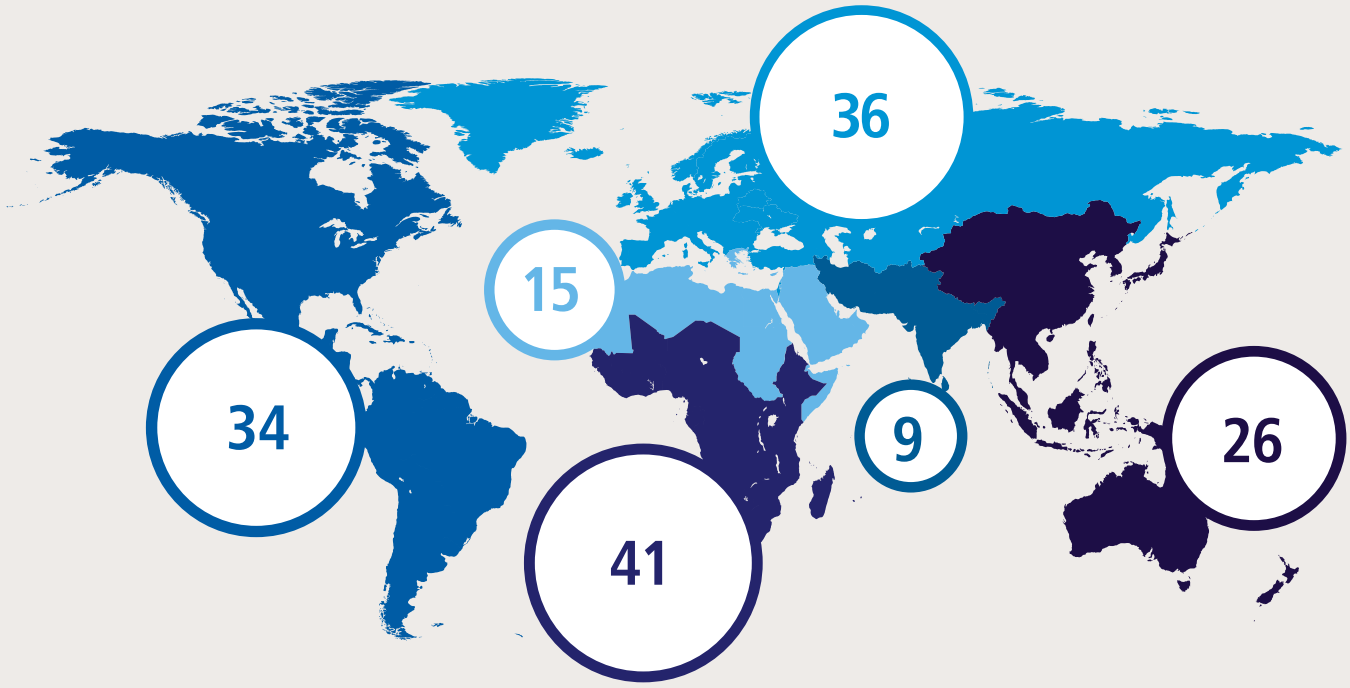
ANNUAL PERFORMANCE REPORT 2018

IPPF



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 Federation of national organizations working with and for communities and individuals.

161 Member Associations and collaborative partners

7 Secretariat offices

31,700 staff

83% of Member Associations have at least one young person on their governing body

83% of Member Associations have a written gender equality policy

Acknowledgements
We would like to express thanks to all 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.

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Photo: IPPF/Alana Holmberg/Tonga

FOREWORD

IPPF's *Annual Performance Report 2018* highlights progress in the third year of our *Strategic Framework 2016–2022*. Performance remains strong and we continue to advance sexual and reproductive health and rights.

This report highlights IPPF's key performance results for 2018, with more detailed information presented in case studies that describe the work we do to champion rights, empower communities, serve people, and to unite and perform.

IPPF collaborates with civil society organizations, legal experts, policy-makers, communities and other stakeholders to influence governments to respect, protect and fulfil sexual and reproductive rights and gender equality. This work is conducted at subnational, national, regional and global levels. In 2018, IPPF contributed to 163 changes in policy or legislation in support or defence of sexual and reproductive health and rights, including 142 wins in 57 countries, and 21 changes at regional and global levels. These changes cover a range of themes: the most common were education and services for young people; promoting gender equality; budget allocations for sexual and reproductive health, including contraception; access to safe and legal abortion; and preventing sexual and gender-based violence. IPPF resists attempts by the opposition to bring about policy and legislative changes that would be harmful to the health and well-being of people and in 2018, seven of IPPF's wins involved successfully defending against the opposition's proposed changes.

In 2018, 119 Member Associations conducted advocacy to influence governments to deliver commitments under the Sustainable Development Goals by allocating financial resources, collecting data and monitoring progress. We also recognize that advocacy brings greatest success when social norms are challenged, and when young people and women are empowered as advocates for change. In 2018, we actively engaged with 1,038 youth and women's groups to take public action in support of sexual and reproductive health and rights.

IPPF believes that to empower individuals to act freely on their sexual and reproductive health and rights, there needs to be a change in public attitudes and an effective mechanism that holds leaders and decision-makers to account. In 2018, 30.8 million young people completed a comprehensive sexuality education programme delivered by IPPF in both formal and non-formal settings. IPPF also provided expertise in the development of curricula to ensure the inclusion of critical components and trained over 150,000 educators to provide sexuality education. To inform and empower people on their sexual and reproductive health and rights, IPPF reached 242.6 million people with positive messages through online and offline channels of distribution, including social media, websites, email, leaflets, posters, public events and theatre productions.

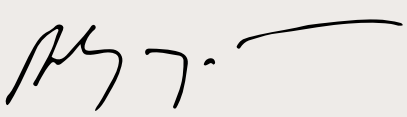
IPPF delivered 223.2 million sexual and reproductive health services in 2018, an increase of seven per cent from 2017; many of these services were delivered in rural and peri-urban areas, locations where there are no other healthcare providers and where without an IPPF health facility, clinical services would remain inaccessible. IPPF's continued efforts to provide young people with youth-friendly services resulted in 95.4 million or 43 per cent of IPPF's global total reaching young people under 25 years. An estimated 8 in 10 of IPPF's clients were poor and vulnerable including 5.1 million crisis-affected people who received sexual and reproductive healthcare at IPPF facilities during both conflict and natural disasters, a significant increase of 62 per cent from 2017.

IPPF provided 23.5 million couple years of protection (CYP) in 2018, an 11 per cent increase from 2017, averting an estimated 10.1 million unintended pregnancies and 3.1 million unsafe abortions. The proportion of long-acting methods contributing to CYP was 66 per cent with increased provision of both implants and intrauterine devices.

Due to the generous support from IPPF's donors, total income generated by the Secretariat was US$133.0 million in 2018, an increase of nearly US$8 million, or six per cent from 2017. Unrestricted grant-receiving Member Associations mobilized local income of US$264.3 million, a decline of nine per cent from 2017; this overall decrease derives from reduced income in a few large Member Associations. However, proportionately more income was raised by Member Associations through social enterprise, at 54 per cent in 2018 in comparison to 48 per cent in 2017.

IPPF continually invests in strategy, systems and policy development. For example, progress was made in 2018 to protect everyone who has contact with the Federation with a new *Safeguarding Framework*, the approval of numerous policies and the establishment of a global incident reporting service.

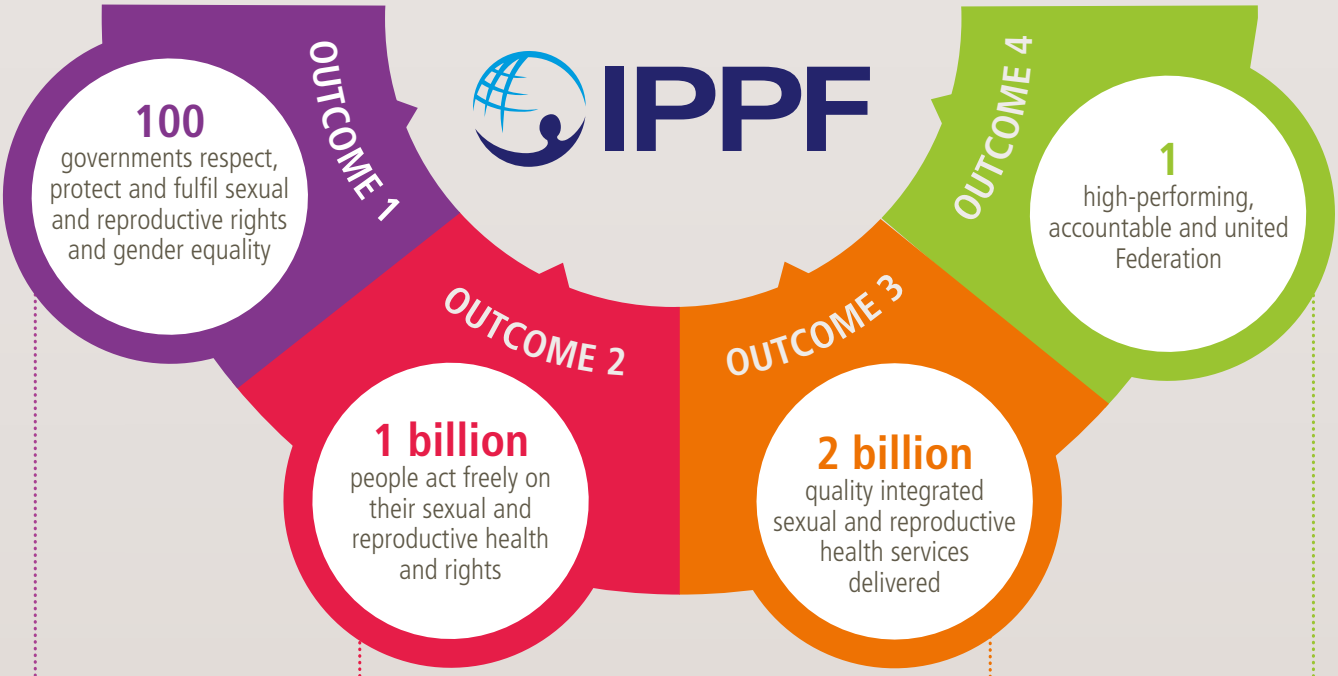
Our performance in 2018 remained strong in all four Outcome areas of the *Strategic Framework 2016–2022*, and we surpassed or made good progress toward the ambitious targets set in 2015 (Annex B, Table B1). The achievements presented in this report result from the commitment and unremitting efforts of all who support, volunteer and work for IPPF. I would like to express my sincere gratitude to you all, and hope you are proud, as I am, of all that we accomplished together in the last year.



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



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

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 advocates for the protection and fulfilment of sexual and reproductive rights and gender equality at subnational, national, regional and international levels. We work in coalitions and partnerships with youth and women leaders and civil society organizations to strengthen advocacy efforts and achieve legal and policy change in support of our mandate. Figure 1 presents IPPF's 2018 results for Outcome 1 priority objectives.

In 2018, IPPF contributed to 163 policy and legislative changes in support or defence of sexual and reproductive health and rights, an increase of 17 from 2017. Member Associations achieved 39 subnational and 103 national wins in 57 countries (Annex A), and Secretariat advocacy efforts led to 17 regional and four global changes.

Figure 2 shows the diversity of themes that IPPF's advocacy work encompasses. In 2018, the highest number of changes relate to the provision of sexual and reproductive health information, education and services for young people. Of these, a third will improve access to comprehensive sexuality education (CSE) for youth. Other significant areas of success comprise changes to promote gender equality, prevent sexual and gender-based violence, expand access to safe and legal abortion and increase budget allocations for sexual and reproductive health, including contraception. IPPF also defends against the opposition's efforts to change laws and policies in ways that would be detrimental to sexual and reproductive health and rights; in 2018, IPPF achieved seven wins that blocked such attempts.

In various global fora, IPPF supported United Nations (UN) Member States to introduce new language in support of sexual and reproductive health and rights and to defend against harmful proposals for changes to text in resolutions of four key UN agencies: the Commissions on the Status of Women, and for Social Development; the High Level Political Forum; and the Third Committee of the UN General Assembly. At the regional level, IPPF achieved 17 wins, 14 in the European Network and three in the Western Hemisphere. These included eight to promote gender diversity and four to increase budgets for sexual and reproductive health; three of these regional wins successfully defended against the opposition.

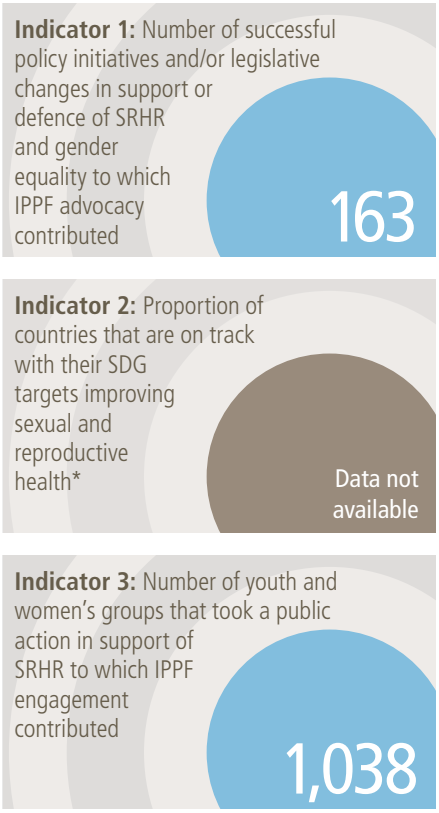
In 2018, 119 Member Associations conducted advocacy to influence governments to deliver targets under the Sustainable Development Goals (SDGs) three and five. These activities call for governments to allocate financial resources to achieve their SDG commitments, and to collect data and present results on progress at country level. IPPF also supported 1,038 youth and women's groups to take public action in support of sexual and reproductive health and rights.

As part of IPPF's 2018 annual campaign, #I Decide: What happens to my body, IPPF launched a report, *Her in charge: medical abortion and women's lives,*[1] which is an urgent call to action for governments, public and private health providers and civil society organizations to increase access to medical abortion, including self-administered medical abortion, as a core component to empower women to realize their reproductive rights.

IPPF continues to engage in movement building in support of sexual and reproductive health and rights through our extensive network of Member Associations and activists. In 2018, IPPF began hosting the SheDecides Support Unit, established to nurture the development of the movement to advocate for the rights of girls and women. The Secretariat for the Nexus Initiative is also hosted by IPPF and focuses on providing support to cross-regional government officials during critical UN negotiations.

In the next section, we present IPPF's success in advocating for gender equality at the UN, and three Member Association advocacy case studies on criminalizing female genital mutilation in Sudan, expanding access to abortion in Ireland and promoting gender equality in Iran.

FIGURE 1
OUTCOME 1: PERFORMANCE RESULTS, 2018



* Metric to be reviewed in 2019 during the Midterm Review of the *Strategic Framework 2016–2022.*

FIGURE 2 NUMBER OF SUCCESSFUL POLICY INITIATIVES AND/OR LEGISLATIVE CHANGES, BY THEME, 2018

38 Education and services for young people	20 Promoting gender equality	19 Budget for SRH, including contraception	19 Access to safe and legal abortion
19 Preventing sexual and gender-based violence	17 Access to SRH services	12 Promoting sexual and gender diversity	6 Access to contraception
6 Support for people living with HIV	3 Promoting sexual and reproductive rights	2 Prioritizing SRH in crisis settings	2 Ending child marriage

Photo: IPPF/WHR/Argentina

ADVOCATING FOR GENDER EQUALITY AT THE UNITED NATIONS (UN)

Much remains to be done to advance the agenda on sexual and reproductive health and rights and gender equality in global spaces where negotiations remain challenging. The sessions of the UN General Assembly Third Committee, responsible for social, humanitarian and cultural affairs, including human rights, took place in October and November 2018. Numerous resolutions relating specifically to gender equality were negotiated by the 193 UN Member States.

Across all the key gender resolutions, some Member States expressed opposition to language on sexual and reproductive health and rights and gender equality. In response, IPPF worked closely with those Member States who are supportive of sexual and reproductive health and rights to successfully defend against the opposition and retain previously agreed language. Furthermore, gains in several resolutions were achieved, for example, access to services in humanitarian settings was included in the resolution on intensifying efforts to end obstetric fistula. Caused by obstructed labour, obstetric fistula is one of the most serious and devastating childbirth injuries. If left untreated, it leads to chronic medical issues and increases the risk of social isolation, poverty and depression.

IPPF worked with Member States from all regions to generate support for sexual and reproductive health and rights issues in intergovernmental negotiations. Statements from these Member States were presented in plenary and IPPF also provided technical advice on specific resolutions. This involved clarifying important concepts, correcting misinformation and providing timely and technically appropriate language proposals to be incorporated into draft resolution texts.

The cross-regional support demonstrated by Member States in negotiations reflects IPPF's successful advocacy approach in terms of defending against opposing voices. Attempts to delete references to sexual and reproductive health and rights, including abortion, were defeated. IPPF's advocacy enabled a strong and cohesive group of countries to hold the middle ground, and the opposition was defeated when its proposals were called to vote.

> Furthermore [...] lack of access to sexual and reproductive health, especially emergency obstetric services, including in humanitarian settings, remains among the leading causes of obstetric fistula, leading to ill health and death for women and girls.[2]

CRIMINALIZING FEMALE GENITAL MUTILATION

Sudan Family Planning Association (SFPA)

In Sudan, there is currently no national law against female genital mutilation. Nearly nine out of 10 women aged 15 to 49 have been cut,[3] and although there are laws in place at state level, these only apply within each state's boundaries. A priority for the Sudan Family Planning Association (SFPA) is to improve gender equality by campaigning for women's rights. SFPA successfully advocated to change the law to criminalize female genital mutilation in two of Sudan's states, North Kordofan and Northern, both with the highest prevalence of cutting in the country at 98 per cent.[4]

In 2018, SFPA organized a series of sensitization meetings targeting civil society, parliamentarians, government officials and non-governmental organizations. The sessions focused on the need for new legislation on female genital mutilation and how to build a movement for change using media campaigns. The importance of including information on the harmful consequences of cutting in school-based comprehensive sexuality education curricula was also discussed during these meetings. Furthermore, SFPA conducted media campaigns, participating in more than 100 radio and television programmes at state and national levels to generate support for legal change.

In both states, SFPA was a member of the parliamentary emergency committees that discussed and developed drafts of the laws against female genital mutilation. SFPA advised parliamentarians and the Ministry of Health on critical amendments to the final drafts. As a result, the Council of Ministers and the parliaments in North Kordofan and Northern states approved legislation criminalizing female genital mutilation in 2018. The new laws widen liability by providing heavy penalties for anyone practising or encouraging cutting. SFPA is now working with these state-level governments to develop policies on how to implement the law, for example, by establishing reporting and complaints mechanisms.

SFPA recognizes that to achieve change, work also needs to be done at the community level. In 2018, peer educators provided comprehensive sexuality education to 330 young people with information on the detrimental effects of female genital mutilation on the health and well-being of women and girls. In addition, four films were produced to use in community-based awareness raising and sensitization sessions, and to empower religious, community and women leaders to be agents of change. Currently, SFPA is providing expertise and support to the federal government to criminalize female genital mutilation at the national level, and to make Sudan a country where this harmful practice is completely eliminated.

> Most women [in Sudan] have been cut between the ages of five and nine.[5]

EXPANDING ACCESS TO SAFE ABORTION

Irish Family Planning Association (IFPA)

Following a referendum in 1983, the Eighth Amendment was inserted into the Irish Constitution giving a fetus an equal right to life as that of a pregnant woman. This made abortion illegal in all cases except when the life of the woman was at risk. The country's political and legal establishment and the anti-choice movement defended the Eighth Amendment, and it took 35 years of work by pro-choice advocates to repeal.

During this time, the Irish Family Planning Association (IFPA) listened to the personal experiences of thousands of women receiving pregnancy counselling and post-abortion care services. Their stories were shared in safe spaces that IFPA organized for discussions between doctors, lawyers, parliamentarians and civil society organizations. Conversations focused on the harmful impact of the law and the dialogue was transformed; personal views and ideology were superseded by concern about abortion as a public health issue and the harm caused to women unable to access abortion care.

Placing abortion within a framework of human rights, IFPA engaged in strategic litigation for access to abortion as a human right. IFPA supported three women to take a case to the European Court of Human Rights in 2005; the judgement created the political imperative to recognize the existing, though highly limited, right to abortion in legislation. IFPA and other civil society organizations engaged in human rights advocacy at the Universal Periodic Review of Ireland in both 2011 and 2016. This resulted in strong criticism of the country's abortion laws by UN Member States and calls for reform by international human rights monitoring bodies.

The momentum for change intensified after the death of Savita Halappanavar in 2012. IFPA used its standing as a reproductive healthcare expert in key fora such as the Irish Citizens' Assembly and the Parliamentary Committee on the Eighth Amendment. IFPA's contribution was invaluable in framing abortion as essential healthcare and as a human right.

On 25 of May 2018, 66 per cent of Ireland's electorate voted to repeal the Eighth Amendment. IFPA now provides free medical abortion up to nine weeks, trains doctors on the provision of safe abortion, and is contributing to the development of a model of abortion care for Ireland's health system.

> "When people have access to calm, reasonable, non-confrontational spaces to have conversations about pregnancy, reproductive healthcare and abortion, the focus shifts from personal discomfort and ideology to public health concerns.
>
> Maeve Taylor, Director of Advocacy, IFPA

INFLUENCING GOVERNMENT COMMITMENT TO GENDER EQUALITY

Family Health Association of Iran (FHAI)

In the Islamic Republic of Iran, women face a range of legal and social challenges that affect their lives. The 2018 *Global Gender Gap Report*, produced by the World Economic Forum, ranks Iran at 142 out of 149 countries in the world on gender equality. This assessment is based on the gap between women and men in terms of economic participation, educational attainment, political empowerment, and health and survival.[6]

Iranian women earn on average only 58 per cent of what their male counterparts are paid for similar work, and although women make up over 50 per cent of university graduates, their participation in the labour force is extremely low at only 17 per cent.[7] Data shows that women suffer discrimination in employment and are also significantly under-represented in senior public and private sector positions.[8] In 2017, following widespread criticism of an all-male cabinet of 12 Vice-Presidents, the Iranian government appointed three women to these roles.[9]

One of the main goals of the Family Health Association of Iran (FHAI) is to ensure fair treatment of both women and men according to their respective needs. In 2018, FHAI worked closely with women's groups and parliamentarians across different government ministries to continue to advocate for increased numbers of women in parliamentary positions and in the workforce. Additionally, as a member of the Health Committee of the National Panel for Women and Family Affairs, FHAI was able to advocate for gender equity at meetings with the Vice Presidency for Women and Family Affairs.

In March 2018, the Health Committee approved a policy in support of women. This includes: agreeing gender equity indicators to evaluate the conditions of women across different themes, including in the workplace; a plan to improve health outcomes by increasing access to sport for girls and women; and a directive that by the end of Iran's 12th Government, 30 per cent of parliamentary positions will be filled by women. Selected government representatives are now responsible for monitoring and tracking progress, and FHAI will continue to monitor the implementation of these measures to hold the Iranian government to account, and will advocate for new initiatives to further advance gender equity in Iran.

> FHAI works closely with women's groups and parliamentarians to increase numbers of women in parliamentary positions and in the workforce.

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 making information on sexual and reproductive health and rights widely available. IPPF's 2018 results for Outcome 2 are presented in Figure 3.

IPPF implements CSE programmes in both in and out of school settings. In 2018, Member Associations provided CSE to 30.8 million young people, a decrease of 0.5 million, or two per cent from 2017. This includes 27.0 million youth who received CSE from the China Family Planning Association. Many other Member Associations reached significant numbers of young people in 2018, including Burkina Faso, Germany, India, Mozambique, Sierra Leone and the United States of America. IPPF also provided expertise in the development of curricula to ensure the inclusion of critical components and trained over 150,000 educators to provide CSE.

IPPF reached 242.6 million people with positive messages on sexual and reproductive health and rights in 2018 through online and offline channels of distribution including social media, websites, email, leaflets, posters, public events and theatre. This represents an increase of 102.2 million, or 73 per cent from 2017, due in large part to the Member Association in the United States where positive messages reached 98.1 million people. The European Network and Western Hemisphere regions contributed 74 per cent of the global IPPF total. Overall, more people are reached through online (71 per cent) than offline channels (29 per cent), with two regions, the Arab World and South Asia, providing more messages via offline channels.

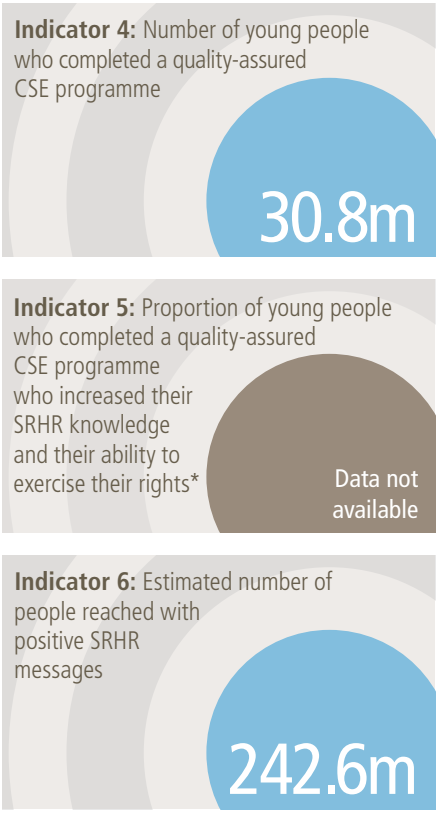
ACT!2030 is a global youth-led social action project coordinated by IPPF, UNAIDS and The PACT. In 2018, young people from 12 countries were trained to collect and use evidence to hold their governments accountable for sexual and reproductive health and rights. The initiative built the capacity of over 600 young people on research and accountability and provided them with opportunities to engage in advocacy at national, regional and global levels.

In 2018, IPPF launched Phase 1 of its CSE Institute focusing on the implementation of CSE programmes by Member Associations and capitalizing on the wealth of experience and best practice in the Federation. The initial stage tested processes for the provision of remote technical assistance between affiliates, and the second involved collaboration with The Open University, based in the United Kingdom, to develop an online CSE training course: 'Taking a pleasure-based approach to comprehensive sexuality education'. The course will be available free of charge on The Open University's learning platform to support educators to develop their skills and confidence.

In November 2018, the IPPF Governing Council passed a resolution to create a new youth manifesto and to review progress in implementing IPPF's youth-centred approach across the Federation.

Two programme successes are presented here to illustrate IPPF's work in expanding access to CSE and information on sexual and reproductive health and rights. The first case from Ukraine focuses on building support for school-based CSE and building the capacity of teachers to deliver effective programmes. The second example highlights how the Tunisian Member Association provides information to ensure young migrants can realise their sexual and reproductive rights and access healthcare, including HIV-related services.

FIGURE 3
OUTCOME 2: PERFORMANCE RESULTS, 2018



*Metric to be reviewed in 2019 during the Midterm Review of the *Strategic Framework 2016–2022*.

BUILDING SUPPORT FOR COMPREHENSIVE SEXUALITY EDUCATION

Women Health and Family Planning (WHFP)

For several years, Women Health and Family Planning (WHFP) advocated for the Sexual and Reproductive Health National Program in Ukraine, which was finally approved in 2017. One of the Program's essential components is CSE, and throughout 2018, WHFP worked closely with government and educators to ensure that CSE programmes are delivered in schools.

In collaboration with the Ministries of Education and Science, WHFP developed a manual for educators. The content includes modules and course material for young people aged 15 to 18 years, and can be used by teachers and school psychologists, or for self-education. The manual contains a set of practical and interactive exercises that help teachers construct a CSE programme. The eight thematic topics include: human rights and the rights of the child; sex and gender; sexuality, sexual behavior, responsibility; growing up and reproduction; health and reproductive health; the relations in our life; effective communication; and sexual and reproductive rights to ensure freedom, equality and dignity of all people. The manual includes guidelines according to the age of the participants and recommends where each topic can be incorporated into the various different school subjects.

The Ministry of Education now officially recommends that the content from the manual is included in the Post-Graduate Pedagogical Institute's curriculum for health educators. In collaboration with the Institute, WHFP trained a team of national trainers who then organized cascade trainings for health educators, school teachers of health and biology and school psychologists. Training was provided to these professionals in different economic, social and cultural environments and in urban, peri-urban and rural locations to ensure wide geographical coverage.

A total of 562 teachers were trained and, as a result, 5,700 young people completed a CSE programme in school.

On an ongoing basis, WHFP assures effective implementation of the cascade training of educators by supervising sessions and providing guidance and technical expertise.

In 2018, WHFP reached nearly 80,000 people with positive messages on sexual and reproductive health and rights through online and offline channels of distribution. WHFP also supports a youth peer education network, delivers a variety of educational programmes for parents, and in 2018, the Member Association conducted two campaigns to raise awareness on the sexual and reproductive health and rights of people with disabilities and cancer prevention for women.

> The manual contains a set of practical and interactive exercises that help teachers construct a CSE programme.

SUPPORTING VULNERABLE GROUPS TO REALISE THEIR RIGHTS AND ACCESS SERVICES

Association Tunisienne de la Santé de la Reproduction (ATSR)

In 2017, the number of migrants in Tunisia was over 57,000,[10] almost equally split between men and women, and the average age was 30 years.[11] Recent research, conducted by the Association Tunisienne de la Santé de la Reproduction (ATSR) in partnership with the United Nations Population Fund (UNFPA), found that the main barriers to the uptake of sexual and reproductive health services by migrants are cost, a result of being unable to work and not having social security coverage; concerns about health provider attitudes; and a lack of knowledge of their rights to healthcare and where to go to obtain free services or support.[12] Data from the research shows that more than 80 per cent of young migrants do not know where they can go for sexual and reproductive health services in Tunisia.[13]

ATSR and UNFPA produced a short documentary highlighting the challenges faced by young migrants and the barriers that prevent them from accessing healthcare and other social and legal services. This film aims to sensitize all health facility staff to ensure that they provide high quality reception, communication and services for migrants. The film is also used to engage with the general public to increase acceptance of young migrants in their communities.

ATSR provides information to migrant groups to increase awareness of their rights and of the various structures that are available to offer assistance. A large proportion of the migrant population in Tunisia is from sub-Saharan Africa,[14] so ATSR delivered training on sexual and reproductive health and rights to a pool of peer educators, all of whom are migrants from sub-Saharan Africa themselves. In 2018, these educators provided information sessions on sexual and reproductive health and rights and on where to access healthcare to a total of 3,170 migrants. ATSR has established its own youth centre to serve young migrants and other key populations. All the services provided are free, and for those who receive a positive diagnosis following an HIV test, ATSR refers and accompanies them to hospital for further support, including antiretroviral therapy.

Sex workers are another vulnerable group supported by ATSR, and many experience the same challenges as young migrants in terms of understanding and being able to act on their sexual and reproductive health and rights.[15] ATSR provides a range of information and services to sex workers with a focus on sexually transmitted infections, including HIV, and how to prevent infection. In 2018, 3,560 sex workers attended ATSR's information sessions following which 300 sex workers were tested for HIV. Again, those who tested positive were supported in accessing healthcare in hospitals.

> ATSR delivers training to peer educators, all of whom are young migrants from sub-Saharan Africa.

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

The results presented in Figure 4 illustrate the continued success of IPPF Member Associations in delivering quality, integrated sexual and reproductive health services, with a focus on reaching those most in need.

In 2018, IPPF delivered a total of 223.2 million clinical services, an increase of 14.3 million, or seven per cent from 2017. Member Associations provided 168.1 million services directly from static clinics, mobile and outreach facilities and community-based distributors (Indicator 7); and enabled the provision of a further 55.1 million services in partnership with public and private providers (Indicator 11). The largest numbers were for contraceptive, gynaecological, sexually transmitted infection and obstetric services. Nearly all service types experienced growth between 2017 and 2018, with the greatest increases in obstetric, urological and abortion-related services.

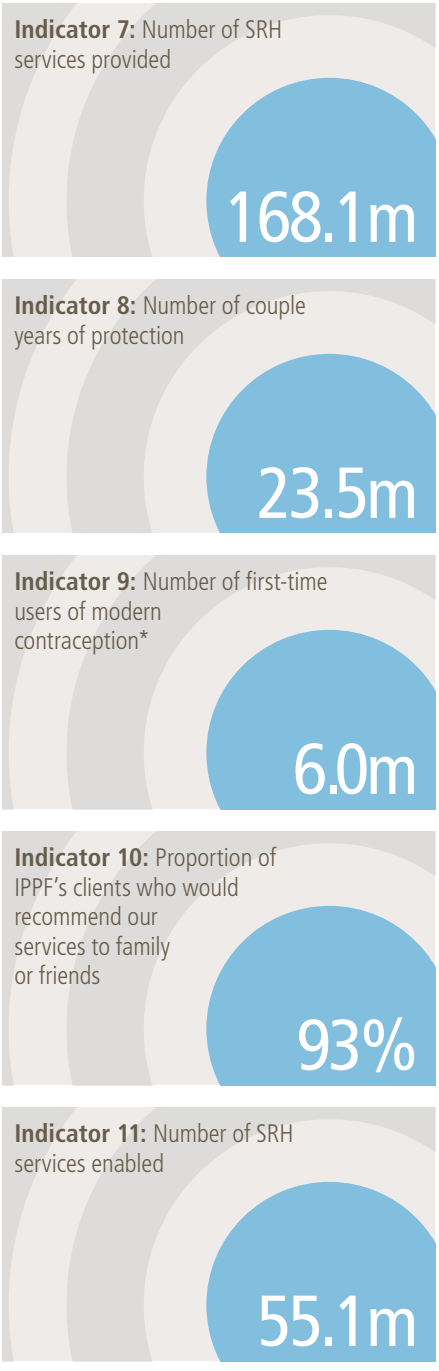
The Africa region contributed 48 per cent of IPPF's total services in 2018; the South Asia and Western Hemisphere regions also delivered significant numbers, at 16 per cent and 15 per cent respectively. In terms of annual growth rate, the regions with the highest performance were South Asia (23 per cent) and the Arab World (19 per cent). Across the globe, 84 per cent of IPPF's services are delivered in countries with the greatest need.[16]

IPPF is committed to providing access to sexual and reproductive healthcare for young people. In 2018, 43 per cent of IPPF's clinical services were delivered to youth; the most common types were contraception, HIV-related services, including sexually transmitted infections, paediatrics and gynaecology. In 2018, an estimated 54.7 million of IPPF's service users were poor and vulnerable, or 81 per cent of the total. Of these, 5.1 million people received healthcare in humanitarian settings, a substantial increase of 62 per cent from 3.1 million in 2017, with the largest numbers in the Central African Republic, Chad, Democratic Republic of Congo, Sudan and Syria.

IPPF provided 23.5 million couple years of protection (CYP) in 2018, an increase of 2.4 million, or 11 per cent from 2017. IPPF's contraceptive services averted 10.1 million unintended pregnancies and 3.1 million unsafe abortions. The regions contributing the largest proportion of IPPF's global CYP were Africa and the Western Hemisphere, at 45 per cent and 32 per cent respectively. The regions exhibiting greatest annual growth were the Arab World (28 per cent) and Africa (17 per cent). The value of CYP for every contraceptive method increased between 2017 and 2018, with intrauterine devices and implants together constituting 59 per cent of IPPF's total CYP. The number of first-time users of modern contraception was 6.0 million in the 58 Family Planning 2020 focus countries where IPPF works. Finally, 93 per cent of IPPF's clients say they would recommend our services to family or friends, demonstrating IPPF's high quality of care.

The following section provides further analysis of IPPF's service statistics. The results from two Innovation Programme research projects offer insight into the value of partnerships between implementing agencies and academic researchers. Case studies are also presented on Member Associations working with crisis-affected populations in Yemen and Indonesia; providing post-abortion care in the Democratic Republic of Congo; and overcoming the effects of the Global Gag Rule.

FIGURE 4
OUTCOME 3: PERFORMANCE RESULTS, 2018



* IPPF reports 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 the under-served

In 2018, IPPF provided sexual and reproductive health services to 54.7 million poor and vulnerable people, or 81 per cent of all IPPF service users. This included 5.1 million crisis-affected people, a significant increase of 2.0 million people or 62 per cent from 2017. Many key populations are typically under-served by public and private healthcare facilities due to a range of factors including age, gender, ethnicity, residence, ability to pay, employment, sexual orientation, gender identity or expression, HIV status, language, religion, education, disability or migrant status. Access to sexual and reproductive healthcare would be extremely constrained for millions of people if IPPF was not providing services to those most in need and/or living in remote locations. Our vision, core values and focus on reaching the poor and vulnerable ensure that no one is denied the services they need due to service provider attitudes, stigma, discrimination or inability to pay.

In 2018, IPPF delivered services and contraceptive commodities in more than 41,134 service delivery points, including 26,652 IPPF-owned static clinics, outreach and mobile facilities, and community-based distributors; 60 per cent are located in rural or peri-urban locations and 81 per cent are community-based distributors. This facilitates ease of access for those who would otherwise have to travel long distances to obtain healthcare. IPPF also expands its reach by enabling other facilities to deliver sexual and reproductive health services, supplying commodities to 9,565 public and private providers, and establishing formal partnerships with 4,917 associated health facilities. These are supported by IPPF with technical assistance, commodities, training, monitoring and quality control.

8 in 10

of IPPF's service users are poor and vulnerable

5.1m

people served in humanitarian settings

81%

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

Young people

People who use drugs

Sex workers

People living with HIV

People in crisis settings

Sexually and gender diverse groups

Survivors of gender-based violence

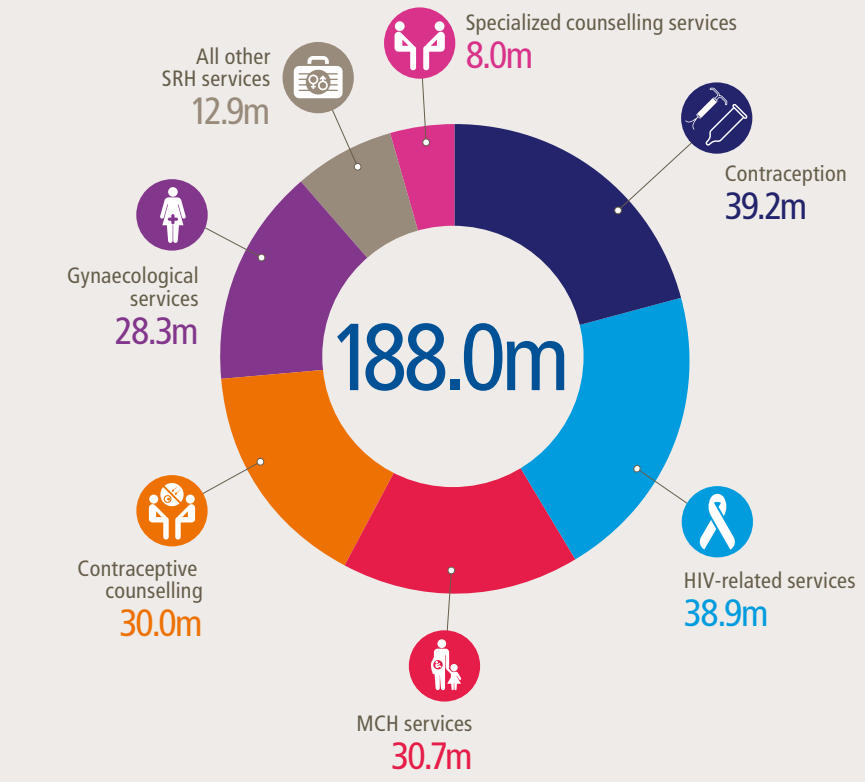
People with disabilities

Investing in countries with the greatest need

Figure 5 illustrates the number of sexual and reproductive health services delivered in countries with low or medium levels of human development in 2018.[17] There were 67 Member Associations with these levels of development and they provided 188.0 million clinical services with the largest numbers as follows: contraception; HIV-related services, including sexually transmitted infections; maternal and child health (MCH); contraceptive counselling; and gynaecology.

In 2018, 71 per cent of IPPF's unrestricted funding supported Member Associations in the countries with disproportionately high rates of maternal and child morbidity and mortality, unmet need for contraception, HIV prevalence, early marriage and childbearing. This focus on countries with the highest level of need means that IPPF resources are invested where they can make the most significant and positive change to people's sexual and reproductive health and well-being.

FIGURE 5 NUMBER OF SRH SERVICES DELIVERED IN COUNTRIES WITH LOW OR MEDIUM HUMAN DEVELOPMENT, BY TYPE, 2018



Ensuring reproductive choice

In 2018, IPPF provided 23.5 million couple years of protection, an increase of 11 per cent from 2017 (Figure 6). This averted 10.1 million unintended pregnancies and 3.1 million unsafe abortions globally.* The methods of contraception with significant annual CYP growth rates were implants (19 per cent), intrauterine devices (17 per cent), injectables (seven per cent) and condoms (six per cent). Between 2017 and 2018, the overall proportion of long-acting reversible methods contributing to CYP grew by three per cent to 59 per cent, whereas short-acting methods and permanent methods dropped by two and one per cent respectively. For IPPF, offering a range of contraceptive choices is explicit in our Integrated Package of Services requiring Member Associations to provide long- and short-acting methods as well as emergency contraception and contraceptive counselling. This ensures service provision is rights-based and enables informed decision-making on whether to have children, how many to have, and how long to space between births. IPPF delivered 35.1 million contraceptive counselling services in 2018, a 13 per cent increase from 2017, with the majority of 71 per cent in Africa and South Asia where there is the most unmet need for contraception and the least access to information, services and commodities.

To ensure reproductive choice and reduce the harmful consequences of unsafe abortion, IPPF provides a range of safe and legal abortion-related services. These comprise pre- and post-abortion counselling, surgical and medical abortion, and treatment of incomplete abortion. In 2018, the total number of abortion-related services increased by 701,410 to 5.3 million, or 15 per cent from 2017 (Table 1). Growth was most significant in medical abortion (38 per cent), abortion consultation services (22 per cent) and surgical abortion (12 per cent). For medical abortion, several countries have substantially increased the number of services provided, including Colombia, Ethiopia, India and Vietnam. In a sample of 14 countries, the proportion of clients accepting a modern method of contraception (excluding condoms or a partner's vasectomy) following an abortion was 85 per cent, with 53 per cent choosing a long-acting method. This is a critical component of comprehensive abortion care as it reduces the risk of a subsequent unintended pregnancy.

To increase access to safe medical abortion, IPPF created the *Medical Abortion Commodities Database*[§] to provide public health professionals with information on the availability of quality misoprostol, mifepristone and combined packs of the drugs that are registered at country level.

FIGURE 6 COUPLE YEARS OF PROTECTION (CYP), BY METHOD, 2018

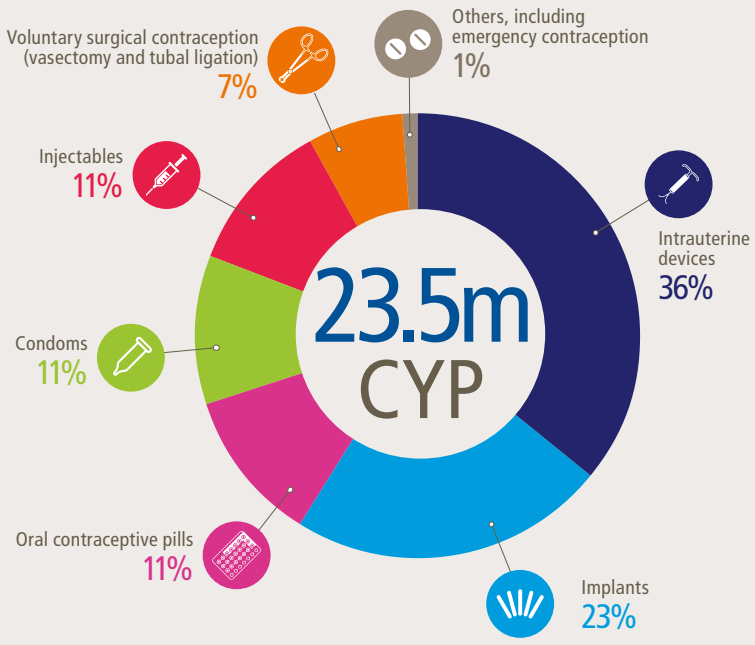


TABLE 1 NUMBER OF ABORTION-RELATED SERVICES DELIVERED, 2017–2018

TYPE OF SERVICE	2017†	2018
Abortion consultation	1,216,574	1,489,688
Pre-abortion counselling	1,292,772	1,408,208
Post-abortion counselling	844,032	886,935
Medical abortion	525,682	726,575
Surgical abortion	587,864	656,345
Treatment of incomplete abortion	122,237	122,820
Total	**4,589,161**	**5,290,571**

† 2017 data revised for one Member Association following publication of the *Annual Performance Report 2017.*

10.1m
unintended pregnancies averted*

3.1m
unsafe abortions averted*

303.3m
condoms distributed

* Using Marie Stopes International's Impact 2 (version 5) estimation model.

§ www.medab.org

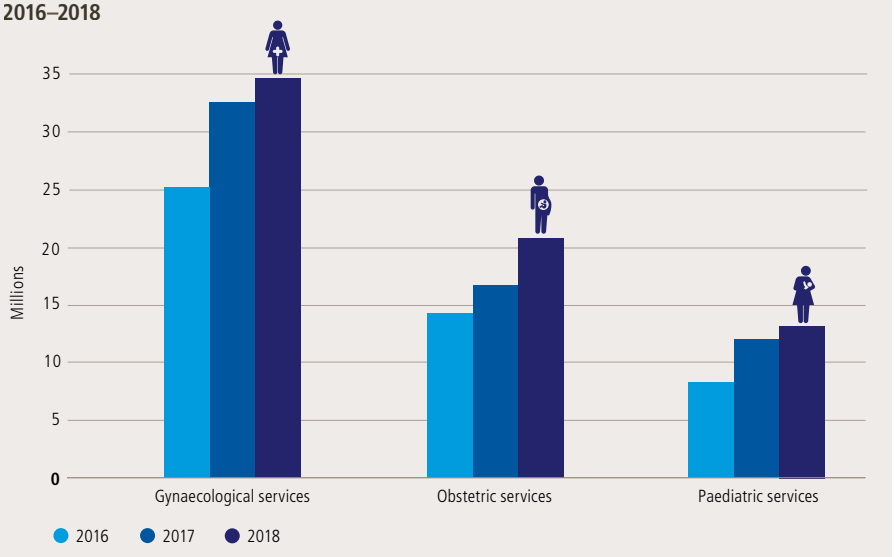
Focusing on the needs of women and girls

IPPF believes that the provision of an integrated package of gender-sensitive and stigma-free sexual and reproductive health services plays a critical role in addressing the specific needs of women and girls. In 2018, an estimated 57.0 million or 84 per cent of all IPPF service users were women and girls. In addition to contraception and abortion-related services, other women-only service types are gynaecology and obstetrics. Figure 7 shows the three-year trends for these services, along with paediatrics. With increases in four regions, Africa, Arab World, East and South East Asia and Oceania, and South Asia, the number of gynaecological services rose by 2.0 million to 34.5 million in 2018, or six per cent from 2017. For women and girls, access to gynaecological services is critical to their health and well-being; these include breast and pelvic examinations, biopsies, imaging and cancer screening, as well as services related to menstruation. Between 2017 and 2018, the number of breast and cervical cancer services increased from 17.2 million to 18.1 million, an annual growth rate of five per cent. The number of services related to menstruation was 912,575 in 2018.

Access to potentially life-saving obstetric services is also critical for women and girls during and after pregnancy, and in childbirth. In 2018, IPPF delivered 20.7 million obstetric services comprising pregnancy tests, pre- and post-natal counselling, ultrasound, vaccinations and delivery. This is an increase of 4.2 million or 25 per cent from 2017. One country, Sudan, made the most significant contribution to the overall global total at 24 per cent. The two Member Associations contributing the most to the total annual growth are Sudan (33 percent) and Syria (17 per cent), both from the Arab World region. For paediatric services, the results for 2018 also reveal strong performance with an increase of 1.1 million to 13.1 million services delivered, or 10 per cent from 2017, with a third of these services being preventive vaccinations for children under five years.

Although not exclusively affected, women and girls are at greater risk of sexual and gender-based violence than men. In 2018, IPPF delivered 3.9 million sexual and gender-based violence services, an increase of 15 per cent from 2017. Most of these services were provided in Africa (36 per cent), the Western Hemisphere (28 per cent), and South Asia (23 per cent).

FIGURE 7 NUMBER OF GYNAECOLOGICAL, OBSTETRIC AND PAEDIATRIC SERVICES DELIVERED, 2016–2018



Delivering HIV-related services

Access to counselling, testing and treatment of sexually transmitted infections, including HIV, is a major factor in reducing pelvic inflammatory disorder, infertility, HIV infection, cervical cancer and adverse neonatal outcomes. The number of HIV-related services delivered by IPPF remained static from 2017 to 2018 at 46.8 million, comprising 27.0 million sexually transmitted infection services with an annual growth rate of eight per cent from 2017, and 19.8 million HIV services, with a decrease of the same percentage. The Africa region constitutes 49 per cent of the global total of HIV-related services, while the East and South East Asia and Oceania and South Asia regions showed the most significant growth since 2017 (at 63 and 25 per cent respectively).

Vaccination against human papillomavirus (HPV) and hepatitis A and B is a growing area of work for IPPF with an annual increase of 26 per cent from 2017. Most of this growth was in the Africa region with the Ugandan Member Association significantly increasing the number of vaccinations provided for both hepatitis B and human papillomavirus.

Meeting young people's needs

IPPF's youth-centred approach endorses key principles for youth participation: rights-based; transparent; voluntary; respectful; inclusive; and safe. IPPF engages youth as leaders, advocates, educators, researchers, volunteers and staff. Young people are elected to IPPF's governing bodies at national, regional and global levels. IPPF implements effective approaches to meet young people's sexual and reproductive health needs including values clarification training for service providers to ensure non-judgemental delivery of healthcare, and strategic partnerships with other providers such as pharmacists who refer young people to IPPF clinics for services. Sensitization activities with parents, teachers and community leaders increase support for the rights of young people, including the right to access youth-friendly services.

In 2018, 95.4 million services were delivered to young people, representing 43 per cent of IPPF's global total, and an increase of eight per cent from 2017. The most common were contraceptive (34 per cent), HIV-related (21 per cent) and paediatric (14 per cent) services.

46.8m

HIV-related services delivered

95.4m

SRH services delivered to young people

CONTRIBUTING TO THE EVIDENCE BASE THROUGH INNOVATION AND RESEARCH

IPPF's Innovation Programme funds partnerships between Member Associations and researchers to generate evidence on the effects of interventions that aim to solve difficult sexual and reproductive health challenges. Each innovative project tests a new idea or programmatic approach, or addresses the needs of a target group for the first time. IPPF staff, with programmatic and technical expertise, identify the most exigent challenges. Member Associations then partner with independent researchers to implement programmes that are rigorously evaluated, in some cases with randomized controlled trials, to generate evidence and provide rationale for the success or failure of the approach. Two of the most recent projects involved the use of mHealth (mobile health) to increase young people's access to contraception in Bolivia, Palestine and Tajikistan, and the provision of post-abortion care during flooding in Bangladesh. Both projects resulted in numerous papers in scientific, peer-reviewed journals[18] and presentations at global conferences.*

Can mHealth increase contraceptive acceptability by young people?

The Innovation Programme identified contraceptive access for young people as a topic of strategic importance to IPPF and the sexual and reproductive health sector. Previous evidence shows that information delivered by mobile phone can improve health behaviour, so the Innovation Programme supported a multi-country research project to evaluate an intervention using mobile phone messaging to broaden contraceptive method choice among young people. Through a competitive process, the London School of Hygiene and Tropical Medicine was chosen to partner with three Member Associations to design and implement the research approach. This included a randomized controlled trial to establish the impact of the intervention on attitudes to contraception, and a process evaluation to understand how and whether the approach was successful.

Over four months, short daily messages were delivered to young people by text message (in Palestine) and via mobile phone application (in Bolivia and Tajikistan). All three countries developed, tested and refined messages which combined established behaviour change models with local culture and context. The messages contained accurate information on contraception, addressed attitudinal barriers to contraceptive uptake, and aimed to empower young people to take control of their reproductive health.

The findings from the studies show that short messages delivered through a mobile phone can improve attitudes toward contraception in different contexts. In Palestine, intervention recipients were statistically more likely than those in the control group to find contraception acceptable: 71 recipients out of 229 (31 per cent) in the intervention group versus 40 out of 235 (17 per cent) in the control group ($p<0.001$), with positive results for the pill, intrauterine device, injection, implant and patch; intervention recipients also had a mean higher knowledge score and were more likely to state their intention to use an effective method of contraception compared to the control group, although these results were not statistically significant.[19]

In Bolivia and Tajikistan, there was evidence of a large increase in acceptability of contraception from baseline to follow-up. For example, in Tajikistan, in the sample of 472 participants, only two per cent (n=10) thought that at least one method of contraception was acceptable at baseline, in comparison to 65 per cent post-intervention (n=307); similarly, acceptability for the individual contraceptive methods rose from one per cent at baseline to between 49 and 58 per cent post-intervention and both results are statistically significant ($p<0.001$).[20]

During the process evaluation, interviews with intervention recipients suggested that the provision of accurate information from a trustworthy source, and in a context where there is currently very little information available, influenced participants' beliefs and intention and potentially also their behaviour. A cost analysis of the intervention indicated that the more people reached, the cheaper it is per beneficiary. As the mobile applications are already built, the intervention can now be offered at low cost in Bolivia and Tajikistan. In Palestine, however, the additional cost of sending text messages means that it is less sustainable.

> This type of funding is hard to come by – to support evidence generation, with the flexibility to try out something new.[21]

Overall, the programme resulted in a well-specified, theory-based intervention delivered by mobile phone for young people and tailored to each country. It showed how similar factors contribute to contraceptive use across three geographically and culturally different settings. The project adds to the body of evidence demonstrating that interventions using mobile phone messaging changed knowledge and acceptability of contraception. Further research is needed to determine the effect of the intervention on use of contraception by young people.

Can post-abortion care be provided during a flood situation?

Another issue identified as lacking in evidence was the provision of sexual and reproductive healthcare in disaster settings. Knowledge of how women cope with pregnancy, miscarriage and unsafe abortion is also limited. In response, the Innovation Programme supported a project with the University of Leicester, the Government of Bangladesh and IPPF South Asia Regional Office on the provision of menstrual regulation and post-abortion care during a flood situation. Aiming to reduce maternal morbidity and mortality in flood-prone areas in Bangladesh, this project is the first to increase skilled management for post-abortion complications in a natural disaster setting, using the United Nations Population Fund's Reproductive Health Kit 8. The Kit is used to treat complications following both miscarriage and unsafe abortion including sepsis, incomplete evacuation

> Innovation is the only sustainable competitive advantage.[22]

* For example, Premier Youth Tech Health Conference, San Francisco (2017); International Conference on Family Planning, Paris (2018); FP2020, Kigali (July 17); Asian Ministerial Conference for Disaster Risk Reduction, New Delhi (2016) and Ulaanbaatar (2018); International Congress on Women's Health and Unsafe Abortion, Bangkok (2019).

CONTRIBUTING TO THE EVIDENCE BASE THROUGH INNOVATION AND RESEARCH CONTINUED

and bleeding. It contains the necessary components in one package so that in an emergency they can be distributed and administered quickly.

The need for these services is revealed from interviews with a sample of married women aged 15 to 49 years who had remained in the area during the flooding and had received menstrual regulation or post-abortion care services at this time.[23] An intensive screening process found 370 women who met the criteria and agreed to be interviewed. Nearly 20 per cent of these women were internally displaced. After receiving menstrual regulation, 23 per cent of women experienced complications including pain, abnormal bleeding, weakness, headache, vertigo, nausea, vomiting or incomplete evacuation. Of these women, nearly three quarters were able to access healthcare; for those who did not, the main barriers stated were cost, being afraid to demand the services and lack of public transport to health facilities. After the floods, only 11 per cent of the women returned to the same facility for contraception.

The research project comprised four key activities: pre-positioning medicines and supplies; capacity building of health workers; assessment of the public healthcare facilities and the perceived quality of menstrual regulation and post-abortion services; and community-based awareness raising.

> Learning from innovation contributes to our evidence base, making IPPF more effective.[24]

Implemented in an area of Bangladesh that experiences flooding on an almost annual basis, the research findings highlight numerous recommendations for implementers and policy-makers (Box 1). Many of these are also applicable in other types of emergency settings as they focus on strengthening public health systems in advance of any disaster.

IPPF/Innovation Programme researcher/Bangladesh

BOX 1: RECOMMENDATIONS TO PROVIDE POST-ABORTION CARE IN A FLOOD SITUATION

Government should establish robust physical and disaster-resilient infrastructure for primary healthcare systems.

Health workers require regular training (refresher, follow-up) and monitoring to ensure quality of service provision. Values clarification training supports health workers to challenge cultural and religious beliefs that hinder the provision of menstrual regulation and post-abortion care.

Local government should provide public boat services for health workers to reach healthcare facilities during flooding.

Community-based awareness raising activities reduce barriers to service uptake and provide information on where to access services.

Assessment of facilities is critical to ensure services are provided safely, hygienically, privately and free of cost.

Procurement of commodities in advance of disasters, with all the necessary components to provide menstrual regulation and post-abortion care, is essential to ensure healthworkers are able to provide these services.

PROVIDING SEXUAL AND REPRODUCTIVE HEALTHCARE IN EMERGENCIES

Yemeni Association for Reproductive Health (YARH)
Indonesian Planned Parenthood Association (IPPA)

Humanitarian crises are increasing in frequency and duration, with numbers doubling between 2005 and 2017 and the length of crises growing from four to seven years.[25] In emergency situations created by conflict or natural disasters, women are especially vulnerable in terms of unintended pregnancy, unsafe abortion and sexual and gender-based violence. At the same time, sexual and reproductive health services are difficult or impossible to access due to damaged or closed health facilities.

In 2018, IPPF launched the *Humanitarian Strategy 2018–2022* with the goal to improve access to life-saving sexual and reproductive healthcare for crisis-affected people. The *Strategy* focuses on advocacy to integrate sexual and reproductive health and rights into disaster management planning and policies; the provision of information, education and clinical services; and increased effectiveness and preparedness planning, especially in high-risk communities.

The Minimum Initial Service Package (MISP), developed by the Inter-Agency Working Group on Reproductive Health in Crises, ensures access to sexual and reproductive health services from the onset of humanitarian emergencies. In coordination with government, United Nations agencies and other service providers, IPPF provides MISP to ensure priority services are available to crisis-affected people. IPPF's humanitarian responses are locally led by Member Association staff who are already on the ground, and can therefore react quickly to support affected communities, often before other emergency relief agencies arrive.

Since 2011, Yemen has been afflicted by a civil war creating the worst humanitarian crisis in the world. Nearly 80 per cent of the population are affected by this crisis; 50 per cent of health facilities are closed, and of those still in operation, more than 70 per cent do not have regular supplies of essential medicines.[26] In collaboration with the Ministry of Health, the Yemeni Association for Reproductive Health (YARH) operates in this difficult environment implementing MISP to ensure access to sexual and reproductive healthcare. In 2018, YARH provided clinical services to 94,215 clients and trained 60 health workers on MISP. Furthermore, the Association organized 1,059 information sessions to raise awareness on the types of services available and where to access them.


Photo: IPPF/Kathleen Prior/Indonesia

IPPF also responds to crises resulting from natural disasters. For example, in August 2018, Lombok Island in Indonesia was hit by a 7.0 magnitude earthquake causing significant damage to buildings and displacing over 400,000 people.[27] The needs of the affected population were substantial and psychological trauma was exacerbated by numerous aftershocks. Many health facilities either collapsed or were not functioning due to limited access to water and/or structural damage.

As a key partner to the Ministry of Health and the United Nations Population Fund, the Indonesian Planned Parenthood Association (IPPA) provided sexual and reproductive health services in the camp established for internally displaced people. Static clinics were set up in tents and outreach teams worked across the camp to ensure access to services for the most vulnerable.

Awareness sessions were attended by 11,033 people, and 4,025 clients received sexual and reproductive healthcare including contraception, antenatal care, safe delivery services, testing and treatment for sexually transmitted infections and dignity kits; 58 per cent of service users also received counselling for psychological trauma.

At the end of the emergency response, IPPA and the local health authorities developed a transition plan to ensure continuity in the provision of services through newly established referral pathways.

> "At the evacuation centre, I was surprised to learn that the first thing people would ask for is contraception. This experience has really opened my eyes."
>
> Jamil, IPPA Volunteer

PROVIDING POST-ABORTION CARE IN A RESTRICTIVE ENVIRONMENT

Association pour le Bien-être Familial/Naissances Désirables (ABEF/ND)

The Democratic Republic of Congo (DRC) has one of the world's highest maternal mortality rates,[28] with unsafe abortion a significant contributing factor.[29] Until March 2018, the provision of abortion in DRC was illegal, and access to post-abortion care extremely limited in public health facilities.[30] The situation was compounded by a lack of access to modern methods of contraception in the country: 40 per cent of married women and 70 per cent of unmarried, sexually active young women report an unmet need for contraception.[31]

The Association pour le Bien-être Familial/Naissances Désirables (ABEF/ND) is responding to this situation by expanding access to post-abortion care within the full extent of the law. Since 2016, ABEF/ND has established and/or refurbished four static clinics in locations with high population density and unmet need for post-abortion care. The Association trained clinic staff on the provision of services including treatment for incomplete abortion, post-abortion counselling and post-abortion contraception. Clinic staff also participated in values clarification workshops, resulting in increased commitment to provide stigma-free post-abortion care.

ABEF/ND raises awareness about the availability of post-abortion care in its own clinics and has also created partnerships with women's organizations and private health clinics for client referrals. The Association has trained focal points from sex worker support groups and in various locations, such as universities, hair salons and markets, to inform their peers about the availability of post-abortion care and contraception and to refer clients to ABEF/ND clinics. Social media platforms, door-to-door campaigns and educational talks have provided information about post-abortion care and the availability of services to women and girls. Furthermore, ABEF/ND held values clarification sessions with media professionals, lawyers, students, civil society organizations and members of parliament to transform perceptions about post-abortion care and contraception.

Through these efforts, ABEF/ND has rapidly expanded the reach of its abortion services. From 2016 to 2018, the Association provided 10,603 clients with treatment for incomplete abortion and 63,326 clients with contraception. In 2018, 94 per cent of post-abortion clients adopted a method of contraception within two weeks. To further increase access to post-abortion care, ABEF/ND is establishing new service delivery points in high need areas, including the eastern DRC.

Since March 2018, abortion is permitted when a woman's mental or physical health is at risk and in cases of rape, incest and fetal anomaly. ABEF/ND is now working with the Ministry of Health and other partners to revise the national guidelines on providing comprehensive abortion care.

OVERCOMING THE EFFECTS OF THE GLOBAL GAG RULE

With the reinstatement and expansion of the Global Gag Rule in 2017, international development organizations that provide abortion-related care are no longer eligible for USAID funding. The result is reduced access to healthcare for millions. IPPF estimated a loss of over US$100 million in funding with 31 Member Associations in sub-Saharan Africa, South Asia and the Western Hemisphere regions affected, with some predicting a reduction in income of up to 70 per cent.

With additional resources received from donors, IPPF established the Global Gag Rule Emergency Fund in January 2018 to compensate for the loss of USAID funding. As a result of the Fund, static clinics and mobile and outreach facilities that were threatened with closure have remained open, reproductive health commodity supplies and equipment have been purchased, and service providers at risk of redundancy have remained in post.

Of the 31 Member Associations affected by the reinstatement of the Global Gag Rule, 23 received grants from the Emergency Fund in 2018, including 10 in Africa, five in South Asia and eight in the Western Hemisphere. By May 2019, grants worth US$3.37 million in total have been disbursed to Associations.

Performance data for 2018 shows that without the Emergency Fund fewer sexual and reproductive health services would have been delivered by Member Associations affected by the loss of income. For example, in Botswana, 54,104 services, or 19 per cent of the total provided in 2018, were supported by the Fund from two clinics that are now functioning only because they received this additional grant. Likewise, in Senegal, 707,490 services, or 51 per cent of the total provided in 2018, were due to receipt of income from the Emergency Fund. The Senegalese Member Association has also been able to finance a mobile clinic to ensure comprehensive service delivery to under-served populations living in hard to reach areas.

In Kenya, the Emergency Fund pays salaries of service providers and other Member Association staff and the operational costs of six static clinics and multiple outreach teams. Without this funding, these facilities would close. In 2018, 300,155 sexual and reproductive health services, or eight per cent of the total, were attributed to the Emergency Fund. In Ethiopia, the loss of funding would have significantly reduced the Member Association's ability to provide services in over 20 facilities. The Emergency Fund supported the Association to establish social franchises and to continue to offer a range of services including contraception, HIV counselling and testing, and treatment of sexually transmitted infections. In 2018, 17 per cent of all services delivered, or 2.2 million, were due to receipt of income from the Emergency Fund.

In the South Asia region, the Emergency Fund supported five Member Associations in Afghanistan, India, Nepal, Pakistan and Sri Lanka affected by an estimated funding loss of over US$7.5 million. As a result, nearly two million sexual and reproductive health services were provided, including 8,923 abortions and 368,644 HIV-related services.

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

Figure 8 presents Outcome 4 performance results from 2018. IPPF's total income generated by the Secretariat increased significantly from US$125.1 million in 2017 to US$133.0 million in 2018, an annual growth rate of six per cent. This reflects an increase of over 50 per cent in restricted income, partially offset by a decrease of 18 per cent in unrestricted income. IPPF's resource allocation system ensures that most unrestricted income is invested in countries with greatest need, with 45 per cent of unrestricted core assigned to the Africa region, and 16 per cent each to the South Asia and Western Hemisphere regions. In 2018, 71 per cent of IPPF's unrestricted income was allocated to countries with low or medium levels of human development.[32]

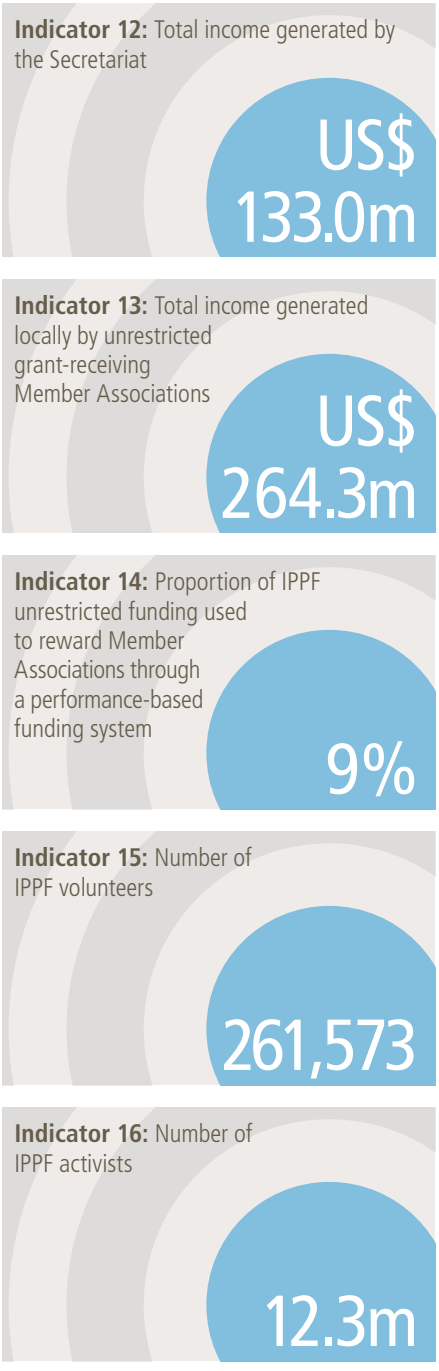
Member Associations are successful in generating income locally through diverse funding streams such as sales of commodities, patient fees and national and international sources, including government. In 2018, unrestricted grant-receiving Member Associations generated a total income of US$264.3 million. This is a nine per cent decrease from 2017, predominantly due to reduced income in several large affiliates. However, the proportion of income raised through social enterprise activities grew from 48 to 54 per cent between 2017 and 2018, indicating the increased focus of Member Associations in applying business models to assure financial sustainability. One approach, with huge potential for IPPF to generate income and reach significant numbers of service users, is workplace service delivery in partnership with the private sector. For example, funding was provided to the Family Planning Association of India by tea plantation owners to ensure access to sexual and reproductive health services for their employees.

The proportion of IPPF unrestricted funding, used to reward Member Associations through a performance-based funding system, increased from five to nine per cent between 2017 and 2018 in the five regions where it is implemented. The system assesses performance in advocacy and education programmes, and the delivery of sexual and reproductive health services.

In 2018, the number of IPPF volunteers rose by 12 per cent to 261,573. IPPF could not achieve the same degree of impact without the valuable contributions of a talented and dedicated pool of volunteers comprising peer educators, nurses, midwives, medical doctors, legal advisers, members of governing boards, community workers and fundraisers. Furthermore, IPPF engages with activists to support and defend sexual and reproductive health and rights. Activists are asked to take action for political and social change, for example, participating in campaigns or demonstrations; sharing positive messages on social media; educating and empowering individuals; and addressing public officials by letter writing or in meetings. In 2018, 12.3 million activists supported IPPF's work by taking action, an increase of nine per cent from 2017.

On the next page, we present two case studies: the first illustrates work done in the Western Hemisphere region to guarantee access to contraception through a social enterprise initiative, and the second describes a pilot programme in the Africa region to engage IPPF volunteers in resource mobilization through individual fundraising.

FIGURE 8
OUTCOME 4: PERFORMANCE RESULTS, 2018



ENSURING ACCESS TO CONTRACEPTIVE SUPPLIES

Four Member Associations in the Western Hemisphere region (Bolivia, Dominican Republic, Guatemala and Venezuela) established INNOVA, a social enterprise programme for the Americas and the Caribbean. The purpose of the initiative is to guarantee access to contraceptive supplies to meet the needs of women, especially the most vulnerable, and to ensure financial sustainability. To be closer to vendors, Member Associations and other potential customers in the region, INNOVA's office is based in Panama City, with high capacity in terms of shipping and warehouse facilities. Each of the four Member Associations, together with the Western Hemisphere Regional Office and the Swedish Association, have contributed their own financial resources and are shareholders.

INNOVA coordinates the supply chain process and sources commodities from different vendors across the globe to ensure more affordable products are available. INNOVA also provides technical support to Member Associations on procurement and supply chain management.

Processing times between the issue of a purchase order and product shipment have been reduced by 50 per cent (75 days on average) in comparison to previous years, and INNOVA's net sales achieved over US$960,000 in 2018, breaking even four years earlier than initially projected. A 66 per cent growth rate in net sales is forecast for 2019 as a result of increased demand for products from Member Associations. Profit is used to cover operational costs and to cross-subsidize other programmes serving the poor and vulnerable. During 2018, INNOVA developed its own brand of male condoms, 'Piel', and several Associations are already spearheading efforts to have it registered in their respective countries. The next step is to develop new brands for injectables, oral contraceptives and lubricants to further increase income through the social enterprise programme.

With the support of INNOVA, Member Associations have access to a continuous supply of contraception at lower prices and with the highest standards of customer service. This means fewer stockouts and increased capacity as reliable vendors. Working together, this Member Association-driven entity is achieving economies of scale through pooled purchases, and is solving contraceptive supply-related challenges that have been endemic in the region for years.

> "INNOVA's quality of service, technical assistance, availability and timely deliveries are its strongest competitive advantages. INNOVA gives us the chance to provide contraceptives steadily to women in Venezuela, despite the current crisis.
>
> Emma Romero, Operations and Logistic Manager, PLAFAM

MOBILIZING IPPF VOLUNTEERS TO GENERATE INCOME LOCALLY

Many international development donors support the work of IPPF; however, to assure financial sustainability that does not rely solely on traditional donor-funded models, diversification of income streams is critical. The IPPF Africa region is implementing an individual fundraising programme designed to take advantage of Africa's evolving philanthropic market which has an estimated 37 million potential donors worth US$2.1 billion.[33]

The African Citizens Initiative for Sexual and Reproductive Health and Rights aims to revive the tradition of IPPF volunteers engaging in resource mobilization activities. Volunteers in the Africa region are provided with the tools and support needed to be effective fundraisers. The regional governing board promoted the African Citizens Initiative to generate commitment from Member Associations. During the project inception phase, Member Association governing bodies were informed and champions identified to lead and coordinate implementation of the activities. Key fundraising messages were developed and supporting materials produced. An intense mobilization campaign targeting both volunteers and staff was then conducted.

To support the Initiative, the Africa Regional Office developed management and risk mitigation systems. These include cash collection vouchers with features to ensure security controls in handling cash donations; an online voucher tracking system that monitors voucher distribution in real time; and a database to collect information on donors, including contact data and donation history.

During the pilot phase, innovative fundraising practices have been tested with some positive results. For example, the Planned Parenthood Association of Zambia organized a raffle and dinner event with gifts donated from various sponsors. Over US$20,000 was raised. To inspire and mobilize branch-level volunteers, Reproductive Health Uganda conducted training in 10 of the 18 branches. This orientation built the capacity of volunteers and staff to use the donor management accountability and voucher tracking systems. The Member Association in Togo supported focus group discussions to develop fundraising messages for various audiences. The process was documented and tools developed to enable other Associations to learn from the experience and develop their own fundraising messages.

Implementation of the African Citizens Initiative pilot phase has strengthened the Africa region's awareness of and potential for resource mobilization approaches in support of organizational sustainability. A number of Member Associations are now fully prepared to conduct effective local fundraising campaigns in 2019, and the overall focus of the Initiative will be to transition from building infrastructure to marketing, communication, and extensive volunteer engagement to begin fundraising in their own communities.

CHALLENGES

The results in this report highlight many positive results achieved by IPPF in 2018. However, external challenges threaten to impede progress toward our vision. These include emergency situations created by conflict or natural disasters; barriers to accessing information, education and clinical services; opposition to sexual and reproductive health and rights; and funding availability. In this section, two IPPF Directors talk about challenges to sexual and reproductive health and rights in their own words.

Manuelle Hurwitz, Director of Programmes

"The world is facing an increase in the frequency and severity of natural disasters linked to climate change, protracted complex emergencies and conflicts. As a result, 135 million people across the world need humanitarian assistance and protection,[34] and there are 25 million refugees and 40 million internally displaced people worldwide.[35]

Humanitarian crises expose weaknesses in health systems, with particularly serious consequences for women, children and young people.[36] Family and social structures are disrupted and essential education, health and social services discontinued. Girls are especially vulnerable to sexual assault, child marriage and exploitation. Such risks increase their vulnerability to sexually transmitted infections, including HIV, unintended pregnancies and unsafe abortion. Boys are also exposed to specific vulnerabilities related to their gender and are also frequently victims of sexual violence.

Sexual and reproductive healthcare, while critical, is often absent from emergency responses where basic needs including access to food and shelter are seen as a priority. Yet crises acutely highlight the importance of ensuring access to sexual and reproductive healthcare. Providing women with the means to prevent unintended pregnancies can empower and improve the socioeconomic status of women. At the same time, preserving their dignity and security through rights-based sexual and reproductive healthcare, not just at times of acute crises, but with sustainable services thereafter, should remain our priority.

Opposition to sexual and reproductive health and rights is challenging in many countries and is driven by conservative cultural forces. Many Member Associations work in countries where policy frameworks and cultural norms place significant barriers on the provision of sexual and reproductive health services. The rise of political and religious opposition to sexual and reproductive health and rights, increasingly supported by questioning evidence and scientific information, makes it challenging for IPPF to counter misperceptions in communities.

These cultural, social and legal factors create further barriers to accessing services. It is a particular challenge to ensure high quality services are provided for marginalized populations; for example, service providers can have stigmatizing attitudes towards young people, and as a result, there is a reluctance among young people to access services, in particular contraception and safe abortion in formal health facilities.

The conservative backdrop in which many Member Associations work means that many face obstacles in providing truly comprehensive sexuality education in both in and out of school settings. The health information young people receive may be of poor quality or non-existent. Without the provision of quality sexual and reproductive health information, they are unable to make decisions regarding their sexual and reproductive lives and embrace their sexuality, including sexual orientation, which will impair their ability to build strong and healthy relationships in the future."

Mina Barling, Director of External Relations

"We are under assault. Women and girls, those on society's sidelines, are in the crosshairs of an extremist opposition, funded and coordinated as never before. At stake are our bodies, our rights, and our chances of becoming a fully realized version of ourselves. This assault is spreading. It is crossing borders and seeping into communities. Decades of evidence-based public health gains and social justice advances are under a fundamentalist threat.

That threat level has risen on a new wave of populism, eroding trust in democracy, exploited by controlling coercives. With it has come a return to patriarchal politics and the institutionalization of bigotry, racism and misogyny. The threat from a galvanized opposition is the threat of untold harm to women, girls and marginalized populations.

IPPF has again been brave and angry in saying no to the Global Gag Rule. The current US Administration endangers the safety and dignity of millions of people. The silencing of many international non-governmental organizations has increased the importance of IPPF standing up and speaking out. The cost is high. Projected losses to IPPF are US$100 million over three years, with people in need of sexual and reproductive health information and services directly affected in 31 countries. It is impossible to quantify the human cost of this extremely damaging policy.

Recent increases in donor funding for sexual and reproductive health and rights, following a period of decline, are promising. Donor governments spent more than US$1.27 billion in bilateral assistance in 2017,[37] including numerous funding pledges in support of SheDecides and FP2020. It is a welcome increase in funding against the previous two years, but still below 2014 levels. Long-term investment in sexual and reproductive health and rights remains uncertain.

Fully embracing sexual and reproductive rights remains a challenge. Some organizations are shying away from evidence-based, harm reduction approaches, including safe abortion programming; others are inadvertently supporting the criminalization of sex work, despite the impact on sex workers' health and well-being. The heterosexist agenda is being promoted within centre right governments, leaving LGBTI groups out of crucial interventions. There is much to fight for, and that fight is now."

NEXT STEPS

Recognizing the need for stronger governance, more impactful resource allocation and greater accountability, IPPF is initiating a process of radical reform.

In May 2019, the IPPF Governing Council launched a process of radical reform that will take an independent and consultative approach to achieve vital transformation of the Federation. The first set of recommended changes will be presented to a general assembly of IPPF Member Associations for approval, before being endorsed by the Governing Council in November 2019.

The Director-General will appoint two independent and expert taskforces to review the Federation's governance structures and resource allocation model. The taskforces will undertake extensive consultation and engagement with IPPF volunteers and staff, donors, partners and supporters. This review will provide much-needed clarity on the optimal use of the Secretariat's financial resources in supporting Member Associations to provide sexual and reproductive health information, education and clinical services, and to advocate for sexual and reproductive rights for all.

In the fourth year of IPPF's *Strategic Framework 2016–2022*, the Federation will continue to focus on our four Outcome areas: champion rights; empower communities; serve people; and unite and perform. Furthermore, with the recent publication of IPPF's new Business Plan, *A roadmap to transform IPPF,*[38] we are now entering a pivotal phase. We have an operational roadmap that will help us increase performance in areas with delayed progress and guide us to profoundly change the culture of IPPF. We have also developed a three-year financial plan to link business planning with the IPPF Secretariat income generation strategy.

IPPF's Business Plan provides focus in terms of strategy and direction, with six clearly delineated solutions for increased investment and effort, as follows:

Solution 1: build the movement

Solution 2: reclaim the space, counter opposition

Solution 3: enable and empower young people

Solution 4: build Member Association capacity

Solution 5: sexual and reproductive health and rights for crisis-affected people

Solution 6: develop leaders, boost culture

As this report has shown, Member Associations are responsible for most of the Federation's performance results in terms of advocacy and the provision of sexual and reproductive health information, education and clinical services. With respect to fundraising and entrepreneurship, two-thirds of the income of unrestricted grant-receiving Associations is generated locally. Affiliates are also leading forces in influencing political spaces and shaping both national and international discourse on health, rights and equality. IPPF's new business model will make optimal use of this potential by placing Member Associations at the centre of the Federation and positioning the Secretariat as an architect of cooperation and enabler of opportunities. This Member Association-centric (MA-centric) approach will drive performance and effectiveness with greater and more direct involvement of affiliates in IPPF's international work. It will also ensure that the expertise, capacity and talent residing in Member Associations is systematically used for the benefit of other affiliates and the Federation as a whole.

IPPF is now better positioned to ensure the safety of all those who have contact with IPPF including beneficiaries, service users, activists, stakeholders, volunteers and staff. IPPF's *Safeguarding Framework* has been further strengthened in 2019 by the approval of a key policy to establish an Independent Complaints Panel to deal with any concerns or complaints raised against IPPF officers at the most senior level of the Federation. The Panel will consist of individuals who have significant expertise and gravitas in their respective fields, and who are external to IPPF's governance and management structures. Effective implementation of IPPF's *Safeguarding Framework* will build on the extensive set of policies approved to date and include training, development of relevant procedures and ongoing support to Member Associations.

In 2019, IPPF will conduct a midterm review of the *Strategic Framework 2016–2022*. The review will enable critical reflection on progress to date, as well as the relevance and importance of the *Framework* in influencing the work of Member Associations, and Regional and Central Offices. The Member Association Survey will assess the value that membership of the Federation brings to affiliates as well as their contribution. A review of IPPF's Performance Dashboard and projections will also be conducted along with an assessment of IPPF's gender equality work and a financial analysis. The midterm review will provide information on results achieved to date for the purposes of learning and accountability. In early 2020, IPPF's global stakeholders will discuss findings and develop recommendations to drive change and maximize results by 2022.

Major, sustained, improved performance is needed in order to deliver our ambitious Strategic Framework for the people and communities we serve. Increased services and revenues, lower costs and more efficient use of assets are all critical.[39]

ANNEXES

Annex A: Number of successful policy initiatives and/or legislative changes, by country, 2018

Annex B: IPPF's Performance Dashboard results, 2016–2018

KEY

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

Photo: IPPF/Xaume Olleros/Togo

ANNEX A: NUMBER OF SUCCESSFUL POLICY INITIATIVES AND/OR LEGISLATIVE CHANGES, BY COUNTRY, 2018

COUNTRY	Number of changes
AFRICA	
Benin	1
Burkina Faso	3
Cameroon	1
Democratic Republic of Congo	1
Kenya	2
Mauritius	1
Uganda	5
ARAB WORLD	
Algeria	1
Mauritania	1
Morocco	1
Palestine	1
Sudan	4

COUNTRY	Number of changes
EUROPE	
Albania	6
Belgium	3
Bosnia and Herzegovina	2
Bulgaria	1
Cyprus	1
France	1
Georgia	4
Ireland	1
Israel	1
Kazakhstan	3
Latvia	3
Lithuania	2
Netherlands	1
North Macedonia	10
Norway	1
Serbia	1
Sweden	4
Tajikistan	5
Ukraine	2

COUNTRY	Number of changes
EAST & SOUTH EAST ASIA & OCEANIA	
Australia	1
Cambodia	3
Democratic People's Republic of Korea	1
Indonesia	1
Mongolia	1
New Zealand	2
Philippines	2
SOUTH ASIA	
India	1
Islamic Republic of Iran	1
Nepal	2
Pakistan	3

COUNTRY	Number of changes
WESTERN HEMISPHERE	
Argentina	5
Bolivia	10
Chile	1
Colombia	14
Dominican Republic	1
Ecuador	1
Guatemala	2
Guyana	1
Honduras	1
Jamaica	1
Mexico	3
Peru	3
Puerto Rico	2
United States of America	2
Uruguay	3

ANNEX B: IPPF'S PERFORMANCE DASHBOARD RESULTS, 2016–2018

TABLE B1: IPPF'S PERFORMANCE DASHBOARD – GLOBAL PERFORMANCE RESULTS, 2016–2018*		2016 baseline results	2017 results	2018 results	2018 targets	Percentage of target achieved	Number of Member Associations reporting 2018	Number of Secretariat offices reporting 2018
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	**163**	**140**	**116%**	58	3
2	Proportion of countries that are on track with Sustainable Development Goal targets improving sexual and reproductive health**	..	..	..	**n/a**	**n/a**	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	**1,038**	**n/a**	**n/a**	86	6
OUTCOME 2 INDICATORS								
4	Number of young people who completed a quality-assured CSE programme	28,113,230	31,346,870	**30,802,589**	**54,500,000**	**57%**	142	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**	**n/a**	n/a	n/a
6	Estimated number of people reached with positive SRHR messages	112,516,902	140,443,427	**242,605,911**	**n/a**	**n/a**	142	7
OUTCOME 3 INDICATORS								
7	Number of SRH services provided	145,078,890	164,136,012†	**168,114,158**	**190,400,000**	**88%**	134	n/a
8	Number of couple years of protection	18,776,343	21,065,169†	**23,476,137**	**20,600,000**	**114%**	131	n/a
9	Number of first-time users of modern contraception	6,336,091	6,102,204	**6,043,082**	**7,900,000**	**76%**	58	n/a
10	Proportion of IPPF's clients who would recommend our services to family or friends	90%	92%	**93%**	**85%**	**109%**	94	n/a
11	Number of SRH services enabled	37,383,977	44,709,391	**55,085,126**	**58,000,000**	**95%**	53	n/a
OUTCOME 4 INDICATORS								
12	Total income generated by the Secretariat (US$)	130,391,389	125,081,940	**132,960,014**	**129,480,060**	**103%**	n/a	7
13	Total income generated locally by unrestricted grant-receiving Member Associations (US$)	291,198,069	291,747,796	**264,262,874**	**373,000,000**	**71%**	119	n/a
14	Proportion of IPPF unrestricted funding used to reward Member Associations through a performance-based funding system	6%	5%	**9%**	**10%**	**89%**	n/a	5
15	Number of IPPF volunteers	172,279	232,881	**261,573**	**n/a**	**n/a**	150	n/a
16	Number of IPPF activists	10,154,353	11,200,237	**12,251,237**	**n/a**	**n/a**	128	3

* Due to rounding, numbers presented throughout these annexes may not add up precisely to the totals indicated and percentages may not sum to 100.
** Metric to be reviewed in 2019 during Midterm Review of IPPF's *Strategic Framework 2016–2022*.
† 2017 data revised for three Member Associations following publication of the *Annual Performance Report 2017*.

TABLE B.2 **OUTCOME 1: PERFORMANCE RESULTS, BY REGION, 2016–2018**

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	**2018**	**14**	**8**	**66**	**11**	**7**	**53**	**4**	**163**
		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					n/a**				
3	Number of youth and women's groups that took a public action in support of SRHR to which IPPF engagement contributed	**2018**	**28**	**274**	**125**	**85**	**39**	**472**	**15**	**1,038**
		2017	88	345	141	39	45	326^	31	1,015
		2016	22	133	177	47	29	234	19	661

** Metric to be reviewed in 2019 during Midterm Review of IPPF's *Strategic Framework 2016–2022.*
^ Includes groups mobilized in global fora.

TABLE B.3 **OUTCOME 2: PERFORMANCE RESULTS, BY REGION, 2016–2018**

OUTCOME 2 INDICATORS		Year	AR	AWR	EN	ESEAOR	SAR	WHR	CO	Total
4	Number of young people who completed a quality-assured CSE programme	**2018**	**1,829,953**	**134,576**	**298,061**	**27,375,587**	**413,395**	**751,018**	**n/a**	**30,802,589**
		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					n/a**				
6	Estimated number of people reached with positive SRHR messages	**2018**	**22,940,165**	**13,656,576**	**23,475,836**	**20,317,019**	**4,577,750**	**155,030,843**	**2,607,722**	**242,605,911**
		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

** Metric to be reviewed in 2019 during Midterm Review of IPPF's *Strategic Framework 2016–2022.*

TABLE B.4 OUTCOME 3: PERFORMANCE RESULTS, BY REGION, 2016–2018

OUTCOME 3 INDICATORS		Year	AR	AWR	EN	ESEAOR	SAR	WHR	CO	Total
7	Number of SRH services provided	**2018**	**67,418,505**	**20,479,211**	**1,355,155**	**17,258,410**	**28,271,745**	**33,331,132**	**n/a**	**168,114,158**
		2017	74,679,705	18,568,823	1,514,770*	14,831,553*	23,137,235	31,403,926*	n/a	164,136,012*
		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	**2018**	**10,498,297**	**1,401,619**	**50,545**	**897,045**	**3,213,046**	**7,415,586**	**n/a**	**23,476,137**
		2017	8,976,026	1,091,185	51,696	879,287	2,878,274	7,188,702*	n/a	21,065,169*
		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†	**2018**	**5,159,478**	**316,907**	**910**	**182,513**	**370,695**	**12,579**	**n/a**	**6,043,082**
		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	**2018**	**93%**	**97%**	**94%**	**89%**	**94%**	**94%**	**n/a**	**93%**
		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	**2018**	**40,541,931**	**5,578,264**	**48,941**	**1,908,040**	**6,444,799**	**563,151**	**n/a**	**55,085,126**
		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

* 2017 data revised for three Member Associations following publication of the *Annual Performance Report 2017.*

† Data is from FP2020 focus countries only: this includes 58 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, seven in South Asia, and three in the Western Hemisphere) in 2018.

TABLE B.5 OUTCOME 4: PERFORMANCE RESULTS, BY REGION, 2016–2018

OUTCOME 4 INDICATORS		Year	AR	AWR	EN	ESEAOR	SAR	WHR	CO	Total
12	Total income generated by the Secretariat (US$)	**2018**								**132,960,014**
		2017			Not applicable by regional breakdown†					125,081,940
		2016								130,391,389
13	Total income generated locally by unrestricted grant-receiving Member Associations (US$)	**2018**	**56,656,276**	**10,325,029**	**4,916,470**	**35,229,752**	**15,277,748**	**141,857,599**	**n/a**	**264,262,874**
		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	**2018**	**10%**	**0%**	**7%**	**6%**	**9%**	**10%**	**n/a**	**9%**
		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	**2018**	**48,114**	**6,661**	**12,711**	**26,679**	**117,778**	**49,630**	**n/a**	**261,573**
		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	**2018**	**7,726**	**4,390**	**18,164**	**14,148**	**42,928**	**12,152,006**	**11,875**	**12,251,237**
		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, 2016–2018

TYPE OF METHOD	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Intrauterine devices	**2018**	**2,363,908**	**727,134**	**25,357**	**286,714**	**1,629,467**	**3,329,116**	**8,361,696**
	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	**2018**	**3,578,547**	**251,637**	**9,738**	**122,257**	**125,248**	**1,377,860**	**5,465,286**
	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
Injectables	**2018**	**1,626,122**	**74,254**	**89**	**52,057**	**224,205**	**606,300**	**2,583,026**
	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
Oral contraceptive pills	**2018**	**1,425,541**	**215,800**	**2,002**	**64,440**	**347,391**	**523,253**	**2,578,426**
	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
Condoms	**2018**	**1,447,039**	**130,575**	**12,783**	**331,440**	**300,467**	**303,244**	**2,525,547**
	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)	**2018**	**49,610**	**-**	**360**	**38,490**	**472,830**	**1,165,350**	**1,726,640**
	2017	49,460	-	890	19,980	475,982	1,179,540*	1,725,852*
	2016	76,880	-	480	12,760	537,612	1,245,480	1,873,212
Emergency contraception	**2018**	**6,562**	**2,181**	**108**	**1,417**	**113,438**	**72,227**	**195,932**
	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	**2018**	**21**	**-**	**58**	**100**	**-**	**38,237**	**38,416**
	2017	38	-	66	78	-	38,135	38,317
	2016	58	-	66	90	-	40,445	40,659
Other barrier methods	**2018**	**949**	**39**	**51**	**130**	**-**	**-**	**1,169**
	2017	2,016	84	46	333	-	250	2,728
	2016	3,166	445	49	126	-	1,200	4,986
TOTAL	**2018**	**10,498,297**	**1,401,619**	**50,545**	**897,045**	**3,213,046**	**7,415,586**	**23,476,137**
	2017	8,976,026	1,091,185	51,696	879,287	2,878,274	7,188,702*	21,065,169*
	2016	7,770,541	955,758	49,680	679,485	2,642,243	6,678,636	18,776,343
Number of responses	**2018**	**(n=39)**	**(n=11)**	**(n=20)**	**(n=24)**	**(n=9)**	**(n=27)**	**(n=130)**
	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)

* 2017 data revised for one Member Association following publication of the *Annual Performance Report 2017.*

TABLE B.7 NUMBER OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES DELIVERED, BY REGION, BY SERVICE TYPE, 2016–2018

TYPE OF SERVICE	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Contraceptive (including counselling)	**2018**	**50,045,161**	**4,524,416**	**328,607**	**6,928,236**	**9,323,181**	**10,050,229**	**81,199,830**
	2017	49,382,792	3,701,321	365,009	7,553,130	7,061,015	8,996,545*	77,059,812*
	2016	47,748,224	2,989,983	374,277	5,890,895	5,892,684	8,980,338	71,876,401
Gynaecological	**2018**	**14,447,215**	**3,611,393**	**93,304**	**2,920,188**	**4,468,395**	**8,973,989**	**34,514,484**
	2017	13,630,202	3,229,263	274,952	2,170,315	4,043,479	9,131,717*	32,479,928*
	2016	9,156,910	2,323,176	150,763	1,837,816	3,123,922	8,529,057	25,121,644
STI/RTI	**2018**	**11,912,116**	**1,596,641**	**370,756**	**3,351,612**	**3,941,885**	**5,849,774**	**27,022,784**
	2017	12,413,437	1,932,467	365,622	1,957,328	2,731,715	5,583,961*	24,984,530*
	2016	10,138,284	1,082,883	339,554	2,223,562	2,129,211	5,046,217	20,959,711
Obstetric	**2018**	**5,504,357**	**6,612,507**	**9,587**	**968,536**	**5,196,101**	**2,391,386**	**20,682,474**
	2017	4,819,390	4,446,537	13,814	997,582	4,052,831	2,205,627*	16,535,781*
	2016	4,472,388	2,344,244	43,323	1,068,801	4,043,146	2,189,092	14,160,994
HIV (excluding STI/RTI)	**2018**	**10,828,649**	**3,316,358**	**199,196**	**992,656**	**2,944,293**	**1,506,700**	**19,787,852**
	2017	13,744,767	2,825,652	194,031	715,745	2,772,713	1,363,157*	21,616,065*
	2016	14,740,366	1,610,558	200,989	719,289	2,479,808	1,269,277	21,020,287
Paediatric	**2018**	**4,190,427**	**3,767,149**	**902**	**1,181,769**	**3,521,063**	**442,895**	**13,104,205**
	2017	3,583,044	3,839,311	440	874,009*	3,078,360	579,479*	11,954,643*
	2016	2,897,906	2,028,557	5,947	820,613	1,772,854	555,470	8,081,347
Specialized counselling	**2018**	**4,757,661**	**857,384**	**277,790**	**1,646,853**	**1,639,158**	**1,456,994**	**10,635,840**
	2017	4,277,655	709,662	227,038*	1,858,157	1,387,075	1,214,600*	9,674,187*
	2016	3,550,259	561,118	336,731	1,372,224	1,008,743	1,281,102	8,110,177
Abortion-related	**2018**	**1,338,294**	**329,895**	**115,343**	**659,178**	**585,720**	**2,262,141**	**5,290,571**
	2017	1,336,228	207,366	114,930	458,827	488,921	1,982,889*	4,589,161*
	2016	1,548,283	187,291	115,299	548,281	442,185	1,923,701	4,765,040
SRH medical	**2018**	**2,701,488**	**445,580**	**3,473**	**151,977**	**1,858,240**	**106,045**	**5,266,803**
	2017	2,917,987	415,839	5,680	244,852	1,535,065	86,864*	5,206,287*
	2016	3,116,699	269,110	5,294	380,033	1,094,769	73,213	4,939,118
Urological	**2018**	**1,078,683**	**538,834**	**1,760**	**168,586**	**833,267**	**421,901**	**3,043,031**
	2017	908,576	372,423	2,912	58,809	714,491	442,090*	2,499,301*
	2016	491,187	172,755	1,671	43,654	485,690	455,699	1,650,656
Infertility	**2018**	**1,156,385**	**457,318**	**3,378**	**196,859**	**405,241**	**432,229**	**2,651,410**
	2017	1,179,708	201,180	5,607	139,821	344,069	375,323*	2,245,708*
	2016	844,782	177,759	24,945	98,664	294,762	336,580	1,777,492
TOTAL	**2018**	**107,960,436**	**26,057,475**	**1,404,096**	**19,166,450**	**34,716,544**	**33,894,283**	**223,199,284**
	2017	108,193,786	21,881,021	1,570,035*	17,028,575*	28,209,734	31,962,252*	208,845,403*
	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	**2018**	**(n=39)**	**(n=11)**	**(n=23)**	**(n=25)**	**(n=9)**	**(n=27)**	**(n=134)**
	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)

* 2017 data revised for three Member Associations following publication of the *Annual Performance Report 2017*.

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KEY ABBREVIATIONS

ABEF/ND	Association pour le Bien-être Familial/Naissance Désirables
AR	Africa region, IPPF
ATSR	Association Tunisienne de la Santé de la Reproduction
AWR	Arab World region, IPPF
CSE	Comprehensive sexuality education
CYP	Couple years of protection
EN	European Network, IPPF
ESEAOR	East and South East Asia and Oceania region, IPPF
FGM	Female genital mutilation
FHAI	Family Health Association of Iran
GGR	Global Gag Rule
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
IDP	Internally displaced persons
IFPA	Irish Family Planning Association
IPPA	Indonesian Planned Parenthood Association
IPPF	International Planned Parenthood Federation
MCH	Maternal and child health
MISP	Minimum Initial Service Package
RTI	Reproductive tract infection
SAR	South Asia region, IPPF
SDG	Sustainable Development Goals
SFPA	Sudan Family Planning Association
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHFP	Women Health and Family Planning
WHR	Western Hemisphere region, IPPF
YARH	Yemeni Association for Reproductive Health

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Published in June 2019 by the International Planned Parenthood Federation
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