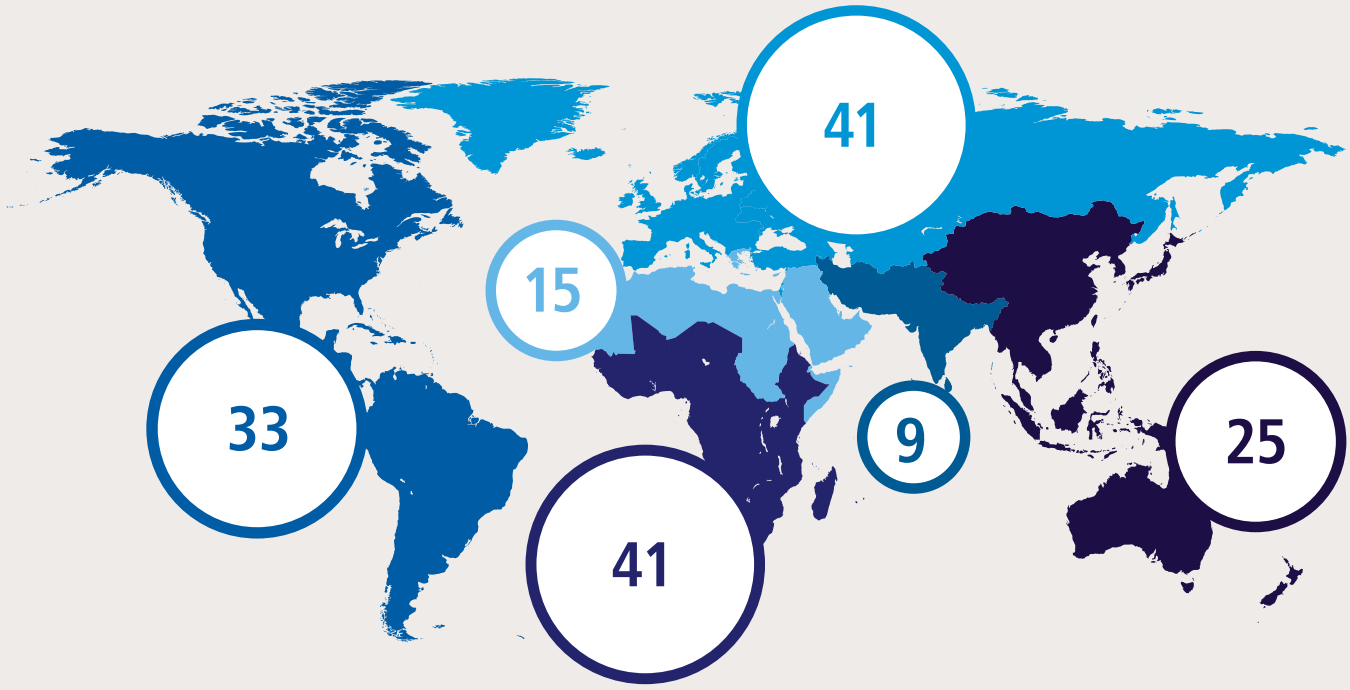
IPPF

ANNUAL PERFORMANCE REPORT 2017



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

29,600 staff

82% of Member Associations have at least one young person on their governing body

81% 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 totals provided. Percentages reflect absolute and not rounded figures, and may not add up to 100 per cent.

FOREWORD

IPPF's *Annual Performance Report 2017* highlights progress made in the second year of our *Strategic Framework 2016–2022*. Performance remains strong in most areas, and we continue to maximize our impact across the globe.

I am pleased to introduce this report in my new role as IPPF's Director-General. I join the organization at a time of great opportunity, but also at a time when we must defend hard-won gains. The following sections present the key performance results for 2017. Additional case studies highlight the work we do to champion rights, empower communities, serve people, and to unite and perform.

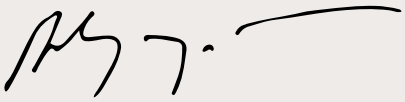
IPPF's advocacy is most effective when we work in partnership with civil society organizations, policy makers and communities to ensure that laws and policies support sexual and reproductive health and rights and gender equality. We face a well-funded and organized opposition determined to undermine progress on sexual and reproductive health and rights. Nevertheless, in 2017, we contributed to 146 advocacy successes at national, regional and global levels, and on a variety of issues ranging from budget allocations for sexual and reproductive health, to preventing sexual and gender-based violence and ending child marriage. Recognizing that working in partnership with other stakeholders is critical to success, we also actively engaged with 1,015 youth and women's groups to take public action in support of sexual and reproductive health and rights.

With positive change in public attitudes as well as effective mechanisms to hold leaders and decision makers to account, people will be empowered to act freely on their sexual and reproductive health and rights. We recognize the importance of providing young people with knowledge and skills to be able to realize their rights. For young people, this means access to information, services and comprehensive sexuality education, and in 2017, 31.3 million young people completed a sexuality education programme delivered by IPPF in both formal and non-formal education settings. We also reached 140.7 million people with positive messages in support of sexual and reproductive health and rights through offline and online channels of distribution, including social media. These messages are rights-based, consistent with IPPF's values, and critical in raising awareness and ensuring public support.

IPPF delivered 208.6 million sexual and reproductive health services in 2017, an increase of 14 per cent from 2016, with 88.6 million or 42 per cent of these services reaching young people under 25 years. The majority of IPPF services are delivered in peri-urban and rural areas, and many are in places where there are no other health care providers present. An estimated 8 in 10 of IPPF's service users were poor and vulnerable, including 3.1 million people affected by a humanitarian crisis. IPPF provided 21.1 million couple years of protection in 2017, a 12 per cent increase from 2016. This averted an estimated 6.6 million unintended pregnancies and 1.7 million unsafe abortions.

In 2017, total income generated by the Secretariat decreased slightly while Member Associations' locally-generated income remained stable, with 48 per cent raised through social enterprise activities. Recognizing the need for increased income as critical to IPPF's success in reaching our ambitious goals, we continue to invest in new business development across the Federation.

The results presented here demonstrate the unwavering efforts of IPPF's volunteers, staff and partners. I acknowledge with deep appreciation all that has been achieved under the leadership of my predecessor, Tewodros Melesse. Continued success will come from working together effectively as a locally owned, globally connected Federation of civil society organizations. It has been a privilege and honour to join IPPF, and I have confidence that with your support, together we will champion, protect and improve sexual and reproductive health and rights for all.



Dr Alvaro Bermejo
Director-General, IPPF

CONTENTS

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

IPPF's advocacy influences governments to respect, protect and fulfil sexual and reproductive health and rights and gender equality. IPPF works in partnerships and coalitions at international, regional and national levels including with United Nations agencies, civil society organizations, and with youth and women advocates and leaders to increase the effectiveness of advocacy initiatives. Figure 1 presents IPPF's 2017 results for Outcome 1 priority objectives.

In 2017, the IPPF Secretariat and Member Associations across the world contributed to 146 policy and legislative changes in support or defence of sexual and reproductive health and rights. This includes 26 subnational and 104 national changes in 66 countries (Annex A). Our advocacy work also contributed to 14 regional changes and two global.

The most common changes comprise increased budget allocations for sexual and reproductive health, education and services for young people, promoting sexual and reproductive rights, and preventing sexual and gender-based violence (Figure 2). IPPF promotes the right of women to choose when and if to have children: sixteen of the changes support access to safe abortion, and five increase access to contraception. IPPF resists attempts by the opposition to bring changes that are harmful to sexual and reproductive health and rights. Seven of the wins in 2017 blocked changes to limit access to contraception or to oppose sexual and gender diversity.

At the global level, IPPF successfully advocated for specific text relating to sexual and reproductive health and rights in two key documents: the final resolution of the United Nations Commission on the Status of Women and the civil society engagement strategy of the Global Financing Facility.

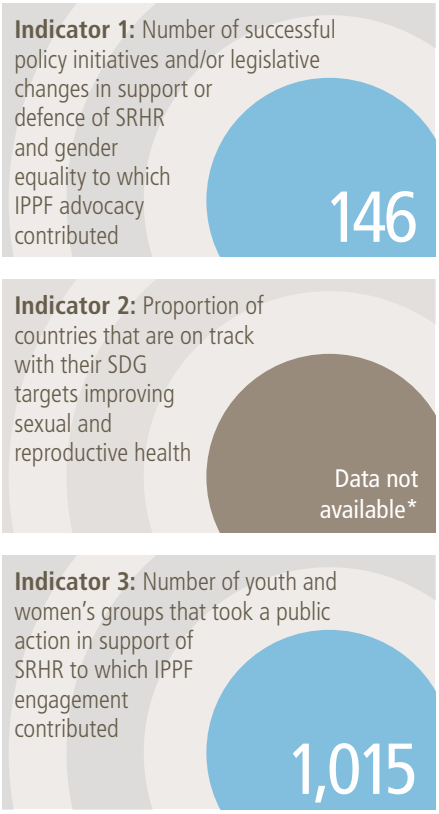
In 2017, at the Family Planning 2020 Summit, IPPF released a report entitled *Under-served and over-looked: Prioritizing contraceptive equity of the poorest and most marginalized women and girls*. This report highlights the need to create political will to ensure equitable access to contraception for all.

In 2017, the global *SheDecides* movement was created as an immediate response to the reinstatement of the Global Gag Rule and the concomitant loss of significant amounts of funding for sexual and reproductive health and rights from the United States government. IPPF was a key partner in the first conference in March 2017 where over US$200 million was raised to bridge the gap in funding. Subsequently, Member Associations from the European Network influenced their governments to make further pledges to the movement.

In 2017, 92 Member Associations conducted advocacy to influence governments to set and deliver targets under the Sustainable Development Goals (SDGs). These activities called for governments to develop SDG workplans and monitoring tools to track progress, and to allocate the budgets and resources needed to achieve the SDGs.

IPPF supported 1,015 youth and women's groups including 456 women's groups, 334 youth groups and 225 groups that describe themselves as improving the lives of both women and young people. Activities undertaken by these groups include making a public statement in support of sexual and reproductive health and rights, adding the group's name to a campaign event or issuing a letter to a public official or decision maker.

FIGURE 1
OUTCOME 1: PERFORMANCE RESULTS, 2017



In the next pages, we present IPPF's success in influencing the Global Financing Facility to engage with civil society, and three Member Association advocacy case studies on sexuality education in Lithuania, protecting human rights in Tunisia, and preventing child marriage in Malawi.

* Data to be collected in 2019.

FIGURE 2 NUMBER OF SUCCESSFUL POLICY INITIATIVES AND/OR LEGISLATIVE CHANGES, BY THEME, 2017

IPPF/Brenda Islas/Mexico

ADVOCATING FOR CIVIL SOCIETY PARTICIPATION IN THE GFF

The Global Financing Facility (GFF) is a major funding mechanism for reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N). It aims to support countries to achieve the health goal of the Sustainable Development Goals by mobilizing additional funding for RMNCAH-N, including sexual and reproductive health and rights, from four sources: domestic government; World Bank; external donors; and private sector resources. It is supported through a multi-donor Trust Fund hosted at the World Bank.

GFF focus countries are required to identify priorities for funding in their Investment Cases. This process should involve all RMNCAH-N stakeholders, including civil society. IPPF has engaged in national and global advocacy on the GFF since it was announced in 2014. For example, in four African countries, Member Associations have monitored the roll-out of the GFF process, and have contributed to the development of national Investment Cases. However, opportunities for civil society participation have been limited, and IPPF has emphasized the need for clearer and more formalized engagement structures. The involvement of civil society organizations in the different stages of the implementation of GFF processes at country level is particularly important in meeting the needs of the vulnerable populations they represent.

The GFF Investors Group, which includes donors, focus country governments, United Nations agencies, private sector and civil society, adopted the GFF *Civil Society Engagement Strategy* in April 2017.[1] This Strategy defines the roles and responsibilities of various stakeholders in promoting meaningful engagement of civil society and provides guidance on their future involvement in GFF processes.

As a member of a coalition of civil society organizations, IPPF contributed to the drafting of the Strategy by proposing specific text for inclusion. As a result, the section on *Roles and Responsibilities: Civil Society* contains reference to the importance of involving civil society with expertise on traditionally neglected and underfunded health and development issues and target populations, including family planning and adolescents. The text proposed by IPPF on the engagement of civil society stakeholders who represent marginalized population groups was also accepted. If implemented, the Strategy will increase civil society participation, and involve stakeholders working on sexual and reproductive health and rights and with vulnerable groups. This will result in strengthened country-level GFF processes and ensure increased transparency and accountability.

> Particular focus will also be placed on the engagement of civil society stakeholders representing marginalized population groups […][2]

INCREASING ACCESS TO SEXUALITY EDUCATION IN SCHOOLS

Family Planning and Sexual Health Association of Lithuania (FPSHA)

Sexuality education has long been a contested topic in Lithuania. There is more awareness now of the need for sexuality education programmes to support young people to exercise their sexual and reproductive health and rights, and to ensure the well-being of children and young people. As a result, comprehensive sexuality education (CSE) is increasingly seen as a factor which will contribute to lower rates of unintended pregnancies[3] and sexually transmitted infections,[4] as well as reducing sexism and homophobia.[5]

When the Family Planning and Sexual Health Association of Lithuania (FPSHA) started to advocate for the introduction of comprehensive sexuality education in schools, it soon became clear that the Ministry of Education was under pressure from Catholic and other anti-choice organizations to provide abstinence-only information. In 2007, a review of the curriculum resulted in another conservative programme, and as it was not mandatory, many young people received no sexuality education at all.

When the programme was under revision again in 2016, FPSHA, in collaboration with other non-governmental organizations, called for a science-based sexuality education curriculum that removed all anti-choice and religious content. FPSHA reviewed and analysed information that was publicized on the government website, and developed strategies to influence the government to move towards a pro-choice approach. During a six-month period, protest letters were sent to the Ministry of Education, demonstrations were organized, and pro-choice organizations were asked to pose questions to the working group and parliamentarians who were in charge of reviewing the sexuality education curriculum.

As a result of this campaign, in 2017, a revised Health and Sexuality and Family Life Education curriculum was approved with new content covering contraception, abortion and the rights of lesbian, gay, bisexual and transgender people. All religious and anti-choice language was removed from both the curriculum and the government website for teachers. FPSHA continues to work with the Ministry of Education and will be providing teacher training on the new sexuality education components.

> CSE goes beyond information, helping young people to nurture positive values about their sexual health. It includes discussions about family life, relationships, culture and gender roles, and addresses rights and gender equality.[6]

PROTECTING HUMAN RIGHTS THROUGH TUNISIAN LAW REFORM

Association Tunisienne de la Santé de la Reproduction (ATSR)

Adopted in 2014, Tunisia's new Constitution enshrines freedom of religion and women's rights. However, Tunisian laws and policies that were incongruous with the new Constitution needed to change and new ones adopted.

In the area of sexual and reproductive health and rights, these changes were driven by advocacy efforts of the Civilian Coalition for Individual Freedoms. Founded in January 2016, the Coalition comprises 28 non-governmental organizations, including the Association Tunisienne de la Santé de la Reproduction (ATSR). ATSR produced leaflets and briefings to distribute to relevant stakeholders, including parliamentarians, ministers, civil society organizations, United Nations agencies and activists. During the pre-session of the Universal Periodic Review (UPR) in 2017, ATSR advocated with permanent delegations from different states to call for the revision of a number of harmful articles in Tunisia's Penal Code. Media campaigns, press releases, an open letter to the President, and meetings held in parliament contributed to success in the following areas.

Tunisia's first national law to combat violence against women was adopted in 2017, covering economic, sexual, political and psychological violence, as well as protection from acts of violence committed by husbands and relatives. The law also calls for practical assistance for survivors, including the provision of sexual and reproductive health services, and legal and psychosocial support.

Article 227 in Tunisia's Penal Code previously enabled any man to escape prosecution if he married the woman he had sexually assaulted; this included young women under the age of 15 years. The coalition's advocacy work called for an amendment of this Article, and sex offenders can now be prosecuted and sentenced to a minimum of five years in prison. Also in support of women's rights, the Tunisian President led a change to allow Muslim women to marry non-Muslim men, increasing their freedom to choose who to marry and ensuring the same rights as those given to men.

The Tunisian government noted, but did not accept, a recommendation made by the UPR to improve the sexual rights of lesbian, gay, bisexual and transgender people. Consensual sex between adults of the same sex remains criminalized, with homosexuality punishable by three years in prison. However, ATSR strongly defended the UPR's recommendations to prohibit anal testing. Subsequently, Tunisian doctors were instructed by the National Council of the Medical Order to inform people accused of homosexuality of their right to refuse anal exams, and that such a refusal is no longer considered as proof of homosexuality. The Minister of Human Rights later confirmed that forced anal exams will no longer be conducted in homosexuality prosecutions.

SUPPORTING YOUNG GIRLS TO MARRY LATER

Family Planning Association of Malawi (FPAM)

Child marriage has strong negative effects on the health of girls due to risks associated with early pregnancy, including maternal mortality, obstetric fistula, premature birth and anaemia. Girls are often forced to leave school when they marry and this decreases their chances of economic independence and success. Child marriage also increases the risks of sexual and gender-based violence. The younger the age at marriage, the greater the impact.[7] Malawi has one of the highest rates of child marriage in the world, with nearly half of girls married before the age of 18 years, and nearly 10 per cent before 15 years.[8] A significant obstacle to ending child marriage in Malawi is poverty, with girls being married at a young age to improve the family's financial status.[9]

In 2017, the Malawian Constitution raised the age of marriage to 18 years for both boys and girls. Previously, marriage could take place at 15 years with parental consent. More advocacy work is required to ensure that this law contributes to the end of child marriage. The Family Planning Association of Malawi (FPAM) builds the capacity of young people to advocate for their rights at both community and national levels. On the Day of the African Child, FPAM supported their Youth Action Movement to present a communiqué to the First Lady of Malawi and a petition to the Parliamentary Caucus on Population, urging the government to retain focus on the issue of child marriage.

Research has shown that a decline in underage marriage is influenced by many factors, including economic, cultural and social factors, rather than a change in law alone.[10] Thus, to ensure that more young people are able to remain unmarried before the age of 18 years, and to annul child marriages that had taken place previously, FPAM implements a community outreach programme and works with schools and parents to support girls to remain in or return to education.

In Liwonde, FPAM held sensitization sessions with community leaders, teachers, parents and young people. During 2017, 91 active groups were formed to raise awareness of the consequences of early marriage and to take action to prevent child marriage; 4,000 young people were educated on their sexual and reproductive rights and the law on child marriage; and 250 leaders were engaged to bring about change in attitudes in their communities. A significant achievement for FPAM was the annulment of 175 child marriages that had previously taken place in Liwonde.

FPAM builds the capacity of young people to advocate for their rights at both community and national levels.

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

IPPF supports people to act freely on their sexual and reproductive health and rights by increasing access to comprehensive sexuality education (CSE) for young people, and by making information on sexual and reproductive health and rights widely available. With the world's largest ever population of young people, there is growing global recognition of the importance of comprehensive sexuality education for ensuring international goals relating to education and health are met.[11] Performance results for Outcome 2 are presented in Figure 3.

IPPF implements comprehensive sexuality education programmes for young people both in and out of school settings. In 2017, Member Associations provided comprehensive sexuality education to 31.3 million young people, an increase of 3.2 million, or 12 per cent, from 2016. This includes 26.9 million youth who received comprehensive sexuality education from the China Family Planning Association. Many other Member Associations also reached significant numbers of young people in 2017, including Burkina Faso, Germany, Mozambique, Sierra Leone and the United States of America.

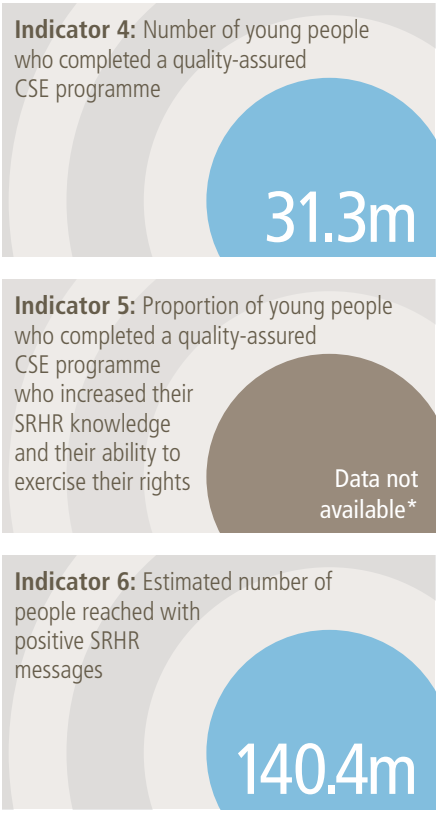
In July 2017, IPPF published the *Deliver+Enable Toolkit: Scaling up comprehensive sexuality education*.[12] This document provides guidance and resources for Member Associations and other stakeholders to deliver programmes in both formal and non-formal education settings, and to develop and implement comprehensive sexuality education policies.

Working in partnership with UNESCO and the PACT for Social Transformation in the AIDS Response (The PACT), IPPF engages with youth-led and youth-focused organizations to champion comprehensive sexuality education and young people's sexual and reproductive health and rights. The partners produced resources to support young advocates to campaign for comprehensive sexuality education and provided funding opportunities for young people to develop their own awareness-raising campaigns. Furthermore, a diverse group of young people was invited to contribute to the review of the *United Nations International Technical Guidance on Sexuality Education*, which was launched in early 2018.

IPPF believes that by providing accurate information on sexual and reproductive health and rights, more people will not only be able to realize their own rights, but will be encouraged to become champions and influence public attitudes and opinions. IPPF reached an estimated 140.7 million people with positive messages on sexual and reproductive health and rights in 2017. This represents an increase of 27.9 million, or 25 per cent, from 2016. The European Network and Western Hemisphere regions together reached 66 per cent of the global total. Messages are distributed via IPPF online (social media, websites) and offline (publications, public events, drama) channels. The global results show that more people are reached through offline (53 per cent) than online channels (47 per cent); although in two regions, significantly more people are reached via online channels (European Network and East and South East Asia and Oceania).

Two programme successes are presented here to illustrate IPPF's work in expanding access to comprehensive sexuality education. The first case from Uruguay focuses on creating more inclusive video resources on sexuality education for young people with disabilities. The second example highlights work undertaken by the Albanian Member Association to reach vulnerable and marginalized young people. Both programmes illustrate the importance of working with a wide range of stakeholders, including the government, teachers, parents and young people, to ensure access to comprehensive sexuality education for all young people.

FIGURE 3
OUTCOME 2: PERFORMANCE RESULTS, 2017



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

PROVIDING SEXUALITY EDUCATION TO ADOLESCENTS WITH DISABILITIES

Iniciativas Sanitarias (IS)

People living with disabilities are more likely to experience physical and sexual abuse, and are more at risk of coercion, including forced sterilization and abortion.[13] A lack of targeted resources, including those on sexuality education, increases vulnerability. Many schools do not have the resources needed to help children who are deaf or blind to learn, and this leads to higher rates of illiteracy. Ensuring all teaching resources, including those on comprehensive sexuality education, are available to young people with disabilities is critical to their learning potential, self-esteem, and ability to protect themselves from all forms of sexual and gender-based violence and abuse.

Since 2006, a national programme on comprehensive sexuality education has been implemented within the formal education system in Uruguay. In 2017, the government signed a partnership agreement with Iniciativas Sanitarias (IS) to develop additional resources in video format for young people with disabilities.

The AMAZE project developed a set of sexuality education videos for 10–14 year olds.[14] These are published under a Creative Commons license, and are freely available online. The videos aim to develop positive attitudes and behaviour, and to increase the knowledge of young people as they transition from childhood to adulthood.

IS worked with Uruguay's National Commission on Sexuality Education, educators, parents, young people and a non-governmental organization specializing on disability, to choose six of the AMAZE videos that are most relevant in the Uruguayan context. The topics cover healthy relationships; identity and expression; long-acting contraception; masturbation; puberty for girls; and puberty for boys. Once selected, IS adapted the videos to provide the content in sign language to enable young people with auditory disabilities to access the information. The videos can be used in both formal and non-formal education settings. As they are online, they are easily accessible and can be viewed in private. In addition, IS developed a practical guide to accompany the videos and assist in face-to-face sessions between educators, parents and young people. The guide addresses specific topics in depth, and presents case studies to help explain the information using real-life examples.

IS is also working with the Secondary Education Council to support the inclusion of deaf students in sexuality education classes provided in lower secondary schools. The videos developed by IS with sign language will ensure that these students are able to participate in programmes provided in schools.

IS is now working to reach another group of young people who have limited access to comprehensive sexuality education by adapting the video content for young people who are blind or have limited vision. This will involve adapting resources in Braille, amplifying text and images, and using three-dimensional materials.

PROVIDING SEXUALITY EDUCATION IN SCHOOLS

Albanian Centre for Population and Development (ACPD)

In 2012, in partnership with the Sexual and Reproductive Health Coalition, the Albanian Centre for Population and Development (ACPD) successfully advocated for the Ministry of Health to adopt an act entitled *Approval of the Positioning Paper on Comprehensive Sexuality Education for Young People in Albania*. Consequently, ACPD was able to gain support in its advocacy efforts to influence the Ministry of Education to develop a sexuality education programme, based on the *It's All One Curriculum*.[15]

The Albanian government's approach is to integrate the content of sexuality education within traditional subjects to normalize conversations on sex and relationships, and to empower young people with the skills and knowledge needed to realize their sexual rights. Teachers and educational professionals have been involved in reviewing the curriculum, and the different components will be incorporated into a range of lessons, such as biology, health and physical education. In 2017, ahead of the country-wide implementation, ACPD trained 100 teachers to use the integrated sexuality education modules in their classes. In turn, they were then able to train a further 200 teachers.

Working with parents, media, decision makers, teachers and the public, ACPD also raises awareness on the importance of providing youth with comprehensive sexuality education in both formal and non-formal education settings, and in particular, the need to incorporate content on sexual pleasure, sexual violence and sex-positive messages.

In 2017, ACPD delivered a comprehensive sexuality education programme to 948 young people, including 110 peer educators who will use this training to work in their communities with other youth. ACPD focuses on the provision of sexuality education to the most vulnerable young people: those who sell sex, inject drugs; live in poverty or in rural communities; and Roma youth. Of the 948 in total, 785 vulnerable young people completed the programme, acquiring much-needed knowledge on a range of sexual and reproductive health and rights issues, life skills such as decision-making, negotiation and communication, and risk reduction strategies. Information on where to go to access sexual and reproductive health services was provided. Following the programme, the majority of the young people who had completed the course (64 per cent) had accessed at least one sexual and reproductive health service from an ACPD clinic.

ACPD has also developed comprehensive sexuality education training for parents. The programme explains the benefits of talking to children about sexuality. It also provides guidance on how to discuss topics such as puberty, first sexual experience, diversity, contraception, risk reduction, consent and boundaries.

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 second year of IPPF's *Strategic Framework 2016–2022*, IPPF continues to make impressive progress in delivering sexual and reproductive health services, and in reaching those most in need, including people affected by humanitarian crises.

Figure 4 presents IPPF's 2017 results for Outcome 3 priority objectives. In 2017, a total of 208.6 million sexual and reproductive health services were delivered, an increase of 26.1 million or 14 per cent from 2016. This includes 163.9 million services provided by IPPF directly (Indicator 7), and a further 44.7 million services that IPPF enabled through partnerships with public and private providers (Indicator 11). The service types that contributed most to the growth were gynaecology, sexually transmitted infections, paediatrics, obstetrics and specialized counselling. Although providing smaller numbers overall, both urology and infertility also experienced significant increases between 2016 and 2017 (51 per cent and 26 per cent respectively).

While the Africa region continues to deliver the largest proportion of IPPF's services, the two regions with the greatest percentage of annual growth were the Arab World (59 per cent) and South Asia (24 per cent). Globally, 85 per cent of IPPF services are delivered in countries identified by the United Nations Development Programme's *Human Development Index* as having low or medium levels of human development.[16]

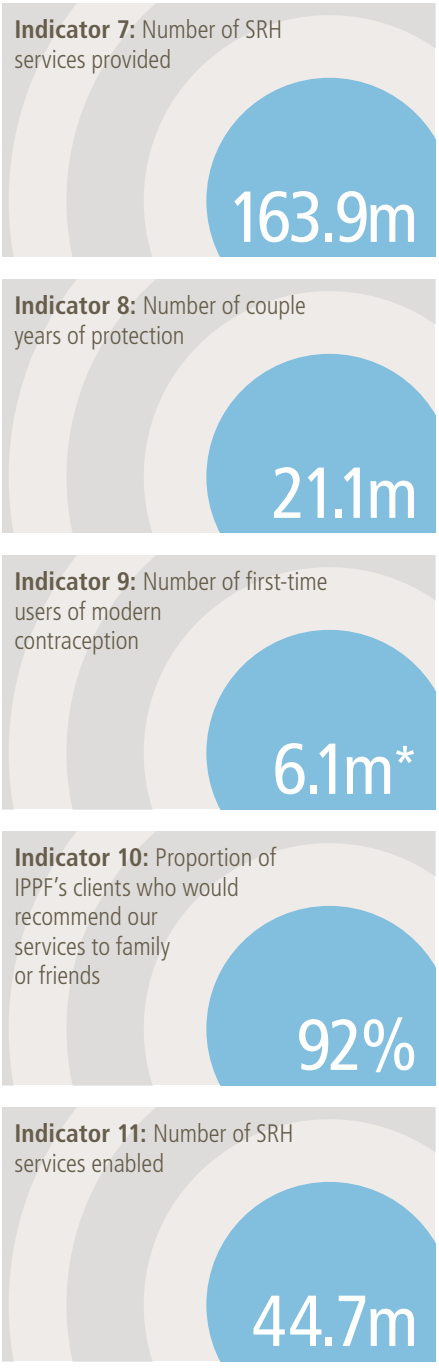
IPPF delivered 88.6 million (42 per cent of IPPF's total) sexual and reproductive health services to young people in 2017. The most common service types were contraception (35 per cent), HIV-related services, including sexually transmitted infections (23 per cent), paediatrics (13 per cent), and gynaecology (nine per cent).

An estimated eight in ten of IPPF's service users are poor and vulnerable (59.1 million). The majority of IPPF health facilities are located in peri-urban and rural areas (60 per cent). This ensures access for the under-served to services in places where fewer government and other private providers are present. An estimated 3.1 million people received services from IPPF in humanitarian settings in 2017, with the largest proportion from two countries, Sudan and Syria in the Arab World region.

In 2017, IPPF provided 21.1 million couple years of protection (CYP), an increase of 12 per cent from 2016. The provision of contraceptive services averted 6.6 million unintended pregnancies and 1.7 million unsafe abortions. The regions contributing the most to IPPF's CYP global total include Africa (43 per cent) and the Western Hemisphere (34 per cent). Intrauterine devices and implants constitute 66 per cent, or 11.8 million, of IPPF's total CYP. The number of first-time users of modern contraception in the 57 Family Planning 2020 focus countries where IPPF works was 6.1 million in 2017, a drop of 200,000 from 2016. This decrease was due to results in one country with performance in the other countries remaining strong. The proportion of IPPF clients who say they would recommend services to family or friends increased slightly from 90 per cent in 2016 to 92 per cent in 2017.

The next section provides an overview of IPPF's service statistics with further analyses and case studies of Member Association programmes: two from the Pacific region on reaching people affected by natural disasters in Vanuatu and Tonga; the provision of reproductive cancer screening in India; and increasing access to communities with high unmet need through social franchise clinics in Ethiopia.

FIGURE 4
OUTCOME 3: PERFORMANCE RESULTS, 2017



* 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.

Reaching those most in need

In 2017, IPPF provided services to an estimated 59.1 million poor and vulnerable people, representing eight in 10 of all services users. This includes an estimated 3.1 million people in humanitarian crises.

Without IPPF, access to sexual and reproductive health services for many people would be severely constrained due to the lack of political will, expertise or institutional capacity. Certain populations are more under-served than others. This can be due to a range of characteristics: age; gender; ethnicity; residence; ability to pay; employment; sexual orientation; gender identity or expression; HIV status; language; religion; education; disability; or migrant status. Access may be denied because of service provider attitudes, stigma, discrimination or restrictive laws and policies.

We delivered services and commodities in more than 40,000 service delivery points, including 24,500 IPPF-owned static clinics, mobile and outreach facilities, and community-based distributors. Sixty per cent of IPPF-owned service delivery points are located in peri-urban and rural areas, and 82 per cent are community-based distributors. This means that many service users are able to access sexual and reproductive health information and services locally. IPPF also supplies contraceptive commodities to nearly 11,100 public and private providers, including pharmacies and private physicians. We have formal partnerships with over 4,500 associated health facilities where we provide training, technical assistance, commodities, monitoring and quality assurance.

IPPF's people-centred approach and values ensure that nobody is turned away, and that tailored service delivery interventions meet the needs of the most vulnerable groups.

8 in 10

of IPPF's service users are poor and vulnerable

3.1m

people served in humanitarian settings

82%

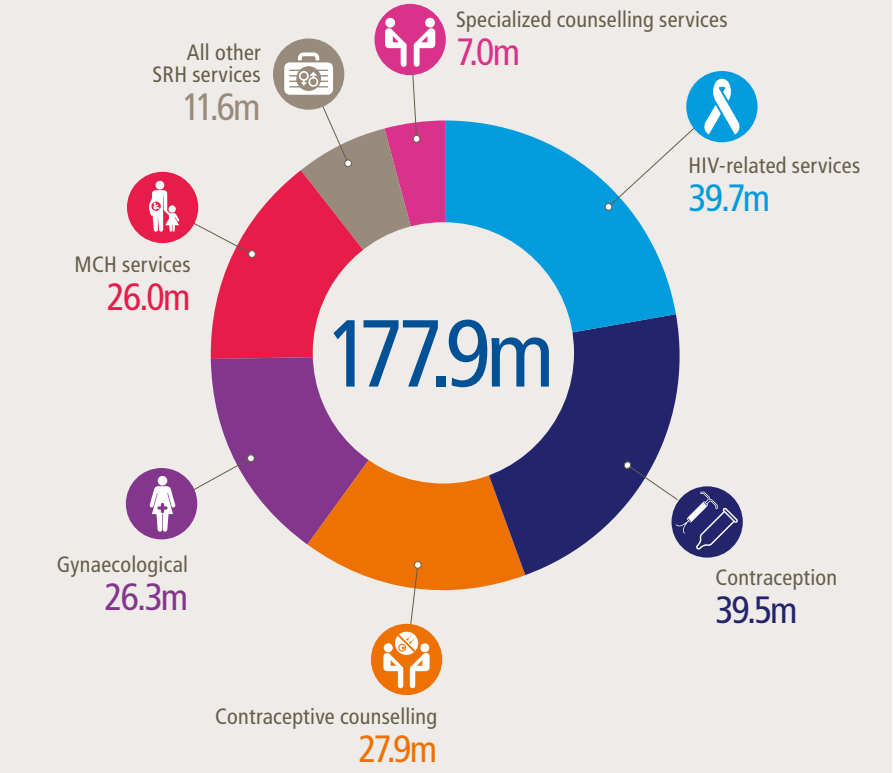
of IPPF-owned service delivery points are community-based distributors

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.[17] 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 2017, Member Associations in the 69 countries with low or medium levels of human development delivered 177.9 million sexual and reproductive health services (Figure 5). The highest numbers were HIV-related services, including sexually transmitted infections, contraception, contraceptive counselling, gynaecology, and maternal and child health (MCH).

FIGURE 5 NUMBER OF SRH SERVICES DELIVERED IN COUNTRIES WITH LOW OR MEDIUM HUMAN DEVELOPMENT, BY TYPE, 2017



Ensuring reproductive choice

In 2017, IPPF provided 21.1 million couple years of protection (CYP) which averted 6.6 million unintended pregnancies and 1.7 million unsafe abortions globally. The methods of contraception that contributed to growth in CYP in 2017 were injectables, implants and intrauterine devices, with annual growth rates of 23, 18 and 17 per cent, respectively. After a significant increase in CYP from oral contraceptive pills in 2016, there was a slight decrease of one per cent in 2017. Figure 6 illustrates IPPF's global CYP by method. The contribution to CYP by condoms remained the same at 11 per cent, but more condoms were distributed in 2017; 284.9 million in comparison to 251.3 million in 2016, and a 13 per cent annual growth rate. The proportion of long-acting methods contributing to CYP increased slightly (by two per cent), short-acting remained the same, and permanent methods decreased (by two per cent) between 2016 and 2017.

Contraceptive counselling is an essential primary healthcare service that supports women, and men, to make their own decisions on which method of contraception is most appropriate for them. Access to contraceptive counselling services is also critical in supporting reproductive choice, including whether to have children, how many to have, and how long to space between births. In 2017, IPPF delivered 31.2 million contraceptive counselling services, an increase of nine per cent from 2016. The majority of these were provided in Africa and South Asia where there is the greatest unmet need for contraception, and where there is least access to information, services and commodities.

IPPF delivers a range of abortion-related services, including pre- and post-abortion counselling, surgical and medical abortion, and treatment for incomplete abortion. In countries with highly restrictive legal environments, harm reduction consultation services are provided to reduce the risk of unsafe abortion for women with unwanted pregnancies.

Between 2016 and 2017, the number of abortion-related services decreased from 4.8 million to 4.6 million, mostly due to abortion consultation services and surgical abortion. The numbers of medical abortion and treatment of incomplete abortion services increased by eight and four per cent, respectively (Table 1).

The provision of contraception after abortion is a critical component of comprehensive abortion care as it reduces the risk of a subsequent unintended pregnancy. In a sample of 121 static clinics, the proportion of service users accepting a modern method of contraception after an abortion (excluding condoms, or a partner's vasectomy) was 77 per cent, with 53 per cent choosing a long-acting method.

FIGURE 6 COUPLE YEARS OF PROTECTION (CYP), BY METHOD, 2017

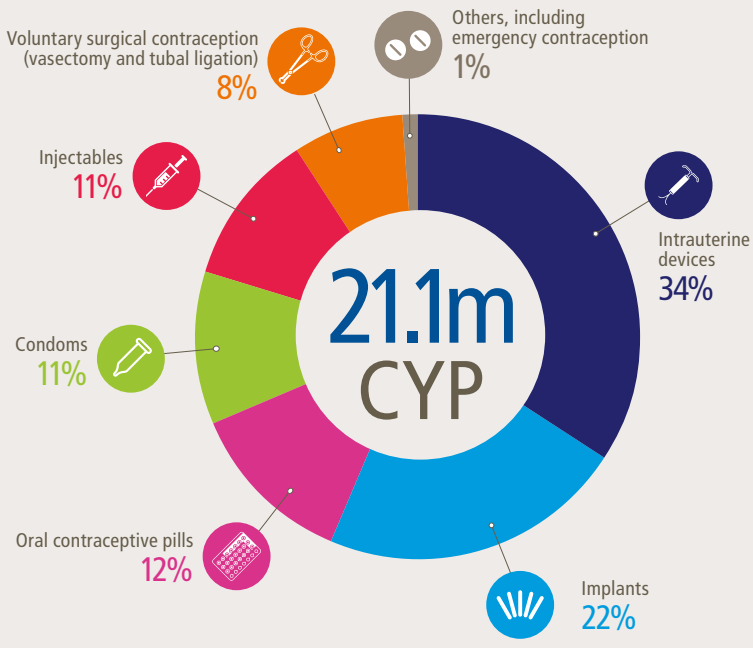


TABLE 1 NUMBER OF ABORTION-RELATED SERVICES DELIVERED, 2016–2017

TYPE OF SERVICE	2016	2017
Pre-abortion counselling	1,303,697	1,293,446
Post-abortion counselling	812,093	848,053
Surgical abortion	612,966	586,025
Medical abortion	481,713	519,851
Treatment of incomplete abortion	117,953	122,226
Abortion consultation services	1,436,618	1,215,569
Total	**4,765,040**	**4,585,170**

6.6m
unintended pregnancies averted*

1.7m
unsafe abortions averted*

284.9m
condoms distributed

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

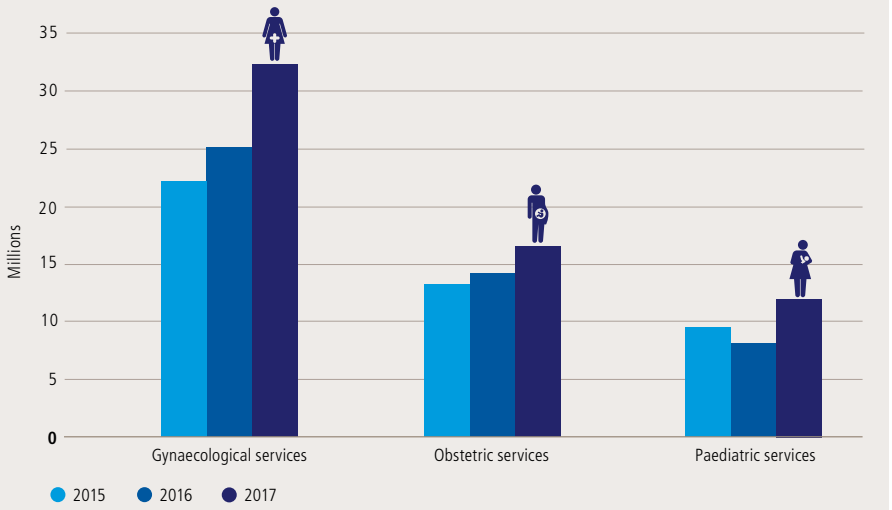
Focusing on the needs of women and girls

The majority of IPPF's services address the sexual and reproductive health needs of women and girls. In 2017, an estimated 78 per cent of all IPPF service users were female. In addition to contraception and abortion-related services, IPPF delivered 32.3 million gynaecological services in 2017, a significant increase of 7.2 million, or 29 per cent, from 2016 (Figure 7), and with increases in all six regions. These services include breast and pelvic examinations, biopsies, imaging and cancer screening. The number of breast and cervical cancer services grew from 14.1 million to 17.0 million between 2016 and 2017, an annual growth rate of 21 per cent. As the case study from India highlights, raising people's awareness of the importance of reproductive cancer screening, as well as ensuring access to services in low-resource settings, is critical to reducing morbidity and mortality rates.

Figure 7 also illustrates the increase of 16 per cent in obstetric services delivered: from 14.2 million to 16.5 million between 2016 and 2017, with Sudan in the Arab World region contributing to the majority of this growth, including the provision of vaginal delivery services by community-based health workers. Similarly, the number of paediatric services rose from 8.1 million to 12.0 million between 2016 and 2017, a 48 per cent increase, with three regions, Africa, Arab World and South Asia, contributing to this growth.

Women and girls are at greatest risk of sexual and gender-based violence, and IPPF delivered 3.4 million prevention, screening and counselling services and referrals in 2017, an increase of nine per cent from 2016. The majority of these services were provided in three regions: Africa (39 per cent), Western Hemisphere (26 per cent) and South Asia (24 per cent).

FIGURE 7 NUMBER OF GYNAECOLOGICAL, OBSTETRIC AND PAEDIATRIC SERVICES DELIVERED, 2015–2017



Delivering HIV-related services

IPPF delivered 46.6 million HIV-related services in 2017, comprising 25.0 million sexually transmitted infection services and 21.6 million HIV services. This represents an increase of 4.6 million, or 11 per cent, from 2016. Five regions reported annual growth: Africa (five per cent); the Arab World (77 per cent); European Network (three per cent); South Asia (19 per cent); and Western Hemisphere (10 per cent).

Sexually transmitted infections contribute greatly to the global sexual and reproductive health burden, including pelvic inflammatory disease, infertility, cervical cancer, and adverse neonatal outcomes. The number of sexually transmitted infection services delivered by IPPF increased by 19 per cent between 2016 and 2017. This result reflects a long-standing commitment to improving access to prevention, testing and treatment services. Growth was also seen in all categories of HIV services with the largest in testing (four per cent), and treatment services (14 per cent).

Meeting young people's needs

IPPF delivered 88.6 million sexual and reproductive health services to young people in 2017; this represents 42 per cent of all services delivered by IPPF. The most common services were contraception (35 per cent); HIV-related services, including sexually transmitted infections (23 per cent); and paediatric services (13 per cent).

IPPF's *Provide: a self-assessment tool for youth-friendly services*[18] describes a systematic approach to measure the youth-friendliness of our services, with a focus on quality of care. The components that are assessed include institutional commitment; facilities; providers; service package; information, education and communication; youth participation; rights; and continuity of care. In line with IPPF's youth-centred approach, young people are included on the assessment team and in the development of action plans. Useful feedback from young service users is also collected during focus group discussions and exit interviews, via suggestion boxes, and from youth members of clinic advisory committees.

3.4m

sexual and gender-based violence services provided

46.6m

HIV-related services delivered

88.6m

SRH services delivered to young people

MEETING SEXUAL AND REPRODUCTIVE HEALTH NEEDS DURING EMERGENCIES

Vanuatu Family Health Association (VFHA)
Tonga Family Health Association (TFHA)

Conflict and crises have dire consequences for women's and girls' sexual and reproductive health and rights. Disintegrating health systems, unsafe environments and prohibitive costs mean that services are limited or inaccessible. Unintended pregnancies, unsafe abortions, sexual and gender-based violence, and maternal morbidity and mortality all increase as a result.

IPPF's Humanitarian Programme works to ensure that sexual and reproductive health needs and rights are not forgotten in emergency situations. In 2017, an experienced humanitarian team with technical and leadership skills was established in two sites (Bangkok and Fiji). The team works closely with all other humanitarian staff based in Member Associations and IPPF Regional Offices to ensure effective emergency response by implementing the Minimum Initial Service Package (MISP) for Reproductive Health in Crises.[19] The IPPF Humanitarian Programme connects key elements of humanitarian action (prevention, preparedness, response, recovery and resilience) with sustainable human development, conducts advocacy to ensure an enabling environment that is supportive of sexual and reproductive health and rights in emergencies, and builds capacity to implement MISP effectively.

A person living in Asia and the Pacific is five times more likely to be affected by natural disasters than anyone living outside the region.[20] Vanuatu is the most at-risk country in the world.[21] In September 2017, volcanic activity on Ambae Island caused the government to declare a state of emergency and evacuate the entire population to nearby islands. Upon return to Ambae in October, the Vanuatu Family Health Association (VHFA) deployed a response team to deliver sexual and reproductive health services, in addition to general health services, during the first 10 days of the humanitarian response. At this time, no other healthcare organization was present on the island. The team later worked collaboratively with the National Health Cluster, community leaders and volunteers, provincial health workers and other civil society organizations to efficiently coordinate and deliver humanitarian services. In total, 23 villages were reached across Ambae Island, and 1,932 beneficiaries (18 per cent of the population) received sexual and reproductive health services. Even when there is no emergency, access to health facilities on the island is very limited, and for some beneficiaries, this was the first time they had ever received sexual and reproductive health services.

Tonga is the world's second most at-risk country.[22] In February 2018, the Tonga Family Health Association (TFHA) instigated an emergency response within days of the severe tropical cyclone known as Gita. Teams travelled to Eua, one of the most affected islands, and in the first month, reached 385 beneficiaries, or eight per cent of the population. TFHA conducted awareness sessions, with a focus on reproductive health, sexual and gender-based violence and the rights of lesbian, gay, bisexual and transgender people, and those with disabilities. Like in Vanuatu, for many women on Eua, this was the first time they had access to sexual and reproductive health information and services. TFHA staff held conversations with women in the privacy of their homes, dispelling myths and encouraging women to use the available services, including contraception, counselling and testing for HIV and other sexually transmitted infections, and pap smears.

> "Today at this [mobile health] clinic I had an antenatal check-up and received medicine for my pregnancy. Normally, to access health care I have to travel far, it's expensive by truck, or a two-hour walk.
>
> IPPF service user, West Ambae, Vanuatu

EXPANDING ACCESS TO REPRODUCTIVE CANCER SCREENING

Family Planning Association of India (FPAI)

In India, breast and cervical cancers account for 49 per cent of all cancer cases in women.[23] High costs of treatment make it unaffordable for many, awareness of cancer as a treatable disease remains low, and access to diagnosis and treatment services is limited.[24] When cancers are diagnosed at an advanced stage, mortality rates are high. However, with early detection and treatment, breast and cervical cancers both have much lower morbidity and mortality rates.

The human papillomavirus can be transmitted through sexual contact and, depending on the virus type, can lead to cervical cancer. This highlights the importance of preventing transmission of the virus, as well as management of genital warts and cervical pre-cancer caused by the human papillomavirus, before cervical cancer develops.

The Family Planning Association of India (FPAI) has worked hard to raise awareness of the link between cervical cancer and unprotected sex, and the importance of prevention and screening. Health education sessions are held in static and mobile clinics, and media campaigns help to ensure information reaches as many as possible, including the most vulnerable groups. The Association provides counselling and screening services, including HIV and other sexually transmitted infection tests, and manual breast examinations. A formal referral protocol with other healthcare facilities enables follow up of clients and provision of emotional support.

To increase choice and access to cervical cancer screening, FPAI trained mid-level healthcare providers to perform visual inspection tests with acetic acid (VIA) or Lugol's iodine (VILI). FPAI supervises newly trained staff to increase their confidence. Refresher training and regular monitoring contribute to lower numbers of positive test results and unnecessary referrals. The alternative option to VIA and VILI screening tests is the pap smear where cells are removed from the cervix and then examined in a laboratory. Pap smears require specialist providers and facilities that are not widely available throughout India. Also, with VIA and VILI, the test results are almost immediate. With pap smears, the results are available much later as samples are assessed by laboratory technicians, and not in situ.

Between 2013 and 2017, there was substantial growth in the number of manual breast examinations provided by FPAI, from 28,593 to 120,317. At the same time, the number of cervical cancer screening services using the visual inspection methods also increased significantly from 2,301 to 22,636.

> Visual inspection of the cervix with acetic acid is a feasible and suitable screening test for cervical cancer in under-resourced settings.[25]

REACHING UNDER-SERVED COMMUNITIES THROUGH SOCIAL FRANCHISE

Family Guidance Association of Ethiopia (FGAE)

In Ethiopia, an estimated 24 per cent of women have an unmet need for modern contraception,[26] and rural communities in particular have limited access to sexual and reproductive health services. Since 2013, Family Guidance Association of Ethiopia (FGAE) has implemented a social franchising programme to increase access to quality, affordable services for low-income populations in peri-urban and rural areas.

In 2017, a review of FGAE's programme was conducted to document the model and develop a guide to support other Member Associations to replicate it. The review also analysed the cost-effectiveness of the programme.

FGAE's network of social franchise clinics is supported and managed by the organization's own static clinics, with clear agreements on obligations relating to commodity supplies, training and technical assistance, branding and data management. Franchise clinics are selected according to a set of criteria comprising location (peri-urban or rural), availability of other public health facilities, and distance from an FGAE static clinic. This selection process ensures the franchise clinics are located in areas with few or no other public health facilities. In addition to counselling and testing for HIV and other sexually transmitted infections, referral for antiretroviral therapy and comprehensive abortion care services, the social franchise clinics provide short- and long-acting contraceptive methods, and referrals for permanent methods.

The costing analysis undertaken for the review of FGAE's social franchise programme estimated the cost per couple year of protection to be between US$0.73 and 1.77. The estimated average cost per DALY-averted* ranged from US$1.38 to 3.30. Further research is required to provide comparative data, but this initial analysis indicates that the social franchising model is a cost-effective approach to reducing unmet needs for contraception, especially in under-served communities.

In terms of performance, between 2014 and 2017, the number of FGAE social franchise clinics increased from 40 to 326. The number of contraceptive services provided grew more than tenfold, from 231,358 to 2,550,430 during the same period. In 2017, the franchise clinics delivered 33 per cent of FGAE's sexual and reproductive health services, almost 50 per cent of its contraceptive services, and 25 per cent of its couple years of protection.

> This initial analysis indicates that the social franchising model is a cost-effective approach to reducing unmet needs for contraception.

* A DALY (disability-adjusted life year) is a measure of disease burden.[27]

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

In 2017, IPPF continued to invest in new systems to increase organizational effectiveness and respond to new opportunities and challenges in the external environment. Performance results for Outcome 4 are presented in Figure 8. IPPF's total income (restricted and unrestricted) generated by the Secretariat was US$125.1 million, US$5.3 million less than in 2016. This four per cent decrease reflects a reduction in restricted multilateral funding, partially offset by increased unrestricted government funding. The majority, 76 per cent, of IPPF's unrestricted income was invested in countries with low or medium levels of human development.[28] Countries in the Africa and South Asia regions received 41 per cent and 19 per cent of IPPF's unrestricted funding, respectively.

Member Associations generate and diversify their own income streams through sales of commodities, patient fees, provision of training, for example to government health workers, and by raising funds from local and international sources, including government. In 2017, unrestricted grant-receiving Member Associations generated a total income of US$291.7 million, a 0.2 per cent increase from US$291.2 million in 2016. Nearly half (48 per cent) of this income was raised through social enterprise activities.

In 2017, IPPF's performance-based funding system was used in five regions to make data-driven decisions about resource allocation to Member Associations. For each Association, unrestricted grants were adjusted according to performance measured by a number of key indicators. The system rewards Member Associations that are most effective in implementing advocacy and education programmes, and delivering sexual and reproductive health services. In the five regions using the performance-based funding system in 2017, five per cent of IPPF's unrestricted income was awarded to high-performing Member Associations.

IPPF was supported by nearly 233,000 volunteers in 2017, an increase of 35 per cent from 2016. Volunteers make a significant contribution to the work and performance of IPPF as peer educators, medical professionals, members of governing bodies, legal advisers and fundraisers. In 2017, a Volunteer Database Management System was developed to support Member Associations to manage information on volunteers and communicate more easily with groups and/or individuals. The database enables Member Associations to coordinate volunteer programmes more effectively and to allocate resources more efficiently.

Opposition groups are a constant threat to the gains achieved by the sexual and reproductive health and rights movement. IPPF responds by engaging activists who support and defend sexual and reproductive health and rights. In 2017, 11.2 million activists agreed to take action for political and social change in support of IPPF's work, an increase of over one million, or 10 per cent, from 2016. Actions taken by activists include participating in campaigns, sharing positive messages in support of sexual and reproductive health and rights on social media, and educating and empowering others to realize their rights.

On the next page, we present examples of initiatives that improve IPPF effectiveness and accountability, and an overview of our investment in social enterprise programmes.

FIGURE 8
OUTCOME 4: PERFORMANCE RESULTS, 2017

Indicator 12: Total income generated by the Secretariat
US$ 125.1m

Indicator 13: Total income generated locally by unrestricted grant-receiving Member Associations
US$ 291.7m

Indicator 14: Proportion of IPPF unrestricted funding used to reward Member Associations through a performance-based funding system
5%

Indicator 15: Number of IPPF volunteers
232,881

Indicator 16: Number of IPPF activists
11.2m

ENSURING PERFORMANCE AND ACCOUNTABILITY

IPPF invests in systems, policies, people and processes to support a culture of performance and accountability. For example, in 2017, IPPF Governing Council approved a new policy on health information systems to provide guidelines on ethical, efficient and effective systems that collect, store and manage clients' information. The policy aims to ensure the use of health information systems for decision making by service providers and clinic managers to increase clinic efficiency and improve client-centred care. A new handbook supports Member Associations to prepare, install and use IPPF's clinic management information systems (CMIS) and to ensure the confidentiality of all client-based information. By the end of 2017, 649 static clinics, from a sample of 45 Member Associations, were using CMIS to manage client-based data, including 413 clinics using the manual CMIS, and 226 using the electronic version.

Published in 2017, IPPF's first ever People Strategy aims to foster greater collaboration and connectivity between all employees, and supports a move towards adopting common approaches and systems, and sharing information for the benefit of the Federation and those we serve. The strategy comprises seven enablers: culture; engagement; performance; leadership and management; people planning; human resources service delivery; and well-being.

At the end of 2016, IPPF Workplace, a new social collaboration platform, was launched. Built using many of the same functionalities as Facebook, its purpose is to improve internal communication and informal knowledge sharing. Staff from five Regional Offices and from over a third of Member Associations are now actively taking part in conversations on the site. Inappropriate content can be reported to the Workplace Content Governing Board, ensuring all posts respect IPPF values. Workplace gives visibility to our work, provides an online discussion space to connect with colleagues easily, and supports our mission to lead a locally owned and globally connected civil society movement.

In 2017, IPPF submitted its first *Accountability Report* [29] in accordance with the membership requirements of Accountable Now. This is a global platform that supports civil society organizations to be transparent, responsive to stakeholders and focused on delivering impact. Reviewed by Accountable Now's independent panel, the feedback received on our report was extremely positive, and IPPF will respond to ensure the highest standards in accountability are maintained throughout the Federation.

> The panel commends IPPF's openness about areas in which it can improve and appreciates the inclusion of concrete actions it plans to take.[30]

EXPANDING SOCIAL ENTERPRISE

IPPF is committed to supporting Member Associations to invest in social enterprise programmes to generate income, diversify funding sources, operate more effectively and efficiently, and achieve greater sustainability. Member Associations use surplus income generated from social enterprise to subsidize sexual and reproductive health services for those who cannot afford to pay, and to implement activities for which no other funding is available.

In 2017, a global research project documented the current scale, size and scope of social enterprise activities in IPPF. Of the Member Associations who responded to the questionnaire, 69 per cent reported social enterprise activity. The most common type of social enterprise was the sale of specialized health and clinical services, and eight Member Associations reported an income of US$1 million and above from this activity. Five Member Associations also raised more than US$1 million from commodity sales.

IPPF's Social Enterprise Acceleration Programme (SEAP) aims to strengthen the capacity of Member Associations to apply entrepreneurial best practice in the health sector while delivering social value and improving lives.

There are a number of Member Associations in IPPF who have many years of experience implementing social enterprise programmes, and who are able to generate income to cover most, if not all, of their expenditure. Recognizing this expertise as a valuable asset, a competitive process to select a Member Association to manage SEAP was undertaken in 2017. FPA Sri Lanka (FPASL), a well-established Member Association with a successful track record in social enterprise, was selected as the SEAP coordinator. FPASL now leads SEAP's grant management (programme and financial management), is responsible for project monitoring, documentation of learning, and the provision of technical assistance and training.

SEAP also has a site on IPPF Workplace to advertise information on the grants available to Member Associations to advance and strengthen their social enterprise work, to connect IPPF experts from different parts of the world, to promote collaboration and to share key resources and the latest thinking on social enterprise.

> Social enterprise is not only about generating income, it is about adopting best business tactics to operate more effectively and efficiently to better achieve our collective mission.
>
> Meradith Leebrick, Associate Director, Social Enterprise Initiative, WHR

NEXT STEPS

IPPF's *Strategic Framework 2016–2022* and its four Outcomes will continue to motivate, inspire and guide our work. Our mission is an ambitious one, but if achieved, we will make a difference to millions of people's lives now, and for generations to come.

In the third year of IPPF's *Strategic Framework 2016–2022*, we will focus our efforts by accelerating action in six areas that are critical to the effective delivery of our *Framework*:

- expand and strengthen the sexual and reproductive health and rights movement
- reclaim the space from the opposition and increase political commitment for sexual and reproductive health and rights
- enable and empower young people through comprehensive sexuality education programmes
- build the capacity of Member Associations to become centres of excellence
- strengthen the provision of sexual and reproductive health information and services in emergencies
- develop IPPF leaders in governance and management to promote a culture of performance throughout the Federation

For each area, a three-year programme of work, developed by groups of IPPF volunteers, staff and external stakeholders, will guide collective action to maximize results.

In 2018, we will be publishing the fourth edition of *IPPF's Medical and Service Delivery Guidelines for Sexual and Reproductive Health*. The updated *Guidelines* will provide up-to-date and detailed information for service providers and clinic managers to ensure adherence to quality standards in the provision of clinical sexual and reproductive health services. Developed in consultation with IPPF's International Medical Advisory Panel and external experts, and using the latest scientific evidence, the next edition of the *Guidelines* will comprise all components of an integrated and comprehensive service package, with new sections on sexual and gender-based violence, prenatal care, infertility, Sayana Press, adolescent sexual and reproductive health, referrals and follow up.

Safeguarding all those who have contact with IPPF, including beneficiaries, service users, activists, stakeholders, volunteers and staff, is a priority in our policies and organizational culture. In 2018, we are revising and expanding our safeguarding approach to include an IPPF code of conduct, new and amended policies, an incident reporting service, a safeguarding learning platform and an extensive training package. IPPF's commitment aims to ensure the safety and well-being of all those we work with, including children, young people, and vulnerable adults, and those who work for us. Our approach will be monitored and assessed, and IPPF's Governing Council will review progress on a regular basis.

Reinstated in 2017, the Global Gag Rule has devastating consequences on the lives of millions of people, in particular, women, girls and the most vulnerable, because of the significant funding cuts to the sexual and reproductive health sector. The opposition, including the political right, and an environment in which resources for international development are threatened, are of grave concern to an organization like ours.

This report highlighted many positive results achieved by the Federation in key areas last year, but IPPF's stagnating income has affected the positive trajectory in other areas. Of greatest concern is the impact at local levels, when clinics and programmes close, trained and committed staff are made redundant, and beneficiaries no longer have access to sexual and reproductive health information, education and services.

Moving forward, we will respond and adapt with increased focus, pace and agility to reduce this risk and ensure IPPF continues to deliver information and services and to champion sexual and reproductive health and rights for all, especially the under-served.

We have a fantastic Strategic Framework. We are making progress but we need a business plan that provides an operational roadmap to a truly transformative IPPF. One that is externally engaged, with brave and diverse voices, and that builds on our experience delivering sexual and reproductive health services. So that we deliver on the strategy. So that everyone can say: "I decide what to do with my body, with my life, with my future".

Dr Alvaro Bermejo, Director-General, IPPF

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 successful policy initiatives and/or legislative changes, by country, 2017

Annex B: IPPF's Performance Dashboard results, 2016–2017

KEY

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

IPPF/Chloe Hall/Mauritania

ANNEX A: NUMBER OF SUCCESSFUL POLICY INITIATIVES AND/OR LEGISLATIVE CHANGES, BY COUNTRY, 2017

COUNTRY	Number of changes
AFRICA	
Botswana	1
Cameroon	1
Ghana	1
Kenya	2
Lesotho	1
Malawi	2
Mozambique	1
Nigeria	1
Tanzania	1
Uganda	8
Zimbabwe	1
ARAB WORLD	
Mauritania	1
Morocco	2
Palestine	2
Tunisia	4

COUNTRY	Number of changes
EUROPE	
Albania	3
Belgium	3
Bulgaria	1
Denmark	1
Finland	3
France	3
Georgia	1
Italy	1
Kazakhstan	2
Kyrgyzstan	3
Latvia	1
Lithuania	2
Luxembourg	1
Macedonia	4
Netherlands	1
Norway	1
Portugal	1
Russia	2
Serbia	2
Sweden	3
Switzerland	1
Tajikistan	6
Ukraine	2
United Kingdom	2

COUNTRY	Number of changes
EAST & SOUTH EAST ASIA & OCEANIA	
Australia	2
Cambodia	1
Democratic People's Republic of Korea	1
Indonesia	2
Philippines	1
Samoa	1
Tuvalu	1
SOUTH ASIA	
Bhutan	1
India	1
Iran	1
Nepal	2
Pakistan	1
WESTERN HEMISPHERE	
Barbados	2
Bolivia	8
Brazil	2
Chile	2
Colombia	3
Dominican Republic	3
Ecuador	1
Guatemala	2
Mexico	1
Paraguay	2
Peru	3
Puerto Rico	2
Trinidad and Tobago	1
United States of America	2
Uruguay	2

ANNEX B: IPPF'S PERFORMANCE DASHBOARD RESULTS, 2016–2017

TABLE B1: IPPF'S PERFORMANCE DASHBOARD – GLOBAL PERFORMANCE RESULTS, 2016–2017		2016 baseline results	2017 results	Number of Member Associations reporting 2017	Number of Secretariat offices reporting 2017
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	**146**	66	4
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	**1,015**	86	6
OUTCOME 2 INDICATORS					
4	Number of young people who completed a quality-assured CSE programme	28,113,230	**31,346,870**	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	112,516,902‡	**140,443,427**	144	5
OUTCOME 3 INDICATORS					
7	Number of SRH services provided	145,078,890	**163,887,066**	134	n/a
8	Number of couple years of protection	18,776,343	**21,087,529**	131	n/a
9	Number of first-time users of modern contraception	6,336,091	**6,102,204**	57	n/a
10	Proportion of IPPF's clients who would recommend our services to family or friends	90%	**92%**	87	n/a
11	Number of SRH services enabled	37,383,977	**44,709,391**	61	n/a
OUTCOME 4 INDICATORS					
12	Total income generated by the Secretariat (US$)	130,391,389	**125,081,940**	n/a	7
13	Total income generated locally by unrestricted grant-receiving Member Associations (US$)	291,198,069	**291,747,796**	119	n/a
14	Proportion of IPPF unrestricted funding used to reward Member Associations through a performance-based funding system	6%	**5%**	n/a	5
15	Number of IPPF volunteers	172,279	**232,881**	153	n/a
16	Number of IPPF activists	10,154,353	**11,200,237**	117	2

* Data to be collected in 2019.

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

‡ Baseline result for 2016 was revised to include data from one Member Association, received after the Annual Performance Report was published in June 2017.

TABLE B.2 **OUTCOME 1: PERFORMANCE RESULTS, BY REGION, 2016–2017**

OUTCOME 1 INDICATORS		Year	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	**2017**	**21**	**9**	**60**	**9**	**6**	**39**	**2**	**146**
		2016	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	**2017**	**88**	**345**	**141**	**39**	**45**	**326***	**31**	**1,015**
		2016	22	133	177	47	29	234	19	661

* Includes groups mobilized in global fora.

TABLE B.3 **OUTCOME 2: PERFORMANCE RESULTS, BY REGION, 2016–2017**

OUTCOME 2 INDICATORS		Year	AR	AWR	EN	ESEAOR	SAR	WHR	CO	Total
4	Number of young people who completed a quality-assured CSE programme	**2017**	**2,620,874**	**76,414**	**306,543**	**27,374,221**	**191,001**	**777,818**	**n/a**	**31,346,870**
		2016	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	**2017**	**21,085,017**	**5,240,433**	**35,377,659**	**15,054,606**	**4,703,063**	**57,020,634**	**1,962,014**	**140,443,427**
		2016	13,042,195	1,215,088	20,045,247	11,187,889	2,663,735	62,122,748‡	2,240,000	112,516,902‡

‡ Baseline result for 2016 was revised to include data from one Member Association, received after the Annual Performance Report was published in June 2017.

TABLE B.4 **OUTCOME 3: PERFORMANCE RESULTS, BY REGION, 2016–2017**

OUTCOME 3 INDICATORS		Year	AR	AWR	EN	ESEAOR	SAR	WHR	CO	Total
7	Number of SRH services provided	**2017**	**74,679,705**	**18,568,823**	**1,512,617**	**14,831,551**	**23,137,235**	**31,157,135**	**n/a**	**163,887,066**
		2016	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	**2017**	**8,976,026**	**1,091,185**	**51,696**	**879,287**	**2,878,274**	**7,211,062**	**n/a**	**21,087,529**
		2016	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*	**2017**	**5,101,023**	**333,254**	**810**	**295,875**	**350,380**	**20,861**	**n/a**	**6,102,204**
		2016	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	**2017**	**93%**	**97%**	**93%**	**83%**	**91%**	**94%**	**n/a**	**92%**
		2016	92%	94%	92%	83%	86%	91%	n/a	90%
11	Number of SRH services enabled	**2017**	**33,514,081**	**3,312,198**	**55,265**	**2,197,022**	**5,072,499**	**558,326**	**n/a**	**44,709,391**
		2016	29,951,314	2,074,995	36,212	1,056,158	3,823,911	441,387	n/a	37,383,977

* Data is from FP2020 focus countries only: this includes 57 countries in total (31 in Africa, five in the Arab World, two in the European Network, 10 in East and South East Asia and Oceania, six in South Asia, and three in the Western Hemisphere).

TABLE B.5 **OUTCOME 4: PERFORMANCE RESULTS, BY REGION, 2016–2017**

OUTCOME 4 INDICATORS		Year	AR	AWR	EN	ESEAOR	SAR	WHR	CO	Total
12	Total income generated by the Secretariat (US$)	**2017**	[Not applicable by regional breakdown][†]							**125,081,940**
		2016								130,391,389
13	Total income generated locally by unrestricted grant-receiving Member Associations (US$)	**2017**	**63,998,677**	**7,542,360**	**7,772,480**	**56,533,159**	**13,606,918**	**142,294,202**	**n/a**	**291,747,796**
		2016	65,638,161	5,341,111	4,481,212	51,280,444	14,477,182	149,979,959	n/a	291,198,069
14	Proportion of IPPF unrestricted funding used to reward Member Associations through a performance-based funding system	**2017**	**3%**	**0%**	**6%**	**2%**	**8%**	**9%**	**n/a**	**5%**
		2016	4%	0%	7%	3%	10%	8%	n/a	6%
15	Number of IPPF volunteers	**2017**	**49,054**	**5,818**	**11,294**	**48,622**	**70,059**	**48,034**	**n/a**	**232,881**
		2016	46,199	6,584	10,317	45,389	15,492	48,298	n/a	172,279
16	Number of IPPF activists	**2017**	**7,440**	**3,156**	**12,463**	**9,464**	**33,012**	**11,112,068**	**22,634**	**11,200,237**
		2016	6,253	2,610	9,872	8,885	2,797	10,118,205	5,731	10,154,353

[†] While resource mobilization is coordinated across the Secretariat, IPPF income 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, 2016–2017**

TYPE OF METHOD	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Intrauterine devices	**2017**	**2,038,489**	**420,424**	**20,335**	**244,957**	**1,591,630**	**2,840,337**	**7,156,171**
	2016	1,424,628	497,477	19,347	199,679	1,348,074	2,651,157	6,140,360
Implants	**2017**	**2,722,738**	**167,081**	**9,288**	**92,015**	**87,838**	**1,517,535**	**4,596,494**
	2016	2,437,908	130,877	7,015	79,297	79,124	1,145,216	3,879,437
Oral contraceptive pills	**2017**	**1,367,922**	**374,376**	**2,553**	**69,558**	**210,418**	**543,145**	**2,567,971**
	2016	1,480,745	251,840	3,097	66,528	222,066	567,218	2,591,494
Injectables	**2017**	**1,465,248**	**35,547**	**66**	**43,349**	**196,803**	**670,998**	**2,412,011**
	2016	1,065,356	31,080	89	49,564	155,627	653,097	1,954,813
Condoms	**2017**	**1,323,108**	**92,436**	**18,259**	**407,725**	**207,557**	**325,143**	**2,374,227**
	2016	1,272,659	43,482	18,867	270,315	195,263	293,596	2,094,180
Voluntary surgical contraception (vasectomy and tubal ligation)	**2017**	**49,460**	**-**	**890**	**19,980**	**475,982**	**1,201,900**	**1,748,212**
	2016	76,880	-	480	12,760	537,612	1,245,480	1,873,212
Emergency contraception	**2017**	**7,008**	**1,237**	**194**	**1,292**	**108,047**	**73,619**	**191,397**
	2016	9,143	557	671	1,126	104,477	81,228	197,201
Other hormonal methods	**2017**	**38**	**-**	**66**	**78**	**-**	**38,135**	**38,317**
	2016	58	-	66	90	-	40,445	40,659
Other barrier methods	**2017**	**2,016**	**84**	**46**	**333**	**-**	**250**	**2,728**
	2016	3,166	445	49	126	-	1,200	4,986
TOTAL	**2017**	**8,976,026**	**1,091,185**	**51,696**	**879,287**	**2,878,274**	**7,211,062**	**21,087,529**
	2016	7,770,541	955,758	49,680	679,485	2,642,243	6,678,636	18,776,343
Number of responses	**2017**	**(n=40)**	**(n=11)**	**(n=20)**	**(n=25)**	**(n=8)**	**(n=27)**	**(n=131)**
	2016	(n=40)	(n=11)	(n=19)	(n=25)	(n=8)	(n=27)	(n=130)

TABLE B.7 **NUMBER OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES DELIVERED, BY REGION, BY SERVICE TYPE, 2016–2017**

TYPE OF SERVICE	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Contraceptive (including counselling)	**2017**	**49,382,792**	**3,701,321**	**365,009**	**7,553,130**	**7,061,015**	**8,978,165**	**77,041,432**
	2016	47,748,224	2,989,983	374,277	5,890,895	5,892,684	8,980,338	71,876,401
Gynaecological	**2017**	**13,630,202**	**3,229,263**	**274,952**	**2,170,315**	**4,043,479**	**8,949,370**	**32,297,581**
	2016	9,156,910	2,323,176	150,763	1,837,816	3,123,922	8,529,057	25,121,644
STI/RTI	**2017**	**12,413,437**	**1,932,467**	**365,622**	**1,957,328**	**2,731,715**	**5,572,007**	**24,972,576**
	2016	10,138,284	1,082,883	339,554	2,223,562	2,129,211	5,046,217	20,959,711
HIV (excluding STI/RTI)	**2017**	**13,744,767**	**2,825,652**	**194,031**	**715,745**	**2,772,713**	**1,358,301**	**21,611,209**
	2016	14,740,366	1,610,558	200,989	719,289	2,479,808	1,269,277	21,020,287
Obstetric	**2017**	**4,819,390**	**4,446,537**	**13,814**	**997,582**	**4,052,831**	**2,190,324**	**16,520,478**
	2016	4,472,388	2,344,244	43,323	1,068,801	4,043,146	2,189,092	14,160,994
Paediatric	**2017**	**3,583,044**	**3,839,311**	**440**	**874,007**	**3,078,360**	**579,682**	**11,954,844**
	2016	2,897,906	2,028,557	5,947	820,613	1,772,854	555,470	8,081,347
Specialized counselling	**2017**	**4,277,655**	**709,662**	**224,885**	**1,858,157**	**1,387,075**	**1,214,372**	**9,671,806**
	2016	3,550,259	561,118	336,731	1,372,224	1,008,743	1,281,102	8,110,177
SRH medical	**2017**	**2,917,987**	**415,839**	**5,680**	**244,852**	**1,535,065**	**86,829**	**5,206,252**
	2016	3,116,699	269,110	5,294	380,033	1,094,769	73,213	4,939,118
Abortion-related	**2017**	**1,336,228**	**207,366**	**114,930**	**458,827**	**488,921**	**1,978,898**	**4,585,170**
	2016	1,548,283	187,291	115,299	548,281	442,185	1,923,701	4,765,040
Urological	**2017**	**908,576**	**372,423**	**2,912**	**58,809**	**714,491**	**432,330**	**2,489,541**
	2016	491,187	172,755	1,671	43,654	485,690	455,699	1,650,656
Infertility	**2017**	**1,179,708**	**201,180**	**5,607**	**139,821**	**344,069**	**375,183**	**2,245,568**
	2016	844,782	177,759	24,945	98,664	294,762	336,580	1,777,492
TOTAL	**2017**	**108,193,786**	**21,881,021**	**1,567,882**	**17,028,573**	**28,209,734**	**31,715,461**	**208,596,457**
	2016	98,705,288	13,747,434	1,598,793	15,003,832	22,767,774	30,639,746	182,462,867
Number of responses	**2017**	**(n=40)**	**(n=11)**	**(n=24)**	**(n=25)**	**(n=8)**	**(n=27)**	**(n=135)**
	2016	(n=40)	(n=11)	(n=23)	(n=25)	(n=8)	(n=27)	(n=134)

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KEY ABBREVIATIONS

ACPD	Albanian Centre for Population and Development
AR	Africa region, IPPF
ATSR	Association Tunisienne de la Santé de la Reproduction
AWR	Arab World region, IPPF
CO	Central Office
CSE	Comprehensive sexuality education
CYP	Couple years of protection
DALY	Disability-Adjusted Life Year
EN	European Network, IPPF
ESEAOR	East and South East Asia and Oceania region, IPPF
FGAE	Family Guidance Association of Ethiopia
FPAI	Family Planning Association of India
FPAM	Family Planning Association of Malawi
FPSHA	Family Planning and Sexual Health Association of Lithuania
GFF	Global Financing Facility
HIV	Human immunodeficiency virus
IPPF	International Planned Parenthood Federation
IS	Iniciativas Sanitarias
MCH	Maternal and child health
MISP	Minimum Initial Service Package
The PACT	PACT for Social Transformation in the AIDS Response
RMNCAH-N	Reproductive, maternal, newborn, child and adolescent health and nutrition
SAR	South Asia region, IPPF
SDG	Sustainable Development Goals
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI/RTI	Sexually transmitted infection/reproductive tract infection
TFHA	Tonga Family Health Association
UNESCO	United Nations Educational, Scientific and Cultural Organization
UPR	Universal Periodic Review
VFHA	Vanuatu Family Health Association
VIA	Visial inspection with acetic acid
VILI	Visual inspection with Lugol's iodine
WHR	Western Hemisphere region, IPPF

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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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Published in June 2018 by the
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