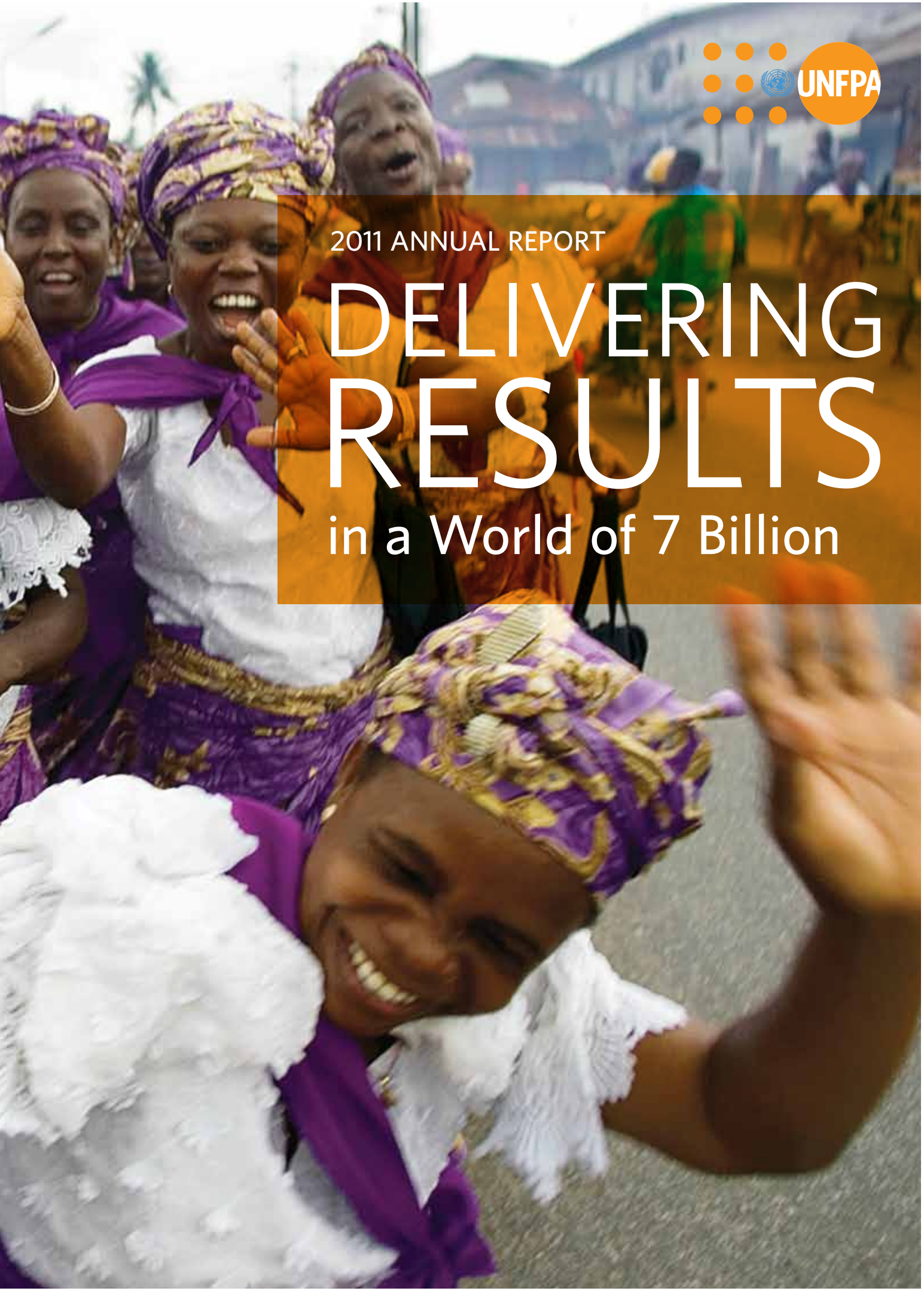

2011 ANNUAL REPORT

DELIVERING RESULTS

in a World of 7 Billion

Contents

Foreword

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In October 2011, the 7 billionth member of the human family was born into a world of vast and unpredictable change: environmental, economic, geopolitical, technological and demographic.

The world's population has more than tripled since the United Nations was created in 1945, and our numbers keep growing. So, too, do the pressures on land, energy, food and water. The global economic crisis continues to shake businesses, governments, communities and families around the world. Joblessness is rising, and social inequalities are growing wider.

The passing of the 7 billion threshold is not about one individual or even one generation. It is a wake-up call to confront grinding poverty and inequality, a call to action to improve the health and conditions of women and girls and empower young people to realize their full potential.

Seven billion people are looking to the United Nations for solutions that address fundamental issues of security, equity and sustainable development. We must respond with compassion, courage and conviction. We must connect the dots between global health, food security, women's empowerment and the rights of young people.

This report shows how UNFPA, the United Nations Population Fund, helped more than 150 governments in 2011 to confront challenges and seize opportunities to work towards a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled.

—United Nations Secretary-General Ban Ki-moon

From the Executive Director

The world's population surpassed 7 billion last year.

What does our world of 7 billion look like? How is it different from the world in the 1960s, when our numbers were half what they are today?

First, we are living longer—20 years longer on average—than we did in the middle of the last century. Our children are healthier, and more of them are surviving into adulthood. More than half of us now live in a city.

We are also younger: today there are 1.8 billion people between the ages of 10 and 24—the largest youth cohort in human history.

At the same time, we are older, with nearly 900 million people over the age of 60.

The picture of today's global population is a collage of diverse human experiences, trends, achievements and contradictions. Through an examination of this diversity, an accurate image of Earth's 7 billion inhabitants begins to emerge.

Some countries in sub-Saharan Africa and Asia have population growth rates that are outpacing economic growth, while many European countries and Japan have fertility rates so low that their governments are concerned about possible labour shortages and how these shortages might stifle economic growth.

With diverse challenges and trends such as these in mind, we must ask which actions we can take today to ensure health, prosperity, equality and environmentally sustainable development in the future.

First, we need to educate and empower girls and women to participate fully in society and ensure they have the power to make informed reproductive decisions. And whatever we do, boys and men must be a part of the solution. A future that is sustainable is one built on equal rights and opportunities.

There are still millions of adolescent girls and boys in the developing world who have little or no access to information about how to prevent pregnancies or protect themselves from HIV. There are still 80 million jobless youth. We must therefore also invest in the health, education and income-earning opportunities of the new generation. This investment would

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yield enormous returns in economic growth and development for years to come.

We also need to strengthen and expand maternal and newborn health care. Hundreds of thousands of women continue to die each year from complications related to pregnancy and childbirth. This loss of life is intolerable in an age when we have the resources and the know-how to prevent these deaths.

In addition, we need to bridge the gap in access to family planning, to make sure that the 215 million women in developing countries who want to use contraceptives have access to them.

The challenges of a world of 7 billion are monumental, numerous and vexing. However, with careful planning and appropriate investments in people today, we can have thriving sustainable cities, productive labour forces that fuel economic growth, youth populations that contribute to the well-being of their societies, and communities where the elderly are productive, healthy and economically secure.

We all have a stake in the future of humanity. Every individual, every government, every business is more interconnected and interdependent than ever, so whatever each of us does now will matter to all of us long into the future. Together we can change and improve the world.

—Babatunde Osotimehin

Preparing for the Challenges of a World of 7 Billion

New population trends

There is much to celebrate in world population trends over the last 60 years, especially the average life expectancy, which leapt from about 48 years in the early 1950s to about 68 in the first decade of the new century. Infant deaths plunged from about 133 in 1,000 births in the 1950s to about 46 per 1,000 today. Immunization campaigns reduced the prevalence of childhood diseases worldwide.

In addition, since the 1960s, fertility—the number of children a woman is expected to have in her childbearing years—dropped by more than half, from about 5.0 to 2.5. This decrease is due partly to various countries' economic growth and development, but it is also the result of a complex mix of social and cultural forces including greater access by women to education, income-earning opportunities, and sexual and reproductive health care, including modern methods of family planning.

As a result of these positive social, economic and health trends, the world's population has grown rapidly, increasing by 1 billion in just the past 12 years and likely to rise another 2 billion by the middle of this century.

Much of the increase is expected to come from high-fertility countries, 39 of which are in Africa, nine in Asia, six in Oceania and four in Latin America. Asia will remain the most populous major area in the world in the twenty-first century, but Africa is projected to gain ground as its population more than triples, with anticipated increases from 1 billion in 2011 to 3.6 billion in 2100. Europe's population is expected to peak around 2025 at 0.74 billion and decline thereafter.

At the same time, the characteristics of our global population are shifting. For example, today there are 893 million people around the world who are over the age of 60. By the middle of this century, that number will rise to 2.3 billion. About one in two people now lives in a city, and in only about 35 years, two out of three will. People under the age of 25 make up 43 per cent of the world's population, reaching as much as 60 per cent in some countries.

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Our record population size may be viewed as a success for humanity. But not everyone has benefited from this achievement or the higher quality of life that this implies. Great economic and social disparities persist between and within countries, and intractable gaps in rights deny men, women, girls and boys equal opportunities in life.

A new path to development that promotes equality, rather than exacerbating or reinforcing inequalities, is more important than ever. UNFPA, the United Nations Population Fund, began charting such a new path in 2011 to ensure that we are able to meet the challenges arising from our demographically diverse world of 7 billion.

Laying foundations for change

Institutional changes that began in 2011 respond not only to the new challenges emerging from a world inhabited by 7 billion people, but also to the rapidly approaching target dates for achieving internationally agreed-upon development and rights objectives.

Many of the goals of the Programme of Action of the 1994 International Conference on Population and Development, upon which UNFPA's mandate is based, have not yet been achieved, even though the target for completion is only about two years away.

In addition, the Millennium Development Goal that UNFPA contributes to most directly—Goal 5, to improve maternal health—is the furthest from attainment by the 2015 deadline.

Against this backdrop of new population dynamics and rapidly approaching targets, UNFPA carried out a review in 2011 of the first three years of the organization's Strategic Plan for 2008 to 2013. On the basis of this review, the organization made recommendations for changes that would enable it to expand the possibilities for women and young people to lead healthy sexual and reproductive lives. This Midterm Strategic Review concluded that the organization has much to be proud of, but that its full potential has still to be realized.

Until the middle of 2011, UNFPA had 13 programming objectives. In response to the Midterm Strategic Review, UNFPA narrowed the focus of its programming, resulting in seven objectives. The new Development Results Framework for UNFPA forms a coherent package of seven core areas where the organization will focus its efforts in 2012 and 2013.

The Midterm Strategic Review also recommended changes to the organization's management and business practices to ensure that human and financial resources are used as efficiently as possible and have maximum impact.

Later in 2011, UNFPA drew up a new Business Plan to help implement the recommendations in the Midterm Strategic Review. The main aim of the Business Plan is to sharpen the focus of UNFPA programmes so as to target the most urgent needs at the country level.

The priorities of the Business Plan are to:

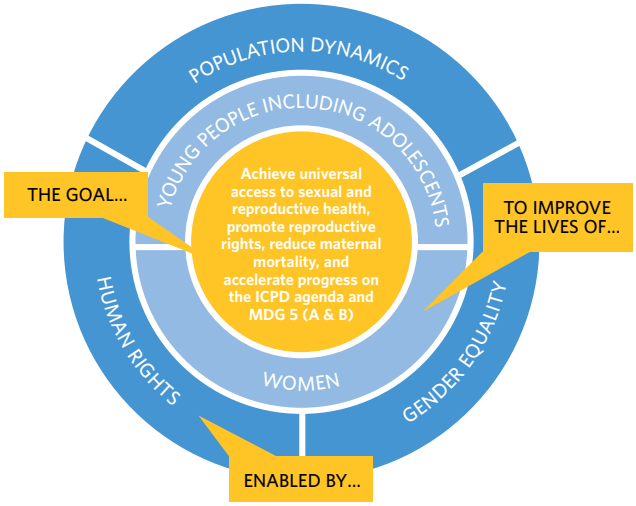
- Focus programmes in countries so these programmes yield greater results, make the most of donor resources and avoid duplication of efforts by other United Nations organizations.
- Place greater emphasis on country programmes and the work of regional offices.
- Improve communications within the organization and with external stakeholders.
- Invest in staff training and performance management.
- Streamline budgeting and reporting.
- Foster collaboration within UNFPA headquarters divisions and with regional and country offices.
- Increase accountability, especially among senior management.

UNFPA also set up two "clusters" in 2011—one to focus on adolescents and youth, and the other to focus on women's reproductive health. This cluster approach aims to maximize results through coherent, integrated planning and increased synergy, making sure that the organization is driven by the demand from the field.

The new cluster approach, according to UNFPA Executive Director Babatunde Osotimehin, "is an innovative way of thinking that will…better utilize our strengths and resources from across the organization."

By the end of 2011, UNFPA had also made substantial progress in developing a new communications strategy to reinforce organizational and programmatic changes and position UNFPA as a thought leader and catalyst for action in core areas in line with the revised Strategic Plan and the new Business Plan.

Sustainable development "is the imperative of the twenty-first century, and it cannot be achieved without equity and human rights," Dr. Osotimehin told the



This graphic shows UNFPA's new emphasis on achieving Millennium Development Goal (MDG) 5-A, to reduce maternal mortality ratios, and on Goal 5-B, to ensure universal access to reproductive health care. The bull's-eye also includes the goal of accelerating progress towards the objectives of the Programme of Action of the International Conference on Population and Development (ICPD). This focused support will improve the lives of women and young people, including adolescents. UNFPA's work will be facilitated by UNFPA support for human rights and gender equality as well as by data collection and analysis.

UNFPA Executive Board at a recent meeting in New York. "It cannot be achieved without empowering women and young people. And it cannot be achieved without improving sexual and reproductive health."

In a world of 7 billion and growing, "we are ready and committed to focus our efforts towards delivering a world where every pregnancy is wanted, every childbirth is safe, and every young person's potential is fulfilled."

About this annual report

The structure of this report reflects the seven outcomes of the new Development Results Framework of the revised UNFPA Strategic Plan. The report's final section, on resources and management, shows provisional income and expenditures for 2011 that are grouped according to programming categories in effect before the revised Strategic Plan was in place.

Ricardo Moreno and Sara Gonzalez, residents of Mexico City, say they plan to get married and have children after they both finish their education and find good jobs.

Creating employment opportunities for young people and ensuring their access to services, such as education and reproductive health care, are critical to the development of countries such as Mexico, where there are 31 million people between the ages of 10 and 24.

UNFPA is helping Mexico reduce poverty and socioeconomic inequalities for young people and people in other age groups through strategic interventions related to sexual and reproductive health that are guided by and reflective of demographic data and trends.

The demand for services is especially high in urban centres such as Mexico City, which has grown from 2.9 million people in 1950 to nearly 21 million people today. Mexico City is a magnet for migrants from rural areas and neighbouring countries in Central America.

Linking Population Dynamics and Development Plans

UNFPA helps governments adjust national development plans, health sector policies, sexual and reproductive health services, and poverty reduction strategies in response to changing population trends. UNFPA also promotes the inclusion of young people, including adolescents, in poverty reduction strategies and encourages youth participation in all levels of policy development, implementation and monitoring.

In some countries today, people under the age of 25 make up as much as 60 per cent of the population. The services that young people need are different from those required by other age groups. Governments with large youth populations may therefore need to reallocate health spending to meet the growing demand for services that benefit youth.

A large and growing segment of young people can support the economic and social development of countries, but it can also pose considerable challenges for countries lacking the resources and capacities to ensure adequate investments in health and education.

The size of a country's youth population can have a profound impact on development and must therefore be taken into account in policymaking. In middle-income and some rapidly developing lower-income countries, for example, the number of years in which a large, young working population can be counted on to fuel development may be fleeting, and governments and the private sector need to act expeditiously to prepare the young for productive roles and create jobs for them early in their working lives.

In much of sub-Saharan Africa, where economic growth rates are relatively high, job growth is not keeping pace with the growth of the population entering the labour force. Development and poverty-reduction policies may need to be revised in such circumstances to create more income-earning opportunities for youth.

A UNFPA report released in 2011, *Population Dynamics in the Least Developed Countries: Challenges and Opportunities for Development and Poverty Reduction*, says that demographic analysis can help governments target investments to meet the needs of current and future generations. Investments in infrastructure and employment will

yield high returns if they are matched by investments in people's education, skills and health, according to the report. This is especially important for young people in the least developed countries, where about 60 per cent of the population is under the age of 25.

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The least developed countries have the highest population growth rate in the world—triple that of other developing countries—and are the least able to meet the needs of growing numbers of people. The overall population of the 48 least developed countries is growing 2.3 per cent annually, nearly twice as fast as that of the developing world in general. Over the next 40 years, the population of the least developed countries will increase by about 100 per cent, whereas the population of the other developing countries will increase by about 30 per cent, and the population of the developed countries will grow by a mere 3 per cent, according to the UNFPA report.

The report argues that the neglect of population dynamics in policymaking is a "consequential omission" that can "ultimately undermine the sustainability and viability of development strategies."

The changing size, location and composition of populations, along with the resources at their disposal, also have major impacts on people's vulnerability and ability to adapt to climate change. In 2011, UNFPA supported the development of tools for improving census analysis related to climate change and the environment and the integration of reproductive health, gender and population dynamics in national climate change responses.

The world is undergoing the largest wave of urban growth in history, with a projected increase of nearly 2 billion more urban residents in the next 20 years, and the vast majority of this urban growth is occurring in developing countries. Effective planning for urbanization is a crucial foundation for development. UNFPA continued to support better integration of urbanization projections into planning and programming in countries such as Brazil, the Russian Federation, India and China to provide guidance for countries experiencing and managing urban transitions. UNFPA also supported studies on links between urbanization, gender and reproductive health.

Highlights

Bosnia and Herzegovina revised the national Social Inclusion Strategy to take into account the country's growing population of older persons.

Côte d'Ivoire collected demographic data from 10 parts of the country to guide a revision of the country's Poverty Reduction Strategy Paper, which details the country's plans to promote growth and reduce poverty through implementation of specific economic, social and structural policies over a period of three years or longer. Côte d'Ivoire also approved a new National Youth Policy that calls for the inclusion of youth concerns in national development and poverty-reduction plans.

Jamaica began the development of a migration policy that will enable the country to engage with its large emigrant community. About one in two Jamaicans lives outside the country. The new policy will help address issues such as a large number of ageing Jamaican emigrants who return home for retirement.

In 2011, the Higher Population Council of **Jordan** developed Demographic Dividend Policies, which call for greater investments in young people now so the country may benefit from the demographic dividend it will experience in the years ahead.

The Pacific-island nation of **Kiribati** named population displacement, migration and family planning as priorities in the country's development plan for 2012 to 2015. The threat of rising sea levels as a result of climate change is partly responsible for recent increases in rural-to-urban migration.

An analysis of census data in 2011 resulted in the inclusion of population issues in the United Nations Development Assistance Framework for **Malawi** for 2012 to 2016.

The **Republic of Moldova** adopted a National Strategic Plan for Demographic Security for 2011 to 2025, which addressed emerging issues such as the growing segment of the population that is older.

When a woman in labour seeks her help, Kanchan Bala Roy is confident she can oversee a safe delivery. The rural health centre where she works was recently equipped for deliveries, as part of a broad initiative to make childbirth in Bangladesh as safe as possible. Kanchan, a family welfare visitor, received new training. She is now better able to manage normal deliveries at the centre or in clients' homes. And she can tell when a mother needs to be rushed to the district hospital. Surgical deliveries have doubled at the district hospital here since a United Nations project last year trained additional doctors and nurses and built a new operating theatre that can accommodate two procedures at a time.

These upgrades are part of a joint effort by UNFPA, UNICEF and the World Health Organization to help the Government of Bangladesh improve maternal and newborn health care. Community clinics, family welfare centres, subdistrict health complexes and hospitals in four of the country's 64 districts received new equipment and stocks of basic drugs and supplies. Health workers at various levels underwent training.

Childbirth in Bangladesh has become safer in the past 20 years, but there is a long way to go. The United Nations estimates that every year more than 7,000 women in Bangladesh die from avoidable causes related to pregnancy and delivery. Three out of four women still deliver babies at home without a skilled birth attendant.

Expanding Access to Maternal and Newborn Health

Increasing access to and use of maternal and newborn health services is at the core of UNFPA's work. This work is helping achieve Millennium Development Goal 5-A, to reduce maternal death, and Goal 5-B, to ensure that everyone has access to reproductive health care. But in many countries, access to health care remains limited, particularly in the least developed countries, where more than half the population lives on $1 a day or less.

As a result, maternal death rates remained high in much of the developing world in 2011, with nearly 800 women dying of pregnancy-related complications and thousands more suffering from debilitating conditions every day. Maternal deaths are concentrated in sub-Saharan Africa and South Asia, which together account for nearly nine in 10 such deaths globally.

United Nations Secretary-General Ban Ki-moon described the state of maternal health as "worrying" at the July launch of the *2011 Millennium Development Goals Report*. "Limited access to proper care makes pregnancy a needlessly high health risk in many developing countries," he commented.

Nevertheless, recent estimates show progress overall, with a drop of 34 per cent in the maternal mortality ratios in developing countries between 1990 and 2008—from 440 maternal deaths per 100,000 live births to 240 maternal deaths per 100,000 live births, respectively.

Some countries have made more progress than others. In Egypt and Sri Lanka, for example, maternal mortality ratios have dropped by two thirds since the early 1990s, demonstrating how much can be achieved when there is adequate political and financial support and when proven, effective approaches are applied.

Mobilizing political and financial support is central to the Secretary-General's Global Strategy on Women's and Children's Health, which UNFPA and other organizations implement. The strategy includes the "Every Woman, Every Child" initiative through which developing countries made 100 new commitments in 2011 to improve maternal, neonatal and child health. UNFPA, in partnership with UNICEF, the World Health Organization, the World Bank and UNAIDS, scaled up

actions in countries such as Afghanistan, Bangladesh, Burkina Faso, Democratic Republic of Congo, Sierra Leone, Zambia and Zimbabwe to enhance financing, strengthen policy and improve service delivery related to women's and children's health.

UNFPA devotes the largest share of its core resources to actions that expand access to or raise the quality of reproductive health, including maternal health. In 2011, these expenditures totalled $158.5 million.

By means of a Maternal Health Thematic Fund (MHTF), in 2011 UNFPA helped mobilize an additional $20 million to jump-start maternal health initiatives in the poorest countries. The MHTF also supports the Campaign to End Fistula, which received $5 million from donors in 2011 to treat and surgically repair obstetric fistula in more than 7,000 women in 43 countries. Obstetric fistula is a debilitating condition that is typically caused by prolonged, obstructed labour. This condition affects mostly young women and occurs more frequently in rural or remote areas compared to urban areas because access to skilled birth attendants is limited in rural areas.

Last year, an estimated 287,000 women died while pregnant or giving birth, and up to 2.6 million newborns died within the first 24 hours of life. Lack of access to quality health facilities or qualified health professionals is to blame for the majority of these deaths. Midwifery services can help bridge the gap and save lives. Also through the MHTF, UNFPA and the International Confederation of Midwives helped 30 countries strengthen midwifery policies, regulatory frameworks, services and training and build national midwifery networks and associations in 2011.

UNFPA and 28 international and non-governmental organizations and academic and other institutions joined forces to publish the *State of World's Midwifery 2011: Delivering Health, Saving Lives*, which showed that 3.6 million maternal deaths, stillbirths and newborn deaths in 58 countries could be averted each year if all women had access to reproductive health services, including access to midwives.

"Developing quality midwifery services should be an essential component of all strategies aimed at improving maternal and newborn health," the report concluded.

In collaboration with the International Confederation of Midwives, UNFPA brought together 70 midwives from 16 countries of Latin America and the Caribbean to develop a five-year strategic plan for strengthening midwifery in the region.

Meanwhile, the Campaign on Accelerated Reduction of Maternal Mortality in Africa—CARMMA—continued to expand, now covering 36 countries. UNFPA and the African Union Commission established CARMMA in 2009 in response to the daunting challenge of reducing maternal mortality in Africa by 75 per cent by 2015, in line with Millennium Development Goal 5. CARMMA uses policy discussions, advocacy and community social mobilization to enlist political commitment and aims to increase resources and bring about societal change in support of maternal health.

Integrating sexual and reproductive health with other health services, including maternal and newborn health as well as HIV prevention and treatment, can result in synergies that improve overall health outcomes.

In 2011, UNFPA supported programmes linking sexual and reproductive health and HIV in Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe. A tool developed by UNFPA to rapidly assess linkages among sexual and reproductive health and HIV services and to identify gaps in quality or coverage was used in 21 countries last year.

Pregnancy is the first point of access to health systems by many women, and therefore comprehensive services may allow these women to benefit from a range of interventions, including HIV prevention and treatment, that can be folded into routine maternal health care. Integrated services may also help prevent mother-to-child transmission of HIV.

The Global Plan to Eliminate New HIV Infections among Children and Keeping Their Mothers Alive guided UNFPA's efforts in 2011 to prevent mother-to-child transmission of HIV in 38 countries. Representatives from 15 southern and eastern

African governments who met in Nairobi in March of 2011 called for the virtual elimination of mother-to-child transmission of HIV by 2015 and pledged adherence to World Health Organization guidelines for giving pregnant women and new mothers a combination of three antiretroviral drugs.

In Madagascar, two out of three newborn care facilities now also offer services related to prevention of mother-to-child transmission of HIV. In Malawi, 80 per cent of all health facilities now offer these services.

"Linking sexual and reproductive health and HIV goes beyond integrating health services," according to UNFPA Executive Director Babatunde Osotimehin. "It demands from us that we fortify the human rights platform—ending stigma, violence and discrimination."

Highlights

The Ministry of Health of **Burundi** institutionalized "maternal death reviews" in 2011 to document the causes of mortality during pregnancy or childbirth, to identify gaps in the coverage or quality of services, and to inform decisions about where resources, equipment and medicines are needed most urgently.

Cambodia trained 834 midwives and deployed them to remote, underserved parts of the country in 2011. Now all health centres in the country have at least one midwife. In addition, 10 doctors were trained in deliveries by Caesarean section, and one doctor was trained in emergency obstetric care.

Cameroon opened eight midwifery schools in 2011 with support from UNFPA, UNICEF, the World Health Organization, the World Bank and UNAIDS.

With support from UNFPA, the **Democratic Republic of the Congo** provided 295 health facilities with equipment and medicines to help save mothers' lives. UNFPA also helped train 87 health professionals in emergency obstetric care and 15 surgeons in obstetric fistula repair.

One hundred health providers in the **Dominican Republic** received specialized training in maternal and prenatal care and are being deployed to facilities near the border with Haiti because of the area's high rate of maternal mortality.

In the **Occupied Palestinian Territory**, UNFPA supported the training of 72 doctors and midwives in advanced life support in obstetrics.

UNFPA supported the training of 18 midwives for each of the 10 states in the newly independent **South Sudan**.

UNFPA supported the improvement or expansion of perinatal services in maternity hospitals in **Tajikistan**, leading to an increase in the number of facility-based deliveries and a reduction in neonatal illness and death.

In border areas of **Argentina, Bolivia, Colombia, Costa Rica, the Dominican Republic, Ecuador, Guatemala, Haiti** and **Mexico,** UNFPA supported efforts to provide sexual and reproductive health care to migrants.

In 2011, UNFPA provided reproductive health and relief supplies, including "dignity kits," information or services in the aftermath of Tropical Storm Washi in the **Philippines**; floods in **Namibia, Pakistan, Sri Lanka, Thailand** and four **Central American countries**; the drought in the **Horn of Africa**; the tsunami in **Japan**; and the breakout of fighting in **Libya**. In addition, **Georgia** and **Kyrgyzstan** developed national emergency preparedness plans that include minimum initial service packages to support reproductive health.

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In the isolated Ethiopian village of Tare, Amsalu Buke is a quiet revolutionary dedicated to the women who live in this region without doctors or roads. Walking across parched fields from hamlet to hamlet, Amsalu, just 20 years old, brings family planning to women so eager for her help that they waylay her on her rounds, pleading discreetly for contraceptives. Very young herself, Amsalu is one of more than 37,000 health extension workers positioned around the country in recent years, according to Fisseha Mekonnen, Executive Director of the Family Guidance Association of Ethiopia, which is working with the Ethiopian Government to improve health and expand access to family planning in rural areas and nursing services in cities.

The corps of health extension workers, many of them very young, is viewed as a basic model for other developing nations with scant health coverage; it is also a model in giving young people a role and a stake in national programmes that matter to everyone, regardless of age. The Programme of Action of the International Conference on Population and Development recognized "the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice." The contraceptive prevalence rate in Ethiopia rose from 8 per cent in 2000 to about 29 per cent today.

Increasing Availability of Family Planning

"The unmet need for safe and effective contraceptive services throughout the world is staggering," states a 2011 briefing paper published jointly by UNFPA and the Center for Reproductive Rights, *The Right to Contraceptive Information and Services for Women and Adolescents.*

Addressing the unmet need for contraceptive information and services "would result in roughly 22 million fewer unplanned births, 25 million fewer induced abortions, and 150,000 fewer maternal deaths each year," the paper added.

While the demand for modern contraception is expected to rise in the coming decade because of the anticipated increase in the number of women of reproductive age and the number of women who wish to have smaller families, funding for family planning "has drastically diminished," from about 55 per cent of total assistance for population programmes in 1995 to only about 8 per cent in 2010. Meanwhile, the global financial crisis has resulted in job losses and reduced wages, translating into greater financial barriers to contraception for women and adolescents.

UNFPA Executive Director Babatunde Osotimehin said in 2011 that the gap between this unmet need and the amount of money available for family planning must be bridged, starting with those in most need—the rural and urban poor, and also young people, upon whom our future rests. An additional $3.6 billion is required annually to close this gap. This sum is in addition to the $3.1 billion being already being invested in family planning each year.

Governments have the primary responsibility of protecting their citizens' reproductive health and rights. But donor governments also have a responsibility to help uphold these rights. "We must galvanize greater political and financial support," Dr. Osotimehin advised. Fulfilling the unmet need for modern family planning in developing countries would cost $3.6 billion annually, but the latest data available in 2011 showed that this investment would actually lower the cost of maternal and newborn health services by $5.1 billion, resulting in a net total savings of $1.5 billion. Investing in voluntary family planning today would not only pay dividends now, but would also help history's largest generation of young people enjoy opportunities and forge a brighter future.

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At the start of the largest international family-planning conference ever, which took place in Dakar, Senegal, in November 2011, Dr. Osotimehin underscored the fact that voluntary family planning can help reduce poverty and contribute to economic development for families, communities and nations. Satisfying the unmet need for family planning in developing countries is essential to upholding women's reproductive rights.

"Options are essential," he declared. Family planning works best when women have a full range of contraceptive options and can choose, access and afford the method best suited to their needs. National design and ownership are essential too. "Each country has its own set of circumstances and cultural considerations that cannot and should not be addressed by outsiders."

UNFPA established its Global Programme to Enhance Reproductive Health Commodity Security in 2007 to help countries ensure access to a reliable supply of contraceptives, condoms, medicine and equipment for maternal health, family planning, and prevention of HIV and other sexually transmitted infections. The programme provides financial and technical support to strengthen health systems and to procure reproductive health commodities.

Donors have contributed $450 million since the programme started. In 2011, the programme spent nearly $78 million on contraceptives and other supplies and on actions to build the capacities of governments in 45 countries to expand access to voluntary family planning. Funding through the programme is additional to amounts provided through UNFPA's core resources for family planning.

Highlights

In **Argentina**, UNFPA supported the training of hospital directors and their legal counsels on rights to reproductive health, including family planning.

Belize trained 88 health professionals in the provision of family planning services and supplies.

Family counselling centres in **Bulgaria** received support from UNFPA and UNICEF to provide family planning services to marginalized groups, including the Roma population.

More than 400 health facilities in the **Central African Republic** distributed the equivalent of 130,000 one-month supplies of the pill, 26,000 doses of injectable contraceptives, and about 13,000 contraceptive implants in 2011.

Eritrea increased the share of health facilities offering at least three modern methods of family planning from 51 per cent to 100 per cent.

UNFPA supported the development of the family planning curriculum for doctors studying at the Centre for Development of Family Medicine in **Kosovo**.

Malawi trained 265 health workers and community-based distributors in the provision of long-term contraceptives.

Through the Global Programme for Enhanced Reproductive Commodity Security, UNFPA and the Government of **Mongolia** procured 1.4 million condoms, 100,000 cycles of oral contraceptives, 5,000 emergency contraceptives, 80,000 vials of injectable contraceptives, 10,000 female condoms and 5,000 intrauterine devices.

Mozambique trained 56 community health workers to promote and raise awareness of family planning with a focus on men.

Niger expanded its network of "schools for husbands" in 2011 to mobilize men to increase demand for family planning.

Swaziland increased access to family planning through all service providers, including ones that offer antiretroviral therapy for HIV. In addition, 150 midwives received training in dispensing modern methods of contraception, and 24 additional health facilities began offering family planning in 2011. Recent surveys show that the contraceptive prevalence rate in the country has risen to 65 per cent and that the unmet need for family planning has decreased to 13 per cent.

The **Syrian Arab Republic** trained 793 midwives and 50 doctors in providing family planning services and supplies in 2011.

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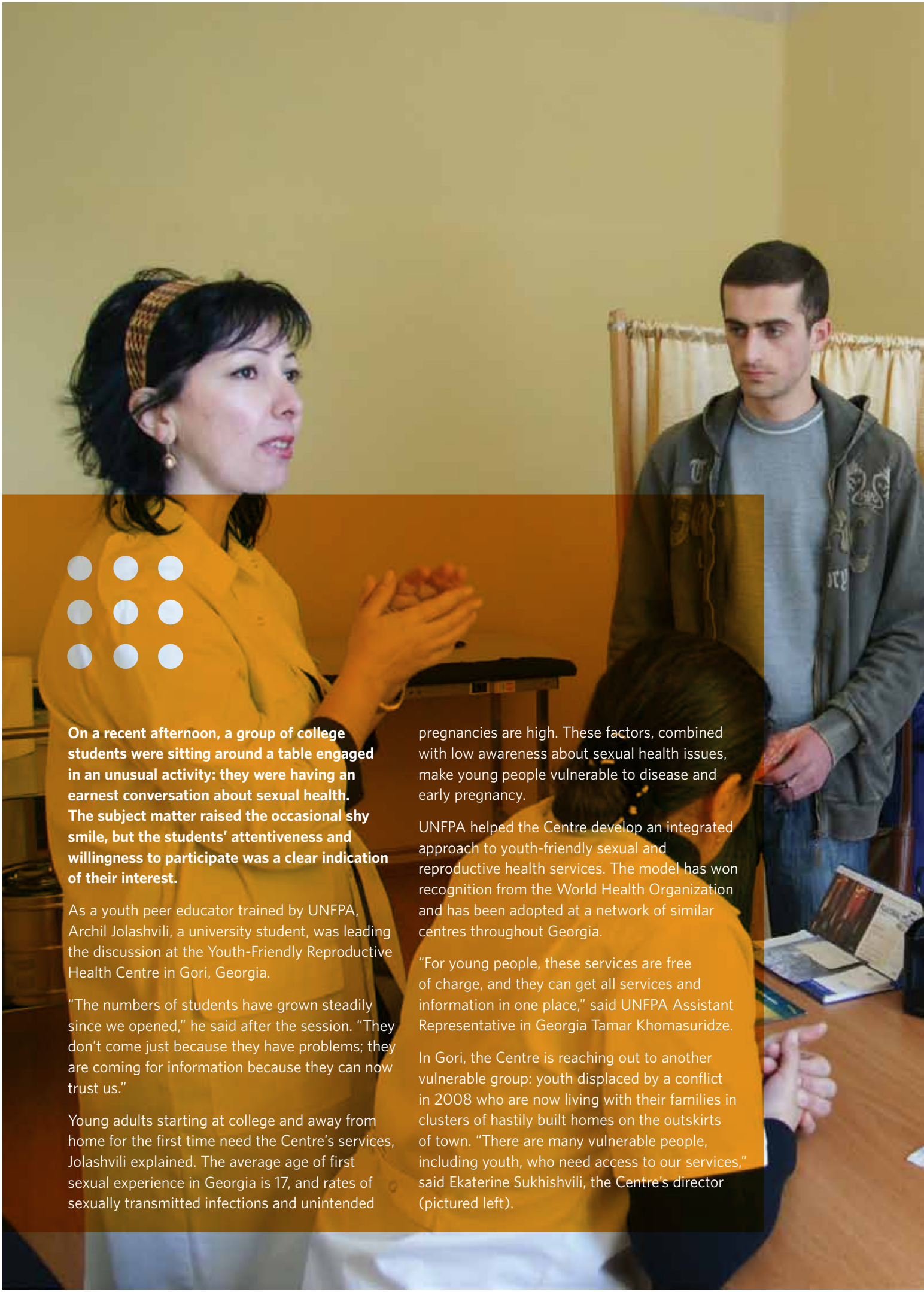

On a recent afternoon, a group of college students were sitting around a table engaged in an unusual activity: they were having an earnest conversation about sexual health. The subject matter raised the occasional shy smile, but the students' attentiveness and willingness to participate was a clear indication of their interest.

As a youth peer educator trained by UNFPA, Archil Jolashvili, a university student, was leading the discussion at the Youth-Friendly Reproductive Health Centre in Gori, Georgia.

"The numbers of students have grown steadily since we opened," he said after the session. "They don't come just because they have problems; they are coming for information because they can now trust us."

Young adults starting at college and away from home for the first time need the Centre's services, Jolashvili explained. The average age of first sexual experience in Georgia is 17, and rates of sexually transmitted infections and unintended pregnancies are high. These factors, combined with low awareness about sexual health issues, make young people vulnerable to disease and early pregnancy.

UNFPA helped the Centre develop an integrated approach to youth-friendly sexual and reproductive health services. The model has won recognition from the World Health Organization and has been adopted at a network of similar centres throughout Georgia.

"For young people, these services are free of charge, and they can get all services and information in one place," said UNFPA Assistant Representative in Georgia Tamar Khomasuridze.

In Gori, the Centre is reaching out to another vulnerable group: youth displaced by a conflict in 2008 who are now living with their families in clusters of hastily built homes on the outskirts of town. "There are many vulnerable people, including youth, who need access to our services," said Ekaterine Sukhishvili, the Centre's director (pictured left).

Strengthening HIV-Prevention Services

An estimated 2,500 young people between the ages of 15 and 24 become infected with HIV every day.

Too many young people still lack full knowledge about how to prevent HIV infection and often face challenges in accessing the services they need, UNFPA Executive Director Babatunde Osotimehin declared on World AIDS Day in 2011. "Investing in young people's health and education, including sexuality education, is a smart strategy with long-term benefits," he said. "By putting young people at the centre of the response, their leadership, initiative and energy can be unleashed for positive change."

The opportunity to improve health for everyone lies in strengthening integrated services, Dr. Osotimehin added. A key strategy to accelerate progress is forging and cultivating partnerships between the sexual and reproductive health communities and HIV communities, including networks of people living with HIV.

"By integrating services, we can improve their quality and accessibility, which means more people will use them. This also improves health and behavioural outcomes, including condom use, people's knowledge about HIV, the health of women and their children, and eliminating mother-to-child transmission of HIV. Addressing HIV as part of normal core services in a medical facility will also help to reduce HIV-related stigma and discrimination," Dr. Osotimehin added.

Representatives from governments, international and non-governmental organizations, academicians and youth leaders from 27 countries agreed at an event hosted by UNFPA in Istanbul in May 2011 that the health of young people in much of Eastern Europe and Central Asia is compromised by insufficient education about and awareness of sexual and reproductive health, and by a lack of access to youth-friendly HIV-prevention and treatment services. The region has the fastest-growing incidence of HIV infection, driven largely by injection drug use and sex work. Conference participants acknowledged positive steps taken in a number of countries in the region to develop teaching materials and provide teacher training to help prevent HIV and sexually transmitted infections, and to promote the use of condoms. Participants added that

"there is sufficient evidence that comprehensive sexual and reproductive health education is essential for the health of young people and does not lead to negative impacts, such as earlier sexual debut or increased sexual activity in young people."

The first Summit of Youth Afrodescendants in 2011 resulted in the Declaration of San José, which calls on governments, civil society and international organizations to support youth of African descent by promoting their rights and ensuring their access to sexual and reproductive health services, with an emphasis on prevention of teenage pregnancies and sexually transmitted infections including HIV, and by providing comprehensive sexuality education.

In 2011, UNFPA-supported young people's networks, such as Youth LEAD in Asia and the Pacific, and the HIV Young Leaders Fund, have enabled youth to voice their opinions and to engage in advocacy and public policy debate on access to services, comprehensive sexuality education, and youth participation in HIV-prevention programmes. Youth LEAD is a regional network that helps develop youth leadership in key populations that are at high risk, in order to strengthen their involvement in community, national and regional programmes. The HIV Young Leaders Fund, supported by UNFPA and others, is a youth-led provider of small grants and technical assistance to youth-led HIV initiatives.

UNFPA helped 87 countries strengthen youth-friendly sexual and reproductive health and HIV services. UNFPA also developed a global strategy to support governments and partners in providing rights-based, gender-sensitive sexuality and HIV education, both in and outside schools. In 2011, national partners in 70 countries received support from UNFPA in designing, implementing and evaluating comprehensive, culturally sensitive and age-appropriate sexuality education programmes.

UNFPA supported initiatives to prevent HIV and sexually transmitted infections among key populations. For example, in 2011, UNFPA enhanced HIV prevention and management and access to sexual and reproductive health services for sex workers in 81 countries in partnership with governments, community and non-governmental organizations. These services included provision of condoms, family planning and economic empowerment initiatives as well as prevention of mother-to-child transmission of HIV.

The UNAIDS Advisory Group on HIV and Sex Work, co-chaired by UNFPA, issued guidance for governments to help them reduce the demand for unprotected paid sex, develop legal and policy frameworks to promote universal access to HIV prevention and treatment, and reduce sex workers' economic vulnerability. UNFPA helped 38 countries address stigma, discrimination and HIV risk among key populations last year.

In the Caribbean, UNFPA's work with key populations led to the creation in 2011 of a Caribbean Coalition that aims to enable civil society organizations to advocate for a rights-based approach to ensuring access to sexual and reproductive health services, including HIV prevention.

UNFPA continued in 2011 to expand access to condoms. Eighty-six countries are implementing "comprehensive condom programming," pioneered by UNFPA. Through this approach, governments receive support for the development of national condom strategies, policies and plans. Among development partners, UNFPA was the largest supplier of male and female condoms to low-income countries in 2010. In 2011, 45 countries with peacekeeping missions or disarmament, demobilization and reintegration programmes distributed condoms to help prevent HIV, as part of a minimum initial service package for reproductive health. UNFPA mobilized about $17 million for the Global Condom Initiative, with an emphasis on female condoms.

Highlights

Bhutan established a Youth-Friendly Health Service at the national hospital to increase young people's access to testing for HIV and sexually transmitted infections. In addition, young people working in drop-in centres received training in 2011 to provide information about sexual and reproductive health to youth.

Eritrea aired television programmes, published articles in the national youth magazine and offered seminars on HIV awareness targeting at-risk youth, especially young women. An estimated 85 per cent of sexually active youth between the ages of 15 and 24 use condoms.

Honduras strengthened 19 centres that provide adolescents and young people with sexual and reproductive health services to prevent HIV and sexually transmitted infections.

Iraq provided training and guidance to health professionals participating in a pilot programme to expand adolescent- and youth-friendly HIV prevention information and services.

In **Malawi**, 80 per cent of all health facilities now provide services to help prevent mother-to-child transmission of HIV.

The National Population and Family Development Board of **Malaysia** and the Malaysian Federation of Reproductive Health Associations launched a project, Kafe@Teen, to increase disadvantaged and vulnerable youth's access to reproductive health and HIV prevention information and services.

The **Republic of Moldova** tapped the power of social media, mobilized peer educators and continued broadcasting radio programmes to raise awareness about the prevention of HIV and sexually transmitted infections. Special events, such as contests about HIV knowledge and condom distribution at night clubs, further helped young people protect themselves from infection.

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Laws and policies are critical to promoting gender equality and protecting women's reproductive rights, but sometimes they are only the first step towards breaking longstanding discriminatory practices. Domestic violence in Mozambique, for example, remains widespread despite laws that have criminalized it, partly because of persistent gender inequality in the country, says Berta Chilundo (pictured), vice president of the Board of Women, Law and Development, or MULEIDE, a non-governmental organization that provides legal aid and psychological support for battered women. "Violence against women in Mozambique is directly related to the social status of women," says Chilundo.

And according to the United Nations Development Assistance Framework for the country, "Persistent gender inequality means that women and children are disproportionately victims of poverty, food insecurity and disease."

Similarly, marriage before the age of 16 is illegal in Mozambique—and many other countries—yet child marriage persists, especially in rural areas. One in five women in the country was married or in a union before the age of 15. In Mozambique as in many other countries, child marriage is more common among girls with little or no education.

Graça Samo, executive director of Forum Mulher, a group that advocates for women's rights and development, says that education of women is crucial to rectifying gender inequalities in Mozambique. Still, education alone cannot resolve the problem, as long as social norms and values perpetuate inequalities between women and men and girls and boys. Samo argues that levelling the playing field for women and men requires interventions not only by the state and non-profits, but also by families, which can have a tremendous influence on how girls—and boys—perceive themselves and each other in society. While it's important to socialize girls in a way that encourages them to recognize their strengths and possibilities, it is equally important to change the way boys are socialized so they understand early in life that gender equality for men and women benefits everyone.

Advocating Gender Equality and Reproductive Rights

UNFPA builds the capacities of governments to implement laws and policies that advance gender equality and reproductive rights, address gender-based violence and eliminate harmful practices, such as female genital mutilation or cutting.

According to a UNFPA report published in 2011, *Population Dynamics in the Least Developed Countries: Challenges and Opportunities for Development and Poverty Reduction*, gender inequality inhibits both economic growth and poverty reduction. The report notes that there is a reinforcing cycle of poverty and gender inequality that is difficult to break without sustained commitment to multidimensional approaches to development that consistently promote gender equality. A significant factor in the negative cycle of poverty and gender inequality is poor health. Poverty undermines women's ability to access health services and particularly interferes with their ability to make independent decisions about their own sexual and reproductive health.

In a statement intended to draw attention to an anti-violence campaign in 2011, UNFPA Executive Director Babatunde Osotimehin said, "When women are healthy and educated and can live free from violence and discrimination, they can participate fully in society and accelerate progress on all fronts."

UNFPA advocated in 2011 for implementation of the Convention on the Elimination of All Forms of Discrimination against Women. UNFPA helped strengthen national capacities in Eritrea, Gabon and Uganda to mainstream consideration of gender in laws and policies and to raise awareness about international human rights treaties that call for gender equality. Under the terms of the Convention, women should have an equal say in decision-making and should have access to family planning without needing the consent of their fathers or husbands.

The Programme of Action of the International Conference on Population and Development stated that "men play a key role in bringing about gender equality since, in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and programme decisions taken at all levels of government." A UNFPA 2011 report, *Engaging Men and Boys in Gender Equality: Vignettes from Asia and Africa*, showcases progress and challenges in Bangladesh,

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Cambodia, the Philippines and Uganda. The report recommends that governments must "mainstream boys' and men's involvement to complement overall efforts for gender equality, equity and development."

Through the Programme of Action, 179 governments also committed to "eliminate all forms of discrimination against the girl child and the root causes of son preference, which result in harmful and unethical practices regarding female infanticide and prenatal sex selection." In June 2011, UNFPA, UNICEF, UN Women, the World Health Organization and the Office of the High Commissioner for Human Rights issued a joint statement calling for an end to gender-biased sex selection and for legislation making it illegal. The statement cited national census data showing worsening sex-ratio imbalances in a number of South Asian, East Asian and Central Asian countries.

Sex selection in favour of boys "is a symptom of pervasive social, cultural, political and economic injustices against women, and a manifest violation of human rights," according to the joint statement.

UNFPA Regional Director for Asia and the Pacific Nobuko Horibe told experts from 11 Asian and Eastern European nations at a forum in Viet Nam in October 2011 that sex selection must be understood as discrimination against women and girls, and that it should end. Horibe said that about 117 million women were "missing" in Asia today. "Improving gender equality and supporting national policies to address sex ratio imbalances require urgent, concerted efforts by all segments of the government and society." Addressing this issue "is central to the work of UNFPA," she said.

In September 2011 the Council of Europe passed a resolution condemning prenatal sex selection, which occurs in countries such as Albania, Armenia, Azerbaijan and Georgia. The practice "finds its roots in a culture of gender inequality and reinforces a climate of violence against women," the resolution stated, calling on UNFPA and other organizations to step up efforts to address the preference for sons.

Many countries also reported progress in abandoning the practice of female genital mutilation and cutting in 2011. Nearly 2,000 communities around the world declared abandonment of the practice last year. Meanwhile, 300 health facilities in a number of countries in Africa integrated prevention of the practice into their antenatal and neonatal care, and more than 600 training programmes for health professionals added prevention into their curricula. Nearly 3,000 religious leaders taught their followers in 2011 that Islam does not sanction the practice and issued 1,000 edicts calling for its abandonment.

Highlights

Armenia developed a national strategy and action plan for gender equality and adopted a law to guarantee equal rights in 2011. The country also developed a national action plan to combat gender-based violence and has begun developing referral systems for survivors.

UNFPA and the Ministry of Social Affairs and Promotion of Women in **Equatorial Guinea** organized workshops to raise community leaders' awareness about gender-based violence and to promote actions that can be taken locally to stop it.

Forty camps for earthquake survivors in **Haiti** became safer for women after UNFPA installed new solar-powered lights near showers, latrines and water-distribution points.

UNFPA collaborated with the African Development Bank to develop a national gender profile for **Tunisia**, to guide decision makers in formulating national development plans.

Men are becoming allies in the fight against gender-based violence in the Kanungu District of **Uganda**. With support from UNFPA, men act as agents for change through small Men's Action Groups, which organize local awareness-raising events and in some instances mediate cases of domestic violence.

With support from UNFPA in 2011, the **United Republic of Tanzania** opened its first clinic for survivors of gender-based violence and child abuse.

Viet Nam carried out a study of parents' preferences for sons over daughters. Results of the study, which will show the causes of the country's sex-ratio imbalance, will be published in 2012.

In a semi-rural area near the Egyptian city of Ismailia, on the west bank of the Suez Canal, Dalia Shams (pictured) offers services from her cramped office that doubles as an examination room at an Egyptian Family Planning Association centre supported by UNFPA through its Youth-Friendly Clinics programme. Shams spends a lot of time listening, especially to adolescent girls. "It starts with a chat so they can learn to trust me," she said. "Then they talk without hiding anything."

"Girls know little about sex and they are afraid," she continued. "They come to ask about losing their virginity in a shower or riding a donkey. They ask about menstrual problems, or infections. Sometimes the mother comes with the girl. She is also afraid." Shams talks to them frankly about sex and also about nutrition, cleanliness and healthy living in general. When she is asked by a mother about whether to have her girl's genitals cut, she must choose her words thoughtfully: "I have to work carefully around the issue not to scare her away." The family planning association opposes the practice, which is still widespread in Egypt although it has been outlawed and is thought to be decreasing.

Shams also counsels young women and men about to be married. Most young women she sees marry between the ages of 18 and 25, she said, although in urban Ismailia, where she grew up, 16-year-old brides are not uncommon, which is in violation of the law. At any age, young women and their husbands know very little about what to expect sexually, since premarital chastity is strongly guarded. When it comes time for family planning, Shams has intrauterine devices, condoms, injectable contraceptives, implants and oral contraceptives to offer. She must wait until after marriage to dispense them because she said a bride's virginity must be intact on her wedding day. But by then the woman has at least been informed about choices.

Increasing Young People's Access to Services

Of the world's 7 billion people, 1.8 billion are between the ages of 10 and 24. "Young people hold the key to the future, with the potential to transform the global political landscape and to propel economies through their creativity and capacities for innovation. But the opportunity to realize youth's great potential must be seized now," UNFPA Executive Director Babatunde Osotimehin said on 26 October, 2011, the day on which the 7 billionth person was projected to have been born. "We should be investing in the health and education of our youth. This would yield enormous returns in economic growth and development for generations to come."

In most industrialized countries and in an increasing number of developing ones, young women and men are marrying later and having fewer children. This trend is linked not only to improved education and jobs, but also to unfettered access to information, sexuality education and sexual and reproductive health services.

Age-appropriate sexuality education helps promote health, prevent HIV and sexually transmitted infections, and stave off unwanted pregnancies among young people. It also promotes equitable gender norms and the empowerment of young women, says UNFPA Technical Division Deputy Director Mona Kaidbey, who was one of the organizers of a Global Consultation on Sexuality Education two years ago.

Sexuality education programmes that address gender and power in relationships are more effective at reducing risky behaviours, Kaidbey said, citing as an example Program H, an initiative in Brazil that works with young men to challenge inequitable gender attitudes and practices. An evaluation of the programme found that risky behaviours—and the incidence of sexually transmitted infections—decreased among participating young people.

The right to comprehensive, non-discriminatory and age-appropriate sexuality education is based on the Programme of Action of the International Conference on Population and Development and a number of international agreements, Kaidbey said, "yet there are

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far too many young people who do not have access to sexuality education programmes."

A briefing paper published jointly by UNFPA and the Center for Reproductive Rights in 2011, *The Right to Contraceptive Information and Services for Women and Adolescents*, says that adolescents frequently encounter significant barriers to accessing contraceptive information and services, leading to high rates of unintended pregnancy and increased risk of HIV and sexually transmitted infections. "Lack of evidence-based sexuality education and information hampers adolescents' ability to make informed decisions around contraceptive use, which in turn leads to high rates of teenage pregnancy and high abortion rates among adolescents and young women," states the report. The countries with high teenage birth rates are concentrated in sub-Saharan Africa and Latin America and the Caribbean, according to the United Nations Department of Economic and Social Affairs.

UNFPA and the governments of Bolivia, Chile, Colombia, Ecuador, Peru and Venezuela developed and began implementing a regional plan in 2011 to prevent adolescent pregnancies. In some of these Andean countries, nearly one in five adolescents between the ages of 15 and 19 is pregnant for the first time. In the Andean region, adolescents account for 18 per cent of all pregnancies.

High rates of adolescent pregnancy in Andean and several other Latin American countries result from factors ranging from early marriage to relatively low rates of contraceptive use, and social exclusion of women, particularly among indigenous groups, according to a UNFPA 2011 report, *Prevención del Embarazo Adolescente* (Prevention of Adolescent Pregnancy).

Complications of pregnancy and childbirth are still the leading causes of death in the developing world among girls between the ages of 15 and 19, Dr. Osotimehin wrote in *The Lancet* in September.

Empowering women and girls "starts with improved access to reproductive health care and family planning," Dr. Osotimehin said in a 2011 UNFPA report, *Population Dynamics in the Least Developed Countries: Challenges and Opportunities for Development and Poverty Reduction*. "Too many teenage girls become mothers, too many die giving birth, too many drop out of school.... When girls are educated, healthy and can avoid child marriage and unintended pregnancy and HIV, they can contribute fully to their societies' battles against poverty," he added.

Highlights

The Ministry of Youth and Sports in **Algeria** received support from UNFPA to increase young people's access to sexual and reproductive health services in 2011.

In **Argentina**, UNFPA provided technical support for implementation of national legislation, Law 26150 on Comprehensive Sexuality Education, which resulted in the development and implementation of online sexuality education training for 7,000 school teachers and development of a toolkit distributed to 6 million families to help build parents' communication skills related to sexuality.

In 2011, **India** trained 2,500 teachers to provide life-skills education, including discussions of sexual and reproductive health, for adolescents in school, and 130 others to provide information about sexual and reproductive health to adolescents who are not in school.

The **Republic of Serbia** has strengthened reproductive health care, sexuality education and HIV-prevention services for Roma youth.

In **South Sudan**, UNFPA supported training of 40 health-care professionals in the provision of adolescent- and youth-friendly services and training of 196 youth sexuality educators who provided information and services to more than 11,000 young people in 2011.

With support from UNFPA and its partners in the United Nations Adolescent Girls Task Force, **Ethiopia**, **Liberia**, **Malawi** and **Guatemala** implemented comprehensive programmes for girls combining education, health care (especially sexual and reproductive health care) and violence prevention in 2011. The Task Force consists of representatives from six United Nations agencies and addresses nearly all aspects of a girl's life.

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Iran completed its latest population and housing census in November 2011. UNFPA provided technical and financial support to the Statistical Centre of Iran, which led the $70 million initiative. For three weeks, 54,000 enumerators and 14,000 supervisors fanned across Iran's 31 provinces to interview an adult from each household. Up to 114,000 individuals nationwide helped manage the census by visiting more than 21 million households in 100,000 rural areas and 1,200 urban centres. More than half of all enumerators were female to ensure that the census was gender-sensitive. Data are being processed and analysed, with final results expected in 2012.

Harnessing the Power of Data

Good policymaking requires reliable data about people and how they live, about their incomes, their ages and whether they live in a city or a rural area. UNFPA helps build governments' capacities for data analysis and for formulating policies that are informed by demographic information, including data about the size of the youth population, access to reproductive health care and gender equality.

Policymaking in areas such as reproductive health, poverty reduction and development should take "due account of current and future population dynamics," stated a 2011 UNFPA report, *Population Dynamics in the Least Developed Countries: Challenges and Opportunities for Development and Poverty Reduction*.

Censuses yield data that provide invaluable insights for policymakers. By the end of 2011, 63 per cent of UNFPA-supported countries had completed population and housing censuses. And between 2007 and 2011, 95 per cent of the countries where UNFPA works had conducted a national household or thematic survey that covered issues related to the Programme of Action of the International Conference on Population and Development.

UNFPA helped lay the groundwork in 2011 for Rwanda's fourth national census in 2012. GPS and other equipment provided by UNFPA to the National Institute of Statistics of Rwanda will be used by cartographers to update maps, ensuring all parts of the country are covered by the census, which will help "create and manage sound policies to appropriately address both current and future needs," says UNFPA Representative in Rwanda Victoria Akyeampong.

In 2011, UNFPA was the world's fourth-largest donor for statistical development, having contributed more than $30 million towards developing countries' data collection and analysis, according to the 2011 report of the Partnership in Statistics for Development in the 21st Century, PARIS21. This partnership is a joint effort of the United Nations, the European Commission, the Organisation for Economic Co-operation and Development, the International Monetary Fund and the World Bank. The PARIS21 Consortium includes national, regional and international statisticians, analysts, policymakers, development professionals and other users of statistics. It provides a forum and a network to promote, influence and facilitate statistical capacity development and the better use of statistics.

In 2011, UNFPA produced a documentary, *Counting the World*, that examines censuses in places as diverse as Belarus, Bolivia, Chad, Indonesia and the Occupied Palestinian Territory. The film, available at unfpa.org and youtube.com, covers all aspects

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of the process, starting from mapping a country or territory, and then figuring out which technologies should be employed, mobilizing and training legions of enumerators, conducting a public awareness campaign, canvassing all households, collecting individual information, compiling millions of questionnaires, and analysing and disseminating data.

The documentary highlights the importance of information about growth, movements, structures, living conditions, spatial distribution and natural resources of a country's population for policy formulation, planning and implementation, as well as for monitoring and evaluation. The unique advantage of the population and housing census is that it represents the entire statistical universe, down to the smallest geographical units.

The census helps policymakers plan for the future in terms of schools, hospitals, roads, urban infrastructure and more. It can measure fertility, mortality and spatial distribution, so as to predict and plan for demographic trends. It can uncover gender disparities in employment, literacy, age of marriage and assets. It can reveal the number of people with disabilities. It can also map out types of dwellings, sources of drinking water, access to telecommunications and patterns of energy use. It can also provide fertility and mortality data.

The world is undergoing the largest wave of urban growth in history, and the number of urban residents is projected to increase by nearly 2 billion in the next 20 years, mainly in developing countries. Cities can concentrate poverty, but for many people in developing countries, cities offer the best hope of escaping it.

With support from UNFPA in 2011, governments of countries such as Brazil, the Russian Federation and India collected or analysed data on urbanization to inform policies in areas that included gender and reproductive health. Fertility rates in cities, for example, are generally lower than in rural areas. But in poor, informal settlements within some cities, fertility rates are higher, reflecting the limited access to reproductive health services, including family planning.

The world is ageing rapidly. However, in most developing countries this issue has garnered only limited attention from policymakers. To address these challenges, UNFPA worked at global, regional and country levels to raise awareness of ageing populations and the need to include the concerns of older persons in national development plans and poverty reduction strategies.

UNFPA also took steps in 2011 to make population data more relevant for individuals. Through a new web application, 7 Billion and Me, at 7billionandme.org, users get a snapshot of the global population size and structure on the day they were born. UNFPA developed the application to draw attention to the world population's surpassing 7 billion in 2011.

Also in support of the 7 Billion Actions campaign, UNFPA and the corporation SAP built a population "dashboard," available at 7billionactions.org/data, that graphically shows trends such as ageing and the emergence of large youth cohorts.

Highlights

With assistance from UNFPA, **Afghanistan** completed a Socio-Demographic and Economic Survey in Bamiyan Province. UNFPA support included training for national and provincial staff of the Central Statistics Organization in collecting, processing, analysing and disseminating data.

The State Statistical Committee of **Azerbaijan** carried out a study on early marriages and the causes of divorce.

UNFPA helped **Benin** lay the groundwork for an upcoming general population and housing census through the training of census workers, including 50 statisticians and demographers.

UNFPA provided technical and financial support to the first population and housing census in **Chad** in nearly 20 years.

Djibouti tapped into data in 2011 from an earlier population and housing census to lay the groundwork for poverty and health surveys scheduled for 2012.

UNFPA and the Government of the **Dominican Republic** provided training and technical assistance to staff of the National Statistics Office to carry out censuses and other data collection and analysis.

Staff of the Bureau of Statistics of **Guyana** received training in 2011 in the use of GPS mapping in the lead-up to a national population and housing census scheduled for July 2012.

In the **Russian Federation**, UNFPA supported the statistics agency, ROSSTAT, to prepare for the country's first reproductive health survey, which will canvass 10,000 women of childbearing age in 60 regions.

The Government Statistical Office of **Viet Nam** carried out a survey of population change in 2011. UNFPA supported the undertaking through technical advice and training in data analysis and the use of census data for development planning.

Resources and Management

Revenue

Total revenue in 2011 reached a record $934 million.

This amount includes $450.7 million in voluntary donor contributions to UNFPA's un-earmarked funding and $38.7 million in other revenue, which supports UNFPA programmes in developing countries and is also used for administration and management, and $444.7 million in funds earmarked for trust funds and special initiatives administered by UNFPA. Figures are provisional as of 30 March 2012.

Included in revenue totals for 2011 are $4.9 million from foundations, $822,629 from corporations, $221,877 from non-governmental organizations or academic institutions, $52,746 from Americans for UNFPA and $68,496 from individuals.

Meanwhile, significant new partnerships and support from the private sector were announced in 2011, including a commitment by Johnson & Johnson to provide $4 million over four years to the "Health 4+" group of organizations (UNFPA, UNAIDS, UNICEF, the World Bank and the World Health Organization) for a joint effort to build human resources in the health sectors of developing countries, starting with Tanzania.

Private sector partners also made in-kind contributions to UNFPA in 2011, including 100,000 packages of sanitary napkins donated for the "dignity kits" that UNFPA distributed to women and girls affected by the conflict in Libya. In addition, a number of corporations, such as SAP and IBM, contributed staff resources and technical assistance to support the 7 Billion Actions campaign.

Expenses

From its regular resources in 2011, UNFPA spent $358.6 million on projects in developing countries. This amount includes $306.9 million on country and regional programmes and $51.7 million on global programmes. From its earmarked funds, UNFPA spent an additional $326.9 million on programmes in developing countries.

INCOME AND EXPENSES 2011
IN MILLIONS OF US$

INCOME
Statement of Financial Performance for the Biennium ended 31 December 2011

REVENUE	
Un-earmarked Contributions (incl. in-kind) 15	450.72
Earmarked Contribution Revenue 15	444.66
Other Revenue 16	38.65
TOTAL REVENUE	**934.02**
EXPENSES	
REGULAR RESOURCES	
Programme Expenses	358.56
Biennial Support Budget Expenses	128.54
Other (regionalization, Atlas, ERP, Security)	11.32
Total Expenses from Regular Resources	498.42
OTHER RESOURCES	
Programme Expenses	326.85
Junior Professional Officers	0.18
Procurement	(1.04)
Total Expenses from Other Resources	325.99
TOTAL EXPENSES	**824.41**
INCOME OVER EXPENSES	**109.61**

ALL FIGURES ARE PROVISIONAL as of 30 March 2012.
Totals may not add up due to rounding.

Two-fifths of UNFPA's expenditures from regular resources in 2011 supported programmes in sub-Saharan Africa. About 44 per cent of regular resources were directed towards initiatives that improve, strengthen or increase access to reproductive health.

Management highlights

In late 2011, UNFPA began implementing its new Business Plan, which aims to sharpen the focus of programmes to meet the most urgent needs at the country level. The Business Plan reinforces recommendations stemming from the organization's Midterm Strategic Review earlier in the year. A new organization-wide communications strategy developed in 2011 will reinforce implementation of the new Business Plan.

Among UNFPA's actions to improve accountability in 2011 was the establishment of an internal audit

TOP 20 DONORS TO UNFPA*
CONTRIBUTION IN US$

DONOR	REGULAR CONTRIBUTIONS[1]
Sweden	67,393,025
Netherlands	60,855,508
Norway	57,113,367
Finland	40,772,532
Denmark	37,794,985
United States	37,000,000
United Kingdom of Great Britain and Northern Ireland	32,208,207
Japan	25,438,946
Germany	21,972,498
Canada	17,868,177
Spain	16,000,000
Switzerland	14,861,996
Australia	10,388,205
Belgium	7,802,024
New Zealand	4,573,775
Ireland	4,295,775
Luxembourg	3,732,394
China	1,050,000
Austria	824,176
France	714,286

DONOR	CO-FINANCING CONTRIBUTIONS[2]
United Kingdom of Great Britain and Northern Ireland	135,167,388
United Nations Inter-Organisational Transfers[3]	106,586,154
European Union	40,526,495
Netherlands	37,967,928
Australia	25,782,802
Denmark	19,588,853
Sweden	10,945,082
France	7,737,381
Luxembourg	6,121,958
Norway	6,072,081
Colombia	5,508,600
Japan	5,500,000
Venezuela	5,077,175
Finland	4,468,189
Gates Foundation	2,441,535
Sierra Leone	2,224,742
Canada	1,417,516
United States	1,399,230
Ireland	1,333,333
Guatemala	1,161,401

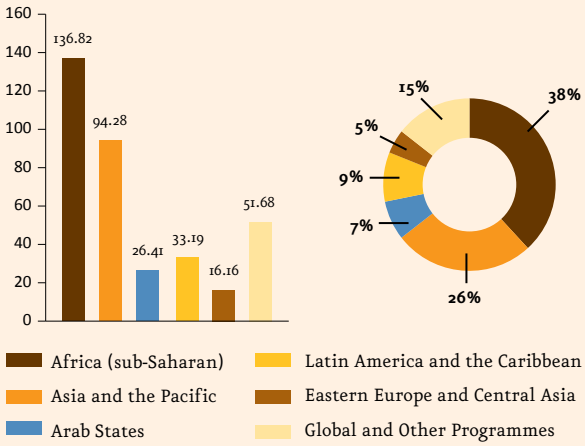
1 These figures represent actual contribution payments received in 2011 for regular resources. They are valued in US$ at the time they were received using the United Nations Operational Rate of Exchange (arranged in descending order).

2 These amounts represent contributions recognized during 2011 as per the agreements signed.

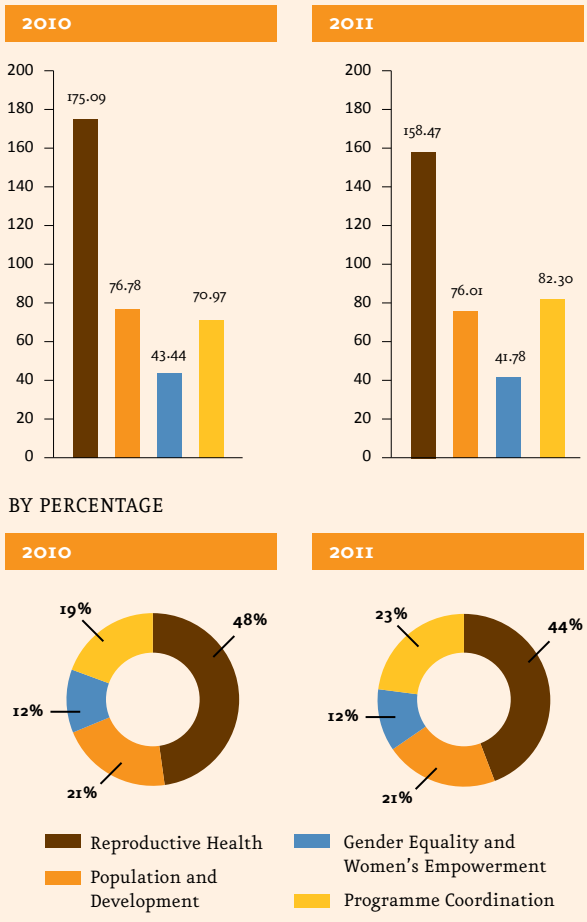
3 Includes Multi-donor Trust Funds and Joint Programme funds received through other United Nations Agencies as well as bilateral transfers from United Nations Agencies.

* ALL FIGURES ARE PROVISIONAL. Interim report prepared is based on preliminary data as of 30 March 2012.

UNFPA ASSISTANCE FOR 2011 BY GEOGRAPHICAL REGION
IN MILLIONS OF US$ AND BY PERCENTAGE
(Programme expenses from regular resources)



UNFPA ASSISTANCE BY PROGRAMME AREA
IN MILLIONS OF US$
(Programme expenses from regular resources)



EXPENSES FOR 2011 BY REGION
REGULAR RESOURCES

REGION	IN MILLIONS US$	% OF TOTAL PROGRAMME
SUB-SAHARAN AFRICA		
BY PROGRAMME AREA		
Reproductive health	59.24	43%
Population and development	29.38	21%
Gender equality and women's empowerment	18.76	14%
Programme coordination and assistance	29.44	22%
Total Region	**136.82**	**100%**
COUNTRY ACTIVITIES BY GROUP*		
GROUP A	123.84	91%
GROUP B	3.00	2%
GROUP C	0.05	0%
Total	126.88	93%
Country	126.88	93%
Regional activities	9.94	7%
Total Region	**136.82**	**100%**
ARAB STATES		
BY PROGRAMME AREA		
Reproductive health	12.85	49%
Population and development	4.68	18%
Gender equality and women's empowerment	3.25	12%
Programme coordination and assistance	5.64	21%
Total Region	**26.41**	**100%**
COUNTRY ACTIVITIES BY GROUP*		
GROUP A	12.28	46%
GROUP B	10.43	40%
GROUP C	0.71	3%
Other	0.20	1%
Total	23.62	89%
Country	23.62	89%
Regional activities	2.79	11%
Total Region	**26.41**	**100%**
EASTERN EUROPE AND CENTRAL ASIA		
BY PROGRAMME AREA		
Reproductive health	6.50	40%
Population and development	3.21	20%
Gender equality and women's empowerment	1.79	11%
Programme coordination and assistance	4.67	29%
Total Region	**16.16**	**100%**
COUNTRY ACTIVITIES BY GROUP*		
GROUP A	0.00	0%
GROUP B	6.40	40%
GROUP C	4.58	28%
Other	0.75	5%
Total	11.73	73%
Country	11.73	73%
Regional activities	4.43	27%
Total Region	**16.16**	**100%**

REGION	IN MILLIONS US$	% OF TOTAL PROGRAMME
ASIA AND THE PACIFIC		
BY PROGRAMME AREA		
Reproductive health	55.67	59%
Population and development	18.44	20%
Gender equality and women's empowerment	8.85	9%
Programme coordination and assistance	11.32	12%
Total Region	**94.28**	**100%**
COUNTRY ACTIVITIES BY GROUP*		
GROUP A	57.13	61%
GROUP B	20.36	22%
GROUP C	10.10	11%
Total	87.59	93%
Country	87.59	93%
Regional activities	6.70	7%
Total Region	**94.28**	**100%**
LATIN AMERICA AND THE CARIBBEAN		
BY PROGRAMME AREA		
Reproductive health	12.88	39%
Population and development	8.34	25%
Gender equality and women's empowerment	5.78	17%
Programme coordination and assistance	6.19	19%
Total Region	**33.19**	**100%**
COUNTRY ACTIVITIES BY GROUP*		
GROUP A	6.43	19%
GROUP B	16.93	51%
GROUP C	3.63	11%
Total	26.98	81%
Country	26.98	81%
Regional activities	6.21	19%
Total Region	**33.19**	**100%**
GLOBAL AND OTHER PROGRAMMES		
BY PROGRAMME AREA		
Reproductive health	11.33	22%
Population and development	11.97	23%
Gender equality and women's empowerment	3.36	6%
Programme coordination and assistance	25.03	48%
Total Global and Other Programmes	**51.68**	**100%**

*** About the country groupings**

Group A: Countries and territories in most need of assistance to realize goals of the International Conference on Population and Development

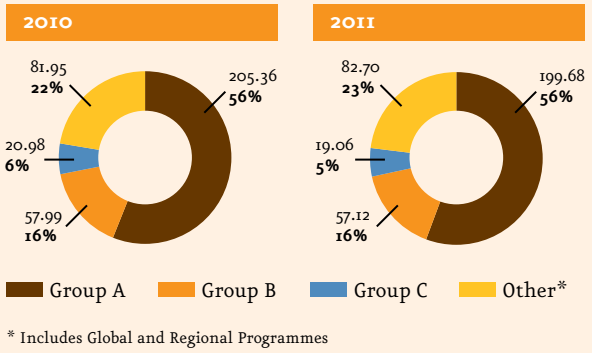
Group B: Countries that have made considerable progress towards achieving goals of the International Conference on Population and Development

Group C: Countries and territories that have demonstrated significant progress in achieving the goals of the International Conference on Population and Development

Other: Countries or territories that received technical assistance or project support from UNFPA but received no regular resources from UNFPA

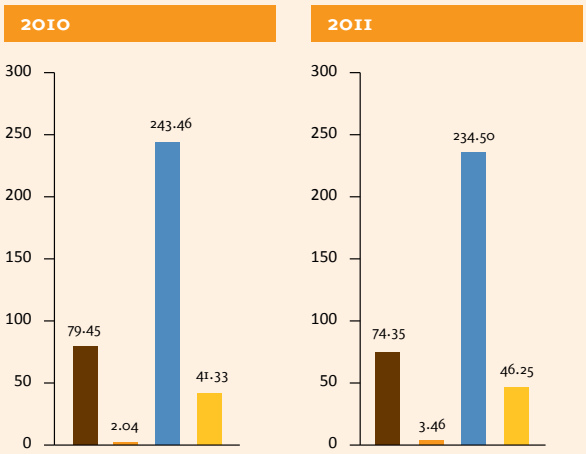
Percentages that are zero are the result of rounding.

REGULAR RESOURCES
EXPENSES BY COUNTRY GROUP
IN MILLIONS OF US$ AND AS A PERCENTAGE OF TOTAL

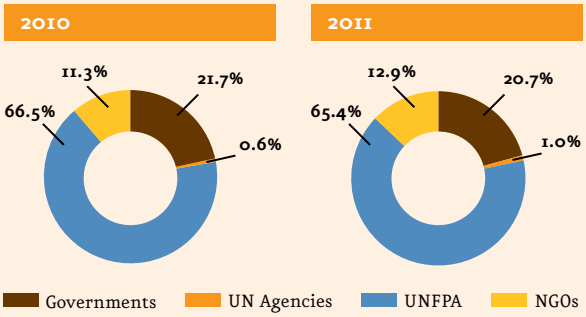


* Includes Global and Regional Programmes

UNFPA ASSISTANCE BY IMPLEMENTING AGENCY
IN MILLIONS OF US$
(Programme Expenses from Regular Resources)



BY PERCENTAGE



monitoring committee to ensure urgent implementation of recommendations by the United Nations Board of Auditors and by UNFPA's Internal Audit.

In response to the Midterm Strategic Review, UNFPA established a new framework for results-based management, and provided guidance for staff to make operations, programmes and administration more effective, and to document achievements to make the organization more accountable to people and donors alike.

In line with the Midterm Strategic Review and with the organization's new Business Plan, UNFPA became more field-focused in 2011. UNFPA finished moving its regional offices for the Arab States and for Eastern Europe and Central Asia to Cairo and Istanbul, respectively, in 2011.

UNFPA increased its humanitarian response capacity in 2011 by training 872 staff or representatives of partner organizations. UNFPA provided humanitarian services in 15 countries last year.

Staff worldwide benefited from knowledge-sharing activities, including webinars that reached more than 2,300 participants worldwide.

Also in 2011, UNFPA launched AccessRH, a new online system that allows governments and non-governmental partners to access product and pricing information about contraceptives and to procure and ensure their timely delivery.

Partnerships

UNFPA carries out much of its advocacy work through partnerships with local and international non-governmental, intergovernmental and other organizations. For example, in Lesotho, UNFPA partnered with local radio stations to broadcast messages on gender-based violence and youth issues. In Latin America, UNFPA formed an alliance with ELIGE/REDLAC, a youth network, to promote the participation of young leaders in discussions leading up to the twentieth anniversary of the International Conference on Population and Development in 2014. Similarly, UNFPA organized a meeting of 30 young parliamentarians in 2011 to inform them about and mobilize support for increased access to reproductive health, ending gender-based violence and promoting equal opportunities for women and men and boys and girls. In Turkey, UNFPA partnered with the Presidency of Religious Affairs to raise the awareness of 80 religious leaders about domestic violence. These leaders in turn trained 8,000 others to address this problem.

Where UNFPA Works

This map shows the 156 countries, territories and other areas where UNFPA worked in 2011 through a network of 112 country offices, five regional and six subregional offices and liaison offices in Brussels, Copenhagen, Geneva, Tokyo and Washington, DC. This map also illustrates maternal mortality ratios in countries, territories and other areas where UNFPA works and for which recent data are available. This map does not show maternal mortality ratios in major donor countries or places where UNFPA does not work. Next to the name of each of the countries, territories or other areas for which recent data are available is a number, showing the extent of progress towards Millennium Development Goal 5-A, reducing maternal mortality ratios annually since 1990 as follows:

1 Countries with maternal mortality ratios less than 50 in 1990.
2 Countries that are "*on track,*" with at least a 5.5% annual decline in maternal mortality ratios since 1990.
3 Countries that are "*making progress,*" with maternal mortality ratios that have fallen between 2% and 5.4% annually.
4 Countries that have made "*insufficent progress,*" with maternal mortality ratios that have fallen less than 2% annually.
5 Countries that have made "*no progress*" in reducing maternal mortality ratios.

Other countries and territories in which UNFPA works, but for which there is no recent data on maternal mortality ratios, are: Anguilla, Antigua and Barbuda, Bermuda, British Virgin Islands, Cayman Islands, Cook Islands, Dominica, Kiribati, Marshall Islands, Montserrat, Nauru, Netherlands Antilles, Niue, Palau, Samoa, Saint Kitts and Nevis, Tokelau, Turks and Caicos Islands, Tuvalu.

Maternal mortality ratios
(deaths per 100,000 live births)
in countries where UNFPA works

Greater than 1000

Chad 5
Sudan* 5

550-999

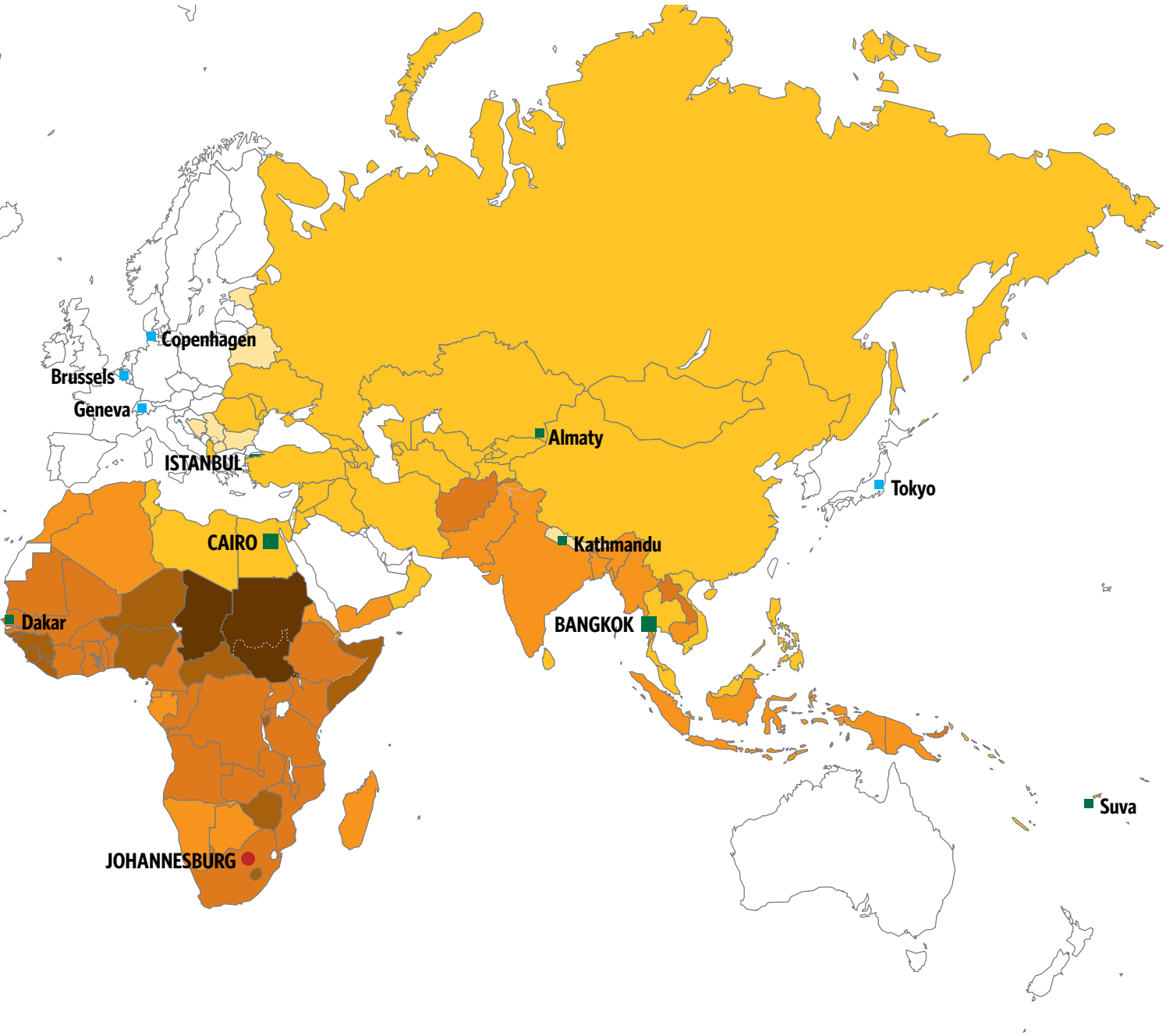
Burundi 4
Central African Republic 4
Guinea 3
Guinea-Bissau 4
Lesotho 5
Liberia 3
Niger 3
Nigeria 3
Sierra Leone 4
Somalia 5
Zimbabwe 5

300-549

Afghanistan 3
Angola 3
Benin 3
Burkina Faso 3
Cameroon 5
Congo 5
Côte d'Ivoire 3
Democratic Republic of the Congo 3
Ethiopia 3
Gambia 3
Ghana 3
Haiti 3
Kenya 4
Lao People's Democratic Republic 2
Malawi 3
Mali 3
Mauritania 4
Mozambique 3
Rwanda 3
Senegal 3
South Africa 5
Swaziland 5
Togo 3
Uganda 3
United Republic of Tanzania 3
Zambia 4

100-299

Algeria 3
Bangladesh 2
Bhutan 2
Bolivia (Plurinational State of) 3
Botswana 5
Cambodia 2
Comoros 3
Djibouti 4
Dominican Republic 3
Ecuador 3
Equatorial Guinea 2
Eritrea 2
Gabon 4
Guatemala 4
Guyana 5
Honduras 3
India 3
Indonesia 3
Jamaica 5
Madagascar 3
Micronesia 4
Morocco 3
Myanmar 3
Namibia 5
Nepal 2
Pakistan 3
Papua New Guinea 3
Paraguay 4
Suriname 5
Timor-Leste 2
Tonga 5
Vanuatu 3
Yemen 3



20-99

Albania	1
Argentina	5
Armenia	1
Azerbaijan	1
Bahamas	1
Barbados	3
Belize	4
Brazil	3
Cape Verde	3
Chile	1
China	1
Colombia	3
Costa Rica	1
Cuba	5
El Salvador	3
Egypt	2
Fiji	1
Georgia	5
Grenada	1
Iran (Islamic Republic of)	1
Iraq	4
Jordan	3
Kazakhstan	3
Kyrgyzstan	4
Lebanon	1
Libya	3
Malaysia	1
Maldives	2
Mauritius	4
Mexico	3
Mongolia	3
Nicaragua	3
Occupied Palestinian Territory	4
Oman	1
Panama	4
Peru	3
Philippines	3
Republic of Moldova	1
Romania	1
Russian Federation	1
Saint Lucia	1
São Tomé and Principe	3
Solomon Islands	3
Sri Lanka	1
Saint Vincent and the Grenadines	1
Syrian Arab Republic	2
Tajikistan	4
Thailand	1
Trinidad and Tobago	1
Tunisia	3
Turkey	1
Turkmenistan	4
Ukraine	1
Uruguay	1
Uzbekistan	1
Venezuela (Bolivarian Republic of)	4
Viet Nam	2

Less than 20

Belarus	1
Bulgaria	1
Bosnia and Herzegovina	1
Estonia	1
Serbia**	1
The former Yugoslav Republic of Macedonia	1

**Maternal mortality ratios for Sudan are from 2010, before South Sudan became a state in 2011. The border between Sudan and South Sudan, however, is indicated on the map.*
***Includes programmes in Kosovo.*

The designations employed and the presentation of material on the map do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties.

2011 PROGRAMME EXPENSES
IN THOUSANDS OF US$ (Includes Regular and Other Resources)

SUB-SAHARAN AFRICA

Angola	2,313
Benin	3,639
Botswana	1,761
Burkina Faso	9,139
Burundi	2,712
Cameroon	4,187
Cape Verde	1,531
Central African Republic	4,876
Chad	7,182
Comoros	1,508
Congo	2,901
Côte d'Ivoire	9,109
Democratic Republic of the Congo	13,602
Equatorial Guinea	1,417
Eritrea	3,203
Ethiopia	19,078
Gabon	1,662
Gambia	1,778
Ghana	3,710
Guinea	3,849
Guinea-Bissau	2,592
Kenya	6,022
Lesotho	2,310
Liberia	4,914
Madagascar	7,279
Malawi	5,843
Mali	4,630
Mauritania	2,869
Mauritius	57
Mozambique	11,833
Namibia	2,802
Niger	9,591
Nigeria	12,803
Rwanda	5,840
São Tomé and Principe	793
Senegal	5,449
Seychelles	16
Sierra Leone	8,714
South Africa	1,934
South Sudan	8,364
Swaziland	2,456
Togo	2,049
Uganda	18,670
United Republic of Tanzania	9,867
Zambia	3,597
Zimbabwe	12,481
Total country programmes	*252,933*
Regional programmes	**14,089**
Total	267,022

ASIA AND THE PACIFIC

Afghanistan	9,140
Bangladesh	17,812
Bhutan	1,321
Cambodia	4,884
China	2,957
Democratic People's Republic of Korea	1,181
India	14,022
Indonesia	5,099
Iran (Islamic Republic of)	1,532
Lao People's Democratic Republic	3,799
Malaysia	393
Maldives	426
Mongolia	3,829
Myanmar	8,242
Nepal	6,068
Pakistan	21,020
Pacific Island countries and territories[a]	4,527
Papua New Guinea	2,706
Philippines	9,287
Sri Lanka	3,204
Thailand	2,103
Timor-Leste	3,643
Viet Nam	7,293
Total country programmes	*134,489*
Regional programmes	**8,649**
Total	143,138

ARAB STATES

Algeria	592
Djibouti	1,594
Egypt	3,534
Iraq	5,355
Jordan	1,067
Lebanon	1,339
Morocco	2,597
Occupied Palestinian Territory	3,944
Oman	656
Republic of Yemen	3,474
Somalia	4,052
Sudan	13,003
Syrian Arab Republic	4,022
Tunisia	948
Total country programmes	*46,176*
Regional programmes	**4,108**
Total	50,284

EASTERN EUROPE AND CENTRAL ASIA

Albania	2,075
Armenia	662
Azerbaijan	863
Belarus	502
Bosnia and Herzegovina	882
Bulgaria	182
Georgia	1,348
Kazakhstan	568
Kyrgyzstan	1,010
Moldova, Republic of	662
Romania	184
Russian Federation	1,340
Serbia[b]	1,110
Tajikistan	936
The former Yugoslav Republic of Macedonia	515
Turkey	1,350
Turkmenistan	763
Ukraine	682
Uzbekistan	1,168
Total country programmes	*16,801*
Regional programmes	**5,789**
Total	22,590

LATIN AMERICA AND THE CARIBBEAN

Argentina	827
Bolivia (Plurinational State of)	3,041
Brazil	2,675
Chile	223
Colombia	9,268
Costa Rica	1,121
Cuba	745
Dominican Republic	1,465
Ecuador	2,717
El Salvador	2,733
Caribbean countries and territories[c]	3,116
Guatemala	6,581
Haiti	7,411
Honduras	2,885
Mexico	2,598
Nicaragua	6,984
Panama	1,350
Paraguay	931
Peru	2,908
Uruguay	1,737
Venezuela (Bolivarian Republic of)	5,011
Total country programmes	*66,326*
Regional programmes	**12,528**
Total	78,854
Global programmes and other activities	123,525
TOTAL PROGRAMME EXPENSES	**685,412**

TOTAL PROGRAMME EXPENSES

Country programmes	516,724
Regional programmes	45,163
Global and other programmes	123,525
Procurement services, junior professional officers and other programmes	(862)
GRAND TOTAL	684,550

Note: This schedule provides a breakdown of programme expenses by region and by country during the year 2011.

a Figures for Pacific multi-islands comprise several islands which, for reporting purposes, are classified under one heading, including the Cook Islands, Fiji, Kiribati, the Marshall Islands, the Federated States of Micronesia, Nauru, Niue, Palau, Samoa, the Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu.

b Includes programmes in Kosovo.

c Figures for Caribbean, English- and Dutch-speaking, comprise several countries and islands which, for reporting purposes, have been classified under one heading, including Anguilla, Antigua and Barbuda, the Bahamas, Barbados, Belize, Bermuda, the British Virgin Islands, the Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, Saint Kitts, Saint Lucia, Saint Vincent and the Grenadines, the Netherlands Antilles, Suriname, Trinidad and Tobago, and the Turks and Caicos Islands.

2011 DONOR COMMITMENTS AND PAYMENTS
CONTRIBUTIONS TOWARDS REGULAR RESOURCES IN US$

DONOR	COMMITMENT FOR CURRENT YEAR	PAYMENTS RECEIVED
Afghanistan	500	–
Albania	1,000	–
Andorra	21,552	21,552
Angola	15,000	15,000
Antigua and Barbuda	1,000	–
Argentina	2,500	–
Armenia	2,500	2,500
Australia	10,388,205	10,388,205
Austria	824,176	824,176
Azerbaijan	5,078	5,078
Bahamas	1,000	–
Bangladesh	27,981	27,981
Barbados	5,000	5,000
Belgium	7,398,083	7,802,025
Belize	2,500	–
Benin	4,000	–
Bhutan	–	5,950
Bolivia (Plurinational State of)	1,000	1,000
Botswana	5,000	–
Burkina Faso	8,013	–
Burundi	769	769
Cambodia	8,264	8,264
Cameroon	20,763	–
Canada	17,686,035	17,868,177
Chad	44,851	–
Chile	5,000	10,000
China	1,050,000	1,050,000
Colombia	10,000	10,000
Congo	50,082	52,119
Cook Islands	1,144	1,164
Costa Rica	5,794	5,308
Côte d'Ivoire[3]	10,000	–
Cuba	5,000	5,000
Cyprus	5,760	11,000
Czech Republic	20,000	20,000
Denmark	37,484,001	37,794,985
Djibouti	3,000	3,000
Dominican Republic	30,000	60,000
Ecuador	1,000	5,000
El Salvador	1,000	–
Equatorial Guinea[3]	41,029	–
Eritrea	4,000	4,000
Estonia	40,928	40,928
Ethiopia	1,769	3,578
Fiji	3,804	2,732
Finland	40,598,291	40,772,532
France	714,286	714,286
Gabon[1]	10,016	10,016
Gambia[2]	11,029	–
Georgia	3,500	3,500
Germany	21,972,497	21,972,497
Ghana	12,500	–
Greece	–	10,000
Guatemala	9,997	–
Guinea-Bissau	1,000	–
Guyana	500	500
Honduras	840	840
Hungary	–	40,000
Iceland	171,592	71,592
India	495,028	495,028
Indonesia	40,721	40,721
Iran (Islamic Republic of)	60,000	–
Iraq	10,000	10,000
Ireland	4,295,775	4,295,775
Israel	20,000	20,000
Italy	394,218	412,088
Japan	25,438,946	25,438,946
Kazakhstan	50,000	50,000
Kenya	9,610	9,610
Kiribati	195	195
Kuwait	10,000	10,000
Lesotho	2,656	5,565
Liberia	10,000	–
Liechtenstein	21,164	–
Luxembourg	3,482,260	3,732,394
Malaysia	200,000	200,000
Maldives	5,000	5,000
Mali	6,010	–
Mauritania	3,351	–
Mauritius	3,454	3,454
Mexico	100,785	100,785
Moldova	3,000	3,000
Monaco	20,035	20,035
Mongolia	1,500	6,646
Morocco	314	10,539
Myanmar	253	481
Nepal	9,662	9,662
Netherlands	59,912,676	60,855,508
New Zealand	4,573,775	4,573,775
Nicaragua	2,000	2,000
Niger	10,000	–
Nigeria[3]	31,166	–
Niue	38	–
Norway	55,742,109	57,113,367
Oman[2]	10,000	10,000
Pakistan	533,466	–
Palau	–	500
Panama	10,000	10,000
Papua New Guinea	4,808	–
Paraguay	500	500
Philippines	20,000	53,776
Poland	10,000	10,000
Portugal	363,372	363,372
Private Contributions	91,025	91,025
Qatar	30,000	30,000
Republic of Korea	100,000	100,000
Romania	10,201	10,201
Russian Federation	300,000	300,000
Rwanda[2]	500	–
Samoa	3,000	–
São Tomé and Principe	20,773	19,803
Saudi Arabia	500,000	1,500,000
Seychelles	3,100	3,100
Sierra Leone	7,273	–
Singapore	5,000	5,000
Slovak Republic	3,914	3,914
Solomon Islands	1,000	–
South Africa	28,893	55,569
Spain	16,000,000	16,000,000
Sri Lanka	18,000	18,000
Suriname	100	–
Swaziland	10,000	–
Sweden	69,370,912	67,393,025
Switzerland[4]	–	14,861,996
Syrian Arab Republic	11,221	11,221
Tajikistan	189	189
Thailand	96,000	96,000
The former Yugoslav Republic of Macedonia	3,000	–
Timor-Leste	3,050	3,050
Togo	13,030	19,545
Tokelau	4,828	4,828
Tonga	100	–
Trinidad and Tobago	5,000	–
Tunisia	16,447	16,447
Turkey	150,000	150,000
Tuvalu	3,000	–
Uganda[2]	10,000	–
United Arab of Emirates	10,000	10,000
United Kingdom of Great Britain and Northern Ireland	30,864,198	32,208,207
United Republic of Tanzania	4,120	8,031
United States of America	37,000,000	37,000,000
Uruguay	–	3,000
Uzbekistan	1,211	1,211
Viet Nam	4,744	17,512
Yemen Arab Republic	30,000	–
Zambia	4,000	–
Zimbabwe	20,000	20,000
Others	948,620	1,339,240
Governments' local contributions	357,516	357,516
Adjustments for prior years[1, 2, 3]	(21,352)	
GRAND TOTAL	**450,714,589**	**469,180,609**

1 Gabon commitment corrected for $108,037 contribution to co-financing mis-recorded as regular resources in prior year.

2 Gambia, Oman, Rwanda and Uganda commitments adjusted in 2011 for change in revenue recognition policy.

3 Payments received in prior years from Côte d'Ivoire, Equatorial Guinea and Nigeria were reclassified to revenue from deferred income per new policy.

4 Switzerland's $14,462,810 commitment for 2011 was recorded in 2010 revenue per earlier revenue recognition policy.

UNITED NATIONS POPULATION FUND
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