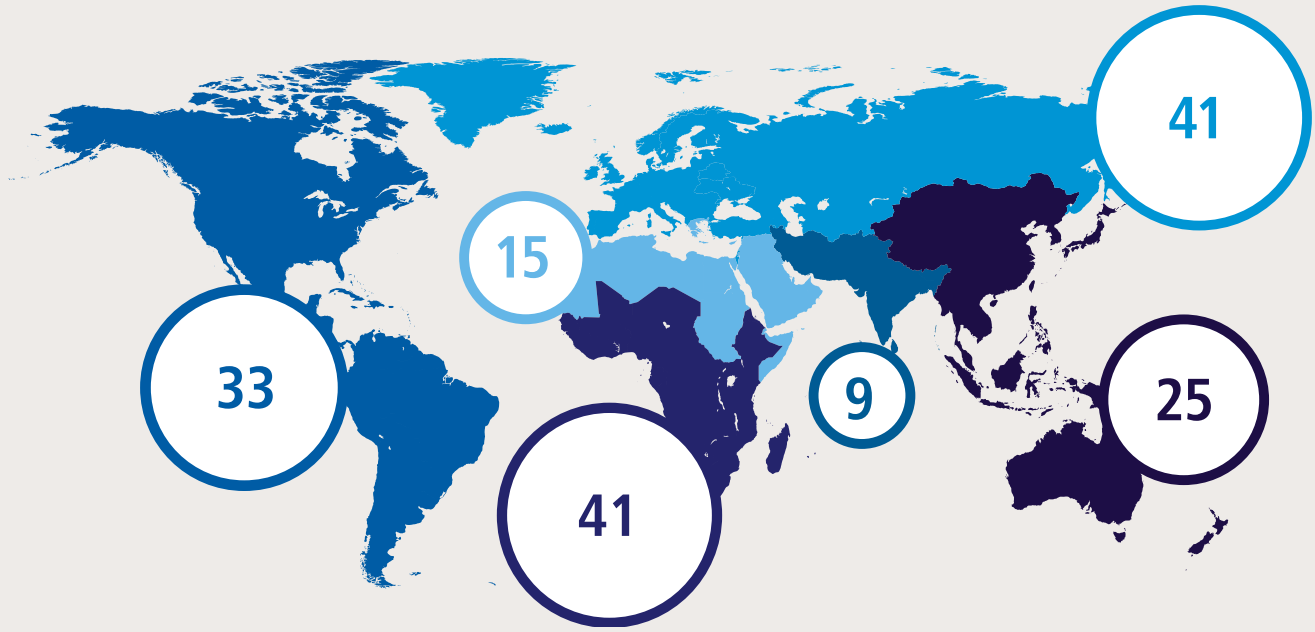
IPPF

ANNUAL PERFORMANCE REPORT 2016



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.

164 Member Associations and collaborative partners

7 Secretariat offices in **12** locations

31,000 staff

86% of Member Associations have at least one young person on their governing body

78% of Member Associations have a written gender equality policy

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

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Throughout this report, the terminology 'Member Association' includes IPPF Member Associations and collaborative partners.

Due to rounding, numbers presented in this report may not add up exactly to the totals provided, and percentages may not precisely reflect the absolute figures.

FOREWORD

This is the first Annual Performance Report on progress in implementing our new *Strategic Framework 2016–2022*. We have started well and remain focused on achieving all that we have promised over the next seven years.

We were able to hit the ground running in 2016 due to our thorough preparation as we moved from one strategic phase to the next. Each of the following sections presents an overview of key performance results for 2016, supplemented by case studies which describe the varied approaches IPPF uses to champion rights, empower communities, serve people, and unite and perform.

Advocacy remains a cornerstone of our work as one of the most effective approaches to ensuring the realization of sexual and reproductive rights. We work in partnership with civil society organizations, policy makers, leaders, advocates and communities to champion rights and defend against those who oppose our vision and our work. IPPF's most remarkable success story for 2016 was the number of policy and legislative changes in support of sexual and reproductive health and rights to which our advocacy contributed. We achieved 175 wins at national, regional and global levels, the highest number of advocacy successes we have ever accomplished in one year. We also proactively engaged with 661 youth and women's groups around the world to take public action in support of sexual and reproductive health and rights.

IPPF believes that the impetus for a major shift in favour of sexual and reproductive health and rights results from changes in public attitudes and opinions. We have continued to invest significantly in the delivery of comprehensive sexuality education for young people to build the skills needed to exercise their rights and to protect their health. In 2016, we provided comprehensive sexuality education programmes to 28.1 million young people, in both formal and non-formal settings. We also provided positive messages in support of sexual and reproductive health and rights to an estimated 112.4 million people, via online and offline channels. This is critical in creating a mass groundswell of well-informed people who can claim their rights, engage with decision makers and hold their leaders to account.

IPPF provides sexual and reproductive health services in our own health facilities, and also in partnership with other public and private providers. We delivered a total of 182.5 million services in 2016, an increase of 4 per cent from 2015, and 41 per cent of the services were provided to young people. Most clients, an estimated eight in ten, were poor and vulnerable, and an estimated 3.2 million people affected by conflict and natural disasters received services from IPPF. We provided 18.8 million couple years of protection in 2016, a 20 per cent increase from 2015, which averted an estimated 5.8 million unintended pregnancies and 1.5 million unsafe abortions.

Key to our success moving forward will be the ability to raise resources and secure financial sustainability, including through social enterprise programmes. Results from 2016 are positive, with growth in income at both the Member Association and Secretariat levels. We are also investing in business processes, systems and people to deliver IPPF's mission of a locally owned, globally connected civil society movement that provides and enables services, and champions sexual and reproductive health and rights for all, especially the under-served.

There are many challenges ahead, with well-resourced opposition groups and populist governments who threaten support and funding for sexual and reproductive health and rights. However, we will stand together, determined and resolute: our values will guide the way we work, and our vision will keep us inspired.

I would like to convey my sincere gratitude to all who have supported our work over the last year, and to all IPPF's volunteers, staff and partners who have made these achievements possible.

Tewodros Melesse,
Director-General, IPPF

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CHAMPION RIGHTS

OUTCOME 1

100 governments respect, protect and fulfil sexual and reproductive rights and gender equality

Priority objective 1: Galvanize commitment and secure legislative, policy and practice improvements

Priority objective 2: Engage women and youth leaders as advocates for change

Volunteers and staff in Member Associations and Secretariat offices work tirelessly to encourage governments and other key decision makers at local, national, regional and international levels to promote and defend sexual and reproductive health and rights. Our effectiveness is increased by working in partnership with other civil society organizations, and with youth and women leaders and advocates. Figure 1 presents IPPF's 2016 baseline results for our Outcome 1 priority objectives.

In 2016, IPPF contributed to 175 changes in policy or legislation in support or defence of sexual and reproductive health and rights. This is the highest number of wins ever achieved by IPPF and includes 25 sub-national and 127 national changes in 72 countries (Annex A). Our advocacy efforts also contributed to 14 policy changes at the regional level, and nine at the global level.

These legal and policy changes cover a range of themes; the most common include promoting sexual and reproductive rights, increasing budget allocations for sexual and reproductive health, and providing comprehensive sexuality education and sexual and reproductive health services to young people (Figure 2). IPPF advocates for legal and policy environments that promote the right to choose when and if to have children: 13 of the changes increase access to abortion, ten increase access to contraception, and six ensure the right to assisted fertility. Eight of the legal and policy changes support sexual and gender diversity.

Five changes at national, regional and global levels promote the prioritization of sexual and reproductive health in crisis situations, including in the Declaration on Disaster Risk Reduction in Asia and the Pacific. At the international level, IPPF advocacy efforts ensured the prioritization of sexual and reproductive health and rights in the G7 commitment to universal health coverage and the final resolution of the Commission on Population and Development. Ten national-level wins in Europe prioritize sexual and reproductive health and rights in international development policies and budgets, and will benefit millions of people in the countries most in need.

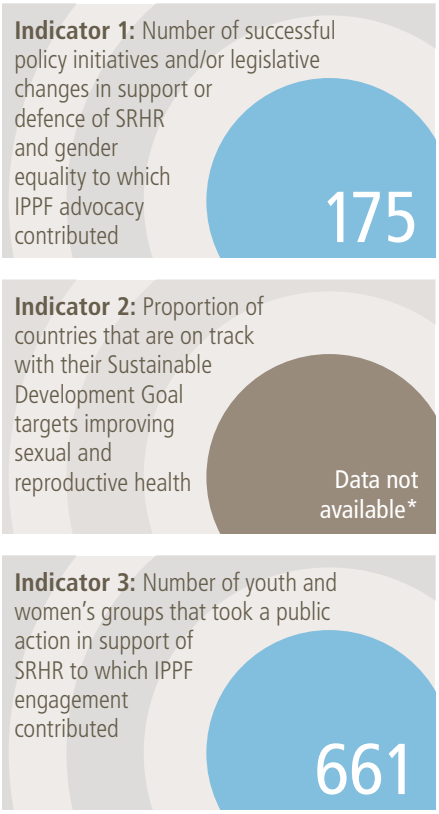
IPPF resists opposition groups attempting to bring about policy and legislative changes that would be harmful to the health and well-being of people in both developed and developing countries. In 2016, ten of the national-level wins involved blocking proposed changes that would have limited access to safe abortion, comprehensive sexuality education and contraception.

In 2015, the United Nations adopted the 2030 Agenda for Sustainable Development. IPPF is working to ensure governments set and remain committed to their targets on gender equality and women's empowerment, sexual and reproductive health, and reproductive rights. We will report on the proportion of countries that are on track in 2019.

In 2016, IPPF worked with 661 youth and women's groups to take public action in support of sexual and reproductive health and rights. Examples of actions include writing a letter to or meeting with a public official, adding the group's name to a campaign event, and participating in a rally, march or demonstration.

In the next pages, we present an advocacy success at the United Nations to protect refugees and migrants, and three Member Association examples on the themes of female genital mutilation, medical abortion, and early marriage.

FIGURE 1 OUTCOME 1: BASELINE RESULTS, 2016



* Data to be collected in 2019.

FIGURE 2 NUMBER OF POLICY AND/OR LEGISLATIVE CHANGES, BY THEME, 2016

37 Promoting sexual and reproductive rights	32 Budget allocations for SRH, including contraception	28 Education and services for young people	15 Access to SRH services
13 Access to safe and legal abortion	10 Access to contraception	9 Preventing sexual and gender-based violence	8 Promoting gender equality
8 Promoting sexual and gender diversity	6 Access to assisted fertility	5 Prioritizing SRH in crisis settings	4 Support for people living with HIV

HERA/Lilika Strezoska/Macedonia

INFLUENCING THE UNITED NATIONS TO PROTECT REFUGEES AND MIGRANTS

In 2015, 65 million people were forcibly displaced by conflict and violence, and another 19 million by natural disaster.[1] People in crisis situations face various sexual and reproductive health risks, including sexual and gender-based violence and a lack of access to adequate maternal and newborn health care. Despite the devastating impacts of these risks on women and girls, sexual and reproductive health and rights have not previously been prioritized in humanitarian settings.

In 2016, IPPF worked with other non-governmental organizations and United Nations agencies to influence United Nations Member States at the General Assembly Summit for Refugees and Migrants. IPPF and partners documented the sexual and reproductive health needs of women affected by crises, and proposed specific language for inclusion in the meeting's outcome document, with a focus on the provision of the *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations* at the onset of all crises. IPPF circulated these recommendations among country representatives who were actively involved in the negotiations, and discussed them with the Meeting Chairs, Member State negotiators and other partners.

Despite some Member States opposing the provision of sexual and reproductive health services to women, and repeatedly trying to block specific language in United Nations agreements, IPPF continued to make the case for why these services are essential. As a result, a paragraph on protecting the rights of women and girls was included in the outcome document of the United Nations General Assembly summit, the *New York Declaration for Refugees and Migrants*.

As part of the negotiations, Member States developed the Comprehensive Refugee Response Framework, which sets out responsibilities of Member States, civil society partners and United Nations agencies during humanitarian situations. It calls for countries to assess and meet the essential needs of refugees. For the first time in an internationally agreed framework, sexual and reproductive health information and services are included as 'essential needs' alongside the provision of safe drinking water, shelter, nutrition, psychosocial support and other health care.

The outcome of this summit demonstrates the critical role of IPPF interventions in United Nations negotiations, as well as the commitment of many governments to uphold the sexual and reproductive rights of those affected by crises.

> We will combat sexual and gender-based violence ... [and] provide access to sexual and reproductive health care services [in crises].
>
> *New York Declaration for Refugees and Migrants*, Paragraph 31[2]

ELIMINATING FEMALE GENITAL MUTILATION

Somaliland Family Health Association (SOFHA)

Female genital mutilation is a deeply embedded cultural practice in Somaliland, where an estimated 99 per cent of girls are cut at the average age of 10 years.[3] There are no laws in Somaliland on female genital mutilation, although there are national policies that oppose the practice. Many religious leaders support one type of female genital mutilation, the 'sunna cut', which is generally the least severe form and is also known as Type I.[4]

The Somaliland Family Health Association (SOFHA) is the country's only reproductive health organization. Since 2009, SOFHA has called for the elimination of female genital mutilation. SOFHA's strategy aims to reach young people and influential community members with information and training on how to be agents of change in their communities, and how to work in partnership with government and civil society to implement the campaign against female genital mutilation. In 2016, and with support from the Ministry of Education, SOFHA led a secondary school programme to inspire the first generation of Somalis to abandon the practice, reaching 5,500 young people. SOFHA trained 300 health care workers and 240 teachers to be active agents of change, carried out an outreach health education programme for women, and engaged religious leaders. In its clinics, the Association provided 1,600 counselling services on female genital mutilation, and provided services to treat complications.

SOFHA was also involved in a research project that provided new data on prevalence, attitudes toward female genital mutilation, and future intentions of cutting. The research showed that 77 per cent of respondents support the elimination of all forms except the 'sunna cut', with only 5 per cent wanting to abandon all forms.[5]

Based on the review findings, SOFHA has increased its campaign efforts. Engagement with health care workers and teachers will continue to build a support system for those that take steps to prevent female genital mutilation. Young women will be encouraged to seek assistance for complications. SOFHA will also continue to implement the school programmes but with additional peer-to-peer training, and the inclusion of new topics such as rape and domestic violence. Finally, SOFHA is now working with the Ministry of Education to develop educational material on the harmful effects of female genital mutilation.

> We do not need to cut our daughters at all, not even the 'sunna'. I will marry whoever I marry but she does not need to be cut. If I have daughters, they will not be cut, not at all.
>
> Research participant

EXPANDING ACCESS TO MEDICAL ABORTION BY MID-LEVEL PROVIDERS

Guyana Responsible Parenthood Association (GRPA)

In 1995, abortion in Guyana became legal without restriction up to eight weeks' gestation, and in certain circumstances beyond eight weeks. Due to a lack of eligible trained providers and political resistance, however, the law was never fully implemented and legal abortion services remained largely unavailable, particularly in the public health system. This limited access, combined with a lack of awareness of the abortion law, have contributed to stigma and high levels of unsafe abortions. Women in remote communities in Guyana, where there is no access to safe and legal abortion, are particularly under-served. They often have no alternative choice; an unsafe abortion is the only option available when faced with an unwanted pregnancy.

In 2014, the Guyana Responsible Parenthood Association (GRPA) partnered with other civil society organizations to advocate for changes to the law to make medical abortion more accessible by allowing mid-level health professionals to provide this service. The Association and its partners conducted awareness-raising activities in the community and with medical personnel on the importance of safe abortion services. GRPA, the Ministry of Health and other partners trained providers from the public health sector on comprehensive abortion care, enabling women to finally be able to access safe and legal abortion services in the public health system.

While this was a major achievement, women in remote areas remained under-served due to the absence of medical doctors in these areas. GRPA, therefore, hired a lawyer to draft a petition to reinterpret the law to increase access to medical abortion for women in isolated communities. This legal proceeding resulted in a court ruling in 2016 that revised the abortion law in Guyana, giving mid-level providers permission to administer medical abortion. Clinicians who practise in remote areas, called 'medexes', can now provide medical abortion, on condition that they notify a medical practitioner. Midwives, nurses and pharmacists have also been given permission to provide medical abortion. Following the change in law, GRPA's provision of abortion-related services increased by 68 per cent from 2015 to 2016, with the number of medical abortions more than doubling.

The Association has held discussions on abortion with faith-based organizations, and conducted workshops for young people, including peer educators, on how to access safe abortion services. GRPA included abortion-related information and education in its comprehensive sexuality education toolkit, which it is currently teaching in schools at the request of the Ministry of Education.

GRPA is now known for its commitment to promote and protect women's sexual and reproductive rights, including the right to terminate a pregnancy, and for providing safe abortion services by staff who are well trained and who respect the rights of all clients.

STRENGTHENING THE CRIMINALIZATION OF EARLY AND FORCED MARRIAGE

Reproductive Health Alliance Kyrgyzstan (RHAK)

In Kyrgyzstan, the legal minimum age of marriage is 18 years, and abducting a woman to marry against her will was criminalized in 2013. Despite these laws, 12 per cent of girls in Kyrgyzstan are still married before they are 18,[6] many after being abducted or parental arrangement. There are some religious leaders who agree to marry children under the age of 18, and these marriages are seen as legitimate by the couple's extended families and in their communities. However, they are not legally recognized nor registered. Girls who marry early are at increased risk of domestic violence, early pregnancy, and complications during pregnancy and childbirth. In Kyrgyzstan, a lack of sexuality education at home and in schools means that most girls who marry young do not know about reproductive health and rights, or contraception.[7]

The Reproductive Health Alliance Kyrgyzstan (RHAK) contributed to a change in legislation to strengthen the penalties applied when the law is broken and increase the protection of girls from early and forced marriage. Working in partnership with the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) and other national women's rights organizations, RHAK staff met with parliamentarians to discuss the negative impacts of early marriage and the need for a more supportive legal environment. These parliamentarians went on to advocate for a revised law during parliamentary hearings.

RHAK helped organize and submit a petition to the Kyrgyz President and parliament, and conducted a media campaign to raise awareness of early and forced marriage and garner public support for a change in legislation. RHAK also conducted a series of training sessions for young people throughout the country on the impacts of early marriage and how to avoid it.

As a result, in November 2016, the Kyrgyz President signed a new law that stipulates a prison sentence of up to five years for anyone who participates in the organization of a marriage where one or both spouses are under 18, and for anyone who performs such a marriage. The penalty applies to parents of both the bride and the groom, as well as religious leaders, and is a significant achievement in preventing early and forced marriage in Kyrgyzstan.

> Child brides face huge challenges. Isolated, often with their freedom curtailed, girls frequently feel disempowered and are deprived of their fundamental rights to health, education and safety.[8]

EMPOWER COMMUNITIES

OUTCOME 2

1 billion
people act freely on their sexual and reproductive health and rights

Priority objective 3:
Enable young people to access comprehensive sexuality education and realize their sexual rights

Priority objective 4:
Engage champions, opinion formers and the media to promote health, choice and rights

Figure 3 presents IPPF's 2016 baseline results for Outcome 2 priority objectives. IPPF is expanding access to comprehensive sexuality education around the world, both in and out of schools, and with a focus on reaching the most marginalized young people. In 2016, Member Associations provided comprehensive sexuality education to 28.1 million young people, an increase of 2.4 million, or 9 per cent, from 2015. This includes 24.2 million young people who received comprehensive sexuality education from the China Family Planning Association. There were a number of African Member Associations that reached many more young people with comprehensive sexuality education in 2016 than in 2015, including those in Ethiopia, Mozambique, Tanzania, Togo and Zambia.

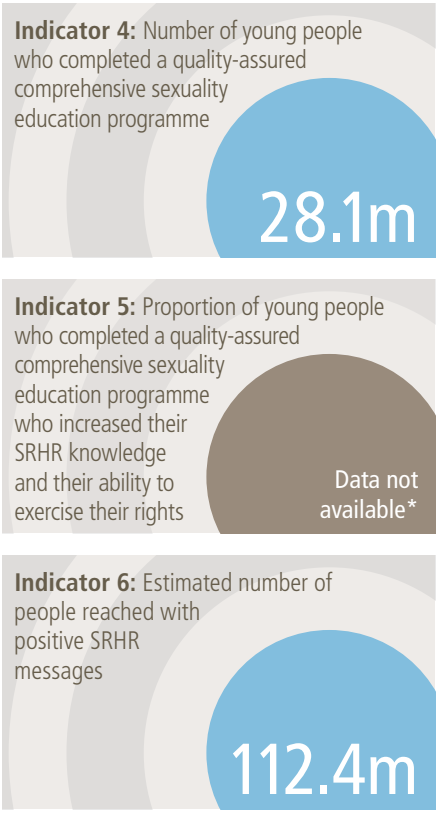
A methodology to measure Indicator 5, the proportion of young people who completed a comprehensive sexuality education programme who increased their knowledge and ability to exercise their rights, is currently being developed.

We also mobilize people who support sexual and reproductive health and rights to help us raise awareness and promote understanding. In 2016, IPPF published a report entitled *Everyone's Right to Know: delivering comprehensive sexuality education for all people*, which calls for increased political commitment to comprehensive sexuality education in schools as well as in non-formal settings. The report highlights the importance of training teachers and other educators to deliver comprehensive sexuality education confidently and with a positive and non-judgmental approach. It also encourages the involvement of civil society organizations, decision makers, religious and community leaders, teachers and parents to build support for comprehensive sexuality education and an enabling environment that respects young people and their sexual and reproductive health and rights.

The impetus for a major shift in favour of sexual and reproductive health and rights often stems from changes in public attitudes and opinions. People need to be empowered to claim their rights, to engage with decision makers and to hold their leaders to account. IPPF's work in 2016 resulted in an estimated 112.4 million people reached with positive messages about sexual and reproductive health and rights. Member Associations and Secretariat offices used both online and offline distribution channels to distribute these messages. More than half (62.0 million) were reached in the Western Hemisphere region; a further 20.0 million people were reached in the European region. The methods of distribution used included social media, websites, reports, public events and drama.

On the next page, we present two examples of the work IPPF is doing to empower young people. The first case, from Pakistan, focuses on the role of young people in changing the attitudes on abortion in their communities. The second example highlights work undertaken by the Kenyan Member Association to raise awareness of the benefits of comprehensive sexuality education, and to provide young people with a safe space to discuss sexual and reproductive health issues using mobile instant messaging.

FIGURE 3 OUTCOME 2: BASELINE RESULTS, 2016



* IPPF is currently developing and testing a methodology to measure Indicator 5.

REDUCING STIGMA AND EMPOWERING YOUNG PEOPLE

Rahnuma-Family Planning Association of Pakistan (Rahnuma)

In Pakistan, young people's access to accurate information about their sexual and reproductive health is limited. Religious and cultural norms consider any discussion of sexuality to be taboo, and this restricts the provision of sexuality education, both in the home and at school. Although over half of all unintended pregnancies in Pakistan end in abortion,[9] information about safe and legal abortion services is not widely available. Stigma and a lack of clarity around the abortion law mean that the majority of abortions are unsafe, and pose a significant risk to women's health.[10]

Rahnuma-Family Planning Association of Pakistan (Rahnuma) is working to reduce the barriers to safe abortion information and services faced by young people. To challenge abortion stigma and discrimination, Rahnuma provides training and sensitization to educate and empower young people, and to encourage them to develop self-esteem and critical thinking skills.

Trained youth volunteers have an important role to play in changing community attitudes on abortion in Pakistan. They facilitate discussions in their communities and provide accurate information about abortion to dispel myths and reframe abortion as both a public health and human rights issue. Data from community surveys conducted by Rahnuma demonstrates a reduction in the level of stigma surrounding abortion since the start of the project: in 2016, respondents reported lower levels of negative stereotyping and discrimination against women who have an abortion than respondents surveyed in 2014.

Rahnuma has established youth-friendly spaces in 19 of its health facilities. These provide areas for learning, discussion and support on a range of sexual and reproductive health and rights issues, including abortion. Young people outside of formal education attend training courses in the youth-friendly spaces to qualify as beauticians or tailors; while there, they are introduced to topics related to sexuality in a safe and comfortable environment. Rahnuma also provides a toll-free helpline for young people to speak to trained counsellors, as young people identified this approach to be less intimidating than face-to-face consultation.

The proportion of all abortion-related services provided to young people in the target sites increased from 13 per cent in 2013 to 31 per cent in 2016, an indication that young people trust that Rahnuma will provide quality, youth-friendly, and non-judgmental services.

> "I am fine now, and wonder that had my friend not brought me to the clinic, I may not have been alive today.
>
> Young Rahnuma client who received treatment for incomplete abortion

PROMOTING COMPREHENSIVE SEXUALITY EDUCATION

Family Health Options Kenya (FHOK)

Family Health Options Kenya (FHOK) began working with the Ministry of Education in 2009 to develop a national curriculum on comprehensive sexuality education. In collaboration with other civil society organizations and the United Nations Educational, Scientific and Cultural Organization (UNESCO), FHOK led a taskforce to support the development of technical guidelines to inform the curriculum. In 2015, the Ministry of Education approved the guidelines, which cover all areas of comprehensive sexuality education as detailed in *It's All One Curriculum*. Unfortunately, opposition from political and religious leaders who object to the curriculum's component on sexuality, which includes sexual norms and pleasure, has hampered its finalization.

To ensure that gains are not lost, FHOK and partners continue to advocate to the Ministries of Health and Education on the importance of a curriculum that adheres to the 2015 guidelines. FHOK has supported meetings between the Ministries of Health and Education to discuss the curriculum further and to highlight the importance of integrating the delivery of education and health services for young people. FHOK and partners have also met with religious leaders at local and national levels to raise awareness on the important health benefits of comprehensive sexuality education, and to garner their support for a national curriculum.

FHOK delivers comprehensive sexuality education via the WhatsApp messaging platform as many young Kenyans now own internet-enabled smartphones. The Association provided digital platform training on comprehensive sexuality education to 19 young people who were then employed as online facilitators. Each facilitator created a WhatsApp group on comprehensive sexuality education and recruited young people to their groups.

In 2016, the digital platform reached 1,821 young people with all components of comprehensive sexuality education and information on where to access sexual and reproductive health services. The facilitators supported 93 referrals, accompanying young people to FHOK static clinics and government facilities. Young people living with HIV use the platform as a safe space where they discuss sexual and reproductive health and HIV-related issues without fear of stigma or discrimination.

> The ultimate goal of *It's All One Curriculum* is to enable young people to enjoy – and advocate for their rights to – dignity; equality; and healthy, responsible and satisfying sexual lives.[11]

SERVE PEOPLE

OUTCOME 3

2 billion quality, integrated sexual and reproductive health services, delivered by IPPF and partners

Priority objective 5: Deliver rights-based services including safe abortion and HIV

Priority objective 6: Enable services through public and private health providers

In the *Strategic Framework 2016–2022*, IPPF is committed to the delivery of an essential package of sexual and reproductive health services that are rights-based, client-centred, gender-sensitive and youth-friendly. IPPF provides information, education and services to the most under-served around the world. This includes our work in humanitarian settings to improve access before, during and after conflict and crisis situations.

Figure 4 presents IPPF's 2016 baseline results for Outcome 3 priority objectives. In 2016, 182.5 million sexual and reproductive health services were delivered, an increase of 7.2 million, or 4 per cent, from 2015. This included 145.1 million services provided by IPPF directly (Indicator 7) and a further 37.4 million services that IPPF enabled through partnerships with public and private providers (Indicator 11). The regions with the most significant increases were the Arab World (33 per cent) and Africa (17 per cent).

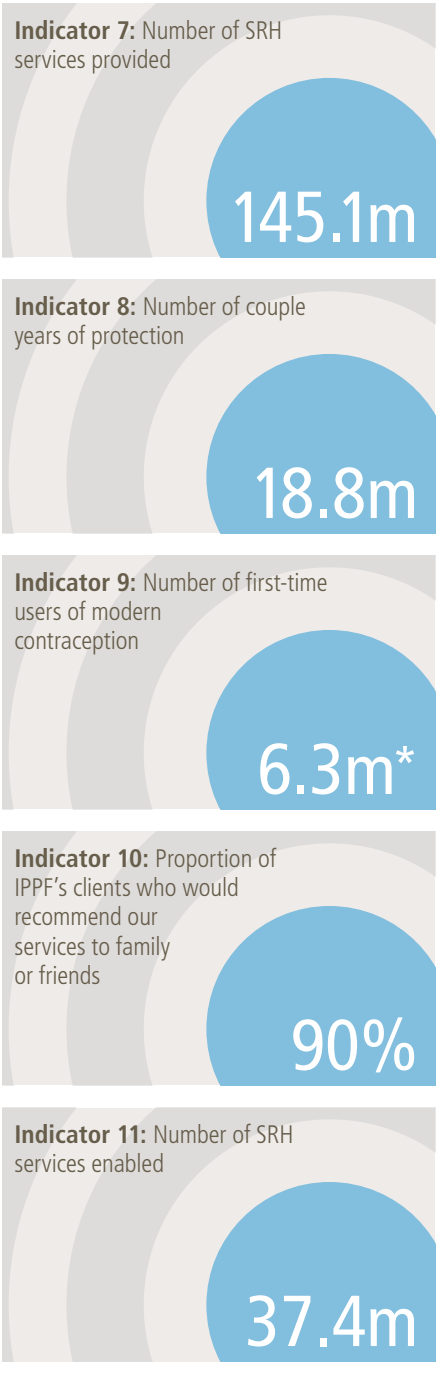
Globally, the number of services delivered to young people in 2016 was 74.6 million, or 41 per cent of all services. There were significant increases in the number of gynaecological, obstetric, abortion-related and sexual and gender-based violence services provided, and these are all critical to women's and girls' health outcomes. An estimated eight in ten service users were poor and vulnerable, and 84 per cent of all IPPF's services were delivered in countries identified by the United Nations Development Programme's Human Development Index as having low or medium levels of human development.[12] Furthermore, an estimated 3.2 million people affected by conflict and natural disasters received sexual and reproductive health services from IPPF in 2016, an increase of 0.9 million, or 39 per cent, from 2015.

In 2016, IPPF provided 18.8 million couple years of protection (CYP), an increase of 3.1 million, or 20 per cent, from 2015. Again, the regions with the largest year-on-year growth were the Arab World (156 per cent) and Africa (54 per cent). Both regions saw significant annual growth in CYP from intrauterine devices (152 per cent in Africa and 113 per cent in the Arab World) and from implants (181 per cent in the Arab World and 76 per cent in Africa).

IPPF's Performance Dashboard to monitor progress of the *Strategic Framework* includes two new service delivery indicators: the number of first-time users of modern contraception and the proportion of IPPF's clients who would recommend our services to family or friends. In 2016, IPPF provided contraception to 6.3 million first-time users of modern contraception in 59 countries that are aligned with the FP2020 focus countries, and we remain on track to achieve our target of 60 million between 2012 and 2020. In 2016, 90 per cent of service users surveyed said they would recommend our services to family or friends. This result demonstrates the high quality of care standards provided by IPPF.

The following section gives an overview of 2016 service statistics with recent trends. Service data presented combines services provided by IPPF directly and those that IPPF enabled through public and private partners. Also included are four case studies of Member Association performance in the delivery of sexual and reproductive health services. The first two highlight examples of direct service provision by IPPF, while the other two illustrate successful models of working in partnership to enable service delivery.

FIGURE 4 OUTCOME 3: BASELINE RESULTS, 2016



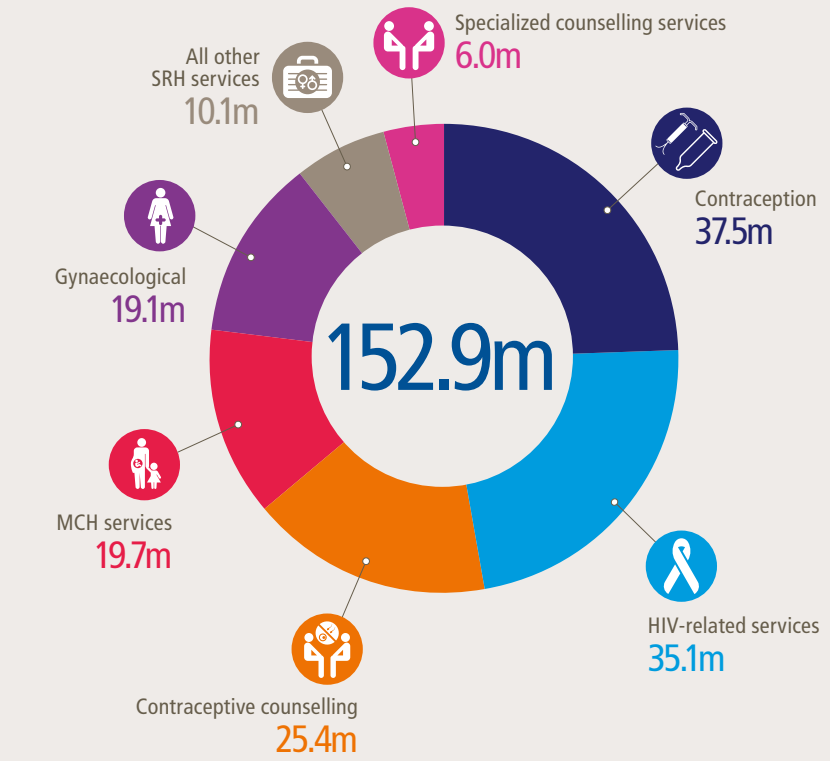
* IPPF is reporting the number of first-time users from FP2020 focus countries only, as per our published commitment to reach 60 million first-time users between 2012 and 2020.

Investing in countries with the greatest need

The majority of our unrestricted funding supports Member Associations in countries with low or medium levels of human development.[13] These countries typically have disproportionately high levels of maternal and child morbidity and mortality, unmet need for contraception, HIV prevalence, and early marriage and childbearing.

In 2016, Member Associations and collaborative partners in 69 countries with low or medium levels of human development delivered a total of 152.9 million sexual and reproductive health services. This represents 84 per cent of all sexual and reproductive health services, and is 6 per cent more than in 2015. The greatest numbers of services delivered in these countries were in the areas of contraception and HIV-related services, including sexually transmitted infections (Figure 5).

FIGURE 5 NUMBER OF SRH SERVICES DELIVERED IN COUNTRIES WITH LOW OR MEDIUM HUMAN DEVELOPMENT, BY TYPE, 2016



Reaching the poor and vulnerable

Upholding the sexual and reproductive health needs and rights of the most under-served remains at the heart of IPPF's people-centred approach. In 2016, IPPF provided services to an estimated 47.2 million poor and vulnerable people, representing nearly eight in ten of all service users. This includes an estimated 3.2 million people in humanitarian crises. Without IPPF, access to sexual and reproductive health services to these under-served groups would be severely limited due to a lack of political will, expertise or institutional capacity. Vulnerable groups differ from country to country, and vary in a wide range of characteristics: age, gender, residence, ability to pay, employment, gender identity or expression, sexual orientation, migrant status, culture, language, religion, education and disability.

Member Associations use local data and develop criteria relevant to their context to determine who is vulnerable and under-served in relation to sexual and reproductive health and rights. They then design programmes to reach those with greatest need, and with a focus on working where there are few, if any, other service providers.

Successful programmatic strategies include training counsellors and peer educators from within the various under-served communities and linking with other specialized civil society organizations that already work with vulnerable groups. We also work in partnership with law enforcement, parents, and community and religious leaders to increase support for access to health care provision for all.

We deliver services and commodities in over 46,000 service delivery points, including 27,860 IPPF-owned static clinics, mobile and outreach facilities, and community-based distributors. The majority (67 per cent) of IPPF-owned service delivery points are located in rural or peri-urban areas.

To further increase access to a wide range of sexual and reproductive health services, we supply contraceptive commodities to nearly 14,300 public and private providers, including pharmacies and private physicians, and partner with over 4,000 clinical providers/facilities.

8 in 10

of IPPF's service users are poor and vulnerable

3.2m

people served in humanitarian settings

Half

of our service delivery points are community-based distributors

Ensuring reproductive choice

Globally, an estimated 225 million women who want to avoid a pregnancy do not use an effective method of contraception.[14] IPPF's Integrated Package of Essential Services reflects our commitment to offering a range of contraceptive choices and requires Member Associations to provide short- and long-acting reversible methods, as well as emergency contraception. The Package also requires the provision of contraceptive counselling as the basis of our rights-based approach and to support informed decision-making about whether and when to have children.

IPPF provided 18.8 million couple years of protection (CYP) in 2016, which helped women avert an estimated 5.8 million unintended pregnancies and 1.5 million unsafe abortions. The largest increases between 2015 and 2016 in CYP were from implants (45 per cent), intrauterine devices (33 per cent) and oral contraceptive pills (23 per cent). The value of CYP for condoms also increased by 14 per cent between 2015 and 2016, with 251.3 million condoms distributed in 2016. IPPF's method mix for CYP is presented in Figure 6. There was a higher proportion of CYP from long-acting reversible methods than in previous years (54 per cent in 2016; 46 per cent in 2015), continuing the annual trend of growth in CYP from intrauterine devices and implants. The proportions of CYP from short-acting and permanent methods were 36 per cent and 10 per cent respectively.

In 2016, IPPF delivered 28.5 million contraceptive counselling services, an increase of 2.9 million, or 11 per cent, from 2015. Furthermore, 89 per cent of contraceptive counselling services (25.4 million) were provided in countries with low or medium human development, where it is a vital primary health care service that supports women to make informed decisions on contraceptive choice.

IPPF promotes and provides safe and legal abortion services. This is based on a conscientious commitment to upholding a woman's right to decide the outcome of her pregnancy and to eradicating the potentially harmful consequences of unsafe abortion. In 2016, IPPF delivered 4.8 million abortion-related services, a 12 per cent increase from 2015 (Table 1). There was annual growth in four of the six service categories, with the largest increase in abortion consultation services, which grew by 26 per cent from 2015.

In a sample of 117 clinics, the proportion of clients accepting a modern method of contraception (excluding condoms and vasectomy) following an abortion was 74 per cent, with 53 per cent using long-acting and reversible methods. The provision of contraception after an abortion is an essential part of comprehensive abortion care and supports women to reduce the risk of further unintended pregnancies.

FIGURE 6 COUPLE YEARS OF PROTECTION (CYP), BY METHOD, 2016

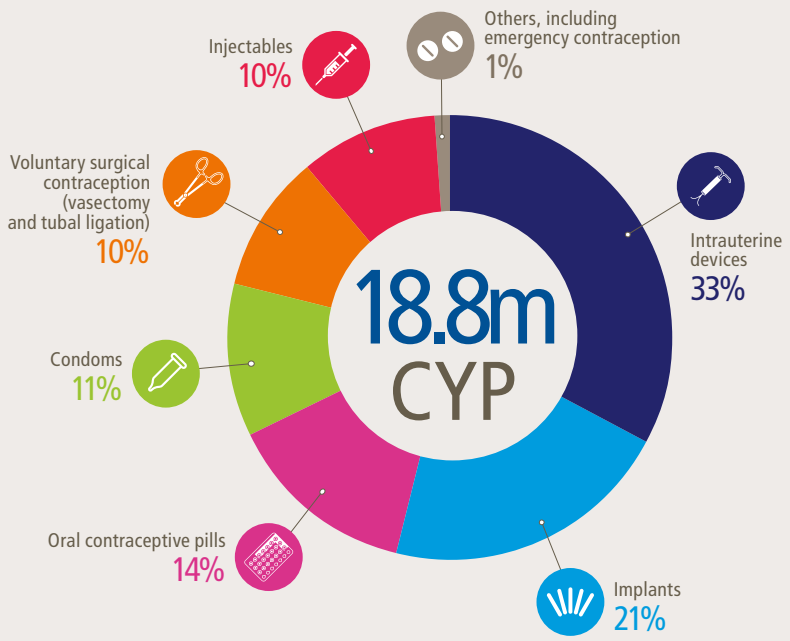


TABLE 1 NUMBER OF ABORTION-RELATED SERVICES DELIVERED, 2015–2016

TYPE OF SERVICE	2015	2016
Pre-abortion counselling	1,311,253	1,303,697
Post-abortion counselling	708,298	812,093
Surgical abortion	531,323	612,966
Medical abortion	433,002	481,713
Treatment of incomplete abortion	136,227	117,953
Abortion consultation services	1,143,795	1,436,618
Total	4,263,898	**4,765,040**

5.8m

Unintended pregnancies averted*

1.5m

Unsafe abortions averted*

251.3m

Condoms distributed

* Using Marie Stopes International's Impact 2 (version 4) estimation model.

Focusing on the needs of women and girls

The majority of IPPF's services are provided to women and girls, who comprised 74 per cent of all service users in 2016. In addition to contraception and abortion-related services, IPPF also delivered 25.1 million gynaecological services in 2016, a 13 per cent increase from 2015 (Figure 7). These included breast and pelvic examinations, biopsies, imaging and cancer screening. There were increases in gynaecological service provision in all six regions, with the most significant rises in East and South East Asia and Oceania (45 per cent), Africa (24 per cent) and the Arab World (14 per cent).

We delivered a further 14.2 million obstetric services, including pre- and post-natal care, pregnancy testing and childbirth services. This represents a 7 per cent increase from 2015, with the largest regional increases in East and South East Asia and Oceania (47 per cent) and Europe (42 per cent). Finally, IPPF delivered 8.1 million paediatric services, such as immunizations and other health care services to children under five. Despite increases in paediatric service provision in four regions, globally there were 15 per cent fewer services than in 2015. This is due primarily to a decrease in one large Member Association in the East and South East Asia and Oceania region. The combined total of these three categories of services to women and children increased by 2.5 million, or 6 per cent, from 2015.

In 2016, IPPF delivered 3.1 million prevention, screening and counselling services related to sexual and gender-based violence, an increase of nearly 1.0 million, or 45 per cent, from 2015. Most of these services were delivered in regions with high levels of intimate partner violence: Africa (40 per cent), the Western Hemisphere (29 per cent) and South Asia (21 per cent).

3.1m

sexual and gender-based violence services provided

FIGURE 7 NUMBER OF GYNAECOLOGICAL, OBSTETRIC AND PAEDIATRIC SERVICES DELIVERED, 2014–2016

Delivering HIV-related services

IPPF delivered 42.0 million HIV-related services in 2016, an increase of 1.2 million, or 3 per cent, from 2015. Four regions reported annual increases in the number of HIV-related services delivered: the European Network (46 per cent), the Arab World (34 per cent), Africa (15 per cent), and East and South East Asia and Oceania (8 per cent).

Africa is the most severely affected region in the global HIV epidemic, and Member Associations in this region delivered 59 per cent of IPPF's total HIV-related services. Between 2015 and 2016, the Africa region saw performance improvement in both sexually transmitted infection counselling (36 per cent) and HIV consultation and counselling, including pre-test, post-test and risk reduction counselling (11 per cent). Strong growth of 28 per cent was also reported for a range of both HIV diagnostic and monitoring tests, including rapid point-of-care, CD4 and viral load tests.

At the end of 2015, IPPF signed a memorandum of understanding with the Joint United Nations Programme on HIV and AIDS (UNAIDS) to work together in 35 countries, mostly in sub-Saharan Africa. The partnership involves advocacy as well as the delivery of prevention and treatment services with the aim of contributing to the UNAIDS Fast-Track Strategy to double the number of people on life-saving HIV treatment by 2020.

Meeting young people's needs

IPPF delivered 74.6 million sexual and reproductive health services to young people in 2016. This represents 41 per cent of all IPPF services delivered, and demonstrates our continued commitment to meeting the sexual and reproductive health needs of young people. The most common types of services delivered to young people were contraception (38 per cent) and HIV-related services, including sexually transmitted infections (24 per cent).

IPPF implements programmes to ensure that our health facilities are youth-friendly, and designed to increase access for young people in terms of opening hours and safe spaces that ensure privacy and confidentiality. A major barrier that prevents young people from accessing sexual and reproductive health information and services is service providers who display judgmental attitudes, particularly on sexual activity among unmarried young people, and often with a gender bias against young women. To remove this barrier, values clarification workshops and specific training courses equip IPPF staff with the skills and expertise they need to provide quality information and services to young people.

MEETING SEXUAL AND REPRODUCTIVE HEALTH NEEDS DURING CYCLONE WINSTON

Reproductive and Family Health Association of Fiji (RFHAF)

In February 2016, the worst storm recorded in the Southern Hemisphere[15] struck Fiji, damaging health centres, birthing facilities and power supplies. Cyclone Winston affected more than 350,000 people, or approximately 40 per cent of the population.[16] Of those, 87,500 were estimated to be women of reproductive age, with more than 13,000 needing access to contraception and 14,000 being pregnant at any given time.[17] Nearly 2,000 women were estimated to be at risk of sexual violence.[18]

Meeting the sexual and reproductive health needs of vulnerable people in crises, especially of women and young girls, is critical and yet often under-prioritized and under-resourced in humanitarian responses. The Reproductive and Family Health Association of Fiji (RFHAF), with support from IPPF's Sub-Regional Office for the Pacific (SROP), responded to the devastation caused by the cyclone with leadership, advocacy and expertise in implementing the *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations*. The RFHAF-SROP team met with the United Nations Population Fund (UNFPA) to offer their expertise and experience implementing MISP. They then jointly advocated for the establishment of the country's first coordinating mechanism for reproductive health.

As a result, the Ministry of Health established the Family Health Sub-Cluster to include sexual and reproductive health as part of the country's formal emergency response. RFHAF was appointed as the focal point, and mandated with the task of carrying out initial needs assessments for sexual and reproductive health. The RFHAF-SROP response team reached more than 11,000 people with contraception, maternal and child health services, HIV tests, and sexual and reproductive health and rights information in 37 villages and settlements. The team also supported emergency evacuations for women with antenatal and post-natal complications. To complement the Ministry of Health's distribution of clean delivery kits for use in childbirth, the RFHAF-SROP team provided dignity kits to pregnant and breastfeeding women. The kits included a sarong, underwear, a whistle, soap and sanitary protection.

Cyclone Winston forced many people to live in temporary shelters, exposing them to a high risk of being bitten by the mosquitoes that transmit dengue fever, a painful and debilitating disease that can be fatal. In response, the RFHAF-SROP team distributed bed nets to reduce rates of transmission.

> The response team reached more than 11,000 people with sexual and reproductive health information and services in 37 villages and settlements.

STRENGTHENING LOCAL HEALTH SYSTEMS IN RESPONSE TO ZIKA

Asociación Pro-Bienestar de la Familia de Guatemala (APROFAM)

While the Zika virus was initially thought to be transmitted solely via the *Aedes aegypti* mosquito, evidence now confirms that it can also be transmitted sexually and from mother to child.[19] Pregnant women infected with Zika are 20 times more likely to give birth to children with Zika-related conditions such as microcephaly than those who test negative for the virus.[20] The impact of the virus on infants and children means that the burden of the epidemic rests on women of reproductive age, particularly poor women living in remote areas where mosquito transmission is difficult to prevent, and where access to quality, affordable contraception is not widespread.

In Latin America, Member Associations are working to fill this critical gap in the response, providing Zika-integrated sexual and reproductive health information, education and services. In 2016, the Asociación Pro-Bienestar de la Familia de Guatemala (APROFAM) trained 226 clinic-based service providers using Zika prevention guidelines and protocols. APROFAM increased the coverage of subsidized contraceptive services offered in its clinics, and employed psychologists to provide psychosocial support to pregnant women and families affected by Zika. APROFAM also trained community volunteers and health promoters, harnessing the strength of its existing network, to provide Zika-integrated contraceptive information, education and services to vulnerable women across the country, including in remote and rural areas, and in indigenous communities.

During the first eight months of implementation, APROFAM provided counselling and consultations on Zika prevention to 20,579 women, and distributed 27,443 contraceptive items. APROFAM has collaborated closely with all levels of the Guatemalan government to prioritize Zika prevention efforts and to ensure timely referrals for Zika-positive pregnant women.

Furthermore, the National Commission of Contraceptive Assurance elected APROFAM as its coordinator for a two-year term. Under APROFAM's leadership, this group is spearheading advocacy efforts to counter a legislative proposal that would threaten funding for contraception nationwide, which would put more women at risk of giving birth to children with Zika-related conditions. APROFAM is also collaborating with partners to develop a web-based tool for organizations that provide contraception to supply data for shared analysis at the regional and national levels.

> APROFAM trained community volunteers and health promoters to provide Zika-integrated contraceptive information and services to vulnerable women in remote areas.

PROVIDING INFORMATION AND SERVICES AT THE WORKPLACE

Family Guidance Association of Ethiopia (FGAE)

In Ethiopia, 26 per cent of married women have an unmet need for contraception.[21] For women who work in farms and factories, this number may be much higher. A combination of long working days, long waiting times at government hospitals, and the risk of losing part of their salary for missing work to attend clinics means that these women have extremely limited access to sexual and reproductive health information, education and services. The consequences are frequent childbearing and high levels of unintended pregnancy, unsafe abortion and HIV infection.

The Family Guidance Association of Ethiopia (FGAE) works with 26 farms and factories to enable the delivery of sexual and reproductive health services, including contraception, to their 65,000 employees. One such farm is the Limmu Coffee Plantation, which has a population of more than 17,000 people. In 2013, FGAE conducted an assessment of the farm's six health clinics and found that service providers were not adequately trained to deliver sexual and reproductive health information and services, and that women had limited access to contraception and were unable to prevent unintended pregnancies. Time off work during maternity leave presented an economic loss for both women and the business, and the farm's management also reported loss in productivity due to maternal morbidity-related sick leave.

Following the assessment, FGAE signed a memorandum of understanding with the farm and now supplies the health clinics with contraceptives. FGAE also provides training, supervision, coaching and mentoring to the service providers working in the farm's health clinics. Given the large numbers of young people working at Limmu, FGAE renovated the clinics to make them youth-friendly and more accessible to the young farm workers. To raise awareness of and advertize the sexual and reproductive health services that are available, the Association distributes leaflets and produces radio broadcasts.

As a result, the provision of sexual and reproductive health services in the Limmu farm clinics has risen dramatically, from 3,734 in 2014 to 24,757 in 2016. The range of services available has also expanded. In 2016, the farm clinics provided certain types of services for the first time, including cervical cancer screening and testing and treatment for sexually transmitted infections.

Finally, during the assessment, FGAE found that there was a disconnect between the farm's health service provision and the local government health system. The Association, therefore, facilitated joint review meetings and site visits to ensure improved collaboration and increased access to services so that all the critical health needs of farm workers are met.

PARTNERING WITH HEALTH FACILITIES TO EXPAND CONTRACEPTIVE PROVISION

Association Ivoirienne pour le Bien-Etre Familial (AIBEF)

In Côte d'Ivoire, 27 per cent of married women have an unmet need for contraception; this rises to 48 per cent for unmarried sexually active women.[22] Only 12 per cent of married women use a modern method of contraception.[23]

In 2015, the Association Ivoirienne pour le Bien-Etre Familial (AIBEF) conducted a situational analysis in 10 of the country's 31 regions, assessing the capacity of 520 health facilities, both public and private, to provide comprehensive contraceptive services. The analysis found that only 41 per cent of the facilities provided short-acting methods, and only 9 per cent of the service providers were adequately trained to provide quality contraceptive services.[24] Stock-outs are particularly high in Côte d'Ivoire for short-acting methods,[25] and this is a contributing factor to the low numbers of facilities that provide them.

To address these gaps, AIBEF built the capacity of both public and private health facilities in the districts where it operates. AIBEF and the Department of Health trained 877 service providers on contraceptive technology. These included doctors, nurses and midwives. As a result, 300 health centres, including nine AIBEF facilities, are now able to offer more contraceptive choice than before. The Association also partnered with UNFPA to ensure the regular supply of a range of contraceptive methods to all health centres.

Furthermore, to increase demand for contraceptive services, AIBEF trained 320 community health workers on contraception, HIV, and social and behaviour change communication. The community health workers conducted home visits, giving information to more than 166,000 people on contraception and where to go for services. As a result, first-time users of contraception more than doubled from 26,000 in 2014 to 63,000 in 2016 in AIBEF facilities.

IPPF/Côte d'Ivoire

UNITE AND PERFORM

OUTCOME 4

1
high-performing, accountable and united Federation

Priority objective 7:
Enhance operational effectiveness and double national and global income

Priority objective 8:
Grow our volunteer and activist supporter base

IPPF is continually investing in structures and systems to adapt to changing environments and to increase operational effectiveness. Baseline results for Outcome 4 priority objectives are presented in Figure 8. Total income generated by the Secretariat increased by US$14.2 million in 2015 to US$130.4 million in 2016. This 12 per cent increase reflects a rise in both restricted and unrestricted funding.

To respond to the increasing pressure on official development assistance budgets, Member Associations continue to diversify their own income streams, through the sale of commodities, in-kind donations, and funds from local and international sources, including government. In 2016, unrestricted grant-receiving Member Associations raised a total of US$291.2 million locally, an increase of US$30.1 million, or 12 per cent, from 2015.

IPPF is evolving its operations and financial structures to incorporate diverse business models that are fit for purpose in each of the specific contexts that we work in around the world. We are supporting Member Associations to develop models to ensure their financial sustainability, including social enterprises. In 2016, a significant 50 per cent of all local income generated by Member Associations was raised through social enterprise activities, including the sale of commodities, patient fees, and income from training.

In 2016, IPPF's performance-based funding system was used in five regions to make data-driven decisions about resource allocation. The system rewarded Member Associations that were most effective in delivering services, comprehensive sexuality education, and advocacy programmes. For each Association, grant levels were adjusted according to performance against a number of key indicators, and this enabled IPPF to invest more resources in Associations that achieved the greatest results. In the five regions implementing performance-based funding in 2016, 6 per cent of IPPF's unrestricted income was used to reward Member Associations.

IPPF continues to focus its investments in countries with the lowest levels of development. In 2016, 78 per cent of all IPPF unrestricted grants went to Member Associations working in countries with low or medium human development,[26] with nearly half (48 per cent) of all IPPF grants allocated to the Africa region.

In 2016, IPPF was supported by nearly 172,300 volunteers, including peer educators, medical personnel, members of IPPF governing bodies, legal advisers and fundraisers. Those volunteers who pay a nominal membership fee are entitled to participate in the democratic functioning of the organization; however, regardless of membership status, volunteers make a significant contribution to the work and performance of IPPF.

The activities of opposition groups, a vocal minority in many places, pose a threat to the gains achieved by the sexual and reproductive health and rights movement. IPPF is responding by recruiting and organizing activists who support and defend sexual and reproductive health and rights. In 2016, 10.2 million activists agreed to take action for political and social change in support of IPPF's work. Actions included participating in campaigns, sharing messages on social media, and educating and empowering others to exercise their rights.

On the next page, we present two successes: a Member Association's social enterprise programme to increase access to contraception, and IPPF's global investment in clinic management information systems.

FIGURE 8 OUTCOME 4: BASELINE RESULTS, 2016

Indicator 12: Total income generated by the Secretariat

US$ 130.4m

Indicator 13: Total income generated locally by unrestricted grant-receiving Member Associations

US$ 291.2m

Indicator 14: Proportion of IPPF unrestricted funding used to reward Member Associations through a performance-based funding system

6%

Indicator 15: Number of IPPF volunteers

172,279

Indicator 16: Number of IPPF activists

10.2m

IMPLEMENTING A SOCIAL ENTERPRISE TO INCREASE CONTRACEPTIVE ACCESS

Asociación Hondureña de Planificación de Familia (ASHONPLAFA)

In Honduras, 11 per cent of married women have an unmet need for modern contraception;[27] this figure is much higher for unmarried women and young girls under 25 years old, at 34 per cent and 45 per cent respectively.[28]

For 40 years, the Asociación Hondureña de Planificación de Familia (ASHONPLAFA) has operated a community-based distribution network to provide contraception to the most vulnerable people in Honduras. The network now has 1,700 health workers who live in communities that would otherwise have little or no access to contraceptive services. The health workers are trained to give information about sexual and reproductive health, provide contraceptive counselling, and distribute a range of contraceptive methods.

ASHONPLAFA's programme was primarily funded by donors and international governmental agencies. With a recent decline in development funding for Latin America, the programme saw a drastic decrease in income, and thousands of vulnerable women were at risk of losing access to contraceptive information and services. As a result, ASHONPLAFA redesigned its strategy and transformed the model into a sustainable social enterprise that generates income through the sale of products, such as condoms, contraceptive pills, injectables and pregnancy tests, rather than relying on external donations. These commodities are sold at prices that are affordable and yet generate enough income to cover the direct and indirect costs of ASHONPLAFA's network.

This community-based network has grown significantly, providing almost four times as many services in 2016 than in 2012. Community health workers distributed and sold 1.4 million contraceptive products in 2016, representing 45 per cent of the Association's total items provided that year. For services that are not available from the community health workers, clients are referred to the closest private or public clinic.

ASHONPLAFA is conducting a market study to determine how to expand its product portfolio to offer clients a wider range of products, such as fortified foods, cooking stoves, solar lamps, mosquito nets and water filters. This will enable the Association to diversify the approaches used to improve the lives of vulnerable clients, while simultaneously increasing revenue to sustain the network of community health workers.

IPPF's Social Enterprise Acceleration Programme strengthens Member Associations' capacity to increase financial resilience, programmatic sustainability, and the ability to meet the needs of the most vulnerable.

IMPLEMENTING CLINIC MANAGEMENT INFORMATION SYSTEMS

IPPF supports Member Associations to install and use clinic management information systems (CMIS) in static clinics. The system is based on client data where each has a unique identification number to enable service providers to easily access the client's history and profile, and provide the best possible care over time. The system improves clinic efficiency by reducing waiting time and by minimizing the amount of records and registers. CMIS also prevents stock-outs at clinics by generating alerts when medical products or drugs are below certain stock levels, or are near expiry. Having CMIS data supports performance monitoring, understanding of the gaps and strengths in service provision, and decision-making to ensure that resources are directed towards those who need them most.

By the end of 2016, 380 clinics in 42 Member Associations were using CMIS to collect and report client-based data. This includes 186 clinics using the manual CMIS and 194 clinics using the electronic version. Use of the system has not only led to improved quality of care, but has also resulted in better understanding and practice of data utilization to make management decisions at clinics. Some Associations have introduced new services, such as screening for cervical cancer, while others have recruited temporary service providers to minimize client waiting times during busy days or seasons.

Use of the system has also generated awareness of the importance of integrated sexual and reproductive health service provision. CMIS has provided data to review the delivery of IPPF's Integrated Package of Essential Services, from the perspective of both service providers and clients. A recent review of data at selected sites in India, Ghana, Kenya and Pakistan is being used to investigate integrated service delivery approaches. One area of focus is on the relationship between the uptake of contraceptive services, especially for first-time users of modern contraception, and links with other non-contraceptive services that are available in the clinics.

Analysis of client-based data has helped Member Associations identify emerging needs among communities and restructure their services to meet those needs. One such analysis indicated the need for integrating sexual and gender-based violence services with other sexual and reproductive health services, particularly safe abortion care.

IPPF's experience using CMIS has highlighted the importance of confidentiality and other ethical parameters in relation to client-based information. It has contributed to a deeper understanding and appreciation of the need to ensure clients' rights, the responsibilities of providers, and the need to maintain these ethical standards for all clients, no matter where they receive care.

NEXT STEPS

The four outcomes of the *Strategic Framework* guide our work as a sexual and reproductive health and rights movement to champion rights, empower communities, serve people, and unite and perform.

In the second year of implementing our new *Strategic Framework 2016–2022*, IPPF will focus on strengthening organizational systems and processes to increase operational effectiveness. At the Secretariat level, further investment in resource planning systems is being made to improve efficiencies and allow more collaborative working among the seven offices that are now located in 12 different locations around the world. We are also strengthening restricted project management and implementation approaches, and improving procurement and supply chain management to ensure commodity security is in line with international quality standards.

In 2016, IPPF's Governing Council approved reforms to make governance more efficient and responsive, while remaining true to its unique strength of being locally owned and globally connected. IPPF will implement these changes by November 2017. The number of members will be reduced from 24 to 18, and six expert advisers will be appointed to bring external perspectives. All Governing Council nominees must meet the stringent qualities defined in IPPF's new policy. Each member will have a performance review before the end of their term and before any potential re-election. Finally, to ensure organizational continuity and institutional knowledge, elections will be staggered with the appointment of one-third of Governing Council members every year.

In March 2017, IPPF opened its Bangkok Hub which comprises the East and South East Asia and Oceania, and South Asia Regional Offices, and the new IPPF Humanitarian Programme. IPPF will increase the scale of humanitarian response and preparedness in disaster- and conflict-prone countries, and strengthen advocacy and support to national governments to enhance integration of sexual and reproductive health in disaster management policies, plans, and coordination mechanisms.

The Mexico City Policy was reinstated in January 2017. This policy, also known as the Global Gag Rule, has a devastating impact on the lives of millions of the world's most vulnerable and under-served, particularly women and girls. Many organizations, including IPPF, are now faced with significant funding cuts. IPPF will work with governments and donors to bridge the funding gap, and we welcomed the *She Decides* initiative launched in March 2017 to raise funding to safeguard sexual and reproductive health and rights in future years.

IPPF will continue to diversify its funding base by identifying opportunities with trusts, foundations, the private sector and local donors. Many Member Associations already raise significant amounts of funds from social enterprise initiatives. To build on this and promote awareness, we will deliver an online course on social enterprise. The five-module course, open to all members of the Federation, introduces the concept of social enterprise and provides step-by-step guidance on how to develop a business idea. We are also carrying out a mapping exercise to create a comprehensive overview of current social enterprise activity across the Federation. This exercise will also provide an understanding of the current needs on which future activities will be based.

With the implementation of the Global Gag Rule and rising populism, IPPF and its partners are facing more opposition than ever before. IPPF will continue to increase political support for sexual and reproductive health and rights at local, national, regional and global levels. We will hold governments to account and track their commitments on Sustainable Development Goals 3 and 5. We will work with youth and women's groups to amplify their voices as advocates for change in support of sexual and reproductive health and rights.

IPPF will develop and disseminate guidelines, policies and best practices on service delivery in line with our Integrated Package of Essential Services and Quality of Care Framework. Further implementation of IPPF's comprehensive sexuality education strategy and use of the *Inside and Out Assessment Tool* to ensure the quality of comprehensive sexuality education programmes will support young people to exercise their rights, to access sexual and reproductive health services, and to protect their health. We will also engage many young people to become agents of change to raise awareness, take action and challenge negative attitudes and opinions that are not based on fact or logic, and that are stigmatizing, discriminatory and damaging to so many people's sexuality, health and well-being.

Recognizing that there is a wealth of expertise, knowledge and experience among Member Associations, and enormous potential for shared learning to contribute to increased performance, IPPF is investing in a Federation-wide technical assistance network. Initial topics will include comprehensive sexuality education, social marketing and social franchising. Associations with expertise in these areas will provide technical assistance to other Associations through a variety of shared learning approaches.

Finally, IPPF will continue implementing the new global communications strategy, prioritizing the production and distribution of powerful digital and socially-shareable content and campaigns. These are designed to increase knowledge of and support for sexual and reproductive health and rights by creating a progressive, influential narrative which engages people by drawing on their own value sets.

IPPF's four outcomes will continue to guide our work and build on the performance achieved in the first year of implementing the *Strategic Framework 2016–2022*. Our focus now is to mobilize the necessary resources to enable us to achieve our important mission.

OUR VISION

ALL PEOPLE ARE FREE TO MAKE CHOICES ABOUT THEIR SEXUALITY AND WELL-BEING, IN A WORLD WITHOUT DISCRIMINATION

IPPF

OUTCOME 1

100
governments respect, protect and fulfil sexual and reproductive rights and gender equality

OUTCOME 2

1 billion
people act freely on their sexual and reproductive health and rights

OUTCOME 3

2 billion
quality integrated sexual and reproductive health services delivered

OUTCOME 4

1
high performing, accountable and united Federation

Galvanize commitment and secure legislative, policy and practice improvements	Enable young people to access comprehensive sexuality education and realize their sexual rights	Deliver rights-based services including safe abortion and HIV	Enhance operational effectiveness and double national and global income
Engage women and youth leaders as advocates for change	Engage champions, opinion formers and the media to promote health, choice and rights	Enable services through public and private health providers	Grow our volunteer and activist supporter base

IPPF'S MISSION

TO LEAD A LOCALLY OWNED GLOBALLY CONNECTED CIVIL SOCIETY MOVEMENT THAT PROVIDES AND ENABLES SERVICES AND CHAMPIONS SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR ALL, ESPECIALLY THE UNDER-SERVED

OUR VALUES

SOCIAL INCLUSION

VOLUNTEERISM

PASSION

DIVERSITY

ACCOUNTABILITY

ANNEXES

Annex A: Number of policy and/or legislative changes, by region and country, 2016

Annex B: IPPF's Performance Dashboard results, 2016

KEY

..	data not available
n/a	not applicable
-	zero

IPPF/ Mustafa Quraishi /Nepal

ANNEX A: NUMBER OF POLICY AND/OR LEGISLATIVE CHANGES, BY REGION AND COUNTRY, 2016

COUNTRY	Number of changes
AFRICA	
Benin	1
Nigeria	1
Senegal	1
Seychelles	1
Togo	2
Uganda	5
ARAB WORLD	
Mauritania	1
Palestine	2
Sudan	1

COUNTRY	Number of changes
EUROPEAN NETWORK	
Albania	7
Armenia	1
Austria	3
Belgium	4
Bosnia and Herzegovina	1
Bulgaria	2
Finland	3
France	4
Georgia	1
Germany	1
Ireland	1
Kazakhstan	1
Kyrgyzstan	3
Latvia	1
Lithuania	2
Macedonia	3
Montenegro	2
Netherlands	1
Norway	3
Poland	1
Portugal	2
Russia	1
Serbia	1
Spain	2
Sweden	3
Switzerland	2
Tajikistan	3
Ukraine	1
United Kingdom	3

COUNTRY	Number of changes
EAST & SOUTH EAST ASIA & OCEANIA	
Australia	4
Cambodia	4
Fiji	2
Indonesia	1
Korea, Democratic People's Republic of	1
Korea, Republic of	1
New Zealand	1
Thailand	1
Tuvalu	1
SOUTH ASIA	
India	1
Iran	1
Maldives	1
Nepal	2
Pakistan	4
Sri Lanka	1
WESTERN HEMISPHERE	
Argentina	1
Belize	1
Bolivia	2
Brazil	1
Colombia	9
Costa Rica	2
Canada	2
Dominica	1
Dominican Republic	4
El Salvador	1
Guatemala	1
Honduras	3
Mexico	2
Paraguay	3
Peru	4
Puerto Rico	1
United States of America	6
Uruguay	3
Venezuela	1

ANNEX B: IPPF'S PERFORMANCE DASHBOARD RESULTS, 2016

TABLE B1: IPPF'S PERFORMANCE DASHBOARD – GLOBAL BASELINE RESULTS, 2016		2016 baseline results	Number of Member Associations reporting	Number of Secretariat offices reporting
OUTCOME 1 INDICATORS				
1	Number of successful policy initiatives and/or legislative changes in support or defence of SRHR and gender equality to which IPPF advocacy contributed	**175**	72	6
2	Proportion of countries that are on track with Sustainable Development Goal targets improving sexual and reproductive health*	**..**	n/a	n/a
3	Number of youth and women's groups that took a public action in support of SRHR to which IPPF engagement contributed	**661**	81	6
OUTCOME 2 INDICATORS				
4	Number of young people who completed a quality-assured comprehensive sexuality education (CSE) programme	**28.1m**	144	n/a
5	Proportion of young people who completed a quality-assured CSE programme who increased their SRHR knowledge and their ability to exercise their rights†	**..**	..	n/a
6	Estimated number of people reached with positive SRHR messages	**112.4m**	91	5
OUTCOME 3 INDICATORS				
7	Number of SRH services provided	**145.1m**	134	n/a
8	Number of couple years of protection	**18.8m**	130	n/a
9	Number of first-time users of modern contraception	**6.3m**	59	n/a
10	Proportion of IPPF's clients who would recommend our services to family or friends	**90%**	77	n/a
11	Number of SRH services enabled	**37.4m**	57	n/a
OUTCOME 4 INDICATORS				
12	Total income generated by the Secretariat (US$)	**130.4m**	n/a	7
13	Total income generated locally by unrestricted grant-receiving Member Associations (US$)	**291.2m**	116	n/a
14	Proportion of IPPF unrestricted funding used to reward Member Associations through a performance-based funding system	**6%**	n/a	5
15	Number of IPPF volunteers	**172,279**	154	n/a
16	Number of IPPF activists	**10.2m**	111	3

* Data to be collected in 2019.

† IPPF is currently developing and testing a methodology to measure this indicator.

TABLE B.2 OUTCOME 1: BASELINE RESULTS, BY REGION, 2016

OUTCOME 1 INDICATORS		AR	AWR	EN	ESEAOR	SAR	WHR	CO	Total
1	Number of successful policy initiatives and/or legislative changes in support or defence of SRHR and gender equality to which IPPF advocacy contributed	11	5	71	17	11	53	7	175
2	Proportion of countries that are on track with their Sustainable Development Goal targets improving sexual and reproductive health	[Data to be collected in 2019.]							
3	Number of youth and women's groups that took a public action in support of SRHR to which IPPF engagement contributed	22	133	177	47	29	234	19	661

TABLE B.3 OUTCOME 2: BASELINE RESULTS, BY REGION, 2016

OUTCOME 2 INDICATORS		AR	AWR	EN	ESEAOR	SAR	WHR	CO	Total
4	Number of young people who completed a quality-assured CSE programme	2,238,789	41,608	239,033	25,019,365	146,242	428,193	n/a	28,113,230
5	Proportion of young people who completed a quality-assured CSE programme who increased their SRHR knowledge and their ability to exercise their rights	[IPPF is currently developing and testing a methodology to measure this indicator.]							
6	Estimated number of people reached with positive SRHR messages	13,042,195	1,215,088	20,045,247	11,187,889	2,663,735	61,971,759	2,240,000	112,365,913

TABLE B.4 OUTCOME 3: BASELINE RESULTS, BY REGION, 2016

OUTCOME 3 INDICATORS		AR	AWR	EN	ESEAOR	SAR	WHR	CO	Total
7	Number of SRH services provided	68,753,974	11,672,439	1,562,581	13,947,674	18,943,863	30,198,359	n/a	145,078,890
8	Number of couple years of protection	7,770,541	955,758	49,680	679,485	2,642,243	6,678,636	n/a	18,776,343
9	Number of first-time users of modern contraception*	5,300,920	309,261	669	347,384	347,813	30,044	n/a	6,336,091
10	Proportion of IPPF's clients who would recommend our services to family or friends	92%	94%	92%	83%	86%	91%	n/a	90%
11	Number of SRH services enabled	29,951,314	2,074,995	36,212	1,056,158	3,823,911	441,387	n/a	37,383,977

TABLE B.5 OUTCOME 4: BASELINE RESULTS, BY REGION, 2016

OUTCOME 4 INDICATORS		AR	AWR	EN	ESEAOR	SAR	WHR	CO	Total
12	Total income generated by the Secretariat (US$)	[Not applicable by regional breakdown.]†							130.4m
13	Total income generated locally by unrestricted grant-receiving Member Associations (US$)	65.6m	5.3m	4.5m	51.3m	14.5m	150.0m	n/a	291.2m
14	Proportion of IPPF unrestricted funding used to reward Member Associations through a performance-based funding system	4%	0%	7%	3%	10%	8%	n/a	6%
15	Number of IPPF volunteers	46,199	6,584	10,317	45,389	15,492	48,298	n/a	172,279
16	Number of IPPF activists	6,253	2,610	9,872	8,885	2,797	10,118,205	5,731	10,154,353

* Data is from FP2020 focus countries only: this inlcudes 59 countries in total (33 in Africa, 5 in the Arab World, 2 in the European Network, 10 in East and South East Asia and Oceania, 6 in South Asia, and 3 in the Western Hemisphere).

† IPPF income generated by the Secretariat is reported at the global level for the Federation as a whole.

TABLE B.6 NUMBER OF COUPLE YEARS OF PROTECTION PROVIDED, BY REGION, BY METHOD, 2015–2016

TYPE OF METHOD	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Intrauterine devices	**2016**	**1,424,628**	**497,477**	**19,347**	**199,679**	**1,348,074**	**2,651,157**	**6,140,360**
	2015	565,290	233,162	29,383	222,020	1,024,635	2,541,309	4,615,798
Implants	**2016**	**2,437,908**	**130,877**	**7,015**	**79,297**	**79,124**	**1,145,216**	**3,879,437**
	2015	1,386,194	46,536	6,938	39,288	94,304	1,102,811	2,676,070
Oral contraceptive pills	**2016**	**1,480,745**	**251,840**	**3,097**	**66,528**	**222,066**	**567,218**	**2,591,494**
	2015	928,312	51,731	3,316	94,944	407,336	616,740	2,102,378
Condoms	**2016**	**1,272,659**	**43,482**	**18,867**	**270,315**	**195,263**	**293,596**	**2,094,180**
	2015	783,165	17,135	11,609	414,100	288,545	315,079	1,829,633
Injectables	**2016**	**1,065,356**	**31,080**	**89**	**49,564**	**155,627**	**653,097**	**1,954,813**
	2015	1,169,831	24,955	41	52,770	241,689	731,227	2,220,514
Voluntary surgical contraception (vasectomy and tubal ligation)	**2016**	**76,880**	**-**	**480**	**12,760**	**537,612**	**1,245,480**	**1,873,212**
	2015	204,720	-	290	19,110	563,230	1,242,130	2,029,480
Emergency contraception	**2016**	**9,143**	**557**	**671**	**1,126**	**104,477**	**81,228**	**197,201**
	2015	6,775	115	418	1,308	99,585	75,108	183,310
Other hormonal methods	**2016**	**58**	**-**	**66**	**90**	**-**	**40,445**	**40,659**
	2015	3	-	70	32	-	49,652	49,756
Other barrier methods	**2016**	**3,166**	**445**	**49**	**126**	**-**	**1,200**	**4,986**
	2015	651	86	65	217	-	2,400	3,420
TOTAL	**2016**	**7,770,541**	**955,758**	**49,680**	**679,485**	**2,642,243**	**6,678,636**	**18,776,343**
	2015	5,044,940	373,720	52,128	843,789	2,719,323	6,676,457	15,710,357
Number of responses	**2016**	**(n=40)**	**(n=11)**	**(n=19)**	**(n=25)**	**(n=8)**	**(n=27)**	**(n=130)**
	2015	(n=39)	(n=10)	(n=15)	(n=25)	(n=8)	(n=27)	(n=124)

TABLE B.7 NUMBER OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES DELIVERED, BY REGION, BY SERVICE TYPE, 2015–2016

TYPE OF SERVICE	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Contraceptive (including counselling)	**2016**	**47,748,224**	**2,989,983**	**374,277**	**5,890,895**	**5,892,684**	**8,980,338**	**71,876,401**
	2015	40,632,473	1,893,329	359,297	8,687,553	8,708,620	9,358,847	69,640,119
Gynaecological	**2016**	**9,156,910**	**2,323,176**	**150,763**	**1,837,816**	**3,123,922**	**8,529,057**	**25,121,644**
	2015	7,394,693	2,042,852	140,644	1,266,732	2,807,325	8,501,638	22,153,884
HIV (excluding STI/RTI)	**2016**	**14,740,366**	**1,610,558**	**200,989**	**719,289**	**2,479,808**	**1,269,277**	**21,020,287**
	2015	13,116,747	1,041,697	116,941	730,949	2,375,630	1,191,825	18,573,789
STI/RTI	**2016**	**10,138,284**	**1,082,883**	**339,554**	**2,223,562**	**2,129,211**	**5,046,217**	**20,959,711**
	2015	8,598,420	975,789	253,294	1,990,826	3,088,491	7,251,013	22,157,833
Obstetric	**2016**	**4,472,388**	**2,344,244**	**43,323**	**1,068,801**	**4,043,146**	**2,189,092**	**14,160,994**
	2015	4,267,894	1,919,597	30,492	726,868	4,066,729	2,180,245	13,191,825
Specialized counselling	**2016**	**3,550,259**	**561,118**	**336,731**	**1,372,224**	**1,008,743**	**1,281,102**	**8,110,177**
	2015	2,583,881	435,522	404,208	1,148,224	1,014,793	966,099	6,552,727
Paediatric	**2016**	**2,897,906**	**2,028,557**	**5,947**	**820,613**	**1,772,854**	**555,470**	**8,081,347**
	2015	2,311,087	1,359,361	521	3,378,442	1,937,906	524,407	9,511,724
SRH medical	**2016**	**3,116,699**	**269,110**	**5,294**	**380,033**	**1,094,769**	**73,213**	**4,939,118**
	2015	3,303,687	206,733	4,078	1,581,179	894,634	397,358	6,387,669
Abortion-related	**2016**	**1,548,283**	**187,291**	**115,299**	**548,281**	**442,185**	**1,923,701**	**4,765,040**
	2015	1,423,874	179,052	120,266	270,073	492,322	1,778,311	4,263,898
Infertility	**2016**	**844,782**	**177,759**	**24,945**	**98,664**	**294,762**	**336,580**	**1,777,492**
	2015	616,976	134,520	19,704	52,298	255,951	279,546	1,358,995
Urological	**2016**	**491,187**	**172,755**	**1,671**	**43,654**	**485,690**	**455,699**	**1,650,656**
	2015	456,414	181,924	1,275	40,891	424,903	400,572	1,505,979
TOTAL	**2016**	**98,705,288**	**13,747,434**	**1,598,793**	**15,003,832**	**22,767,774**	**30,639,746**	**182,462,867**
	2015	84,706,146	10,370,376	1,450,720	19,874,035	26,067,304	32,829,861	175,298,442
Number of responses	**2016**	**(n=40)**	**(n=11)**	**(n=23)**	**(n=25)**	**(n=8)**	**(n=27)**	**(n=134)**
	2015	(n=39)	(n=11)	(n=21)	(n=25)	(n=9)	(n=27)	(n=132)

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KEY ABBREVIATIONS

AIBEF	Association Ivoirienne pour le Bien-Etre Familial
APROFAM	Asociación Pro-Bienestar de la Familia de Guatemala
AR	Africa region, IPPF
ASHONPLAFA	Asociación Hondureña de Planificación de Familia
AWR	Arab World region, IPPF
CMIS	Clinic management information system
CO	Central Office, IPPF
CSE	Comprehensive sexuality education
CYP	Couple years of protection
EN	European Network, IPPF
ESEAOR	East and South East Asia and Oceania region, IPPF
FGAE	Family Guidance Association of Ethiopia
FHOK	Family Health Options Kenya
GRPA	Guyana Responsible Parenthood Association
HERA	Health Education and Research Association, Macedonia
HIV	Human immunodeficiency virus
IPPF	International Planned Parenthood Federation
MCH	Maternal and child health
MISP	Minimum Initial Service Package
RFHAF	Reproductive and Family Health Association of Fiji
RHAK	Reproductive Health Alliance Kyrgyzstan
RTI	Reproductive tract infection
SAR	South Asia region, IPPF
SOFHA	Somaliland Family Health Association
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SROP	Sub-Regional Office for the Pacific, IPPF
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UN WOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
WHR	Western Hemisphere region, IPPF

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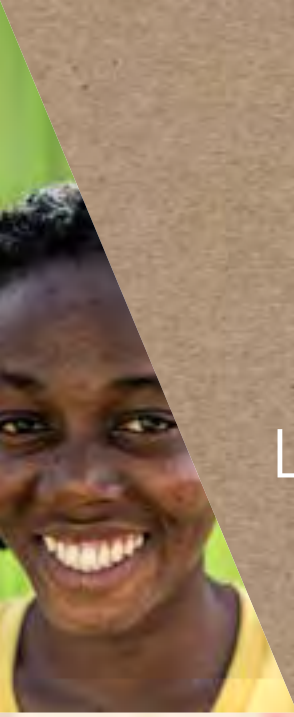

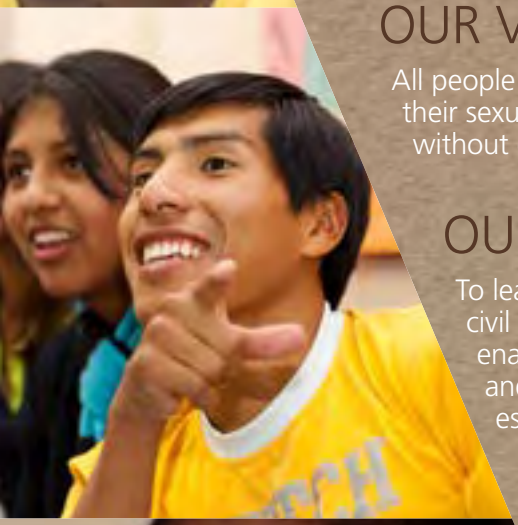

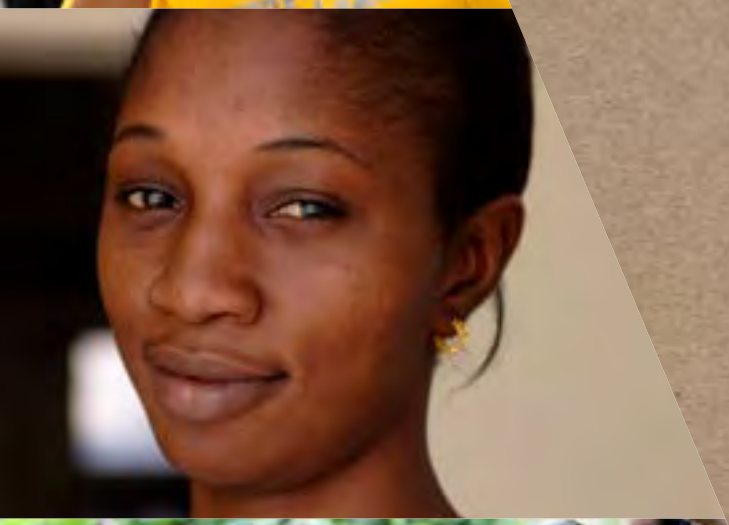

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OUR MISSION

To lead a locally owned, globally connected civil society movement that provides and enables services and champions sexual and reproductive health and rights for all, especially the under-served.

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