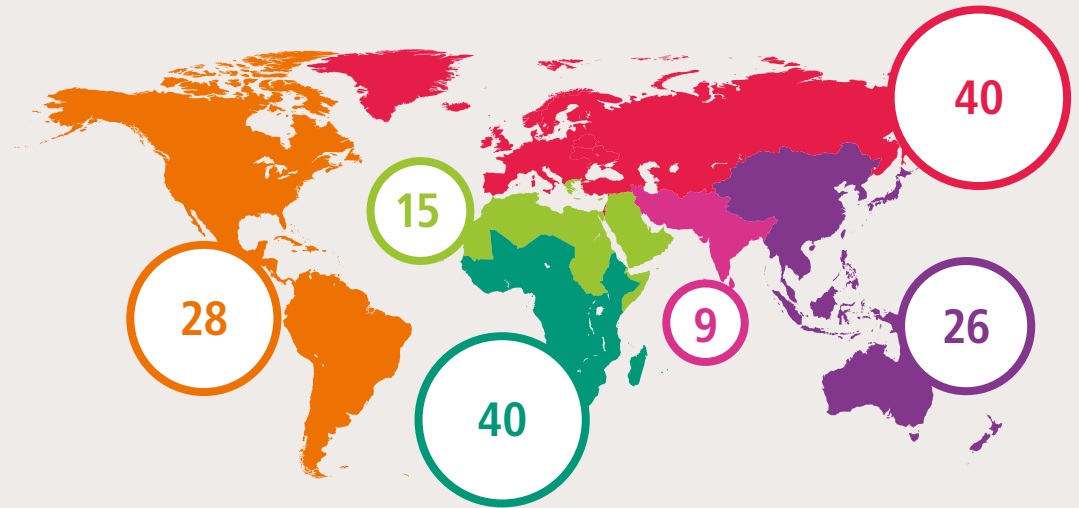




ANNUAL PERFORMANCE REPORT 2014–2015

Who we are

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



158 Member Associations
and collaborative partners

Millions of volunteers

32,000+ staff

83% of Member Associations
have a written HIV
workplace policy on
non-discrimination

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

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

Acknowledgements

We would like to express thanks to Member Association, Regional Office and Central Office volunteers and staff who have contributed to this report.

Editorial

Heidi Gagnebe-Marriott
Tremayne Stanton-Kennedy

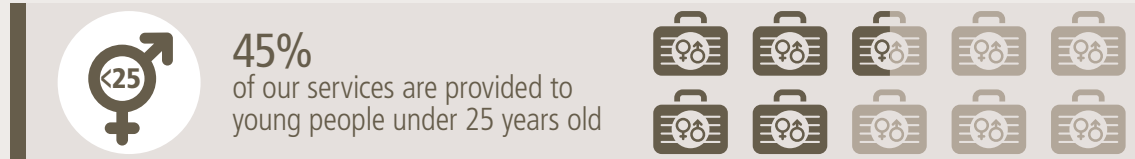
Data analysis

Mahua Sen

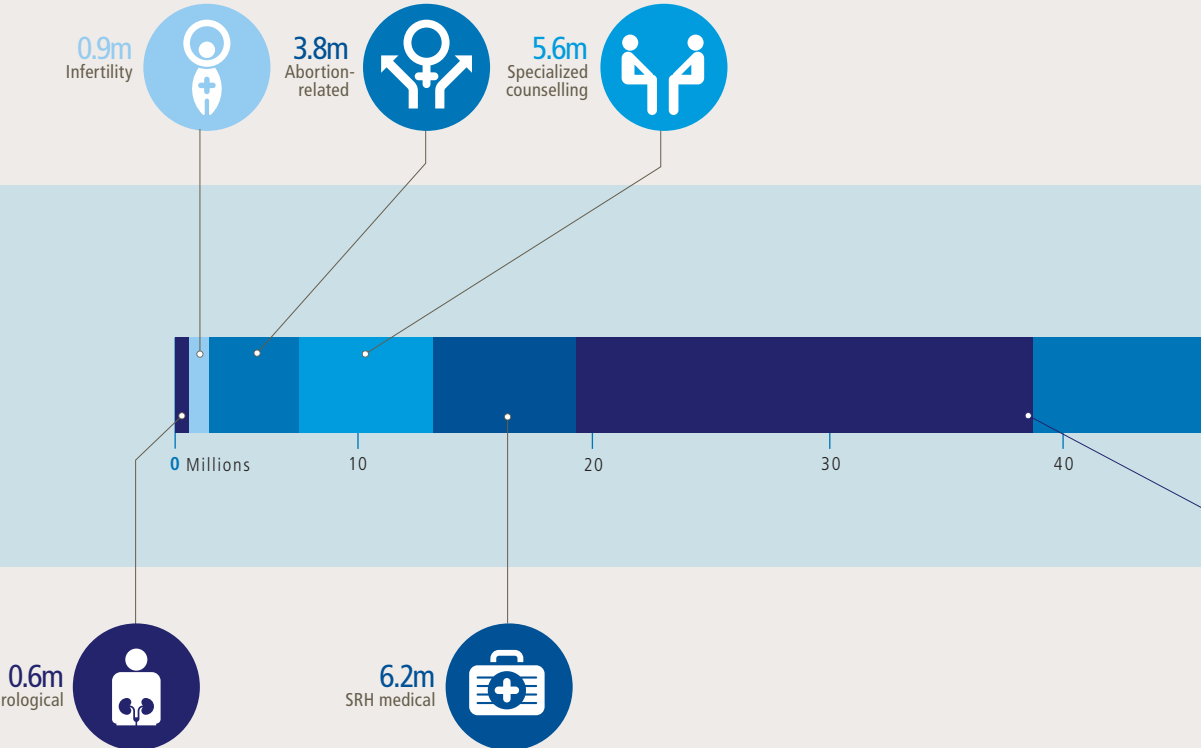
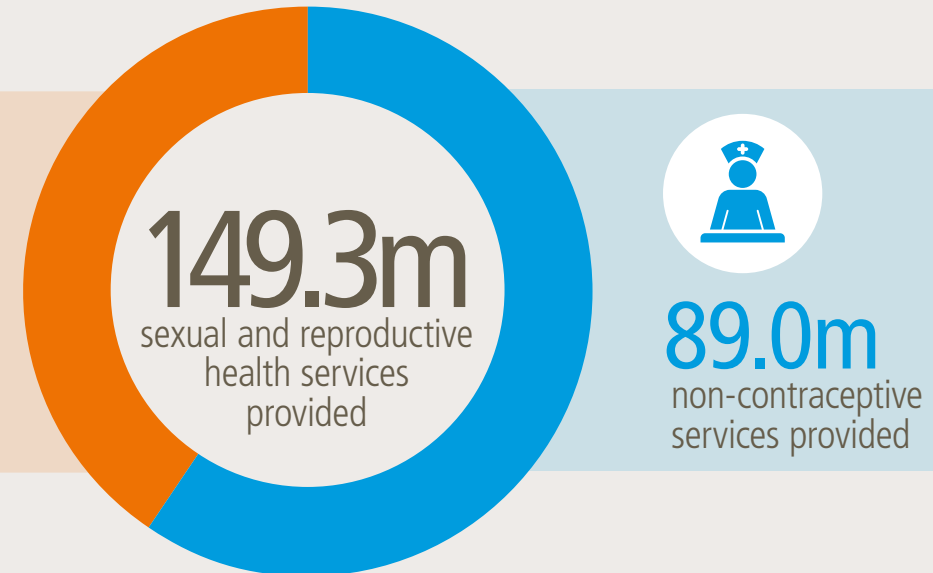
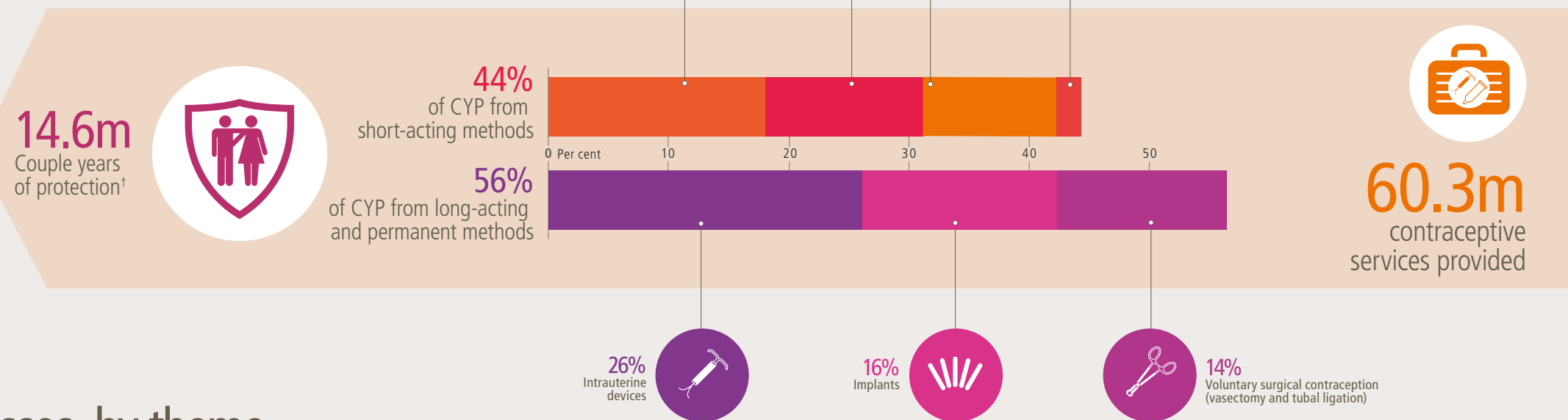
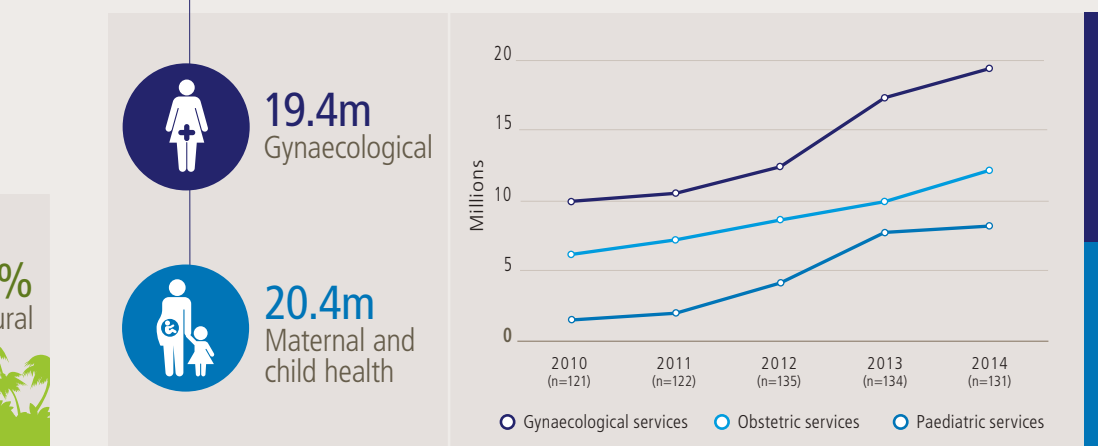
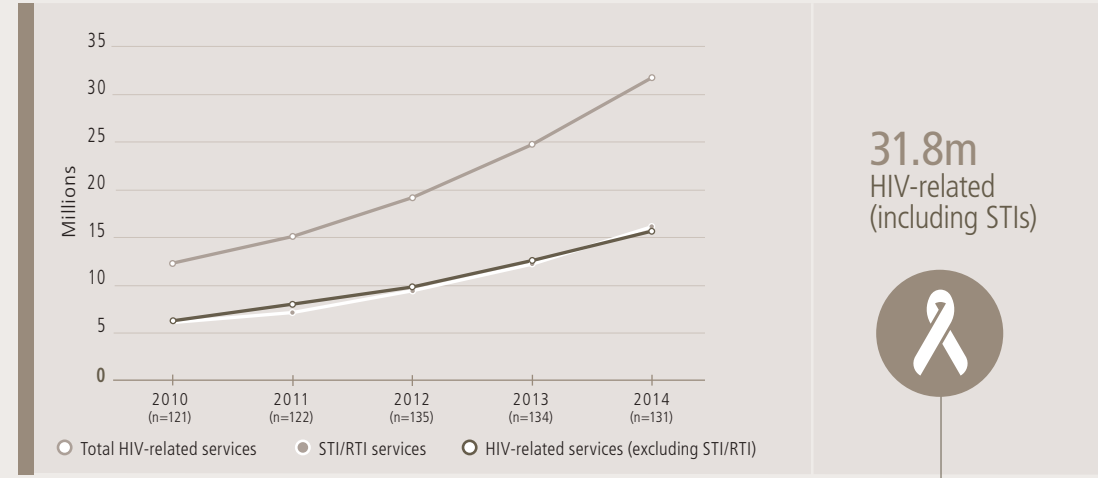
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IPPF's results in 2014*



Advocacy successes, by theme



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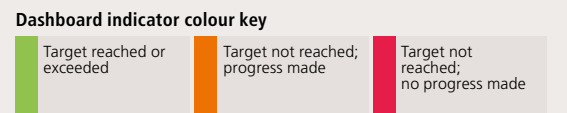
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* Due to rounding, numbers presented throughout this document may not add up precisely to the totals provided and percentages may not precisely reflect the absolute figures. † Couple years of protection refers to the total number of years of contraceptive protection provided to a couple. The numbers of unintended pregnancies and unsafe abortions averted are estimated using Marie Stopes International's Impact 2 model.

Foreword

There is much to celebrate from our 2014 results with success in each of IPPF's three Change Goals: Unite, Deliver and Perform. As the current *Strategic Framework* draws to a close, we continue to strengthen our efforts to maximize the impact we have.

Our three Change Goals guide us in prioritizing our work in delivering the *Strategic Framework 2005–2015*. We use our Performance Dashboard of indicators to closely monitor progress on an annual basis, and results presented in this *Annual Performance Report 2014–2015* show that our performance remains strong and that we have surpassed many of our ambitious targets.

In 2014, IPPF worked hard to influence governments and other key decision makers at national, regional and global levels. Member Associations and collaborating partners in 55 countries contributed to 81 changes in policy or legislation that support or defend sexual and reproductive health and rights, and that cover a range of themes. At the regional and global levels, IPPF's advocacy contributed to 18 changes of which 12 were advances in safeguarding sexual and reproductive health and rights and gender equality in the new Sustainable Development Goals. We worked strategically with national governments and multilateral organizations, and with other civil society organizations to influence in the BRICS countries. Our popular and successful campaign, *I Decide*, showed that people across the world support sexual and reproductive health and rights for all.

With the delivery of 149.3 million sexual and reproductive health services in 2014, I am pleased to report that we remain on course to reach our target of doubling services between 2010 and 2015. Nearly one in two of our services was provided to a young person under the age of 25. Our commitment to reaching those who are most in need of sexual and reproductive health information and services is

unwavering with an estimated 52.6 million of our clients being poor or vulnerable. This represents 85 per cent of our total number of service users, which is the highest proportion ever recorded for IPPF. The 14.6 million couple years of protection that IPPF provided in 2014 represents a significant increase of 21 per cent from 2013. Examples from programmes implemented by Member Associations highlighted in this report illustrate our strong performance in service provision, while remaining fully committed to quality assurance and meeting the needs of the under-served.

To strengthen organizational effectiveness, five regions now implement the performance-based funding system that rewards high performing Member Associations with increased resources. Peer learning and sharing between Member Associations were key areas of investment in 2014, and contributed to enhanced capacity building and programme development. Improved business processes and systems are leading to more cost-effective service delivery. Our data remain an invaluable asset to us in providing key information for decision making, and examples of how this has led to improvements in performance can be found in the Perform section.

The process of developing IPPF's *Strategic Framework 2016–2022* continued throughout 2014, and IPPF's Governing Council approved the *Framework* in November. Currently, country strategies and strategic plans are being developed by Member Associations and the Secretariat, as well as a Performance Dashboard to monitor progress

between 2016 and 2022. Full implementation of the new *Strategic Framework* will begin in January 2016 and IPPF is excited about moving into the next ambitious phase of our history.

I would like to express my sincere gratitude to IPPF volunteers, staff and partners for all that you have contributed, and the differences you have made. These are your results and I hope you are proud of all you have achieved in the last year. We are providing sexual and reproductive health information and services to millions of people, reaching more of the under-served than ever before and strengthening public, political and financial commitment to sexual and reproductive health and rights. We have achieved much, though we still have far to go.

I look forward to working with all of you to build a world without discrimination where all people are free to make choices about their sexuality and well-being.

Tewodros Melesse,
Director-General, IPPF



unite a global movement fighting for sexual rights and reproductive rights for all

In 2014, the Federation implemented its largest-ever international advocacy programme, continuing and building on its role as a leading civil society voice for sexual and reproductive health and rights with a focus on the new Sustainable Development Goals.

Throughout 2014, IPPF continued to build public, political and financial support for sexual and reproductive health and rights. Progress on IPPF's advocacy performance targets is presented in Figure 1. Unite performance indicators U.1 and U.2 both surpassed their 2014 targets. Member Associations and collaborating partners in 55 countries contributed to 81 policy and legislative changes in support of sexual and reproductive health and rights in their countries. These successes cover a range of themes, as illustrated in Figure 2, and many focus on controversial issues. In 2014, five of the policy and legislative changes supported the sexual and reproductive health and rights of the most vulnerable; 19 changes promoted or defended the rights of women who choose to terminate an unwanted pregnancy; and 22 increased national budget allocations for contraception or access to contraception. IPPF's advocacy work also involves resisting powerful opposition groups driven by political, religious and cultural forces, and defending hard won positions in support of sexual and reproductive health and rights. In 2014, Member Associations blocked ten changes that would have negatively impacted on the sexual and reproductive health and rights, as well as the gender equality, of millions of people in countries as diverse as Latvia, the Philippines and Puerto Rico. Six of these wins were in Europe and defended a woman's right to choose an abortion.

In regional and international fora, IPPF advocacy efforts resulted in 18 policy and legislative changes. Of these, 12 were in support of sexual and reproductive health and rights and gender equality in the new Sustainable

Figure 1: Unite – performance results in 2014



Development Goals. IPPF worked with regional groups, including parliamentarians and first ladies, and utilized the United Nations' Commissions on the Status of Women, and on Population and Development, as well as the 20-year review of the *Beijing Declaration and Platform for Action*, to secure high-level commitments and advances.

In 2014, 54 per cent of Member Associations monitored how their governments were implementing obligations derived from international human rights treaties which they have ratified. This is a slight drop of 1 per cent from 2013, and the target of 58 per cent was missed. However, this result still illustrates the unwavering commitment of these Member Associations to hold their governments to account on promises they have made, and to ensure policies are implemented. Examples of this work from the European Network are described in detail in the Perform section, demonstrating how Member Associations share technical expertise and knowledge on using human rights instruments in extremely complex bureaucratic systems.

Since the beginning of IPPF's current *Strategic Framework* in 2005, Member Associations have contributed to an impressive 734 advocacy wins in 150 countries. This remarkable achievement impacts positively on millions of lives across the globe: increasing access to information, education and services; helping people to realize their sexual and reproductive rights; reducing stigma and discrimination; and ensuring the poorest and most vulnerable are heard. As a leading global advocate on sexual and reproductive health and rights, IPPF plays a critical role in encouraging governments and other key decision makers at national, regional and international levels to promote and defend sexual and reproductive health and rights. In this section, we highlight some of the advocacy successes from 2014, including our work to influence the new Sustainable Development Goals.

Figure 2: Number of policy and/or legislative changes, by theme, 2014



In 2014, Member Associations and collaborative partners contributed to

81 policy and/or legislative changes

in support or defence of sexual and reproductive health and rights in

55 countries.

Influencing the post-2015 framework

IPPF promotes sexual and reproductive health and rights by engaging with decision makers in national governments, regional institutions and at international fora. During 2014, IPPF mobilized Member Associations and other civil society organizations around the world to promote sexual and reproductive health and rights as central to the new Sustainable Development Goals including through the International Conference on Population and Development (ICPD) review process. IPPF advocated to governments, United Nations agencies and other decision makers to:

- create a goal on gender equality, women's rights and women's empowerment, including universal access to sexual and reproductive health and rights, elimination of violence against women and girls and gender-based violence, legal equality for women, and women's equal participation in public life and decision making
- make universal access to sexual and reproductive health and rights a target under a goal on health, with sexual and reproductive health services included in the package of essential services for universal health coverage and care proposed by the World Health Organization
- mainstream gender equality and sexual and reproductive health and rights in other goals, and to disaggregate data by age and sex

At a series of key moments in 2014 and 2015, IPPF emphasized sexual and reproductive health and rights by speaking on high-level panels, producing persuasive briefings, collaborating with like-minded partners, hosting influential events and launching IPPF's worldwide *I Decide* campaign.

2014 YEAR ROUND The Open Working Group, New York

IPPF and partners succeeded in ensuring that sexual and reproductive health and rights were mentioned at every stocktaking and consensus building session held by the Open Working Group of 70 governments tasked with developing the new Sustainable Development Goals.

Facilitated by IPPF's new United Nations liaison office and the High-Level Task Force for the ICPD, IPPF worked with women's and youth coalitions to amplify the collective call for change at the United Nations. Advocacy by Member Associations strengthened support for sexual and reproductive health and rights at the national level. Endorsement was secured from governments in every region of the world, and the Open Working Group's final report represented an advance on the Millennium Development Goals with proposals for a goal on gender equality and women's empowerment, and with targets on sexual and reproductive health and reproductive rights.

2014 MAY World Health Assembly, Geneva

At the 67th World Health Assembly, IPPF called on ministers of health and the World Health Organization to go beyond the existing Millennium Development Goal 5b and to prioritize targets on sexual and reproductive health and rights in the new Sustainable Development Goals. IPPF called for inclusion of family planning in the *Every Newborn Action Plan* and for an indicator on access to affordable essential drugs and commodities, including contraception, reproductive health care, and maternal and child health supplies.

2014 MAY/ONWARDS *I Decide* campaign, worldwide

IPPF's global *I Decide* campaign, launched on the *Vision 2020* day of action in May 2014, has secured popular support from around the world. To date, more than 400,000 people have signed IPPF's petition calling on leaders across the world to support sexual and reproductive health and rights so that everyone can decide what happens to their body, who they live with and the size of their family. Campaign messages were shared with supporters through social media, videos, email action alerts and events. During the United Nations General Assembly in September 2014, an estimated 2 million people were reached through a social media Thunderclap and campaign messages from around the world were displayed in New

York's Times Square. IPPF's social media campaign won a prize at the Population Institute's 35th media awards, and will continue until the petition is handed in ahead of the 2015 United Nations General Assembly.

2014 JUNE Partnership for Maternal, Newborn and Child Health (PMNCH) Partners' Forum, South Africa

IPPF hosted an event with USAID and the World Health Organization at the Partners' Forum. The event focused on the importance of sexual and reproductive health and rights in the new Sustainable Development Goals, and attracted high-level participants including government ministers.

2014 SEPTEMBER United Nations General Assembly, New York

As the first civil society speaker at the Special Session on the ICPD at the United Nations General Assembly, IPPF's Director-General challenged world leaders to take action on sexual and reproductive health and rights. He called for the ICPD commitments to be included in the new Sustainable Development Goals, and to put women and girls at the centre of the global development agenda.

With support from the governments of Liberia and Norway, and the Permanent Mission of Denmark to the United Nations, IPPF's President chaired an event to increase the visibility of sexual and reproductive health and rights as a critical component of the new Sustainable Development Goals. The State Secretary of the government of Norway emphasized the need to recognize and protect individual human rights, including sexual rights. The Speaker of the Cook Islands Parliament outlined the challenges of ensuring access to sexual and reproductive health services for a geographically-dispersed population. Liberia's Minister of Gender and Development reiterated her government's support for sexual and reproductive health and rights, highlighting the impact these services make, especially in a country facing challenges such as Ebola. IPPF's Director-General concluded the event with a call to governments to ensure sexual and reproductive health and rights are realized for all.

Also, at the United Nations General Assembly, the IPPF Africa Regional Office convened an event of first ladies from Algeria, Chad, Comoros, the Democratic Republic of Congo, Ghana, Mali, Namibia, Rwanda and Zambia, together with advisers from the Gambia, Kenya and Uganda, to discuss the *Common African Position on the Post-2015 Development Agenda*. The first ladies called on leaders to prioritize women's health and access to sexual and reproductive health and rights.

2014 OCTOBER/ ONWARDS

The Global Financing Facility

The World Bank and governments of Canada, Norway and the United States have created the innovative Global Financing Facility (GFF) that aims to mobilize funds for reproductive, maternal, newborn, child and adolescent health (RMNCAH) in support of the United Nations *Every Woman Every Child* global movement, and the delivery of the new Sustainable Development Goals. The GFF's aims are to improve the health and quality of life of women, adolescents and children, as well as to reduce the numbers of preventable stillbirths, and maternal and child deaths by 2030.

IPPF mobilized civil society advocates to analyse intelligence on the GFF from the World Bank and governments, and to call for stronger accountability mechanisms, transparency, specific funding for reproductive health commodities and more consultation with key stakeholders, including civil society. IPPF advocated at various meetings with World Bank officials and engaged with allies on the development of the GFF's business plan.

2014 DECEMBER

United Nations Secretary-General's report

When the United Nations Secretary-General released the unedited version of *Road to Dignity by 2030: Ending Poverty, Transforming All Lives and Protecting the Planet*, a report on the new Sustainable Development Goals,

IPPF immediately responded to the United Nations Secretary-General's office to successfully secure references to sexual health in the final version.

2015 MARCH

The United Nations Commission on the Status of Women

In the build-up to the 20th anniversary of the *Beijing Declaration and Platform for Action*, a series of national and regional reviews, and ultimately a global review, were conducted to assess progress. The *Platform for Action* focused on promoting women's participation in decision making, eliminating violence against women, increasing resources for women's health, and initiatives to address sexual and reproductive health. IPPF's second report in the *Vision 2020* series, *Sexual and Reproductive Health and Rights: The Key to Gender Equality and Women's Empowerment*, was launched at the Commission on the Status of Women. The report provided evidence of how sexual and reproductive health and rights are critical to achieving gender equality and women's full participation in social, economic, public and political life, and why a target on sexual and reproductive health and rights must be included under a Sustainable Development Goal on gender equality and women's empowerment.

2015 APRIL

The United Nations Commission on Population and Development

The 48th session of the Commission on Population and Development was called *Realizing the Future We Want* and debated integration of population issues into sustainable development, including the new Sustainable Development Goals. IPPF supported 21 people on official government delegations, and also organized and participated in civil society pre-meetings and regional and youth caucuses. Throughout the negotiations, IPPF advocated for the inclusion of progressive text and for supportive government statements.

Increasing advocacy on the Sustainable Development Goals

IPPF provided national civil society organizations outside the Federation with small grants to support their efforts to secure sexual and reproductive health and rights as priorities with their governments. The grants enabled these organizations to meet with government delegates and to influence official statements and negotiating positions.

IPPF's small grants programme has supported over 30 grants in 25 countries. The following examples show how four civil society organizations used the grants:

Benin

Coordinated meetings with the government to shape thinking on both the review of the International Conference on Population and Development and the new Sustainable Development Goals.

Kyrgyzstan

Organized national consultations to gather young people's priorities for the new Sustainable Development Goals and provided input into the government's position on sexual and reproductive health and rights.

Liberia

Conducted network building and training for other civil society organizations, including legal and media organizations, resulting in new coalition partners promoting sexual and reproductive health and rights.

Nepal

Produced regular radio shows to build support for sexual and reproductive health and rights, including among policy makers.

Uniting regionally and globally

Despite the major focus on the new Sustainable Development Goals, IPPF was also able to continue its other regional and international advocacy initiatives successfully.

Family Planning 2020 (FP2020)

IPPF is part of the FP2020 Global Reference Group. We contribute to international working groups, facilitate a Listserv with a regular newsletter reaching civil society organizations in over 100 countries, and advocate for increased access to rights-based family planning services across the world.

IPPF worked in partnership with Advance Family Planning to mobilize action at district, national and international levels with a focus on the implementation of commitments made by governments in 2012 at the *London Summit on Family Planning*. In 2014, IPPF's Director-General spoke on a high-level panel about the importance of maintaining momentum on contraception and maternal and newborn health, alongside the United Kingdom's International Development Secretary, Justine Greening, and Melinda Gates of the Bill & Melinda Gates Foundation.

As a partner in the USAID-funded *Evidence Project*, IPPF began research into how social accountability mechanisms can increase access to contraceptive services.

World Bank reproductive health funding

Given current changes to the international development financing landscape, IPPF urged the World Bank to increase funding and to champion sexual and reproductive health and rights. During the World Bank's Spring Meetings in April 2014, IPPF hosted a high-profile panel with the United Kingdom's Executive Director to the Bank, the Bank's Sector Manager for Health, Nutrition and Population, and Princess Sarah Zeid of Jordan, a newborn and maternal health advocate. At this event, IPPF's *Scorecard*, which assesses the Bank's *Reproductive Health Action Plan*, was launched and discussed.

IPPF's broader advocacy efforts with the World Bank included promoting sexual and reproductive health and rights indicators for inclusion in the Bank's *International Development Association Results Measurement System* (IDA 17). This is important because the IDA assists low income countries with grants and concessional loans, including funds to strengthen health systems. IPPF was successful in securing a new indicator on contraceptive prevalence rate which can be used to monitor progress at the national level, and to indicate where Bank investment is needed.

Sexual rights and the Universal Periodic Review

IPPF Member Associations continue to use the United Nations Universal Periodic Review process to raise concerns and make recommendations about sexual rights in their countries. IPPF trains Member Associations and other civil society organizations on how to use the Universal Periodic Review to bring political attention to issues that too often go unrecognized. In 2014, four Member Associations submitted shadow reports to the United Nations Human Rights Council in Geneva, and another two made oral statements to highlight rights violations and advocated for governments to champion sexual rights issues at the United Nations in Geneva.

Ending sexual violence

Spearheaded by Angelina Jolie, the Special Envoy of the United Nations High Commissioner for Refugees, the *Global Summit to End Sexual Violence in Conflict* was the largest-ever gathering on this issue. IPPF organized and chaired a panel discussion on the theme *Sexual Violence, Sexual and Reproductive Health and Rights, and Gender Equality: Responding Now, Preventing in the Future*. A packed room heard powerful testimonies from a survivor of sexual violence from Venezuela and a young leader from Colombia who spoke about the situation of women in armed conflict. UNFPA's expert on gender-based violence in South Sudan, a specialist on gender equality from the Swedish Development Department and IPPF's President together called on governments to tackle sexual and

reproductive health and rights by addressing underlying barriers to gender equality and ensuring that the new Sustainable Development Goals address violence against women and girls.

Working with the African Union and parliamentarians

IPPF has established a Liaison Office in the African Union headquarters in Addis Ababa to influence policy processes at the African Union and the United Nations Economic Commission for Africa. Staff in Addis worked with IPPF colleagues in the Africa Regional Office to ensure that sexual and reproductive health and rights, comprehensive sexuality education and gender equality were included in the Outcome Document of the *9th Regional Conference on Women (Beijing+20)*, endorsed by African ministers of gender.

The African Union has requested that the IPPF Africa Regional Office works with civil society organizations across Africa to conduct a review of the *Maputo Plan of Action*. The plan is Africa's policy framework for universal access to comprehensive sexual and reproductive health services, including family planning. The review will assess progress and make recommendations for the next phase.

IPPF convened the General Assembly of the African Parliamentary Forum on Population and Development in the Ivory Coast. The assembly produced a positive statement on Africa's position on sexual and reproductive health and rights for the new Sustainable Development Goals. This was taken forward to the *6th International Parliamentarians' Conference on the Implementation of the ICPD Programme of Action* in Sweden where African parliamentarians reaffirmed their commitment to gender equality, women's empowerment, elimination of violence against women, and universal access to sexual and reproductive health services.

Joining voices around the world for family planning

IPPF's *Joining Voices** advocacy project builds on the momentum of the *2012 London Summit on Family Planning*. The Summit called for action to give women and adolescent girls greater freedom to access family planning services wherever they are in the world. It culminated in a series of Family Planning 2020 (FP2020) pledges, with donor and recipient countries committing to increase financial and political support for family planning.

The *Joining Voices* project plays an important role in supporting civil society advocacy on family planning to make sure commitments are delivered. Three examples below illustrate how Member Associations are working to hold governments to account on their FP2020 pledges.

PHILIPPINES

The Family Planning Organization of the Philippines and the Philippine Legislators' Committee on Population and Development Foundation joined forces to raise awareness of national commitments to family planning at events with legislators, civil servants and international development agencies. A short film and accompanying factsheet were used to remind policy makers of the benefits of supporting family planning and the need to increase investment.

SOLOMON ISLANDS

The Solomon Islands Planned Parenthood Association worked with the Ministry of Health and UNFPA to put family planning on the national agenda. For the first time, a national conference brought together provincial ministers of health, health coordinators, and religious and community leaders resulting in greater consensus on how to increase access to family planning in key provinces, especially for young people.

ZAMBIA

The Planned Parenthood Association of Zambia promoted the FP2020 Costed Implementation Plan across the country, recruited 20 family planning ambassadors, and ensured broad civil society participation to implement the plan.

As part of *Joining Voices*, Countdown 2015 Europe is a consortium of 15 leading European non-governmental organizations, of which over half are IPPF Member Associations, working to ensure funding for sexual and reproductive health and rights in developing countries. Coordinated by IPPF's European Network and working with European Union institutions, Countdown 2015 Europe holds donors to account for their policy and funding commitments to achieve universal access to reproductive health and to address the unmet need for family planning. The Countdown 2015 Europe partnership's efforts to date have seen funding for family planning increase in nine of the 12 project countries, including the examples below.

DENMARK

In 2014, the Danish government reviewed its strategy of support for sexual and reproductive health and rights. It also developed a new strategic framework for gender equality, rights and diversity for Danish international development. Both strategies strengthen the government's long-term, dedicated commitment to sexual and reproductive health and rights.

FRANCE

With the passing of France's first law on international development assistance, Parliament will now be able to contribute to the content of aid programmes rather than simply approving budgets. The law is in force to 2019 and commits to sexual health and reproductive rights, including gender equality. French political solidarity for sexual and reproductive health and rights remains prominent.

SWITZERLAND

Swiss development assistance for sexual and reproductive health increased between 2014 and 2015, and the latest health policy document from the Swiss government explicitly identifies maternal, newborn and child health, as well as sexual and reproductive health as a thematic priority. Switzerland recognizes the right to sexual and reproductive health for all, including full reproductive choices for women, men and adolescents.

IPPF in partnership with BRICS

More than 42 per cent of the world's population live in the five BRICS countries of Brazil, Russia, India, China and South Africa,¹ which means that the policies and views of governments in these countries are critical for the health and well-being of billions of people. IPPF works in BRICS countries in partnership with civil society organizations, including Member Associations, to raise awareness among the leaders and policy makers of the importance of sexual and reproductive health and rights.

In March 2014, South Africa hosted the *BRICS Inaugural Seminar of Officials and Experts on Population Matters*. IPPF's Director-General and the Western Hemisphere Regional Director participated, alongside Member Associations and representatives from other civil society organizations mobilized by IPPF. A milestone agreement was reached with the BRICS countries adopting a framework for ongoing cooperation and learning on contraception, sexual and reproductive health and reproductive rights, gender equality and women's rights.

In February 2015, IPPF convened a civil society forum in Brasilia, ahead of the *First BRICS Meeting of Ministers Responsible for Population Matters*. IPPF worked with civil society organizations, including the Member Associations of China and India, to review the zero draft of the *Agenda for BRICS Cooperation on Population Matters 2015–2020*. Country official delegates were encouraged to support sexual and reproductive health and rights, and gender equality in negotiations on the content of the final document. Following this work, the agenda agreed by ministers at the *First BRICS Meeting of Ministers Responsible for Population Matters* reflects many of IPPF's key concerns such as sexual and reproductive health rights, and empowerment of women and girls.

*Civil society organizations advocating on FP2020 can find resources and news in English and French at www.joiningvoices2020.org and www.countdown2015europe.org/europes-funding.

Programme successes: Unite

Raising the profile of family planning with governments



Family Planning Association of Nepal (FPAN)



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



Reproductive Health Uganda (RHU)

The President of Nepal expressed his support for the Family Planning Association of Nepal (FPAN) and IPPF's *I Decide* campaign at the *First National Population Conference* in Kathmandu in June 2014. Subsequently, FPAN's work led to Nepal celebrating its first national Family Planning Day in September 2014. The day was inaugurated by Nepal's Health and Population Secretary, the Minister of Health and Population, and the National Planning Commission. The Family Planning Day represents a significant achievement for FPAN's advocacy work, especially as family planning was previously decreasing in visibility in the domestic policy agenda.

Rahnuma-Family Planning Association of Pakistan (Rahnuma-FPAP) is part of Pakistan's national FP2020 Champions Group. Rahnuma-FPAP has agreements with national and provincial ministries, including the Ministry of National Health Services, the Population Welfare Department in Punjab, and the National Institute of Population Studies, and implements maternal and newborn child health programmes in the provinces of Balochistan, Punjab and Sindh. These programmes support service delivery and family planning in line with the national government's commitment to FP2020.

Rahnuma-FPAP, working with other civil society organizations, advocated for more family planning services with the provincial governments of Khyber Pakhtunkhwa, Punjab and Sindh. Together, these three provinces account for more than 85 per cent of the total population of Pakistan.² As a result, the provincial governments have incorporated commitments on family planning into their draft population policies and other influential policy documents; increased budgetary lines for contraception in both 2013–14 and 2014–15; allocated resources to procure contraceptives; established and reconfigured health delivery points to strengthen service reach; and increased their targets for contraceptive prevalence rates.

Uganda held its *National Conference on Family Planning* in July 2014. The President of Uganda positioned family planning as vital for national development, and this increased opportunities for Reproductive Health Uganda (RHU) to promote family planning with decision and policy makers. The Member Association won commitments from four administrative districts to devote a percentage of locally-generated revenues to sexual and reproductive health services. RHU continues its work reviewing the *Public Health Act* to

ensure a strong position on reproductive health and family planning, and to push for the implementation of supportive policies on community-based distribution of injectable contraception and task-sharing.

In 2014, the government of Uganda launched its US\$200 million official *Family Planning Costed Implementation Plan, 2015–2020* (FP-CIP) to reduce unmet need for contraception from 40 to 10 per cent, and increase the modern contraceptive prevalence rate to 50 per cent by 2020.

RHU convened and led a youth group and an expert group to provide feedback during the FP-CIP's development process. Of the 18 countries preparing FP-CIPs, this is the only example of these plans being developed following this approach. RHU's activities were instrumental in ensuring that young people's needs and a rights-based approach to family planning programmes were included in the plan. The Association also worked with the government to ensure that the FP-CIP is fully costed, and to raise resources with bilateral donors to fund its various components.



IPPF/Graeme Robertson/Palestine

Programme successes: Unite

Increasing government budget for reproductive health supplies



Association Mauritanienne pour la Promotion de la Famille (AMPF)

Frequent commodity shortages have a detrimental impact on sexual and reproductive health and rights, hence governments need to dedicate a specific budget for these items. The Association Mauritanienne pour la Promotion de la Famille (AMPF) focused its advocacy work on funding for sexual and reproductive health commodities, creating and leading a coalition of non-governmental organizations to advocate collectively with the Ministry of Health, the Ministry of Finance and a network of supportive parliamentarians. In 2014, AMPF succeeded in securing a new budget line dedicated to reproductive health commodities, including contraceptives.

Despite this success, AMPF judged that the proposed amount in the new budget was insufficient and so continued to advocate for increased access to sexual and reproductive health services and supplies. By the end of 2014, AMPF obtained an increase of 33 per cent in the national budget allocated to reproductive supplies. AMPF's work ensured health centres can provide a continuous supply of sexual and reproductive health commodities, including contraceptives, enabling people to prevent unwanted pregnancies and protect themselves from HIV and sexually transmitted infections.

Assuring women's right to abortion in Italy

European Network

Women face serious difficulties accessing abortion services in Italy due to the increasing number of doctors who refuse to carry out procedures on the grounds of conscientious objection. This opposition creates barriers for women seeking abortion, despite the fact that Italian law guarantees women's right to access reproductive health care services, including abortion.

IPPF European Network challenged this situation by lodging a collective complaint against the Italian government with the Committee of Social Rights of the Council of Europe, the most important human rights institution in the region. The complaint argued that weak regulation of the conscientious objections of health personnel violated women's rights to health protection, as stipulated in the European Social Charter. In March 2014, IPPF's complaint was successfully backed by the Committee which stated that Italy was in violation of its own abortion law for its failure to organize the provision of abortion services in a way that ensures clients' needs are met. The Committee confirmed that women in Italy face numerous challenges and agreed that variations in the availability of services from one region to another mean that women face territorial and economic discrimination when searching for an abortion provider. In addition, insufficient national data on abortion

provision prevents the Italian government from being able to assess the seriousness of the situation.

IPPF continues to work with partners in Italy to fight for full implementation of the law. Discussions are underway with the Italian Ministry of Health focusing on a new study on demand for services, creating national guidelines for hospitals, and challenging the resistance of a large number of medical faculties to include abortion in their curricula.

This historic case has highlighted the crucial balance between women's right to health, the responsibility of a state to fulfil women's rights, and a service provider's freedom of conscience. It sets an important precedent in case law at a time when conscientious objection is increasingly being used by anti-choice movements to undermine European women's reproductive rights.

Improving access to abortion in the Dominican Republic

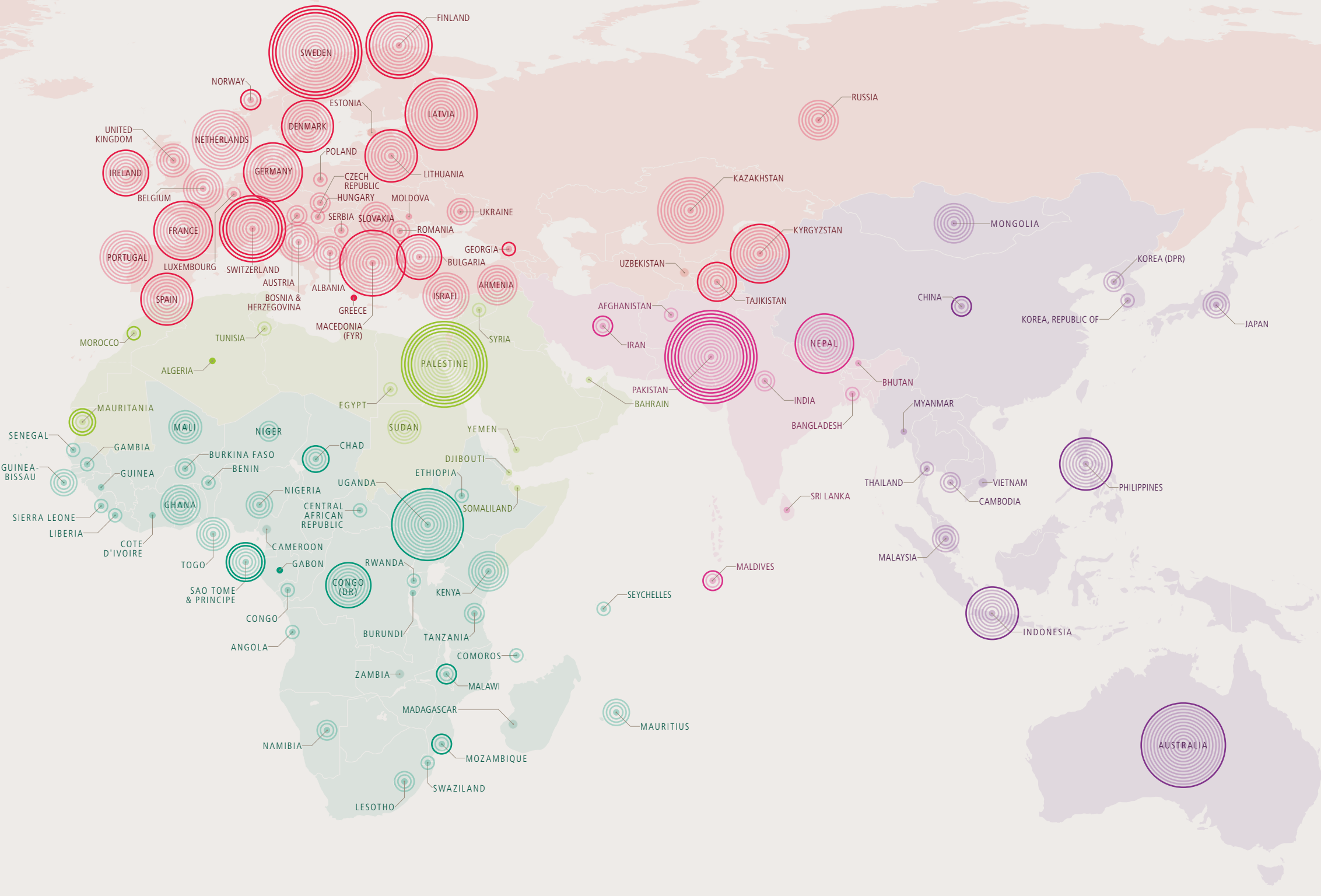


Asociación Dominicana Pro-Bienestar de la Familia (PROFAMILIA)

In 2014, the President of the Dominican Republic was requested to sign a new version of the penal code that still maintained the criminalization of abortion under all circumstances. The President refused, and the Asociación Dominicana Pro-Bienestar de la Familia (PROFAMILIA) began working closely with legislators and other groups to propose changes to the sections on abortion to support a woman's right to choose. PROFAMILIA responded to opposition from the Catholic Church by building advocacy partnerships, holding press conferences and providing facts about unsafe abortion to the President's advisers. In addition, PROFAMILIA requested national and international organizations to send public letters addressed to the President, asking him to respect the rights of women as guaranteed by the Dominican Republic's constitution and international human rights treaties ratified by the Dominican Republic.

As a result, the President argued for the decriminalization of abortion in three situations: rape or incest; fetal malformation incompatible with life; or when a woman's life is in danger. The revised penal code was finally approved by Congress in December, with the President signing shortly thereafter.

Changing laws and policies to support and defend sexual and reproductive health and rights around the world



From 2005 to 2014, Member Associations and collaborating partners contributed to

734 policy and/or legislative changes

in support or defence of sexual and reproductive health and rights in

150 countries*

Key

Number of policy and/or legislative changes	Year of policy and/or legislative change
---	--



KIRIBATI

A map of the Pacific Islands region, specifically focusing on the area around Vanuatu, Fiji, Samoa, and Tonga. The islands are depicted in a stylized, light blue color. Labels with lines pointing to specific islands are: VANUATU (top left), FIJI (center), SAMOA (top right), and TONGA (bottom right).

* See Annex A for number of policy and/or legislative changes, by country, 2005–2014.

deliver access for all: to reduce unmet need by doubling IPPF services

IPPF has committed to doubling the number of sexual and reproductive health services provided between 2010 and 2015. In 2014, results show significant progress towards achieving this ambitious target.

Figure 3 presents IPPF's 2014 performance in the delivery of sexual and reproductive health services, couple years of protection and comprehensive sexuality education. Overall, the results show three indicators surpassing their 2014 targets, while the remaining five show year-on-year progress but remain below target.

IPPF has committed to doubling the number of sexual and reproductive health services provided between 2010 and 2015, and trebling them by 2020. Results from 2014 show that we are on track by delivering 149.3 million services in 2014, a 9 per cent increase from 2013 (Figure 4). At 66.6 million, almost half of all services were provided to young people, but the target was missed. The number of couple

years of protection increased by 21 per cent to 14.6 million; however, this remains below the target of 15.1 million for 2014. The number of HIV-related services increased significantly, by 29 per cent from 2013 to 31.8 million, and exceeded the 2014 target by 6.7 million. The estimated number of service users who are poor and vulnerable increased from 48.8 million to 52.6 million (Figure 5), exceeding the 2014 target by over 10 million, and reaching the highest-ever proportion of service users who are poor and vulnerable, at 85 per cent. This demonstrates IPPF's continued commitment to reaching the under-served and those with greatest need.

The number of abortion-related services grew by 27 per cent from 2013 to 3.8 million, a considerable annual increase but below the target of 4.9 million. The proportion of Member Associations providing the full Integrated Package of Essential Services (see Annex C) increased from 26 per cent in 2013 to 30 per cent, but did not reach the target of 44 per cent. Finally, the number of young people who received comprehensive sexuality education from Member Association staff remained the same at 25.2 million. This includes 20 million young people who received comprehensive sexuality education from the China Family Planning Association.

The following section examines service statistics and trends presented alongside examples of Member Association programmes that contribute to IPPF's overall performance in the provision of sexual and reproductive health services.

Figure 3: Deliver – performance results in 2014

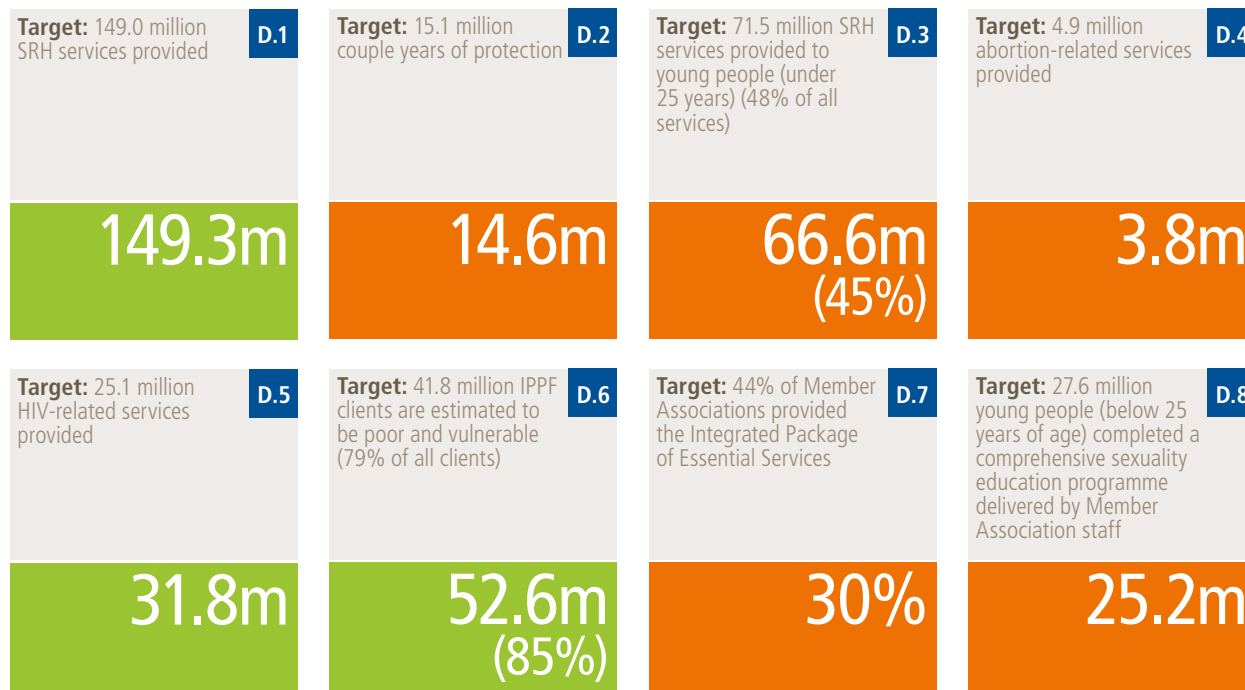
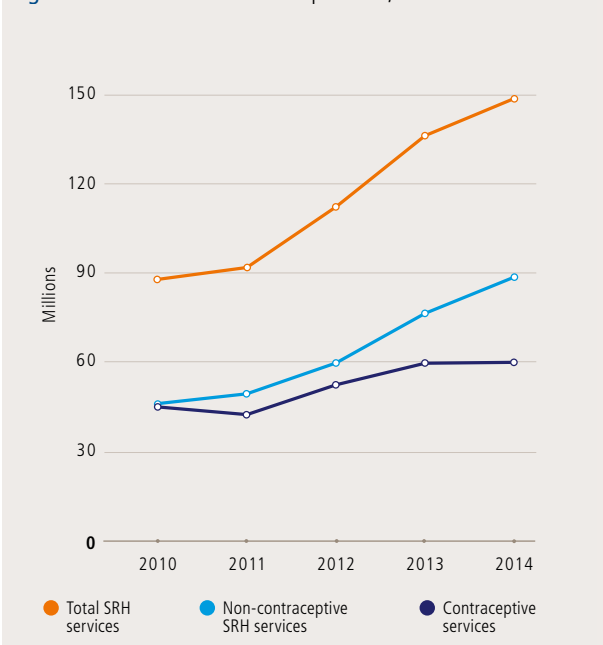


Figure 4: Number of SRH services provided, 2010–2014



Investing in countries with the greatest need

The majority of IPPF's unrestricted investments are made in countries with the greatest need for sexual and reproductive health information, education and services. These countries, identified by the Human Development Index as having low or medium levels of human development, have disproportionately high levels of maternal and child mortality, unmet need for contraception, HIV prevalence, and early marriage and childbearing.

In the 73 countries identified as having low or medium levels of human development³ and where there is an IPPF Member Association or collaborating partner, the total number of sexual and reproductive health services provided in 2014 reached 122.4 million, an increase of 13 per cent from 2013. The most common categories of services provided were contraception, maternal and child health, and HIV-related services (Figure 6).

Figure 5: Estimated number of IPPF clients; number and percentage of clients who are poor and vulnerable, 2010–2014

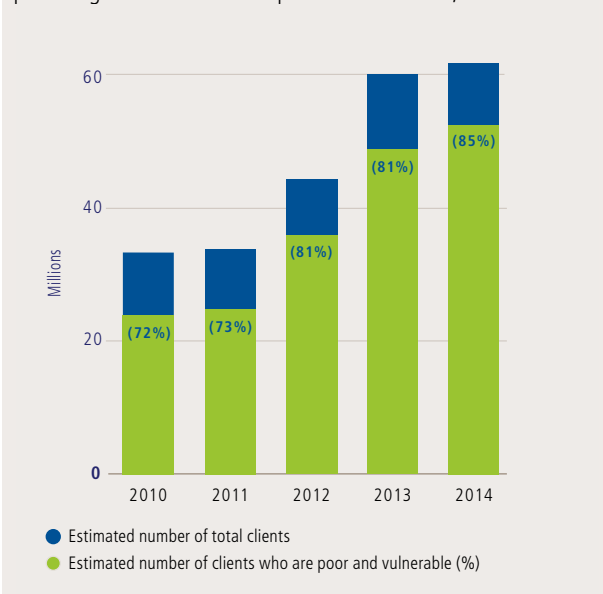
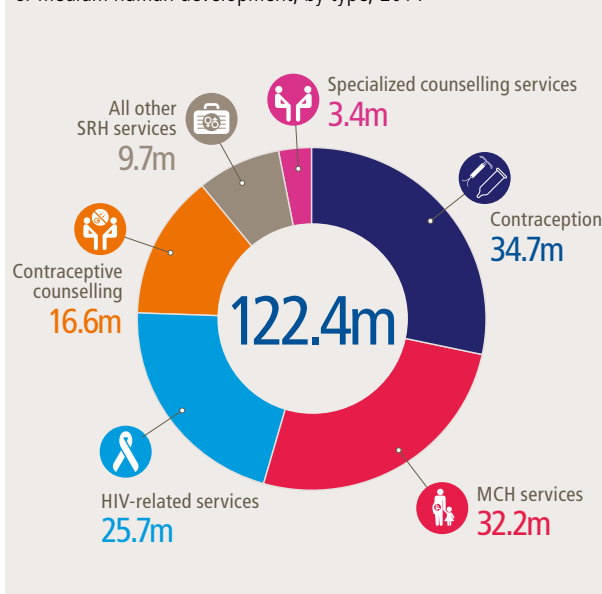


Figure 6: Number of SRH services provided in countries with low or medium human development, by type, 2014



Reaching poor and vulnerable groups

In 2014, IPPF reached 52.6 million poor and vulnerable service users with sexual and reproductive health services, 3.7 million more than in 2013. The estimated proportion of all service users who are poor and vulnerable is 85 per cent, the highest ever achieved by IPPF. These results illustrate IPPF's commitment to serving those most in need of sexual and reproductive health services.

IPPF has more than 54,000 service delivery points, and 59 per cent of them are located in peri-urban or rural areas. This enables Member Associations to provide information, education and services to people living in hard-to-reach areas where there are few, if any, other service providers. Member Associations provide services to under-served groups who are not reached by other public or private providers, due to a reluctance to work with such marginalized populations, the additional costs involved or an absence of the specialized skills needed. Such groups are often those with greatest need, and include young people, sex workers, men who have sex with men, people who inject drugs, sexually diverse populations and prisoners.

85% of IPPF's service users are poor and vulnerable



Contraception

The number of couple years of protection (CYP) provided in 2014 increased by 21 per cent to 14.6 million, which averted an estimated 5.9 million unintended pregnancies and 677,000 unsafe abortions. In the Africa and Arab World regions, the percentage increases from last year were 83 and 37 per cent respectively. In Africa, the growth was predominantly due to injectables, intrauterine devices and oral contraceptive pills. In the Arab World, it was due mainly to intrauterine devices and implants.

IPPF remains committed to providing a range of contraceptive choices to service users. Our Integrated Package of Essential Services requires Member Associations to provide short- and long-acting reversible methods, as well as emergency contraception. Figure 7 presents the method mix of IPPF's CYP: 44 per cent was provided by short-acting methods; 42 per cent by reversible long-acting methods; and 14 per cent by permanent methods. The number of CYP provided by implants and injectables continued to increase in 2014, a trend seen in previous years. CYP from implants rose by 71 per cent to 2.4 million. Injectables contributed to an increase in CYP by 17 per cent from 2013 to 1.9 million. In addition, 10 million more oral contraceptive pills were provided in 2014 increasing the CYP from oral pills by 33 per cent to 2.7 million in 2014.

The Integrated Package of Essential Services requires the provision of contraceptive counselling as the basis of our rights-based approach and to support informed decision making about when, if and how many children to have. In 2014, IPPF provided 18.7 million contraceptive counselling services, with the majority (16.6 million, 89 per cent) being provided in countries with low or medium levels of human development. This primary health care service is critical in reducing unmet need, raising awareness and ensuring that the chosen contraceptive method is appropriate, reliable and safe for every woman.

5.9m

Unintended pregnancies averted*

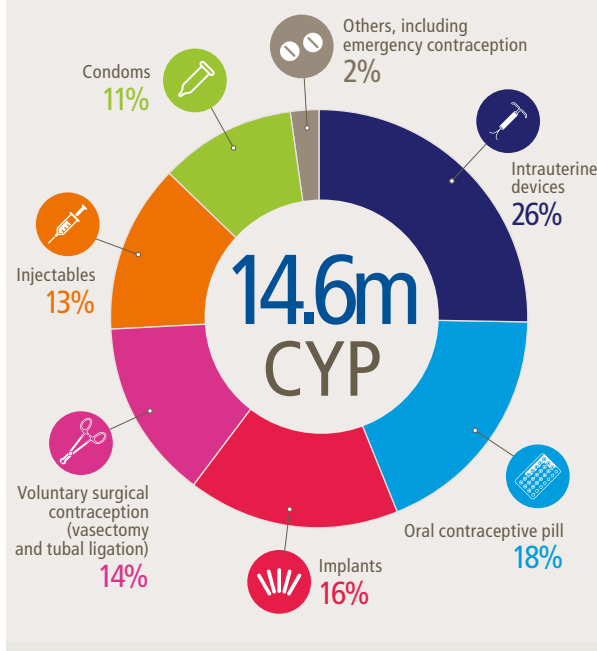


677,000

Unsafe abortions averted*



Figure 7: Couple years of protection (CYP), by method, 2014



* Using Marie Stopes International's Impact 2 estimation model

Abortion-related services

The number of abortion-related services increased by 27 per cent, from 3.0 million in 2013 to 3.8 million in 2014. Annual growth occurred in all service categories, with the largest increases in treatment of incomplete abortion (54 per cent), abortion consultation including harm reduction services (52 per cent), post-abortion counselling (37 per cent) and medical abortion (27 per cent) (Table 1). IPPF encourages all Member Associations to provide a minimum package of essential abortion services, and supports the expansion of comprehensive abortion care with those Associations already delivering essential services.

IPPF continues to make progress in increasing access to safe abortion services, post-abortion care and contraceptive services through the *Global Comprehensive Abortion Care Initiative* (GCACI). In 2014, the 11 participating Member Associations provided 61,337 clients with an abortion or treatment for incomplete abortion, 12 per cent more than in 2013. Contraceptive services were provided to 662,256 clients, an increase of 30 per cent from 2013. The use of client-based data to inform and develop programmatic strategies and decisions contributed to these achievements, leading to the identification of key interventions. At the beginning of 2014, IPPF brought together Member Associations from 26 countries to a global meeting to share their experiences, successes and challenges in expanding the provision of abortion-related services.

In 2014, technical support was provided to seven Member Associations to strengthen the capacity of clinics and their staff to provide medical abortion, and to improve commodity security. The IPPF abortion portfolio was further diversified with a new programme on abortion-related stigma and its effect on young people's access to safe abortion information and services. Programme activities will focus on stigma in both communities and clinics, and will support young volunteers and advocates to reduce abortion-related stigma.

Table 1: Number of abortion-related services, by type, 2013–2014

Type of service provided	2013	2014
Pre-abortion counselling	1,004,201	1,236,780
Post-abortion counselling	492,156	674,641
Surgical abortion	533,085	544,080
Medical abortion	341,783	433,109
Treatment of incomplete abortion	123,384	190,331
Abortion consultation services	462,161	700,942
Total	2,956,770	3,779,883

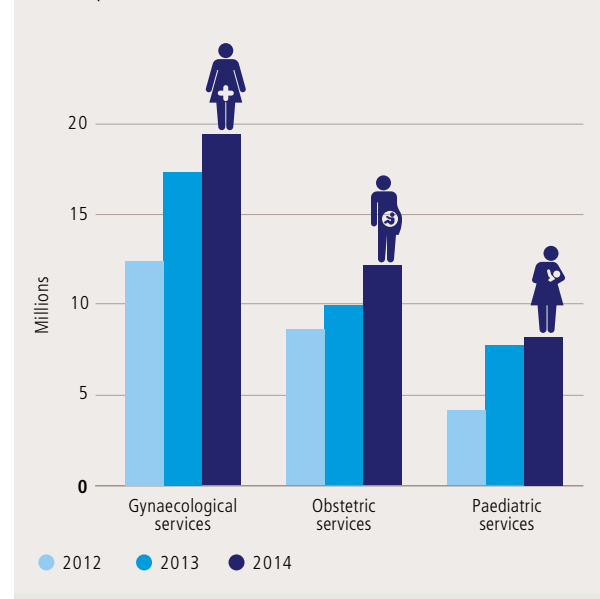
Member Associations in Benin, Burkina Faso, India and Pakistan implemented an adapted version of the *Ipas Stigmatizing Attitudes, Beliefs and Actions Scale*, a tool to measure baseline community-level abortion stigma. The results are now being used to inform programme design and interventions. In 2016, further research will be conducted to explore whether the interventions have reduced levels of stigma. IPPF is also raising awareness and tackling abortion-related stigma with an innovative series of short films, *Women's Voices*,⁴ telling the real abortion stories of three women from Cameroon, France and India. Although each woman's experience is different and unique, what they have in common is that the decision they made was right for them and their families.

IPPF has identified a set of clear criteria for Member Associations to follow when adopting the harm reduction approach. During 2014, IPPF continued to build internal capacity to implement this approach for increasing access to a range of safer abortion services, even in the most restrictive settings.

Focusing on the needs of women and girls

At 77 per cent, the majority of IPPF's service users are women and girls. In addition to contraception and abortion services, IPPF also provided 19.4 million gynaecological services, including breast and pelvic examinations, biopsies, imaging and cancer screening in 2014 (Figure 8). A further 12.2 million obstetric services such as pre- and post-natal care, pregnancy testing and deliveries, were provided. In relation to child health, IPPF provided 8.2 million paediatric services last year. The combined number of these services provided to women and children increased by 4.7 million, or 14 per cent from 2013.

Another key component of IPPF's service package which is vital to the health of women and girls is sexual and gender-based violence services. In 2014, Member Associations provided 1.9 million prevention, screening and counselling services related to sexual and gender-based violence, with a 25 per cent increase in prevention and screening services from 2013.

Figure 8: Number of gynaecological, obstetric and paediatric services provided, 2012–2014

IPPF's ground-breaking and inclusive policy on gender equality

In May 2014, the IPPF Governing Council approved a revised gender equality policy to support a human rights framework which prohibits any discrimination, exclusion or restriction on the basis of sex, age, gender, gender identity, sexual orientation, marital status, physical and mental disability, or health status. The progressive policy promotes a definition of gender equality which is broader than equality between men and women, and sets out specific targeted actions to ensure that all individuals, whether they identify as women, men, lesbian, gay, bisexual, transgender or intersex, have access to equality of opportunity in the workplace and in programmes.

The guiding principles of the policy include supporting women and girls to become leaders and to participate on an equal basis with men in every area of the Federation's work. In relation to sexual and reproductive health and rights, women and girls bear the largest share

of the costs, dangers and burden, and it is equitable and fair that they should have at least an equal share in all institutional decision-making processes. Gender norms also reinforce rigid constructs of masculinity and femininity creating a disproportionate impact on individuals whose sexual orientation and gender identity do not conform.

An audit of the gender equality policy will review gender balance of volunteers and staff every three years to determine representation across all levels of the Federation. The audit will also assess programme delivery, mainstreaming in the workplace, and positions disaggregated by salary. The function of this policy is to achieve gender equality for all, focusing on the social norms that impact on an individual's ability to participate equally and freely in society, to achieve their full potential.

HIV-related services

IPPF provided 31.8 million HIV-related services in 2014, an increase of 7.0 million, or 28 per cent, from 2013. As in previous years, the majority of services were provided by African Member Associations: 17.0 million HIV-related services in 2014, a 57 per cent increase over 2013. In South Asia, 4.1 million HIV-related services were provided in 2014, up 35 per cent from 2013. Five out of six regions provided more HIV-related services in 2014 than in 2013. Furthermore, the number of condoms distributed in 2014 was 187.3 million, an increase of 14 per cent from 2013.

Table 2 shows the growth in all categories of HIV-related services: prevention services increased by 18 per cent; HIV counselling and testing rose by 29 per cent; and the number of treatment, care and support services increased by 17 per cent. The largest increase was in the number of sexually transmitted infection services provided, from 12.2 million in 2013 to 16.1 million in 2014, or 32 per cent more. Faced with a growing global incidence of viral hepatitis, syphilis, gonorrhoea, chlamydia and trichomoniasis, these results reflect IPPF's commitment to increase access to sexually transmitted infection prevention, testing and treatment services. Such services are vital for improving other health outcomes such as maternal and child health, infertility and prevention of related cancers.

Men who have sex with men, people who inject drugs, sex workers and transgender people are disproportionately affected by HIV. When compared to the general population, people from these four key groups are between 12 to 49 times more likely to be living with HIV,⁵ and are often unable or unwilling to visit government or private health providers due to real or perceived stigma and discrimination. To reduce such barriers to uptake, IPPF delivers integrated sexual and reproductive health and HIV-related services in a confidential and stigma-free environment.

In 2014, 72 per cent of Member Associations implemented specific strategies to increase access to integrated services for at least one of the key populations or people living with HIV. The proportions of Member Associations addressing the needs of these various groups range from 31 per cent working with people who inject drugs to 69 per cent providing services to people living with HIV. Strategies to support key populations include community-based outreach, training peer educators, developing partnerships with local networks, and supporting the immediate partners of individuals from the key populations. A number of Member Associations also offer other services that act as an entry point to access sexual and reproductive health services; for example, laser hair removal for transgender women or harm reduction information and services for people who use drugs.

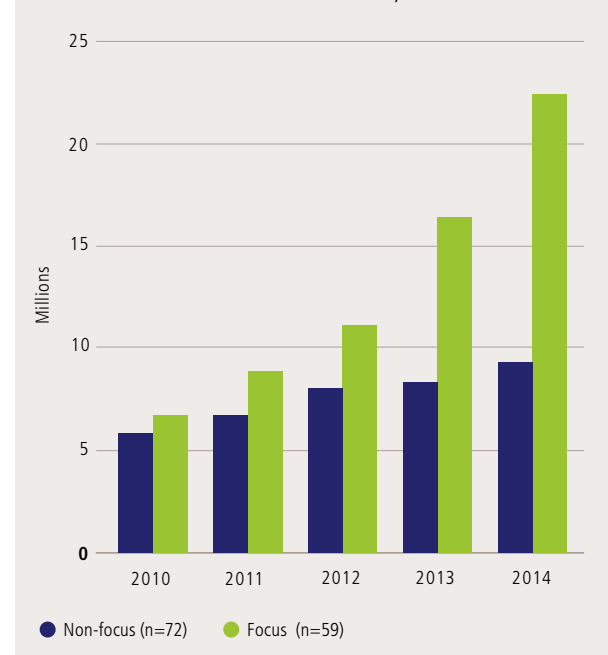
Since 2004, IPPF has implemented an approach of intensive capacity building on HIV knowledge and skills with a select number of focus Member Associations. The success of this strategy in increasing the provision of HIV-related services is highlighted in Figure 9, which compares the performance of focus and non-focus Member Associations. Between 2010 and 2014, focus Associations experienced a much greater growth rate of 234 per cent in comparison to 60 per cent for non-focus Associations.

Methods to build capacity in focus Member Associations include participation in HIV competencies workshops, involvement in international and regional conferences, and bespoke training on specific HIV themes. These focus Associations now play a central role in IPPF's response to HIV and many have become valuable partners to national Ministries of Health as experts in delivering integrated HIV and sexual and reproductive health services.

Table 2: Number of HIV-related services provided, by type, 2013–2014

Type of service provided	2013	2014
Prevention	4,337,081	5,108,657
Counselling and testing	7,491,330	9,681,619
Treatment, care and support	730,374	857,064
STI services	12,181,720	16,110,693
Total	24,740,505	31,758,033

Figure 9: Number of HIV-related services provided, focus and non-focus Member Associations, 2010–2014



Eliminating mother-to-child transmission of HIV



Indonesian Planned Parenthood Association (IPPA)



Family Planning Association of India (FPAI)



Association Mauritanienne pour la Promotion de la Famille (AMPF)

An HIV-positive mother can transmit HIV to her child during pregnancy, labour, delivery and through breastfeeding. Transmission rates range from 15 to 45 per cent, but with effective interventions can be reduced to below 5 per cent.⁶ An estimated 50 per cent of mother-to-child transmission can be attributed to the fear of discrimination that dissuades mothers from being tested for HIV and from accessing or continuing treatment at any point on the continuum of care.⁷ With programmes designed to reduce transmission rates, Member Associations are contributing towards the UNAIDS *Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive*. Member Associations provide HIV testing and treatment services and also address the stigma and challenges associated with accessing and adhering to these services.

Indonesia

In Indonesia, the province of Papua has the highest number of new HIV infections at almost 15 times more than the national average.⁸ Stigma against people living with HIV, together with a lack of awareness about testing services, contribute to low voluntary testing rates. To address this, the Indonesian Planned Parenthood Association (IPPA) now includes testing as part of an integrated service package in its Papua clinics.⁹ Women are offered testing when they seek other sexual and reproductive health services, and this approach reduces

stigma and ensures confidentiality for all service users. The Member Association has also trained outreach workers to raise awareness of mother-to-child transmission and the importance of voluntary HIV counselling and testing. Additionally, in a strong patriarchal society where men make decisions about health care, IPPA's work to raise awareness among men and community leaders about the importance of testing has proved to be critical in supporting women to access these services.

India

The Family Planning Association of India (FPAI) implements its maternal HIV programme in three states: Andhra Pradesh, Karnataka and Maharashtra. Most of the pregnant women enrolled in the programme learned of their HIV status during antenatal visits. Such a diagnosis can be traumatic, especially if mothers have misleading preconceptions about HIV.

Psychosocial support is provided by FPAI-trained peer mothers recruited from the community who themselves experienced pregnancy and childbirth while HIV-positive. They are able to advise newly-diagnosed pregnant women on how to reduce the risk of HIV transmission, and they encourage women to maintain treatment regimens. Visits take place in the home or at the treatment centre, depending on the mother's preference. The peer mothers also accompany enrolled

mothers to clinics, support them to negotiate low-cost services, distribute food packages and provide vital information.

Mauritania

The Association Mauritanienne pour la Promotion de la Famille (AMPF) works in under-served areas that are not covered by government health providers, including slums around major cities. These areas often have concentrations of people displaced due to conflict in neighbouring countries. The Member Association provides sexual and reproductive health services in static and mobile clinics and during home visits by community health workers. In 2014, AMPF began offering people living with HIV and their partners a package of services to support the elimination of mother-to-child transmission of HIV. The package includes testing as well as counselling, psychosocial support and risk reduction practices. In addition, AMPF runs interactive educational sessions with the male partners of women living with HIV in Nouadhibou.

“My daughter was diagnosed with HIV during her first antenatal care visit. Unfortunately, her husband didn't accept this diagnosis and abandoned her. I didn't know about HIV and we are too worried to say anything to our neighbours or extended family. I am grateful to the peer mothers who have been supporting us and guided us on what we should do during the pregnancy and how we can take care of my daughter and her baby.”

Mother of client accessing FPAI services in Bangalore

Providing services to young people

In 2014, IPPF provided 66.6 million sexual and reproductive health services to young people. This represents 45 per cent of all services provided, and illustrates our commitment to the largest generation of young people ever. Over the last five years, IPPF has focused on the needs of young people, with the proportion of sexual and reproductive health services provided to youth rising from 35 per cent in 2010 to 45 per cent in 2014. The most common services accessed by young people in 2014 were contraception (37 per cent), HIV-related services (22 per cent) and gynaecology (10 per cent).

In 2014, IPPF began to reflect on how to expand strategies to provide youth friendly sexual and reproductive health services using an approach which puts young people at the centre of decision making and programming. Involving youth in planning, implementation and evaluation of programmes supports their active participation and empowerment. IPPF has been at the forefront of youth participation for many years, with a focus on young people as volunteers, board members, advocates and peer educators. More recently, Member Associations have expanded their peer education programmes to include the provision of sexual and reproductive health services. Experience and research have shown the opportunity to link educational activities with service provision, and peer educators are now increasingly providing contraceptives, including injectables, and counselling.

To investigate the potential of scaling up the provision of services, IPPF conducted a review of existing peer provision models in operation across the Federation and in other health organizations. The review covered both the published and grey literature and examined innovative programmes, including mHealth and eHealth, and the acceptability of the approaches to both service users and providers. IPPF is now developing guidelines for different models of service provision by young peer providers.

Researching legal barriers to young people's access to sexual and reproductive health services

To a greater or lesser degree, access to sexual and reproductive health services for young people is limited in all countries around the world. Some barriers are prescribed by law while others derive from social norms and religious beliefs relating to young people's sexuality. The negative consequences of young people's restricted access to services are well documented, but until now there has been little research into the role of law in influencing this access.¹⁰

Laws can act as barriers to the uptake of sexual and reproductive health services, but they can also facilitate access when they empower young people to make informed decisions about their own sexual health, and create a framework where young people's rights are protected and promoted without discrimination.

Working with the Coram Children's Legal Centre, IPPF commissioned a multi-country research project to raise awareness of the direct and indirect impact that laws, and the ways in which they are interpreted, have on young people's access to sexual and reproductive health services, and on their sexual rights and freedoms. After two years of research, the inception report and three case studies were published in 2014.¹¹ The series, *Over-protected and Under-served: Legal Barriers to Young People's Access to Sexual and Reproductive Health Services*, reviews existing information concerning young people's access to sexual and reproductive health services. It contains a global mapping of the ways in which different legal systems impose restrictions on young people's access to sexual and reproductive health services, both directly and indirectly.

Qualitative research methods were used to develop the case studies. Young people were the main respondents, with their views, opinions and perceptions on the role of the law remaining central to the findings and recommendations of the series. Their feedback was

combined with interviews and focus group discussions held with public service providers, policy makers and Member Association staff.

Three case study countries were selected to represent different legal systems and contrasting social, cultural, religious and political traditions – El Salvador, Senegal and the United Kingdom. El Salvador is an example of a predominantly restrictive legal environment for young people's access to sexual and reproductive health services. However, there are some facilitative policies such as one that mandates reproductive health education in schools, and another requiring that pregnant girls are not to be excluded from school. In Senegal, the law contains a mixture of restrictive and facilitative policies, and the United Kingdom was included as an example of a relatively non-restrictive environment.

The country reports highlight the direct legal barriers young people face in accessing sexual and reproductive health services, such as the complete ban on abortion in El Salvador, as well as indirect barriers, which often result from young people's and providers' uncertainty regarding laws. One such example is confusion over the legal age of consent for sexual intercourse at 16 years old in Senegal. Many young people thought it was 18, in line with the age at which one can legally marry. Although Senegalese law does not restrict access to sexual and reproductive health services by age, young people explained to researchers that staff at clinics and pharmacies still asked for proof that they were over 18 before providing contraceptives.

This research is intended to contribute to international dialogue about young people's evolving capacities and sexual rights, to build evidence and knowledge in this area, and to guide future advocacy and programming work with the aim of fulfilling young people's sexual and reproductive health and rights.

Saving lives in crises

Over the course of 2014, through the *Sexual and Reproductive Health Programme in Crisis and Post-crisis Situations* (SPRINT Initiative), IPPF worked in nine countries in response to six natural disasters and in four conflict-affected areas. These included Typhoon Haiyan in the Philippines, an earthquake in Pakistan, floods in Bangladesh and the Solomon Islands, a landslide in Afghanistan, conflicts in the Central African Republic, Ethiopia and Myanmar, and working with refugees in Ethiopia and Uganda.

IPPF provides a range of services in emergency situations such as contraception, maternal and newborn care, referrals for emergency obstetric care, sexual and gender-based violence services, counselling, HIV testing, sexually transmitted infection treatment, hygiene and dignity kits, and safe blood transfusion kits. In total, over 328,000 people received services from IPPF in 2014, including 198,000 refugees and 130,000 people affected by natural disasters. Over half of the women who accessed

services were either pregnant or breastfeeding, and with support from IPPF, mothers were able to give birth safely and their newborns received medical care during these crises.

IPPF's approach to working in crisis situations extends to advocacy and resource mobilization, establishing country coordinating teams, developing curricula and manuals, and training health care and community workers. To support people during emergency situations, awareness-raising activities are also conducted with a focus on sexual and reproductive rights, sexual violence prevention, and where to go to access services. This multi-pronged approach means that capacity to respond quickly and effectively is established, and response rates are minimized. In 2014, a programme of training of trainers was implemented to establish a core group of 141 trainers, who are now responsible for rolling out trainings at national and local levels. Training has also been provided on monitoring and evaluation in crises for performance measurement, as well as to improve methods of estimating

beneficiary numbers for planning purposes, and to track service provision and commodities against needs. Extensive work in partnership and commitments with other stakeholders, including UNFPA, UNHCR, the World Health Organization, the Red Cross and the Women's Refugee Commission, means that IPPF is in a stronger position to engage and influence policy makers and to ensure that sexual and reproductive health and rights are integrated into emergency response at national, regional and international levels.

In Pakistan and the Solomon Islands, two post-emergency reviews were undertaken by external evaluators to assess the performance of IPPF in providing assistance in humanitarian settings. In both cases, results were positive: response was said to be effective and timely; and the provision of sexual and gender-based violence services and ongoing activities in evacuation centres were seen as particularly important outcomes.



IPPF/Suzanne Lee/Philippines

IPPF/Graeme Robertson/Palestine



Explaining performance trends

As IPPF reaches the penultimate year of the *Strategic Framework 2005–2015*, performance data show significant achievements have been made in all six regions: Africa (AR); Arab World (AWR); European Network (EN); East and South East Asia and Oceania (ESEAOR); South Asia (SAR); and the Western Hemisphere (WHR). Table 3 presents the ten-year cumulative totals for the main sexual and reproductive health service categories. Table 4 focuses on the annual results for 2014 by region, with information on a number of additional key performance indicators, including the proportion of IPPF service users who are poor and vulnerable, and the proportion of Member Associations providing IPPF's Integrated Package of Essential Services.

Since investing in data systems, definitions and reporting frameworks, increases in performance due to improved data quality are less significant than in previous years. Future investment in improving data capture will focus on service provision in geographically-isolated locations where some data remain under-reported, for example, from remote outreach facilities and community-based distributors.

Service growth for many Member Associations has resulted from an increase in efficiencies and the implementation of strategies to provide more people with more services, and in more locations. This has been driven by the use of information to make decisions, including performance, financial and operational data, as well as a renewed focus on working with under-served populations.

Since the beginning of IPPF's *Strategic Framework 2005–2015*, we have achieved the following:

827 million



SRH services provided

97.6 million



couple years of protection

1.5 billion*



condoms distributed

* 1 billion = 1,000,000,000

Table 3: Cumulative results by region, 2005–2014

Indicator	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of sexual and reproductive health services (including contraception) provided	268,286,266	28,280,441	14,827,971	99,663,659	147,749,133	268,447,220	827,254,690
Number of couple years of protection	16,247,771	2,884,328	462,159	6,588,327	21,144,960	50,224,191	97,551,736
Number of sexual and reproductive health services (including contraception) provided to young people under 25 years	120,771,854	10,282,426	6,522,207	31,149,959	67,492,356	89,981,798	326,200,600
Number of HIV-related services provided	49,379,777	3,748,442	2,340,300	15,707,701	15,877,166	40,853,185	127,906,571
Number of condoms distributed	362,984,255	8,503,352	10,087,581	208,514,303	315,730,780	615,574,231	1,521,394,502
Number of abortion-related services provided	2,898,789	484,591	877,655	1,810,040	3,368,607	7,221,136	16,660,818

Table 4: Results by region, 2014

Indicator	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of sexual and reproductive health services (including contraception) provided	68,440,043	7,033,947	1,441,574	17,865,237	25,748,477	28,751,235	149,280,513
Number of couple years of protection	4,782,919	325,161	41,359	708,758	2,927,656	5,770,382	14,556,235
Number of sexual and reproductive health services (including contraception) provided to young people under 25 years	31,528,229	3,296,049	820,190	8,537,572	11,292,624	11,090,263	66,564,927
Number of HIV-related services provided	16,966,369	1,248,493	363,533	2,909,875	4,103,844	6,165,919	31,758,033
Number of condoms distributed	81,250,006	1,544,291	1,259,872	26,353,371	41,470,715	35,379,501	187,257,756
Number of abortion-related services provided	1,234,460	130,814	128,333	408,147	468,291	1,409,838	3,779,883
Estimated percentage of Member Association clients who are poor and vulnerable	91%	86%	57%	80%	88%	74%	85%
Proportion of Member Associations providing the Integrated Package of Essential Services*	26%	50%	n/a [†]	4%	56%	43%	30%

* There are eight components in the Integrated Package of Essential Services: sexuality counselling, contraception, safe abortion care, STI/RTI, HIV, gynaecological, obstetric and gender-based violence services (see Annex C for details). Exceptions are permitted in relation to the context in which the Member Associations are working; for example, legislative constraints or other providers offering accessible, quality and affordable services.

[†] This indicator does not apply to the Member Associations in the European Network as governments and private agencies are the main providers of sexual and reproductive health services. The core focus of Member Associations in this region is advocacy, and while some Member Associations do provide sexual and reproductive health services, it is not strategic for them to provide a wide range of services.

Programme successes: Adolescents


Tackling early and forced marriage

Association Nigérienne pour le Bien-Être Familial (ANBEF)

In 2014, the African Union launched the *Campaign to End Child Marriage* and individual Member States have launched their own national campaigns.

Niger has the highest prevalence of early and forced marriage in the world where nearly three-quarters of girls marry before the age of 18 and nearly one-third of girls are married before the age of 15.¹² The practice leads to a high risk of infant and maternal mortality and nearly all girls who marry early drop out of school.^{13, 14} The rate is highest in the south of the country, with almost 90 per cent of girls in the Diffa, Maradi and Tahoua regions being married before they are 18 years old.¹⁵

The Member Association in Niger, the Association Nigérienne pour le Bien-Être Familial (ANBEF), is working in 20 villages in the Maradi and Tahoua regions to mobilize community and religious leaders to transform attitudes about early and forced marriage. ANBEF trained peer educators who, in turn, conducted awareness-raising talks with over 10,400 people, including young men and women. Peer educators report that increased community awareness is translating into greater discussion on the topic in public and religious spaces, and on local radio stations. In clinics, doctors and nurses sensitize women on the risks of early and forced marriage, highlighting the impact on the health and overall well-being of girls.

Nearly one-third of girls are married before the age of 15 and nearly all girls who marry early will drop out of school.¹⁶ 

Supported by 20 community chiefs, 12 municipal mayors and six regional prefects, education activities have expanded from community level to the municipal and regional levels of government. Support is now growing for girls to stay in school as a result of ANBEF's work in these regions.

Increasing access to youth friendly services in poor urban settings

Asociación Dominicana Pro-Bienestar de la Familia (PROFAMILIA)

In the Dominican Republic, under IPPF's *Choices and Opportunities* programme, the Asociación Dominicana Pro-Bienestar de la Familia (PROFAMILIA) is implementing a strong community-led and youth-friendly project to increase access to an essential package of age-appropriate sexual and reproductive health services for young people, including the expansion of post-abortion care services. Operating in some of the most under-served communities in poor urban settings, the project has specific interventions aimed at young people in informal workplaces and young girls involved in sex work.

Using a peer health promoter network, one of the objectives of this project is to promote clinical services for young people. The Member Association employs Youth Health Promoters for each clinic to deliver comprehensive sexuality education in schools, and to distribute condoms. The Promoters divide their time between working in the clinics and the community, and are involved in work planning and review of data for making programmatic decisions. They also manage a group of young volunteers who are enlisted to provide information to other youth in their neighbourhood, and when needed, to make referrals to clinic services. The support and supervision provided to young volunteers is seen as key to the success of this peer network model.

Most of the peer promoters are girls aged 15 to 19 years. A significant number of those who seek them out are boys aged 10 to 14. Many of these boys have dropped out of school, or do not attend regularly, and so do not benefit from sexual and reproductive health education provided in the curricula. Building on these initial interactions, the boys become more likely to access other sexual and reproductive health services from clinics. By developing trusting relationships, the taboo of talking about sexuality is diminished, and all the peer promoters are confident discussing a range of sexual and reproductive health issues, including sexual pleasure, gender norms and sexually transmitted infections.

As a result of this project, and the adoption of its network approach, PROFAMILIA has experienced a steady increase in the number and proportion of services provided to young people. PROFAMILIA more than doubled the number of services delivered to young people since 2010. As a proportion of all services, those accessed by young people rose from 31 per cent to 38 per cent over the same period.

Programme successes: HIV and AIDS

Working with the Global Fund to Fight AIDS, Tuberculosis and Malaria

 **Family Life Association of Swaziland (FLAS)**

 **Family Planning Association of Sri Lanka (FPASL)**

IPPF is partnering with the *Global Fund to Fight AIDS, Tuberculosis and Malaria* (Global Fund), with many of our Member Associations being either the Principal or Sub-recipients of grants for national HIV programmes.

The Family Life Association of Swaziland (FLAS) promotes the integration of HIV and sexual and reproductive health within programmes supported by the Global Fund. In 2011, the Association joined the Country Coordinating Mechanism as a non-governmental representative, and in 2014, FLAS was elected Chair. In this position, the Association has been able to safeguard sexual and reproductive health and gender issues in the national HIV/tuberculosis policy concept note. The concept note advocates treatment with antiretroviral drugs at an earlier stage to ensure access for over 60,000 newly-eligible people.¹⁷ This would achieve 75 per cent treatment coverage of all those who are HIV-positive in Swaziland, enabling them to live healthier, longer lives.¹⁸

In 2014, the Family Planning Association of Sri Lanka (FPASL) became a Sub-recipient under the *Multi-Country South Asia Global Fund HIV Programme* in 2014. This is a regional programme that is addressing the HIV epidemic among transgender people and men who have sex with men.

The Association is improving coordination with local governments and health care providers through provision of technical assistance and capacity building activities to strengthen community support systems.

As the only non-governmental Global Fund recipient in Sri Lanka, the financial investment enabled the Association to reach 14,220 people from key populations (including men who have sex with men, sex workers and people who inject drugs) with a sexual health package. FPASL trained peer educators to engage with these key populations through three national networks of people living with HIV. The Member Association's work affects more than 50 per cent of those receiving treatment in the country and around 400 people living with HIV received travel grants to reach their treatment services each month.¹⁹

At 27 per cent, Swaziland has the highest incidence in the world of HIV and AIDS among adults aged 15 to 49.²⁰



Developing HIV prevention report cards for sex workers

 **Kazakhstan Association for Sex and Reproductive Health (KMPA)**

 **Reproductive Health Alliance Kyrgyzstan (RHAK)**

 **Russian Family Planning Association (RFPA)**

 **Tajikistan Family Planning Association (TFPA)**

At 11 per cent, the world's second highest HIV prevalence rate among sex workers is in Eastern Europe and Central Asia.²¹ Not only are sex workers disproportionately affected by HIV, they are also highly marginalized and subject to discrimination.²²

IPPF is committed to making public health facilities a safe environment for sex workers by providing services that are free from stigma. To support this work, the IPPF European Network and Member Associations in Kazakhstan, Kyrgyzstan, Russia and Tajikistan developed national HIV prevention report cards with recommendations for key stakeholders and service providers.²³ These give an at-a-glance summary of HIV statistics, including data on HIV prevention for sex workers. The cards also provide information on the five components that are essential for effective action on HIV prevention for key populations: legal and social context, availability of services, accessibility of services, participation and rights, and violence.

Laws that criminalize sex workers make it difficult for them to exercise their human rights and access health services. Extreme sexual and gender-based violence, including rape and beatings by clients and the police, are systemic in all four countries.

Criminalization of sex workers gives the perpetrators of violence a sense of impunity and deters sex workers from seeking help.

The report cards, produced in cooperation with the Sex Workers' Rights Advocacy Network and UNFPA, are an excellent advocacy tool for in-country partners working with and for sex workers to improve the current situation. Launched at the International AIDS Society Conference in Melbourne in July 2014, they are designed to stimulate dialogue about how to promote the health and rights of sex workers and to encourage good practice.

In total, 16 Member Associations in the European Network have programmes to support sex workers. These include providing sexual and reproductive health services through clinical outreach teams; empowering sex workers to tackle discrimination and to enjoy equal sexual rights and opportunities; and advocacy to oppose the criminalization of sex work.

Programme successes: Abortion

Preventing unsafe abortion through harm reduction

Palestinian Family Planning and Protection Association (PFPPA)

A harm reduction approach to prevent unsafe abortion integrates a set of policies, programmes and practices to ensure that in a highly restrictive, criminalized or stigmatized environment, any woman who requires termination of an unwanted pregnancy is provided with essential information and resources to do so safely. This approach is based both on human rights and public health principles. In human rights terms, it empowers women to make decisions about their reproductive lives that are right for them. On public health grounds, the approach underscores the ethical responsibility of health systems and providers to minimize risk of harm to women who seek services in restricted settings.

The Palestinian Family Planning and Protection Association (PFPPA) is implementing a harm reduction approach in an environment where legal access to safe abortion is severely restricted. Facing an increasing number of women seeking care for complications resulting from unsafe abortion, PFPPA is implementing a dual approach to address this issue. Firstly, to raise awareness of the harmful consequences of unsafe abortion, PFPPA conducts educational and outreach sessions, home visits, community meetings and dialogues with community and religious leaders. PFPPA also led a mass media campaign, working with television, radio and print media to reach a wider audience with clear messages in support

of a woman's right to choose, as well as information on the implications of current abortion laws in Palestine and the consequences of unsafe abortion.

The second strategic approach involves the provision of counselling and consultation services in a safe and confidential setting, as well as information on the safer options available. PFPPA also provides post-abortion services, including treatment for incomplete abortion, as well as contraceptive counselling and modern methods of contraception.

Using the harm reduction approach, PFPPA is supporting women to make informed choices and reducing the impact of unsafe abortion in Palestine. In 2014, PFPPA provided over 2,500 women with approximately 5,300 harm reduction services.

Increasing access to safe abortion services for young women

Kazakhstan Association on Sexual and Reproductive Health (KMPA)

Planned Parenthood Association of Ghana (PPAG)

In 2014, IPPF continued to support initiatives that expand access to safe abortion services for young women. As part of a package of outreach strategies, Member Associations in Kazakhstan and Ghana are using modern communication tools to increase the availability of information for young people, while acknowledging that they also face stigma and socio-cultural barriers.

The Kazakhstan Association for Sexual and Reproductive Health (KMPA) is providing sexual and reproductive health services, including contraception and safe abortion, in schools and universities. KMPA uses a variety of approaches which include integrated community outreach with young peer educators; working in partnership with higher education institutions to conduct awareness sessions; providing clinical services, including evening services; using social media to disseminate information; and training providers on how to ensure that their youth friendly services are safe, confidential and non-discriminatory. Implementing this strategy is creating accessible services that meet the needs of young people.

Drawing on experience from the IPPF *Global Comprehensive Abortion Care Initiative*, the Planned Parenthood Association of Ghana (PPAG) broadcasts regular radio discussions on FM stations within its catchment areas to create

demand for the Association's services. PPAG also answers questions on air from callers to educate and to encourage listeners to visit the clinics. A mobile messaging app offers an interactive discussion space that is familiar to young people.

This strategy is particularly useful for clinics whose clientele include young people and students, many of whom use mobile phones. It allows PPAG to communicate directly with young people who might be difficult to reach in other ways, to answer their questions with the assurance of privacy and confidentiality, and to refer them to clinics for contraception and safe abortion services as required. It is possible to send images as well as text via the phone app, which is particularly useful for showing young people information on contraceptive methods and diagrams relating to sexual and reproductive health.

As a result of these strategies, the number of clients provided with safe abortion services by PPAG increased by 25 per cent in 2014 compared to 2013, with 62 per cent of clients being young people.

Programme successes: Access

Improving the quality of cervical cancer screening and preventative treatment

Reproductive Health Uganda (RHU)

Reproductive Health Uganda (RHU) is providing cervical cancer screening services using visual inspection with acetic acid, and preventive therapy using cryotherapy. The services are offered in both static clinics and outreach facilities, and in collaboration with government health centres.

RHU faced challenges in reaching women in the relevant 30 to 49 age bracket and was having low positive diagnosis rates. So, in 2014, technical support was provided and quality of care assessments undertaken to strengthen providers' knowledge and practical skills. Supportive supervision of service providers by qualified nurses, learning aids and refresher training now ensure consistent levels of knowledge and skills. Data show that this targeted approach has led to significant improvements in the quality of services. For example, the positive diagnosis rate has increased from an average of 3 per cent to between 9 and 14 per cent in the three clinics visited by monitoring staff. This means that women who would previously have been undiagnosed are now screened effectively, and when required, are able to access preventive therapy.

However, not all of RHU clinics provide preventive therapy so RHU also works with other health facilities that provide cryotherapy. By establishing close working partnerships with selected providers and strong referral systems, information flows well between RHU staff and the other

health providers. This information is vital as it supports continuity of patient care and identification of clients who had a positive diagnosis but did not receive cryotherapy services. When this is the case, RHU providers encourage women to access the care they need.

“Before, I could not go for treatment because of the long distance and a lack of money for transport. When RHU later acquired cryotherapy equipment, and upon following me up and re-screening me, I was found to still have a positive lesion, for which cryotherapy was successfully carried out.”

28-year-old mother of three

Promoting programmatic and financial sustainability in Latin America

Asociación Pro-Bienestar de la Familia Colombiana (PROFAMILIA)

Centro de Investigación, Educación y Servicios, Bolivia (CIES)

Many health organizations struggle to deliver services to the most vulnerable populations while still maintaining financial viability. Two Member Associations in the Western Hemisphere region, Asociación Pro-Bienestar de la Familia Colombiana (PROFAMILIA) and Centro de Investigación, Educación y Servicios (CIES) in Bolivia, are seeking to promote programmatic and financial sustainability through a social enterprise approach. PROFAMILIA and CIES have demonstrated that investing in sustainability and developing social enterprise business models can enable Member Associations to generate a profit to finance further growth and development, as well as the delivery of services to vulnerable populations.

PROFAMILIA developed five service lines that encompass its organizational operations in Colombia. Each line acts as a self-sustainable business model, where the revenue-generating activities aim to produce sufficient resources to cover operational costs while also supporting social programmes to improve the sexual and reproductive health of vulnerable populations. For example, US\$170,000 profit from the pharmaceutical sales business line was used to finance over 230,000 adolescent services at PROFAMILIA's youth centres.

In Bolivia, CIES made significant investments in the organization's internal structure and data analysis systems to support income generation and cost efficiencies. Its aim is to promote financial self-sustainability within each clinic, allowing for the subsidization of integral programming to meet the needs of vulnerable populations. Revenue is generated through the sale of diversified services and commodities at competitive prices in 16 national clinics. In 2014, this strategy resulted in a 29 per cent increase in revenue and an 8 per cent increase in service volume.

perform a relevant and accountable Federation

Throughout 2014, IPPF continued to invest in and strengthen organizational systems and business processes to support a strong culture of performance, effectiveness, learning and accountability. Our work is maximizing impact and value for money across the Federation.

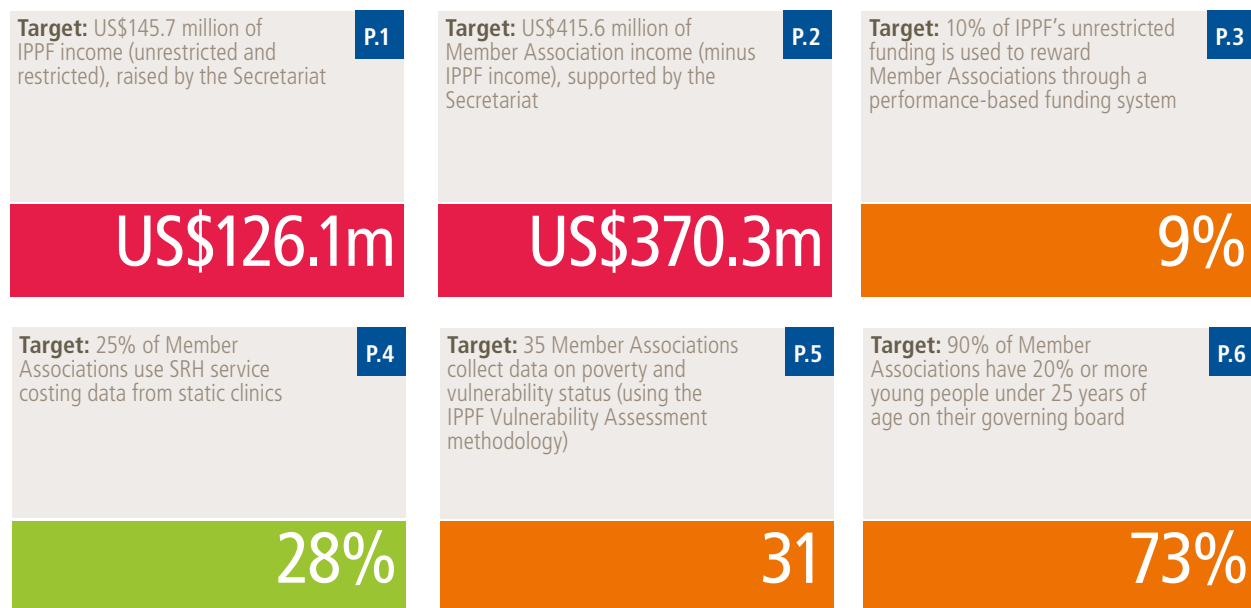
IPPF's achievements for the change goal Perform are presented in Figure 10. The results are positive overall, with four indicators making progress, but with only one of these surpassing the target. Indicators P.1 and P.2 on income saw a decline and did not achieve the target set for 2014. Total income raised by the Secretariat fell by US\$10.0 million, from US\$136.1 million in 2013 to US\$126.1 million in 2014. This represents a drop of 7 per cent, and is explained predominantly by a decline in the American dollar exchange

rate. Income raised by Member Associations, including funds from international donors and locally-generated income, dropped by 4 per cent, from US\$384.1 million in 2013 to US\$370.3 million in 2014. Again, the American dollar exchange rate impacted on these results, as well as an income decline from two large Member Associations. The comparable data set, excluding these two Associations, shows that income generated by Member Associations rose by 3 per cent between 2013 and 2014.

Throughout 2014, IPPF made good progress towards implementing systems that drive our performance culture. The performance-based funding system is now used in five of IPPF's six regions, and there was an increase from 7 to 9 per cent in the proportion of IPPF's unrestricted income being used to reward Member Associations demonstrating strong performance. There was a slight increase in the proportion of Associations using costing data to assess static clinic performance in the delivery of sexual and reproductive health services. An additional 11 Member Associations began using IPPF's *Vulnerability Assessment* methodology to collect data on the poverty and vulnerability status of their clients, bringing the total to 31 in 2014. Finally, the proportion of Member Associations that have 20 per cent or more young people on their governing board grew by an impressive 10 per cent between 2013 and 2014. This is strong year-on-year progress but remains below the challenging target set at 90 per cent.

There are a number of examples presented in this section to demonstrate our focus on improving IPPF's performance. Approaches include using tools to strengthen curricula and programme interventions with a focus on comprehensive sexuality education; learning and capacity building among Member Associations to transfer knowledge, experience and expertise; cost-effectiveness analysis to make financial savings and increase financial sustainability; and using client feedback and clinic management information systems to inform programme management.

Figure 10: Perform – performance results in 2014



Investing for results

In 2014, all of IPPF's donors increased or held level their unrestricted funding to IPPF in their own currency. However, total IPPF income raised by the Secretariat from governments, foundations and other sources fell from US\$136.1 million in 2013 to US\$126.1 million in 2014. Seventy per cent of the decline was due to the strengthening of the American dollar against donor currencies. Furthermore, Australia's commitment of US\$4.0 million was delayed to 2015 as its financial year differs from that of IPPF.

Analysis of total IPPF expenditure by programme area shows that access, abortion, advocacy and capacity building received the greatest amount of funding in 2014, followed by adolescents and resource mobilization. Overall, 69 per cent of funding was invested in IPPF's five strategic priorities: adolescents, HIV and AIDS, abortion, access and advocacy. The remaining 31 per cent was spent on IPPF's four supporting strategies: resource mobilization, governance and accreditation, capacity building, and monitoring and evaluation.

The proportion of total Secretariat income available as unrestricted funds was 63 per cent in 2014, compared to 62 per cent in 2013. Unrestricted funding received by Member Associations supports critical areas such as organizational effectiveness, partnership development, strategic planning, learning, financial sustainability, innovation, data quality improvement, and monitoring and evaluation. Despite the fall in total unrestricted income from US\$84.7 million in 2013 to US\$79.7 million in 2014, grants to Member Associations and other partners rose by US\$1.8 million, or 4 per cent, in 2014.

IPPF continues to invest in countries with the lowest levels of development and the greatest unmet needs for sexual and reproductive health and rights. In 2014, 71 per cent of grants to Member Associations and other partners went to those working in countries with low or medium human development.²⁴ Member Associations and collaborating

partners in countries with the highest development needs are located in Africa and South Asia, and these two regions received 40 per cent and 20 per cent respectively of IPPF total grants awarded.

Bilateral donors and other international funding agencies increasingly provide grants directly to partner organizations in the countries where programmes are implemented. It is therefore important for Member Associations to invest in fundraising strategies and to generate local income. IPPF is committed to strengthening the financial sustainability of Member Associations by investing more funds and technical assistance in resource mobilization with expenditure of US\$9.3 million in 2014, 18 per cent more than in 2013.

Excluding IPPF grants, Member Association income fell by US\$13.8 million to US\$370.3 million in 2014. This decline is explained by losses due to the American dollar exchange rate and reduced income from two large Member Associations. Excluding data from these two Member Associations, a comparison of trends in income generated shows an increase of 3 per cent between 2013 and 2014. Income raised by grant-receiving Member Associations represents 85 per cent of their overall funding, and illustrates the success of the majority of Associations in increasing their financial sustainability by generating income independently of IPPF. Detailed information on IPPF finances is available in the *IPPF Financial Statements 2014*.²⁵

Innovation in resource mobilization

IPPF is investing in strengthening its systems to respond effectively to competitive tendering and bidding for national and global development programmes. Part of this work has involved building capacity in Regional Offices and Member Associations to adopt the successful thinking and strategies that for-profit management consultancies use to attract new donor income. Acquiring knowledge of competitive bidding approaches and improving business practices have created more effective resource mobilization teams.

In 2014, IPPF volunteers and staff from all regions of the Federation received training on how to engage effectively with donors and prepare winning proposals. Staff from different areas of speciality worked together during this training to design business processes to increase income for IPPF. Following the training, the IPPF Africa Regional Office redesigned its approach to bidding for restricted funding. Now, when funding opportunities are identified, the Regional Office brings together a cross-functional bid team, including staff from programmes, monitoring and evaluation, finance and human resources, who work in close collaboration with the resource mobilization team and the Member Associations involved.

The process supports the sharing of ideas and expertise, including the local, context-specific knowledge of Member Associations and the sector-level knowledge of innovation and good practice in sexual and reproductive health and rights located in the Africa Regional Office. This change in approach recently resulted in the Regional Office winning its first significant bid, which will increase the capacity of the Member Association in Nigeria to scale up service delivery.

Improving IPPF's comprehensive sexuality education programmes

The majority of Member Associations implement comprehensive sexuality education programmes for young people. IPPF's new tool, *Inside & Out*, is used to review and assess the comprehensiveness and quality of these programmes.* In 2014, IPPF supported 36 Member Associations to use the tool, leading to improvements in both curricula content and programme delivery.

Developed in partnership with UNESCO, the *Inside & Out* tool is based on international evidence and best practice in the development and content of effective curricula. The standards are based on two resources: the *It's All One Curriculum*²⁶ developed by the Population Council and IPPF, and IPPF's *Framework for Comprehensive Sexuality Education*.²⁷ The *Inside & Out* tool has been used by Member Associations to improve the sexuality education content in their curricula by mapping the components against these standards. The analysis also reviews programme approaches, language and messaging, monitoring and evaluation, and training provided to educators. Where gaps are shown, the Member Association can strengthen its curriculum to ensure that all components are included. The analysis also scores the comprehensive sexuality education programmes in a standardized way to highlight where performance is strong as well as identifying areas where improvements are needed in programme implementation.

As part of the *Inside & Out* self-assessment process, Member Associations use the *Demystifying Data* tool (see box) to explore demographic and socio-economic data in each country context and to review information on young people's sexual and reproductive rights. This ensures that curricula and programme approaches are designed to respond to the most pressing needs of young people.

Feedback from participants after the *Inside & Out* training workshops demonstrates that the assessments of comprehensive sexuality education curricula and programme approaches can lead to significant improvements, as seen in the following examples.

Redesign of comprehensive sexuality education programmes to increase effectiveness

Following an assessment of its sexuality education programme using *Inside & Out*, the Health Education and Research Association (HERA) in Macedonia is increasing the involvement of parents and school authorities to expand young people's access to comprehensive sexuality education. HERA will include a stronger focus on gender-based violence and violence in relationships, which was identified as lacking in the content of its comprehensive sexuality education programme.

Meanwhile, the Association Sénégalaise pour le Bien-Être Familial (ASBEF) is now involving religious leaders in the design and implementation of youth programmes. As religious leaders hold significant influence over young

people and their families, ASBEF hopes this initiative will increase the acceptance of sexuality education throughout the country by creating community acceptance, decreasing opposition and encouraging young people to participate.

When Reproductive Health Uganda (RHU) used *Inside & Out*, it identified a need to strengthen linkages between comprehensive sexuality education and service delivery to ensure young people are aware of and able to access services. In addition, using the *Demystifying Data* tool revealed a need to update the content of RHU's comprehensive sexuality education programme as statistics related to young people's sexual and reproductive health had changed since the Association last developed its materials. As a result, RHU is now revising the content to bring it up to date.

Making complex data sets useful for decision makers

The challenges that young people face when trying to access sexual and reproductive health information and services can be explored interactively for 30 different countries using an online tool developed by IPPF in partnership with the Guttmacher Institute.²⁸ Compiled from national surveys, the *Demystifying Data* digital visualization tool makes extensive data accessible to non-technical analysts.

Demystifying Data was launched online in October 2014 and complements a printed guide that explains the practical meaning of the data in clear, non-technical language.²⁹ Both resources help health care providers, educators and advocates in the field of sexual and reproductive health and rights to better understand and use evidence on young people's knowledge and behaviour. The guide provides demographic and socio-economic information about young people, as well

as measures of their need for, access to and use of sexual and reproductive health information and services.

The interactive online data tool enables data to be explored in an accessible and interactive way. Users can select options to compare differences across categories such as countries, urban or rural areas, age groups and wealth quintiles. In 2014, training on the tool was provided to show participants how data can inform their programme and policy design, and the ways in which data can be used as evidence to strengthen arguments in funding proposals.

The *Demystifying Data* tool won second place in a data visualization contest held by On Think Tanks in 2014. The competition rewards data visualization techniques that can inspire, encourage and strengthen capacity for think tanks around the world to influence and inform policy.

* For further information, please contact the IPPF Youth Team via info@ippf.org.



IPPF/Katie Chau/Ethiopia

Advocating as an agent for change with government

After using the *Inside & Out* tool, the Family Planning Organization of the Philippines (FPOP) shared the results of its assessment with the Ministry of Education, other key stakeholders and relevant organizations. The tool is now being used to assess the government's comprehensive sexuality education curriculum to address any gaps.

The Cameroon National Planning Association for Family Welfare (CAMNAFAW) is using the findings from its assessment in advocacy meetings with UNFPA representatives and the Minister for the Promotion of Women and the Family, the Minister of Social Affairs, and the Minister of Youth and Civic Education. CAMNAFAW is advocating for comprehensive sexuality education to be included in the youth reproductive health programmes for vulnerable groups.

As a monitoring and evaluation person “
I am not experienced at programme management but the tool has taught me what comprehensive sexuality education is and how to measure it.

Training workshop participant

“I have identified missed things in our comprehensive sexuality education curriculum and realized we need to design one curriculum document and develop reference materials for specific target groups.

Training workshop participant

Leading the way on comprehensive sexuality education

Family Health Options Kenya (FHOK)

The Kenyan Ministry of Education convened a technical working group in 2009 to inform the development of a new national comprehensive sexuality education curriculum. Family Health Options Kenya (FHOK) was one of a number of civil society organizations invited to join the group, with members sharing their expertise and examples of curricula.

In 2014, the Member Association collaborated with the other organizations on the technical working group to present a unified position on the sexuality education principles they all shared. Adding further legitimacy to its position as a leading sexual and reproductive health organization, FHOK used the *Inside & Out* tool to demonstrate the quality and comprehensiveness of its curriculum.

FHOK invited a representative from the Ministry of Education to use the *Inside & Out* tool to assess the existing national curriculum and the different curricula produced by other organizations in Kenya. By working through this process together, FHOK strengthened its relationship with officials at the Ministry of Education and increased their awareness of the essential components of a quality comprehensive sexuality education programme.

This was an important collaboration: the Ministry of Education and the Kenya Institute of Curriculum Development have worked closely with FHOK to develop technical guidelines on age-appropriate comprehensive sexuality education. These guidelines are now being used to revise and improve Kenya's national curriculum.

Federation-wide learning: capitalizing on Member Association expertise

Being part of a large Federation means that many Member Associations have the opportunity to learn from and share their expertise with others. While Regional Offices provide technical support to Member Associations in their regions, there is a growing trend to promote capacity building directly between Associations. In addition, as experts in the field of implementing sexual and reproductive health and rights programmes, Member Associations are also asked by external private and public health organizations to share their knowledge and experience.

Promoting excellence through Learning Centres in the Africa region

The Africa Regional Office has supported nine Member Associations to become designated Learning Centres. These Centres offer training and other forms of technical assistance to organizations, both within and outside the Federation. Based at the Member Associations of Cameroon, Côte d'Ivoire, Ethiopia, Ghana, Kenya, Mozambique, Swaziland, Togo and Uganda, the Learning Centres promote peer-to-peer learning by transferring expertise in how to design innovative programmes. These Member Associations consistently demonstrate their capacity to provide quality sexual and reproductive health information and services, and have the expertise, skills and systems to provide technical support to other Member Associations. Each Centre reflects the acknowledged strengths of that particular Member Association.

In 2014, volunteers and staff of the Member Associations with Learning Centres took part in refresher training in their core areas of expertise to strengthen their ability to provide support on topics in demand. These included family planning, with a focus on long-acting and permanent methods; public–private partnerships; and how to deliver integrated sexual and reproductive health and HIV-related services. Member Associations were supported to convert areas within their facilities into meeting spaces, and to develop or adapt training modules based on national sexual and reproductive health policies and curricula.

Exchange visits involving the Member Associations in Cameroon, Ghana and Uganda offered valuable opportunities to share experiences in the day-to-day management of running a Learning Centre. Technical assistance was provided to the Member Associations in Côte d'Ivoire, Swaziland and Togo to develop their five-year Learning Centre operational and business plans.

Reproductive Health Uganda (RHU) demonstrates one example of a Learning Centre building the capacity of multiple Member Associations across the region. RHU provided training to Member Associations from Ethiopia, Kenya, Malawi and Mozambique on how to design and manage surgical camps, as well as training for Member Associations in Ethiopia, Kenya, Malawi, Namibia, Swaziland and Tanzania on a parent-focused intervention exploring the sexual and reproductive health and rights of young people.

In 2014, three Member Associations with Learning Centres were successful in generating income from training public or private health providers. The Family Guidance Association of Ethiopia trained 2,628 health professionals from public and private clinics, generating 16.7 million Birr (US\$816,000); Family Health Options Kenya trained 300 service providers, generating 3 million Ksh (US\$32,000); while Côte d'Ivoire's Association Ivoirienne pour le Bien-Être Familial trained nearly 200 service providers and generated 62.6 million FCFA (US\$100,000).

Improving cervical cancer prevention through capacity building in the Caribbean

Despite being highly preventable with early detection and treatment, cervical cancer is the fourth leading cause of cancer deaths for women in the Caribbean.³⁰ Under the auspices of its South-South learning programme, the Western Hemisphere region is extending access for cervical cancer services by facilitating the use of a cost-effective, single visit approach for treatment. Visual inspection with acetic acid (VIA) and treatment with cryotherapy allow cervical cancer to be diagnosed and treated in the same visit. This reduces loss to follow-up as well as saving time and costs for service users who would otherwise need to

attend a second visit for treatment. The techniques also enable increased service delivery in rural and remote areas since they do not depend on laboratory analysis, facilities for storing samples or expensive medical equipment.

The Guyana Responsible Parenthood Association, in partnership with Jhpiego and the Guyana Ministry of Health, led training for doctors and nurses from the Member Associations of Belize, Grenada, St Lucia, Suriname, and Trinidad and Tobago to increase their capacity to deliver cervical cancer prevention services using VIA. At the end of the week-long workshop, participants were assessed on their detection and treatment skills to ensure high levels of quality assurance.

The learning has enabled these Member Associations to launch their own cervical cancer prevention programmes and expand delivery in their clinics. During the first screening campaign using the new treatment in Grenada, women queued for six hours to register. Demand exceeded the daily threshold of 50 women, which led the Member Association to open new targeted clinic slots for treatment in the following week.

The Member Associations involved in this initiative are further increasing the availability of services in their countries with knowledge transfer to others. For example, the Belize Family Life Association is partnering with its Ministry of Health to train government providers, and expand the reach of the service across the whole country.

Using human rights instruments as effective advocacy tools in Europe

Global conventions, treaties and laws that address human rights can be powerful tools to reinforce sexual and reproductive health advocacy. These human rights instruments create mechanisms to hold governments accountable in implementing their domestic policies and to fulfil their international commitments. However, the complex language and bureaucratic systems constructed around international human rights create barriers for organizations to be effective actors in these arenas.



IPPF/Jon Spaul/Colombia

To increase the advocacy capacity of three eastern European Member Associations, the European Network facilitated a learning exchange led by the Irish Family Planning Association (IFPA). IFPA shared its expertise gained from working with different human rights treaty monitoring bodies over the years with the Member Associations of Georgia, Macedonia and Romania. In these three countries, the governments were scheduled to be reviewed in the next six to 18 months by one of the United Nations treaty monitoring bodies relevant to sexual and reproductive health and rights.

IFPA trained the three Associations to use human rights instruments, clarifying what human rights instruments are and how the systems in which they operate function. Through a mapping exercise, the Member Associations identified agreements related to sexual and reproductive health and rights to which their governments have committed, and IFPA provided guidance on how the Associations can then hold their governments to account for these commitments. Furthermore, the training with

IFPA supported the Member Associations to develop and use specific language related to rights violations to build their capacity to be effective in making future submissions to human rights bodies. As a result of the technical support received from IFPA, all three Member Associations were able to use their skills to build in-country advocacy coalitions with new partners, undertake joint advocacy visits to Geneva, and to make submissions to a United Nations treaty monitoring body on various issues related to sexual and reproductive health and rights.

The Member Association in Georgia, HERA XXI, made two submissions: the first in the name of HERA XXI to the Human Rights Committee, and the second as part of a collective submission to the Committee on the Elimination of Discrimination against Women by a number of Georgian organizations. Oral statements and presentations were made to both committees, and HERA XXI produced summary documents and advocacy cards for one-to-one advocacy. The Member Association in the Republic of Macedonia, Health Education and Research

Association (HERA), drafted a submission to the Human Rights Committee with endorsement from a number of other Macedonian organizations. Societatea de Educatie Contraceptiva si Sexuala (SECS), the Member Association in Romania, drafted two submissions to the United Nations Committee on Economic, Social and Cultural Rights. Each submission had the endorsement of a number of other organizations, and SECS also delivered an oral statement to the Committee.

IFPA supplemented its support through mentoring, research, compiling useful resources and providing feedback on the advocacy strategies of the three Member Associations.

**MOVING
FORWARD
TOGETHER**

Developing IPPF's *Strategic Framework 2016–2022*

IPPF's current strategic framework comes to an end in 2015. Developing and agreeing a new strategy for the Federation has been a collaborative and inclusive process with three distinct overlapping elements: engage, focus and implement. IPPF's Governing Council approved the *Strategic Framework 2016–2022* in November 2014.

Engage

IPPF engaged with multiple stakeholders and consulted extensively on the draft strategy during 2014, gaining invaluable feedback from the rich diversity of IPPF Member Associations and the country contexts in which they work.

Our partners, donors and other stakeholders offered their expert guidance and opinions on IPPF's role in providing sexual and reproductive health services and enabling others to deliver services, and in championing sexual and reproductive health and rights for all, especially those who are under-served.

Focus

Our new strategy focuses on four key outcomes:

- 100 governments respect, protect and fulfil sexual and reproductive rights and gender equality
- 1 billion people to act freely on their sexual and reproductive health and rights
- 2 billion quality integrated sexual and reproductive health services delivered
- a high-performing, accountable and united Federation

Implement

Implementation will begin in 2016. Country-level strategic plans are being developed to define the contributions that each Member Association can make to the new *Strategic Framework*. The Secretariat is also developing an implementation plan, together with a framework of expected results to monitor progress. Implemented together, these plans will enable us to move forward as a united Federation to achieve our mission where all people are free to make choices about their sexuality and well-being, in a world without discrimination.

Programme successes: Perform

Improving performance and cost-effectiveness in service delivery



Family Health Options Kenya (FHOK)

Reproductive Health Uganda (RHU)

The *Branch Performance Tool* provides Member Associations with information that supports management to take decisions to improve performance and make financial savings. Introduced in 2012, the tool uses existing service statistics and financial data to compare performance across different clinics and outreach facilities on a number of efficiency scores. These include ratio of clients to staff per day; number of sexual and reproductive health services and couple years of protection provided; cost per service; and overheads as a percentage of costs.

Nineteen Member Associations in the Africa region were using the tool in 2014 to promote a culture of performance underpinned by data that support operational, financial, strategic and management decision making. Examples of decisions taken as a result of using the tool include relocating facilities to areas with greater unmet need in Benin, and providing additional support and resources to a high-performing clinic to expand the range of services provided in Togo.

Branch Performance Tool analyses provide the information needed by management to encourage critical and strategic thinking and reflection; this, in turn, results in better decision making

on how to improve performance related to a variety of parameters including service delivery, finance, commodities, administration and human resources.

The Member Associations in the Africa region that have been trained and are now using the *Branch Performance Tool* have invested significantly in strengthening data quality and data-driven decision making. For example, many Associations now use monthly standardized data capture tools, indicator definition guidelines, and routine data quality assessment with monthly review of data quality and performance. Member Associations also use opportunities to learn and share their experiences of using the tool with one another in various fora.

The *Branch Performance Tool* enabled Family Health Options Kenya (FHOK) to identify a clinic in the western part of the country where contraceptive provision was consistently low. Investigating further, management found that the limited availability of commodities, along with myths and misconceptions about contraception and, for some people, the inability to pay for these services were the main reasons for low uptake. As a result, FHOK embarked on an improvement plan. In partnership with the Ministry of Health and others, the Member Association was able to improve commodity security

and affordability, and service providers received training on contraceptive technology with a focus on long-acting reversible methods. Young contraceptive champions were recruited to disseminate information and make referrals, and social media were used to address the myths and misconceptions about contraception.

The performance of this clinic has improved dramatically with statistics showing that only 5,000 couple years of protection were provided in 2013, in comparison to nearly 18,000 in 2014, with implants contributing over 70 per cent of this total. There has also been a reduction in the cost per couple year of protection from US\$50 to US\$15. The cost recovery ratio has increased and financial savings are being used to subsidize clinics in poorer areas, and to provide contraception to those clients who cannot afford to pay.

In Uganda, use of the *Branch Performance Tool* indicated that a specific clinic in the northern district appeared to have lower performance levels than others in the country. The analyses revealed that despite a high client load, there was a low cost recovery ratio and a low proportion of young service users, as well as data inconsistencies. Reproductive Health Uganda (RHU) used these results to develop a targeted

programme of improvement while taking into consideration the complications of working in a post-conflict area with significantly high unmet need for contraception.

One of the main challenges experienced by the clinic was regular stock-outs of key supplies, including contraceptives, HIV testing kits and other laboratory commodities. To address this, a partnership was established with the District Health Office to distribute supplies to the clinics. This, together with improvements in the Member Association's own commodity supply management system, has resulted in securing a range of commodities and thereby reducing stock-out rates.

Negotiations with local radio stations led to marketing information being broadcast free of charge, which attracted increasing numbers of service users to the clinic, in particular more young people. Contraceptive services provided to young people increased by 11 per cent between 2013 and 2014 in this clinic. Overall, changes made by RHU have resulted in an increase in cost recovery from 8 to 31 per cent since implementation.

Programme successes: Perform

Driving performance through client feedback and evaluation



Family Planning Association of Bangladesh (FPAB)



Indonesian Planned Parenthood Association (IPPA)



Sudan Family Planning Association (SFPA)

One key objective of the *Global Comprehensive Abortion Care Initiative* is to collect and use client-based data to inform programme management. Data are captured through feedback forms, and the Clinical Management Information System provides clinics with manual or electronic records about their service users. These data are regularly analysed and discussed by clinic staff. During 2014, Member Associations in Bangladesh, Indonesia and Sudan made a total of 23 programme decisions after reviewing data.

Bangladesh

During a review of clinic performance, the Family Planning Association of Bangladesh (FPAB) observed that one particular clinic experienced a significant rise in the number of services provided. Based in Laxmipur, this clinic had held a series of awareness-raising events to convey key messages on sexual and reproductive health, including safe menstrual regulation, and to promote free service days. Data showed that following these events, there was a 95 per cent increase in the number of clients seeking menstrual regulation between April and September 2014. Learning from the experience, FPAB is replicating this strategy across all its clinics to increase access to safe menstrual regulation services.

Indonesia

The Indonesian Planned Parenthood Association (IPPA) is using client data collected through the Clinical Management Information System to improve quality of care through effective monitoring. IPPA began providing medical abortion services in 2014, and data on complication rates following the procedure are carefully recorded and monitored. This enables clinic managers to follow up on any complications quickly, identify the cause, and take steps to assure the quality of the medical abortion services provided. In addition, IPPA clinics are collecting data to identify areas not reached by services and populations that do not currently access IPPA's clinics. IPPA has used these analyses to implement targeted messaging campaigns aimed at under-served groups to increase client flow to clinics.

Sudan

Despite ongoing outreach efforts by the Sudan Family Planning Association (SFPA), few women were seeking post-abortion care services in its clinics. An analysis of service user feedback and meetings with community-based agents indicated that many clients were accessing a smaller package of services from their local community-based agents and not travelling to clinics for other services. The community-based agents are trained

by the clinic to provide basic sexual and reproductive health services in the community, but they do not offer more complex counselling or services, including treatment for incomplete abortion. The Member Association took the decision to build the capacity of community-based agents to identify and refer women to clinics for post-abortion care. Training on when to refer, together with a system of referral coupons, empowered agents to ensure that women in their catchment areas would be supported to access the services they need in SFPA clinics. The coupon system also enables the clinics and community-based agents to identify those women who do not attend their referral appointment to ensure follow-up. Data from 2014 show an increase of 54 per cent in the number of women seeking post-abortion care services at SFPA's clinics.

In 2014, a total of 3,700 women in Bangladesh, Indonesia and Sudan received an abortion or treatment for incomplete abortion by the three IPPF Member Associations, representing a 24 per cent increase over 2013.



Refining data for decision making



Syrian Family Planning Association (SFPA)

Since the beginning of the humanitarian crisis in Syria in 2011, the Syrian Family Planning Association (SFPA) has provided sexual and reproductive health services in extremely challenging conditions. As part of the effort to strengthen the performance culture of the Association, and with a focus on improving data quality, SFPA received comprehensive training on standardized data collection systems for service statistics, definition guidelines and how to use data to inform decision making. Agencies such as UNFPA and UNICEF have both acknowledged the efforts made by the Association to provide quality data, and UNFPA is funding the salaries of SFPA's service statistics officers.

A focus on data quality and using data have both contributed to an improvement in performance of the Association with the number of services rising from 140,000 in 2012, to 970,000 in 2013 and subsequently 1.1 million in 2014. Not only are more data being captured, but they are also now disaggregated by type of service, location, age group and type of service channel. By utilizing these data, SFPA has been able to define the package of services to be delivered by mobile clinics in crisis settings, and has increased the number of service delivery sites to address unmet need from 35 in 2012 to 74 in 2014.

Programme successes: Perform

Strengthening information systems to improve service efficiency

Centro de Investigación, Educación y Servicios, Bolivia (CIES)


Centro de Investigación, Educación y Servicios (CIES) in Bolivia is a pioneer in the use of electronic health records. Drawing on the evolving needs of the organization, newly available technologies and a commitment to improving health outcomes for service users, CIES re-engineered its data system to create client-based electronic health records. These records incorporate advanced features such as reminders, validation tools and online service user history to support better case management.

There are multiple benefits in having a clinical management system that uses electronic health records. Results from CIES's experience demonstrate that service providers benefit from improved coordination, continuity and quality of care provided, along with increased efficiency in clinic management. For service users, the benefits relate not only to their clinic experience, such as reduced waiting times, but also ultimately in their health outcomes due to improved coordinated care when they consult different providers on different health concerns.

In CIES, the clinic management system supported the introduction of doctors' agendas and a scheduling module. In one of CIES's busiest clinics, the new system has reduced client waiting times from 2.5 hours to 30 minutes, and has increased clinic efficiency by reducing paper-based forms from 21 to just three. With less time spent

filling out multiple forms with information already given, providers have more time to spend with service users. In addition, automatic features such as alerts in the health records prompt service providers to ensure client follow-up, for example, when a positive test result indicates that treatment is required, or where service users have not returned for important follow-up care. In such circumstances, these alerts contribute to improved health outcomes.

From the perspective of clinic management, CIES is now able to use dashboards with graphics to show comparative three-year results of service performance, clinic by clinic. These data track progress monthly and are linked to a number of trend graphs posted on CIES's website, an excellent example of commitment to full transparency on performance.

 This electronic health record is both intelligent and dynamic. We can consider, provide follow-up, and address clients' needs in all areas of their health, in order of priority and severity of those needs.

Medical provider in a CIES clinic

Inter-regional training on the harm reduction model

Iniciativas Sanitarias, Uruguay

Reproductive Health Uganda (RHU)

The harm reduction approach reduces maternal morbidity and mortality caused by unsafe abortion in countries with restrictive legal environments, and provides women with information on how to terminate their unwanted pregnancies in a safer manner. Pioneered by the Member Association in Uruguay, Iniciativas Sanitarias, the approach triggered a process that resulted in the decriminalization of abortion in that country, and has since been replicated in several Latin American countries.

During 2014, an inter-regional exchange enabled a multi-disciplinary team from Iniciativas Sanitarias to share their experiences of implementing the harm reduction model with Member Associations from Benin, Egypt, Ghana, Syria, Tanzania and Uganda, and two Regional Offices (Africa and the Arab World).

The format of the exchange was a training of trainers workshop on how to provide harm reduction services, including counselling and information on safer ways to end an unwanted pregnancy in countries with restrictive legal environments. The three-day training used a variety of methodologies including case reviews, structured group discussions, video critique and role play to help the trainees understand the core principles and key components of a harm reduction programme.

Reproductive Health Uganda (RHU) had begun piloting a harm reduction model and was able to share its success with participants to demonstrate the model's efficacy in the African context. Building on the experience of Iniciativas Sanitarias and RHU, the participants are now using this shared experience to introduce harm reduction programmes.

The two teams from the Africa and Arab World Regional Offices are developing action plans to incorporate this approach within the IPPF spectrum of safe abortion care. This will create opportunities for Member Associations to provide the maximum range of safe abortion services within each of their legal contexts. These regional action plans will identify appropriate geographical target locations and assess Member Association capacity to implement the harm reduction approach.

Next steps

The year ahead will conclude our current strategy and we are dedicated to fulfilling our change agenda by delivering on our commitment to double sexual and reproductive health services by 2015, and ensuring sexual and reproductive health and rights are reflected in the new Sustainable Development Goals.

Unite

IPPF will influence the final negotiations on the new Sustainable Development Goals and the related Financing for Development process. We will prepare the ground for the crucial national processes that will follow, to ensure strong sexual and reproductive health and rights targets are set within each country's Sustainable Development Goals plan. For the new goals to improve lives on the ground, we need to influence national- and district-level decision makers, and the main focus for IPPF in 2015 and 2016 will be to build and consolidate this work.

Following on the success of the *I Decide* petition, we will support Member Associations during 2016 to promote goals five and eight of IPPF's *Vision 2020* manifesto. Goal five calls for the involvement of young people in all policy decisions affecting them; goal eight aims to ensure comprehensive sexuality education for all by 2020. Our experience and knowledge will be shared to help civil society and other stakeholders engage the largest-ever generation of young people as service users and providers, activists and volunteers, and we will continue to build the capacity of young people as powerful advocates. IPPF will forge new partnerships with organizations promoting gender equality and women's empowerment to highlight the importance of sexual and reproductive health and rights. We will also work with civil society allies to influence in the BRICS countries, to advance family planning, and to use human rights mechanisms for accountability.

Deliver

IPPF's commitment to quality of care remains a key issue as we strive to increase the number of sexual and reproductive health services provided. We will build on the work previously undertaken across the Federation to support client-centred, rights-based services, and to empower service providers in identifying concerns and proposing concrete solutions to improve quality of care. Standards of quality, assessed as part of IPPF's accreditation system, cover quality of care management as well as the Integrated Package of Essential Services (IPES), the minimum package of services that Member Associations are expected to provide in static clinics to meet the most pressing sexual and reproductive health needs of service users. Future efforts will focus on improving compliance with IPES.

As part of our ambition to treble services by 2020, we have identified a number of service delivery channels and programme approaches with the potential for scale-up. Funding has been allocated to strengthen work in several critical areas: sexual and gender-based violence, cervical cancer screening and preventive therapy, social franchising and the provision of long-acting contraceptives. In 2015 and 2016, we will review how these programmes are working, with a view to implementing the successful initiatives more widely. Following an independent evaluation, the role of the IPPF International Medical Advisory Panel is being strengthened with a focus on providing specialist medical and scientific evidence, and by developing recommendations for best practice.

Perform

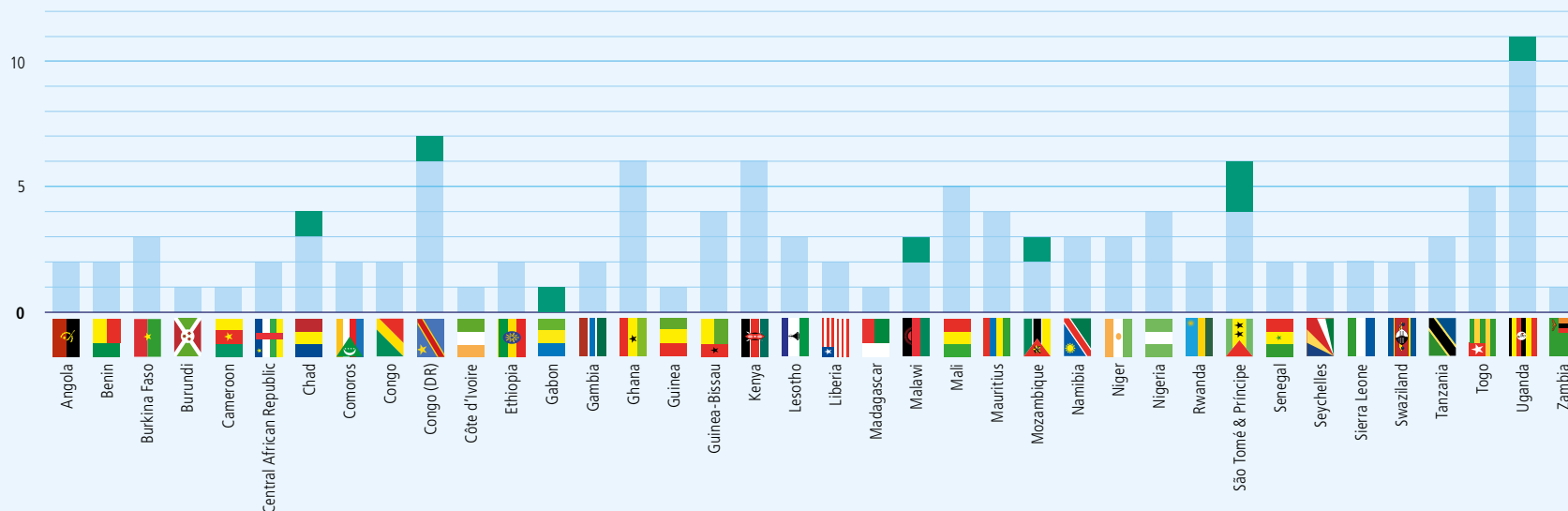
As a Federation, we are currently planning for our new strategic period at the national and Secretariat levels. Performance, accountability, efficiency and effectiveness are being examined so that our internal systems and business processes can best support our work. Member Associations are developing their own strategic plans to align with the global framework, and by reflecting on the external environment, each plan will remain relevant to the national context. As part of this process, costing analyses, marketing and sound business planning will be critical in ensuring financial sustainability for Member Associations into the future.

Our phase three accreditation system for Member Associations is being pilot tested ahead of its global launch in 2016. This phase has more emphasis on the implementation of tools, systems, procedures and policies while reaffirming Member Associations' commitment to the IPPF vision, mission and core values. We are also establishing an updated performance planning and reporting system to ensure we capture our investment and results across all Member Associations and the Secretariat.

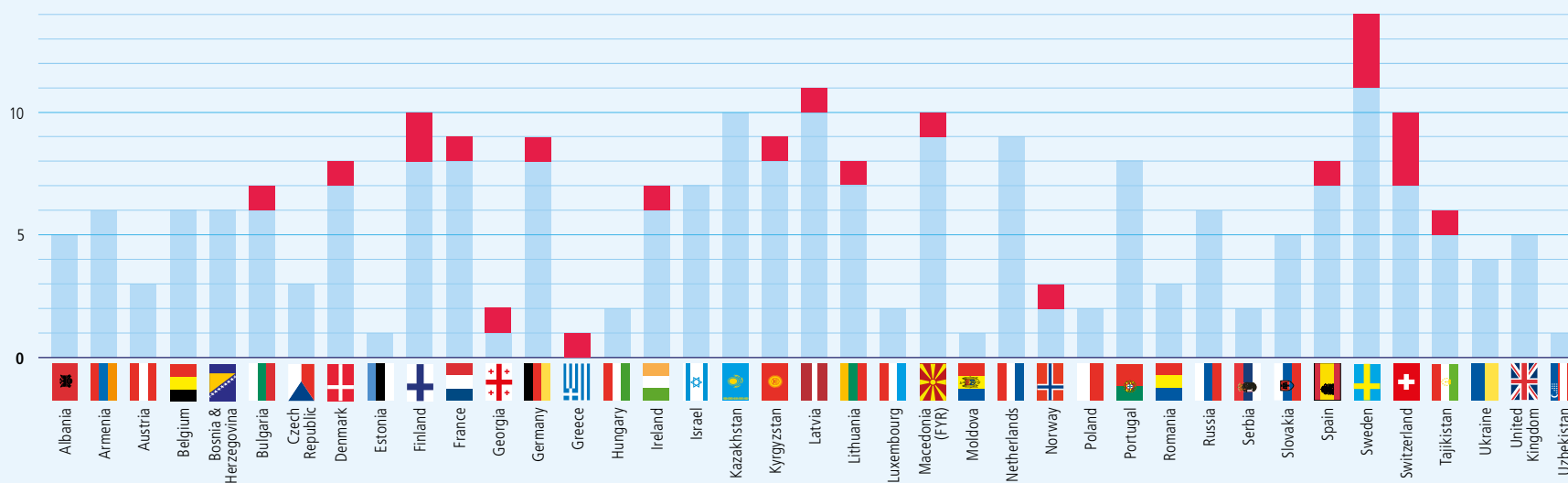
As we conclude our current strategy, and conscious that we have much to learn from our experience, Member Association Executive Directors gathered together in May 2015 to share expertise and innovative approaches. Ongoing learning from each other will be critical to the success of our new *Strategic Framework 2016–2022*.

Annex A: Number of policy and/or legislative changes, by country, 2005–2014

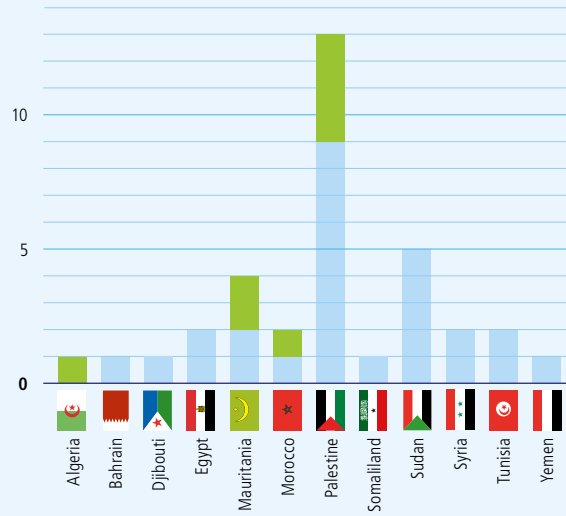
Africa



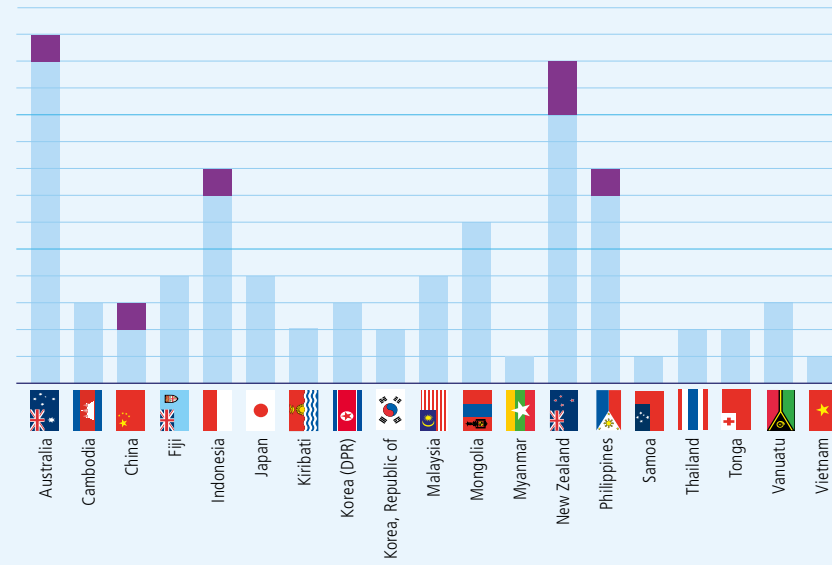
European Network



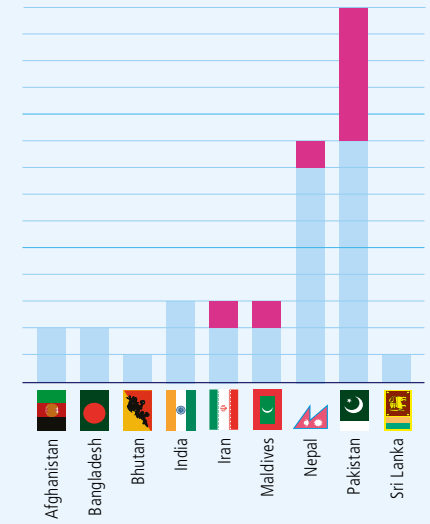
Arab World



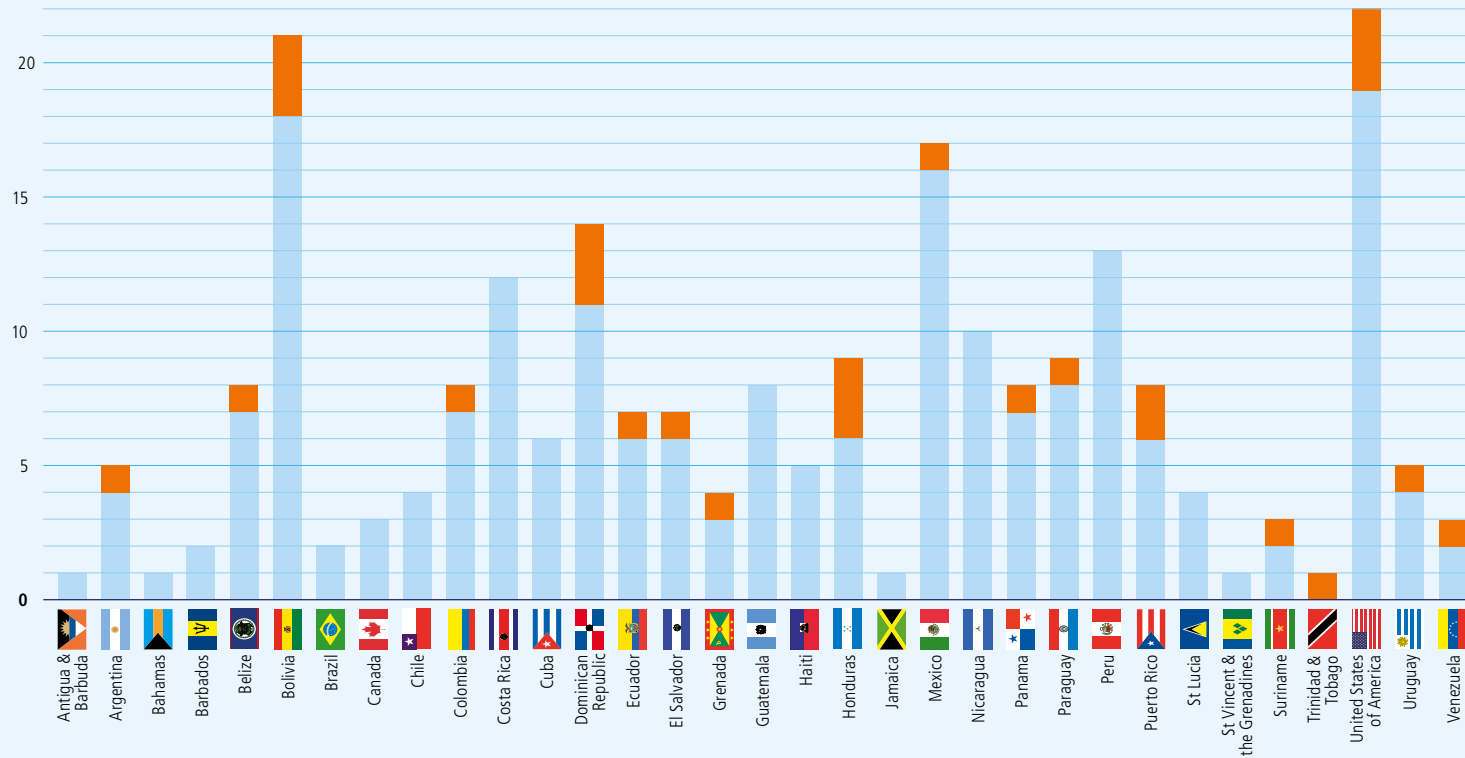
East and South East Asia and Oceania



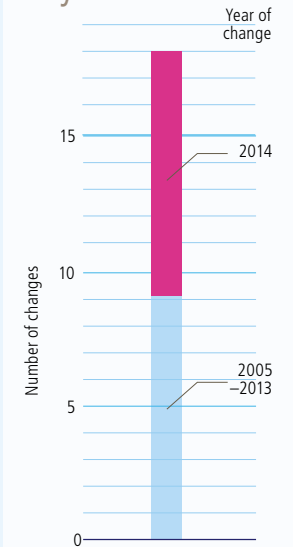
South Asia



Western Hemisphere



Key



Annex B: Global performance results, by region, 2010–2014

Table B.1: Online survey response rate, 2010 and 2014

IPPF region	Year	Total number of Member Associations/ collaborative partners	Number of Member Associations/ collaborative partners that responded	Response rate (per cent)
Africa	2014	40	39	98%
	2010	37	37	100%
Arab World	2014	15	14	93%
	2010	15	13	87%
European Network	2014	40	39	98%
	2010	41	41	100%
East and South East Asia and Oceania	2014	26	26	100%
	2010	22	22	100%
South Asia	2014	9	9	100%
	2010	9	9	100%
Western Hemisphere	2014	28	27	96%
	2010	29	29	100%
Total	2014	158	154	97%
	2010	153	151	99%

Table B.2: Online service statistics module response rate, 2010 and 2014

IPPF region	Year	Total number of Member Associations/ collaborative partners that provide services	Number of Member Associations/ collaborative partners that responded	Response rate (per cent)
Africa	2014	40	38	95%
	2010	37	37	100%
Arab World	2014	12	11	92%
	2010	13	9	69%
European Network	2014	22	21	95%
	2010	22	18	82%
East and South East Asia and Oceania	2014	25	25	100%
	2010	22	22	100%
South Asia	2014	9	9	100%
	2010	8	8	100%
Western Hemisphere	2014	27	27	100%
	2010	28	27	96%
Total	2014	135	131	97%
	2010	130	121	93%

Table B.3: IPPF's performance dashboard – global performance results, 2010–2014

Indicator	2010 (baseline/ actual, if available)	2011 (actual, if available)	2012 (actual)	2013 (actual)	2014 (target)	2014 (actual)	% of target achieved	2015 (target)
Unite*								
U.1 Number of successful policy initiatives and/or positive legislative changes in support or defence of SRHR to which Member Associations' advocacy contributed	47	116	105	97	50	81	162%	50
U.2 Number of successful regional and global policy initiatives and/or positive legislative changes in support or defence of SRHR to which IPPF's advocacy contributed	n/a	5	11	13	5	18	340%	5
U.3 Proportion of Member Associations monitoring obligations made by government in the international human rights treaties that they have ratified	n/a	n/a	42%	55%	58%	54%	93%	61%
Deliver								
D.1 Number of SRH services provided	88.2m	89.6m	112.7m	136.7m	149.0m	149.3m	100%	176.4m
D.2 Number of couple years of protection	8.9m	9.1m	11.8m	12.1m	15.1m	14.6m	97%	17.8m
D.3 Number of SRH services provided to young people (under 25 years) (as a % of all services provided)	31.0m (35%)	37.4m (42%)	45.1m (40%)	66.2m (48%)	71.5m (48%)	66.6m (45%)	93% (94%)	88.2m (50%)
D.4 Number of abortion-related services provided	1.8m	1.9m	2.4m	3.0m	4.9m	3.8m	78%	7.1m
D.5 Number of HIV-related services provided	12.3m	15.2m	19.2m	24.7m	25.1m	31.8m	127%	29.7m
D.6 Estimated number of IPPF clients who are poor and vulnerable (as a % of all clients)	23.9m (72%)	24.9m (73%)	36.1m (81%)	48.8m (81%)	41.8m (79%)	52.6m (85%)	126% (108%)	49.5m (80%)
D.7 Proportion of Member Associations providing the Integrated Package of Essential Services	7%	14%	21%	26%	44%	30%	68%	55%
D.8 Number of young people (below 25 years of age) who completed a comprehensive sexuality education programme delivered by Member Association staff	n/a	4.4m	18.2m	25.1m	27.6m	25.2m	91%	30.4m
Perform								
P.1 Total IPPF income (unrestricted and restricted), raised by the Secretariat (US\$)	124.2m	127.6m	144.8m	136.1m	145.7m	126.1m	87%	154.3m
P.2 Total Member Association income (minus IPPF income), supported by the Secretariat (US\$)	289.9m	324.3m	372.1m	384.1m	415.6m	370.3m	89%	439.3m
P.3 Proportion of IPPF's unrestricted funding used to reward Member Associations through a performance-based funding system	n/a	1%	6%	7%	10%	9%	90%	10%
P.4 Proportion of Member Associations using SRH service costing data from static clinics	n/a	n/a	13%	27%	25%	28%	112%	30%
P.5 Number of Member Associations collecting client data on poverty and vulnerability status (using the IPPF Vulnerability Assessment methodology)	n/a	1	10	20	35	31	89%	45
P.6 Proportion of Member Associations that have 20 per cent or more young people under 25 years of age on their governing board	57%	58%	58%	63%	90%	73%	81%	100%

Dashboard indicator colour key

Target reached or exceeded	Target not reached; progress made	Target not reached; no progress made
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* There is an additional target for Unite (U.4): the inclusion of SRHR or components of SRHR in the post-2015 development framework and/or in preparatory documents, to which IPPF's advocacy contributed. This will be reported on in 2015, and via U.2 in the interim period.

Table B.4: Change Goal UNITE – performance results, by region, 2010–2014

Indicator*	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
U.1 Number of successful policy initiatives and/or positive legislative changes in support or defence of SRHR to which Member Associations' advocacy contributed	2014	8	8	22	6	8	29	81
	2013	18	2	32	9	7	29	97
	2010	9	2	12	8	2	14	47
U.2 Number of successful regional and global policy initiatives and/or positive legislative changes in support or defence of SRHR to which IPPF's advocacy contributed	2014	5	0	2	1	1	3	18 [†]
	2013	1	1	5	1	1	1	13 [‡]
	2010	n/a	n/a	n/a	n/a	n/a	n/a	5 [‡]
U.3 Proportion of Member Associations monitoring obligations made by government in the international human rights treaties that they have ratified	2014	51%	21%	67%	46%	56%	63%	54%
	2013	51%	29%	61%	46%	44%	77%	55%
	2010	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* There is an additional target for Unite (U.4): the inclusion of SRHR or components of SRHR in the post-2015 global development framework and/or in preparatory documents, to which IPPF's advocacy contributed. This will be reported on in 2015, and via U.2 in the interim period.

† Includes six global advocacy successes.

‡ Includes four global advocacy successes; the wins in ESEAOR and SAR were counted as one, as a joint Asia Pacific initiative.

‡ Includes five global advocacy successes; regional data were not collected in 2010.

Table B.5: Change Goal DELIVER – performance results, by region, 2010–2014

Indicator	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
D.1 Number of SRH services provided	2014	68,440,043	7,033,947	1,441,574	17,865,237	25,748,477	28,751,235	149,280,513
	2013	56,224,075	5,324,128	1,513,632	18,503,983	22,954,892	32,222,952	136,743,662
	2010	29,968,031	1,930,746	1,506,577	9,493,922	14,664,943	30,668,160	88,232,379
D.2 Number of couple years of protection	2014	4,782,919	325,161	41,359	708,758	2,927,656	5,770,382	14,556,235
	2013	2,612,058	236,825	44,087	720,455	2,778,020	5,687,013	12,078,458
	2010	1,102,342	269,789	36,136	834,726	1,903,573	4,781,999	8,928,565
D.3 Number of SRH services provided to young people (under 25 years) (as a % of all services provided)	2014	31,528,229 (46%)	3,296,049 (47%)	820,190 (56%)	8,537,572 (48%)	11,292,624 (44%)	11,090,263 (39%)	66,564,927 (45%)
	2013	31,648,417 (56%)	2,469,046 (46%)	741,829 (49%)	7,491,076 (40%)	10,619,393 (47%)	13,264,128 (41%)	66,233,889 (48%)
	2010	11,317,560 (38%)	424,714 (22%)	779,239 (52%)	2,382,796 (33%)	6,882,495 (47%)	9,214,640 (30%)	31,001,444 (35%)
D.4 Number of abortion-related services provided	2014	1,234,460	130,814	128,333	408,147	468,291	1,409,838	3,779,883
	2013	542,659	84,603	107,591	278,138	382,454	1,561,325	2,956,770
	2010	165,161	40,149	101,806	169,098	500,816	793,869	1,770,899
D.5 Number of HIV-related services provided	2014	16,966,369	1,248,493	363,533	2,909,875	4,103,844	6,165,919	31,758,033
	2013	10,816,060	927,296	294,321	2,831,187	3,041,772	6,829,869	24,740,505
	2010	3,786,620	283,963	203,939	1,380,321	1,587,416	5,048,516	12,290,775
D.6 Estimated number of IPPF clients who are poor and vulnerable (as a % of all clients)	2014	27,130,781 (91%)	2,613,076 (86%)	1,463,017 (57%)	7,814,164 (80%)	8,226,905 (88%)	5,334,712 (74%)	52,582,655 (85%)
	2013	21,647,085 (83%)	2,354,933 (85%)	1,391,101 (60%)	8,378,044 (76%)	9,422,826 (88%)	5,655,969 (78%)	48,849,958 (81%)
	2010	4,640,396 (73%)	347,441 (49%)	478,508 (30%)	6,894,071 (77%)	5,780,588 (82%)	5,746,949 (68%)	23,887,953 (72%)
D.7 Proportion of Member Associations providing the Integrated Package of Essential Services*	2014	26%	50%	n/a [†]	4%	56%	43%	30%
	2013	13%	45%	n/a [†]	0%	56%	50%	26%
	2010	5%	0%	n/a [†]	4%	13%	15%	7%
D.8 Number of young people (below 25 years of age) who completed a comprehensive sexuality education programme delivered by Member Association staff	2014	591,554	1,043	473,997	22,381,707	212,849	1,573,019	25,234,169
	2013	873,340	1,689	437,939	22,447,386	162,712	1,176,516	25,099,582
	2010	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* There are eight components in the Integrated Package of Essential Services: sexuality counselling, contraception, safe abortion care, STI/RTI, HIV, gynaecological, obstetric and gender-based violence services (see Annex C for details). Exceptions are permitted in relation to the context in which the Member Associations are working; for example, legislative constraints or other providers offering accessible, quality and affordable services.

† This indicator does not apply to the Member Associations in the European Network as governments and private agencies are the main providers of sexual and reproductive health services. The core focus of Member Associations in this region is advocacy, and while some Member Associations do provide sexual and reproductive health services, it is not strategic for them to provide a wide range of services.

Table B.6: Change Goal PERFORM – performance results, by region, 2010–2014

Indicator	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
P.1 Total IPPF income (unrestricted and restricted), raised by the Secretariat, in US\$ millions	2014							126.1
	2013							136.1
	2010							124.2
		[Not applicable by regional breakdown]*						
P.2 Total Member Association income (minus IPPF income), supported by the Secretariat, in US\$ millions	2014	60.4	4.6	4.1	127.9	18.1	155.2	370.3
	2013	55.2	4.6	4.9	142.5	17.9	159.0	384.1
	2010	34.3	4.4	4.6	88.5	14.3	143.8	289.9
P.3 Proportion of IPPF's unrestricted funding used to reward Member Associations through a performance-based funding system	2014	10%	0%	10%	10%	10%	10%	9%
	2013	5%	0%	10%	10%	10%	6%	7%
	2010	n/a	n/a	n/a	n/a	n/a	n/a	n/a
P.4 Proportion of Member Associations using SRH service costing data from static clinics	2014	21%	33%	0%	20%	67%	38%	28%
	2013	31%	30%	0%	18%	56%	36%	27%
	2010	n/a	n/a	n/a	n/a	n/a	n/a	n/a
P.5 Number of Member Associations collecting client data on poverty and vulnerability status (using the IPPF Vulnerability Assessment methodology)	2014	13	3	0	4	5	6	31
	2013	5	0	0	3	5	7	20
	2010	n/a	n/a	n/a	n/a	n/a	n/a	n/a
P.6 Proportion of Member Associations that have 20 per cent or more young people under 25 years of age on their governing board	2014	90%	79%	69%	65%	89%	52%	73%
	2013	77%	71%	63%	62%	44%	47%	63%
	2010	73%	39%	42%	59%	44%	69%	57%

* While resource mobilization is coordinated across the Secretariat, the majority of IPPF income is reported at the global level for the Federation as a whole.

Table B.7: Number of couple years of protection provided, by region, by method, 2010–2014

Type of method	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of responses	2014	(n=38)	(n=10)	(n=20)	(n=24)	(n=9)	(n=26)	(n=127)
	2013	(n=39)	(n=11)	(n=20)	(n=26)	(n=9)	(n=29)	(n=134)
	2010	(n=37)	(n=9)	(n=18)	(n=22)	(n=8)	(n=27)	(n=121)
Intrauterine devices	2014	443,255	242,124	23,443	242,058	960,374	1,791,135	3,702,389
	2013	396,051	192,349	22,209	207,166	797,980	1,746,698	3,362,453
	2010	236,998	235,258	9,531	213,573	443,213	1,604,423	2,742,996
Oral contraceptive pill	2014	1,399,568	33,683	5,249	60,177	427,103	743,339	2,669,119
	2013	578,948	18,826	6,369	152,463	455,862	800,430	2,012,899
	2010	156,677	20,214	2,191	125,498	370,609	545,658	1,220,847
Implants	2014	1,296,345	21,833	544	54,394	109,188	909,864	2,392,168
	2013	481,480	9,339	6,799	39,251	99,745	758,851	1,395,465
	2010	133,076	385	3,477	16,610	13,911	197,905	365,364
Voluntary surgical contraception (vasectomy and tubal ligation)	2014	67,230	-	290	76,060	738,398	1,193,420	2,075,398
	2013	40,670	-	180	32,450	757,815	1,199,120	2,030,235
	2010	13,210	-	3,760	33,220	530,833	1,258,620	1,839,643
Injectables	2014	891,297	13,050	628	54,353	258,008	653,649	1,870,985
	2013	658,311	10,342	29	63,257	237,221	636,373	1,605,534
	2010	289,276	7,271	46	75,021	171,968	428,810	972,392
Condoms	2014	677,083	12,869	10,499	219,611	345,589	294,829	1,560,481
	2013	451,314	5,101	7,671	224,150	348,513	331,506	1,368,256
	2010	261,970	5,247	15,613	368,052	311,215	622,026	1,584,123
Emergency contraception	2014	6,915	509	513	1,162	88,997	90,688	188,783
	2013	3,868	41	365	1,093	80,883	120,467	206,717
	2010	1,303	391	86	1,287	61,825	122,960	187,852
Other hormonal methods	2014	109	-	96	58	-	70,458	70,721
	2013	19	-	265	46	-	93,388	93,718
	2010	15	-	-	90	-	689	794
Other barrier methods	2014	1,116	1,092	98	884	-	23,000	26,191
	2013	1,396	827	200	578	-	179	3,180
	2010	9,816	1,022	1,434	1,375	-	907	14,554
Total	2014	4,782,919	325,161	41,359	708,758	2,927,656	5,770,382	14,556,235
	2013	2,612,058	236,825	44,087	720,455	2,778,020	5,687,013	12,078,457
	2010	1,102,341	269,788	36,138	834,726	1,903,574	4,781,998	8,928,565

Table B.8: Number of sexual and reproductive health services provided, by region, by service type, 2010–2014

Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of responses	2014	(n=38)	(n=11)	(n=21)	(n=25)	(n=9)	(n=27)	(n=131)
	2013	(n=39)	(n=11)	(n=20)	(n=26)	(n=9)	(n=29)	(n=134)
	2010	(n=37)	(n=9)	(n=18)	(n=22)	(n=8)	(n=27)	(n=121)
Contraceptive (including counselling)	2014	33,077,706	1,059,860	366,073	6,794,082	10,093,135	8,879,481	60,270,337
	2013	30,599,413	795,843	413,444	6,886,842	10,983,863	10,279,728	59,959,133
	2010	16,817,092	634,570	324,929	4,621,885	7,909,074	13,506,032	43,813,582
Gynaecological	2014	5,705,374	1,539,829	144,073	1,538,828	2,923,278	7,558,157	19,409,539
	2013	3,893,087	1,192,483	194,176	1,722,947	1,844,284	8,492,873	17,339,850
	2010	450,223	381,383	88,872	1,115,931	900,651	7,023,958	9,961,018
STI/RTI	2014	6,153,417	612,330	223,126	1,984,749	2,034,447	5,102,624	16,110,693
	2013	3,196,533	468,709	145,257	1,763,451	1,399,150	5,208,620	12,181,720
	2010	444,918	111,195	74,734	741,253	756,790	3,924,661	6,053,551
HIV and AIDS (excluding STI/RTI)	2014	10,812,952	636,163	140,407	925,126	2,069,397	1,063,295	15,647,340
	2013	7,619,527	458,587	149,064	1,067,736	1,642,622	1,621,249	12,558,785
	2010	3,341,702	172,768	129,205	639,068	830,626	1,123,855	6,237,224
Obstetric	2014	3,297,813	1,748,052	40,089	869,957	3,953,816	2,251,975	12,161,702
	2013	2,392,488	1,013,722	48,505	1,542,596	2,504,204	2,436,668	9,938,183
	2010	770,240	289,563	19,428	810,009	1,450,436	2,836,314	6,175,990
Paediatric	2014	2,069,909	687,164	1,152	3,093,629	1,848,229	496,585	8,196,668
	2013	1,569,934	739,501	234	3,185,489	1,735,221	516,824	7,747,203
	2010	261,267	35,891	230	77,559	856,439	277,427	1,508,813
SRH medical	2014	3,798,828	64,501	6,366	687,815	1,245,149	421,095	6,223,754
	2013	3,757,839	177,395	3,431	646,304	958,808	541,399	6,085,176
	2010	4,561,180	28,891	10,208	336,304	497,681	106,808	5,541,072
Specialized counselling	2014	1,526,113	401,584	382,703	1,449,818	757,900	1,098,244	5,616,362
	2013	2,195,596	292,024	439,247	1,306,898	1,338,975	1,091,277	6,664,017
	2010	3,082,671	223,702	753,106	914,430	867,061	802,455	6,643,425
Abortion-related	2014	1,234,460	130,814	128,333	408,147	468,291	1,409,838	3,779,883
	2013	542,659	84,603	107,591	278,138	382,454	1,561,325	2,956,770
	2010	165,161	40,149	101,806	169,098	500,816	793,869	1,770,899
Infertility	2014	579,471	84,273	7,310	74,288	155,294	78,725	979,361
	2013	301,688	53,772	9,842	59,174	135,927	72,139	632,542
	2010	9,370	2,448	202	31,370	2,594	221,708	267,692
Urological	2014	184,000	69,377	1,942	38,798	199,541	391,216	884,874
	2013	155,311	47,489	2,841	44,408	29,384	400,850	680,283
	2010	64,207	10,186	3,857	37,015	92,775	51,073	259,113
Total	2014	68,440,043	7,033,947	1,441,574	17,865,237	25,748,477	28,751,235	149,280,513
	2013	56,224,075	5,324,128	1,513,632	18,503,983	22,954,892	32,222,952	136,743,662
	2010	29,968,031	1,930,746	1,506,577	9,493,922	14,664,943	30,668,160	88,232,379

Annex C: Components of IPPF's Integrated Package of Essential Services



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Key abbreviations

AIDS	Acquired immune deficiency syndrome	KMPA	Kazakhstan Association for Sex and Reproductive Health
AMPF	Association Mauritanienne pour la Promotion de la Famille	Ksh	Kenyan Shilling
ANBEF	Association Nigérienne pour le Bien-Être Familial	MCH	Maternal and child health
AR	Africa region, IPPF	PFPPA	Palestinian Family Planning and Protection Association
ASBEF	Association Sénégalaise pour le Bien-Être Familial	PMNCH	Partnership for Maternal, Newborn and Child Health
AWR	Arab World region, IPPF	PPAG	Planned Parenthood Association of Ghana
BRICS	Brazil, Russia, India, China and South Africa	PROFAMILIA	Asociación Dominicana Pro-Bienestar de la Familia
CAMNAFAW	Cameroon National Planning Association for Family Welfare	PROFAMILIA	Asociación Pro-Bienestar de la Familia Colombiana
CIES	Centro de Investigación, Educación y Servicios, Bolivia	Rahnuma-FPAP	Rahnuma-Family Planning Association of Pakistan
CYP	Couple years of protection	RFPA	Russian Family Planning Association
EN	European Network, IPPF	RHAK	Reproductive Health Alliance Kyrgyzstan
ESEAOR	East and South East Asia and Oceania region, IPPF	RHU	Reproductive Health Uganda
FCFA	Colonies françaises d'Afrique franc	RMNCAH	Reproductive, maternal, newborn, child and adolescent health
 FHOK	Family Health Options Kenya	RTI	Reproductive tract infection
FLAS	Family Life Association of Swaziland	SAR	South Asia region, IPPF
FP2020	Family Planning 2020	SECS	Societatea de Educatie Contraceptiva si Sexuala, Romania
FPAB	Family Planning Association of Bangladesh	SFPA	Sudan Family Planning Association
FPAI	Family Planning Association of India	SFPA	Syrian Family Planning Association
FPAN	Family Planning Association of Nepal	SPRINT	Sexual and reproductive health programme in crisis and post-crisis situations
FPASL	Family Planning Association of Sri Lanka	SRH	Sexual and reproductive health
FP-CIP	Family Planning Costed Implementation Plan	SRHR	Sexual and reproductive health and rights
FPOP	Family Planning Organization of the Philippines	STI	Sexually transmitted infection
GCACI	Global Comprehensive Abortion Care Initiative	TFPA	Tajikistan Family Planning Association
GFF	Global Financing Facility	UNAIDS	Joint United Nations Programme on HIV/AIDS
HERA	Health Education and Research Association, Macedonia	UNESCO	United Nations Educational, Scientific and Cultural Organization
HERA XXI	Health Education and Research Association XXI, Georgia	UNFPA	United Nations Population Fund
HIV	Human immunodeficiency virus	UNHCR	Office of the United Nations High Commissioner for Refugees
ICPD	International Conference on Population and Development	UNICEF	United Nations Children's Fund
IDA	International Development Association	USAID	United States Agency for International Development
IFPA	Irish Family Planning Association	VIA	Visual inspection with acetic acid
IPES	Integrated Package of Essential Services	WHR	Western Hemisphere region, IPPF
IPPA	Indonesian Planned Parenthood Association		
IPPF	International Planned Parenthood Federation		

Thank you

With your support, millions of people, especially the poorest and most vulnerable, are able to realize their right to sexual and reproductive health. Without your generosity, this would not be possible.

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