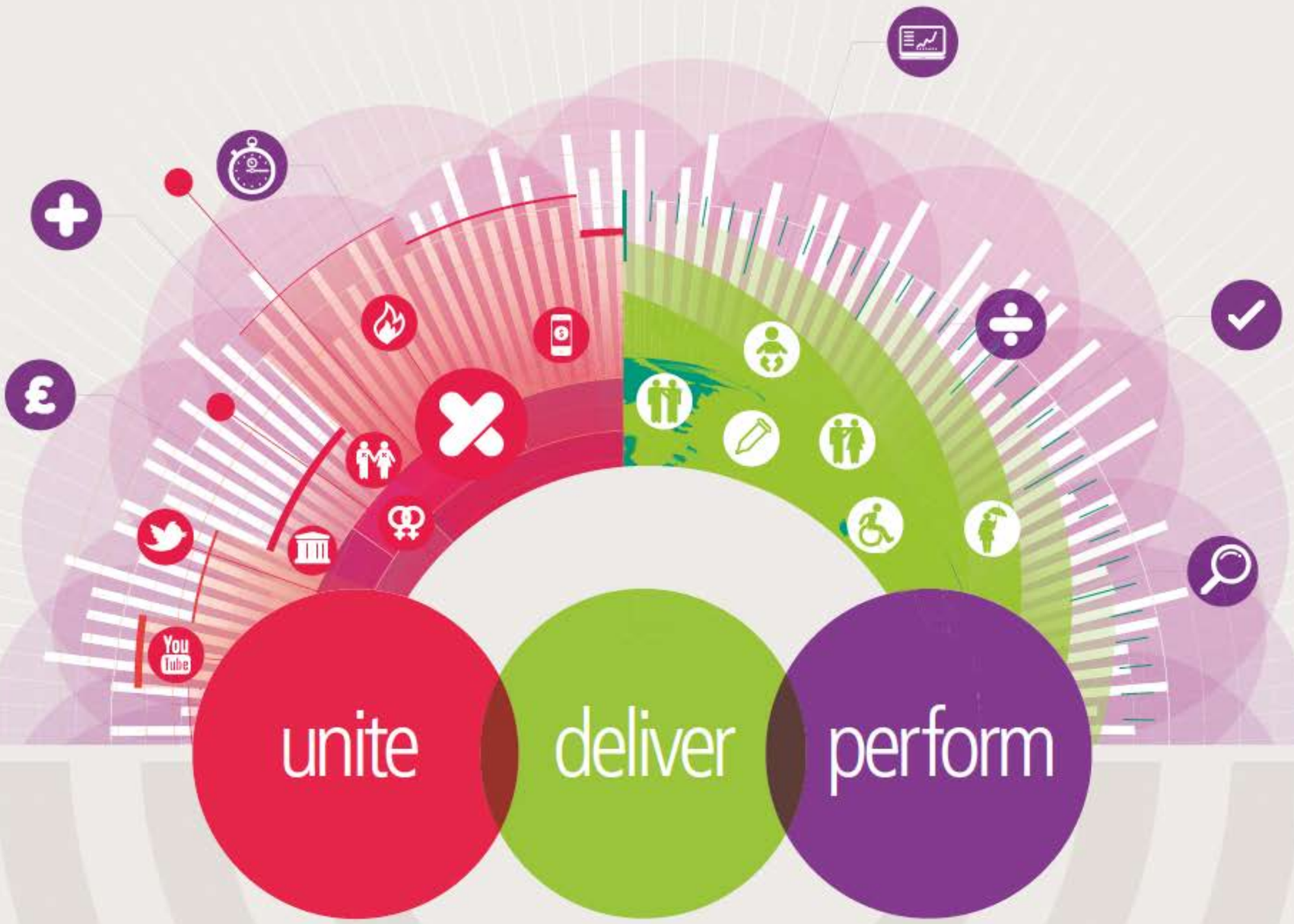
IPPF

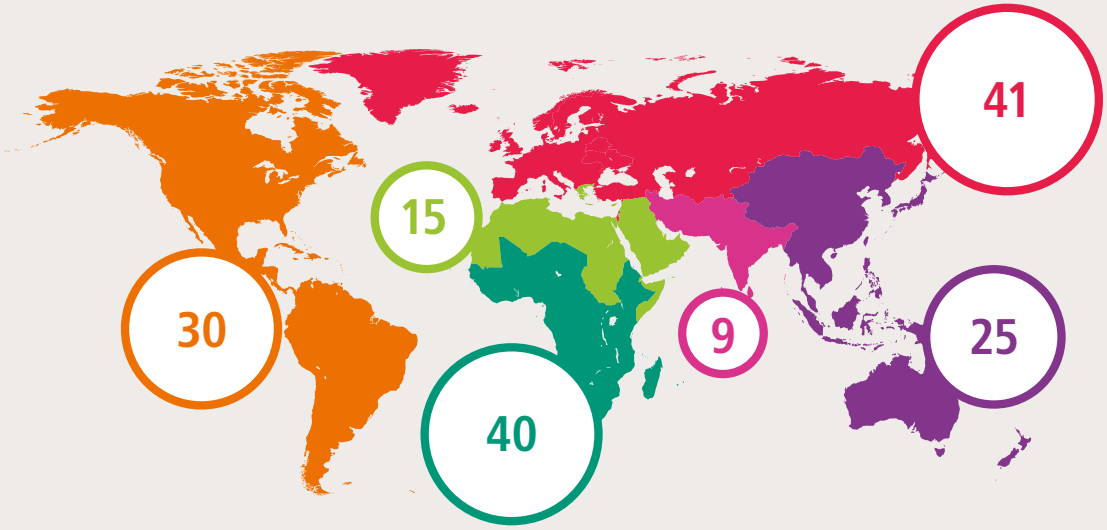
From choice, a world of possibilities



Annual Performance Report 2015

Who we are

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



160 Member Associations and collaborative partners

Millions of volunteers

33,000 staff

86% of Member Associations use a written curriculum to provide comprehensive sexuality education to young people

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

71% of Member Associations have a written gender equality policy

Acknowledgements

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

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Contents

Dashboard indicator colour key

≥98% OF TARGET REACHED

80% TO 97% OF TARGET REACHED

<80% OF TARGET REACHED

Foreword

This is the last Annual Performance Report to present results on IPPF's implementation of the *Strategic Framework 2005–2015*. We made significant progress in all three Change Goals – Unite, Deliver and Perform – and we have achieved many of our ambitious targets.

In the final year of IPPF's *Strategic Framework 2005–2015*, we did not lose sight of the promises we made many years previously. We persevered in our fight to see sexual and reproductive health and rights included in the 2030 Agenda for Sustainable Development, and our grit and determination were rewarded with a goal on gender equality and women's empowerment, and additional targets on sexual and reproductive health and reproductive rights. In the Unite chapter, we summarize the efforts made across the whole of the Federation – at national, regional and international levels – illustrating the milestones achieved along the way that ultimately contributed to this momentous result. We also present the results of IPPF's advocacy work in 2015 at the national level, with a focus on women's and girls' rights and empowerment.

Following IPPF's commitment to doubling the number of sexual and reproductive health services provided between 2010 and 2015, we have made every effort to realize this promise. In 2015, 175.3 million services were delivered by Member Associations, with almost one in two services going to a young person under 25 years. This is a staggering achievement, and tantalizingly close to the aspirational and bold target set at 176.4 million. I am proud of these results and in awe of all those who contributed to such a remarkable outcome. Our data show that we reached more people while ensuring the proportion of our service users who are poor and vulnerable remained high. In 2015, an estimated 50.6 million poor and vulnerable people received services, 82 per cent of all IPPF clients, and we continued to expand our work in humanitarian settings.

The 15.7 million couple years of protection provided in 2015 represents an increase of over 76 per cent from 2010, with a continued focus on providing a range of contraceptive choices, including long-acting reversible and short-acting methods, as well as emergency contraception. In the Deliver chapter, more service trends are provided, with details on HIV and abortion-related service provision, and case studies that highlight successful programmes in different countries.

In the Perform chapter, we highlight the accreditation system, and strengthened business processes and information management systems. Data remain an invaluable asset for decision making and driving performance. Despite challenges in the funding environment, we have become a cost-conscious and cost-effective organization and have been able to achieve more with fewer resources, as the results in this report show. However, moving forward, it is imperative that new resources are mobilized.

In May 2015, IPPF brought Executive Directors from each national Member Association together with Governing Council members and Secretariat staff for a Global Gathering in Bangkok. As the photographs opposite highlight, participants from over 150 countries shared their diverse experiences and lessons learned, and discussed how to embrace the next phase of IPPF's history and deliver on a new ambitious mandate. The 2016–2022 strategy, *Locally Owned, Globally Connected: A Movement for Change*, was presented with a call for passion, engagement and creativity from a united Federation. Since the meeting, IPPF has embarked on an organizational change project to realize this new vision. Member Associations and the Secretariat developed strategic and implementation plans to ensure that we were ready to begin implementing the new Strategic Framework in January 2016.

As always, these results belong to IPPF's volunteers, staff and partners. The achievements have been made possible through their hard work, passion, expertise and determination. This is evident in every country that I visit, and with every partner that I meet. As I listen to people whose lives have been changed by our work, I am more convinced than ever that we can effect a sea change so that everyone is free to make choices about their sexuality and well-being, in a world without discrimination.

My sincere thanks to all who have supported our work over the last year and during the previous decade. We have walked a long road, delivered over 1 billion sexual and reproductive health services, and learned many lessons along the way. But now we begin a new journey – and we are wiser, stronger and fitter. I hope you will join us along the way.

Tewodros Melesse
Director-General, IPPF


IPPF/Thailand

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

In 2015, IPPF's advocacy efforts culminated in the inclusion of gender equality and women's empowerment, and sexual and reproductive health and reproductive rights in the new Sustainable Development Goals. This will shape the international development agenda for the next 15 years.

IPPF plays a critical role in encouraging governments and other key decision makers at national, regional and international levels to promote and defend sexual and reproductive health and rights. Figure 1 presents IPPF's performance against cumulative targets for 2010 to 2015: all the targets were achieved. During this six-year period, Member Associations contributed to a remarkable 528 in-country legal and policy changes, impacting positively on millions of lives around the world. IPPF advocacy work also contributed to 74 regional and global policy changes. Examples included the prioritization of sexual and reproductive health and rights in key publications such as the *Outcome Document of the 9th Regional Conference on Women (Beijing+20)* in Africa; the Association of Southeast Asian Nations (ASEAN) *Human Rights Declaration*, and the United Nations report *Road to Dignity by 2030: Ending Poverty, Transforming All Lives and Protecting the Planet*.

In 2015, IPPF's advocacy continued to increase public, political and financial support for sexual and reproductive health and rights. Member Associations and collaborative partners in 48 countries contributed to 82 policy or legislative changes that support sexual and reproductive health and rights in their countries. These successes cover a range of themes, with more than a quarter promoting or defending access to safe and legal abortion (Figure 2). In four countries, new legislation has been passed to protect children from early, forced and child marriage, and another seven wins resulted in an increase in funding for sexual and reproductive health in national budgets.

Figure 1: Unite – cumulative performance results, 2010–2015

U.1	U.2	U.3	U.4
Target: 300 successful policy initiatives and/or positive legislative changes in support or defence of SRHR to which Member Associations' advocacy contributed	**Target:** 30 successful regional and global policy changes in support or defence of SRHR to which IPPF's advocacy contributed	**Target:** By 2015, 61% of Member Associations monitor obligations made by governments in the international human rights treaties that they have ratified	**Target:** Inclusion of SRHR or components of SRHR in the post-2015 development framework to which IPPF's advocacy contributed
528	74	60%	Yes

Member Associations have continued to resist powerful opposition groups attempting to bring about legislative or policy changes that would be harmful to the health and well-being of millions of people. In 2015, Member Associations helped block 14 changes in countries as diverse as Ecuador, New Zealand and Russia. Nine of these wins defended a woman's right to terminate her pregnancy, four blocked potential cuts to sexual and reproductive health budgets, and one prevented legislation that could have led to the criminalization of HIV transmission.

IPPF's advocacy also resulted in 22 policy changes at regional and international levels in 2015. We worked tirelessly to secure high level commitment to sexual and reproductive health and rights, for example from the Council of the European Union, and at the International Conference on Financing for Development and the United Nations Commission on the Status of Women.

In 2015, 60 per cent of Member Associations monitored obligations made by governments in international human rights treaties that they have ratified. This is an increase from 54 per cent in 2014, and highlights the ongoing commitment of Member Associations to hold governments to account for promises they have made on human rights.

The highlight of IPPF's advocacy achievements in 2015 was the inclusion of gender equality and women's empowerment, sexual and reproductive health, and reproductive rights in the 2030 Agenda for Sustainable Development.

This section presents IPPF's work to mobilize civil society and influence the new development agenda, as well as four case studies that illustrate how Member Associations' advocacy efforts have contributed to improved policy and legal environments in their countries.

Figure 2: Number of policy and/or legislative changes, by theme, 2015

22 Access to safe and legal abortion

19 Promoting sexual and reproductive rights

16 Education and services for young people

07 Support for people living with HIV

07 National budget allocations for SRH, including contraception

05 Access to contraception

04 Ending child, early and forced marriage

02 Prevention of sexual and gender-based violence

In 2015, Member Associations and collaborative partners contributed to

82 policy and/or legislative changes

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

48 countries.

Contributing to the global development agenda

In 2015, United Nations Member States adopted the 2030 Agenda for Sustainable Development including 17 Sustainable Development Goals. Since 2012, IPPF has attended all the major events leading up to the finalization of the Agenda, emphasizing the importance of sexual and reproductive health and rights, and advocating for their inclusion in the Sustainable Development Goals (Figure 3).

In 2015, IPPF was present at all the relevant events to influence negotiations on the final text of the Agenda. Despite the challenging environment, IPPF's effective advocacy strategy, implemented at national, regional and global levels, made a powerful contribution resulting in a stand-alone goal on gender equality and women's empowerment; and targets on sexual and reproductive health and reproductive rights. From 2012 to 2015, 34 of IPPF's 64 regional and global wins reported under indicator U.2 during that four-year period were related to influencing the 2030 Agenda for Sustainable Development.

Mobilizing, leading and enabling civil society

The key to IPPF's success was the range of tailored advocacy strategies that were implemented across the globe. We influenced civil society coalitions and governments in over 120 countries. At the critical 47th Session of the Commission on Population and Development, 54 Member Associations represented civil society on their government delegations. IPPF also provided grants and technical assistance to 29 grassroots organizations in 21 countries to increase their capacity to play a key role in the negotiations on the Sustainable Development Goals.

IPPF also developed and disseminated regular updates, advocacy briefs, details of preferred text for outcome documents, and examples of letters to decision makers. These resources were invaluable in supporting Member Associations and other civil society organizations. IPPF amplified the voices of national advocates at regional and international levels, enabling them to develop common positions and advocacy messages.

> The tools I received were really very effective to translate global advocacy messages and facts into local language and context.
>
> Advocacy grant recipient, Bangladesh

Figure 3: Timeline of events where IPPF influenced the 2030 Agenda for Sustainable Development

Participation in international and regional policy processes

Member Association representatives secured places on delegations from numerous countries to negotiate at key events. They also provided advice to governments on language to be used in resolutions in support of sexual and reproductive health and rights.

IPPF worked hard to ensure sexual and reproductive health and rights were included in regional fora and preparatory negotiations. For example, IPPF's Liaison Office in Addis Ababa played a key role by collecting and sharing intelligence and interacting with African Union decision makers to ensure sexual and reproductive health and rights remained on the political agenda. The IPPF Western Hemisphere Regional Office made a significant contribution to the Montevideo Consensus for Population and Development 2013 and its operational guide.

This document details what actions governments in the region need to take to improve sexual and reproductive health and rights in their countries and enables civil society organizations, including IPPF, to hold them to account. The IPPF European Network influenced the language and tone of the European Union's position on the Sustainable Development Goals which was successfully used during negotiations with other countries at the United Nations to secure the inclusion of sexual and reproductive health, reproductive rights and gender equality.

IPPF's United Nations Liaison Office in New York ensured IPPF had a sustained presence through the entire United Nations process related to the 2030 Agenda. The Office also provided IPPF with the latest intelligence and maintained relationships with governments' United Nations representatives.

Because of IPPF's unwavering advocacy efforts, the outcomes of many of the key events that influenced the development framework recognized the critical role that sexual and reproductive health and rights must play in global sustainable development.

> IPPF unquestionably had an impact within the process. The totality of IPPF's presence and its convening of civil society created global pressure and momentum for recognition of sexual and reproductive health and rights within the Sustainable Development Goals.
>
> External evaluation of IPPF project Civil Society and Beyond[1]

New York, USA 2014

58th Session of the Commission on the Status of Women

Outcome document called for a stand-alone goal on gender equality and women's empowerment in the post-2015 development agenda

Addis Ababa, Ethiopia 2015

Third International Conference on Financing for Development

Outcome document highlighted the diverse and specific development needs in middle income countries, and called for states to address them in their strategies and policies

New York, USA 2015

Negotiations on final text of the 2030 Agenda for Sustainable Development

Final text included a goal on gender equality and women's empowerment; targets on sexual and reproductive health and reproductive rights; and positive references to human rights and universality

2015

Open Working Group on the Sustainable Development Goals

Final report called for targets on sexual and reproductive health and reproductive rights, and a goal on gender equality and women's empowerment

New York, USA 2014

Global Financing Facility

New mechanism hosted by the World Bank which funds sexual, reproductive, maternal, newborn, child and adolescent health in support of Sustainable Development Goals 3 and 5

2015

SUSTAINABLE DEVELOPMENT GOALS
17 GOALS TO TRANSFORM OUR WORLD

Good health and well-being (Goal 3)

Target 3.1: Reduce maternal mortality
Target 3.3: End the epidemic of AIDS and other diseases
Target 3.7: Ensure universal access to sexual and reproductive healthcare services

Gender equality (Goal 5)

Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights

Programme successes: Unite

Ending child, early and forced marriage in Chad

Association Tchadienne pour le Bien-Etre Familial (ASTBEF)

Chad has the second highest rate of child marriage in the world. A staggering 68 per cent of the country's girls are married before they are 18 years old, and 29 per cent are married by the age of 15.[2] One in two girls in Chad gives birth before they are 18.[3] Girls who get married early are at increased risk of complications during pregnancy and childbirth, sexual and gender-based violence, dropping out of school, and living in poverty.

The Association Tchadienne pour le Bien-Etre Familial (ASTBEF) is an active member of the international platform Girls not Brides. For more than three years, ASTBEF worked with other national organizations, the United Nations Population Fund and young people to garner public and political support to address this issue and to raise awareness of the implications of early marriage. ASTBEF's volunteers and staff organized advocacy meetings with government representatives at all levels and met with officials from the Ministries of Public Health, Youth and Sports, and Women and Social Action to discuss the implications of child, early and forced marriage, and the need for legislation to protect girls.

With leadership and participation from its Youth Action Movement, ASTBEF carried out sensitization activities for parents and government officials on the economic and social impact of adolescent pregnancy and the need to invest in young people. The Youth Action Movement mobilized more than 350 young people to participate in the President's *Ending Child Marriage Together* ceremony, where the President launched a national campaign to prevent child marriage and signed a historic bill to set the minimum age for marriage at 18 years.

The new law stipulates a prison sentence of five to ten years, as well as a fine of up to US$8,600, for anyone who forces a minor into marriage. These penalties also apply to anyone who officiates at a marriage of minors in civil, religious or traditional ceremonies.

ASTBEF recognizes that passing the law is just the first step and continues to work tirelessly to prevent child, early and forced marriage in Chad. ASTBEF has held public events and discussions to raise awareness of the law and of its importance in protecting girls from early and forced marriage, and from female genital mutilation. The Youth Action Movement organized an awareness-raising caravan and reached more than 10,000 people with messages on the importance of ending child marriage. The Association also signed framework agreements with two ministries that provide government funding to support ongoing work to stop child, early and forced marriage in Chad.

Criminalizing violence against women in Algeria

Association Algérienne pour la Planification Familiale (AAPF)

Domestic violence is common in Algeria, accounting for 58 per cent of all cases of sexual and gender-based violence and killing up to 200 women annually.[4] Due to stigmatization and fear of further violence, many women do not report to the authorities, and it is thought that the actual figures are seriously under-estimated.

Since 2011, the IPPF member in Algeria, Association Algérienne pour la Planification Familiale (AAPF), has led a coalition of national non-governmental organizations to address sexual and gender-based violence and to promote women's social and economic rights. The coalition worked with parliamentarians, government ministries, media representatives and legal professionals to promote a new law that criminalizes violence against women.

AAPF organized seminars, conferences and meetings to build consensus on the urgency of having laws to protect and promote women's rights, and to encourage public debate on the issue. The domestic violence section of the bill faced strong resistance from the opposition, who claimed it was not in line with Islamic values, threatened the institution of marriage, and intruded on the intimacy of couples.

After being stalled in the Senate for eight months, the Algerian government finally passed legislation in 2015 that criminalizes two types of violence against women: domestic violence and public harassment. Men who injure their wives face up to 20 years in prison, and judges can now hand out life sentences to men who kill their wives. Publicly harassing women and girls can lead to imprisonment for up to one year. The law also safeguards women's financial assets.

However, a clause to allow survivors of domestic violence to absolve their husbands significantly weakens the law. Therefore, in collaboration with the coalition, AAPF is now advocating for an amendment to remove this clause because family pressure and inequality between men and women can lead to many survivors withdrawing their complaints.

> This law is a very positive first step, but it includes an unfortunate clause, the pardon clause, which exempts the perpetrator from prosecution if pardoned by the victim.

AAPF statement

Programme successes: Unite

Transforming the abortion law in France

Le Planning Familial

Abortion during the first 12 weeks of pregnancy has been legal in France since 1975. However, until 2015, a woman had to prove that she was in distress and have two medical consultations, at least seven days apart, before being allowed to terminate her pregnancy. Medical abortion was only available from doctors, and surgical abortion procedures could only be carried out in hospitals. Together, these factors contributed to reduced access to safe and legal abortion services for women in France.

The French IPPF Member Association, Le Planning Familial, has worked for years to bring about changes to this law. The Association advocated for the removal of barriers to uptake, including those related to cost, and for an increase in the types of facilities and personnel that are legally permitted to terminate pregnancies. Le Planning Familial advised Ministry of Health officials on the importance of ensuring access for every woman, including from vulnerable groups such as undocumented migrants.

Proposed changes to the law to increase access to safe and legal abortion were met with fierce opposition from the anti-choice movement. Nevertheless, Le Planning Familial remained steadfast in its advocacy to promote women's rights.

In 2015, the French government passed a landmark health law that increases access to safe abortion. Women over 18 years can now legally terminate their pregnancies following only one consultation, and without any reflection period or the need to prove that the pregnancy has put them in distress. Midwives can provide medical abortions for the first time, and the legal provision of surgical abortion now extends beyond public hospitals to local reproductive health centres.

Since 2013, abortion costs have been covered by national health insurance but other associated costs, such as pre-abortion counselling and ultrasound scans, were payable by women needing them. Under the revised law, these services are now also provided free of charge.

Following the remarkable change in legislation, Le Planning Familial has continued to work to counter stigma associated with abortion. With the support of the government, the Association has also initiated a national free and anonymous helpline for those seeking information about abortion, contraception or sexuality.

Promoting contraceptive rights and choice

Family Planning Association of India (FPA India)

More than 20 per cent of married women in India have an unmet need for contraception.[5] Injectable contraceptives have been available in India for more than two decades, but only from the private sector. Some groups staunchly resisted the introduction of injectables into the national health programme, and perpetuated myths of their negative health effects.

The Family Planning Association of India (FPA India) has spent years countering the opposing arguments. In partnership with the Advocating Reproductive Health Coalition, FPA India presented government officials with evidence to dispel myths and highlight the effectiveness of injectable contraceptives. The Association shared its own experience of providing injectables with government officials, raised awareness among the public of the benefits of injectables, and organized press conferences to promote the advantages of an expanded range of contraceptive methods.

In 2015, as a result of FPA India's advocacy, and following a recommendation by the country's Drug Technical Advisory Body, the Ministry of Health added injectables to the list of contraceptive methods that are available free of charge under the national health programme.

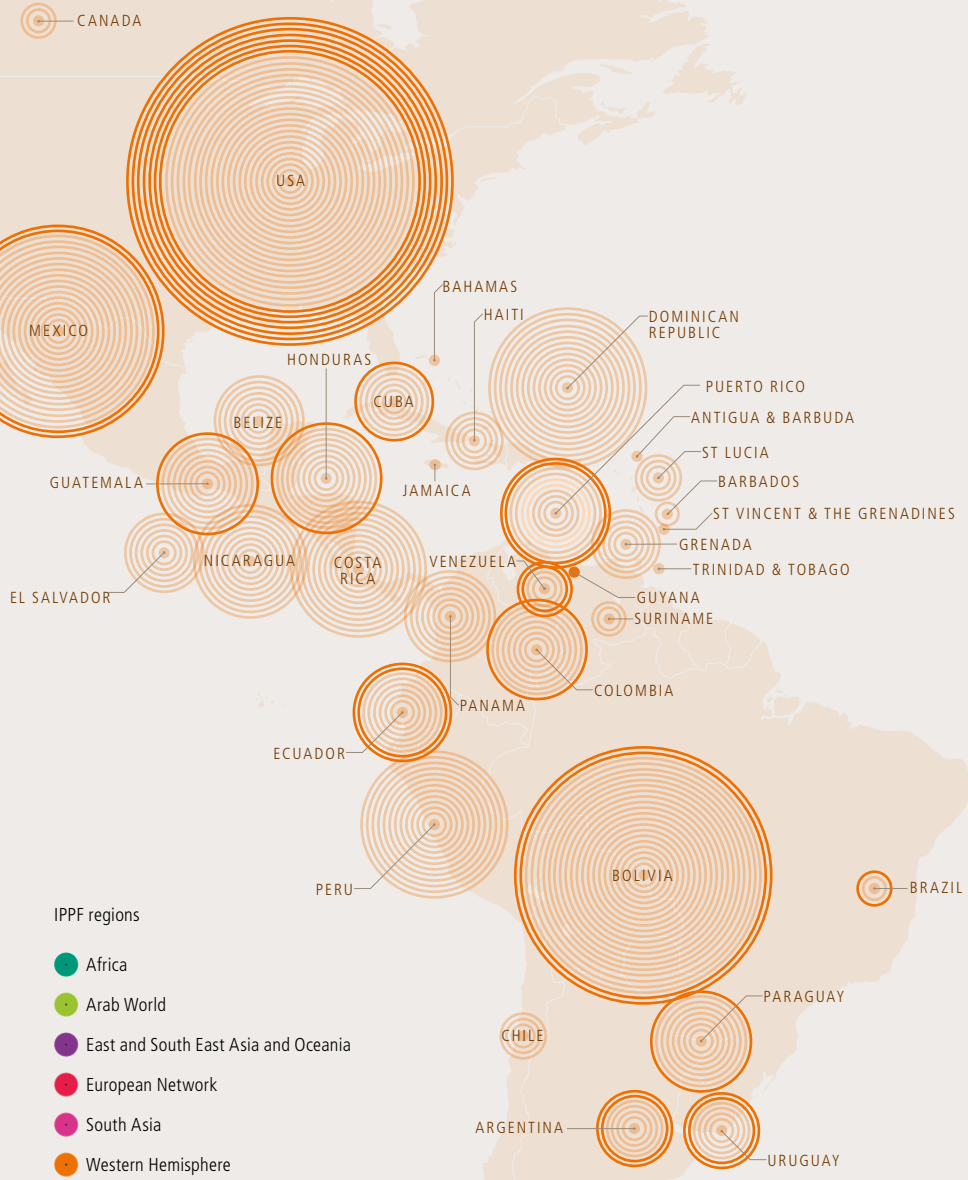
A lack of a rights-based approach and a focus on achieving annual targets mean that sterilization may be offered to women as the only contraceptive choice available.[6] Furthermore, unsafe sterilization camps are not uncommon in India, and more than a third of women who have undergone tubal ligation did not give their informed consent.[7] In late 2014, the deaths of 13 women following unsafe procedures at an unregulated camp in Chhattisgarh highlighted the need for stricter regulations.

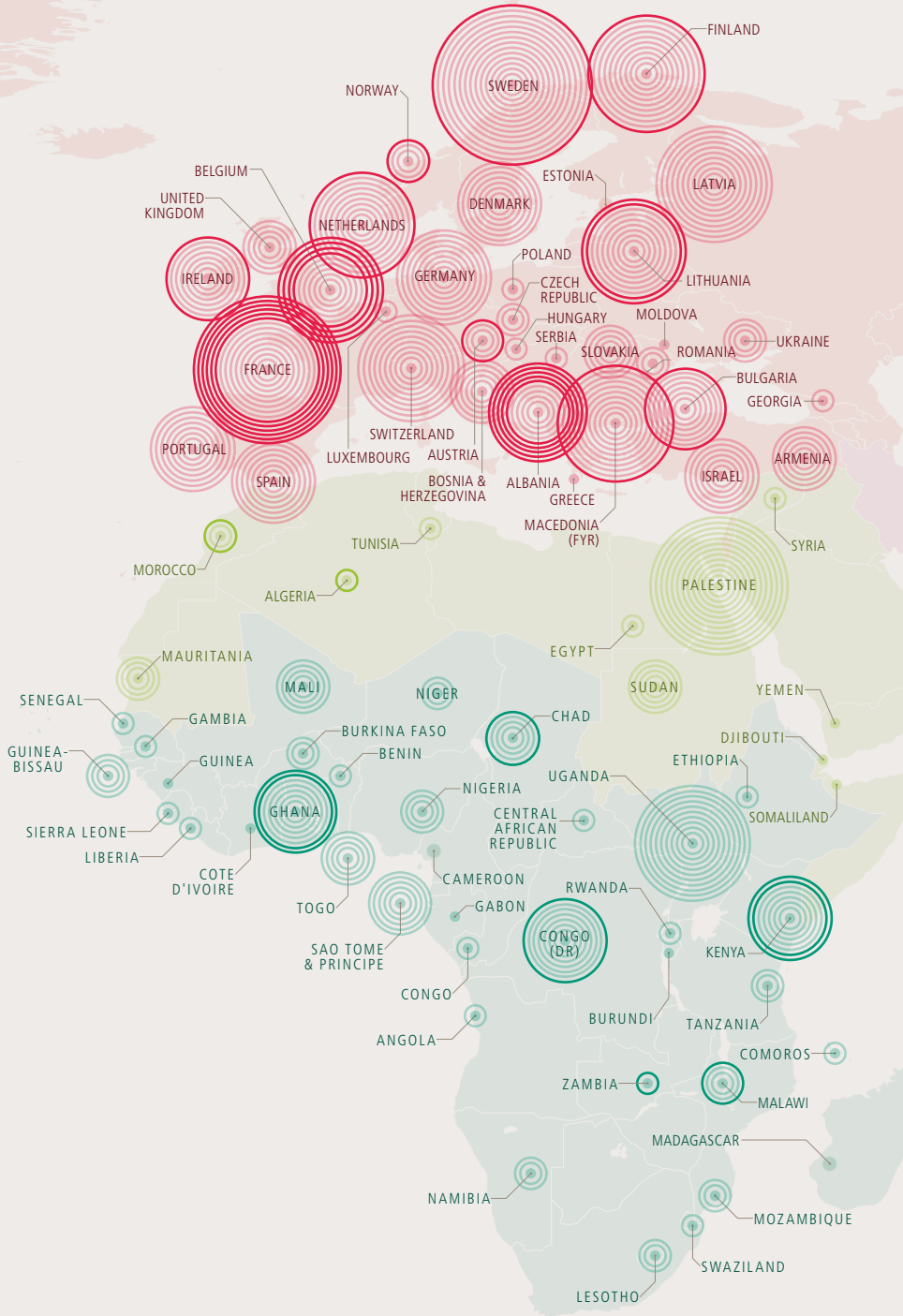
FPA India worked with other organizations to prepare a report on this incident. The Association also organized public hearings on the importance of quality of care, and prepared a media statement emphasizing the need for the provision of contraception to be embedded in a framework of clients' rights.

As a result of this pressure, the Ministry of Health issued a mandate to all Indian states requiring service providers to offer a range of contraceptive choices without coercion, and to be trained on the national standards and guidelines for sterilization procedures. The mandate stipulates that sterilization can now only be provided in health facilities with functioning and safe operating theatres, and state facilities are subject to periodic quality assurance checks by district officials.

IPPF's advocacy achievements, 2005–2015

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



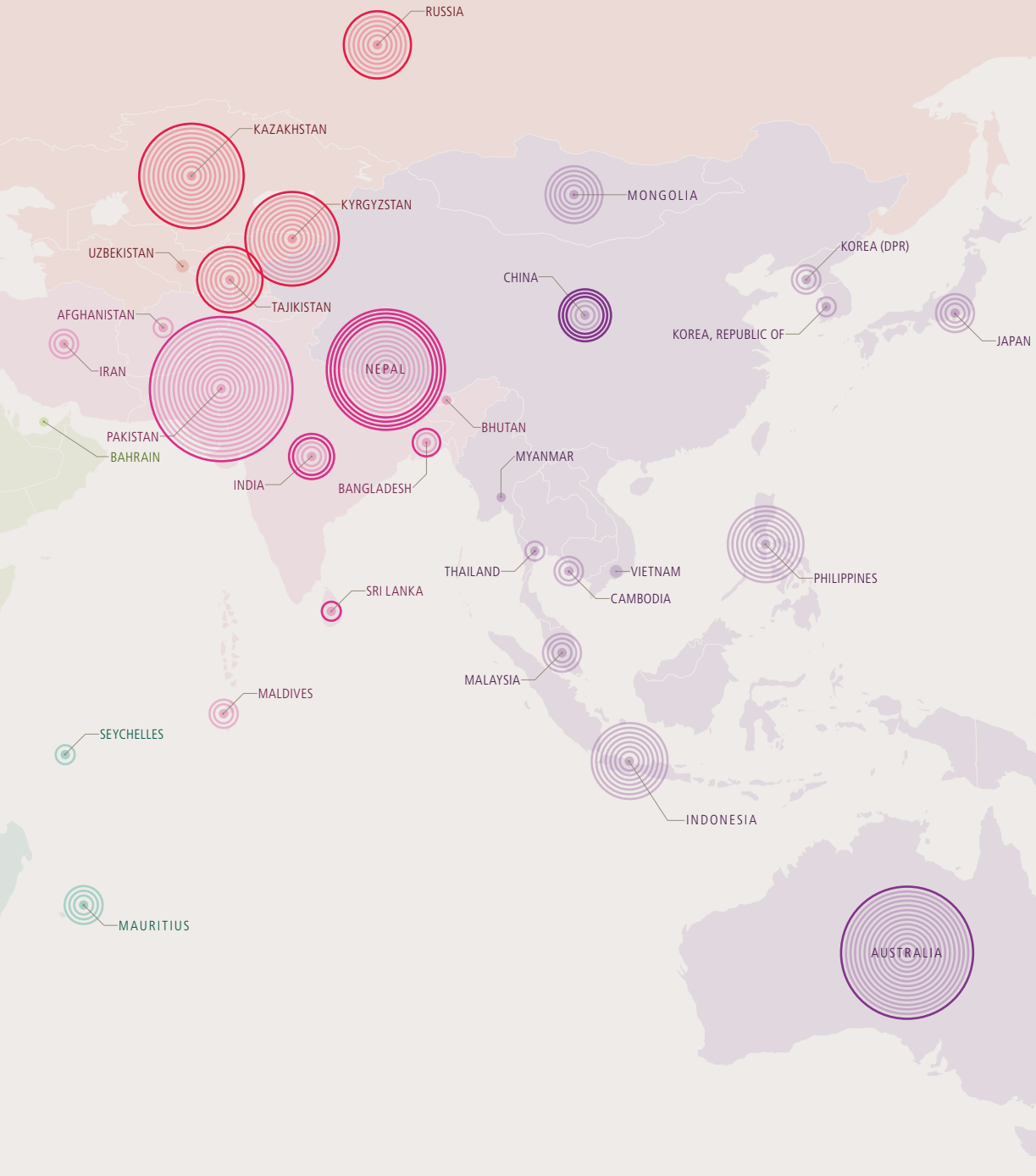


From 2005 to 2015, Member Associations and collaborative partners contributed to

816 policy and/or legislative changes

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

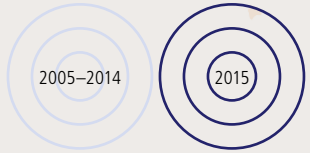
151 countries*



Key

Number of policy and/or legislative changes

Year of policy and/or legislative change



* See Annex A for number of policy and/or legislative changes, by country, 2005–2015.

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

Results from 2015 demonstrate IPPF's performance and commitment to delivering sexual and reproductive health information, education and services to more people, particularly the under-served, and in more locations.

Figure 4 presents cumulative data from 2010 to 2015 on sexual and reproductive health services provided, couple years of protection and comprehensive sexuality education. IPPF performance has been monitored against a set of ambitious targets since 2010. Results indicate that we have made significant progress with six indicators reaching their cumulative targets. The number of abortion-related services made impressive year-on-year progress, with a record 4.3 million services provided in 2015, an increase of 13 per cent from 2014, and almost 140 per cent from 2010. However, the cumulative target of 20.4 million between 2010 and 2015 was missed by 3.6 million. The proportion of Member Associations providing the Integrated Package of Essential Services also made substantial progress, from 7 per cent in 2010 to 36 per cent in 2015. At the global level, the target of 55 per cent was not reached, but it was achieved by three regions, the Arab World, South Asia and the Western Hemisphere. The Integrated Package consists of eight components with multiple service types (Annex C), and the indicator requires all eight to be provided. To make further progress, we will support the 27 Member Associations who scored seven out of eight components to ensure that the target is reached as soon as possible.

Figure 4: Deliver – cumulative performance results, 2010–2015

Target: 723.4 million SRH services provided **D.1**	**Target:** 72.9 million couple years of protection **D.2**	**Target:** 328.7 million SRH services provided to young people (under 25 years) (45% of all services) **D.3**	**Target:** 20.4 million abortion-related services provided **D.4**
751.9m	72.1m	323.1m (43%)	16.8m
Target: 119.9 million HIV-related services provided **D.5**	**Target:** 199.4 million IPPF clients are estimated to be poor and vulnerable (77% of all clients) **D.6**	**Target:** By 2015, 55% of Member Associations provide the Integrated Package of Essential Services **D.7**	**Target:** 87.4 million young people completed a comprehensive sexuality education programme delivered by Member **D.8**
143.8m	237.0m (80%)	36%	98.6m

When IPPF refocused efforts with the three Change Goals, an ambitious commitment was made to double the number of sexual and reproductive health services by 2015 from 2010 baseline data. We are proud to announce that 175.3 million services were provided in 2015, only 1 per cent below the goal of 176.4 million. This is a remarkable achievement and a result of Member Associations' unwavering efforts and commitment.

Service provision in 2015 increased by 17 per cent from 2014 (Figure 5), almost double the rate of growth achieved between 2013 and 2014. The most significant increases by region were in Africa, the Arab World and the Western Hemisphere with annual growth rates highest for sexually transmitted infections, HIV and AIDS, paediatrics, contraception, gynaecology and infertility.

The following section examines service statistics and recent trends presented alongside four case studies of Member Association programmes that have contributed to IPPF's overall performance in the provision of sexual and reproductive health services.

Figure 5: Number of SRH services provided, 2010–2015

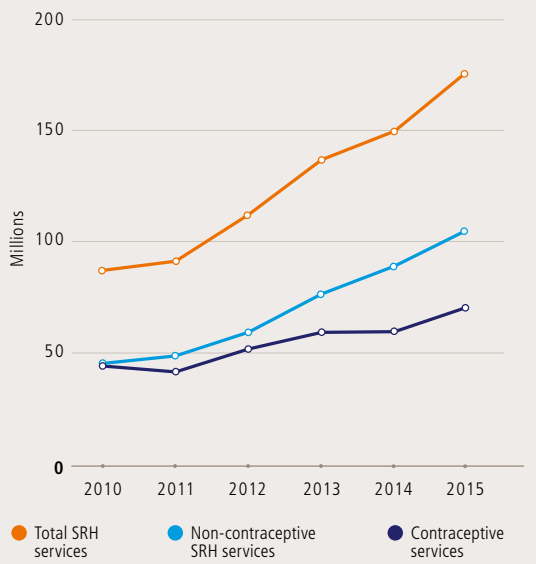
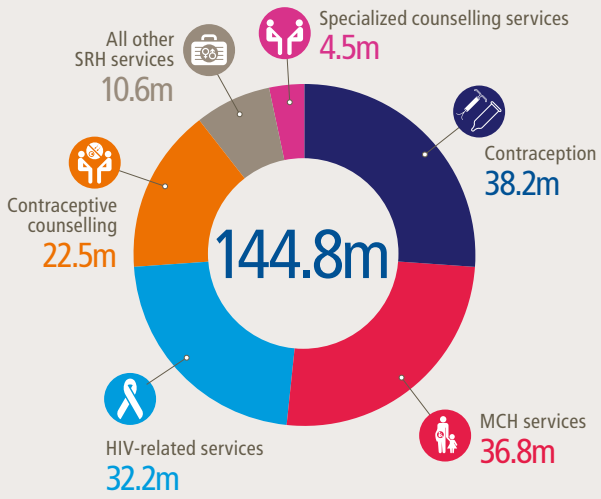


Figure 6: Number of SRH services provided in countries with low or medium human development, by type, 2015



Investing in countries with the greatest need

IPPF invests the majority of its unrestricted funding in countries with the greatest needs for sexual and reproductive health information, education and services. These countries, identified by the United Nations Development Programme's Human Development Index as having low or medium levels of development, typically have disproportionately high levels of maternal and child morbidity and mortality, unmet need for contraception, HIV prevalence, and early marriage and childbearing.

Member Associations and collaborative partners in 71 countries with low or medium levels of human development[8] provided a total of 144.8 million sexual and reproductive health services in 2015. This is an annual increase of 22.4 million, or 18 per cent, and represents 83 per cent of all services provided by IPPF. The greatest numbers of services provided in these countries were in the areas of contraception, maternal and child health, and HIV-related services (Figure 6).

82% of IPPF's service users are poor and vulnerable

Reaching poor and vulnerable groups

IPPF remains committed to serving those most in need of sexual and reproductive health information and services. In 2015, we provided services to an estimated 50.6 million poor and vulnerable service users, which represents 82 per cent of all service users.

Member Associations provide information, education and services to people living in hard-to-reach areas where there are few, if any, other service providers. IPPF has over 45,000 service delivery points, including static clinics, community-based distributors, and mobile and outreach teams. Member Associations also work in partnership with other facilities, for example, with private physicians and pharmacies, and through social marketing programmes. More than half of IPPF's service delivery points are located in peri-urban or rural areas (55 per cent).

Member Associations provide services to under-served groups who are not reached by other public or private providers, due to a reluctance to work with them, the additional costs involved, or an absence of the specialized skills needed. These groups include young people, sex workers, men who have sex with men, people who inject drugs, sexually diverse populations and prisoners. IPPF uses a variety of strategies to serve these groups, including linking with other organizations that already work with them, and training counsellors and peer educators from within the various marginalized communities. Clinics also organize special sessions for those who prefer to attend at convenient times that are dedicated to meeting their specialized needs in a non-judgemental setting.

More than half

of our service delivery points are community-based distributors

Ensuring contraceptive choice

The number of couple years of protection (CYP) provided in 2015 increased by 8 per cent to 15.7 million, which helped women avert an estimated 4.8 million unintended pregnancies and 1.2 million unsafe abortions.

Figure 7 presents IPPF's method mix for CYP in 2015: 41 per cent was provided by short-acting methods; 46 per cent by reversible long-acting methods; and 13 per cent by permanent methods. This is similar to previous years but with a slightly higher proportion of long-acting reversible methods, due to a 25 per cent increase in CYP from intrauterine devices between 2014 and 2015. Other significant increases in CYP were seen for injectables (19 per cent), condoms (17 per cent) and implants (12 per cent).

IPPF's Integrated Package of Essential Services (Annex C) reflects our commitment to offering a range of contraceptive choices to service users and requires Member Associations to provide short- and long-acting reversible methods, as well as emergency contraception. The Package also requires the provision of contraceptive counselling as the basis of our rights-based approach and to support informed decision making about whether and when to have children, and how many to have. In 2015, IPPF provided 25.6 million contraceptive counselling services, an increase of 5.7 million, or 29 per cent, from 2014. Most of these counselling services (22.5 million, 88 per cent) were provided in countries with low or medium levels of human development. This primary healthcare service is essential for reducing unmet need and ensuring that everyone has the opportunity to choose a contraceptive method that is appropriate, reliable and safe.

Following the London Summit on Family Planning in 2012, IPPF pledged to reach 60 million first time users of modern contraception by 2020, in 59 countries aligned with the FP2020 focus countries. In 2015, IPPF provided contraception to 6 million first time users, and we are on track to achieve our target. We will continue to prioritize the unmet needs of young people and the poorest and most marginalized to ensure that our contraceptive services reach those in greatest need.

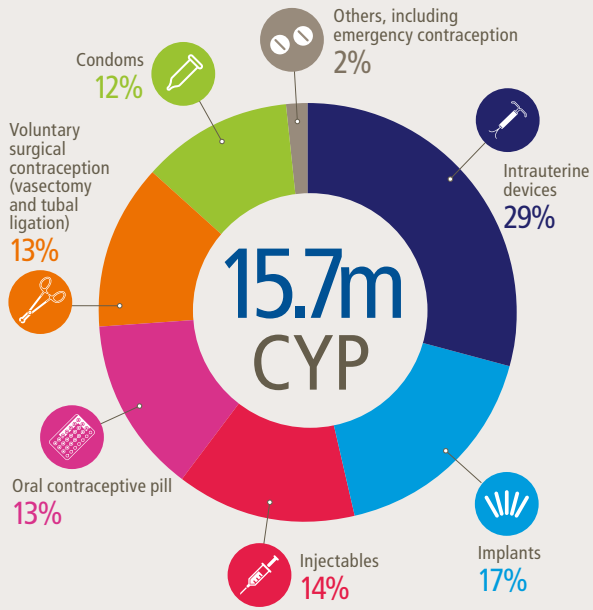
4.8m

Unintended pregnancies averted*

1.2m

Unsafe abortions averted*

Figure 7: Couple years of protection (CYP), by method, 2015



* Using Marie Stopes International's Impact 2 (version 3) estimation model

Providing abortion-related services

IPPF provided 4.3 million abortion-related services in 2015, a 13 per cent increase from 2014. Since 2010, there has been significant growth in all service categories, particularly abortion consultation, medical abortion and treatment of incomplete abortion (Table 1).

Through the Global Comprehensive Abortion Care Initiative, IPPF provides intensive technical support to Member Associations to deliver abortion care and contraceptive services. In 2015, an evaluation of the Initiative highlighted the programme's achievements in expanding abortion service provision, and particularly in reaching poor and vulnerable groups, including young people. The evaluation also recognized that there has been a substantial improvement in the quality of care of all sexual and reproductive health services provided in clinics that received technical support, clinical guidance and close monitoring.

IPPF is a technical leader on abortion, and in 2015, we contributed to the development of World Health Organization recommendations to expand health worker roles to include the provision of safe abortion services. This extended role aims to address the shortage of skilled healthcare professionals who are qualified to provide abortion, which is one of the major barriers to women accessing safe abortion.

Table 1: Number of abortion-related services, by type, 2010 and 2015

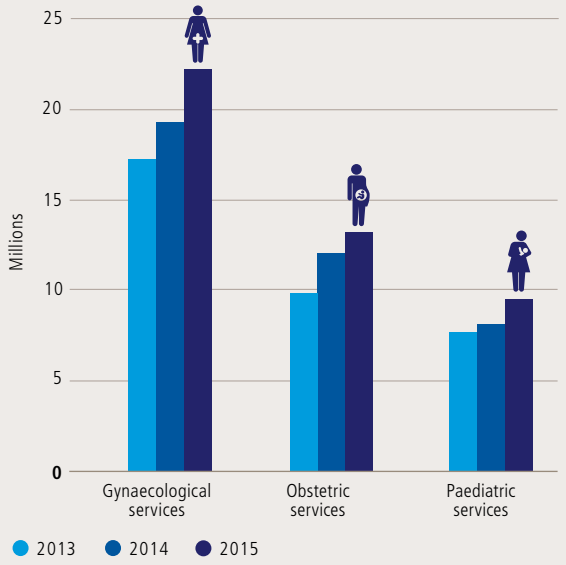
Type of service provided	2010	2015
Pre-abortion counselling	603,594	1,311,253
Post-abortion counselling	371,310	708,298
Surgical abortion	382,960	531,323
Medical abortion	160,174	433,002
Treatment of incomplete abortion	40,012	136,227
Abortion consultation services	212,849	1,143,795
Total	1,770,899	**4,263,898**

Focusing on the needs of women and girls

The majority of IPPF's services are provided to women and girls, who comprised 81 per cent of all service users in 2015, up from 77 per cent in 2014. In addition to contraception and abortion-related services, IPPF also provided 22.2 million gynaecological services in 2015, including breast and pelvic examinations, biopsies, imaging and cancer screening (Figure 8). In addition, IPPF provided 13.2 million obstetric services such as pre- and post-natal care, pregnancy testing and childbirth services, as well as 9.5 million paediatric services. The combined number of these services provided to women and children increased by 5.1 million, or 13 per cent, between 2014 and 2015.

In 2015, Member Associations provided 2.1 million prevention, screening and counselling services related to sexual and gender-based violence, a 15 per cent increase from 2014. The majority of these services were provided in Africa (34 per cent), the Western Hemisphere (28 per cent) and South Asia (26 per cent), where there are very high prevalence rates for intimate partner violence: at 37 per cent, 30 per cent and 38 per cent, respectively.[9]

Figure 8: Number of gynaecological, obstetric and paediatric services provided, 2013–2015



Providing HIV-related services

IPPF provided 40.7 million HIV-related services in 2015, a 28 per cent increase from 2014. African Associations delivered more than half of these services, with the same growth rate of 28 per cent from 2014. Five out of six regions provided more HIV-related services in 2015 than in 2014. The number of condoms distributed in 2015 increased by 17 per cent to 219.6 million. Annual growth occurred in all HIV-related service categories, with the largest increase in the provision of services related to sexually transmitted infections, which grew by 38 per cent to 22.2 million in 2015 (Table 2).

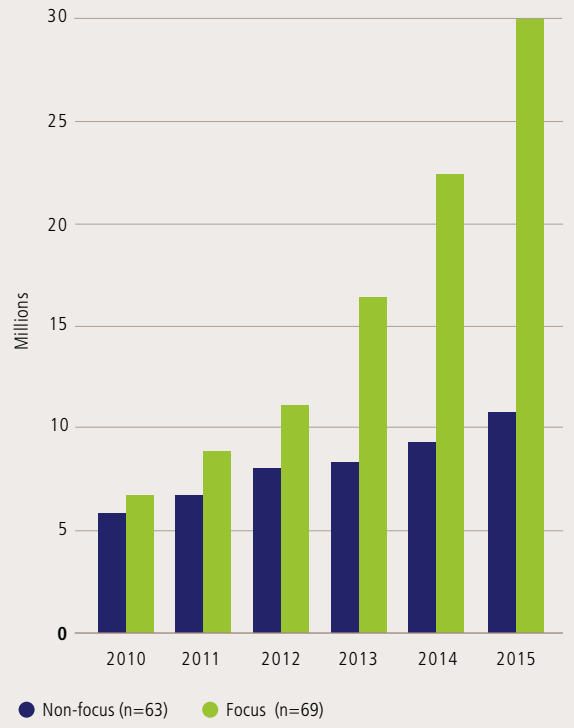
IPPF provided more than three times the number of HIV-related services in 2015 than the 12.3 million provided in 2010. Most of this growth was in the Africa region, which is the most severely affected region in the global HIV epidemic. A combination of Secretariat support to Member Associations, technical engagement and restricted funding contributed to the impressive growth in HIV-related services during this period, particularly in sexually transmitted infection services. Since 2004, IPPF has implemented a strategy of intensive capacity building on HIV knowledge and skills for a select number of focus Member Associations. From 2010 to 2015, the number of HIV-related services provided in these focus countries grew more than four times as quickly as in the other countries (Figure 9).

An online survey carried out as part of an endline review of IPPF's HIV strategy from 2010 to 2015 showed that 94 per cent of Member Associations are now in a stronger position in terms of their HIV response. For example, many have made significant progress in the provision of a wide range of HIV-related services, including antiretroviral therapy, and in reaching out to people living with HIV and other key populations that are disproportionately affected by HIV. The integration of HIV services into existing sexual and reproductive health service programmes has also been extremely successful and ensures access to care in a stigma-free environment.

Table 2: Number of HIV-related services provided, by type, 2014–2015

Type of service provided	2014	2015
Prevention	5,108,657	5,937,408
Counselling and testing	9,681,619	11,593,236
Treatment, care and support	857,064	1,043,145
STI services	16,110,693	22,157,833
Total	**31,758,033**	**40,731,622**

Figure 9: Number of HIV-related services provided, focus and non-focus Member Associations, 2010–2015



Meeting young people's needs

IPPF provided 76.8 million sexual and reproductive health services to young people in 2015, a 15 per cent increase over 2014. This represents 44 per cent of total service provision and illustrates IPPF's continued commitment to the largest-ever generation of young people. The most common types of services provided to young people in 2015 were contraceptive (37 per cent) and HIV-related (24 per cent). In 2015, 45 Member Associations provided more than half of their services to young people, up from 36 Associations in 2014.

Over the past five years, IPPF has expanded its role in promoting and delivering comprehensive sexuality education. An impressive 86 per cent of Member Associations have developed their own curricula based on IPPF's *Framework for Comprehensive Sexuality Education*, and 44 per cent have used IPPF's assessment tool *Inside and Out* to ensure the comprehensiveness and quality of their programmes.

To reach the most vulnerable groups of young people, IPPF invests in delivering comprehensive sexuality education in non-formal settings. In 2015, IPPF trained nearly half a million young peer educators who can design and lead sessions that are adapted to the needs and wants of the young people they reach. Their approaches to delivering the sessions are often more creative and engaging than those in formal settings.

IPPF has further developed its innovative work to tackle abortion stigma, as experienced by young people. In 2015, IPPF created new resources to support Member Associations and external organizations to develop accurate and non-stigmatizing messages and communication on abortion,[10] and to support discussion of abortion in education programmes for young people.[11]

Responding to the earthquake crisis in Nepal

In humanitarian settings, a lack of obstetric services increases maternal and newborn mortality rates. Limited access to contraception contributes to higher numbers of unintended pregnancies, and when safe abortion services are also unavailable, more women die as a result of unsafe abortion. Sexual and gender-based violence and survival sex – where sex is traded for food, water and shelter – increase sexually transmitted infections, including HIV. Yet, despite these risks, sexual and reproductive health and rights have not been prioritized in emergencies, and women and young people often bear the greatest burden. In 2015, an estimated 2 million women and children affected by conflict and natural disasters received sexual and reproductive health services from IPPF.

On 25 April 2015, a devastating earthquake struck Nepal, destroying or damaging more than 1,000 health facilities and leaving approximately 126,000 pregnant women in urgent need of clean delivery and reproductive health kits.[12] An estimated 40,000 women of reproductive age were left at increased risk of sexual violence.[13] Initial reports estimated that more than 14,000 deliveries would take place each month in the affected areas of the country, with 15 per cent of them experiencing complications.[14]

IPPF's Sexual and Reproductive Health Programme in Crisis and Post-crisis Situations (SPRINT) works in areas affected by natural disasters and conflict. Within days of the earthquake, the Family Planning Association of Nepal (FPAN), with support from SPRINT, had begun to set up mobile medical camps to provide a broad range of sexual, reproductive and other health services, including emergency obstetric care, maternal and newborn care, contraception, hygiene and dignity kits, sexual and gender-based violence services, HIV testing, and sexually transmitted infection treatment and counselling.

IPPF and FPAN set up three maternity care centres to respond to the need for childbirth support, as well as four safe and private spaces for women and girls, pregnant women and lactating mothers. These spaces offered information and services to women and girls, and were used for group counselling, and recreational and skills building activities. FPAN reached more than 19,000 people with sexual and reproductive health information and services in affected areas, both rural and urban.

During the response, the IPPF SPRINT team built the capacity of FPAN staff to engage in the humanitarian coordination cluster mechanisms, which bring together international agencies at the onset of an emergency to coordinate a collaborative response. FPAN and other partners were also trained to provide the *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations*. The MISP is designed to reduce mortality and morbidity associated with reproductive health, and includes a set of essential life-saving activities to be implemented at the onset of a crisis.

> In these difficult times, any bit of help is welcome. I'm very happy that at the camp people have actually thought about a woman's needs, especially a new mother's needs. I'm really grateful that, for once, my requirements have been considered.

25-year-old Nepali mother of a newborn

IPPF/Nepal

IPPF/Graeme Robertson/Venezuela

Regional performance trends

In the final year of IPPF's *Strategic Framework 2005–2015*, our performance data highlight the significant achievements made in all six regions: Africa (AR), Arab World (AWR), European Network (EN), East and South East Asia and Oceania (ESEAOR), South Asia (SAR) and Western Hemisphere (WHR). Globally, between 2005 and 2015, IPPF provided more than 1 billion sexual and reproductive health services, nearly 113.3 million couple years of protection, and over 1.7 billion condoms. Table 3 presents cumulative totals for the main sexual and reproductive health categories by region, with more services being provided in the Africa region than in any other.

Table 4 provides the annual results for the final year of the Strategic Framework by region, with information on some additional key indicators, including the proportion of service users who are poor and vulnerable, and the proportion of Member Associations providing IPPF's Integrated Package of Essential Services.

Strategies that focus on countries with the highest potential for service growth and where needs are the greatest have made the most significant contributions to the performance results presented here. Member Associations have worked hard to reach previously under-served people, providing new types of sexual and reproductive health services and in new locations. Using information to review performance and support decision making has also led to increased efficiency and better results, year-on-year.

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

1 billion
SRH services provided

113 million
couple years of protection

1.7 billion
condoms distributed

Table 3: Cumulative results by region, 2005–2015

Indicator	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of sexual and reproductive health services (including contraception) provided	352,992,412	38,650,817	16,278,691	119,537,694	173,816,437	301,277,081	**1,002,553,132**
Number of couple years of protection	21,292,711	3,258,049	514,287	7,432,116	23,864,283	56,900,647	**113,262,093**
Number of sexual and reproductive health services (including contraception) provided to young people under 25 years	160,591,338	15,326,863	7,281,664	39,250,115	78,652,630	101,884,144	**402,986,754**
Number of HIV-related services provided	71,094,944	5,765,928	2,710,535	18,429,476	21,341,287	49,296,023	**168,638,193**
Number of condoms distributed	456,964,097	10,559,540	11,480,647	258,206,268	350,356,116	653,383,743	**1,740,950,411**
Number of abortion-related services provided	4,322,663	663,643	997,921	2,080,113	3,860,929	8,999,447	**20,924,716**

Table 4: Results by region, 2015

Indicator	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of sexual and reproductive health services (including contraception) provided	84,706,146	10,370,376	1,450,720	19,874,035	26,067,304	32,829,861	**175,298,442**
Number of couple years of protection	5,044,940	373,720	52,128	843,789	2,719,323	6,676,457	**15,710,357**
Number of sexual and reproductive health services (including contraception) provided to young people under 25 years	39,819,484	5,044,437	759,457	8,100,156	11,160,274	11,902,346	**76,786,154**
Number of HIV-related services provided	21,715,167	2,017,486	370,235	2,721,775	5,464,121	8,442,838	**40,731,622**
Number of condoms distributed	93,979,842	2,056,188	1,393,066	49,691,965	34,625,336	37,809,512	**219,555,909**
Number of abortion-related services provided	1,423,874	179,052	120,266	270,073	492,322	1,778,311	**4,263,898**
Estimated percentage of Member Association clients who are poor and vulnerable	88%	86%	35%	74%	78%	66%	**82%**
Proportion of Member Associations providing the Integrated Package of Essential Services*	26%	64%	n/a†	13%	56%	54%	**36%**

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

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

Programme successes

Meeting the sexual and reproductive health needs of young people

Family Planning Organization of the Philippines (FPOP)

In the Philippines, 10 per cent of 15- to 19-year-old girls are already mothers or pregnant with their first child,[15] and 78 per cent of first sexual encounters among this age group are unprotected.[16] Nearly 18 per cent of married women and girls have an unmet need for contraception;[17] for unmarried women and girls, this unmet need jumps to almost 70 per cent.[18] Sexual and reproductive health information and services are not provided by government health facilities according to youth friendly standards, leaving young people vulnerable to unplanned pregnancies and exposure to sexually transmitted infections.

From 2011 to 2015, the IPPF Member Association, Family Planning Organization of the Philippines (FPOP), addressed the high unmet need for sexual and reproductive healthcare among young people in six provinces through the Choices and Opportunities project. FPOP expanded service provision to previously under-served and vulnerable youth, including young lesbian, gay, bisexual and transgender people, commercial sex workers, out-of-school youth, unmarried young women, young people living with HIV and young mothers. During the five-year period, FPOP provided nearly 438,000 sexual and reproductive health services to young people in these provinces, and more than 5,000 young people completed a comprehensive sexuality education programme provided by the Association.

There were two main determinants of the Member Association's success. The first was the involvement and leadership of young people. FPOP hired young people to manage and implement the youth programme and trained more than 4,000 young people, including marginalized youth, as service providers, peer motivators and educators, and advocates for comprehensive sexuality education. FPOP peer educators and service providers coordinated with community leaders and church groups to provide comprehensive sexuality education and sexual and reproductive health services to young people.

Secondly, in collaboration with other organizations and youth networks, FPOP worked with the Department of Education to develop a framework on comprehensive sexuality education and accompanying teaching modules. The government integrated this framework into the national curriculum, a huge achievement in a country where young people's access to sexual and reproductive health information and services has been fiercely opposed by the politically influential Catholic Church for years. FPOP trained 1,875 teachers, parents and other community members on the framework to orient them on its key components, ensure that they were fully knowledgeable about the sexual and reproductive health and rights of young people, and build their capacity to provide comprehensive sexuality education in schools and in the community.

Improving quality of care through service integration

Family Life Association of Swaziland (FLAS)

At 26 per cent, Swaziland has the highest HIV prevalence in the world.[19] Young women are disproportionately affected, and 40 per cent of the country's 23- and 24-year-old women are living with HIV.[20] The IPPF Member Association, Family Life Association of Swaziland (FLAS), began to systematically integrate HIV services with other sexual and reproductive health services in 2008, and has since made significant progress in the number, range and quality of services it provides.

Service integration ensures that clients receive comprehensive care in a stigma-free setting. As a result of the Association's package of services, a more diversified clientele – including sex workers, men who have sex with men, and women in rural communities – now access services. FLAS offers a full package of HIV-related services, including counselling and testing, prevention of mother-to-child transmission, antiretroviral therapy and psychosocial support. HIV-related services have become a key entry point for clients to receive a wide range of other sexual and reproductive health services. In 2010, clients received an average of two services per visit; by 2015, this had risen to five.

Between 2010 and 2015, the number of HIV-related services provided by FLAS nearly trebled, reaching 116,504 in 2015. During the same period, overall sexual and reproductive health service provision grew by 149 per cent to a total of more than 260,000 services in 2015.

Swaziland has the world's highest incidence of tuberculosis,[21] and 77 per cent of tuberculosis patients are also HIV positive.[22] The country also has the world's seventh highest rate of cervical cancer.[23] Service integration has inspired FLAS to introduce new services, including tuberculosis screening and routine cervical screening for all women living with HIV using visual inspection of the cervix with acetic acid.

The success of FLAS has led it to become the Africa region's Centre of Excellence for HIV and sexual and reproductive health service integration. FLAS provides technical support to other African Member Associations, to ministries of health from Swaziland and other African countries, and to national civil society organizations.

> I have known my [HIV] status since 2004 and I didn't know much about the importance of Pap smear [and] family planning. The integration of services helped me a lot to also understand my health.
>
> FLAS service user

Programme successes

Improving access to and quality of abortion services

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

An estimated 20 per cent of Pakistani women have an unmet need for contraception, resulting in high levels of unintended pregnancy and induced abortion.[24] Abortion in Pakistan is legally restricted to saving the life of the woman or providing it as 'necessary treatment' early in pregnancy.[25] This vague definition, coupled with strong abortion stigma, create a challenging environment in which to provide abortion-related services.

With support from the Global Comprehensive Abortion Care Initiative, Rahnuma-Family Planning Association of Pakistan (Rahnuma-FPAP) has transformed its abortion programming, with significant progress made in the number and quality of abortion-related services provided within the law. After training medical staff on the provision of surgical and medical abortion, and stocking clinics with the relevant supplies and equipment, Rahnuma-FPAP began offering these services in 2011. Service providers also received training on pre- and post-abortion counselling, post-abortion care, and using data to make decisions. In 2015, Rahnuma-FPAP provided 162,963 abortion-related services and 1,851,451 contraceptive services, compared with 99,588 and 939,442, respectively, in 2010.

Rahnuma-FPAP has conducted values clarification training for service providers, focusing on the importance of safe abortion and framed within the legal and religious contexts in Pakistan. Following the training, many service providers no longer had reservations about providing abortions, and some who had previously turned away clients seeking abortion services said they would no longer do so.[26]

> Doctors don't usually tolerate questions. I asked a lot of questions because I was so anxious. They were really patient.
>
> Rahnuma-FPAP service user

Rahnuma-FPAP has integrated safe abortion-related care into its existing and robust quality assurance system, which includes monitoring visits by quality assurance doctors, clinic audits, client exit interviews, focus group discussions and clinic suggestion boxes.

To destigmatize abortion, Rahnuma-FPAP has built relationships with influential women in communities who raise awareness about abortion and accompany women to clinics. The Association has also held sensitization sessions with community health providers, conducted door-to-door visits, and established referral linkages with public and private providers.

Serving remote communities sustainably in El Salvador

Asociación Demográfica Salvadoreña (ADS)

More than a third of El Salvador's population live in rural areas,[27] where women are disproportionately affected by limited access to sexual and reproductive health services in comparison to those who live in towns and cities.[28] Providing healthcare in remote areas requires additional time and transportation costs, and since rural service users are less able to pay standard rates for services, healthcare facilities cannot use service fees to sustain these programmes. The Asociación Demográfica Salvadoreña (ADS) has implemented a social enterprise model to respond to these challenges. This model generates income from urban-based healthcare facilities to finance a community-based health promotion programme designed to reach the under-served.

ADS has trained more than 800 women as community health promoters to provide sexual and reproductive health information and services to clients who would otherwise have extremely limited access to healthcare. They also refer clients to ADS facilities and to other providers for services that they cannot provide themselves, such as diagnostic imaging for obstetric care and testing for sexually transmitted infections. In 2015, this programme supported the provision of more than 625,000 services to people in rural communities; the provision of injectable contraceptive services made up 38 per cent of this total.

ADS' innovative financing model successfully sustains the programme. An overwhelming 95 per cent of ADS' total income is generated locally, mostly through service fees, and is used to cross-subsidize programmes that provide health services to the under-served. ADS operates static clinics and a hospital that provide services at affordable prices and yet still result in a net profit. This financial surplus is then used to fund 90 per cent of the community outreach programme, as well as the Association's youth, HIV, and sexual and gender-based violence programmes.

In addition to sustaining its community-based work, the model for generating local income has enabled ADS to steadily grow its income by 5 per cent annually. This growth has supported an increase in the overall number of sexual and reproductive health services provided by the Association, from just over 450,000 in 2010 to 1.6 million in 2015. During this same period, the estimated number of ADS clients who were poor or vulnerable rose from 39 per cent to 78 per cent, illustrating the Association's dedication to serving those with the greatest need.

ADS' well-planned cross-subsidization strategy enables the Association to provide essential services to the most vulnerable populations, through a financially sustainable approach that does not rely on external funding.

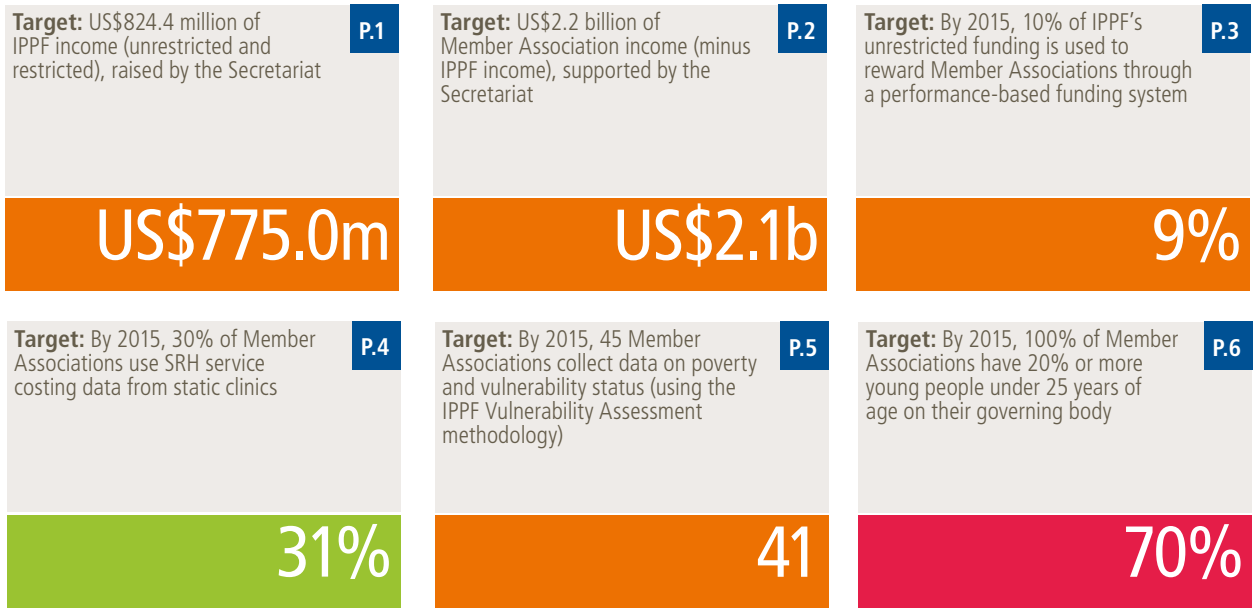
perform a relevant and accountable Federation

In 2015, IPPF invested in learning, business processes and information management systems to drive performance and value for money. Increasingly, data are used to provide information that guides decision making, and to ensure accountability to our clients, donors and partners.

IPPF's cumulative achievements from 2010 to 2015 for the Change Goal Perform are presented in Figure 10. Overall, the results are positive although there is still room for progress. One indicator surpassed its target of 30 per cent: the proportion of Member Associations using costing data in static clinics to assess performance in delivering sexual and reproductive health services has been rising steadily over the past four years and now stands at 31 per cent.

Four indicators reached 90 per cent or more of their cumulative targets: IPPF income (94 per cent); Member Association income (93 per cent); the percentage of unrestricted income used in the performance-based funding system (90 per cent); and the number of Member Associations using the IPPF Vulnerability Assessment methodology (91 per cent). The ambitious target of 100 per cent of Member Associations having at least 20 per cent young people on their governing body by 2015 was not reached, although at 70 per cent, progress made represents a noteworthy increase from 57 per cent in 2010.

Figure 10: Perform – cumulative performance results, 2010–2015



For the last two years, total IPPF income raised by the Secretariat as well as income raised by Member Associations were significantly devalued by the US dollar strengthening against donor and local currencies. Despite this, between 2010 and 2015, the Secretariat secured US$775.0 million. Furthermore, Member Associations generated income of US$2.1 billion to support IPPF's work, almost achieving the target of US$2.2 billion. IPPF made progress in implementing processes and systems to drive our performance culture. In 2015, 9 per cent of IPPF's unrestricted income was used to reward Member Associations through a performance-based funding system. This remains one percentage point below target; however, five out of six IPPF regions are using the system and met the target of 10 per cent.

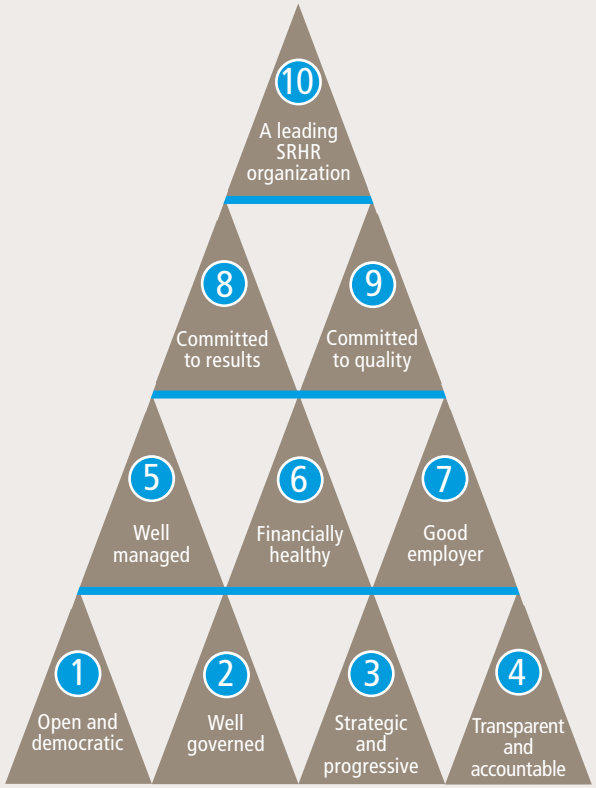
In 2015, 10 additional Member Associations began using IPPF's Vulnerability Assessment methodology to collect data on poverty and vulnerability status of service users. This is an impressive result, with 41 Associations now using data to design programmes that ensure access to services by those most in need.

This section highlights initiatives to improve organizational effectiveness, including our accreditation programme and the use of a health management information system, DHIS2, to collect, manage and use data from Member Associations and collaborative partners.

Improving performance through accreditation

Launched in 2003, IPPF's accreditation system assesses Member Association compliance against a set of membership standards. In 2007, an independent evaluation found that the system had substantially benefited Member Associations by increasing their credibility both nationally and internationally, and improving accountability to both donors and clients. Member Associations felt that for accreditation to be of greatest value, it should be an ongoing process and not just a one-off exercise. IPPF, therefore, revised the system and implemented a second accreditation phase from 2009 to 2014.

Figure 11: IPPF's 10 membership principles



The second phase assessed Member Associations' compliance with 10 principles of membership (Figure 11), 49 standards and 170 checks. Member Association staff completed a self-assessment tool which was reviewed by accreditation team members before the onsite visit. This preparatory work allowed more time to be spent reviewing evidence in the field and for discussions between the parties involved. Member Associations' partners were consulted by the accreditation team to assess the relevance of each Association's work in its country context. To encourage exchange of experience and expertise, Member Associations were asked to provide examples of good practice on IPPF's knowledge sharing platform Exchange. As a result, Member Associations have sought technical assistance from each other on good governance practices and volunteer management systems, among others.

A total of 139 accreditation reviews were conducted; three Member Associations were exempt due to conflict in their countries. Of those reviewed, 117 Member Associations were (re)accredited, and another 15 were asked to address areas of non-compliance that were identified. Of the remaining seven, three Associations were expelled from the Federation due to continued failure to comply with the standards and responsibilities of IPPF membership; two were placed under suspension; and two Associate Members did not have their membership renewed.

In 2013, IPPF began to revise the accreditation system for a third phase. To learn about what worked well and what could be done better, IPPF conducted surveys with volunteers and staff of Member Associations. Feedback was also collected from IPPF accreditation staff, Governing Council members, donors and other organizations.

Feedback from the consultative review indicated that the accreditation system is a supportive and collaborative process that has increased Member Associations' sense of belonging to the Federation. The most common improvements made by Associations as a result of accreditation were in the areas of constitutions, policy amendments, financial management and governance. When asked to name one aspect of the accreditation process that should change, the overwhelming response was 'nothing'. Many mentioned the importance of the self-assessment tool because, as one respondent said, "even without the actual accreditation review, the tool and process are empowering, allowing the Member Association to evaluate its strengths and weaknesses."

Member Associations contributed valuable feedback which has been taken on board in the third phase. For example, some respondents suggested that it would be useful to have more guidance on the documentation and evidence required to support the accreditation onsite visit. As a result, IPPF developed a set of three glossaries to guide Member Associations: Definitions of Terms, Suggested List of Evidence, and Must-Have Policies.

IPPF's Governing Council approved a one-year break between the second and third phases to allow the online reporting system to be revised and to enable those Associations in the follow-up stage of the process to address areas of non-compliance before the launch of the third phase in 2016. This latest accreditation phase consists of 48 membership standards and continues to be based on the 10 principles introduced in phase two. However, additional focus is placed on a rights-based approach; commitment to IPPF's new vision, mission and values according to our *Strategic Framework 2016–2022*; advocacy and public image building; sustainability; ownership of the process by Member Association stakeholders; and greater emphasis on the rights and needs of service providers.

The IPPF accreditation system will continue to build a more effective Federation of locally owned and high performing civil society organizations that champion and advance sexual and reproductive health and rights.

> Every non-compliance is actually a way to improve our organization.
>
> Member Association staff member

Investing for results

In 2015, all but two donors increased or held level their unrestricted funding to IPPF. Despite this, overall income raised by the Secretariat from governments, foundations and other sources fell from US$126.1 million in 2014 to $116.2 million in 2015. This 9 per cent decrease was due to the continued strengthening of the US dollar against donor currencies. Detailed information on IPPF finances is available in the *IPPF Financial Statements 2015*.[29]

IPPF continues to invest in countries with the lowest levels of development. In 2015, 80 per cent of all IPPF grants to Member Associations and collaborative partners went to those working in countries with low or medium human development,[30] an increase from 71 per cent in 2014. Countries with the highest development needs are located in Africa and South Asia, and 45 per cent and 19 per cent of IPPF's unrestricted cash and commodity grants were allocated to those two regions, respectively.

IPPF Regional Offices used the performance-based funding system to determine individual Member Association grant levels, which are adjusted according to performance against a number of key indicators. The system rewards Member Associations that are most effective in delivering rights-based information, education and services, as well as advocacy programmes. As a result, IPPF is able to invest further resources in Associations that achieve the greatest results.

In 2015, an online platform was developed on IPPF's extranet site, Exchange, to host the *Funding Formula*, which is a step-by-step guide with tools and practical resources for Member Associations to plan an effective resource mobilization programme. In addition to funds from donors, Member Associations have very diverse income streams, including sales of commodities and expertise, in-kind donations and local government support. This income is extremely important in securing financial sustainability in the long term, especially with increasing pressure on official development assistance budgets.

Strengthening systems – DHIS2 implementation

In 2015, IPPF built a new database in the open source software DHIS2 to collect service statistics data from Member Associations and collaborative partners. Data elements include sexual and reproductive health services, type and location of service delivery points, contraceptive items distributed, and first time contraceptive users. The database is available in Arabic, English, French and Spanish. Over 100 validation checks were put in place to ensure data quality at the point of data entry, and more than 50 dashboards were built to support the data review and cleaning process. An online training module was developed and shared in multiple languages to assist users, and 10 years of IPPF's historical data were migrated to DHIS2 to support trends analyses from 2005.

IPPF trained a large number of Secretariat staff to prepare for 2015 data entry by Member Associations. Following the training, staff were encouraged to develop dashboards that are most helpful for internal use, reporting to donors and other partners, and linking with national reporting systems. More than 300 dashboards have now been developed to support data review, analysis and reporting. We currently have over 400 registered DHIS2 users across the Federation, and all Member Associations and collaborative partners entered 2015 data onto the system.

In the future, we will incorporate additional data elements and indicators, disaggregate data by age, sex and individual service delivery points, and begin to collect data more frequently. Automatic import of data from clinic-based management information systems will be supported, and additional client-based indicators will be developed.

DHIS2 has significantly reduced the burden of entering, reviewing and analysing data. Indicators that previously required manual calculations are now automated and this reduces human effort and error. At national, regional and global levels, DHIS2 helps IPPF to monitor performance and ensures progress continues to be made in achieving our ambitious targets.

Rewarding performance: IPPF wins network prize

The Reproductive Health Network grant for Cervical Cancer Screening and Preventative Therapy is being implemented in four countries in the Africa region (Kenya, Nigeria, Tanzania and Uganda). The initiative is a collaboration among IPPF, Marie Stopes International and Population Services International.

In 2015, a data quality assessment was undertaken by an external organization. Each country's data management system was reviewed, and data accuracy, timeliness and completeness were verified for the second year of project implementation. The results were used to guide an independent panel's decision regarding bonus awards for the best performing partner and country. The assessment also provided advice to improve data management systems and data quality for each implementing partner.

After reviewing both results and data quality, the performance assessment committee awarded the prize to IPPF for the following reasons:

- the largest absolute increase in the number of programmes
- the largest absolute increase in the number of women screened and treated
- the move from expensive Pap smears to the more cost-effective visual inspection approaches, using acetic acid or Lugol's iodine solution
- the best data audit scores

Recommendations from the data assessment are now being taken forward, with a focus on ensuring data quality and utilization to guide decision making and drive increased performance.

Programme successes: Perform

Measuring vulnerability to improve planning and decision making

Association Marocaine de Planification Familiale (AMPF)

In Morocco, large disparities exist in sexual and reproductive health outcomes. These relate to economic status, educational attainment, ethnicity, gender and other social attributes. An equity-focused approach to programming requires the collection of data that measure the extent to which programmes reach those who are poor and vulnerable, and using that information to improve access to those most in need.

In 2015, the IPPF member in Morocco, Association Marocaine de Planification Familiale (AMPF), applied IPPF's Vulnerability Assessment methodology[31] in all 25 of its static clinics to collect and analyse data on the sexual and reproductive health vulnerability of clients. The Association found that its vulnerable clients are primarily sex workers, released prisoners, bus drivers, migrants and people living in rural and peri-urban areas. Having data on the number of vulnerable clients and their types of vulnerability has enabled AMPF to make informed decisions to reach higher proportions of clients who are poor or vulnerable, resulting in an increase from 55 per cent in 2014 to 64 per cent in 2015.

Before 2015, AMPF had implemented a single strategy across all regions of the country to provide community-based sexual and reproductive health services. However, data from the vulnerability assessment review indicated that types of vulnerability differed depending on region. As a result,

> Now we have the data, we need to better prioritize programmatic activities and identify the target groups.
>
> AMPF staff member

AMPF designed different programme approaches to provide community-based services to the varied groups: rural populations in the north, industrial workers in the centre, and bus drivers and migrants in the south central areas of the country. The Association is also now providing more HIV-related services in the two regions where there are the majority of vulnerable clients at risk of contracting HIV.

AMPF is using the findings of the assessment to renegotiate donor partnership agreements. For example, one of the Association's donors was interested in working in southern Morocco on prenatal care. Data on vulnerability, however, indicated that sex workers constitute the highest percentage of vulnerable clients in that region. AMPF, therefore, has requested to work on the elimination of mother-to-child transmission of HIV among sex workers in that region.

The Vulnerability Assessment methodology provides critical data to guide decision making and supports AMPF's focus on reaching those most in need.

Providing technical support on management information systems

Reproductive Health Alliance Kyrgyzstan (RHAK)
Tajikistan Family Planning Association (TFPA)

Client-based clinic management information systems improve the accuracy and richness of client and service data, the quality of reporting, and the quality of care provided. The Reproductive Health Alliance Kyrgyzstan (RHAK) developed its own custom designed electronic clinic management information system in Russian. Since implementing the system in 2013, RHAK has been able to reduce the burden of data collection, reporting and analyses of both client and service data, as well as make use of data for decision making to improve performance.

When the Tajikistan Family Planning Association (TFPA) began providing sexual and reproductive health services in 2014, a manual system was initially used to register clients and collect data on the number of services provided. This system was time consuming, and data analyses were unreliable as input and calculations had to be done manually. IPPF European Network (EN) staff suggested that RHAK support TFPA in the set-up of its new clinic. They also suggested that TFPA use the Kyrgyz management information system as it is in Russian and links to the most commonly used accounting system in Central Asia. With funding from IPPF EN, RHAK staff installed the electronic system in TFPA's static clinic in 2015, and trained programme and clinic staff on how to use it.

> For a long time, I worked in public facilities, using old methods of service and client registration. With this system, I understand how new technology can ease your work and improve service quality.
>
> TFPA gynaecologist

As a result, TFPA has improved client data security, client and service registration, and reporting. With more accurate and reliable data, the Association is now able to make data-driven decisions more confidently. For example, the system's logistics section monitors clinic stock and expenses and has enabled TFPA to make more precise procurement projections, resulting in improved management of commodities supplies. TFPA's performance is also benefiting from analysing trends related to services and client profile data, and understanding what services are being provided and to whom.

The technical support provided to TFPA by RHAK illustrates one of the benefits of being a member of IPPF: the opportunity to learn from and share with other members who are experts in implementing sexual and reproductive health and rights programmes. This decentralized technical support strengthens partnerships and peer exchange across the global network.

Next steps

IPPF's new *Strategic Framework 2016–2022* is a bold and aspirational vision that sets out priority areas to drive our work over the next seven years, to ensure that everyone is free to make choices about their sexuality and well-being, in a world without discrimination.

IPPF's *Strategic Framework 2016–2022* was finalized following an extensive global consultation process within IPPF, and with donors and partners. It responds to IPPF's strengths and potential, as well as the key social, political and demographic trends that influence sexual and reproductive health and rights. Member Associations have used the global Framework to develop their own strategies, designed to be the most effective in each local context and responding to the needs of the most marginalized groups.

IPPF will continue in its unique role as the leading advocate of sexual and reproductive health and rights, convening and supporting civil society to participate in national, regional and global political processes. We will address controversial issues that others shy away from, and will mobilize wherever and whenever sexual and reproductive rights are threatened by the opposition. We will also hold governments to account for commitments they have made, with a particular focus on contributions to the new Sustainable Development Goals 3 and 5.

We will strengthen our links with youth and women's organizations and provide pathways for women and young leaders, particularly girls, to champion and advocate for gender equality, women's empowerment, and sexual and reproductive health and rights. Moving forward, we will support young people to exercise their rights, build life skills, and access sexual and reproductive health information and services. We will expand our work on comprehensive sexuality education and extend beyond the classroom to reach out-of-school youth. IPPF will implement public campaigns to raise awareness of sexual and reproductive health and rights issues, generate support, and contribute to changes in public attitudes and opinions.

We will deliver the highest quality sexual and reproductive health services, including contraception, gynaecology, obstetrics, safe abortion, sexual and gender-based violence, and HIV-related services. We will expand access through a diverse range of service delivery points in urban, peri-urban and rural areas. We will invest in effective supply chain management, equipment, infrastructure, systems and personnel. Our services will be client-centred and rights-based, and we are as committed as ever to providing these services to those who are the poorest and most vulnerable – upholding our reputation as a health provider that is welcoming to all. IPPF will build on our existing humanitarian work to develop effective emergency response programmes in conflict and crisis settings. We will also advocate for other organizations to integrate sexual and reproductive health services into their emergency relief efforts.

As a volunteer-based organization, IPPF benefits significantly from the contributions made by volunteers in governing bodies, and as peer educators, medical professionals, fundraisers, advocates, community distributors of contraception and legal advisers. IPPF will invest further in volunteer programmes to increase organizational effectiveness, accountability and value for money, as well as raise the profile of volunteers both internally and externally. This investment will enable the Federation to scale up its contribution to the sustainable development of societies through active citizen participation within countries and beyond.

We will engage with activists to advance sexual and reproductive health and rights, focusing initially in countries where Member Associations have the interest and potential to grow their supporter base. A strong activist community will influence decision makers and hold leaders to account. Such grassroots support is critical as it provides an alternative voice to the opposition who pose a threat to hard won gains in sexual and reproductive health and rights.

Over the next seven years, IPPF will implement models of financial sustainability that focus on business planning and generating income from diverse sources. We have set an ambitious target of doubling income by 2022 because such an increase will be critical in helping us achieve our goals. Progress in delivering the Strategic Framework will be measured through a dashboard of global expected results, to be reported on annually, and data management systems will support ongoing programmatic and management decision making to ensure operational effectiveness.

With the right support, we are confident that we will be able to build on achievements to date to lead a locally owned, globally connected civil society movement that delivers services and champions sexual and reproductive health and rights for all, especially the under-served.

OUR VISION

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

IPPF

OUTCOME 1

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

OUTCOME 2

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

OUTCOME 3

2 billion
quality integrated sexual and reproductive health services delivered

OUTCOME 4

1
high performing, accountable and united Federation

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

IPPF'S MISSION

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

LOCALLY OWNED GLOBALLY CONNECTED: A MOVEMENT FOR CHANGE

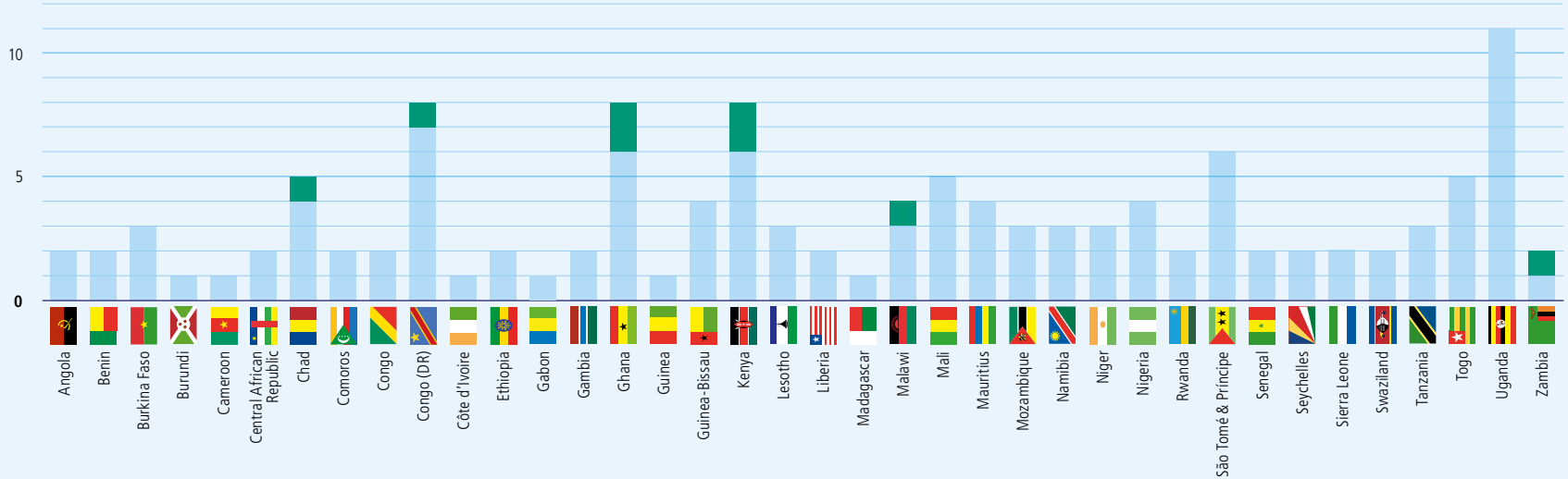
STRATEGIC FRAMEWORK 2016–2022

OUR VALUES

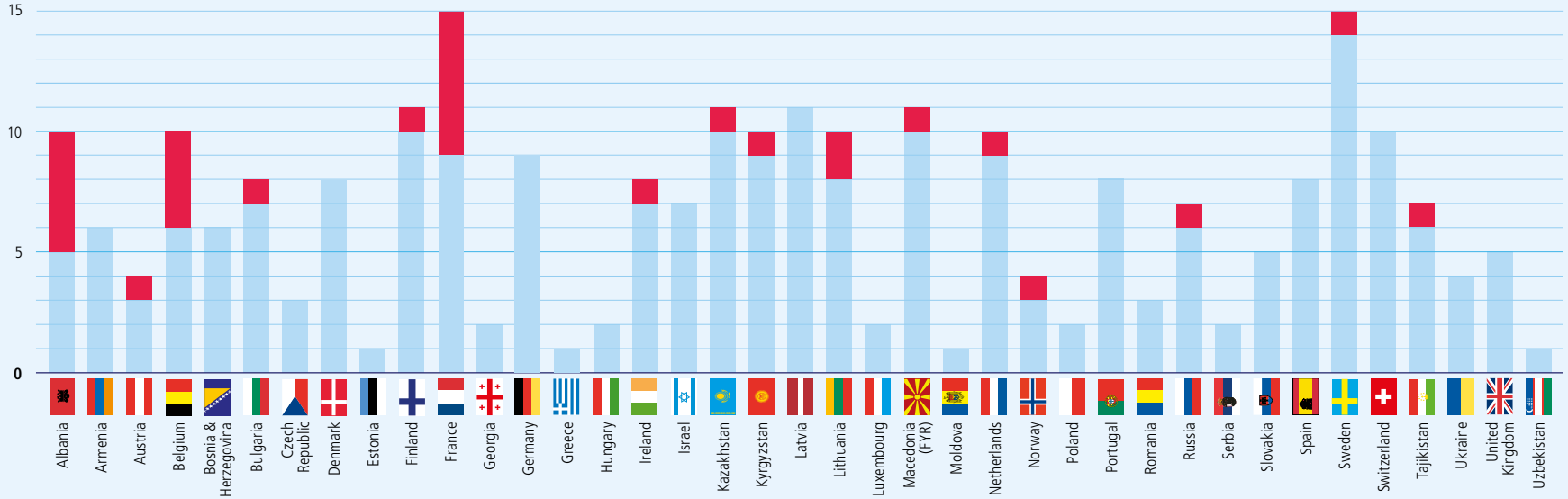
SOCIAL INCLUSION · DIVERSITY · PASSION · VOLUNTEERISM · ACCOUNTABILITY

Annex A: Number of policy and/or legislative changes, by country, 2005–2015

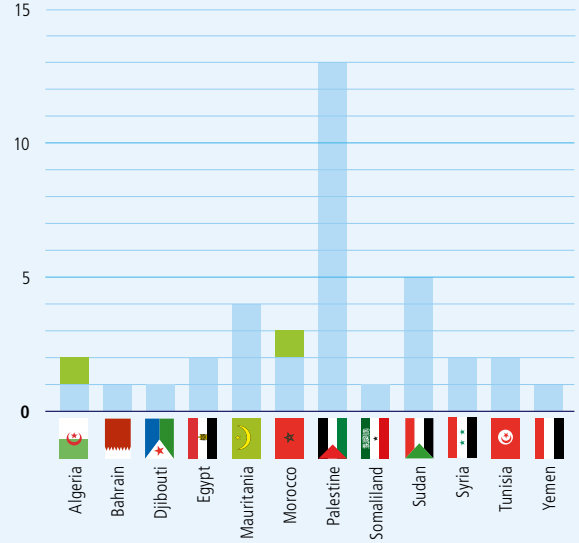
Africa



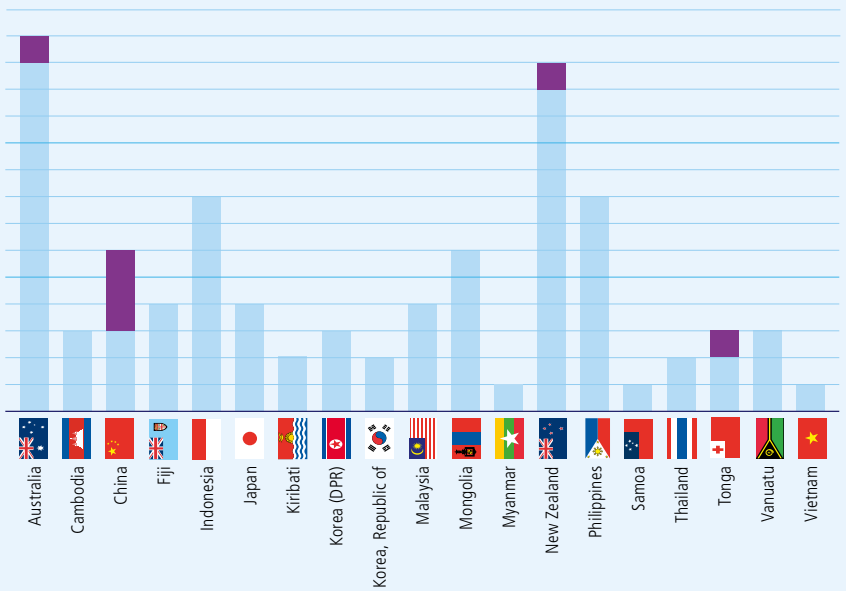
European Network



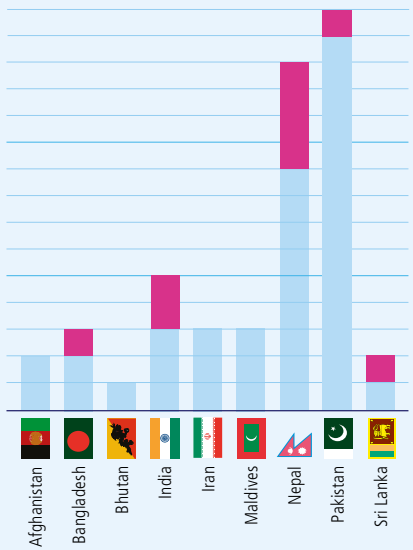
Arab World



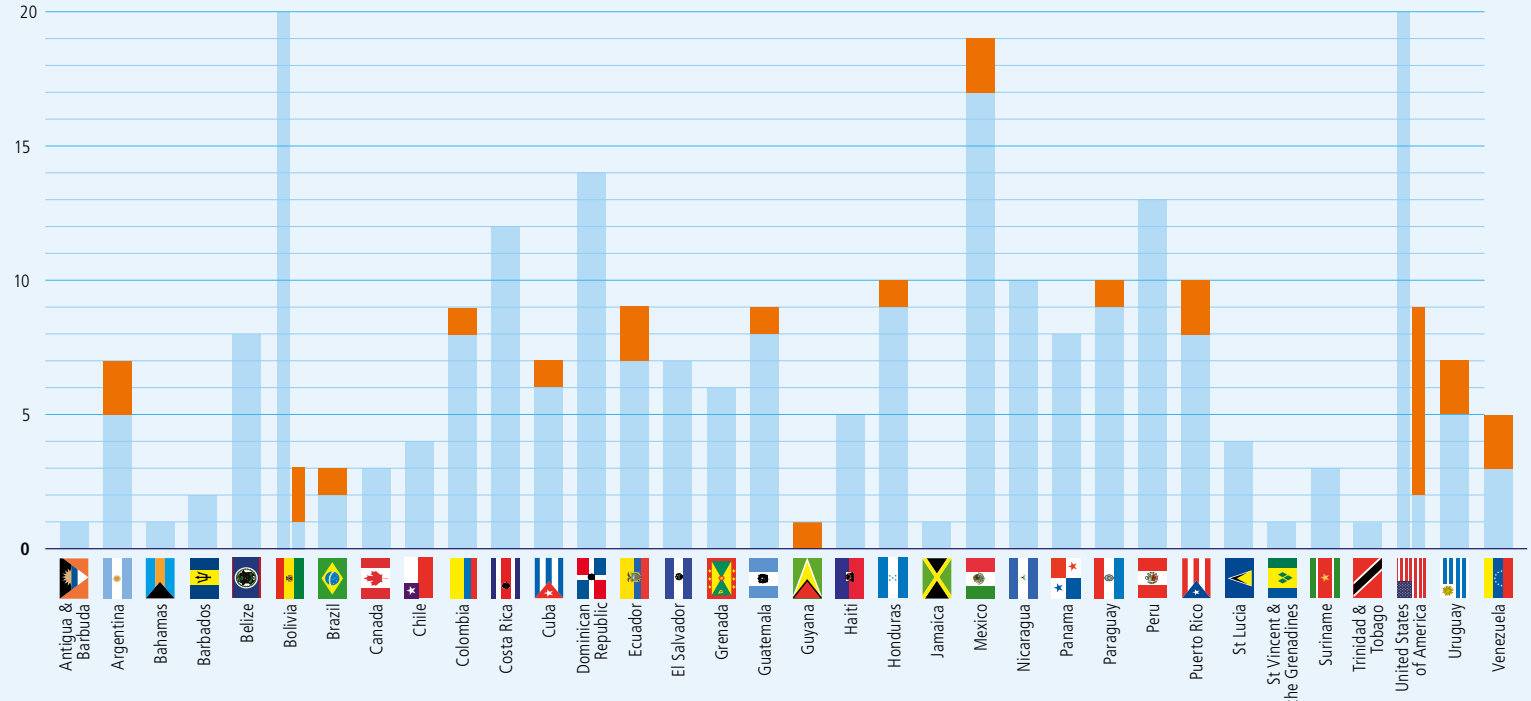
East and South East Asia and Oceania



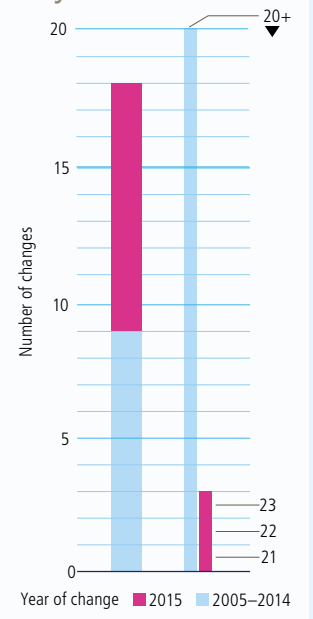
South Asia



Western Hemisphere



Key



Annex B: Global performance results, by region, 2010–2015

Table B.1: Online survey response rate, 2010 and 2015

IPPF region	Year	Total number of Member Associations/ collaborative partners	Number of Member Associations/ collaborative partners that responded	Response rate (per cent)
Africa	2015	40	37	93%
	2010	37	37	100%
Arab World	2015	15	14	93%
	2010	15	13	87%
European Network	2015	41	37	90%
	2010	41	41	100%
East and South East Asia and Oceania	2015	25	25	100%
	2010	22	22	100%
South Asia	2015	9	9	100%
	2010	9	9	100%
Western Hemisphere	2015	30	29	97%
	2010	29	29	100%
Total	2015	160	151	94%
	2010	153	151	99%

Table B.2: Online service statistics module response rate, 2010 and 2015

IPPF region	Year	Total number of Member Associations/ collaborative partners that provide services	Number of Member Associations/ collaborative partners that responded	Response rate (per cent)
Africa	2015	40	39	98%
	2010	37	37	100%
Arab World	2015	12	11	92%
	2010	13	9	69%
European Network	2015	22	21	95%
	2010	22	18	82%
East and South East Asia and Oceania	2015	25	25	100%
	2010	22	22	100%
South Asia	2015	9	9	100%
	2010	8	8	100%
Western Hemisphere	2015	27	27	100%
	2010	28	27	96%
Total	2015	135	132	98%
	2010	130	121	93%

Key

.. data not available

n/a not applicable

- zero

Table B.3: IPPF's performance dashboard – global performance results, 2010–2015

Indicator	2010	2011	2012	2013	2014	2015	2010-15 target	2010-15 actuals	% 2010-15 target achieved	% change 2010-15
Unite										
U.1 Number of successful policy initiatives and/or positive legislative changes in support or defence of SRHR to which Member Associations' advocacy contributed	47	116	105	97	81	**82**	**300**	**528**	**176%**	**74%**
U.2 Number of successful regional and global policy changes in support or defence of SRHR to which IPPF's advocacy contributed	5	5	11	13	18	**22**	**30**	**74**	**247%**	**340%**
U.3 Proportion of Member Associations monitoring obligations made by governments in the international human rights treaties that they have ratified	..	..	42%	55%	54%	**60%**	**61%**	**60%**	**99%**	**43%**
U.4 Inclusion of SRHR or components of SRHR in the post-2015 development framework, to which IPPF's advocacy contributed	n/a	n/a	n/a	n/a	n/a	**Yes**	**Yes**	**Yes**	**100%**	**n/a**
Deliver										
D.1 Number of SRH services provided	88.2m	89.6m	112.7m	136.7m	149.3m	**175.3m**	**723.4m**	**751.9m**	**104%**	**99%**
D.2 Number of couple years of protection	8.9m	9.1m	11.8m	12.1m	14.6m	**15.7m**	**72.9m**	**72.1m**	**99%**	**76%**
D.3 Number of SRH services provided to young people (under 25 years) (as a % of all services provided)	31.0m (35%)	37.4m (42%)	45.1m (40%)	66.2m (48%)	66.6m (45%)	**76.8m (44%)**	**328.7m (45%)**	**323.1m (43%)**	**98%**	**148%**
D.4 Number of abortion-related services provided	1.8m	1.9m	2.4m	3.0m	3.8m	**4.3m**	**20.4m**	**16.8m**	**82%**	**139%**
D.5 Number of HIV-related services provided	12.3m	15.2m	19.2m	24.7m	31.8m	**40.7m**	**119.9m**	**143.8m**	**120%**	**231%**
D.6 Estimated number of IPPF clients who are poor and vulnerable (as a % of all clients)	23.9m (72%)	24.9m (73%)	36.1m (81%)	48.8m (81%)	52.6m (85%)	**50.6m (82%)**	**199.4m (77%)**	**237.0m (80%)**	**119%**	**112%**
D.7 Proportion of Member Associations providing the Integrated Package of Essential Services	7%	14%	21%	26%	30%	**36%**	**55%**	**36%**	**65%**	**414%**
D.8 Number of young people (below 25 years of age) who completed a comprehensive sexuality education programme delivered by Member Association staff	..	4.4m	18.2m	25.1m	25.2m	**25.7m**	**87.4m**	**98.6m**	**113%**	**484%**
Perform										
P.1 Total IPPF income (unrestricted and restricted), raised by the Secretariat (US$)	124.2m	127.6m	144.8m	136.1m	126.1m	**116.2m**	**824.4m**	**775.0m**	**94%**	**-6%**
P.2 Total Member Association income (minus IPPF income), supported by the Secretariat (US$)	289.9m	324.3m	372.1m	384.1m	370.3m	**358.8m**	**2.2b**	**2.1b**	**93%**	**24%**
P.3 Proportion of IPPF's unrestricted funding used to reward Member Associations through a performance-based funding system	..	1%	6%	7%	9%	**9%**	**10%**	**9%**	**90%**	**800%**
P.4 Proportion of Member Associations using SRH service costing data from static clinics	..	..	13%	27%	28%	**31%**	**30%**	**31%**	**103%**	**138%**
P.5 Number of Member Associations collecting client data on poverty and vulnerability status (using the IPPF Vulnerability Assessment methodology)	..	1	10	20	31	**41**	**45**	**41**	**91%**	**4,000%**
P.6 Proportion of Member Associations that have 20 per cent or more young people under 25 years of age on their governing body	57%	58%	58%	63%	73%	**70%**	**100%**	**70%**	**70%**	**23%**

Dashboard indicator colour key

≥98% OF TARGET REACHED | 80% TO 97% OF TARGET REACHED | <80% OF TARGET REACHED

Table B.4: Change Goal UNITE – performance results, by region, 2010–2015

Indicator	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
U.1 Number of successful policy initiatives and/or positive legislative changes in support or defence of SRHR to which Member Associations' advocacy contributed	**2015**	**8**	**2**	**29**	**6**	**9**	**28**	**82**
	2014	8	8	22	6	8	29	81
	2010	9	2	12	8	2	14	47
U.2 Number of successful regional and global policy changes in support or defence of SRHR to which IPPF's advocacy contributed	**2015**	**0**	**0**	**10**	**0**	**0**	**3**	**22***
	2014	5	0	2	1	1	3	18†
	2010	..	..	..	..	..	..	5‡
U.3 Proportion of Member Associations monitoring obligations made by governments in the international human rights treaties that they have ratified	**2015**	**62%**	**29%**	**68%**	**44%**	**56%**	**79%**	**60%**
	2014	51%	21%	67%	46%	56%	63%	54%
	2012≠	62%	29%	49%	12%	22%	48%	42%
U.4 Inclusion of SRHR or components of SRHR in the post-2015 development framework to which IPPF's advocacy contributed	**2015**	[Applies only to 2015 and not applicable by regional breakdown]						**Yes**

* Includes nine global advocacy successes

† Includes six global advocacy successes

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

≠ Baseline data available from 2012

Table B.5: Change Goal DELIVER – performance results, by region, 2010–2015

Indicator	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
D.1 Number of SRH services provided	**2015**	**84,706,146**	**10,370,376**	**1,450,720**	**19,874,035**	**26,067,304**	**32,829,861**	**175,298,442**
	2014	68,440,043	7,033,947	1,441,574	17,865,237	25,748,477	28,751,235	149,280,513
	2010	29,968,031	1,930,746	1,506,577	9,493,922	14,664,943	30,668,160	88,232,379
D.2 Number of couple years of protection	**2015**	**5,044,940**	**373,720**	**52,128**	**843,789**	**2,719,323**	**6,676,457**	**15,710,357**
	2014	4,782,919	325,161	41,359	708,758	2,927,656	5,770,382	14,556,235
	2010	1,102,342	269,789	36,136	834,726	1,903,573	4,781,999	8,928,565
D.3 Number of SRH services provided to young people (under 25 years) (as a % of all services provided)	**2015**	**39,819,484 (47%)**	**5,044,437 (49%)**	**759,457 (52%)**	**8,100,156 (41%)**	**11,160,274 (43%)**	**11,902,346 (36%)**	**76,786,154 (44%)**
	2014	31,528,229 (46%)	3,296,049 (47%)	820,190 (56%)	8,537,572 (48%)	11,292,624 (44%)	11,090,263 (39%)	66,564,927 (45%)
	2010	11,317,560 (38%)	424,714 (22%)	779,239 (52%)	2,382,796 (33%)	6,882,495 (47%)	9,214,640 (30%)	31,001,444 (35%)
D.4 Number of abortion-related services provided	**2015**	**1,423,874**	**179,052**	**120,266**	**270,073**	**492,322**	**1,778,311**	**4,263,898**
	2014	1,234,460	130,814	128,333	408,147	468,291	1,409,838	3,779,883
	2010	165,161	40,149	101,806	169,098	500,816	793,869	1,770,899
D.5 Number of HIV-related services provided	**2015**	**21,715,167**	**2,017,486**	**370,235**	**2,721,775**	**5,464,121**	**8,442,838**	**40,731,622**
	2014	16,966,369	1,248,493	363,533	2,909,875	4,103,844	6,165,919	31,758,033
	2010	3,786,620	283,963	203,939	1,380,321	1,587,416	5,048,516	12,290,775
D.6 Estimated number of IPPF clients who are poor and vulnerable (as a % of all clients)	**2015**	**29,911,487 (88%)**	**3,256,690 (86%)**	**311,300 (35%)**	**7,596,887 (74%)**	**4,878,921 (78%)**	**4,608,827 (66%)**	**50,564,112 (82%)**
	2014	27,130,781 (91%)	2,613,076 (86%)	1,463,017 (57%)	7,814,164 (80%)	8,226,905 (88%)	5,334,712 (74%)	52,582,655 (85%)
	2010	4,640,396 (73%)	347,441 (49%)	478,508 (30%)	6,894,071 (77%)	5,780,588 (82%)	5,746,949 (68%)	23,887,953 (72%)
D.7 Proportion of Member Associations providing the Integrated Package of Essential Services*	**2015**	**26%**	**64%**	**n/a†**	**13%**	**56%**	**54%**	**36%**
	2014	26%	50%	n/a†	4%	56%	43%	30%
	2010	5%	0%	n/a†	4%	13%	15%	7%
D.8 Number of young people who completed a comprehensive sexuality education programme delivered by Member Association volunteers and staff	**2015**	**627,757**	**1,525**	**16,345**	**24,432,920**	**348,030**	**260,482**	**25,687,059**
	2014	591,554	1,043	473,997	22,381,707	212,849	1,573,019	25,234,169
	2011≠	218,454	6,366	473,634	2,444,751	143,843	1,161,261	4,448,309

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

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

≠ Baseline data available from 2011

Table B.6: Change Goal PERFORM – performance results, by region, 2010–2015

Indicator	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
P.1 Total IPPF income (unrestricted and restricted), raised by the Secretariat, in US$ millions	**2015**							**116.2**
	2014			[Not applicable by regional breakdown]*				126.1
	2010							124.2
P.2 Total Member Association income (minus IPPF income), supported by the Secretariat, in US$ millions	**2015**	**55.6**	**4.9**	**2.3**	**137.0**	**18.6**	**140.3**	**358.8**
	2014	60.4	4.6	4.1	127.9	18.1	155.2	370.3
	2010	34.3	4.4	4.6	88.5	14.3	143.8	289.9
P.3 Proportion of IPPF's unrestricted funding used to reward Member Associations through a performance-based funding system	**2015**	**10%**	**0%**	**10%**	**10%**	**10%**	**10%**	**9%**
	2014	10%	0%	10%	10%	10%	10%	9%
	2011†	0.3%	0%	0%	0.2%	0%	5%	1%
P.4 Proportion of Member Associations using SRH service costing data from static clinics	**2015**	**35%**	**21%**	**3%**	**26%**	**67%**	**36%**	**31%**
	2014	21%	33%	0%	20%	67%	38%	28%
	2012‡	15%	0%	0%	8%	56%	7%	10%
P.5 Number of Member Associations collecting client data on poverty and vulnerability status (using the IPPF Vulnerability Assessment methodology)	**2015**	**19**	**3**	**0**	**7**	**6**	**6**	**41**
	2014	13	3	0	4	5	6	31
	2011†	0	0	0	0	0	0	1
P.6 Proportion of Member Associations that have 20 per cent or more young people under 25 years of age on their governing body	**2015**	**84%**	**86%**	**62%**	**72%**	**100%**	**45%**	**70%**
	2014	90%	79%	69%	65%	89%	52%	73%
	2010	73%	39%	42%	59%	44%	69%	57%

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

† Baseline data available from 2011

‡ Baseline data available from 2012

Table B.7: Number of couple years of protection provided, by region, by method, 2010–2015

Type of method	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Intrauterine devices	2015	565,290	233,162	29,383	222,020	1,024,635	2,541,309	4,615,798
	2014	443,255	242,124	23,443	242,058	960,374	1,791,135	3,702,389
	2010	236,998	235,258	9,531	213,573	443,213	1,604,423	2,742,996
Implants	2015	1,386,194	46,536	6,938	39,288	94,304	1,102,811	2,676,070
	2014	1,296,345	21,833	544	54,394	109,188	909,864	2,392,168
	2010	133,076	385	3,477	16,610	13,911	197,905	365,364
Injectables	2015	1,169,831	24,955	41	52,770	241,689	731,227	2,220,514
	2014	891,297	13,050	628	54,353	258,008	653,649	1,870,985
	2010	289,276	7,271	46	75,021	171,968	428,810	972,392
Oral contraceptive pills	2015	928,312	51,731	3,316	94,944	407,336	616,740	2,102,378
	2014	1,399,568	33,683	5,249	60,177	427,103	743,339	2,669,119
	2010	156,677	20,214	2,191	125,498	370,609	545,658	1,220,847
Voluntary surgical contraception (vasectomy and tubal ligation)	2015	204,720	-	290	19,110	563,230	1,242,130	2,029,480
	2014	67,230	-	290	76,060	738,398	1,193,420	2,075,398
	2010	13,210	-	3,760	33,220	530,833	1,258,620	1,839,643
Condoms	2015	783,165	17,135	11,609	414,100	288,545	315,079	1,829,633
	2014	677,083	12,869	10,499	219,611	345,589	294,829	1,560,481
	2010	261,970	5,247	15,613	368,052	311,215	622,026	1,584,123
Emergency contraception	2015	6,775	115	418	1,308	99,585	75,108	183,310
	2014	6,915	509	513	1,162	88,997	90,688	188,783
	2010	1,303	391	86	1,287	61,825	122,960	187,852
Other hormonal methods	2015	3	-	70	32	-	49,652	49,756
	2014	109	-	96	58	-	70,458	70,721
	2010	15	-	-	90	-	689	794
Other barrier methods	2015	651	86	65	217	-	2,400	3,420
	2014	1,116	1,092	98	884	-	23,000	26,191
	2010	9,816	1,022	1,434	1,375	-	907	14,554
Total	2015	5,044,940	373,720	52,128	843,789	2,719,323	6,676,457	15,710,357
	2014	4,782,919	325,161	41,359	708,758	2,927,656	5,770,382	14,556,235
	2010	1,102,341	269,788	36,138	834,726	1,903,574	4,781,998	8,928,565
Number of responses	2015	(n=39)	(n=10)	(n=15)	(n=25)	(n=8)	(n=27)	(n=124)
	2014	(n=38)	(n=10)	(n=20)	(n=24)	(n=9)	(n=26)	(n=127)
	2010	(n=37)	(n=9)	(n=18)	(n=22)	(n=8)	(n=27)	(n=121)

Table B.8: Number of sexual and reproductive health services provided, by region, by service type, 2010–2015

Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Contraceptive (including counselling)	**2015**	**40,632,473**	**1,893,329**	**359,297**	**8,687,553**	**8,708,620**	**9,358,847**	**69,640,119**
	2014	33,077,706	1,059,860	366,073	6,794,082	10,093,135	8,879,481	60,270,337
	2010	16,817,092	634,570	324,929	4,621,885	7,909,074	13,506,032	43,813,582
STI/RTI	**2015**	**8,598,420**	**975,789**	**253,294**	**1,990,826**	**3,088,491**	**7,251,013**	**22,157,833**
	2014	6,153,417	612,330	223,126	1,984,749	2,034,447	5,102,624	16,110,693
	2010	444,918	111,195	74,734	741,253	756,790	3,924,661	6,053,551
Gynaecological	**2015**	**7,394,693**	**2,042,852**	**140,644**	**1,266,732**	**2,807,325**	**8,501,638**	**22,153,884**
	2014	5,705,374	1,539,829	144,073	1,538,828	2,923,278	7,558,157	19,409,539
	2010	450,223	381,383	88,872	1,115,931	900,651	7,023,958	9,961,018
HIV and AIDS (excluding STI/RTI)	**2015**	**13,116,747**	**1,041,697**	**116,941**	**730,949**	**2,375,630**	**1,191,825**	**18,573,789**
	2014	10,812,952	636,163	140,407	925,126	2,069,397	1,063,295	15,647,340
	2010	3,341,702	172,768	129,205	639,068	830,626	1,123,855	6,237,224
Obstetric	**2015**	**4,267,894**	**1,919,597**	**30,492**	**726,868**	**4,066,729**	**2,180,245**	**13,191,825**
	2014	3,297,813	1,748,052	40,089	869,957	3,953,816	2,251,975	12,161,702
	2010	770,240	289,563	19,428	810,009	1,450,436	2,836,314	6,175,990
Paediatric	**2015**	**2,311,087**	**1,359,361**	**521**	**3,378,442**	**1,937,906**	**524,407**	**9,511,724**
	2014	2,069,909	687,164	1,152	3,093,629	1,848,229	496,585	8,196,668
	2010	261,267	35,891	230	77,559	856,439	277,427	1,508,813
Specialized counselling	**2015**	**2,583,881**	**435,522**	**404,208**	**1,148,224**	**1,014,793**	**966,099**	**6,552,727**
	2014	1,526,113	401,584	382,703	1,449,818	757,900	1,098,244	5,616,362
	2010	3,082,671	223,702	753,106	914,430	867,061	802,455	6,643,425
SRH medical	**2015**	**3,303,687**	**206,733**	**4,078**	**1,581,179**	**894,634**	**397,358**	**6,387,669**
	2014	3,798,828	64,501	6,366	687,815	1,245,149	421,095	6,223,754
	2010	4,561,180	28,891	10,208	336,304	497,681	106,808	5,541,072
Abortion-related	**2015**	**1,423,874**	**179,052**	**120,266**	**270,073**	**492,322**	**1,778,311**	**4,263,898**
	2014	1,234,460	130,814	128,333	408,147	468,291	1,409,838	3,779,883
	2010	165,161	40,149	101,806	169,098	500,816	793,869	1,770,899
Urological	**2015**	**456,414**	**181,924**	**1,275**	**40,891**	**424,903**	**400,572**	**1,505,979**
	2014	184,000	69,377	1,942	38,798	199,541	391,216	884,874
	2010	64,207	10,186	3,857	37,015	92,775	51,073	259,113
Infertility	**2015**	**616,976**	**134,520**	**19,704**	**52,298**	**255,951**	**279,546**	**1,358,995**
	2014	579,471	84,273	7,310	74,288	155,294	78,725	979,361
	2010	9,370	2,448	202	31,370	2,594	221,708	267,692
Total	**2015**	**84,706,146**	**10,370,376**	**1,450,720**	**19,874,035**	**26,067,304**	**32,829,861**	**175,298,442**
	2014	68,440,043	7,033,947	1,441,574	17,865,237	25,748,477	28,751,235	149,280,513
	2010	29,968,031	1,930,746	1,506,577	9,493,922	14,664,943	30,668,160	88,232,379
Number of responses	**2015**	**(n=39)**	**(n=11)**	**(n=21)**	**(n=25)**	**(n=9)**	**(n=27)**	**(n=132)**
	2014	(n=38)	(n=11)	(n=21)	(n=25)	(n=9)	(n=27)	(n=131)
	2010	(n=37)	(n=9)	(n=18)	(n=22)	(n=8)	(n=27)	(n=121)

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

1 Counselling

A: Sex and sexuality counselling

or

B: Relationship counselling

2 Contraception

A: Counselling

and

B: Oral contraceptive pills

and

C: Condoms

and

D: Injectables

and

E: At least one long-acting and reversible contraceptive: intrauterine device/system OR implants

and

F: At least one emergency contraceptive method

3 Safe abortion care

A: Pre- and post-abortion counselling

and

B: At least one of:

surgical abortion

or

medical abortion

or

incomplete abortion treatment

4 STIs/RTIs

A: At least one STI/RTI treatment method

or

B: At least one STI/RTI lab test

5 HIV

A: Pre- and/or post-test counselling

and

B: HIV lab tests

6 Gynaecology

A: Manual pelvic examination (auto-qualify if provides Pap smear)

and

B: Manual breast examination

and

C: Pap smear OR other cervical cancer screening method

7 Obstetrics

A: Confirmation of pregnancy

and

B: Prenatal care

8 Gender-based violence

A: Screening for gender-based violence

and

B: Referral mechanisms for clinical, psychosocial and protection services

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Key abbreviations

AAPF	Association Algérienne pour la Planification Familiale
ADS	Asociación Demográfica Salvadoreña
AIDS	Acquired immune deficiency syndrome
AMPF	Association Marocaine de Planification Familiale
AR	Africa region, IPPF
ASEAN	Association of Southeast Asian Nations
ASTBEF	Association Tchadienne pour le Bien-Etre Familial
AWR	Arab World region, IPPF
CYP	Couple years of protection
EN	European Network, IPPF
ESEAOR	East and South East Asia and Oceania region, IPPF
FLAS	Family Life Association of Swaziland
FPA India	Family Planning Association of India
FPAN	Family Planning Association of Nepal
FPOP	Family Planning Organization of the Philippines
HIV	Human immunodeficiency virus
IPPF	International Planned Parenthood Federation
MCH	Maternal and child health
MISP	Minimum Initial Service Package
Rahnuma-FPAP	Rahnuma-Family Planning Association of Pakistan
RHAK	Reproductive Health Alliance Kyrgyzstan
RTI	Reproductive tract infection
SAR	South Asia region, IPPF
SPRINT	Sexual and Reproductive Health Programme in Crisis and Post-crisis Situations
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TFPA	Tajikistan Family Planning Association
WHR	Western Hemisphere region, IPPF

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Published in June 2016 by the International Planned Parenthood Federation

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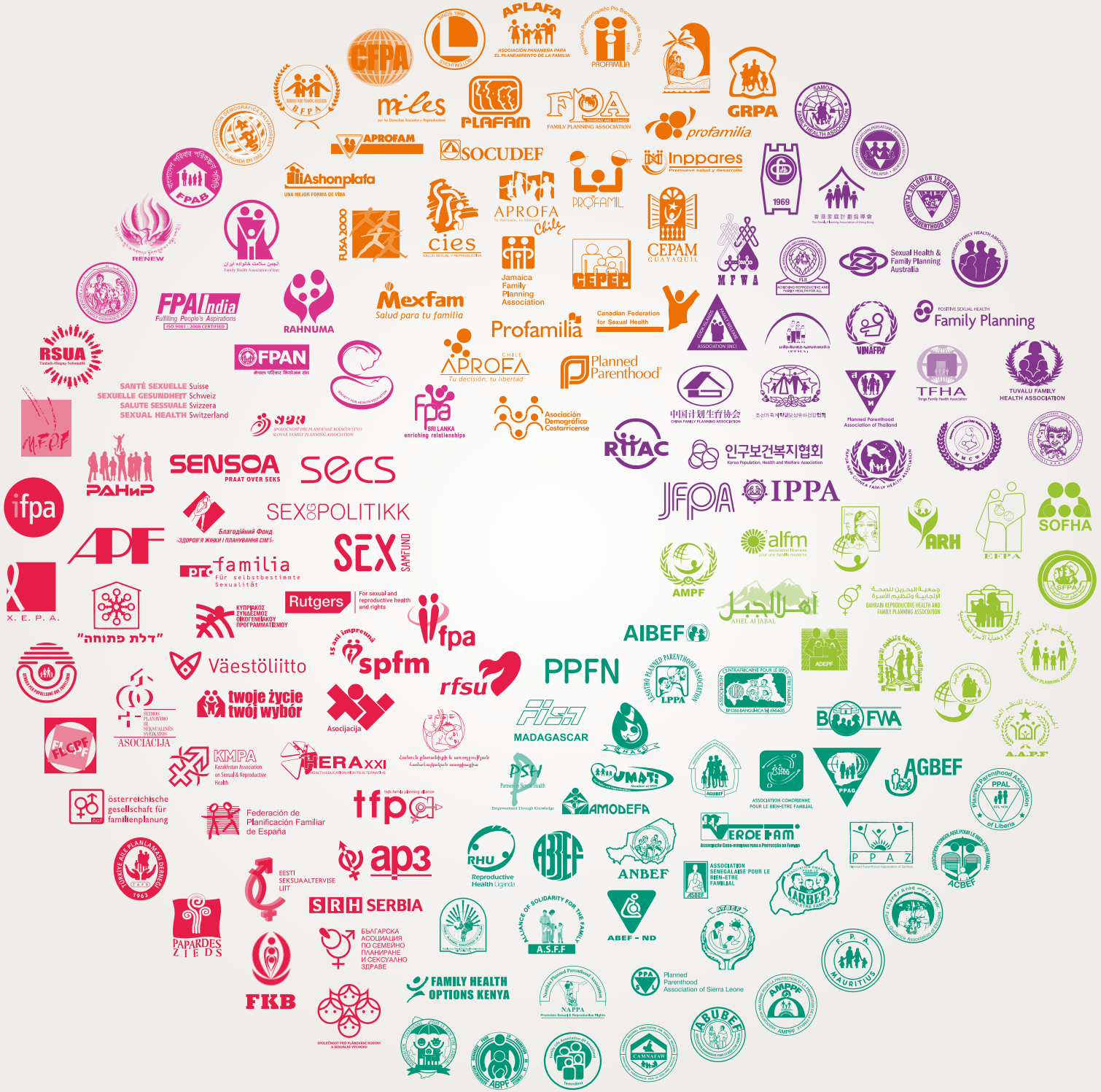
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Ashonplafa
UNA MEJOR FORMA DE VIDA
APROFA
Chile
PROFAMIL
cies
CEPAM
GUAYAQUIL
CEPEP
Jamaica Family Planning Association
MFWA
Sexual Health & Family Planning Australia
RENEW
RUSA 2000
FPA India
Fulfilling People's Aspirations
ISO 9001 : 2008 CERTIFIED
RAHNUMA
Mexfam
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Profamilia
Canadian Federation for Sexual Health
RSUA
FPAN
APROFA
Tu decisión, tu libertad
Planned Parenthood
SANTÉ SEXUELLE Suisse
SEXUELLE GESUNDHEIT Schweiz
SALUTE SESSUALE Svizzera
SEXUAL HEALTH Switzerland
SPR
SPOLOČNOSŤ PRE PLÁNOVANÉ RODIČOVSTVO
SLOVAK FAMILY PLANNING ASSOCIATION
fpa
SRI LANKA
enriching relationships
Asociación Demográfica Costarricense
中国计划生育协会
CHINA FAMILY PLANNING ASSOCIATION
RHAC
인구보건복지협회
Korea Population, Health and Welfare Association
Planned Parenthood Association of Thailand
VNAFPW
Family Planning
TFHA
TUVALU FAMILY HEALTH ASSOCIATION
РАНиР
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«ЗДОРОВ'Я ЖІНКИ І ПЛАНУВАННЯ СІМ'Ї»
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Für selbstbestimmte Sexualität
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ΚΥΠΡΙΑΚΟΣ ΣΥΝΔΕΣΜΟΣ ΟΙΚΟΓΕΝΕΙΑΚΟΥ ΠΡΟΓΡΑΜΜΑΤΙΣΜΟΥ
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AHEL AIJABAL
جمعية البحرين للصحة الانجابية وتنظيم الاسرة
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AIBEF
Is ami impreuna
spfm
Väestöliitto
rfsu
PPFN
twoje życie twój wybór
Asocjacja
LPPA
CENTRAFRICAINE POUR LE BIEN-ETRE FAMILIAL
ADEPF
BFWA
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FLCPF
SEKSUALINIS SVEIKATOS ASOCIACIJA
Fisa
MADAGASCAR
KMPA
Kazakhstan Association on Sexual & Reproductive Health
HERAXXI
HEALTH EDUCATION RIGHTS ALTERNATIVE
UMATI
AMODEFA
AGBEF
PPAG
ASSOCIATION COMORIENNE POUR LE BIEN-ETRE FAMILIAL
Planned Parenthood Association of Liberia
österreichische gesellschaft für familienplanung
Federación de Planificación Familiar de España
tfp
VEROFAM
Associação Cabo-verdiana para a Promoção da Família
PPAZ
ACBEF
EESTI SEKSUAALTERVISE LIIT
ap3
RHU
Reproductive Health Uganda
ABFF
ANBEF
ASSOCIATION SENEGALAISE POUR LE BIEN-ETRE FAMILIAL
ARBEF
SRH SERBIA
PAPARDES ZIEDS
БЪЛГАРСКА АСОЦИАЦИЯ ПО СЕМЕЙНО ПЛАНИРАНЕ И СЕКСУАЛНО ЗДРАВЕ
ALLIANCE OF SOLIDARITY FOR THE FAMILY
A.S.F.F
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