Associations that provide sexual and reproductive health services, 82 per cent completed the online service statistics module. This is an increase of 18 per cent from 2005. In chapter two, the data from 2007 are compared with those from 2005 to indicate progress as well as highlighting areas where further investment may be needed.

Chapter three: IPPF's 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 2007 in these four 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.

Chapter four: Next steps

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

Annex A: Global indicators

In Annex A, the results of IPPF's global indicators by region for 2005, 2006 and 2007 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 2007, according to the three sources of funding to Member Associations; IPPF, local and international income.

Information on IPPF's publications and resources, and further details of our work can be found on the IPPF website at **www.ippf.org**.

1 Key achievements

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, an example from each of IPPF's regions, and our global advocacy work, are presented to highlight our key achievements from 2007.

Adolescents and young people

With over one billion people between the ages of 15 and 24, there are more sexually active young people today than ever before. However, in many societies there is a misinformed belief that young people are not sexual beings and this leads to poor access to high quality, youth friendly, comprehensive sexual and reproductive health information and services.

IPPF 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.

IPPF works to ensure that all young people are able to lead healthy, fulfilling lives. This is achieved through our focus on youth advocacy, youth participation, comprehensive sexuality education, quality youth friendly services and addressing gender inequality.

IPPF adopts a rights-based approach to our work on adolescents and young people, which builds on the Convention on the Rights of the Child. This approach ensures that we contribute to the holistic development of each young person through the promotion of equity, respect, diversity and a positive approach to young people's sexual health. The following case studies provide examples of how we remain true to these commitments.

Youth involvement in the South Asia region

Since late 2005, the South Asia region has been involved in a three-year initiative to increase the involvement of young people as advocates, volunteers and equal partners in youth programmes, at both the regional and Member Association levels. The initiative has provided a forum for young people to express themselves and their needs, and it has built the capacity of many young people in terms of governance and project management. The initiative has promoted equal partnership between adults and youth, and provided the opportunity for sharing and learning of good practice in youth sexual and reproductive health. It has facilitated sharing among young people, between the Member Associations in the region, and with other organizations working with people living with HIV.

Achievements

One of the first activities involved a survey undertaken by young people themselves in seven countries to explore and better understand young people's attitudes to sexuality and reproductive health and rights, and to identify the barriers to information and services faced by young people. The survey findings highlighted areas of sexual and reproductive health and rights of key interest to youth, and where their greatest gaps in knowledge are. The results also revealed concerns about the youth friendliness of services, and a lack of safe abortion and HIV-related services. To build the capacity of young people in project planning and implementation, a small fund of US$1,000 was given to the Member Associations of Bangladesh, India, Iran, Nepal, Maldives, Pakistan and Sri Lanka. The fund was used to implement three-month long projects to provide project design, implementation and management experience to young people. The overall objective of these projects was to improve participation of young people.

The project implemented by young people at the Member Association in India began by establishing three youth committees and a project advisory committee. The objective of the project was to strengthen the involvement of youth, and young people were given the chance to be directly involved in project planning, budgeting and decision making on youth programmes. Everyone involved in this initiative recognized that involving youth from the beginning of the project design and planning stage resulted in more innovative projects that directly address the needs of young people. The participation of youth has also resulted in a strong feeling of ownership of the youth activities taking place in the community, leading to a greater uptake of services by young people.

Another component of the youth involvement initiative is the first ever regional youth network, known as the South Asia Regional Youth Network (SARYN). The network was launched at a summit held in Sri Lanka in November 2006. The summit was attended by youth volunteers and staff from all the Member Associations in the South Asia region. The objectives of SARYN are to provide a forum for young people to express themselves as active participants and decision makers, to build leadership capacities among young people in the South Asia region, and to promote the sharing of best practices on sexual and reproductive health and rights among young people.

In 2007, young people from SARYN undertook month-long internships in organizations working with people living with HIV in their respective countries. These organizations included the Network for Positive Persons in India; the Blue Diamond Society in Nepal who work on the promotion and protection of the rights of sexual minorities, and HIV and AIDS prevention and care with men who have sex with men; Youth Vision who work with drug users and HIV positive people and their families in Nepal; Lanka Plus, the only organization of people living with HIV in Sri Lanka; and HAMRAHI in Pakistan who run voluntary counselling and testing centres for truck drivers. The young interns explored issues of stigma and discrimination that people living with HIV face.

A young intern from the Member Association in India working with the Network of Positive Persons said "This internship has brought about a marked change in my attitude and perception about people living with HIV, and programmes that are needed. Before I thought that the only real need was to raise awareness about HIV prevention, but this internship broadened my understanding. I now realize that there is a need to go beyond awareness and prevention, and to incorporate a rights-based approach to treatment and to care and to address stigma and discrimination."

The young people who volunteered with Lanka Plus, have continued to work with the organization to develop a website and work together on improving documentation. All these partnerships between young interns and organizations working with people living with HIV have built the capacity of young people to be sexual and reproductive health and rights ambassadors in their individual countries, and have strengthened the links between these organizations and IPPF Member Associations.

A second youth summit in 2007 provided the young interns with the opportunity to share their experiences and best practice with other young people in the region, and a self-enquiry tool, developed at the South Asia Regional Office, was introduced. This tool was designed to help young people go through a process of self-reflection and to enable them to share their concerns on sexual and reproductive health and rights issues. Sessions on youth participation and dealing with peer pressure and different types of behavior and negotiation skills were also held. The South Asia Regional Office staff used the summit as an opportunity to prepare 24 of the participants as media journalists to attend the 8th International Congress on AIDS in Asia and the Pacific (ICAAP).

Challenges and lessons learned

For young people to continue to be involved in a meaningful way, they need to feel valued by the Member Associations that they work with. At first, the Associations were reluctant to allow young people to engage with an issue as sensitive as abortion. However, during the process of working together, they have built mutual trust and the young people were involved in discussions on abortion which then informed programme planning on the provision of abortion-related services. This illustrates the significant contribution young people in the South Asia region are making, and the respect they now command from their seniors.

The young people created an e-forum to enable them to continue dialogue and share ideas and experience. It was intended that these e-forums would allow the participating young people to discuss and explore issues important to them. However, one of the major constraints in the project has been sustaining momentum of the e-forum, and therefore maintaining contact between young people throughout the region. It has been difficult to maintain enthusiasm over longer periods of time without regular opportunities to meet face to face. More innovative ways of

continuing this contact beyond the meetings have been explored, and the South Asia Regional Office has worked with SARYN to establish their own site on Facebook called 'One Voice'. Using a social networking site allows the young people to connect with each other in a more visual and engaging way. The network members are able to upload photographs to illustrate their vision and understanding of issues such as women's empowerment or vulnerable and marginalized communities, and to stimulate discussion.

Young people have been active participants throughout the development and evolution of SARYN. Not only was the need to establish such a network articulated by the young people in the first place, but they defined their own mission and ways of working. There is now a group of over 30 young people active within this project and who are currently involved in expanding the youth groups in their countries. SARYN will continue to be a vital strength to the Member Associations in the region to ensure that young people's voices are heard, and the sexual and reproductive health needs and rights of young people are met, particularly for those most vulnerable and marginalized.

Working with sexually diverse youth in Latin America

- **Centro Paraguayo de Estudios de Poblacíon (CEPEP), Paraguay**
- **Asociación Chilena de Protección de la Familia (APROFA), Chile**
- **Asociacion Civil de Planificacion Familiar (PLAFAM), Venezuela**

In Latin America, deeply ingrained cultural myths and prejudices influence the perception and treatment of lesbian, gay, bisexual, transgender and questioning individuals (LGBTQ). From a public health perspective, cultural biases translate into an unmet need for programmes that respect the rights and address the sexual and reproductive needs of LGBTQ populations.

In 2005, IPPF Western Hemisphere region launched a pilot project to address the needs of LGBTQ youth, a population that often suffers from poor health and social outcomes. Working with Member Associations in Mexico and Peru, the project created sensitivity and awareness at all levels in these organizations and supported an institutional approach to sexual diversity through policies, educational materials and various activities.

The current project, expanded to Chile, Paraguay and Venezuela, includes the following objectives: 1) to build the capacity of the Western Hemisphere Regional Office to institutionalize sexual diversity work in the region, particularly with young people; and 2) to increase the capacity of Member Associations in Chile, Paraguay and Venezuela to address the needs of sexually diverse youth.

Achievements

A key contribution of the Western Hemisphere region's sexual diversity work has been the development of a variety of programme planning and evaluation tools to improve Member Associations' work with sexually diverse youth in the region. The tools include an index used to assess agency readiness to work with sexually diverse populations, a guide of indicators useful for planning service provision or advocacy projects, and a survey, including an attitude scale, to measure provider and staff knowledge and attitudes to working with sexually diverse populations.

The 'Agency Readiness Index' is a tool designed to help agencies assess the extent to which their procedures and staff attitudes enable them to work effectively with young LGBTQ populations. The tool takes the user through a series of steps including highlighting the organization's strengths, identifying areas in which improvement is needed and developing a plan to enhance organizational performance. The tool involves self-assessment, scoring, and development of an action plan.

The 'Sexual Diversity Indicators Guide' offers a wide range of indicators that are useful in planning, monitoring and evaluating projects addressing the needs of young sexually diverse populations. The indicators fall into the categories of internal policies, referrals, quality of care, service provision, information, education and communication, awareness raising and staff training, including sensitization. This tool has been used in the planning phase and log frame design of each of the country projects.

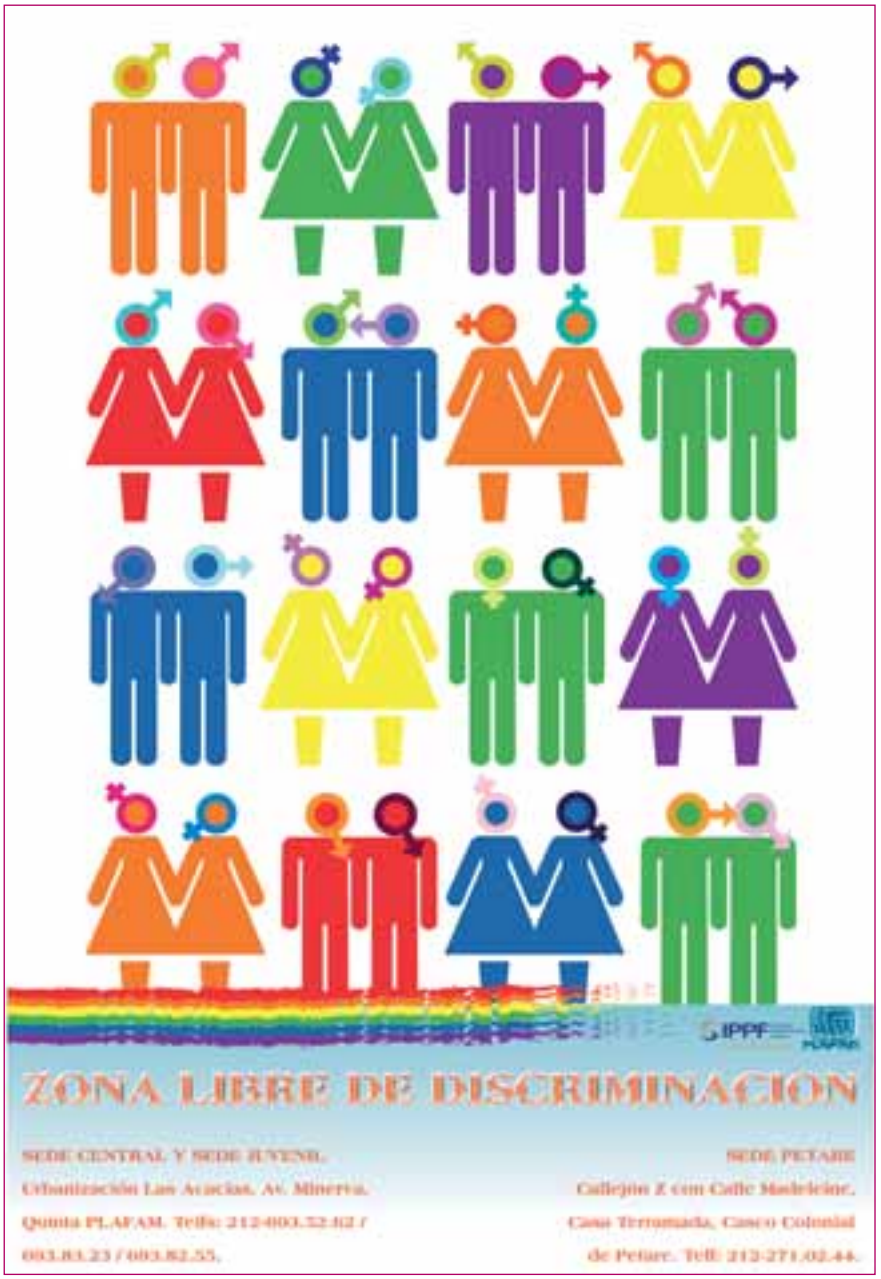
The sexuality knowledge, attitude and practice survey was implemented in Chile, Paraguay and Venezuela to assess staff attitudes and practices with respect to sexually diverse populations. The survey revealed attitudes among staff members that were not positive towards young sexually diverse populations, and each Member Association used the findings to initiate discussions on working with LGBTQ youth. For example, Paraguay is a very conservative country, and the Member Association leadership were aware that shifting to a more sexually diverse-friendly model would require a lot of education and sensitization, particularly with the additional focus of youth. This was confirmed by the results of the survey where responses indicated that substantial proportions of staff had limited understanding of diverse sexuality and potentially problematic attitudes. This reflects the homophobia and stigma that is widespread in Latin America. Staff from all three Member Associations were encouraged to view this as a learning opportunity and were assured that the Regional Office was committed to providing the necessary support to strengthen their ability to provide high quality services to sexually diverse youth.

The survey was implemented with all levels of staff, including administrative, clinical, and executive staff as well as the board of directors. The results

of the survey were used to design sensitization sessions for all staff. Special attention was paid to the attitudes of clinical and other staff that would have direct interaction with clients. For all three countries, this project has been the first of its kind and a new opportunity for staff to examine and discuss their biases and prejudices around issues of sexual diversity and youth as a group.

Sensitization sessions and training for service providers were informed by the results of the knowledge, attitude and practice surveys, and specifically tailored to staff needs and attitudes.

Member Associations expressed a desire to have a safe space to ask questions, voice concerns, and most importantly, identify ways they can contribute to making their clinic friendlier to sexually diverse young people. In response to this request, training sessions were designed to include role plays, active debate, and question and answer sessions. In an effort to build South to South capacity within the region, a member of staff who works on sexual diversity issues at the Member Association in Peru conducted training for Member Association staff in Paraguay.



Overall, the change in staff attitudes has been positive, as a service provider in Paraguay remarked "The issue of sexual diversity was completely new for me. It is difficult because we live in a society that discriminates against people with different sexual orientation, but with increased awareness, I had the opportunity to dispel misconceptions."

Challenges

These projects covered new ground for all three Member Associations, and each of them spent a significant amount of time learning about issues related to sexual diversity, sexual rights and the implications for service delivery. Raising awareness and changing attitudes needs to be an ongoing and long-term process, which requires an institutional commitment supported by the Associations' senior management teams. The next phase of the project will focus on strengthening service provision and ensuring the quality of services to young LGBTQ.

Lessons learned

Building strategic partnerships with local organizations with expertise in working with sexually diverse populations has proven an invaluable strategy. The Member Association in Chile, for example, established a working group with gay, lesbian, bisexual and transgender advocacy and activist groups who assisted them in producing information, education and communication materials, and in the sensitization and training of the Association's staff.

Building alliances with the young LGBTQ communities has been vital in raising the profile of each of the Member Associations as organizations that are addressing the rights and needs of young LGBTQ. Allocating sufficient time to these partnerships, establishing mutual goals, and defining clear roles and responsibilities were critical factors in making these alliances work.

HIV and AIDS

From providing family planning in a voluntary counselling and testing session, to ensuring that antiretroviral treatment can be provided in a traditional sexual and reproductive health setting, it is clear that HIV, sex and reproduction are intimately linked and that together they provide an avenue to respond effectively to clients' needs.

IPPF 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.

While the rhetoric on linkages between HIV and sexual and reproductive health has grown louder, questions of cost and efficiency, and identifying entry points for integration remain largely unanswered. The challenge now is to move from the 'why' to the 'how'. To address this, IPPF, together with UNFPA, UNAIDS, WHO and the Cochrane Collaboration HIV Review Group, are working to systematically address the practicalities of integration in various national contexts. Answering the 'how' of integration will provide an opportunity for IPPF to further pioneer the global linkages agenda. IPPF's Member Association in Sudan is working both to effectively integrate HIV-related services into their existing sexual and reproductive health services, and to tackle the issue of stigma and discrimination.

HIV service delivery to vulnerable groups

Sudan Family Planning Association (SFPA), Sudan

Sudan has a population of over 36 million, with 67 per cent of the population living in rural areas,[1] and the largest internally displaced population in the world.[2] In recent years, the country has seen a dramatic growth of peri-urban areas which lack even the most basic infrastructure and health services. Sexual and reproductive health needs are largely unmet. The national HIV prevalence rate is estimated to be 1.6 per cent with 600,000 people currently living with HIV in Sudan,[3] although the number of people living with HIV is almost certainly under-reported in a country with limited testing provision.

Since 2001, the government of Sudan declared HIV and AIDS to be a national disaster. In 2006, the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) began supporting the Sudanese government to provide treatment, care and support for people living with HIV. The government has also embraced the World Health Organization's '3 x 5 Initiative' to increase access to antiretroviral treatment. However, despite the plan to expand its treatment programme, access has remained very limited for most Sudanese people. Of those adults and children with advanced HIV, only 1.3 per cent are receiving antiretroviral treatment.[4]

HIV puts huge pressures on health systems. In Sudan, a resource-poor environment in terms of health, the integration of HIV with sexual and reproductive health services offers an effective route for reaching women, young girls and other groups vulnerable to HIV infection. However, little integration has been done to date in the government sector, despite the recognition that it would strengthen the response to HIV. The Sudan Family Planning Association (SFPA) has responded to this need by strengthening linkages between its sexual and reproductive health and HIV-related services in twelve clinics across the country. More recently, SFPA has begun to integrate voluntary counselling and testing as well as prevention of mother to child transmission services into their existing programmes.

Achievements

SFPA has a strong partnership with the Sudan National AIDS Programme at both country and state levels, as well as being a member of a network of non-governmental organizations working in the field of HIV and AIDS. SFPA is also a sub-recipient of the Global Fund, through UNDP, which demonstrates the Fund's recognition of SFPA as a local partner with the capacity to implement HIV and AIDS programmes.

In Sudan's government hospitals, stand-alone centres provide voluntary counselling and testing services, and the Ministry of Health chose

SFPA to train the staff at these centres to adhere to existing national protocols and guidelines, and to follow a rights-based approach in their work. The Member Association itself provides voluntary counselling and testing services which they have integrated into their existing sexual and reproductive health centres. What makes SFPA's centres pioneers in this field, is their focus on the prevention of mother to child transmission, and the broad range of services provided. These include counselling and advice on preventing unintended pregnancies and protecting sexual partners from infection, voluntary counselling and testing for pregnant women to know their HIV status, pre- and post-natal care including counselling and advice on breastfeeding, and ongoing psychosocial support for HIV positive mothers. Furthermore, the Association has a strong referral system with government hospitals to ensure access to other pre- and post-natal services to meet all the needs of HIV positive women. These include the provision of cesarean sections, antiretroviral treatment and other services related to delivery, specifically aimed at HIV positive women.

SFPA also conducts HIV prevention activities with internally displaced people, including awareness raising sessions and campaigns held in camps and sensitization activities to reduce stigma and discrimination. SFPA distributes condoms, provides voluntary counselling and testing, as well as testing and treatment for sexually transmitted infections. They have also established a strong referral system from the outreach and mobile services working in these camps to their integrated reproductive health centres which provide a comprehensive range of HIV-related services.

SFPA holds regular meetings with religious leaders on the issue of HIV and AIDS, and this has resulted in sessions being held in mosques as part of Friday sermons. These sessions not only provide information on HIV and AIDS but also publicize the availability of voluntary counselling and testing and other services at the SFPA sexual and reproductive health centres. The involvement of religious leaders has been crucial in gaining approval and commitment from the community, as well as increasing attendance at the centres.

Challenges

One major challenge faced by SFPA was the government's earlier lack of recognition of HIV and AIDS as a serious threat in Sudan. The lack of testing facilities resulted in a low reported HIV prevalence rate which meant that government decision makers did not take the issue seriously. Despite significant opposition, SFPA persisted in working closely with the Ministry of Health to prioritize a coordinated national response, which was finally put in place in 2006. After this, and with the recognition by the Sudanese government that HIV and AIDS is of critical importance, the new challenge was to find ways to expand the provision of HIV-related services and to integrate them into sexual and reproductive health services. The overall lack of skills and experience of service providers, particularly in rural areas, was a major obstacle to providing quality HIV-related services, and SFPA has had to dedicate significant amounts of time to capacity building and training, before being able to provide high quality HIV-related services.

Another challenge for SFPA relates to their work with internally displaced people who have extremely limited access to health services. The rural location and temporary nature of camps, the low level of education of many displaced people, and the trauma and stigma associated with displacement all combine to increase barriers to access. In response to the specific needs of internally displaced people for health care, SFPA has established mobile services that visit the camps and provide a range of sexual and reproductive health services, including information on HIV prevention, condoms and rapid HIV testing facilities.

HIV remains taboo because of religious beliefs, social attitudes and cultural norms which make people vulnerable to HIV and create barriers to access due to increased stigma and discrimination. To overcome these challenges, SFPA works intensively with local communities, HIV positive people and their families to combat stigma and discrimination in these communities.

Lessons learned

A number of different elements have contributed to proving the credibility of SFPA as an effective provider of HIV-related services in Sudan. The Association has many years experience providing a broad range of sexual and reproductive health services, and is certified within the IPPF Quality of Care initiative. These factors were all important in convincing donors, the government and local communities of the crucial role played by SFPA, both as a service provider and as a key partner with the government in developing and implementing the national HIV and AIDS plan.

Effective HIV prevention activities must include both the provision of information and a broad range of sexual and reproductive health services including, for example, counselling, condoms, sexually transmitted infection testing and treatment, voluntary counselling and testing, and the prevention of mother to child transmission. The integration of HIV-related services within SFPA's existing sexual and reproductive health programmes allows people to access information and services in a place that they are already familiar and comfortable with, and which is not associated with the stigma of HIV that stand alone, dedicated voluntary and counselling centres may have.

Abortion

Access to safe legal abortion is a public health and human rights imperative. However, while intense debates and controversies surrounding abortion rage on, millions of women, especially young women, continue to suffer the adverse consequences of unsafe abortions.

IPPF 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.

IPPF is committed to the provision of safe and affordable abortion services to the fullest extent permitted by the local law, as part of a comprehensive package of sexual and reproductive health services. Many IPPF Member Associations work in difficult legal and socio-cultural conditions in relation to abortion. The work of the Indonesian Planned Parenthood Association described below, demonstrates how IPPF's pro-choice values are translated into practice in the Indonesian context.

Reducing unintended pregnancies and unsafe abortion practices

Indonesian Planned Parenthood Association (IPPA), Indonesia

Indonesia has a high maternal mortality rate, and many of these deaths are caused by unsafe abortion. The law on abortion is highly restrictive, and culturally, terminating an unwanted pregnancy is also an unacceptable practice in many traditional communities. However, in spite of the legal restrictions to abortion in Indonesia, it is estimated that about 80 per cent of unwanted pregnancies end in abortion. Estimates suggest 2.5 million abortions occur in the country each year, and unsafe abortion contributes up to 30 per cent of maternal deaths in the country.[5]

As access to safe abortion is limited, the most common method chosen involves traditional practices using herbs and medicines. Many clients who come to IPPA's clinics have already tried, and failed, to terminate their unwanted pregnancy using this method. Women in Indonesia also have access to misoprostol, available from pharmacies. Although marketed as a treatment for gastric ulcers, people know that it can also be used to terminate a pregnancy. It can be bought without a prescription and therefore without medical consultation, advice or information about required dosage. This means that the risks of an incomplete abortion and other complications are increased, and as a result, the availability of post-abortion care in this context is vital.

The Indonesian Planned Parenthood Association (IPPA) has included abortion as one of its priority areas in its 2005-2009 strategic plan. Three main strategies have been identified to address the abortion issue in the Indonesian context:

- provide contraception to prevent unwanted pregnancy
- improve access to safe abortion-related services
- initiate advocacy activities to strengthen the commitment of parliamentarians, government, communities and religious leaders to ensure access to safe abortion, reduce the incidence of unsafe abortions, and protect abortion providers

IPPA's main abortion-related activities in 2007 included conducting research to assess clients' needs, developing guidelines on counselling clients for seeking safe abortion, providing abortion-related and family planning services, disseminating sexual and reproductive health information, building the capacity of service providers and advocacy. To combat national opposition to the provision of safe abortion, IPPA continues to play an active role in challenging the negative impact of Decree no. 23/1992, which states that abortions can only be carried out if it is proven to save the life of the woman, by providing evidence that appropriate care reduces levels of morbidity and mortality amongst women with unwanted pregnancies.

In October 2007, IPPA conducted a baseline survey of 1,030 respondents from 22 sub-districts in which IPPA is active. The locations were selected because they have high maternal mortality rates. The survey investigated knowledge on contraceptive services, safe abortion, unsafe abortion and accessing health services. The survey showed that 47 per cent of respondents had no knowledge of contraceptives, 57 per cent equate an unwanted pregnancy with an extra-marital pregnancy, and 43 per

The Indonesian Member Association played a leading role in meetings with other agencies such as the Ministry of Law, Regulations and Human Rights and the police, to promote reproductive health services, including safe abortion. They also provided input during parliamentary sessions related to abortion, as well as creating opportunities for discussion and dialogue with Muslim leaders.

cent considered abortion to be an act of murder. Around 50 per cent stated that if they experienced an unwanted pregnancy they would seek an abortion although 17 per cent did not know where they could access a safe abortion.

Many women in Indonesia have unintended pregnancies due to a lack of accurate information on family planning. One woman came to an IPPA clinic with her three children, the youngest just eight months old. As she was still breastfeeding, she did not use contraception because people had told her that she could not get pregnant whilst breastfeeding. "I found that I missed my period and got so confused and frightened of being pregnant again. I told my husband about my fears of being pregnant and he asked his friends how to stop this pregnancy. His friend told him that misoprostol could do that. He bought it for me and I took some hoping that my period would appear, but it didn't happen. I got really worried. I had already taken some herbs as well. I was afraid if I continued with this pregnancy my baby would now be disabled. I had to stop this pregnancy." Eventually the woman was told by her neighbour that the IPPA clinics provide safe abortion services to women such as herself. The pregnancy was terminated, the woman received post-abortion care which included counselling, information and access to contraception.

Achievements

IPPA serves as a source of information on sexual and reproductive health for the local, national and international (Al Jazeera TV) media, enabling pro-choice messages to be widely disseminated. Together with other agencies, IPPA also played an active role in the 'Save lives through safe abortion' programme which included a literature review on the application of national decree number 23/1992, which states that abortions can only be carried out if proven to save the life of the woman. IPPA provided data on comprehensive sexual and reproductive health services in their clinics and participated in providing inputs to review and revise the law. The Member Association played a leading role in meetings with other agencies such as the Ministry of Law, Regulations and Human Rights, and the police, to promote reproductive health services, including safe abortion. They also provided input during parliamentary sessions related to abortion, as well as creating opportunities for discussion and dialogue with Muslim leaders. As a result of these efforts, a book has been produced by Muslim organizations entitled 'The reinterpretation of Islamic law on abortion'. This serves as an excellent advocacy tool regarding abortion and Islamic law as it is produced by Muslim organizations themselves to address the issue.

IPPA has also managed to garner greater support for comprehensive abortion care services among decision makers and opinion leaders. An advocacy seminar was conducted on unwanted pregnancy and its related problems in November 2007. It was attended by 388 people, including government officials, women leaders, community and religious leaders, representatives from the Indonesia Midwives Association and the Indonesia Doctors Association, obstetricians and gynaecologists, general hospital directors, and school and university students. The event was broadcast by a local private TV station.

The Member Association has secured the commitment of board members and clinic staff to provide rights-based services for the prevention of unwanted pregnancy and unsafe abortion. A national meeting was conducted in August 2007 to build commitment among the

organization's staff and volunteers. The meeting was attended by the Regional Director of the IPPF East and South East Asia and Oceania region, as well as the programme director and key staff and board members from IPPA. During the meeting a statement of commitment towards the prevention of unwanted pregnancy was signed by all participants.

To support service providers in IPPA clinics to provide high quality abortion-related services, IPPA has developed counselling guidelines on abortion-related services which provide guidance for clinic staff to provide pre- and post-abortion counselling and care. Furthermore, training on surgical abortion and post-abortion contraception was provided to clinic staff who received certificates of competence to provide safe abortion services to protect the life of the woman.

Challenges

In Indonesia, abortion is legal under very restrictive conditions, and the regulations that do exist are not clear. Some fundamentalist groups that strongly oppose the provision of safe abortion have intimidated service providers who are now reluctant to provide safe legal abortion services.

In addition, some religious leaders who are in parliament have declared abortion 'haram', meaning illegal according to Muslim law. At the same time, however, the religious leaders do support what they term 'medical abortion', referring to traditional methods using local herbs which are ineffective and potentially harmful. As a result of a police raid at one of IPPA's clinics, services at some of the clinics were affected and one clinic has only just reopened. In some of the clinics, the Member Association was forced to limit their abortion services to married women only, and unmarried clients were referred to other IPPA clinics or other agencies. This was done to maintain the support of local authorities and to prevent existing services being compromised.

All who work with IPPA have been provided with information on how to handle potentially difficult and hostile situations, and risk management guidelines have also been developed. Due to the issues of legality and difficulties of providing safe abortion in the Indonesian context, IPPA is in contact with local legal aid agencies to secure their support in the event of any legal action taken against them as providers of comprehensive abortion care.

Lessons learned

The availability of comprehensive clinical protocols for safe abortion and the development of abortion counselling guidelines have been vital to ensure that service providers follow and learn from best practices. The introduction of abortion counselling guidelines has emphasized the importance of pre- and post-abortion counselling for all clients seeking abortion services. The systematic provision of post-abortion counselling and contraception reduces the incidence of future unintended pregnancies and makes the issue of abortion more acceptable within the Indonesian context.

Due to the sensitive nature of abortion in an Islamic country, community sensitization activities, particularly with Muslim leaders, are crucial to ensure that barriers to service uptake are reduced. Opposition from religious groups can severely hamper service provision and uptake, by intimidating service providers and harassing clients and their partners. Significant work on raising awareness about reproductive rights is needed to combat myths and misconceptions around abortion, and to ensure that people have correct information about the use of traditional herbs and medicines.

Access

Despite landmark agreements recognizing sexual and reproductive health and rights as critical to development, there are still major obstacles to accessing quality sexual and reproductive health information and services for many, and especially for the poor, marginalized, under-served and socially-excluded groups.

IPPF 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.

A major focus of IPPF is to increase the number of people reached by quality sexual and reproductive health services. IPPF is committed to prioritizing access to the most under-served groups who for reasons such as poverty, geographic inaccessibility, marital status, culture, age, gender or sexuality are not adequately served by established sexual and reproductive health service delivery programmes.

This case study on the work of IPPF's Member Association in Bosnia and Herzegovina highlights how the Federation is working to ensure access to high quality sexual and reproductive health services for one of the most marginalized groups in Europe, those vulnerable to trafficking, or who have been trafficked, for sexual exploitation.

Human trafficking for sexual exploitation in Europe

Association for Sexual and Reproductive Health XY (XY), Bosnia and Herzegovina

Bosnia and Herzegovina is presently in political and economic transition, and in a period of post-war reconstruction. Economic disparities, high unemployment rates and poor social conditions have made Bosnia and Herzegovina susceptible to human trafficking for sexual exploitation. Gender inequality and a lack of knowledge and skills in sexual and reproductive health and rights, particularly around gender-based violence and abuse, increase women's vulnerability to trafficking, as does a lack of education and meaningful employment opportunities. Human trafficking is a violation of human rights, and those involved suffer psychological and physical abuse, and social stigmatization. Trafficking for sexual exploitation has a particularly profound impact on sexual and reproductive health.

In the past, women were trafficked into Bosnia and Herzegovina from foreign countries. More recently, human trafficking for sexual exploitation involves people from within the country. The Roma community, the largest minority group in Bosnia and Herzegovina, is particularly vulnerable to trafficking here, as are asylum seekers and refugees due to their illegal status and inability to gain legal employment.

Within Bosnia and Herzegovina, a number of non-governmental organization programmes and to a lesser extent, governmental initiatives, have been set up to address the issue of trafficking. In 2002, the first National Action Plan for Combating Human Trafficking was created. However, there is still no comprehensive, coordinated response to the sexual and reproductive health and rights and needs of those most at risk of trafficking, or those that have been trafficked. To exacerbate matters, policy makers do not acknowledge trafficking as a sexual and reproductive health problem, and this is reflected in action plans that lack a comprehensive approach to sexual and reproductive health and rights.

The Green Light Project, implemented by the Association for Sexual and Reproductive Health XY, focuses on the link between sexual and reproductive health and rights and the problem of human trafficking and sexual exploitation. This approach is unique in Bosnia and Herzegovina, as anti-trafficking initiatives usually focus primarily on the prevention of trafficking, and therefore only on what can be done at the pre-trafficking stage.

In contrast, XY is implementing activities at both the pre- and post-trafficking stages. At the pre-trafficking stage, activities focus on empowering vulnerable young people to make informed choices concerning their sexual and

reproductive health and to reduce their risk of being trafficked. At the post-trafficking stage, activities improve access to quality sexual and reproductive health and rights information and services by trafficked persons, and also reintegration into communities without fear of stigma and discrimination. People who are trafficked are vulnerable to unwanted pregnancy, sexually transmitted infections and HIV, and this is exacerbated by their lack of access to sexual and reproductive health information and services, as well as general health services.

The Green Light Project has also focused on increasing awareness of non-governmental organizations, policy makers and other key decision makers on the need to address the sexual and reproductive health and rights aspects of trafficking. As part of the project, XY advocates for improved policies and increased funding to be spent on this issue.

Achievements

The Green Light project has strengthened the capacity of XY to address the sexual and reproductive health issues of those affected by trafficking. XY has also provided training for partner organizations working in the field of trafficking on the sexual and reproductive health and rights of those that are trafficked.

A peer education manual on gender, rights and trafficking has been developed in partnership with non-governmental organizations and the IPPF European Network Regional Office. The new manual was field tested by peer education programmes for high school students in four districts of the country. XY has also established partnerships with the Youth Friendly Centre in Sarajevo, and in 2007, seven survivors of trafficking used XY's services via referrals from the Centre. This is a direct result of close collaboration with the Centre and providing training and guidelines on identifying those being trafficked.

Due to the implementation of a high level advocacy strategy, there has been increased recognition among government officials and key policy makers of sexual and reproductive health and rights as primary and fundamental elements of trafficked persons' legal and human rights. Advocacy work has included XY being a member of a Parliamentary Group for Population and Development's Secretariat. This group raises awareness in parliament on the need to integrate sexual and reproductive health into anti-trafficking programmes with a focus on government-level action plans and policies. As a result of strong and coordinated lobbying and high level advocacy work, the activities of the Green Light Project were included in the annual report of the State Coordinator, and a component of sexual and reproductive health and rights is now part of the New Action Plan to Combat Human Trafficking 2008-2012.

In addition, the Ministry of Health requested support from XY in the development of a new project to work with service providers. As a result, the Ministry of Health and XY have matched funds for developing guidelines for medical professionals that provide services, including sexual and reproductive health services, for trafficking survivors.

Challenges and lessons learned

Initially, the survivors of trafficking were not comfortable talking about their sexual and reproductive health, and were more at ease talking about the psychological effects of being trafficked. Also, all of the women that XY spoke with as part of the Green Light Project claimed that they were physically healthy, fearful of the stigmatization associated with sexual health issues. However, a representative from an anti-trafficking organization working in partnership with XY said "These women are in a terrible state when they come to the shelter. We have cases of permanently damaged health due to unsafe abortions and sexually transmitted infections." This demonstrates the huge unmet need for sexual and reproductive health services for these women.

One of the main obstacles encountered in the implementation of this project was the initial reluctance by other organizations to accept XY as a partner. XY worked hard to highlight to these organizations that their area of expertise was in sexual and reproductive health and rights and not trafficking per se, and through ongoing dialogue with the partner organizations, and transparency in the implementation of their activities, XY succeeded in creating strong partnerships with four organizations working in the field of trafficking.

Advocacy

IPPF aims to improve the quality of life of individuals by campaigning for sexual and reproductive health and rights through its advocacy and services, especially for poor and vulnerable people. The political and controversial nature of sexual and reproductive health makes advocacy a core part of our work at all levels: community, national, regional and global.

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

Advocating for the implementation of the Maputo Plan of Action

IPPF Africa region

Since 2003, the IPPF Africa region has been spearheading efforts to ensure that sexual and reproductive health issues are given more attention in Africa's development agenda, and that they are prioritized in resource allocation at the national and regional levels. The IPPF Africa Regional Office has been working in collaboration with key regional stakeholders, the African Union Commission, UNFPA Africa divisions and several national governments, to ensure a supportive environment for sexual and reproductive health. This collaborative effort resulted in the adoption of two key regional strategies on sexual and reproductive health, the 'Continental Policy Framework on Sexual and Reproductive Health and Rights', by African health ministers in 2005 and endorsed by African Heads of State in 2006, and the 'Maputo Plan of Action', adopted by African Health ministers in 2006 and endorsed by the African Union. The Maputo Plan of Action translates the policy framework into clear goals, outcomes, outputs, indicators, timelines and costing.

While the political commitment of African leaders is encouraging, with most countries endorsing the regional strategies, the reproductive health indicators are not improving. There is clearly an urgent need to translate Africa's commitment into tangible realities in terms of providing financial support, building effective partnerships and ensuring universal access to sexual and reproductive health in the region.

Achievements

In 2007, the IPPF Africa region advocated for the implementation of the Maputo Plan of Action at national and sub-regional levels. They initiated policy dialogues with key stakeholders including regional economic communities, civil society and the media. At the national level, the Africa Regional Office continued to strengthen its Member Associations' capacity to conduct effective advocacy with government authorities and other key stakeholders. The Regional Office supported the Member Associations of Burkina Faso, The Gambia, Ghana and Tanzania to implement a European Commission funded project titled 'From donorship to ownership'. The project aimed to increase financial commitments for sexual and reproductive health through promoting the ownership of regional strategies by national governments, in particular the Maputo Plan of Action.

Partnerships between the Member Associations in the region and the corresponding regional economic communities were established during a series of regional meetings. In July 2007, the Regional Office, the African Union Commission and the UNFPA Africa Division jointly organized a planning meeting on the implementation of the Maputo Plan of Action. The meeting was attended by representatives from the Common Market for Eastern and Southern Africa, the Southern Africa Development Community, the Economic Community of West African States, the East African Community, the Central Africa Community, the Pan African Parliament, the New Partnership for Africa's Development and Partners in Population and Development. These organizations play a crucial role in monitoring the progress of policies and declarations adopted by governments.

The main objectives of the meeting were to discuss policies and strategies related to sexual and reproductive health, with a particular focus on the Maputo Plan of Action. Each regional economic community worked collaboratively to produce a plan for working together on promoting the implementation of the Maputo Plan, as well as future plans for joint advocacy, resource mobilization and

monitoring and evaluation of various continental policies. One major outcome of the meeting was for the IPPF Africa Regional Office to work with the Africa Union Commission on developing a reader-friendly summary of the Maputo Plan to support local and civil society organizations in their advocacy efforts.

A consultative meeting for West African civil society organizations was held in Ghana in August. The meeting was organized in collaboration with the African Union Commission, the West African Health Organization and the Economic Community of West African States. It was attended by participants from 15 countries in Africa. A key outcome of the meeting was the development of national plans to speed up the implementation of the Maputo Plan of Action. These national plans outline the important role of civil society in national level advocacy initiatives, and Member Associations agreed to work at the country level to coordinate the implementation of these action plans.

Many of the organizations that are part of these regional economic communities have not paid attention to social issues in the past as their main focus has been on trade. However, they do play a key role in ensuring governments' implementation of regional agreements, and by establishing working partnerships with these organizations, the IPPF Africa region has raised awareness of the link between sexual and reproductive health and regional development. This has resulted in a much strengthened voice campaigning for sexual and reproductive health and rights in Africa. Follow-up meetings between the regional economic communities and civil society organizations are planned for 2008 in Eastern, Central and Southern Africa.

The IPPF Africa region has also developed strong working relations with the media in various countries in the region. A consultative meeting for West Africa Francophone media houses and Member Associations was held in October 2007 in the Côte d'Ivoire. The overall objective of the meeting was to familiarize leading journalists with the Maputo Plan of Action and its importance to development in their respective countries. Participants attended from

> The ultimate goal of this Maputo Plan of Action is for African governments, civil society, the private sector and all development partners to join forces and redouble efforts, so that together the effective implementation of the continental policy, including universal access to sexual and reproductive health by 2015 in all countries in Africa, can be achieved.
>
> **(The Maputo Plan of Action)**

eight countries, and consisted of journalists and editors from both the public and private, print and electronic media. An immediate outcome of the meeting was that the Minister for Health in Côte d'Ivoire organized a national dissemination workshop on the Maputo Plan of Action for key stakeholders in the country later that month. This meeting was held at the offices of the Member Association in Cote d'Ivoire, and contributed significantly to strengthening the relationship between the media and those Member Associations attending the meeting.

Media training in sexual and reproductive health issues was conducted for senior journalists from nine countries in eastern and southern Africa. Participants from Ethiopia, Kenya, Lesotho, Malawi, Namibia, Swaziland, Tanzania, Uganda and Zambia attended. The workshop, held in Nairobi in May, strengthened the journalists' understanding of key sexual and reproductive health and rights issues and challenges in the Africa region, as well as to brainstorm difficulties the media encounter when reporting on these issues. Some of the topics covered included the linkages between sexual and reproductive health and poverty, human rights, HIV and AIDS, youth, gender, culture and religion. Sessions were held on communicating reproductive health issues, generating ideas for stories, sourcing information, and developing relationships with reproductive health experts. Leading sexual and reproductive health and rights experts from Kenya made presentations on various topics around the Maputo Plan of Action, and engaged in discussions with the journalists, who later developed story ideas around these presentations.

The IPPF Africa region also participated in the 20th Edition of Pan African Film and Television Festival, the oldest and leading film festival that brings together over 4,000 filmmakers and producers from Africa. To encourage film makers to produce films and documentaries on reproductive health, IPPF presented a special award to a film on sexual and reproductive health and rights and also organized a panel discussion on the theme of safe motherhood, chaired by the First Lady of Burkina Faso. The event generated good media coverage on sexual and reproductive health-related topics and several African film makers expressed interest in producing documentaries on maternal mortality in partnerships with IPPF in the future.

Challenges and lessons learned

Civil society often lacks coordination, and for effective advocacy, it is essential to speak with one unified voice. However, many of the organizations who work in partnership on advocacy issues may also be in competition with each other, and, of course, have their own individual agendas. It is essential therefore to have a very clear advocacy goal that all partners support, and which does not impede other areas of work. Focusing on advocating for the implementation of the Maputo Plan of Action at national and sub-regional levels was a clear mandate that all member organizations worked towards together.

IPPF's global advocacy initiatives

Effective advocacy requires coordination at both the country and global levels, and IPPF, including the Central Office, Regional Offices and Member Associations around the world, advocate to build political, public and financial support for sexual and reproductive health and rights.

The World Bank has championed the sexual and reproductive health and rights of women for decades, yet in April 2007, a managing director of the Bank ordered staff to remove all references to family planning from its country assistance programme document for Madagascar. IPPF was also concerned that the family planning component of the World Bank's draft Health, Nutrition and Population strategy had been removed, and that this could significantly undermine sexual and reproductive health globally. If the draft remained unchallenged, family planning would become a low priority for future World Bank funding, with serious consequences on the lives of millions of people.

IPPF coordinated an urgent response, mobilizing its grassroots network of Member Associations to make their concerns known to both their ministers and their governments' World Bank representatives. National governments were asked to uphold their commitment to family planning and to ensure that the draft strategy would not be accepted by the Executive Board unless the full family planning grant provision was reinstated. Despite an extremely tight timeframe for action, Member Associations worked with individual parliamentarians and other key decision makers to contest the draft strategy.

While these activities took place at country level, IPPF was working to stimulate debate in key global media and to make the issues more widely known. IPPF was also working with other civil society organizations to coordinate global advocacy efforts and mobilize all the networks available to oppose the draft strategy. As a result, prior to the World Bank meeting with its Executive Directors to approve the strategy, the Bank reinstated family planning and reproductive health as a priority issue in the final Health, Nutrition and Population Strategy. IPPF's advocacy activities also resulted in the creation of an informal group of civil society organizations and World Bank officials to ensure sexual and reproductive health remains a central component of all future World Bank strategies.

The European Network gained visibility and support for sexual and reproductive health at the regional and international levels through activities with a number of Brussels-based civil society networks, the European Parliament, the Council of Europe and the European Commission. The European Network and the Africa Regional Office worked together to monitor discussions at the European

Union Africa Summit which resulted in the signing of a new Joint European Union and Africa strategy. This will take the Africa and European Union relationship to a new strategic level with strengthened political partnership and cooperation at all levels.

The Western Hemisphere Regional Office played a lead role in a campaign for an independent and strengthened United Nations entity, promoting gender equality and women's empowerment. The Western Hemisphere Regional Office held meetings with the Office of the High Commissioner for Human Rights, UNFPA, UNIFEM, women's organizations and different government delegations on UN reform. Together with Central Office, the Western Hemisphere Regional Office participated in the 51st session of the Commission on the Status of Women and organized a parallel event entitled 'Responding to violence against women and girls'. The Western Hemisphere region also advocated for the decriminalization of abortion throughout the region and had notable victories in Colombia and Mexico. Their online advocacy via **www.FreeChoiceSavesLives.org** continued to promote sexual and reproductive rights throughout the region.

The Arab World Regional Office organized a regional conference to raise awareness about the connection between sexual and reproductive rights and human rights. The conference attracted parliamentarians, regional experts, youth advocates and service providers from 13 countries and issued the 'Rabat Declaration' which stressed the principles of national ownership and leadership. The Arab World Regional Office also participated in the 'Pan Arab Safe Motherhood Initiative', the 37th annual conference of the Cairo Demographic Centre, the League of Arab States' tenth meeting of National Population Committees and the League of Arab States Youth Forum.

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. Global results from 2005 and 2007 are presented in this chapter.

Global indicators results 2007

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. These global indicators results illustrate IPPF's commitment to tackling this vast unmet need.

Collecting our performance data

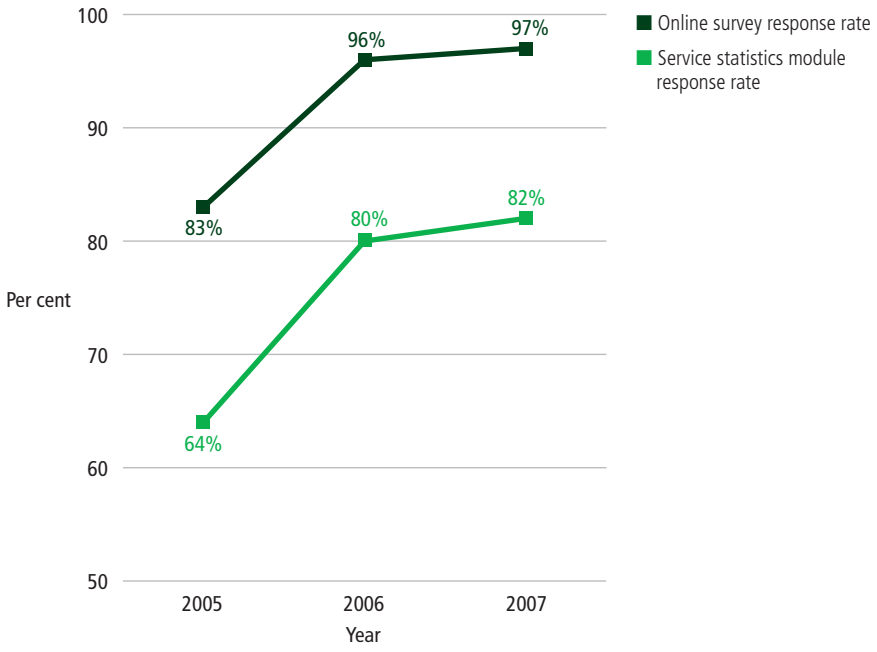
The thirty global indicators are divided between the Five 'A's: adolescents, HIV and AIDS, abortion, access and advocacy. The global indicators results are presented each year to IPPF's decision makers on Governing Council and each of the six Regional Councils. The data also provide key information that is used by Member Associations' governance volunteers and staff to improve their own programmes, and by Regional Offices to identify where Member Associations most need technical support. A complete set of results and regional breakdowns for 2005, 2006, and 2007 are presented in Annex A.

Global indicators data are collected annually from all of IPPF's Member Associations. Collection of these data involves a major collaborative effort for 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 Office staff and again by Central Office staff, before regional and global analyses are conducted.

Baseline data were collected in 2005, and the results from 2007 presented in this chapter are compared with 2005 data. It should be noted, however, that due to differences in response rates between the two years, the data sets are not directly comparable. In 2007, 97 per cent of Member Associations completed the online survey (147 out of 152 Member Associations), an increase of 14 per cent from 2005 (Figure 2.1). Of those Associations that provide sexual and reproductive health services, 82 per cent completed the online service statistics module (111 out of 135 Member Associations) in 2007. This is an increase of 18 per cent from 2005 (Figure 2.1). The 2007 data include major service-providing Member Associations reporting service data for the first time, including France and Germany. Also some Member Associations reported data on their youth services for the first time in 2007. The percentage changes therefore should be viewed within the context of the number of responses (n), which are presented in the tables throughout this chapter.

Overall, the increasing response rates for both the global indicators survey and the service statistics module illustrate IPPF's increased commitment to providing support to Member Associations to improve their data collection, and to reporting globally on progress made.

Figure 2.1: **Online survey and services statistics response rates**



Adolescents – results

Table 2.2: **Adolescents indicators results, 2005 and 2007**

Indicator		2005	2007
1	Proportion of Member Associations with 20 per cent or more young people under 25 years of age on their governing board	31.7%	**42.2%**
		(n=126)	(n=147)
2	Percentage of Member Association staff who are under 25 years of age	4.0%	**4.4%**
		(n=126)	(n=147)
3	Proportion of Member Associations providing sexuality information and education to young people	95.2%	**93.9%**
		(n=126)	(n=147)
4	Proportion of Member Associations providing sexual and reproductive health services to young people	93.7%	**95.2%**
		(n=126)	(n=147)
5	Proportion of Member Associations advocating for improved access to services for young people	98.4%	**98.6%**
		(n=126)	(n=147)
6	Number of sexual and reproductive health services (including contraception) provided to young people under 25 years of age	7,869,331	**15,356,348**
		(n=87)	(n=111)

(n=number of Member Associations that provided data)

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 2007, 42.2 per cent of Member Associations had at least a 20 per cent membership of young people on their governing board, which is a 10.5 per cent increase from 31.7 in 2005.* However, despite this progress, the data show that there is still a need for IPPF to renew its commitment to achieving this part of the IPPF policy on young people across the Federation. The Africa region is currently strongest in implementing the policy's recommendation, having 62.2 per cent of its Member Associations with 20 per cent of young people on their governing boards. Overall, 6.4 per cent of governing board members are young women, and 3.8 per cent are young men.

The percentage of Member Association staff under 25 years is 4.4 per cent, a slight increase from 4.0 per cent in 2005. Regional differences are minor with the East and South East Asia and Oceania region having the highest proportion of young staff (9.3 per cent), and the Africa region the lowest proportion (2.6 per cent) in 2007. There are more young female staff (3.3 per cent) than young male staff (1.1 per cent). Overall, 70.0 per cent of IPPF's Member Associations have at least one staff member under the age of 25 years, and the roles and responsibilities of staff under 25 vary from medical receptionists, community educators, accountants and library assistants to nurses, counsellors, advocacy officers and project coordinators.

Information and education on sexuality for adolescents

Results for 2007 indicate that, at 93.9 per cent, slightly fewer Member Associations provide sexuality information and education to young people, than in 2005 (95.2 per cent). A Member Association gains a positive score for this indicator if it provides both sexuality information and education to young people. Following a 100 per cent score in 2006, we worked with Member Associations to increase their understanding of the difference between 'sexuality information' and 'sexuality education', and this has resulted in a more accurate reflection of the work taking place.

Over 90 per cent of IPPF's Member Associations reach young people who are in and out-of-school, and unmarried. Slightly fewer Member Associations reach married youth

***** The calculation of this indicator has been revised in 2007, and data from 2005 and 2006 were re-analyzed to provide a figure for comparative purposes.

(87.8 per cent). Other target groups include youth under 12 years of age (61.9 per cent), young people living with HIV and AIDS (74.8 per cent), gay, lesbian and bisexual youth (53.0 per cent), and marginalized or socially-excluded groups of youth (83.7 per cent). For all target groups, slightly more sexuality information programmes are conducted than sexuality education, although the differences are minor.

Advocating for increased access for youth

In five out of the six regions, all Member Associations advocate for improved access to services for young people. In the Africa region, the figure is also high, at 94.6 per cent. Overall, the global figure is 98.6 per cent. The main target groups for this advocacy work include young people themselves (95.2 per cent), youth organizations, teachers and parents (92.5 per cent), government decision makers and the media (91.2 per cent), community and religious leaders (79.6 per cent) and lawyers or legal bodies (43.5 per cent).

Providing sexual and reproductive health services to young people

Overall, 95.9 per cent of IPPF's Member Associations provided sexual and reproductive health services to young people in 2007, a slight increase from 93.7 per cent in 2005. The wide range of sexual and reproductive health services provided include 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.

In 2007, 15,356,348 sexual and reproductive health services were provided to young people. This is a third of all sexual and reproductive health services provided by IPPF and a significant increase of over 95 per cent since 2005, when 7,869,331 services were provided. Table 2.3 illustrates the breakdown of sexual and reproductive health services provided to young people, by type.

Listening to young clients

In 2007, 78.9 per cent of IPPF's Member Associations reported having procedures in place to ensure young clients' perceptions on service provision are taken into account in all service delivery points. The procedures include satisfaction surveys, exit interviews and suggestion boxes. The majority of those Member Associations, 90.5 per cent, also have mechanisms in place to implement recommendations from young clients.

Ninety one per cent of Member Associations reported that they include 'communicating with young people' in their staff training module. Other topics covered in training include informed consent and confidentiality issues (89.1 per cent), medical and technical protocols (75.5 per cent), legal situations of youth sexual and reproductive health and rights, child protection policy and procedures (72.1 per cent). These topics ensure that service providers are able to work in the best interests of young people and are equipped to offer high quality youth friendly services.

Table 2.3: **Number of services provided to young people, by type, in 2005 and 2007**

Type of services provided	Number of services provided to young people	
	2005	2007
All contraceptive services (including contraceptive counselling)	4,507,646	**8,346,997**
Maternal and child health services†	1,236,701	**2,587,067**
Gynaecological services	956,945	**1,289,496**
Other sexual and reproductive health counselling services	304,474	**1,098,524**
Other sexual and reproductive health medical services	350,502	**764,381**
Sexually transmitted and reproductive tract infection services	251,229	**539,468**
HIV-related services	135,080	**435,843**
Abortion-related services	60,102	**204,545**
Urological services	33,194	**46,757**
Infertility services	33,458	**43,270**
Total	7,869,331	**15,356,348**

† Includes obstetrics and paediatric services

HIV and AIDS – results

Table 2.4: **HIV and AIDS indicators results, 2005 and 2007**

Indicator		2005	2007
7	Proportion of Member Associations with a written HIV and AIDS workplace policy‡	31.0%	**50.3%**
		(n=126)	(n=147)
8	Proportion of Member Associations providing HIV-related services along the prevention to care continuum	31.7%	**40.1%**
		(n=126)	(n=147)
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%	**53.1%**
		(n=126)	(n=147)
10	Proportion of Member Associations with strategies to reach people particularly vulnerable to HIV infection	69.8%	**75.5%**
		(n=126)	(n=147)
11	Proportion of Member Associations conducting behaviour change communication activities to reduce stigma and promote health-seeking behaviours	66.7%	**71.4%**
		(n=126)	(n=147)
12	Number of HIV-related services provided	1,320,599	**3,287,697**
		(n=87)	(n=111)
13	Number of condoms distributed	97,855,691	**125,601,990**
		(n=87)	(n=111)

(n=number of Member Associations that provided data)

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 2007, 40.1 per cent of IPPF's Member Associations provided at least six of these nine services compared to 31.7 per cent in 2005. Africa was the strongest region with 73.0 per cent of its Member Associations providing at least six of these service elements along the prevention to care continuum.

The most common types of services provided in 2007 are condom distribution (90.5 per cent), information, education communication/behaviour change communication (85.7 per cent of Member Associations), sexually transmitted infection management and treatment (70.7 per cent), and voluntary counselling and testing (68.0 per cent). Psychosocial support is provided by 58.5 per cent of Associations, 36.1 per cent provided treatment of opportunistic infections, and 30.6 per cent provided prevention of mother to child transmission services. Only 13.6 per cent and 10.9 per cent of Member Associations provided palliative care and antiretroviral treatment respectively.

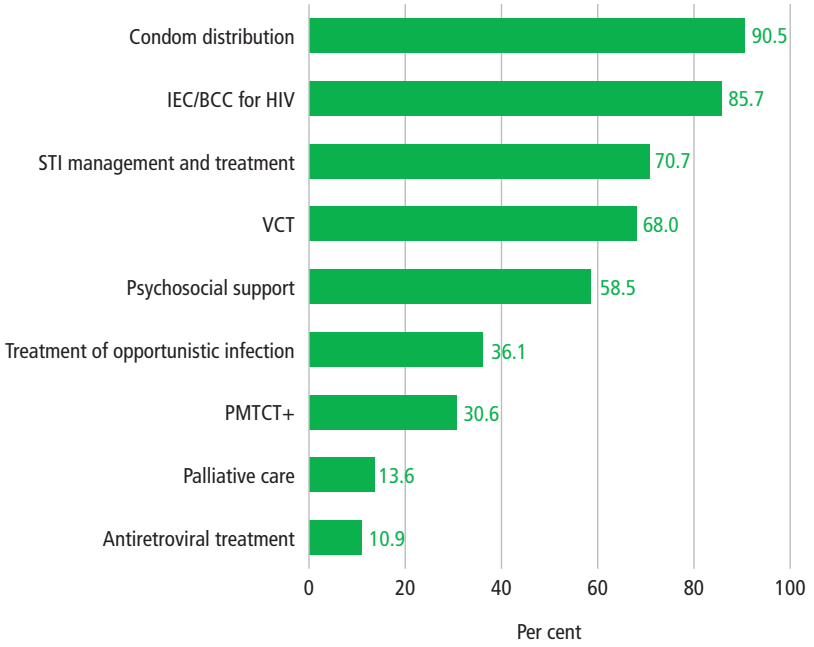
Nearly two and a half times more HIV-related services were provided in 2007 compared to 2005, a significant increase from 1.3 million to 3.3 million. Table 2.5 illustrates the breakdown of these services by type. Thirty per cent of HIV-related services were provided to young people (n=975,311) in 2007.

‡ This indicator was revised in 2006, and data from 2005 were re-analyzed to provide a figure for comparative purposes.

Table 2.5: **Number of HIV-related services provided, by type, in 2005 and 2007**

Type of HIV-related services provided	Number of HIV-related services provided	
	2005	2007
Sexually transmitted and reproductive tract infection services	818,550	**1,843,977**
HIV prevention counselling	221,294	**457,072**
HIV voluntary counselling (pre- and post-test)	76,221	**414,684**
HIV serostatus lab tests	42,524	**316,722**
Opportunistic infection treatment	40,954	**162,664**
All other HIV and AIDS services§	42,641	**29,129**
HIV psychosocial support and post-exposure prophylaxis (PEP)	859	**27,090**
Other HIV lab tests	72,143	**24,655**
Antiretroviral treatment	565	**9,349**
AIDS home care treatment	4,848	**2,355**
Total	1,320,599	**3,287,697**

Figure 2.6: **Percentage of Member Associations that provide HIV and AIDS services along the prevention to care continuum**



In 2007, over 125.6 million condoms were distributed globally by IPPF's Member Associations, a significant rise of 28 per cent since 2005 (97.9 million condoms). The majority of condoms were distributed by the Western Hemisphere region (over 65 million), followed by South Asia (25 million) and Africa (over 18 million).

§ Some Member Associations were unable to provide the breakdown of services by type, so these services were included in 'All other HIV and AIDS services'.

Stigma associated with HIV is one of the primary hurdles in accessing health services. IPPF is working in partnership with UNAIDS, ICW and GNP+ on 'The People Living with HIV Stigma Index' to increase access to prevention, care and support.

(http://www.stigmaindex.org)

Working with vulnerable groups

Groups that may be particularly vulnerable to HIV infection include people living with HIV (PLHIV), sex workers, men who have 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 these vulnerable groups including mobile clinics, voluntary counselling and testing for specific populations, participation of people living with HIV in governance and advisory capacities, and partnerships with other organizations working with vulnerable groups. In 2007, the proportion of Member Associations with strategies to reach at least one group of people vulnerable to HIV infection was 75.5 per cent, an increase from 69.8 per cent in 2005. More Member Associations have strategies to reach sex workers (62.1 per cent) and people living with HIV (55.2 per cent), followed by men who have sex with men (51.7 per cent), and gay and bisexual men (51.7 per cent), newly married women (41.4 per cent), internally displaced persons (41.4 per cent) and migrants (37.9 per cent). Fewer Associations implement strategies to reach injecting drug users (13.8 per cent).

Promoting the rights of people living with HIV and AIDS

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 71.4 per cent in 2007. Promotion of health-seeking behaviour is most common for sex workers (52.4 per cent), people living with HIV (50.3 per cent), newly married women (41.5 per cent), and migrants (40.8 per cent). Other target groups include internally displaced persons (31.3 per cent), men who have sex with men (30.6 per cent), gay and bisexual men (26.5 per cent), and injecting drug users (25.9 per cent). In 2007, more Member Associations are working with all of these groups than were in 2005.

In 2007, the proportion of Member Associations that had a written HIV and AIDS workplace policy in place was 50.3 per cent, a significant increase from 31.0 per cent in 2005. Four regions, the Arab World, European Network, South Asia and Western Hemisphere, all have significantly more Member Associations with HIV workplace policies in place since 2005.

Abortion – results

Table 2.7: **Abortion indicators results, 2005 and 2007**

Indicator		2005	2007
14	Proportion of Member Associations advocating for reduced restrictions and/or increased access to safe legal abortion	53.2%	**66.7%**
		(n=126)	(n=147)
15	Proportion of Member Associations conducting IEC activities on (un)safe abortion, the legal status of abortion and the availability of legal abortion services	43.7%	**56.5%**
		(n=126)	(n=147)
16	Proportion of Member Associations providing abortion-related services	82.5%	**85.7%**
		(n=126)	(n=147)
17	Number of abortion-related services provided	219,229	**652,010**
		(n=87)	(n=111)

(n=number of Member Associations that provided data)

Advocating for access to safe legal abortion

The proportion of Member Associations advocating for reduced restrictions and/or increased access to safe legal abortion increased from 53.2 per cent in 2005 to 66.7 per cent in 2007. The results of Member Associations' advocacy work in 2007 are illustrated by the successful national policy or legislative changes in support of safe abortion in which the Member Associations played a key role. Examples from Portugal, Slovakia and Togo are described in detail on page 35.

Indicator 15 is a composite indicator made up of three components: information, education and communication activities on (un)safe abortion, on the legal status of abortion and on the availability of legal abortion services. The global indicators data show that more Member Associations are involved in providing IEC activities on (un)safe abortion (85.7 per cent) and on the legal status of abortion (74.1 per cent), than on the availability of legal abortion services (63.3 per cent). Each of these three categories shows an increase in comparison with the results from 2005. The proportion of Member Associations conducting IEC on all three components was 56.5 per cent in 2007, an increase from 43.7 per cent in 2005.

The key target groups for these IEC activities on abortion include young people, men, women's groups, community groups, parents, community leaders and health professionals.

Increasing access to abortion-related services

In 2007, the proportion of Member Associations providing abortion-related services was 85.7 per cent, a slight increase from 82.5 per cent in 2005. The proportion of Associations providing surgical and/or medical abortion was 20.7 per cent in 2007. Figure 2.8 illustrates the different types of abortion-related services provided by IPPF's Member Associations. The most common services provided are post-abortion care (76.9 per cent), pre-abortion counselling (70.1 per cent), referrals to external abortion services (64.6 per cent), and management of abortion-related complications and incomplete abortion (49.0 per cent). All these categories show an increase of between three to nine per cent compared to 2005 results. The proportion of Member Associations providing surgical abortion (17.7 per cent), medical abortion (13.6 per cent), and finally surgical abortion (D&C and D&E) (8.2 per cent) only increased marginally from their 2005 values.

In 2007, the total number of abortion-related services provided by Member Associations was 652,010, almost three times the number of services provided in 2005 (219,229). The most common types of abortion-related services provided are post-abortion counselling, pre-abortion counselling, and induced surgical abortion (Table 2.9).

Compared to 2005, the biggest change in results is in the number of induced surgical abortion services provided, which increased from 16,964 to 121,911. Pre-abortion counselling and post-abortion care also increased significantly. In contrast, the numbers of medical abortion services provided by IPPF decreased by 15 per cent compared to 2005.

Post-abortion care is a core component of a comprehensive abortion care package; and this includes supporting the client to discuss and adopt a chosen contraceptive method with a view to avoiding future unintended pregnancies.

(IPPF's 'First trimester abortion guidelines and protocols: Surgical and medical procedures' 2008)

Figure 2.8: **Percentage of Member Associations providing abortion-related services**

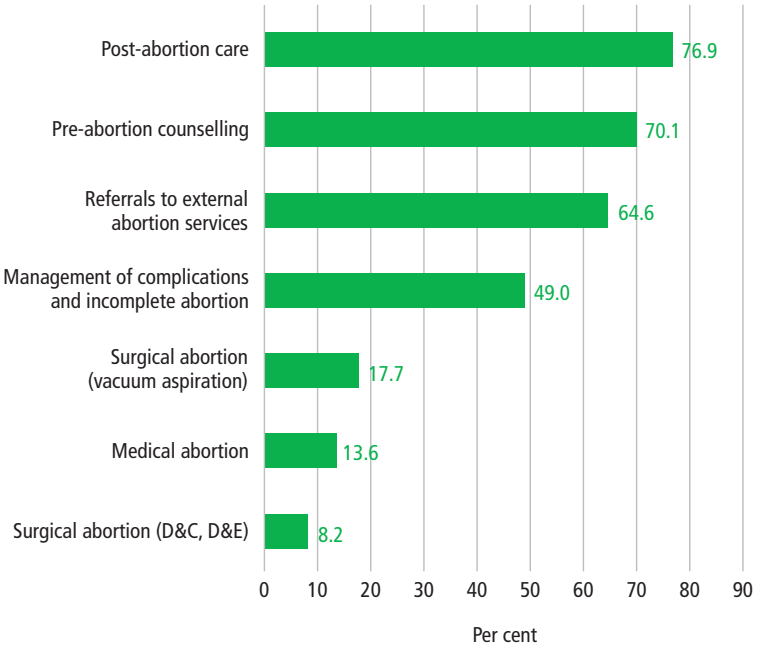


Table 2.9: **Number of abortion-related services provided, by type, in 2005 and 2007**

Type of abortion-related service	Number of services provided	
	2005	2007
Pre-abortion counselling	53,707	**275,380**
Post-abortion counselling	109,638	**186,012**
Induced surgical abortion	16,964	**121,911**
Post-abortion care	9,651	**36,373**
Medical abortion	13,047	**11,720**
Referrals to external abortion services	2,538	**11,500**
Abortion – consultation/diagnostic	13,684	**9,114**
Total	219,229	**652,010**

Access – results

Table 2.10: **Access indicators results, 2005 and 2007**

Indicator		2005	2007
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)	**89.1%** (n=147)
19	Estimated percentage of Member Association clients who are poor, marginalized, socially-excluded and/or under-served	56.6% (n=126)	**59.8%** (n=147)
20	Number of Couple Years of Protection (CYP)**	6,121,077 (n=87)	**7,585,595** (n=111)
21	Number of contraceptive services provided	17,335,608 (n=87)	**24,807,708** (n=111)
22	Number of non-contraceptive sexual and reproductive health services provided	13,416,374 (n=87)	**21,236,517** (n=111)
23	Number of service delivery points	58,470 (n=87)	**55,920** (n=111)
24	Proportion of Member Associations with gender-focused policies and programmes	72.2% (n=126)	**70.7%** (n=147)
25	Proportion of Member Associations with quality of care assurance systems, using a rights-based approach††	65.0% (n=126)	**77.6%** (n=125)

(n=number of Member Associations that provided data)

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 for improved access to sexual and reproductive health services by such vulnerable groups was 89.1 per cent.

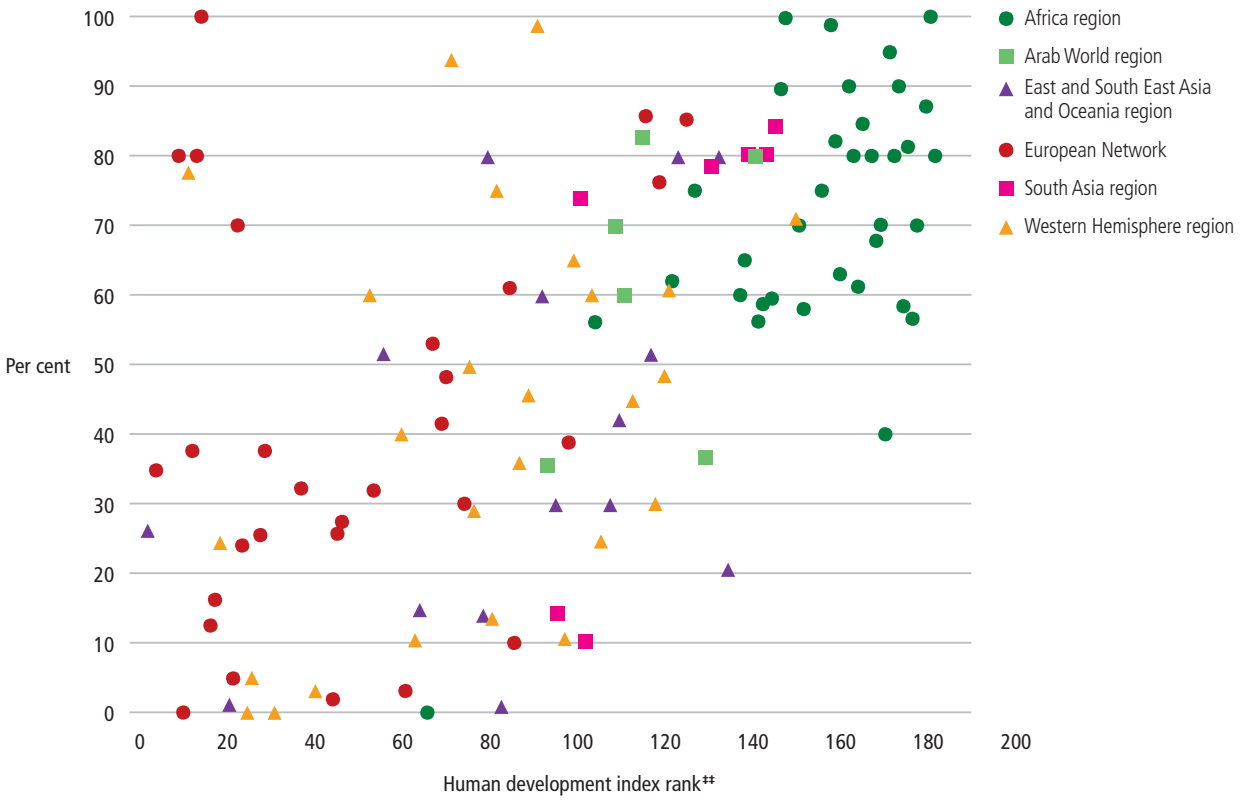
IPPF employed many different strategies to increase access to services by poor and marginalized groups including community-based services (74.1 per cent), subsidized services (64.6 per cent), outreach and mobile services (63.9 per cent), and specially adapted fee structures (50.3 per cent).

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

** Couple years of protection (CYP) refers to the total number of years of contraceptive protection provided to a couple.
†† This analysis is based on the 125 Member Associations that responded to the quality of care questions on the online survey.

Figure 2.11: **Estimated percentage of Member Association clients who are poor, marginalized, socially-excluded and/or under-served, by human development index rank**



The accurate collection of these data is challenging. 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 as their gender alone acts as a barrier to health, education and/or employment opportunities.

In 2007, the estimated number of clients served by Member Associations was 30,691,089. The estimated proportion of clients who were poor, marginalized, socially-excluded and/or under-served was 59.8 per cent. In the Africa region, the estimated proportion of clients who were poor, marginalized, socially-excluded and/or under-served was 82.8 per cent. In South Asia, it was 80.0 per cent, and in the Arab World, it was 67.1 per cent. In countries with low human development according to UNDP's Human Development Index rankings, the percentage of poor, marginalized, socially-excluded and/or under-served clients was 85.3 per cent.

Figure 2.11 illustrates the estimated percentages of poor, marginalized, socially-excluded and/or under-served clients by country, according to their Human Development Index ranking. In this diagram, most of the countries in the Africa region are in the top right corner, illustrating that in the countries with the highest levels of development need, proportionately more of our Member Associations' clients are poor and vulnerable. For example, Ethiopia reported that the estimated proportion of their clients that are poor, marginalized, under-served and/or socially-excluded was 90.0 per cent in 2007, and in Sierra Leone, it was 80.0 per cent. In a number of countries ranked as having relatively high development need within other IPPF regions, the Member Associations also serve high numbers of poor and marginalized groups. For example, the estimated proportion of clients that were poor or marginalized in Bangladesh and Pakistan was both 80.0 per cent, Egypt 82.8 per cent, Nepal 84.0 per cent, Tajikistan 85.2 per cent, Uzbekistan 85.7 per cent, and in Brazil, it was 93.8 per cent.

There are also some countries with high levels of human development where the Member Association is proactively addressing the needs of the poor, marginalized, socially-excluded and/or under-served in their country such as Austria (100 per cent), France and Denmark (both 80.0 per cent), and the United States (77.6 per cent).

‡‡ High human development = index ranking 1 to 70; medium human development = index ranking 71-155; low human development = index ranking 156-177. http://hdr.undp.org/en/statistics/

Figure 2.12: **Number of contraceptive and non-contraceptive SRH services provided, 2005-2007**

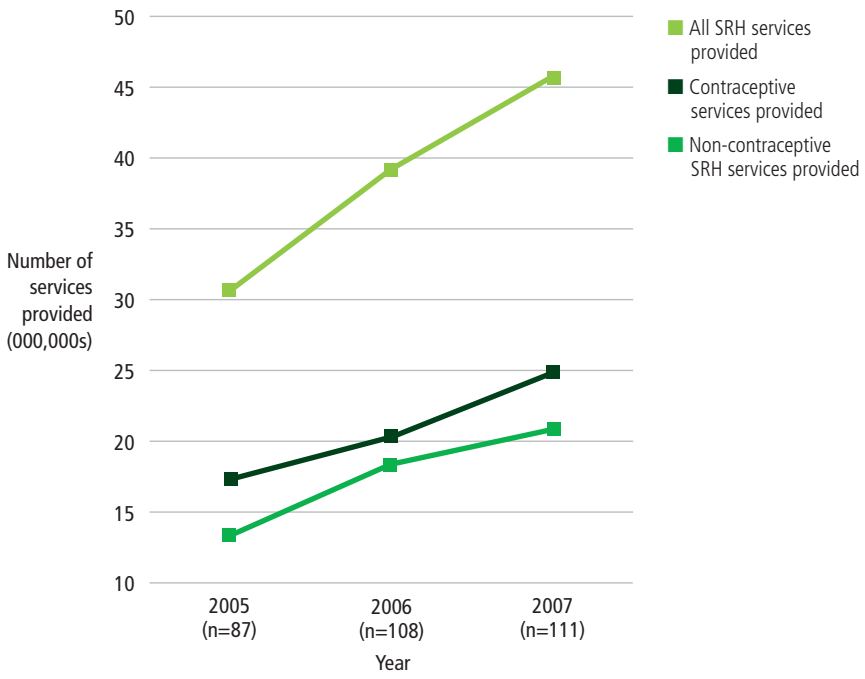
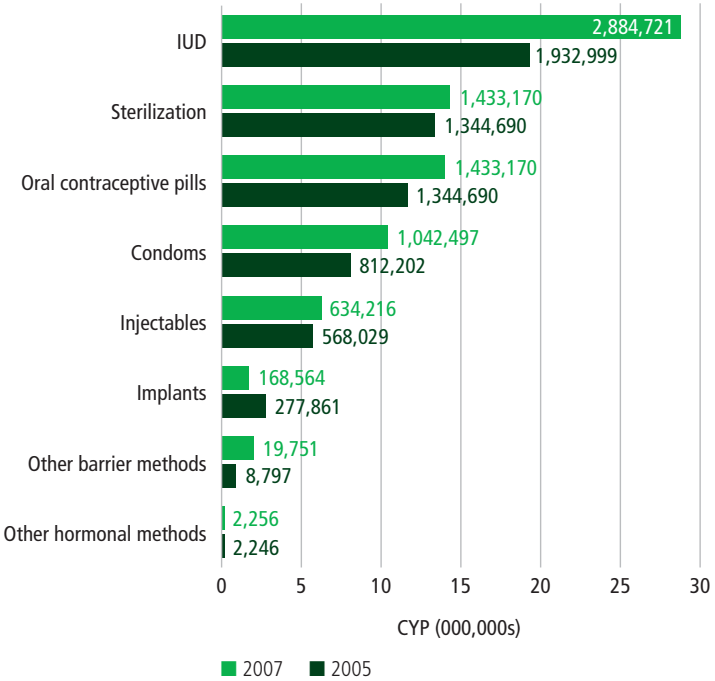


Figure 2.13: **Number of Couple Years of Protection (CYP) provided, by method, in 2005 and 2007**



Providing sexual and reproductive health services

In 2007, IPPF provided a total of 46,061,744 sexual and reproductive health services globally, and a third of these were provided to young people. Figure 2.12 shows the increases in numbers of contraceptive and non-contraceptive sexual and reproductive health services provided between 2005 and 2007, with an overall increase in services provided of over 49.8 per cent.

The numbers of clinic-based service delivery points increased since 2005, from 5,286 to 6,157 in 2007, whereas the number of non-clinic based service delivery points has dropped from 53,184 to 49,763.***** Overall, the number of IPPF service delivery points dropped from 58,470 in 2005 to 55,920 in 2007.

In 2007, the global couple years of protection (CYP) provided by IPPF Member Associations was 7,585,595, a significant increase of 24 per cent from 2005. Figure 2.13 illustrates the breakdown of CYP values for different methods of contraception.

Compared to 2005, most of the increase in CYP was contributed by the IUD which rose by 49.2 per cent. There was also an increase of 28.4 per cent in CYP for condoms. All other methods went up slightly with the exception of implants for which the CYP value dropped by 39.3 per cent.

***** A clinic-based service delivery point provides clinic-based sexual and reproductive health services. They can be static or mobile. A non-clinic based service delivery point is defined as a channel of distribution that does not provide clinic-based sexual and reproductive health services. These include community-based distribution, social marketing, government channels of distribution, private physicians that distribute contraceptives and other commodities provided by the Member Association.

Figure 2.14: **Number of contraceptive services provided, by type, in 2005 and 2007**

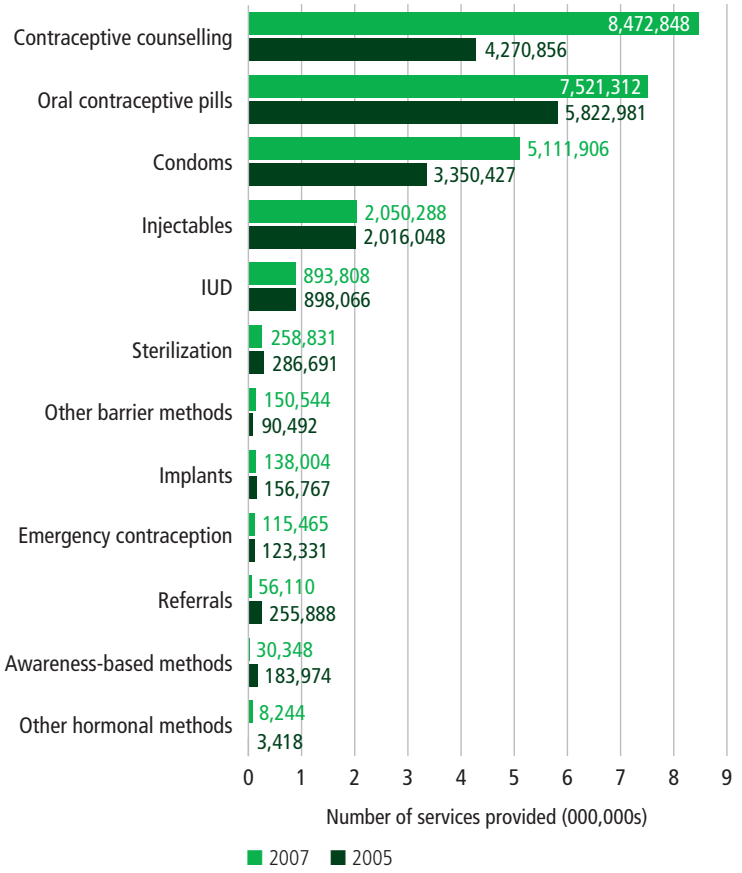
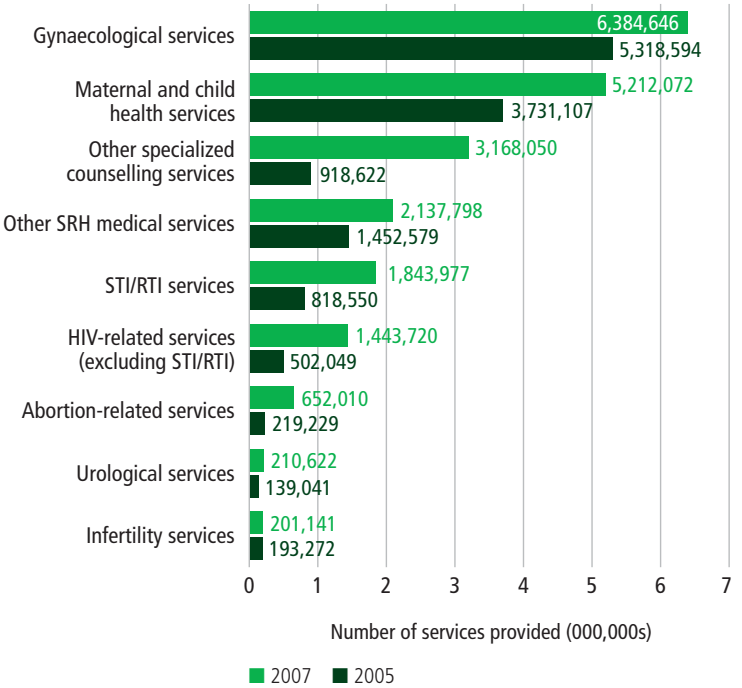


Figure 2.15: **Number of non-contraceptive SRH services provided, by type, in 2005 and 2007**



In 2007, the total number of contraceptive services provided was 24,807,708, an increase of 43 per cent from 2005. Of the total number of services provided, 8,346,997 were provided to young people (33.7 per cent). Figure 2.14 illustrates the numbers of contraceptive services provided, by type.

In 2007, the total number of sexual and reproductive health services provided, excluding contraceptive services, was 21,254,036, an increase of 58 per cent from 2005. Of the total number of services provided, 7,009,351 were provided to young people (33.0 per cent). Figure 2.15 illustrates the numbers of non-contraceptive sexual and reproductive health services provided by Member Associations by type of service.

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 2007 was 70.7 per cent. Seventy seven per cent of Associations had a gender equity policy in place, and many more (91.2 per cent) were implementing gender-focused programmes. These programmes include women's empowerment (78.9 per cent), women's participation (80.3 per cent), women's rights in clinics (76.9 per cent), men's needs (66.0 per cent), gender-based violence (74.1 per cent), gender capacity building (61.9 per cent), and monitoring and evaluation of gender programmes (41.5 per cent).

Table 2.16: **Proportion of Member Associations with quality of care standards in place, by type of standard**

Quality of care standards	Proportion 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	97.6%
Procedures to ensure clients' perceptions on service provision are taken into account	89.6%
Orientation and ongoing training provided to staff in all service delivery points	94.4%
Mechanisms to regularly assess technical competence of service providers	87.2%
Implements strategies/approaches to assess quality of care provided	88.0%
All service delivery points have the right conditions to deliver sexual and reproductive health services	96.8%

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 is 73.5 per cent, ranging from approximately 90 per cent in the Europe, South Asia and Western Hemisphere regions, to around 55 per cent in the Africa, Arab World and East and South East Asia and Oceania regions. However, this is still below the 100 per cent figure that IPPF requires as its gender equity policy. The proportion of women on IPPF's governing boards globally is 55.4 per cent. In terms of staff in management positions, 72.7 per cent are 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 2007 is 77.6 per cent, a significant increase from 65.0 per cent in 2005. Table 2.16 illustrates the proportion of Member Associations with the different quality of care standards in place. Compared to 2005, all these categories show an increase of between 10 to 12 per cent.

In an attempt to ensure high quality of care, IPPF's Member Associations provide professional training and development in sexual and reproductive health and rights to their service providers. In 2007, Member Associations provided such training to counsellors (81.0 per cent), nurses (78.2 per cent), teachers (68.7 per cent), doctors (64.6 per cent) and midwives (60.5 per cent).

Advocacy – results

Table 2.17: **Advocacy indicators results, 2005 and 2007**

Indicator		2005	2007
26	Proportion of Member Associations involved in influencing public opinion on sexual and reproductive health and rights	71.4% (n=126)	**80.3%** (n=147)
27	Proportion of Member Associations involved in advancing national policy and legislation on sexual and reproductive health and rights	90.4% (n=126)	**88.4%** (n=147)
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)	**47** (n=147)
29	Proportion of Member Associations involved in counteracting opposition to sexual and reproductive health and rights	80.2% (n=126)	**82.3%** (n=147)
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)	**85.7%** (n=147)

(n=number of Member Associations that provided data)

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 2007 was 80.3 per cent, an increase from 71.4 per cent in 2005.

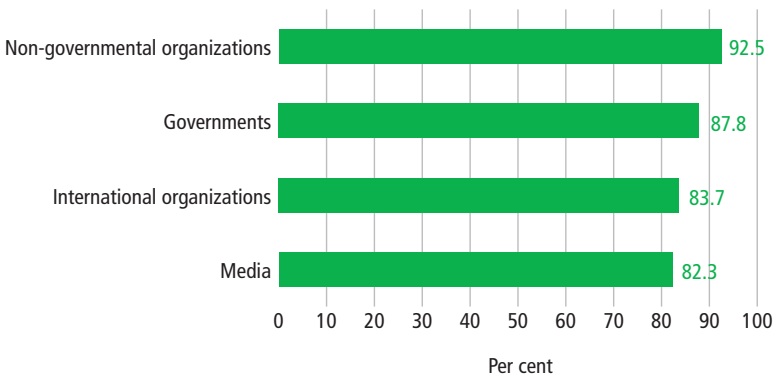
Advancing national policy and legislation

In 2007, the proportion of Member Associations conducting advocacy activities to advance national policy and legislation on sexual and reproductive health and rights was 88.4 per cent, a slight drop from 90.4 per cent in 2005. The key activities that Associations implemented in their campaigns included public education (89.1 per cent), working with the media (86.4 per cent), and informing policy makers (76.4 per cent). The target groups for advocacy activities for policy and legislation on sexual and reproductive health and rights include government decision makers (86.4 per cent), mass media (85.0 per cent), the general public (87.1 per cent), and community and religious leaders (74.1 per cent).

Working in partnerships with other organizations to advance sexual and reproductive health and rights is a key advocacy strategy, and IPPF's Member Associations collaborated with other non-governmental organizations (92.5 per cent), governments (87.8 per cent), international organizations (83.7 per cent), and also with mass media (82.3 per cent) to increase pressure to effect positive change (Figure 2.18).

The results of Member Associations' advocacy work at the country level 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 2007, there were 47 policy or legislative changes, and Box 2.19 provides a selection of some of these changes.

Figure 2.18: **Percentage of Member Associations working in advocacy partnerships, by type of partner**



Box 2.19: Examples of successful national policy and legislative changes in support of sexual and reproductive health and rights to which IPPF's Member Associations' advocacy efforts have contributed in 2007

Adolescents

The IPPF Member Association in **The Former Yugoslav Republic of Macedonia** was selected by the Ministry of Health to take an active role in the development of the National Strategy for Health and Development of Adolescents, and the National AIDS Strategy, focusing on HIV prevention among young people aged 15 to 24.

HIV and AIDS

The IPPF Member Association in **Sudan** contributed to the process of developing a new law protecting people living with HIV. The law outlines the right to non-discrimination, the right to work and access to services.

In **Vanuatu**, there was no national policy on HIV and AIDS before 2007. The Vanuatu Family Health Association (VFHA) lobbied for the introduction of a policy and was invited to participate in the drafting committee. The policy was finally launched on World AIDS Day 2007.

Abortion

Following a long period during which the IPPF Member Association in **Portugal** advocated for changes in the abortion laws, in February 2007, a referendum to allow all women to seek abortion services on demand until the 10th week of pregnancy, was held. The result was a majority vote in favour of changing the existing law. Previously, abortions were only allowed in Portugal in cases of rape, a threat to the health of the mother or serious foetal abnormality. Once approved in parliament, the law will reduce unsafe abortion practices in the country.

The advocacy activities of the Member Association in **Togo** and other partners have resulted in a new law on sexual and reproductive health in 2007. This law includes a section on abortion which unequivocally gives the women in Togo the right to access abortion in the cases of impairment of the fetus, incest, rape, and threat to the life or health of women.

The **Slovak** Family Planning Association advocated against outlawing abortion, a request made by the Christian Democratic party in 2001. In 2007, the Constitutional Court finally ruled that it is not unconstitutional to perform abortion at a woman's request in the first trimester of pregnancy.

Access

The **Gambian** Member Association successfully lobbied with government to include contraceptives in the list of essential drugs. The act was passed in parliament in 2007, and contraceptives are now formally recognized as essential drugs for the first time in the country.

In 2007, the Family Planning Association of **Pakistan** entered a collaborative partnership with the national health policy unit and the Ministry of Health. Following this, a chapter on reproductive health has been included in the National Health Policy for the first time.

In **Colombia**, the National Council on Health Safety now includes hormonal contraceptives and male condoms in the Compulsory Health Plan and the Subsidized Health Plan. The Scientific Advisor at Asociación Pro-Bienestar de la Familia Colombiana (PROFAMILIA), the IPPF Member Association in Colombia, provided direct technical assistance to the Council.

Human trafficking

A bill on the Suppression of Human Trafficking and Sexual Exploitation was debated in the Cambodian parliament in December 2007, and the law was passed in January 2008. The Member

Association in **Cambodia** (RHAC), is a member of the Secretariat of a national NGO coalition which pushed for the adoption of this law.

Gender-based violence

In the **Dominican Republic**, technical personnel from the Asociación Dominicana Pro-Bienestar de la Familia (PROFAMILIA) actively participated in the development of national norms on gender-based violence. The protocols on service provision developed by the organization also served as a reference in the development of these national norms.

Advocacy

During 2007, the Planned Parenthood Federation of **America** (PPFA) conducted grassroots organizing, direct and indirect advocacy, and coalition work at the state and federal levels to bring about positive policy change. The achievements included legislation to increase access to comprehensive sexuality education in four states, expanding access to emergency contraception in five states, restoring or increasing family planning funding in 15 states, expanding Medicaid family planning coverage in seven states and achieving equity in insurance coverage for contraception in one state.

"Every minute, a woman dies in childbirth. For every woman who dies, 20 or more experience serious complications."

(www.unfpa.org/mothers/index.htm)

Counteracting opposition

The proportion of Member Associations counteracting opposition to sexual and reproductive health and rights was 82.3 per cent in 2007, a slight increase from 80.2 per cent in 2005. The main opposition strategies being counteracted by Member Associations include misinformation or misrepresentation of sexual and reproductive health and rights (74.1 per cent), de-funding or cutting funds to sexual and reproductive health and rights (42.2 per cent), undermining existing policy or legislation (46.9 per cent), and blocking or opposing new policy and legislation (41.5 per cent).

Additional data reveal that religious leaders were viewed as the source of opposition by 74.1 per cent of Member Associations. Other sources of opposition mentioned by the Member Associations were community leaders (40.8 per cent), governments (29.3 per cent) and the media (27.9 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 in 2007 was 85.7 per cent, dropping slightly from 86.5 per cent in 2005. More Member Associations were advocating with governments for specific financial commitment in their national budget lines on sexual and reproductive health (73.5 per cent) than were advocating for governments to meet financial commitments under international agreements such as Cairo (62.6 per cent).

Additional information revealed that some Member Associations participated in various processes to influence national funding mechanisms including national development plans (38.8 per cent), poverty reduction strategy papers (32.7 per cent), medium term expenditure frameworks (14.3 per cent), sector-wide approaches (34.7 per cent), country coordinating mechanisms (49.0 per cent) and donor national-level programmes (46.9 per cent).

Member Associations undertake a number of activities to advance international and regional agreements and strategies relevant to sexual and reproductive health and rights. In 2007, these included influencing positions held by national governments on international agreements, strategies and policies relevant to sexual and reproductive health and rights (62.6 per cent), monitoring national governments' implementation of international agreements, strategies and policies relevant to sexual and reproductive health and rights (51.7 per cent), attending and advocating at meetings held by major international non-governmental organizations (72.8 per cent), and participating in the coordination of advocacy activities (73.5 per cent).

Eighteen per cent of IPPF's Member Associations provide technical assistance in advocacy to other IPPF Member Associations in developing countries, and/or to other civil society organizations.

Highlights from IPPF's global indicators 2007

This chapter has presented IPPF's global indicators results from 2007 and compared them with those from 2005. More Member Associations provided data in 2007 than in 2005, an increase of 14 per cent on the survey, and 18 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 2007 have increased dramatically, for example, the number of condoms distributed has risen from nearly 98 million in 2005 to over 125.6 million in 2007. Almost double the numbers of sexual and reproductive health services were provided to young people in 2007, and the global Couple Years of Protection rose from 6.1 million in 2005 to 7.6 million in 2007.

In 2007, IPPF served 30.7 million clients. The estimated proportion of IPPF's clients that are poor, marginalized, socially-excluded and/or under-served in 2007 was nearly 60 per cent, with the highest proportions in Africa (83 per cent) and South Asia (80 per cent).

The number of Associations with HIV workplace policies in place in 2007 was 50.3 per cent, a significant increase from 31.0 per cent in 2005. The proportion of Associations with quality of care assurance systems went up by 13 per cent between 2005 and 2007. There were 47 important national policy or legislative changes that Member Associations contributed to in 2007, changes that will dramatically improve sexual and reproductive health and rights for millions around the world.

IPPF's global achievements in 2007 demonstrate the importance of the Federation as a global voice advocating for sexual and reproductive health and rights, and as a major service provider in the field of sexual and reproductive health. 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 the strengths, as well as areas requiring further investment in programmes, governance and management. Regional Offices can use the data to identify where technical support needs to be directed and to assist in decisions about resource allocation. Access to the global indicators data through a variety of online reports on IPPF's extranet means that the data are being utilized extensively across the Federation in an effort to increase organizational effectiveness and accountability.

3 IPPF's supporting strategies

IPPF's four supporting strategies reinforce the Strategic Framework and ensure good governance and accreditation to ensure quality, effectiveness and accountability; resource mobilization essential to fund IPPF's work; capacity building to support Member Associations; and monitoring, evaluation and learning to capture and utilize knowledge and expertise. This chapter reviews work undertaken in these areas in 2007.

Governance and accreditation

The accreditation process enables volunteers and staff to systematically reflect on all aspects of their work and to be better equipped to serve clients, govern well and manage effectively.

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

Governance

A Governance Task Force was established by IPPF's Governing Council in 2006, to make recommendations to strengthen governance and volunteerism in the Federation. In 2007, as a first step in its work, the Task Force revised the policy on volunteering to provide better guidance to Member Associations on how to involve volunteers and to underline the important role volunteers play in the Federation. A volunteer in IPPF shares the Federation's mission, vision and values and offers their time, knowledge, skills and experience free of charge to a Member Association.

The policy on volunteering asks Member Associations to:

- encourage young people and adults, who subscribe to the mission and core values of IPPF, to play their part in the sexual and reproductive health and rights movement in their country
- provide existing and potential volunteers with the opportunities, information and training they need to develop their interests and skills and make a contribution to the work of the Member Association
- demonstrate the contributions volunteers make to the work of the Member Association, document these and share them on a regular basis with their volunteers
- encourage and develop volunteers to take on leadership, governance and resource mobilization responsibilities

The Task Force has also produced a Code of Good Governance which Governing Council agreed should be adhered to by all governing bodies in the Federation. The major challenge will be for each governing body to meet these principles in practice. An easy-to-use, self-assessment tool has been developed to provide support, and a governance handbook is also in progress.

IPPF Governing Council met in May 2008 and adopted a number of other Task Force recommendations to improve the governance of the Federation. These will make regional governance more effective and responsive, by reducing the size of governing bodies, by developing the capacity of volunteer and staff leadership, and by providing opportunities for exchange between Member Associations. Governing Council has also agreed to the establishment of an annual award to individuals and organizations that have made outstanding contributions in the field of sexual and reproductive health and rights.

Throughout 2007, the Western Hemisphere region led a series of workshops based on real life case studies of governance issues.

"I have gained a lot from the community and benefited from knowing about family planning. I have benefited personally by learning new things, skills and ideas. I want to share my good fortune with my community."

Debo Cham, District volunteer in Njaba Kunda, The Gambia

One of the key issues addressed was how to resolve dysfunctional working relations between a Board and the Executive Director using a model for conflict resolution. During the workshops, guidance on recognizing and categorizing symptoms of conflict was provided, and a plan of action to improve working relations was developed. Another key issue addressed in the workshops was how to expand the volunteer base of Member Associations and how to find strong candidates with the desired skills and backgrounds who can serve as Board members. This involved mapping the current situation, identifying gaps and needs, and developing a plan on how to involve them in the work of the Member Association in the long term.

Accreditation

2007 was the final year of the first five-year cycle of accreditation reviews. By the end of the year, nearly all full Member Associations had been reviewed with the few remaining being undertaken early in 2008.

Member Associations in Afghanistan, Australia, Belgium, Botswana, Canada, the Caribbean, Central African Republic, Djibouti, Gabon, Hong Kong, Iceland, Ireland, Japan, Liberia, Luxembourg, Mauritania, Namibia, Netherlands, Norway, Portugal, Puerto Rico, Samoa, Sierra Leone, Singapore, Switzerland, Tajikistan, Togo, United States, and Vanuatu all underwent an accreditation review in 2007.

Australia, Canada, Hong Kong and the United States, as well as Bolivia which underwent its accreditation review in 2008, all complied fully with IPPF Membership Standards at the time of the review, bringing the number of Member Associations complying with all standards at the actual time of review since 2003 to eleven.

The Associations in Austria, Australia, Djibouti, France, Germany, Hong Kong, Hungary, Ireland, Latvia, Mauritania, Puerto Rico, Turkey and the United States were accredited in 2007. A further ten Member Associations were recommended for accreditation at Governing Council in May 2008.

The accreditation process has proven to be a valuable tool for organizations operating in countries where civil society is in its early stages of development. This is because the systematic review provides an opportunity to build capacity in governance and management.

Evaluation of IPPF's accreditation system

An independent evaluation of the accreditation system was completed as planned in August 2007. The report provided an overview of achievements and valuable recommendations on how to improve the system. Key recommendations from the evaluation included the need to streamline membership standards, to pay more attention to performance and the relevance of the Association's work in its country context. A further recommendation was to align the accreditation review tool more closely with the specific developmental phase of each Member Association.

IPPF's Membership Committee and Governing Council reviewed the evaluation findings in detail and asked the Secretariat to revise the accreditation system in line with the recommendations. At its meeting in May 2008, the Governing Council approved the revised set of membership standards and procedures. There are now 49 Membership Standards, organized within the following ten membership principles:

1. open and democratic
2. well governed
3. strategic and progressive
4. transparent and accountable
5. well managed
6. financially healthy
7. good employer
8. committed to results
9. committed to quality
10. a leading sexual and reproductive health and rights organization

The revised accreditation system will begin the next cycle in 2009 and will run over a five-year period during which time all Member Associations will be reviewed for compliance with standards.

Resource mobilization and finance

IPPF's resource mobilization involves diversifying and expanding its funding base to ensure sustainability of programmes and to minimize the negative effects of a difficult global financial environment for sexual and reproductive health.

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

The global campaign for the health Millennium Development Goals

In 2007, international efforts to increase the effectiveness of funding continued to develop, particularly in the health sector. The mid-point report of the Millennium Development Goals (MDGs) highlighted that progress in achieving the health goals (MDG 1b, MDG 4, MDG 5 and MDG 6) has been slow and that, at current rates of progress, they will not be achieved by 2015.[1] The failure to achieve these Millennium Development Goals will also affect progress in other development goals, particularly those related to poverty, gender and education.

Any reduction in funding from official development assistance would result in IPPF's Member Associations being forced to cut the sexual and reproductive health services they provide. IPPF closely tracks the channels and flows of official development assistance to remain aware of the international funding situation. This is essential to ensure that IPPF is well-informed, able to identify the entry points for seeking to increase the total funding available to sexual and reproductive health and rights, and able to use evidence to develop strategies in resource mobilization.

Government commitments to increase both the amount and effectiveness of official development assistance have resulted in increased investment in delivering better health care. Such an increase in investment means that existing health systems are strengthened at the national and transnational levels. A global campaign for the health MDGs was launched during 2007 to bring together a number of government-led initiatives[2] that aim to accelerate progress on the health MDGs. These initiatives have progressed throughout 2008 at various international meetings, including the Tokyo International Conference on African Development convened by the Japanese Government during their presidency of the G8. The eight international health agencies, called the Health 8,[3] have operationalized these initiatives by developing a combined work programme that will look at improving inter-agency oversight, coordination and strategic guidance at both national and international levels. The work programme includes a number of international working groups. At the national level, it will support the development of one national health plan and budget with country-based appraisal, monitoring and reporting. This plan and budget will receive support from a country health sector team. Donor governments will provide recipient governments with long-term predictable financing. These developments have the potential to make a significant contribution towards achieving comprehensive primary health care, and this is particularly true if they are harmonized with the efforts of other donor governments who are not actively participating in the global campaign.

As noted in last year's Annual Performance Report, the modalities of official development assistance are changing, with decision making taking place more and more at country level. The global campaign will increase the pace at which this change occurs, and it is vital that civil society has the skills and funds to effectively engage in these government-led processes. Similarly, to ensure that sexual and reproductive health and rights are fully integrated into national health plans, it is important that IPPF's Member Associations are engaged in the process. Member Associations are civil society organizations that play an important role in ensuring that the health needs of poor and vulnerable groups are met. There is also a clear and unique role for civil society to act as a watchdog on these initiatives, and particularly so for organizations working in sexual and reproductive health and rights.

Resource mobilization in 2007

A major priority for IPPF continues to be the need to strengthen its resource mobilization efforts at all levels of the Federation. In May 2007, IPPF's Governing Council met to review and assess how the changing architecture governing the distribution of official development assistance will affect the Federation. Recommendations

from the meeting were to review IPPF's existing resource mobilization policy, to develop a global resource mobilization strategy and to invest in developing the capacity of Member Associations to raise resources. As a result, a new policy on resource mobilization was agreed by the Governing Council at its November 2007 meeting. A global strategy has also been developed which emphasizes the crucial role of action at both national and regional levels. The changes to the overseas development aid architecture were also discussed at Regional Council meetings throughout the summer of 2007 and follow-up plans were developed.

Work to strengthen resource mobilization efforts has continued to gain momentum throughout 2008. A guide to support Member Associations undertaking resource mobilization was piloted in the Africa region with support of colleagues from Botswana, The Gambia, Ghana, Kenya and Malawi, and the guide will shortly be available in Arabic, English, French and Spanish. A series of tools and resources were also developed to assist Member Associations in managing restricted funding. These include understanding donor procurement regulations, contract management checklists and restricted project guidelines.

Financial review

Full details of IPPF's 2007 financial results are provided in a separate document entitled 'IPPF Financial Statements 2007'. These have been prepared according to UK accounting and charity reporting and were audited by KPMG LLP. The 'IPPF Financial Statements' provide information on funding received by individual Member Associations from IPPF directly. They do not include the non-IPPF income or information on the expenditure of the Associations.

IPPF's income

Income received by IPPF from governments, foundations and other sources has increased by 39 per cent over the past five years, and 12 per cent compared with 2006. In 2007, income reached a 13-year high at US$120.6 million (Table 3.1). The main source of income continues to be government contributions which accounted for 64 per cent in 2007. Restricted government grants amounted to US$11.2 million, up from US$5.8 million in 2006. Grants from multilaterals and other income sources amounted to US$28.9 million compared with US$24.7 million in the previous year. In 2007, local currency funds from the governments of Australia, Canada and Finland all increased, while negotiations of new funding agreements with the governments of Australia, Finland, Japan, The Netherlands, Republic of Korea, Sweden and the UK will provide additional stability to the funding base of the Federation.

In 2008, increases in funding are anticipated from the governments of Australia, Finland, New Zealand, Sweden, the United Kingdom and the William and Flora Hewlett Foundation. The continued weakening of the US dollar against many international currencies increased the value of many local currency contributions. Restricted funding was received for an increasingly diverse range of priority programmes that will build capacity in accordance with IPPF's Strategic Framework. For example, in 2007, IPPF received funding from the governments of Australia (access), Denmark (adolescents) and Japan (HIV and AIDS), as well as from a consortium of European donors to support the 'Safe Abortion Action Fund', which is administered by IPPF. For the first time ever, IPPF received funding from the Spanish Government to support work with internally displaced populations in Sudan. IPPF's restricted funding, combined with support from multilateral (particularly the European Development Fund, the Joint United Nations Programme on HIV and AIDS and the United Nations Population Fund) and private sources, allowed IPPF to continue to increase the diversity of its funding base throughout the year.

Table 3.1: **Summary of income, 2005-2007**

	2005	2006	2007
Type of income	**US$'000**	**US$'000**	**US$'000**
Unrestricted			
Government	64,994	71,421	**75,571**
Multilaterals etc.	6,448	5,157	**7,161**
Other	2,233	5,233	**3,984**
Restricted			
Government	4,006	5,798	**11,160**
Multilaterals etc.	14,615	19,569	**21,764**
Other	227	257	**927**
Total	**92,523**	**107,435**	**120,567**

Source: IPPF Financial Statements 2005, 2006, 2007.

Table 3.2: **Summary of expenditure, 2005-2007**

	2005	2006	2007
Type of expenditure	**US$'000**	**US$'000**	**US$'000**
Grants to Member Associations and partners	56,358	61,288	**61,770**
Programme activities	18,856	20,397	**24,586**
Support costs	13,483	9,981	**8,255**
Fundraising	2,558	2,758	**3,228**
Governance	2,285	2,251	**2,521**
Trading company	1,897	1,577	**1,514**
Total	95,437	98,252	**101,874**

Source: IPPF Financial Statements 2005, 2006, 2007.

Table 3.3: **IPPF grant funding per region, 2005-2007**

	2005	2006	2007
Region	**US$'000**	**US$'000**	**US$'000**
Africa	20,790	21,685	**22,560**
Arab World	5,343	4,998	**4,556**
East and South East Asia and Oceania	6,781	6,574	**6,855**
Europe	3,946	5,294	**3,286**
South Asia	8,850	9,129	**8,940**
Western Hemisphere	10,648	13,608	**15,573**
Total	**56,358**	**61,288**	**61,770**

Source: IPPF Financial Statements 2005, 2006, 2007.

Table 3.4: **Percentage of unrestricted resource allocation to Member Associations by UNFPA category, 2005-2007**

Country classification	**2005**	**2006**	**2007**
A – Highest need	63.9	60.4	**61.0**
B – High need	25.3	25.2	**26.3**
C – Low need	6.0	8.2	**6.4**
O – Other	4.8	6.2	**6.3**
Total	100	100	**100**

IPPF's expenditure

The overall expenditure in 2007 was US$101.9 million (Table 3.2). This compared with US$98.3 million in the previous year. Grants to Member Associations remained almost static at US$61.8 million (Table 3.3).

In Table 3.4, grants to Member Associations and partners are classified according to the UNFPA country methodology to illustrate how IPPF resources are being allocated to countries with the greatest sexual and reproductive health needs. In 2007, IPPF allocated 87.3 per cent of unrestricted funding to category A and B countries.

Member Association income

IPPF conducts analyses on the overall funding received by grant-receiving Member Associations, and 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$207.0 million to US$281.7 million, or by 36.1 per cent.

Regional comparisons show considerable differences among Member Associations in terms of relying on IPPF for their funding, and the case study from Sri Lanka in Box 3.5 illustrates one Association's progress towards financial sustainability. 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 vulnerable groups, it is not always possible to achieve this whilst providing services for free or which do not fully cover costs. This emphasizes the need for IPPF to strengthen its resource mobilization efforts at all levels of the Federation.

Box 3.5: **Towards financial sustainability in Sri Lanka**

Over the last decade, IPPF has reduced the amount of unrestricted funding given to Member Associations in lower priority countries, and this has allowed the Federation to increase funding for those countries where the sexual and reproductive health needs are greatest.

In 2001, the South Asia Regional Office and the Family Planning Association of Sri Lanka (FPASL) agreed that, over a period of time, IPPF unrestricted funding to the Association would be phased out. During the subsequent six-year period, FPASL focused on activities to increase the organization's sustainability, and for the first time in 2007, they did not receive unrestricted funding from IPPF. The steps taken by FPASL to become a financially sustainable organization whilst retaining a mandate of serving the poor and vulnerable, are summarized below.

Initially, FPASL conducted an assessment of its performance in institutional, programmatic and financial sustainability. The organization scored highly in programmatic and institutional sustainability, but performed less well in financial sustainability. FPASL had strong financial management but was struggling with elements of value for money and revenue stability. Following the assessment, FPASL conducted a cost structure analysis, reviewing costs per client, procurement procedures and overhead expenditures. To strengthen revenue stability, FPASL increased its capacity to manage restricted funding, and established income-generating activities and a revolving fund to help diversify its funding base.

FPASL obtains most of its revenue from a contraceptive retail sales programme which began as a limited social marketing exercise and is now the nation's largest contraceptive retail provider, distributing 6.9 million condoms in 2007. This allows FPASL to generate income whilst keeping prices low and affordable. Further income is generated through the provision of training in a variety of technical skills.

Throughout this period, FPASL was clear that it would not compromise on its commitment to ensuring good reproductive and sexual health for all women and men. Its service delivery points still target vulnerable populations and 73 per cent of FPASL's clients are poor, marginalized, under-served and/or socially-excluded. The Association does not aim to recover all the costs of these programmes through income generation, and they are supported by government funding in some of the poor and rural areas, and subsidized by the profit-making social marketing programme.

Capacity building

Capacity building is a continual process through which IPPF ensures it has the ability to implement its Strategic Framework, and which guarantees the delivery of effective programmes throughout the world.

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

Capacity building increases the skills and experience of IPPF staff and volunteers, and provides the opportunity for exchange of information and good practices. IPPF invests in capacity building by employing both traditional and innovative methods. Workshops, information sharing, publications, partnerships, high-level conferences, toolkits and bespoke technical support were utilized to build capacity at all levels of the Federation. The following examples illustrate a variety of capacity building initiatives undertaken during 2007.

Abortion

In 2007, IPPF Secretariat staff jointly facilitated a workshop for all Member Association Executive Directors in the Africa region. The workshop covered issues such as clients' rights, conscientious objection, stigma, and the influence of religion. All participants received up-to-date information on abortion protocol, data collection, interpretation of national abortion laws, and referral networks. In collaboration with Ipas, the East and South East Asia and Oceania Regional Office held a five-day 'train the trainers' workshop for service providers from four Member Associations in the region, where training on manual vacuum aspiration was provided.

Access to information is vital to the provision of quality services and increased capacity. The weekly 'Abortion Abstract', which is distributed to all IPPF Member Associations, provides a crucial link between local situations and global experience and debates. The newly-published book entitled 'Abortion: A Worldwide Perspective', co-authored by IPPF staff, provides a pro-choice advocacy tool with country comparisons on abortion laws. The book also highlights the positive results of decriminalizing abortion.

In conjunction with the International Federation of Gynecology and Obstetrics and other affiliated partner organizations, IPPF participated in a working group on the prevention of unsafe abortion. As part of its mandate, the working group is currently undertaking a situational analysis of unsafe abortion. A second programme, in partnership with the University of California, places university fellows in Member Association clinics to facilitate the sharing of information.

Adolescents

An increasing awareness that young men feel isolated from sexual and reproductive health programming guided IPPF's capacity building work with adolescents throughout 2007. The IPPF meeting, entitled 'Young men, sexuality, and sexual and reproductive health and rights', resulted in a knowledge base from which future work on young men will be informed. At the conference, Member Associations shared their lessons learned from working with young men in relation to parenthood, sexuality, HIV and sexual violence.

As a result of capacity building workshops and consultations held in Burkina Faso and Nicaragua, a step-by-step toolkit for designing and implementing rights-based programmes for young people was developed. Case studies from the comprehensive sexuality education project in Burkina Faso and the stigma project in Nicaragua are included in the toolkit. Two other resources to assist in building capacity were also developed in 2007. The 'From Evidence to Action' toolkit provides Member Associations with advocacy strategies and advice on how to support sexuality education and respond to opposition. Sexuality education teaching guidelines were also produced in collaboration with the Population Council and other partner organizations. Finally, a framework for youth peer education programmes was developed. Using international expertise and experiences from the field, and involving young people themselves, the framework incorporates not only the planning, implementation, and evaluation elements of such programmes, but also a comprehensive range of sexual and reproductive health and rights topics for peer educators to teach.

The Innovation Fund fosters, pilots and promotes ground-breaking initiatives in support of IPPF's strategic priorities, which enhance learning and contribute to increased relevance and effectiveness of sexual and reproductive health programmes.

HIV and AIDS

Capacity building in HIV and AIDS follows five distinct strategies: strengthening HIV capacity; technical support to Regional Offices; bespoke technical support to Member Associations; engagement and action; and internal workshops. As a central component of this strategy, twenty countries were selected as the main focus of IPPF's HIV interventions. The chosen Member Associations participate in an annual competencies workshop which, in 2007, took place in Nairobi and focused on the link between sexual and reproductive health and HIV.

IPPF publishes a quarterly newsletter on HIV and AIDS to encourage learning across the Federation and to celebrate pioneering work. This newsletter enables Member Associations to keep abreast of key issues and trends. In 2007, the four issues of the newsletter focused on: HIV research, including male circumcision; involvement of people living with HIV and AIDS; building the evidence base for linking sexual and reproductive health and HIV; and targeting prevention strategies for young women and girls.

Access

The International Medical Advisory Panel (IMAP), a group composed of leading experts in the sexual and reproductive health field, produced regular statements throughout 2007 regarding best practice, notably on the issues of male circumcision and the role of the HPV vaccine. The quarterly IPPF Medical Bulletin, which is translated into Arabic, French and Spanish, addresses cutting edge medical issues and is circulated to all Member Associations. In 2007, the Bulletin covered the issues of female genital mutilation, reproductive tract infections, and sexually transmitted infections, male circumcision and HIV, and cervical cancer prevention.

Innovation Fund

One of the core objectives of the Innovation Fund is to strengthen the capacity of Member Associations to innovate. One ongoing capacity building strategy employed by Innovation Fund staff is the creation of project support teams for each project. Each team consists of one Innovation Fund team member, one or more technical team member(s) with relevant expertise, a project finance adviser, and Regional Office staff. The teams provide bespoke support tailored to the specific needs of the diverse array of the Innovation Fund projects. In 2007, project support teams assisted with project implementation in North Korea and India, evaluation support in Peru, and the development of toolkits and peer education modules in Bosnia and Herzegovina.

Additionally, information sharing took place at the inter-regional and regional levels in 2007. Staff members from the Bulgarian Innovation Fund project visited the Tunisian Member Association to learn how to run mobile service units, and the Bosnian Member Association to learn about their programmes on sex trafficking.

Conclusion

Through concerted efforts on the part of staff at all levels, capacity building continues to play a key role in the implementation of IPPF's Strategic Framework (2005-2015) for all technical teams. In 2007, workshops, information sharing, toolkits, technical visits, and day-to-day support at all levels formed part of IPPF's capacity building strategy.

Monitoring and evaluation, including knowledge management

Monitoring, evaluation and learning provide the information needed to analyze and reflect upon the process that led to results in ways which enable continuous improvement, as well as increasing our accountability both to those we serve and to those who support our work.

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

Monitoring, evaluation and learning

In 2007, the South Asia Regional Office produced a social audit manual on how to implement and monitor programmes using rights-based and participatory principles and techniques. The manual provides guidance on the process of active participation of stakeholders as an integral part of an assessment. It provides a set of tools to conduct information gathering activities including mapping of services, exit interviews and focus group discussions. It also provides guidance on orientation training of stakeholders including civil society, government partners and marginalized and vulnerable communities. The manual includes case studies from Bangladesh, India, Nepal, Pakistan and Sri Lanka where the manual has been field tested.

The Western Hemisphere Regional Office worked with the Margaret Sanger Centre International to produce the STEPS monitoring and evaluation toolkit. This is an interactive online tool that organizations can use to create their own project monitoring and evaluation systems [**www.stepstoolkit.org**].

Information about the toolkit, and other useful resources on monitoring, evaluation and learning, was included in IPPF's e-learning resource. 'E-learning' is produced by Central Office three times a year. It shares online resources, tools, good practices and news on organizational learning, monitoring and evaluation, and is distributed widely throughout the Federation.

In 2007, Central Office organized a five-day training workshop in Delhi, attended by monitoring and evaluation staff from the six Regional Offices and Central Office. The training focused on building capacity on organizational learning and evaluation, and additional training sessions were facilitated by external experts on social audit and operations research.

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. During 2007, the 2006 global indicator results were shared with Governing Council and Regional

Councils to provide them with the evidence they require to monitor our progress in relation to the 2005 baseline data and against strategic and operational plans. The results are also shared with IPPF's donors at the annual donors' meeting and are published annually in a number of different publications.

Each IPPF region has their own strategic plan which focuses on the Five 'A's. In 2007, the Africa Regional Office conducted a mid-term review of its strategic plan. The research and evaluation department organized two workshops focusing on the internal review of the plan. The first workshop was attended by Regional Office staff and each unit conducted a self-assessment. The second workshop was attended by the Executive Directors of Member Associations and the 'Most Significant Change' methodology was used to guide the assessment process.

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.

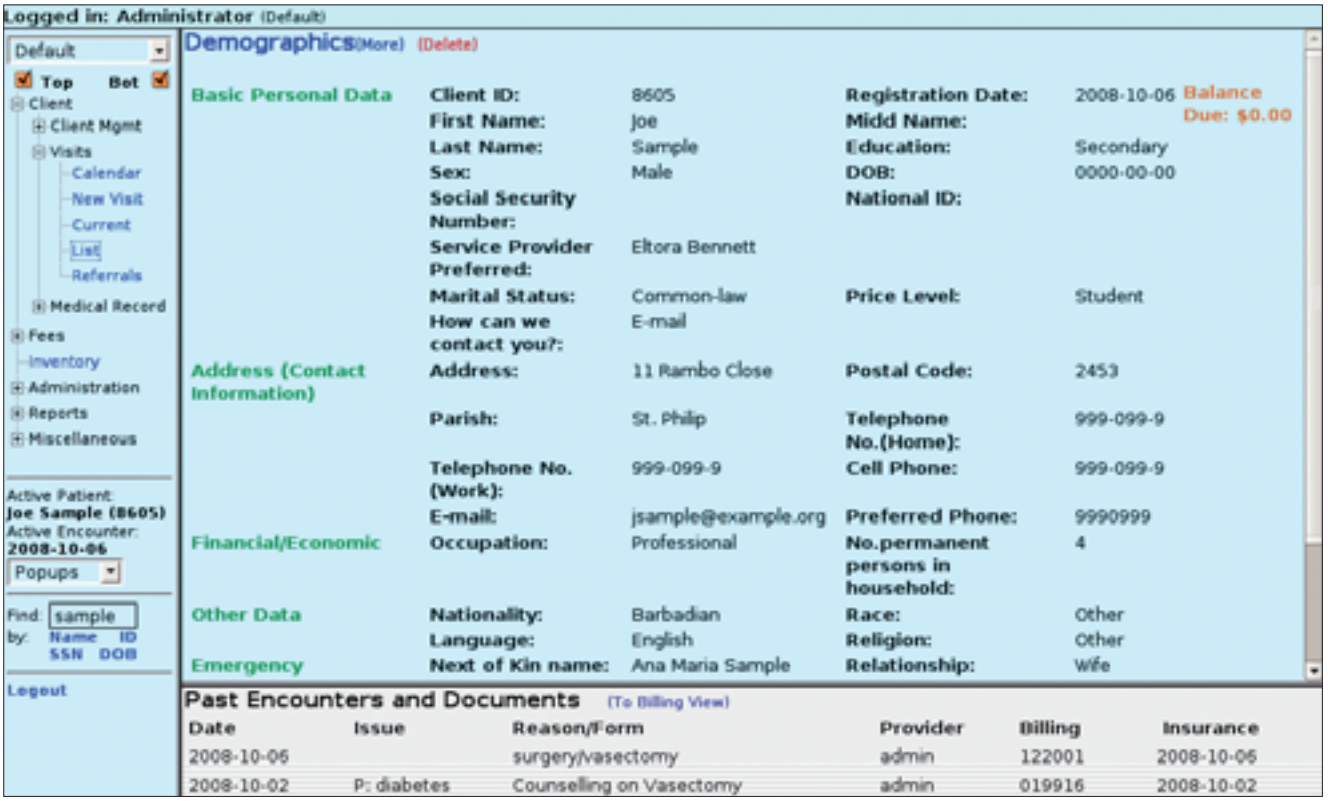
In 2007, the Arab World Regional Office held a three-day training workshop on monitoring and evaluation attended by staff and volunteers from all 13 Member Associations in the region. The workshop covered basic principles of evaluation, the difference between monitoring and evaluation, the process of supervisory field visits, and an introduction to the 'Most Significant Change' methodology. Each Member Association was provided with a full training package, including a trainer guide, so that they were able to replicate the training with staff from their own organizations.

In 2007, the European Network conducted training with participants from eight Member Associations, and the South Asia Regional Office with six Member Associations, both on service statistics data collection and analysis. The East and South East Asia and Oceania region held a regional workshop to develop Member Associations' capacity in project development and proposal writing through results-based management.

The electronic Integrated Management System (eIMS)

2007 marked the seventh year of IPPF using eIMS to report on annual results and achievements. With new enhancements, the system is now able to facilitate Annual Programme Budget preparations and submissions as well as reporting on results and achievements. Reporting in 2007 consisted of programme and project-related lessons learned, activities completed and financial data, annual service statistics and global indicators. With 147 Member Associations

Figure 3.6



reporting their global indicators results and 111 providing service statistics data, the eIMS is now being used by an increasing number of users for data analysis, including both staff and volunteers throughout the Federation. Various reports have been developed to allow analysis at the 'touch of a button' to facilitate the use of data for reflection, review and utilization.

Another significant development in 2007 was the integration of the eIMS and Connect. The eIMS is the IPPF extranet accessible by Member Associations, and Connect is the IPPF intranet where information is shared between Regional Offices and the Central Office. It provides a document library and serves as a collaboration tool with access to shared workspaces and discussion forums. Integrating the various sources of information is a crucial development for IPPF's commitment to knowledge management and organizational learning.

Clinical management system

In 2007, IPPF obtained restricted funding to develop a clinical management system which will enable the Member Associations to collect data directly from their clinics (Figure 3.6). IPPF invested in an open source clinical system that is already running successfully across the globe in hundreds of clinics. The decision to use a licence-free and already existing system with a large international user base will ensure the long term sustainability of this clinical management tool. The system facilitates client management, integrates financial and inventory systems, and provides comprehensive analysis reports for all levels of the Federation, including the service delivery point itself. Also, the data will feed directly into IPPF's service statistics module.

The Non-Profit Knowledge Initiative (NPOKI)

The Non-Profit Organization Knowledge Initiative (NPOKI) is finally on its way to becoming registered as a charitable organization, and has successfully hired an Executive Director. As a result, the initiative has continued to expand on various development projects which are shared across the participating organizations. A particular success has been the development of a tool which monitors indicator performance against various different donor frameworks. This was created specifically for the NPOKI member, the International AIDS Vaccine Initiative, but following some initial live tests, the system will soon be implemented by several others, including IPPF.

The continual exchange of knowledge that NPOKI provides has helped IPPF to find a suitable open source system for its clinical management requirements. Current investments into the client management tool will benefit an array of NPOKI members and ensure long term sustainability through its multiple uses and sizeable developer community.

Organizational learning

An IPPF organizational learning strategy was produced in 2006, and throughout 2007, IPPF has been promoting a more systematic approach to organizational learning across the Federation. In recognition of organizational learning as a priority area, the Knowledge Management and Evaluation Unit changed its name to the Organizational Learning and Evaluation Unit, and two new members of staff were recruited.

To promote a culture of sharing and learning at Central Office, regular informal learning sessions were introduced in January 2007. These sessions are held every two weeks and members of IPPF staff or external speakers present on a topic of interest, followed by a discussion. A review of the initiative was conducted in October 2007 with a survey emailed to all staff at Central Office, and the responses were overwhelmingly positive.

Central Office also organized the first ever IPPF Learning Day in January 2008. The Learning Day was structured around sessions, presentations and activities that encouraged staff to do something different from their normal working day, and to interact with other staff members that they usually have little contact with. The success of the Learning Day 2008 means that it will be held on an annual basis. Central Office also began documenting successful practices or initiatives taking place throughout IPPF, by building up a portfolio of case studies relating to organizational learning. To date, two case studies have been written documenting the Western Hemisphere Regional Office's use of regular week-long monthly travel bans to try to improve communication, sharing and learning, and the Learning Day held at Central Office.

4 Next steps

This final chapter in the Annual Performance Report summarizes some of the areas that IPPF will concentrate on in the coming years. We will focus on improving the delivery of high quality sexual and reproductive health services on the ground and strengthening our global network, and we will continue to review progress made in implementing our Strategic Framework 2005-2015.

Looking ahead…

As a global service provider and leading advocate of sexual and reproductive health, IPPF will continue to improve the lives of millions of women, men and young people around the world.

Improving performance

A major focus for IPPF will be to increase the volume of services provided and the number of people reached, especially the poor, marginalized, under-served and/or socially-excluded. We will continue to concentrate on improving the quality of services, ensuring that they are comprehensive, client-centred and rights-based in all our service delivery points. We will also contribute to reducing the global unmet need for family planning by ensuring that our Member Associations have access to a comprehensive range of commodities, including contraceptives.

Another major focus for IPPF in the near future is in supporting Member Associations to develop and implement effective resource mobilization and advocacy strategies. In the current international funding environment, it is vital that Member Associations have the capacity to access the maximum funds available to support their work and to expand the reach of services provided. With stronger advocacy programmes, Member Associations will be able to contribute to increased public, political and financial commitment to sexual and reproductive health and rights at national, regional and international levels. One key global campaign for IPPF, following the momentum built during 2007 and 2008 on the Millennium Development Goals Review and the G8 Summit, will be to address inequality in levels of maternal mortality that exist in the world today.

Another important initiative which will contribute to the increased performance of our Member Associations is the recently revised accreditation system. The new system, for which the next round of implementation will begin in 2009, has a greater focus on effective programme delivery, organizational development and the strategic role each Member Association plays in the field of sexual and reproductive health in their country.

Key priorities in HIV and AIDS

Evidence from our presence at the International AIDS Conference in Mexico in August 2008 confirms IPPF as a key player in the global response to HIV and AIDS. One of IPPF's key priorities over the past five years was to strengthen the integration of sexual and reproductive health and HIV and AIDS. We are currently building on the significant amount of experience gained to expand the number of, and provide support to, Member Associations implementing integration programmes.

IPPF will strengthen its work to reduce HIV stigma and discrimination with the roll out of the 'People Living with HIV Stigma Index', working together with GNP+, ICW and UNAIDS as our key partners, and we will also be leading an advocacy campaign against the criminalization of HIV transmission.

Significant initiatives

Recommendations from IPPF's Governance Task Force will continue to be implemented throughout 2009. These recommendations will build leadership among IPPF volunteers, strengthen partnerships between governance and management in Member Associations, and ensure more efficient use of governance funds at both regional and international levels. Furthermore, a handbook, built around the Code of Good Governance, will provide concrete advice on how governing body members can perform their governance functions in line with the Code.

The Declaration of Sexual Rights, adopted by Governing Council in May 2008, will be a major focus for 2009 and beyond. The Declaration will commit IPPF to increase its responsiveness to all who seek services, and to build understanding and awareness of sexual and reproductive rights. As well as being central to our service delivery, this Declaration will become the basis for advocacy at the community, country, regional and international levels.

Throughout 2009 and 2010, IPPF will conduct a mid-term review of its Strategic Framework 2005-2015. The results will enable IPPF to monitor progress in implementing the Strategic Framework and to identify areas of priority and investment for the remaining period of the Framework.

15 and counting

The year 2009 will mark the 15th anniversary of the International Conference on Population and Development held in Cairo in 1994. IPPF's focus will be a communications campaign, '15 and counting', the overarching aim of which will be to concentrate minds and actions on the needs and rights of young people throughout the ICPD +15 year.

Annex A: Global indicators by region*

Table A.1: **Online survey response rate**

IPPF region	Year	Total number of Member Associations	Number of Member Association responses	Response rate (per cent)
Africa	**2007**	**40**	**37**	**93**
	2005	39	30	77
Arab World	**2007**	**13**	**11**	**85**
	2005	14	12	86
European Network	**2007**	**41**	**41**	**100**
	2005	40	31	78
East and South East Asia and Oceania	**2007**	**21**	**21**	**100**
	2005	20	17	85
South Asia	**2007**	**8**	**8**	**100**
	2005	8	8	100
Western Hemisphere	**2007**	**29**	**29**	**100**
	2005	30	28	97
Total	**2007**	**152**	**147**	**97**
	2005	151	126	83

Table A.2: **Online service statistics module response rate**

IPPF region	Year	Total number of Member Associations that provide services	Number of Member Associations providing data	Response rate (per cent)
Africa	**2007**	**39**	**34**	**87**
	2005	38	29	76
Arab World	**2007**	**10**	**8**	**80**
	2005	11	9	82
European Network	**2007**	**31**	**17**	**55**
	2005	33	2	6
East and South East Asia and Oceania	**2007**	**20**	**18**	**90**
	2005	19	14	74
South Asia	**2007**	**7**	**7**	**100**
	2005	8	8	100
Western Hemisphere	**2007**	**28**	**27**	**96**
	2005	28	25	89
Total	**2007**	**135**	**111**	**82**
	2005	137	87	64

***** Cuba is a Member Association of IPPF. It is not currently assigned to any region but receives technical support from the Western Hemisphere region (WHR). Cuba has been included with WHR's data in 2007 and 2006 for the purposes of this analysis due to its geographical location. In 2005, data from Cuba were not available. This is the same for all the following tables.

Table A.3: **Summary of adolescents indicators, 2005–2007**

(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‡	**2007**	**62.2%**	**18.2%**	**39.0%**	**28.6%**	**0.0%**	**51.7%**	**42.2%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		2006	52.6%	0.0%	28.9%	23.8%	0.0%	46.4%	35.2%
			(n=38)	(n=12)	(n=38)	(n=21)	(n=8)	(n=28)	(n=145)
		2005	33.3%	25.0%	38.7%	23.5%	0.0%	39.3%	31.7%
			(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	**2007**	**2.6%**	**6.3%**	**2.9%**	**9.3%**	**5.6%**	**3.5%**	**4.4%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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	**2007**	**91.9%**	**100.0%**	**92.7%**	**95.2%**	**87.5%**	**96.6%**	**93.9%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		2006	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
			(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	**2007**	**100.0%**	**100.0%**	**92.7%**	**100.0%**	**75.0%**	**96.6%**	**95.9%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		2006	100.0%	100.0%	94.7%	100.0%	100.0%	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	**2007**	**94.6%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**98.6%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		2006	100.0%	100.0%	97.4%	100.0%	87.5%	100.0%	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 under 25 years of age	**2007**	**2,807,076**	**401,153**	**560,488**	**921,531**	**5,270,838**	**5,395,262**	**15,356,348**
			(n=34)	(n=8)	(n=17)	(n=18)	(n=7)	(n=27)	(n=111)
		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)

† Refer to tables A.1 and A.2 on page 52 for a summary of Member Association response rates. This is the same for all the following tables.
‡ The calculation of this indicator has been revised in 2007, and data from 2005 and 2006 were re-analyzed to provide a figure for comparative purposes.

Table A.4: **Summary of HIV and AIDS indicators, 2005–2007**

(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	**2007**	**40.5%**	**54.5%**	**46.3%**	**38.1%**	**100.0%**	**62.1%**	**50.3%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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**	**2007**	**73.0%**	**18.2%**	**17.1%**	**28.6%**	**50.0%**	**44.8%**	**40.1%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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	**2007**	**54.1%**	**81.8%**	**48.8%**	**52.4%**	**50.0%**	**48.3%**	**53.1%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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	**2007**	**89.2%**	**63.6%**	**68.3%**	**76.2%**	**87.5%**	**69.0%**	**75.5%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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	**2007**	**81.1%**	**54.5%**	**68.3%**	**61.9%**	**87.5%**	**72.4%**	**71.4%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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††	**2007**	**846,349**	**62,409**	**164,308**	**610,145**	**805,010**	**799,476**	**3,287,697**
			(n=34)	(n=8)	(n=17)	(n=18)	(n=7)	(n=27)	(n=111)
		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	**2007**	**18,101,728**	**499,112**	**897,880**	**15,155,980**	**25,878,755**	**65,068,535**	**125,601,990**
			(n=34)	(n=8)	(n=17)	(n=18)	(n=7)	(n=27)	(n=111)
		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)

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

†† Data from Planned Parenthood Federation of America (PPFA) were not available at the time of this publication. However, we have access to their data from 2005 and 2006. In 2005, PPFA provided 280,589 HIV-related services and in 2006 the figure increased to 314,160.

Table A.5: **Summary of abortion indicators, 2005–2007**

(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	**2007**	**67.6%**	**81.8%**	**80.5%**	**52.4%**	**50.0%**	**55.2%**	**66.7%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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 activities on (un)safe abortion, the legal status of abortion and the availability of legal abortion services	**2007**	**37.8%**	**63.6%**	**78.0%**	**61.9%**	**50.0%**	**44.8%**	**56.5%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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	**2007**	**89.2%**	**72.7%**	**87.8%**	**90.5%**	**87.5%**	**79.3%**	**85.7%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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‡‡	**2007**	**40,775**	**29,137**	**92,914**	**122,052**	**167,945**	**199,187**	**652,010**
			(n=34)	(n=8)	(n=17)	(n=18)	(n=7)	(n=27)	(n=111)
		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)

‡‡ Data from Planned Parenthood Federation of America (PPFA) were not available at the time of this publication. However, we have access to their data from 2005 and 2006. In 2005, PPFA provided 262,514 abortion-related services and in 2006 the figure increased to 289,750.

Table A.6: **Summary of access indicators, 2005–2007**

(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	**2007**	**91.9%**	**81.8%**	**87.8%**	**90.5%**	**75.0%**	**93.1%**	**89.1%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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	**2007**	**82.8%**	**67.1%**	**58.4%**	**13.8%**	**80.0%**	**61.4%**	**59.8%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		2006	77.0%	64.3%	47.1%	18.5%	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)§§	**2007**	**652,656**	**203,654**	**147,098**	**524,333**	**1,666,008**	**4,391,846**	**7,585,595**
			(n=34)	(n=8)	(n=17)	(n=18)	(n=7)	(n=27)	(n=111)
		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***	**2007**	**4,128,616**	**656,204**	**504,470**	**3,870,044**	**6,351,051**	**9,297,323**	**24,807,708**
			(n=34)	(n=8)	(n=17)	(n=18)	(n=7)	(n=27)	(n=111)
		2006	3,280,159	1,578,506	116,411	1,839,72	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†††	**2007**	**2,871,130**	**783,007**	**1,521,562**	**2,220,740**	**5,089,107**	**8,768,490**	**21,254,036**
			(n=34)	(n=8)	(n=17)	(n=18)	(n=7)	(n=27)	(n=111)
		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)

§§ Couple years of protection (CYP) refers to the total number of years of contraceptive protection provided to a couple by method.

******* Data from Planned Parenthood Federation of America (PPFA) were not available at the time of this publication. However, we have access to their data from 2005 and 2006. In 2005, PPFA provided 2,497,602 contraceptive services and in 2006 the figure increased to 2,697,410.

††† Non-contraceptive SRH services provided by PPFA was 8,847,669 in 2005 and 9,113,099 in 2006.

Table A.6: **Summary of access indicators, 2005–2007** continued

(n=number of Member Associations that provided data)

	Indicator	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Overall
23	Number of service delivery points ‡‡‡	**2007**	**3,760**	**1,626**	**442**	**7,011**	**12,811**	**30,270**	**55,920**
			(n=34)	(n=8)	(n=17)	(n=18)	(n=7)	(n=27)	(n=111)
		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	**2007**	**67.6%**	**100.0%**	**61.0%**	**76.2%**	**62.5%**	**75.9%**	**70.7%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		2006	81.6%	100.0%	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§§§	**2007**	**83.3%**	**100.0%**	**53.6%**	**70.0%**	**85.7%**	**92.6%**	**77.6%**
			(n=36)	(n=7)	(n=28)	(n=20)	(n=7)	(n=29)	(n=125)
		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)

‡‡‡ In 2007, these service delivery points included 6,157 clinic-based service delivery points and 49,763 non-clinic based service delivery points, (community-based volunteers, social marketing outlets, private physicians, pharmacies, government clinics and other agencies).

§§§ This analysis is based on the 125 Member Associations who provide clinical services.

Table A.7: **Summary of advocacy indicators, 2005–2007**

(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	**2007**	**70.3%**	**90.9%**	**82.9%**	**100.0%**	**75.0%**	**72.4%**	**80.3%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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	**2007**	**75.7%**	**90.9%**	**95.1%**	**95.2%**	**87.5%**	**89.7%**	**88.4%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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	**2007**	**9**	**2**	**11**	**5**	**3**	**17**	**47**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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	**2007**	**86.5%**	**90.9%**	**87.8%**	**61.9%**	**87.5%**	**79.3%**	**82.3%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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	**2007**	**83.8%**	**90.9%**	**92.7%**	**90.5%**	**62.5%**	**79.3%**	**85.7%**
			(n=37)	(n=11)	(n=41)	(n=21)	(n=8)	(n=29)	(n=147)
		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)

Table A.8: **Number of sexual and reproductive health services provided (excluding contraceptive services) by region and by service type, 2005–2007**

(n=number of Member Associations that provided data)

Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of responses	**2007**	**(n=34)**	**(n=8)**	**(n=17)**	**(n=18)**	**(n=7)**	**(n=27)**	**(n=111)**
	2006	(n=37)	(n=10)	(n=10)	(n=17)	(n=8)	(n=26)	(n=108)
	2005	(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	(n=87)
Gynaecological services	**2007**	**188,427**	**186,244**	**84,060**	**891,790**	**338,226**	**4,695,899**	**6,384,646**
	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
Obstetrics services	**2007**	**440,135**	**107,803**	**26,221**	**211,129**	**1,721,306**	**1,432,917**	**3,939,511**
	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
Other SRH medical services	**2007**	**413,831**	**119,097**	**726**	**208,326**	**961,078**	**434,740**	**2,137,798**
	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
Paediatrics services	**2007**	**241,632**	**39,908**	**753**	**27,566**	**640,120**	**322,582**	**1,272,561**
	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
Other specialized counselling services	**2007**	**671,340**	**231,179**	**1,147,159**	**98,386**	**367,475**	**652,511**	**3,168,050**
	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
STI/RTI services	**2007**	**188,826**	**42,723**	**66,398**	**456,995**	**536,433**	**552,602**	**1,843,977**
	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-related services	**2007**	**657,523**	**19,686**	**97,910**	**153,150**	**268,577**	**246,874**	**1,443,720**
	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	**2007**	**40,775**	**29,137**	**92,914**	**122,052**	**167,945**	**199,187**	**652,010**
	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
Infertility services	**2007**	**24,199**	**6,103**	**5,164**	**17,077**	**83,242**	**65,356**	**201,141**
	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
Urological services	**2007**	**4,442**	**1,127**	**257**	**34,269**	**4,705**	**165,822**	**210,622**
	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
Total	**2007**	**2,871,130**	**783,007**	**1,521,562**	**2,220,740**	**5,089,107**	**8,768,490**	**21,254,036**
	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

Table A.9: **Number of contraceptive services provided by region and by service type, 2005–2007**
(n=number of Member Associations that provided data)

Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of responses	**2007**	**(n=34)**	**(n=8)**	**(n=17)**	**(n=18)**	**(n=7)**	**(n=27)**	**(n=111)**
	2006	(n=37)	(n=10)	(n=10)	(n=17)	(n=8)	(n=26)	(n=108)
	2005	(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	(n=87)
Oral contraceptives	**2007**	**720,326**	**225,492**	**70,023**	**1,267,705**	**2,004,266**	**3,233,500**	**7,521,312**
	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	**2007**	**1,771,849**	**272,819**	**240,465**	**1,130,065**	**2,068,378**	**2,989,272**	**8,472,848**
	2006	739,062	323,973	48,536	403,202	717,307	2,922,880	5,154,960
	2005	318,702	251,165	17,600	374,766	1,196,998	2,162,136	4,321,367
Condoms	**2007**	**888,052**	**38,358**	**160,523**	**1,224,659**	**1,301,925**	**1,498,389**	**5,111,906**
	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	**2007**	**563,532**	**37,495**	**116**	**118,224**	**613,821**	**717,100**	**2,050,288**
	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	**2007**	**87,585**	**61,682**	**1,880**	**104,887**	**154,634**	**483,140**	**893,808**
	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	**2007**	**1,201**	**125**	**375**	**4,119**	**129,548**	**123,463**	**258,831**
	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	**2007**	**19,346**	**6,030**	**17,098**	**2,495**	**8,024**	**3,117**	**56,110**
	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
Awareness based methods	**2007**	**446**	**0**	**3,004**	**4,475**	**5,246**	**17,177**	**30,348**
	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
Implants	**2007**	**33,963**	**481**	**0**	**2,309**	**40,359**	**60,892**	**138,004**
	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	**2007**	**21,657**	**13,586**	**2,631**	**6,826**	**106**	**105,738**	**150,544**
	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
Other hormonal methods	**2007**	**0**	**0**	**6**	**0**	**0**	**8,238**	**8,244**
	2006	0	0	35	0	0	8,605	8,640
	2005	0	0	114	0	0	3,304	3,418
Emergency contraceptive services	**2007**	**20,659**	**136**	**8,349**	**4,280**	**24,744**	**57,297**	**115,465**
	2006	18,382	32	19	4,935	2,721	57,208	83,297
	2005	28,855	1,084	155	667	3,886	38,173	72,820
Total	**2007**	**4,128,616**	**656,204**	**504,470**	**3,870,044**	**6,351,051**	**9,297,323**	**24,807,708**
	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

Table A.10: **Number of Couple Years of Protection (CYP) provided by region and method, 2005–2007**

(n=number of Member Associations that provided data)

Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of responses	**2007**	**(n=34)**	**(n=8)**	**(n=17)**	**(n=18)**	**(n=7)**	**(n=27)**	**(n=111)**
	2006	(n=37)	(n=10)	(n=10)	(n=17)	(n=8)	(n=26)	(n=108)
	2005	(n=29)	(n=9)	(n=2)	(n=14)	(n=8)	(n=25)	(n=87)
IUD	**2007**	**193,704**	**160,475**	**130,064**	**166,891**	**328,185**	**1,905,404**	**2,884,723**
	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	**2007**	**5,140**	**0**	**0**	**17,780**	**529,360**	**880,890**	**1,433,170**
	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	**2007**	**154,737**	**23,904**	**1,853**	**164,652**	**429,384**	**625,890**	**1,400,420**
	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	**2007**	**150,244**	**4,143**	**7,452**	**125,795**	**214,794**	**540,069**	**1,042,497**
	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	**2007**	**114,056**	**10,297**	**7,478**	**42,202**	**151,901**	**308,281**	**634,215**
	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	**2007**	**28,290**	**2,635**	**0**	**4,885**	**12,362**	**120,393**	**168,565**
	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	**2007**	**6,485**	**2,200**	**251**	**2,128**	**22**	**8,663**	**19,749**
	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	**2007**	**0**	**0**	**0**	**0**	**0**	**2,256**	**2,256**
	2006	0	0	2	0	0	2,431	2,433
	2005	0	0	4	0	0	2,242	2,246
Total	**2007**	**652,656**	**203,654**	**147,098**	**524,333**	**1,666,008**	**4,391,846**	**7,585,595**
	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

Annex B: IPPF's income by region

Table B.1: **Total Member Association income by region, 2006–2007**

Region	IPPF total income	Increase/ (Decrease)	Local income	Increase/ (Decrease)	International income	Increase/ (Decrease)	Grand total	Increase/ (Decrease)
	$000's		$000's		$000's		$000's	
Africa								
2006	21,685		5,163		11,294		38,142	
2007	**22,560**	**4%**	**6,817**	**32%**	**13,645**	**21%**	**43,022**	**13%**
Arab World								
2006	4,998		2,019		714		7,731	
2007	**4,556**	**-9%**	**1,476**	**-27%**	**595**	**-17%**	**6,627**	**-14%**
East and South East Asia and Oceania								
2006	6,573		54,507		3,636		64,716	
2007	**6,854**	**4%**	**54,161**	**-1%**	**3,046**	**-16%**	**64,061**	**-1%**
European Network								
2006	5,294		334		331		5,959	
2007	**3,286**	**-38%**	**94**	**-72%**	**772**	**133%**	**4,152**	**-30%**
South Asia								
2006	9,129		6,029		2,886		18,044	
2007	**8,940**	**-2%**	**8,022**	**33%**	**2,889**	**0%**	**19,851**	**10%**
Western Hemisphere								
2006	13,609		101,972		12,519		128,100	
2007	**15,574**	**14%**	**110,463**	**8%**	**17,987**	**44%**	**144,024**	**12%**
Total								
2006	61,288		170,024		31,380		262,692	
2007	**61,770**	**1%**	**181,033**	**6%**	**38,934**	**24%**	**281,737**	**7%**

Table B.2: **Total income for grant-receiving Member Associations, 2003–2007**

Year	IPPF total income	Increase/ (Decrease) 2003 as base year	Local income	Increase/ (Decrease) 2003 as base year	International income	Increase/ (Decrease) 2003 as base year	Grand total	Increase/ (Decrease) 2003 as base year
	$000's		$000's		$000's		$000's	
2003	41,773		123,555		41,662		206,990	
	20%		60%		20%		100%	
2004	45,226	8%	140,229	14%	50,373	21%	235,828	14%
	20%		59%		21%		100%	
2005	56,357	35%	165,986	34%	42,021	1%	264,364	28%
	21%		63%		16%		100%	
2006	61,288	47%	170,024	38%	31,380	-25%	262,692	27%
	23%		65%		12%		100%	
2007	**61,770**	**48%**	**181,033**	**47%**	**38,934**	**-7%**	**281,737**	**36%**
	22%		**64%**		**14%**		**100%**	

Table B.3: **Africa region: Sources of funding (2007 actual)**

Figure 1: **Local income $000's**

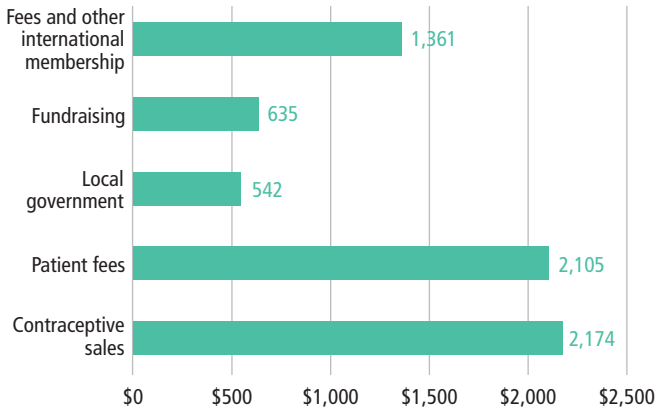


Figure 2: **International income $000's**

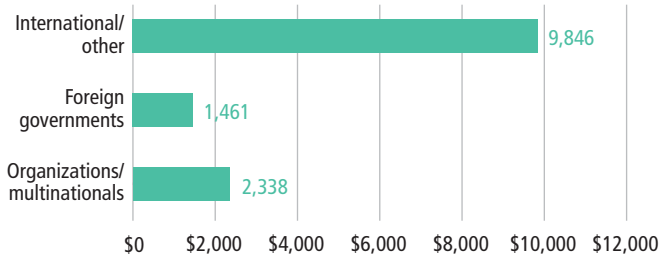


Figure 3: **IPPF total income $000's**

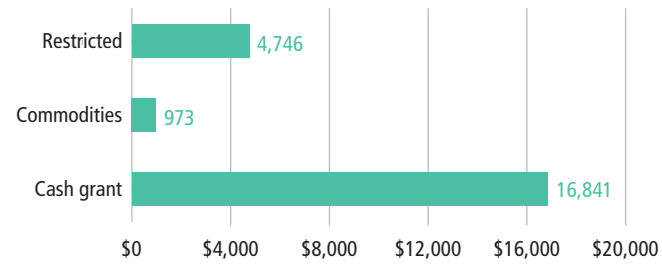
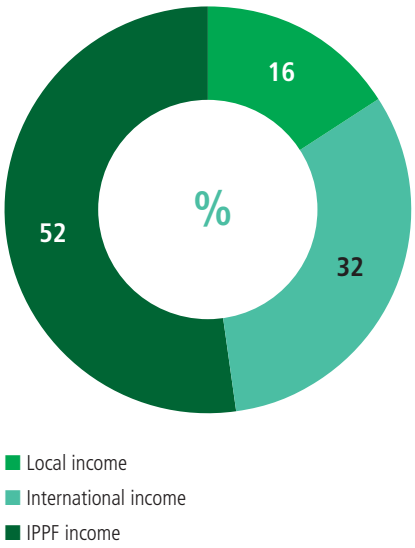


Figure 4: **Income $000's**



Key trends for the Africa region

Total income for the Africa region in 2007 amounted to US$43.0 million – an increase of 13 per cent from 2006.

Local income increased by 32 per cent and international income by 21 per cent.

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

IPPF income represented 57 per cent in 2003, reducing to 52 per cent in 2007, indicating less reliance on IPPF as the main funding, mechanism.

Table B.4: **Arab World region: Sources of funding (2007 actual)**

Figure 1: **Local income $000's**

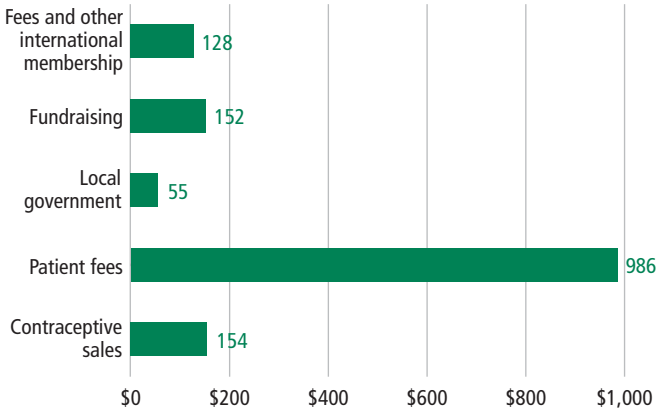


Figure 2: **International income $000's**

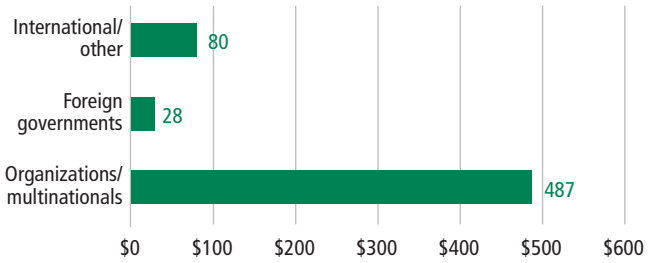


Figure 3: **IPPF total income $000's**

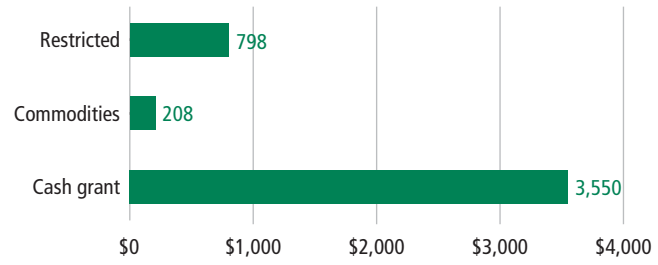
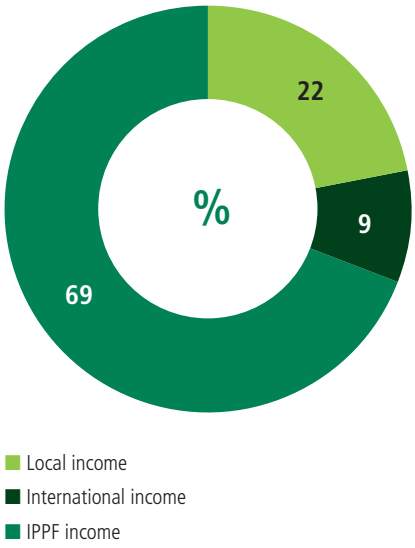


Figure 4: **Income $000's**



Key trends for the Arab World region

Total income for the Arab World region in 2007 amounted to US$6.6 million – a decrease of 14 per cent from 2006.

The main reason for the decrease is the structure of the Egyptian Member Association with independent branches being introduced, as well as no operation in Lebanon.

Local income decreased by 27 per cent and international income fell by 17 per cent.

IPPF income reduced by 9 per cent representing less restricted funding being available than in 2006.

IPPF income represented 42 per cent in 2003, increasing to 69 per cent in 2007, indicating more reliance on IPPF as the main funding mechanism.

Table B.5: **East and South East Asia and Oceania region: Sources of funding (2007 actual)**

Figure 1: **Local income $000's**

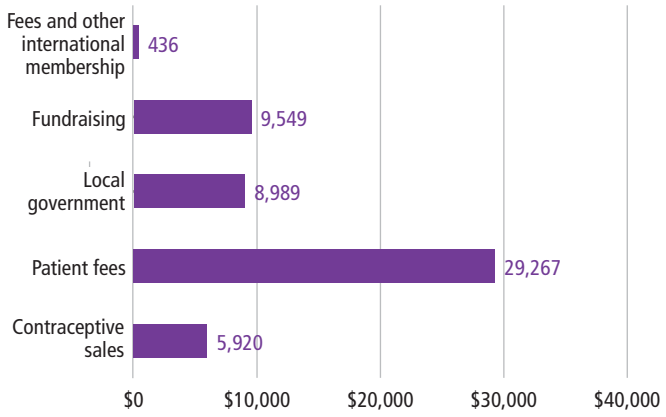


Figure 2: **International income $000's**

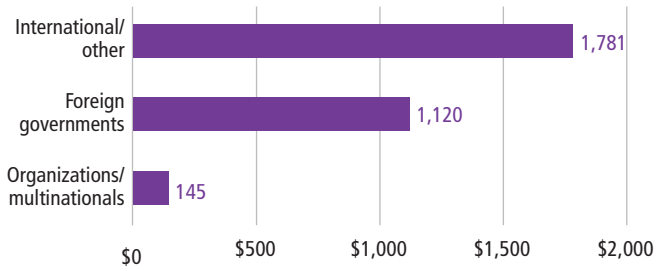


Figure 3: **IPPF total income $000's**

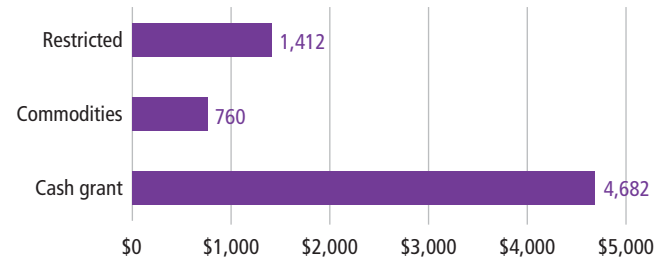
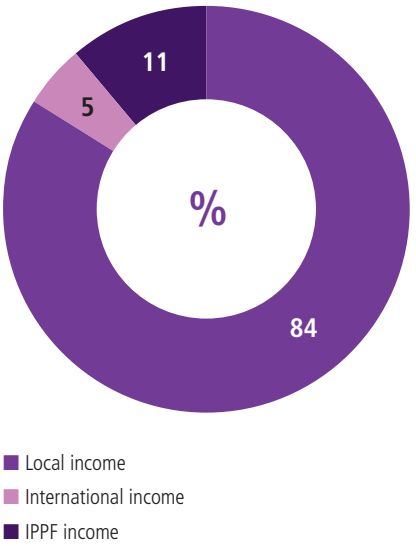


Figure 4: **Income $000's**



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 2007 amounted to US$64.1 million – a similar level to 2006.

Local income remained static whilst international income reduced by 16 per cent.

IPPF income increased by 4 per cent representing less restricted funding being available.

IPPF income represented 6 per cent in 2003, increasing to 11 per cent in 2007, indicating an overall diversified source of funding beyond IPPF.

Table B.6: **European Network: Sources of funding (2007 actual)**

Figure 1: **Local income $000's**

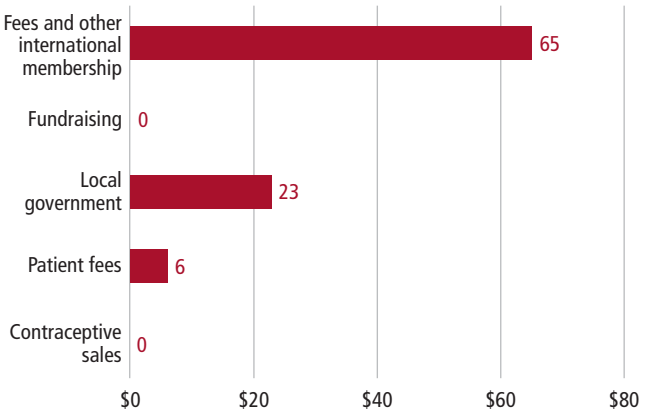


Figure 2: **International income $000's**

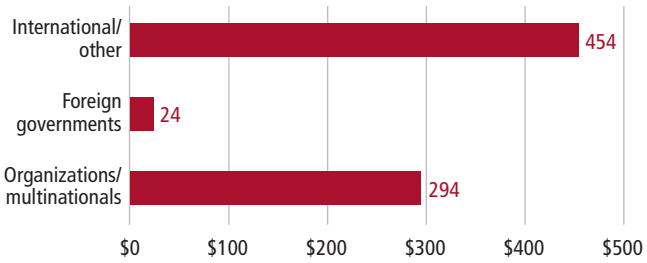


Figure 3: **IPPF total income $000's**

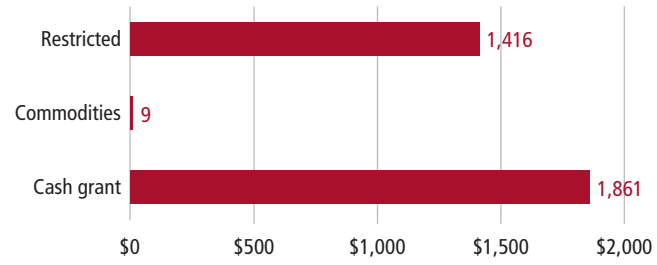
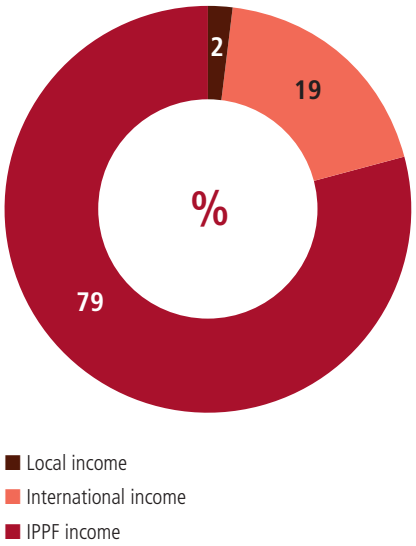


Figure 4: **Income $000's**



Key trends for the European Network

Total income for the European Network in 2007 amounted to US$4.1 million – a decrease of 30 per cent from 2006.

Local income decreased by 72 per cent whilst international income increased by 133 per cent.

IPPF income decreased by 38 per cent representing less restricted funding available.

IPPF income represented 35 per cent in 2003, increasing to 79 per cent in 2007, 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 B.7: **South Asia region: Sources of funding (2007 actual)**

Figure 1: **Local income $000's**

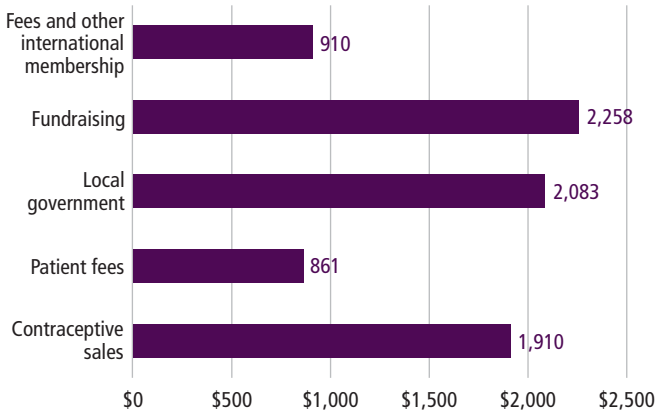


Figure 2: **International income $000's**

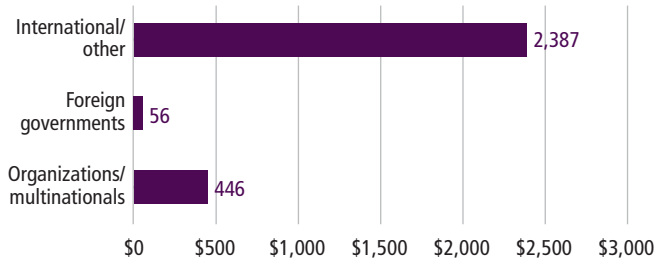


Figure 3: **IPPF total income $000's**

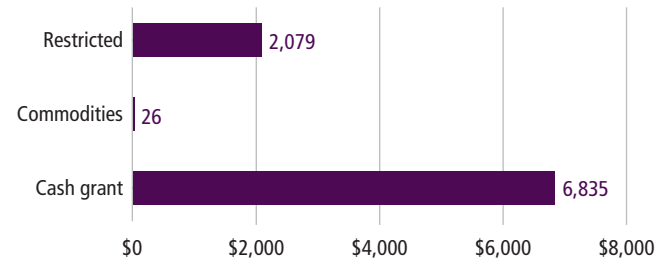
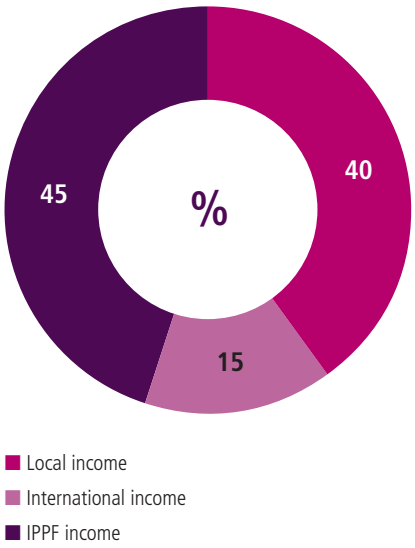


Figure 4: **Income $000's**



Key trends for the South Asia region

Total income for the South Asia region in 2007 amounted to US$19.9 million – an increase of 10 per cent from 2006.

Local income increased by 33 per cent whilst international income remained static.

IPPF income decreased by 2 per cent representing less restricted funding available at IPPF level.

IPPF income represented 54 per cent in 2003, decreasing to 45 per cent in 2006, indicating less reliannce on IPPF as the main funding mechanism.

Table B.8: **Western Hemisphere region: Sources of funding (2007 actual)**

Figure 1: **Local income $000's**

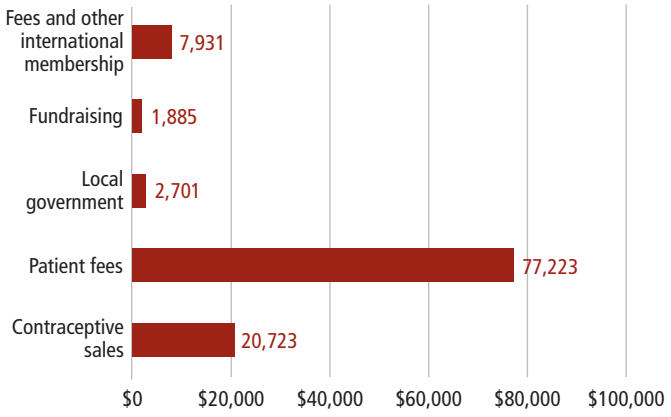


Figure 2: **International income $000's**

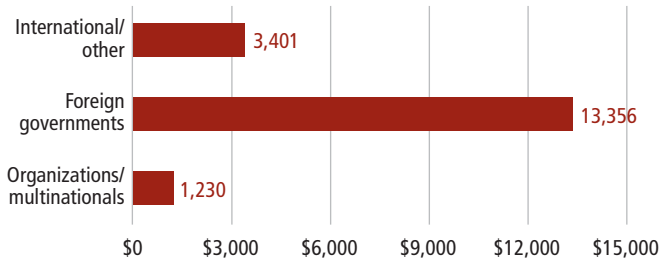


Figure 3: **IPPF total income $000's**

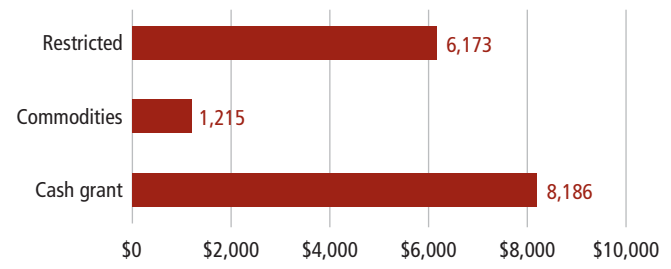
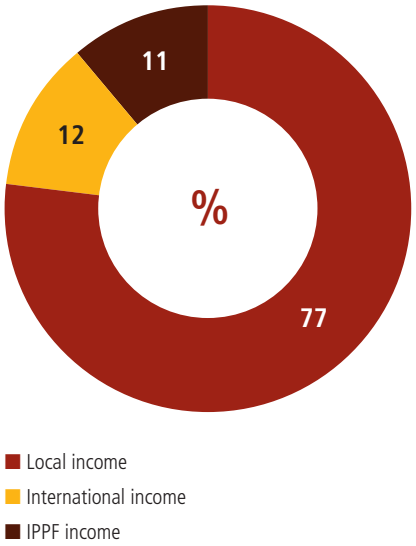


Figure 4: **Income $000's**



Key trends for the Western Hemisphere region

Total income for the Western Hemisphere region in 2007 amounted to US$144.0 million – the same level as 2006.

Local income increased by 8 per cent and international income by 44 per cent.

IPPF income increased by 14 per cent representing greater restricted funding available at the IPPF level.

IPPF income represented 6 per cent in 2003, but has increased to 11 per cent in 2007, however the region continues to have well diversified source of funding beyond IPPF.

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Chapter 1

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Chapter 3

1 The Millennium Development Goals Report 2007, UN, New York. http://mdgs.un.org/unsd/mdg/Resources/Static/Products/Progress2007/UNSD_MDG_Report_2007e.pdf

2 The Global Campaign for the Health Millennium Development Goals was launched by the Norwegian Government and can also be referred to as the International Health Partnership Plus. They include the International Health Partnership, Catalytic Initiative to Save a Million Lives, Providing for Health, Innovative Results Based Financing, the Network for Global Leaders for MDGs 4 and 5 and Deliver Now for Women and Children.

3 The Health 8 (H8) brings together The Gates Foundation, GAVI Alliance, Global Fund to Fight AIDS, TB and Malaria, UNAIDS, UNFPA, UNICEF, World Health Organization and World Bank.

Key abbreviations

AIDS	Acquired immune deficiency syndrome
APROFA	Asociación Chilena de Protección de la Familia
AR	Africa Region, IPPF
AWR	Arab World Region, IPPF
BCC	Behaviour change communication
CPEP	Centro Paraguayo de Estudios de Poblacion
CYP	Couple years of protection
eIMS	electronic Integrated Management System
EN	European Network, IPPF
ESEAOR	East and South East Asia and Oceania Region, IPPF
FPASL	Family Planning Association of Sri Lanka
GLBTQ	Gay, lesbian, bisexual, transgender and questioning
HIV	Human immunodeficiency virus
IEC	Information, education and communication
IPPA	Indonesian Planned Parenthood Association
IPPF	International Planned Parenthood Federation
IT	Information technology
IUD	Intrauterine device
MDG	Millennium Development Goal
NPOKI	Non-Profit Organization Knowledge Initiative
ODA	Official development assistance
PLAFAM	Asociación Civil de Planificación Familiar
PLHIV	People living with HIV
PMTCT+	Prevention of mother to child transmission
RTI	Reproductive tract infection
SAR	South Asia Region, IPPF
SARYN	South Asia Regional Youth Network
SFPA	Sudan Family Planning Association
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UN	United Nations
UNFPA	United Nations Population Fund
VCT	Voluntary counselling and testing
WHR	Western Hemisphere Region, IPPF
XY	Association for Sexual and Reproductive Health XY, Bosnia and Herzegovina

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The Government of the United Kingdom

The Joint United Nations Programme on HIV/AIDS (UNAIDS)

The Libra Foundation

The Louis and Harold Price Foundation

The Overbrook Foundation

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Annual Performance Report

2007–2008

Published in October 2008 by the International Planned Parenthood Federation

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UK Registered Charity No. 229476

Printed on 75% recycled, chlorine-free paper, an NAPM approved recycled product.

"The Annual Performance Report demonstrates yet again the difference that IPPF Member Associations are making to people's lives across the globe."
Dr Gill Greer, Director-General, IPPF

Every day, in 181 countries around the world, IPPF is delivering high quality sexual and reproductive health information and services. With over 30,000 staff and millions of volunteers, our global network is committed to working in partnership with, and serving their, communities. Find out more about what we do and how we do it.

This Annual Performance Report highlights some of IPPF's achievements during 2007 from around the world. Case studies on each of the five priority areas of adolescents, HIV and AIDS, abortion, access and advocacy are presented from each of our six regions, and the results of our global indicators illustrate progress we are making in the implementation of our Strategic Framework 2005–2015. Key initiatives to improve the Federation's organizational effectiveness and accountability are also highlighted.

Designed by Engage Group www.engagegroup.co.uk