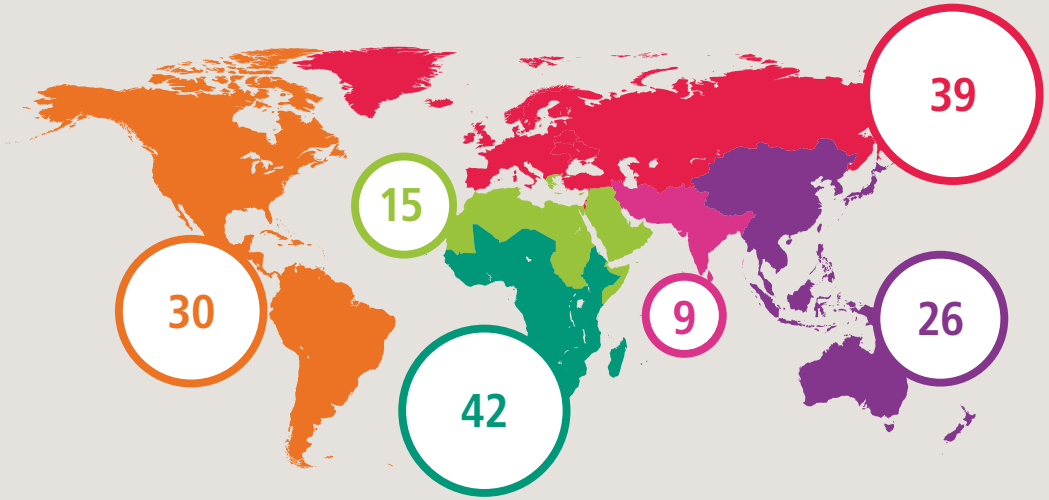
IPPF

From choice, a world of possibilities

Annual Performance Report 2013–2014

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.



161 Member Associations and collaborative partners

Millions of volunteers

33,000+ staff

87% of Member Associations have a written HIV workplace policy on non-discrimination

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

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

Acknowledgements

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

Editorial

Heidi Gagnebe-Marriott
Catherine Kilfedder

Data analysis

James Newton
Mahua Sen

Design and production

Brooke Boyanton
Laura Feeney
Yasmin Khan

IPPF's results in 2013*

164m condoms distributed

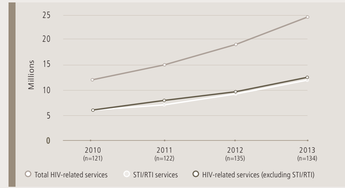
11% Condoms

60.1m people received services from IPPF

8 out of 10 people we serve are poor and vulnerable

Young people | People who use drugs | Sex workers | People living with HIV | Displaced populations | Sexually diverse groups | Men who have sex with men | Survivors of gender-based violence | People with disabilities

48% of our services are provided to young people under 25 years old



24.8m HIV-related (including STIs)

5.0m unintended pregnancies averted†

580,000 unsafe abortions averted†

12.1m Couple years of protection†

17% Oral contraceptive pill

13% Injectables

3% Others

44% of CYP from short-acting methods

56% of CYP from long-acting and permanent methods

0 Per cent 10 20 30 40 50

28% Intrauterine devices

17% Voluntary surgical contraception (vasectomy and tubal ligation)

12% Implants

59.9m contraceptive services provided

136.6m sexual and reproductive health services provided

76.8m non-contraceptive services provided

0.7m Infertility

3.0m Abortion related

6.7m Specialized counselling

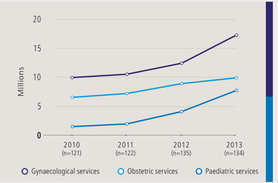
0.6m Urological

6.1m SRH medical

0 Millions 10 20 30 40 50 60 70

17.3m Gynaecological

17.7m Maternal and child health



Advocacy successes, by theme

66 Member Associations contributed to

97 policy and/or legal changes in support or defence of sexual and reproductive health and rights

25 Education and services for young people

17 Access to safe and legal abortion

13 Promoting sexual and reproductive rights

12 Access to contraception

11 Prevention of sexual and gender-based violence

07 National budget allocations for SRH, including contraception

07 Support for people living with HIV

05 SRHR of vulnerable populations

Location of our 60,227 service delivery points

41% Urban

59% Peri-urban and rural

* Due to rounding, numbers presented throughout this document may not add up precisely to the totals provided and percentages may not precisely reflect the absolute figures.

† Couple years of protection refers to the total number of years of contraceptive protection provided to a couple. The numbers of unintended pregnancies and unsafe abortions averted are estimated using Marie Stopes International's Impact 2 model.

Contents

Foreword

2013 was our second year implementing IPPF's three Change Goals – Unite, Deliver and Perform. We have monitored the trajectory of our growth in performance to date, and are already seeing remarkable success in all three areas.

Our Change Goals help us to prioritize our work in delivering the Strategic Framework 2005–2015, and ultimately, to maximize impact for those people with the greatest unmet need for sexual and reproductive health and rights. Our Performance Dashboard of indicators closely monitors our progress, and the results from 2013 are presented in this report. I am delighted to inform you that we have surpassed the majority of our targets to date.

Throughout 2013, IPPF saw great success in influencing governments and other key decision makers at national, regional and global levels to promote and defend sexual and reproductive health and rights. Member Associations in 66 countries contributed to 97 changes in policy or legislation that support or defend sexual and reproductive health and rights. At the regional and global levels, IPPF's advocacy contributed to 13 changes, of which 10 were advances in safeguarding sexual and reproductive health and rights in the post-2015 development framework.

In the 20th year of the International Conference on Population and Development (ICPD), IPPF mobilized civil society at regional and global levels. Member Associations and other partners worked together to identify future priorities for the implementation of the ICPD Programme of Action, to harness political commitment, and to secure a place for sexual and reproductive health and rights in the post-2015 development framework, supported by IPPF's Vision 2020.

We have set ourselves an ambitious target to double the number of sexual and reproductive health services provided between 2010 and 2015, and trebling by 2020. With the delivery of 136.6 million services in 2013, I am pleased to report that we surpassed the annual target by 10.8 million services. Also, for the first time ever, almost half of our sexual and reproductive health services were provided to young people. Our commitment to serving those who are most in need of sexual and reproductive health information and services is confirmed with an estimated 48.8 million of our clients being poor or vulnerable, representing 81 per cent of our total clientele. The 12.1 million couple years of protection that IPPF provided in 2013 averted 5.0 million unintended pregnancies and 580,000 unsafe abortions. Throughout this report, examples from Member Associations illlustrate how we are increasing our performance in service provision while remaining committed to the under-served. Employing a diverse range of strategies and working with other public and private partners and health facilities are proving to be effective ways to reach more people than ever with quality services.

IPPF is committed to a performance culture and to maintaining a triangle of mutual accountability for the promises we have made – to ourselves, to our donors and partners, and to public citizens around the world. In 2013, we invested heavily in improving data quality, particularly in terms of service statistics and costing data, and we continued to implement data-driven decision making as a systematic and institutional approach across all levels of the Federation. Organizational learning is also a key strength and opportunity for IPPF with 2013 seeing an increased commitment to supporting capacity building, learning and sharing opportunities between Member Associations, as highlighted by a number of examples in this report.

The process of developing IPPF's next Strategic Framework (2016–2022) has involved extensive consultation and reflection in 2013 and 2014. Review of past performance, as well as future challenges to be faced and opportunities to be embraced, have been taken into account throughout the development process and in identifying what our future vision, mission, values and focused priorities will be. We are expecting the Strategic Framework to be finalized in November 2014, followed by revision of country strategies and updating internal systems in preparation for full implementation from January 2016.

Thank you, as ever, to the IPPF volunteers and staff, and our partners around the world for your commitment and support. Moving forward, we will continue our unified efforts to enable the provision of sexual and reproductive health services to the most under-served, and to encourage decision makers to prioritize sexual and reproductive health and rights as a key component in the next development agenda.

Tewodros Melesse, Director-General, IPPF

> People should have the right to decide who they live with; what happens to their bodies; if, when and how many children to have; and the right to determine their futures freely and safe from harm. IPPF works on these issues every day.
>
> Tewodros Melesse

IPPF/Peter Caton/Bangladesh

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

IPPF convenes civil society and influences national governments and international decision makers to support and promote sexual and reproductive health and rights. Our 2013 progress illustrates our dedication to and leadership of the global movement for sexual and reproductive health and rights.

In 2013, IPPF continued resolutely in its role as the leading global advocate for sexual and reproductive health and rights. IPPF encourages governments and other key decision makers at national, regional and global levels to promote sexual and reproductive health and rights, to change policies and laws, and to fund programmes and service delivery. IPPF's 2013 advocacy performance against targets is presented in Figure 1. Two Unite indicators surpassed their targets. Member Associations' advocacy efforts contributed to 97 changes in policy and/or legislation in support or defence of sexual and reproductive health and rights. This is nearly double the target of 50 and demonstrates the tireless efforts of the Member Associations that contributed to the changes.

Recognizing the importance of a supportive legal environment for meeting the unmet need for contraception of 220 million women,[1] Member Associations contributed to 17 changes that promote access to contraception or relate to national budget allocations for contraception (Figure 2). Of these, five were directly related to commitments that African governments made to the Family Planning 2020 global partnership.

IPPF works on controversial issues that others avoid, often advocating on behalf of those who are most marginalized. In 2013, five of the legislative and policy changes were specifically related to vulnerable and under-served groups, including sex workers, rural populations and transgender people.

Figure 1: Unite – performance results in 2013

Member Associations have continued to resist opposition, challenging those that attempt to bring about legislative or policy changes that would be harmful to sexual and reproductive health and rights. In 2013, Member Associations helped block eight changes that would have negatively impacted on sexual and reproductive health, five of which were related to abortion in Europe.

To secure a place in the post-2015 development framework, a large part of IPPF's regional and global advocacy focuses on positioning sexual and reproductive health and rights in fora such as the Commission on Population and Development. IPPF's advocacy contributed to 13 global and/or regional policy initiatives or legislative changes in 2013 in support of sexual and reproductive health, more than doubling the target of five. Of these, 10 involved advances in safeguarding sexual and reproductive health and rights in the post-2015 development framework.

In 2013, 55 per cent of Member Associations monitored the obligations by governments made in the international human rights treaties that they have ratified. This increase from 42 per cent in 2012 is encouraging and a testament to Member Associations' willingness to hold their governments to account for promises they have made in relation to human rights. This indicator was new in 2012, and with two years of data, targets have now been set to monitor progress for 2014 and 2015 (Annex B, Table B.3).

The following section presents regional and global advocacy successes, including examples of where IPPF is making progress in helping shape the post-2015 development agenda. It also highlights some of the advocacy work that Member Associations are doing to bring about change in policy and legislation in support or defence of sexual and reproductive health and rights.

Figure 2: Number of policy and/or legislative changes, by theme, 2013

25 Education and services for young people

17 Access to safe and legal abortion

13 Promoting sexual and reproductive rights

12 Access to contraception

11 Prevention of sexual and gender-based violence

07 National budget allocations for SRH, including contraception

07 Support for people living with HIV

05 SRHR of vulnerable populations

In 2013, Member Associations contributed to 97 policy and/or legislative changes in support of sexual and reproductive health and rights in **66** countries

Uniting regionally and globally

The primary focus of IPPF's advocacy at regional and global levels has been to ensure that governments and international agencies demand that sexual and reproductive health and rights are included in the post-2015 development framework.

Advocating at the United Nations

During the 47th Session of the Commission on Population and Development in April 2014, governments from around the world committed to a historic level of support for sexual and reproductive health and reproductive rights, reinforcing the International Conference on Population and Development's (ICPD) Programme of Action and in anticipation of the forthcoming post-2015 development framework. In advance of the event, Member Associations worked with their governments to develop strong and progressive country statements and to have civil society representation on their national delegations. The IPPF Secretariat supported this national advocacy by sharing key messages and intelligence, drafting sample advocacy letters, and preparing briefing materials on how to engage in the process.

IPPF's presence was the largest ever, with 156 volunteers and staff from Member Associations and the Secretariat. Furthermore, volunteers and staff from a record number of 54 Member Associations represented civil society on their government delegations. Bringing one-third of the representation of civil society supporting sexual and reproductive health and rights, IPPF was recognized by many as the convener of civil society on these issues. IPPF held three side events and participated in a further two.

IPPF was also instrumental in organizing the sexual and reproductive health and rights Youth Caucus in collaboration with the Youth Leadership Working Group, mobilizing more than 70 young advocates who delivered statements to Member States on youth issues.

Building on momentum from the successful 2013 Asia Pacific Population Conference (page 7), IPPF supported the Pacific government delegations to participate as a strong, united and progressive voice, marking the first time that the Pacific United Nations bloc has been active in sexual and reproductive health negotiations. This group was a major contributor to the dominance of voices from the Global South during the negotiations, where they pushed for access to safe abortion, sexual and reproductive health education and services for adolescents, and recognition of sexual orientation and gender identity.

The final resolution makes a clear link between the ICPD and the post-2015 development agenda. It contains strong language related to sexual and reproductive health and rights, including addressing violence and discrimination. The resolution calls on countries to use the outcome documents of the 2013 regional conferences on population and development for regional-specific guidance for implementation. This is significant as the regional declarations are strong in terms of comprehensive sexuality education, sexual rights, adolescents and abortion.

IPPF's involvement at the 58th Commission on the Status of Women in March 2014 contributed to an outcome document that explicitly states the need for gender equality and the protection and fulfilment of the human rights of women and girls. The theme of the session was the post-2015 development agenda.

In the lead-up to the event, IPPF organized two briefing sessions for United Nations missions to advocate for the inclusion of strong language related to sexual and reproductive health and rights in the outcome document. Some of the participating missions asked IPPF to suggest language and positions, which they used during the negotiations.

IPPF organized a side event at the 58th Commission, inviting senior staff of United Nations missions and agencies, non-governmental organizations and media representatives. Key speakers included the Minister of Women's Rights from France, the Minister of Gender and Development from Liberia, and Directors from the World Bank, UNFPA and United Nations Women. At the event, IPPF spoke about Millennium Development Goal 5b (achieve universal access to reproductive health). In comparison to the other Millennium Development Goals, 5b has made the least progress to date, and the discussion focused on how the seven-year delay before including Goal 5b in the development framework hampered progress in improving maternal health. The need to include universal access to sexual and reproductive health and rights from the beginning of the next framework was emphasized to avoid repeating this mistake. During the negotiations, IPPF chaired a group that tracked Member State positions and advised on key blockages and opportunities.

> [The Commission] urges States to tackle critical remaining challenges through a transformative and comprehensive approach and calls for gender equality, the empowerment of women and the human rights of women and girls to be reflected as a stand-alone goal and to be integrated through targets and indicators into all goals of any new development framework.
>
> 58th Commission on the Status of Women outcome document, Paragraph 43[2]

The outcome document calls for a stand-alone goal on gender equality to be included in the post-2015 development agenda, as well as gender-specific targets across all other development goals. It outlines gaps in gender equality and women's empowerment that the Millennium Development Goals have not adequately addressed. These include violence against women and girls; early and forced marriage; and women's sexual and reproductive health and reproductive rights.

Influencing regional population conferences

IPPF has continued its efforts to uphold and advance the ICPD Programme of Action regionally and to promote the connection between sexual and reproductive health and rights and sustainable development. In 2013, IPPF convened civil society to engage in and influence the outcomes of regional population conferences as part of the ICPD Beyond 2014 Review. IPPF worked with a diverse range of partners to mobilize civil society around common positions for each regional population conference. The overall goal was to ensure that the unfinished business of the ICPD and emerging sexual and reproductive health and rights issues are taken forward in the future implementation of the ICPD, and are prioritized in the post-2015 development agenda. Each of the five inter-governmental conferences resulted in regional declarations that identify emerging priorities for the future implementation of ICPD. Highlights from the regional conferences are given below.

88
commitments in Africa

AFRICA

IPPF's role: Convened 100 African civil society organizations to discuss the review and make recommendations for the post-2015 development agenda

Outcome document highlight: 88 commitments that set out concrete actions and Africa's priorities on population in the post-2015 development agenda

EUROPE

IPPF's role: Convened a civil society meeting with more than 70 participants from 28 countries to analyse the conference outcomes and identify regional priorities

Outcome document highlight: Supports sexual and reproductive health and rights as essential to achieving gender equality, social justice and sustainable development

ARAB WORLD

IPPF's role: Mobilized civil society organizations and youth to successfully influence the outcomes of the population conference

Outcome document highlight: A call for the elimination of female genital mutilation, early and forced marriage, and gender-based violence

ASIA PACIFIC

IPPF's role: Mobilized Pacific Island parliamentarians around the Moana Declaration and 130 civil society organizations to support a civil society declaration on sexual and reproductive health and rights

Outcome document highlight: A call for the review and repeal of laws that criminalize abortion

THE AMERICAS AND THE CARIBBEAN

IPPF's role: Co-organized a civil society forum and supported the participation of more than 50 advocates from traditionally under-represented groups, including young people, and indigenous and Afro-descendant groups

Outcome document highlight: The first-ever inter-governmentally agreed definition of sexual rights

LOOKING FORWARD

IPPF will continue to advocate for these priorities to be reflected in government positions on the ICPD Index Report and in the post-2015 development framework.

Holding governments to account

From 2008 to 2013, IPPF implemented a five-year advocacy initiative in 11 countries in Latin America, Central Asia and Eastern Europe. The goal of the Joining Forces for Voice and Accountability Initiative (Voices) was to ensure that governments improve their sexual and reproductive health and rights policies, programmes and services, particularly for poor and vulnerable people. An external evaluation found that Voices effectively influenced decision makers and increased accountability of governments.

During the five years, 75 coalitions were created or strengthened and 1,044 individuals from civil society were trained on issues related to advocacy, sexual and reproductive health and rights, accountability and governmental and budgetary monitoring. As a result, Member Associations and civil society networks have become adept at influencing policy. In all 11 countries, governments adopted policies supporting sexual and reproductive health and rights, with a total of 111 policy changes. These achievements are particularly impressive since the countries were chosen due to their lack of prioritization of sexual and reproductive health and rights, weak political will among decision makers, and few mechanisms for civil society to hold them accountable.

As a result of the initiative, the level of knowledge and attitudes of decision makers, the general public and the media regarding sexual and reproductive health and rights have improved. Member Associations are playing an increasingly important role in the sexual and reproductive health and rights debate and are seen as leaders and experts in this field.

Voices provided the most under-served people with information, legal frameworks and effective mechanisms to exercise their rights. As a result, those who most often lack a voice were empowered and are now able to make free and informed choices about their sexual and reproductive health, and to access services.

Shaping African development

The Tokyo International Conference on African Development (TICAD) has become a major global framework for Asia and Africa to collaborate on promoting Africa's development. TICAD is organized by the government of Japan, the African Union Commission, the United Nations, the United Nations Development Programme and the World Bank.

In early 2013, IPPF participated in the fifth TICAD preparatory meeting in Addis Ababa, where we organized a petition to prioritize reproductive health in the conference outcome document. The petition was signed by 130 civil society organizations. IPPF's active participation and advocacy during the preparatory meeting resulted in ministers and delegates of five African countries requesting that reproductive health, contraception and the Maputo Plan of Action be included in the draft outcome document. Later in the year, IPPF participated in the TICAD event in Yokohama, where the IPPF Director-General submitted letters from African leaders demanding prioritization of sexual and reproductive health including contraception, as well as the signed petition, to the TICAD organizers. IPPF co-hosted a side event on contraception that was attended by more than 350 participants. The high-level panel included United Nations Population Fund Executive Director Babatunde Osotimehin, the presidents of Liberia and Malawi, and foreign ministers from Ethiopia and Japan.

The sexual and reproductive health and rights language included in the draft outcome document and discussed during the preparatory meeting remained in the final conference document. It calls for increased coverage for maternal, newborn and child health care; increased provision of reproductive health services; and prevention and treatment of HIV. This document will inform Japanese priorities in African development, and in the post-2015 development agenda.

The Safe Abortion Action Fund

Supporting the global movement to increase access to safe abortion services, IPPF hosts the Secretariat of the Safe Abortion Action Fund (SAAF). SAAF is a multi-donor fund that supports local and national non-governmental organizations, including Member Associations, in abortion-related advocacy, service delivery and research worldwide. The SAAF Secretariat is responsible for day-to-day fund management as well as coordinating technical support in proposal development and project implementation to grantees when needed.

During the second round of funding (2011–2014), SAAF supported 35 projects in 26 countries. In the area of advocacy, the SAAF grantee in Kazakhstan mobilized organizations to successfully block a proposed parliamentary bill to restrict when abortion is permitted. As part of a successful service delivery project in the Democratic Republic of Congo, the SAAF grantee provided training and support to 100 service providers who then provided post-abortion care services to 2,700 women. In the area of research, SAAF supported a Bangladeshi organization to use a study of menstrual regulation to improve service quality.

SAAF is currently in its third and largest funding round, with 110 projects in 55 countries. During the third round (2014–2017), the SAAF Secretariat will facilitate technical support to grantees to increase their organizational capacity and strengthen project implementation. Recognizing the importance of learning and knowledge sharing, SAAF has established a virtual community for current and former grantees. It hosts discussions and provides a space where the SAAF Secretariat and grantees can share experiences and resources.

Programme successes: Member Association advocacy

Holding governments to account for their contraceptive security commitments in Africa


Association de Bien-Etre Familial – Naissances Désirables (ABEF-ND)


Planned Parenthood Association of Ghana (PPAG)


Family Planning Association of Malawi (FPAM)


Planned Parenthood Federation of Nigeria (PPFN)


Reproductive Health Uganda (RHU)

Civil society plays a crucial role in holding governments to account for promises they have made relating to health and development, and for ensuring increased access to contraception. In 2013, five African Member Associations successfully advocated to their governments to pass policy and legislation that support elements of commitments made at the London Summit on Family Planning in 2012 and subsequently to Family Planning 2020 (FP2020).

The Democratic Republic of Congo

The government of the Democratic Republic of Congo made a commitment to FP2020 at the International Conference on Family Planning in Addis Ababa in 2013. The government drafted a National Strategy on Family Planning and promised to include US$1.0 million in the national budget to purchase contraceptives.

The Association de Bien-Etre Familial – Naissances Désirables (ABEF-ND) engaged the support of other national organizations and networks whose efforts convinced the government to make a commitment to procuring contraceptives. Together, they worked with the Ministry of Public Health, the President and the First Lady to encourage them to take responsibility for the country's contraceptive security.

Their advocacy efforts resulted in the budget allocation as well as the passing of a new law on contraception in early 2014. Previously, contraceptive procurement depended solely on donor support, so this marks the first time that the government has allocated funding from the national budget to purchase contraceptives.

Ghana

At the 2012 London Summit on Family Planning, the government of Ghana pledged to make contraception free in the public sector. In 2013, the government made a step toward fulfilling this commitment by adding contraception to the list of free services provided to women as part of maternal health care.

The Planned Parenthood Association of Ghana (PPAG) played a very active role in making this change a reality. The Association participated in the Contraceptive Security Committee, which is tasked with finding solutions to challenges to contraceptive availability. PPAG also worked on the committee that develops strategies for making contraception free in Ghana. These committees advise the Ministry of Health on contraceptive issues, and PPAG continues to be an active member of both.

Malawi

Following advocacy by the Family Planning Association of Malawi (FPAM), the government delivered on its promise to include contraceptives in the national budget. FPAM worked with parliamentarians, traditional and religious leaders, and other non-governmental organizations to build their understanding of the effects of high fertility rates and the need for contraceptive security in the country. Previously, there was no official government commitment to ensuring contraceptive security in the country, and procurement of supplies was only possible through donor funds. Following the creation of the new budget line, FPAM has noted an improvement in the availability of contraceptive supplies in health facilities throughout the country.

Nigeria

The Nigerian government pledged a significant increase in the national budget for contraceptive procurement. The Planned Parenthood Federation of Nigeria (PPFN) worked with Ministry of Health technical staff and policy makers to convince them of the importance of realizing this commitment. As a result, the government allocated an additional US$8.4 million to purchase contraceptives in 2013.

Uganda

In 2013, the Ugandan government increased the annual budget allocation for contraceptive supplies in line with its 2012 commitment, from US$3.3 million to US$5.0 million. The government also promised to strengthen institutional capacity of public and community-based services to increase choice and quality of contraceptive services. In 2013, the government approved a task shifting policy whereby clinical staff other than doctors can provide sterilization. Previously, only fully qualified doctors were allowed to carry out such procedures.

These changes followed targeted advocacy by Reproductive Health Uganda (RHU) and civil society partners. RHU met with and advised members of parliament and key staff from the Ministry of Health and the Ministry of Financial Planning and Economic Development. RHU also worked with the media to publicize the issue of contraceptive security.

IPPF recognizes that while these are major advocacy achievements, Member Associations and other civil society organizations need to continue to advocate to, and work with, their respective governments to ensure they fulfil their promises to increase access to contraception.

Respecting the sexual rights of adolescents

Instituto Peruano de Paternidad Responsable (INPPARES)

Instituto Peruano de Paternidad Responsable (INPPARES) worked for seven years in partnership with Women's Link Worldwide and other civil society organizations to overturn legislation in Peru that was harmful to young people's health, sexual rights and autonomy.

In 2006, the government of Peru amended the Criminal Code to protect young people from sexual abuse and violence. Although its intention was to take a tough stance against sexual abuse committed against a minor by an adult, the amendment also criminalized all sexual activity among adolescents between 14 and 18 years old, regardless of consent, with sentences of up to 20 years in prison.

The revised Criminal Code increased the risk of unwanted pregnancy and maternal mortality among adolescent girls. In Peru, where 13 per cent of girls give birth before they are 18,[3] the threat of harsh legal penalties imposed under the amended legislation kept many girls from accessing contraception, and when faced with pregnancy, seeking antenatal care. Medical practitioners were reluctant to give contraception to young people, and were unclear whether they were legally permitted to provide care to pregnant girls.

To challenge this amendment criminalizing sexual activity among adolescents, INPPARES worked in a coalition of advocacy groups. The coalition undertook a high-risk strategy by initiating a legal process with the Constitutional Court, claiming that the amendment was unconstitutional. The strategy was risky because if the court refused their claim, it would reinforce the law's legitimacy and leave little recourse to have it overturned in the future.

Before the proceedings began, the court asked to see 5,000 signatures from Peruvians who believed the law should be changed. At this point, INPPARES revised its strategy and looked to the country's young people to lead this advocacy campaign. Within weeks, more than 50 youth groups across the country were mobilized and out in the streets. They issued press statements, organized rallies and wrote letters to the court. By reaching out to people living in both rural and urban provinces, the youth network exceeded the target by more than double with 10,609 signatures.

In early 2013, the court announced that the law had been changed, with immediate effect. While the law continues to protect young people against sexual abuse and violence, it now explicitly recognizes the sexual rights of adolescents and the importance of respecting those rights, and will improve health outcomes.

> As a youth activist, being part of this historic process to enforce human rights in Peru is an honour. It fills me with hope that young people like me can fulfil our dream of building a more egalitarian society that respects the rights of adolescents.
>
> INPPARES youth advocate

Liberalizing abortion with a fatwa

Society for Health Education (SHE)

A national-level fatwa has been released in the Maldives stating that abortion is permissible under five circumstances, including rape and incest. Previously, abortion was only permissible to save the life or preserve the health of the woman. The fatwa was issued by the Ministry of Islamic Affairs, which gives it legal weight at the national level.

The Member Association in the Maldives, the Society for Health Education (SHE), conducted awareness raising activities among the general public, policy makers and key professional groups on the public health and social justice aspects of unsafe abortion. These advocacy initiatives included workshops and the formation of a steering committee to sensitize religious leaders and relevant stakeholders about unsafe abortion and its consequences.

As part of its advocacy strategy, SHE strengthened its collaboration with the Ministry of Islamic Affairs. SHE also conducted a baseline survey on pregnancies resulting from incest and rape, the findings of which contributed significantly to the ongoing dialogue that the Association had with the Ministry of Islamic Affairs.

Changing the law to protect young survivors of rape

Association Marocaine de Planification Familiale (AMPF)

Violence against women and girls is a devastatingly common occurrence in Morocco, with 63 per cent of women aged 18 to 64 having experienced violence.[4] Despite the country's 2011 constitution which calls for gender equality and equal rights, legislation does not adequately protect women and girls from violence.

The Association Marocaine de Planification Familiale (AMPF) joined forces with other national women's rights organizations to raise public awareness and encourage the government to modify one of the most important laws concerning women's rights.

Previously, an article of the Moroccan penal code allowed rapists of underage girls to avoid prosecution and many years in jail by marrying the girls they had raped. A clause in the article specified that when an underage survivor of rape marries the perpetrator, "he can no longer be prosecuted except by persons empowered to demand the annulment of the marriage and then only after the annulment has been proclaimed". This effectively prevented prosecutors from pursuing rape charges independently.

Families of raped girls find themselves under pressure to agree to rapists marrying their daughters to evade prosecution; or demand that the couple are married to avoid the shame, dishonour and blame attached to the rape survivor.

In 2012, 16-year-old Amina Filali killed herself to escape a forced and abusive marriage to the man who had raped her. Her parents had demanded that the marriage take place to avoid family dishonour, and a judge had agreed. Amina's death brought this issue to light and a number of peaceful protests were held. AMPF and partners organized protests to show how rape, and early and forced marriage have a negative impact on women's health. In early 2014, the government repealed the penal code article that protected men who raped girls and subsequently married them.

Early and forced marriage is not uncommon in Morocco, particularly in rural areas: 16 per cent of girls are married before the age of 18.[5] The Association will continue to work with the government to outlaw early and forced marriage. The clause in the penal code that relates to early and forced marriage has been under review in the Moroccan Parliament, but the outcome has been postponed for further consultation.

> One thing I can say for sure is that we have sent a strong message, one that says women have to be at the centre of the discussions about laws that affect them.
>
> Fadoua Bakhadda, AMPF Executive Director

Decriminalizing abortion in Ireland

Irish Family Planning Association (IFPA)

Every year, thousands of women travel from Ireland to the United Kingdom for safe and legal abortion services. The Irish Family Planning Association (IFPA) has been working tirelessly to ensure women living in Ireland have access to safe and legal abortion services in their own country without fear of imprisonment.

In 1993, the Supreme Court ruled that abortion is lawful when there is a threat to the life of the woman, including suicide. However, the Irish Constitution gives the right to life to 'the unborn', which conflicts with the Supreme Court's ruling. No legislation followed to uphold the Supreme Court ruling or to clarify when an abortion may be lawfully performed, so abortion remained unavailable to all women.

IFPA has worked for many years to advocate for legislation that decriminalizes abortion. The Association supported three women to challenge the Irish government's abortion ban at the European Court of Human Rights. The Court unanimously ruled that Ireland's abortion laws violated women's human rights and that the government needed to make life-saving abortion services available. The case was lodged in 2005 and ruled on in 2010.

In 2011, Ireland's human rights record was reviewed as part of the United Nations Universal Periodic Review mechanism. IFPA issued a joint report with the Sexual Rights Initiative on the human rights violations of women and girls living in Ireland who are denied access to safe and legal abortion services. The report made six strong recommendations, including one to enact legislation to clarify when abortion is legal in line with the 2010 European Court of Human Rights ruling.

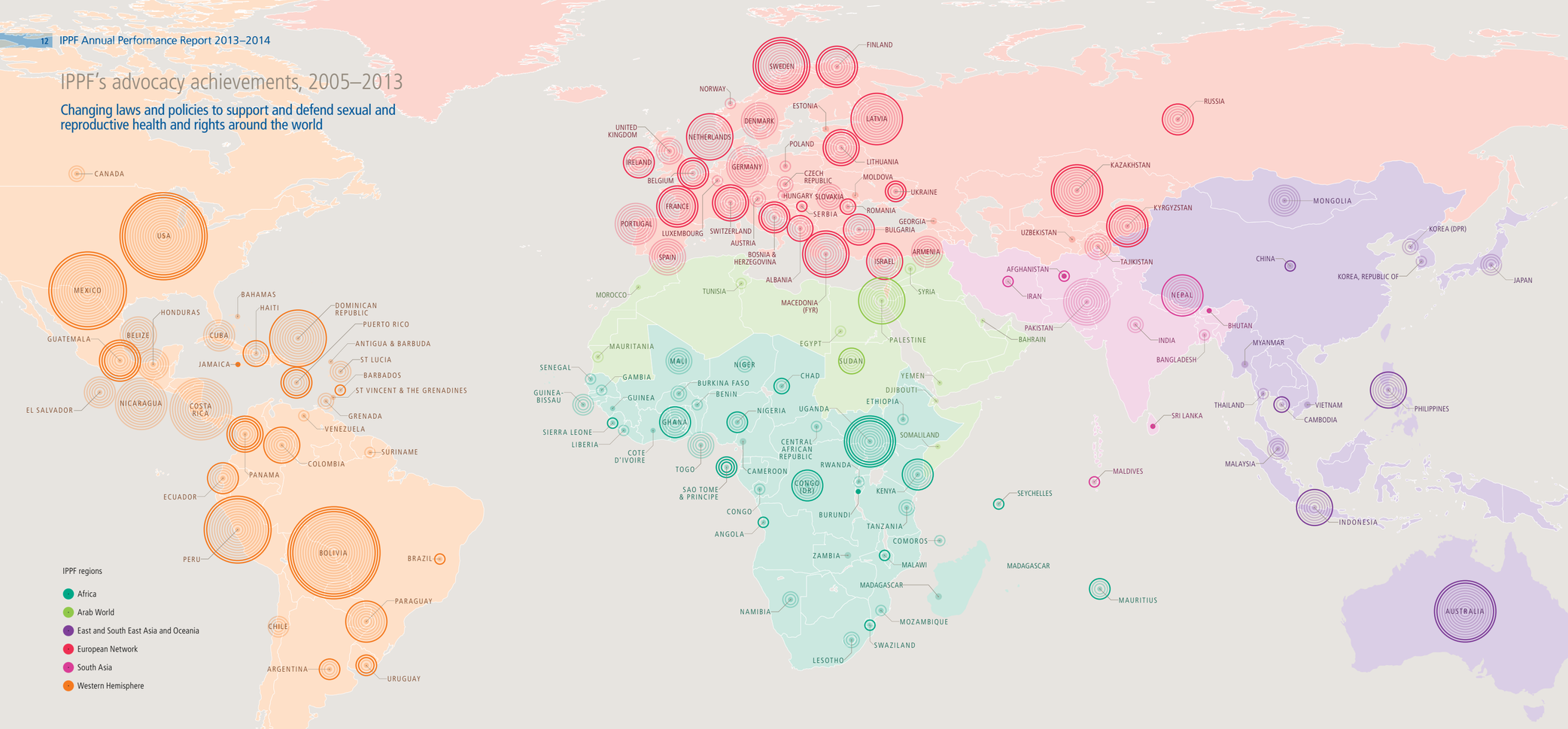
> The European Court of Human Rights is clear that [European member] states must guarantee rights that are practical and effective, not only theoretical or illusory. The women who use our services in circumstances where pregnancy endangers their lives require and deserve nothing less.
>
> Niall Behan, IFPA Chief Executive

IFPA led a civil society campaign to advocate for life-saving abortion services in Ireland. The Association also engaged the media and gave presentations to politicians on the impact of restrictive abortion laws on women.

In 2013, the Irish government passed the Protection of Life during Pregnancy Act, allowing termination to save the life of the mother or to prevent suicide. This legislation effectively decriminalizes abortion and clarifies that abortion may be lawfully performed when there is a threat to the life of the woman or to prevent suicide.

IPPF's advocacy achievements, 2005–2013

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



From 2005 to 2013, Member Associations contributed to

653 policy and/or legislative changes

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

146 countries*

Key

Number of policy and/or legislative changes

Year of policy and/or legislative change

KIRIBATI

* See Annex A for number of policy and/or legislative changes, by country, 2005–2013.

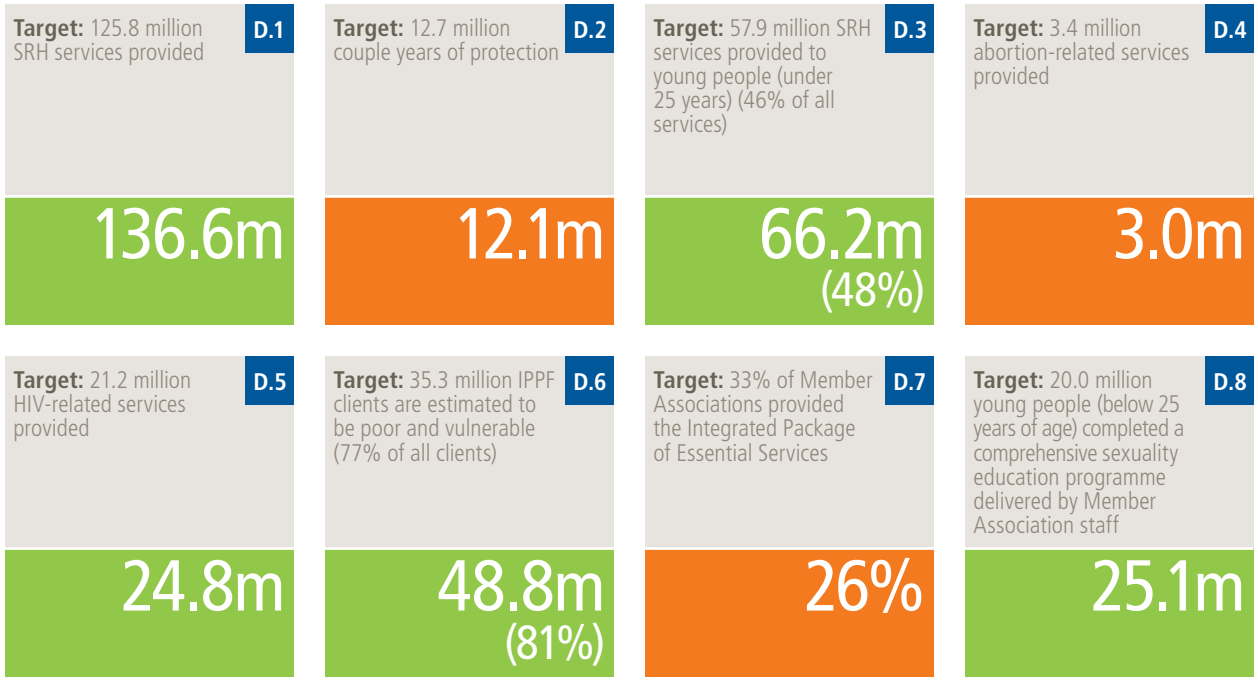
unite

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

IPPF is on target to achieve our goal of doubling services by 2015, a milestone towards our commitment to treble services by 2020. Our 2013 results show significant progress in providing sexual and reproductive health services, especially to those who are most in need.

Figure 3 presents IPPF's 2013 performance in the delivery of sexual and reproductive health services and comprehensive sexuality education. Overall, the results are positive with five indicators surpassing their targets, and the other three showing progress compared to last year but remaining below their targets. IPPF has committed to doubling the number of sexual and reproductive health services provided between 2010 and 2015 and trebling by 2020. Results from 2013 show that we remain on target to achieve our goal. IPPF delivered 136.6 million sexual and reproductive health services in 2013, a 21 per cent increase from 2012 and 10.8 million higher than the target (Figure 4). Nearly half of all services (66.2 million) were provided to young people, an annual increase of 47 per cent and 8.3 million higher than the target. Significant progress was also made in the number of HIV-related services provided, with a 29 per cent year-on-year increase, and exceeding the target by 3.6 million. The estimated number of IPPF clients who are poor and vulnerable increased by 12.7 million to 48.8 million, surpassing the target by 13.5 million (Figure 5). The proportion remained unchanged at 81 per cent, demonstrating our commitment to reaching those with the greatest need. The number of couple years of protection increased by 2 per cent to 12.1 million but did not meet the target of 12.7 million.

Figure 3: Deliver – performance results in 2013*



The number of abortion-related services grew by 24 per cent from 2012, which is a considerable increase but below the target of 3.4 million. The proportion of Member Associations providing the full Integrated Package of Essential Services increased by five percentage points from last year to 26 per cent but did not meet the target of 33 per cent. Finally, the number of young people who received comprehensive sexuality education from Member Association staff increased 38 per cent from last year to 25.1 million. This includes 20.0 million young people who received comprehensive sexuality education from the China Family Planning Association (CFPA).

In this section, key service statistics and trends are presented alongside examples of Member Association programmes that contribute to IPPF's overall performance in the provision of sexual and reproductive health services.

* See Annex B for performance results, by region, 2010–2013.

Figure 4: Number of SRH services provided, 2010–2013

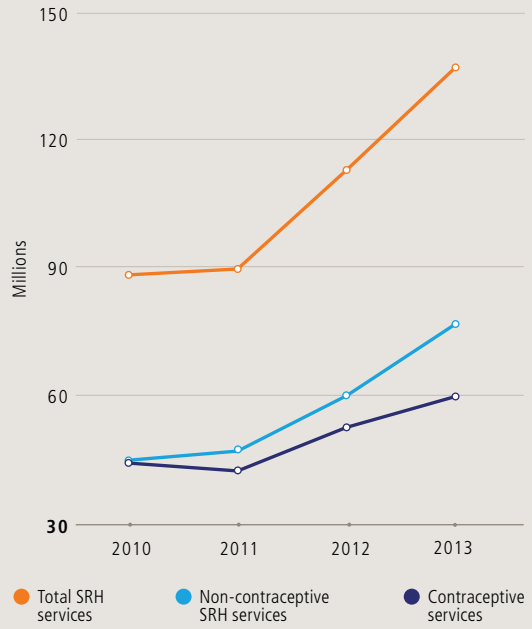
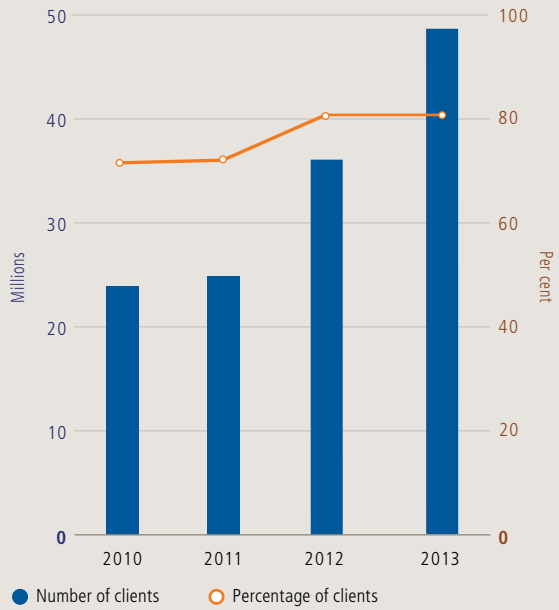


Figure 5: Estimated number and percentage of IPPF clients who are poor and vulnerable, 2010–2013

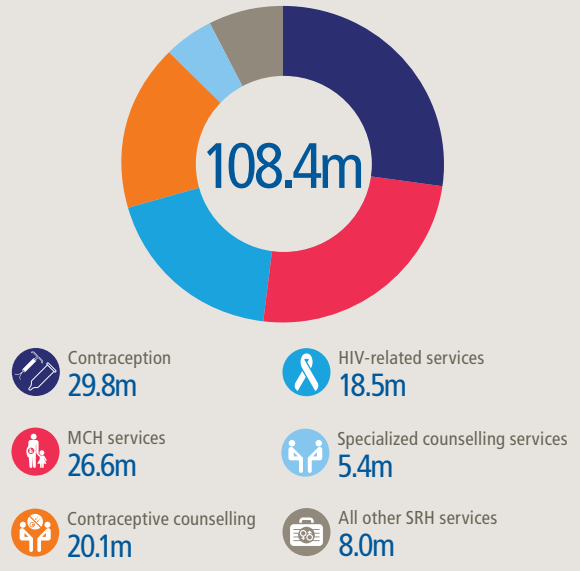


Investing in countries with the greatest need

IPPF invests the majority of its core funding in countries with the greatest needs for sexual and reproductive health services. These countries have disproportionately high levels of maternal and child morbidity and mortality, unmet need for contraception, HIV prevalence, and early marriage and childbearing.

Member Associations in 81 countries with low or medium levels of human development[6] provided a total of 108.4 million sexual and reproductive health services in 2013. This is an annual increase of 29.2 million, or 37 per cent, and represents 79 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 (MCH) and contraceptive counselling, closely followed by HIV-related services (Figure 6).

Figure 6: Number of SRH services provided in countries with low or medium human development, by type, 2013



Reaching under-served factory workers

Reproductive Health Association of Cambodia (RHAC)

In Cambodia, thousands of young women from rural areas move to cities to work in factories. These women often do not know where to go for sexual and reproductive health services, and for many, the services remain inaccessible due to cost or limited opening hours. The Reproductive Health Association of Cambodia (RHAC) is responding to this unmet need by providing information and free services to women working in factories.

RHAC has established formal partnerships with 30 factories in three major urban areas of Cambodia. Member Association staff deliver interactive and entertaining events at lunchtime to provide information on sexual and reproductive health, including HIV. The factory workers are given vouchers that they can redeem at RHAC clinics for a range of free sexual and reproductive health services including contraception, post-abortion care, cervical cancer screening and treatment, HIV counselling and testing, referrals for antiretroviral treatment, and testing and treatment of sexually transmitted infections.

Since the women work six days a week in the factories, RHAC has adapted its clinic hours to ensure they are open on Sundays during the workers' time off. For those factories that have on-site clinics to treat workplace injuries and minor illnesses, RHAC has provided training to the factory clinic staff on health education, client rights, basic clinical skills, and providing information about contraception and testing for sexually transmitted infections. RHAC is developing plans to upgrade these factory clinics to provide more services on site.

Expanding contraceptive choice in West Africa

Association Béninoise pour la Promotion de la Famille (ABPF)

Association Burkinabè pour le Bien-Etre Familial (ABBEF)

Association Togolaise pour le Bien-Etre Familial (ATBEF)

Some of the lowest rates of contraceptive use in the world are in West African countries. In Benin, only 6 per cent of women use a modern method of contraception; in Togo and Burkina Faso, the rates are 13 per cent and 15 per cent, respectively.[7] From 2011 to 2013, EngenderHealth's RESPOND project worked in partnership with Member Associations in these three countries to strengthen their capacity to provide a range of contraception, particularly long-acting and reversible methods.

All three Member Associations completed a self-assessment to determine their capacity to provide a range of contraceptive methods. These assessments revealed a number of areas for programmatic improvement, including the need to ensure service quality, offer contraception at affordable prices, engage men, raise awareness about long-acting methods, and build community support for contraceptive uptake. Following the assessments, the Member Associations developed action plans to increase their capacity to provide contraception. They all worked with religious leaders, raising their awareness of the benefits of contraception and engaging them as contraceptive champions. They also implemented peer education strategies to raise awareness about contraception and create demand for contraceptive services. Staff received training in contraceptive counselling, the provision of a range of contraceptive methods, and facilitative supervision that emphasizes mentoring, joint problem solving and two-way communication.

In 2013, the combined total of couple years of protection provided by the three Member Associations was 152,000, up 67 per cent from when the project began in 2011.

Contraception

The number of couple years of protection (CYP) provided in 2013 increased by 2 per cent to 12.1 million. In the Africa and South Asia regions, where there is the greatest unmet need for contraception, there were 10 per cent and 21 per cent increases, respectively. In Africa, this growth was mainly due to injectables, intrauterine devices and oral contraceptive pills, whereas in South Asia, it was due to intrauterine devices and implants.

IPPF is committed to ensuring contraceptive method choice. Our Integrated Package of Essential Services requires Member Associations to provide a range of short- and long-acting and reversible methods, including emergency contraception. The method mix of IPPF's CYP is presented in Figure 7: 39 per cent was provided by long-acting methods, 44 per cent by short-acting, and 17 per cent by permanent methods. The number of CYP provided by implants and injectables continued to rise in 2013; CYP from implants increased by 35 per cent to 1.4 million, and CYP from injectables grew to 1.6 million, up 19 per cent from 2012.

IPPF adheres to a rights-based approach and provides counselling to women and couples so they can make informed decisions about whether and when to have children, and how many to have. In 2013, IPPF provided 22.5 million contraceptive counselling services, a 42 per cent increase over 2012. The majority of these services (20.1 million) were provided in countries with low or medium levels of human development.

5.0m

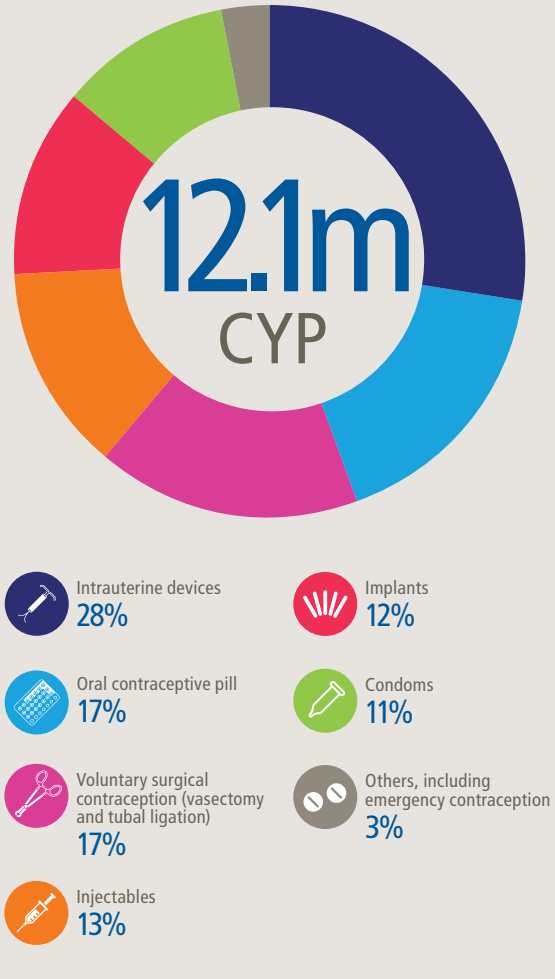
Unintended pregnancies averted*

580,000

Unsafe abortions averted*

* Using Marie Stopes International's Impact 2 estimation model

Figure 7: Couple years of protection (CYP), by method, 2013



HIV-related services

The number of HIV-related services that IPPF provided grew from 19.2 million in 2012 to 24.8 million in 2013, an increase of 29 per cent. African Member Associations provided 10.8 million HIV-related services in 2013, a 53 per cent increase over 2012, while HIV-related services provided in South Asia totalled 3.0 million, up 64 per cent from 2012.

There was annual growth in all of the service categories (Table 1), with the largest increase in prevention services, up by 88 per cent to 4.3 million. The number of treatment, care and support services increased by 33 per cent to just over 735,000, while counselling and testing services grew by 9 per cent to 7.5 million. Five out of six regions provided more HIV-related services in 2013 than in 2012.

Sexually transmitted infection services increased by 30 per cent, from 9.4 million in 2012 to 12.2 million in 2013. Faced with a growing global incidence of viral hepatitis, syphilis, gonorrhoea, chlamydia and trichomoniasis, there is a renewed commitment across the Federation to increase access to sexually transmitted infection prevention, testing and treatment services. As a fundamental component of sexual and reproductive health, this focused commitment will not only help to treat sexually transmitted infections and reduce complications, but also represents an integral and cost-effective intervention to prevent HIV transmission and cancers related to sexually transmitted infections.

Since 2004, IPPF has applied a strategy of targeted and intensive HIV capacity building for up to 24 Member Associations, known as the HIV Global Focus Member Associations. Following the success of this strategy, a further 35 HIV Intensive Focus Member Associations were added in 2009. Their programmes have become models for our work on HIV. Several approaches were used to build capacity, including participation in an HIV competencies workshop every two years, involvement in international and regional conferences, bespoke training on specific HIV themes, and regular updates from IPPF's Central Office on relevant HIV issues. In addition, the Global Focus Member Associations provided technical support to the Intensive Focus Member Associations.

The success of this strategy in increasing the provision of HIV-related services is highlighted in Figure 8, which illustrates how services have grown more quickly for the focus Member Associations than for others. The Global Focus Member Associations provided 2.7 million services in 2009 in comparison to 8.0 million in 2013, an increase of 190 per cent over the four-year period. Comparable increases of 1.8 million to 8.5 million reflect similar improvements in performance for the Intensive Focus Member Associations (376 per cent increase). For the other 90 Member Associations that have not been directly supported by the HIV strategy, there has been growth from 5.0 million in 2009 to 8.4 million in 2013, but this is a lower rate of increase (66 per cent), highlighting the success of the targeted HIV capacity building strategy.

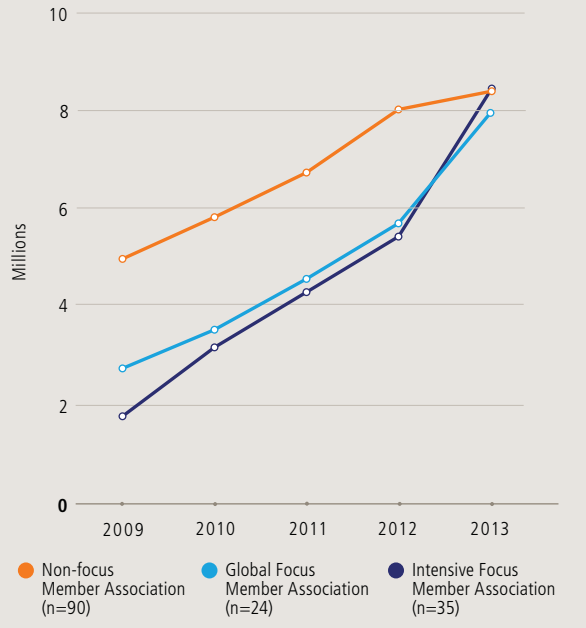
> The competency workshops have been a key part of an effective strategy to ensure growth of our HIV programme. Because of the workshops, we have been able to compress our learning curve and therefore plan and implement innovative and cutting edge programmes, train a cadre of service providers and ensure community engagement.

Assistant Secretary General
(Programme Implementation), FPA India

Table 1: Number of HIV-related services provided, by type, 2012–2013

Type of service provided	2012	2013
Prevention	2,304,415	4,328,680
Counselling and testing	6,926,531	7,525,152
Treatment, care and support	551,399	735,163
STI services	9,385,948	12,172,326
Total	**19,168,293**	**24,761,321**

Figure 8: Number of HIV-related services provided, by type of focus Member Association, 2009–2013



Abortion-related services

The number of abortion-related services provided increased by 24 per cent, from 2.4 million in 2012 to 3.0 million in 2013. There was annual growth in all service categories, with significant increases in clinical abortion services, including treatment of incomplete abortion (145 per cent increase), medical abortion (73 per cent increase), abortion consultation services (41 per cent increase) and surgical abortion (38 per cent increase) (Table 2). The increases in clinical abortion services can be attributed to consistent messaging and targeted technical assistance from the Secretariat in line with the Abortion Strategic Action Plan's key objective to increase access to essential abortion services. These include the provision of pre- and post-abortion counselling and at least one of the following clinical abortion services: provision of induced abortion services using surgical or medical methods or provision of treatment for an incomplete abortion, as defined by IPPF's Integrated Package of Essential Services (Annex C).

IPPF's efforts to improve access to quality medical abortion services showed promising results in 2013, with increases in the provision of medical abortion-related services in all six regions. To expand access to medical abortion, IPPF conducted pilot studies to assess feasibility and acceptability of services, trained mid-level service providers, and strengthened quality assurance processes through a review of clinical outcomes and pharmaco-vigilance activities. IPPF also increased partnerships and collaboration with professional bodies and organizations to press for the registration of medical abortion commodities.

For the 12 Member Associations involved in the Global Comprehensive Abortion Care Initiative, the number of clients provided with an abortion or treated for incomplete abortion grew by 32 per cent from 2012, while the total number of clients for contraception increased by 95 per cent. The Initiative has helped to spearhead the Federation's effort to build technical capacity at regional and Member Association levels. It has driven implementation of good practice in the provision of medical abortion according to World Health Organization guidelines, as well as expansion of vacuum aspiration as a safe surgical abortion procedure.

Table 2: Number of abortion-related services, by type, 2012–2013

Type of service provided	2012	2013
Pre-abortion counselling	991,650	1,040,934
Post-abortion counselling	458,058	492,156
Surgical abortion	387,327	533,085
Medical abortion	198,105	341,783
Treatment of incomplete abortion	50,365	123,384
Abortion consultation services	301,220	425,435
Total	2,386,725	**2,956,777**

The Initiative has also strengthened the counselling skills of providers for the immediate uptake of post-abortion contraception.

In 2013, IPPF commissioned small research projects in 17 Member Associations to understand the role and influence of stigma on access to safe abortion services. Findings revealed that waiting times at registration and client flow patterns at each clinic were two of the important factors affecting the experience of abortion stigma within a facility. For example, clients seeking post-abortion care indicated that minimal waiting times at registration, quick access to services and not meeting more than two or three staff during the entire experience in a clinic ensured that feelings of stigma were minimal when accessing abortion care.

Based on these research results, IPPF recommends that clinics support a system of triage at registration to fast track clients who are seeking post-abortion care and to minimize waiting times. Similarly, IPPF is also reviewing client flow pathways and exploring options that limit the number of staff who are required to interact with a client during the provision of abortion services.

Reaching poor and vulnerable people

In 2013, IPPF reached 48.8 million poor and vulnerable clients with sexual and reproductive health information and services, 14.6 million more than in 2012. The estimated proportion of all clients who are poor and vulnerable is 81 per cent. These results illustrate IPPF's commitment to serving those most in need of sexual and reproductive health services.

IPPF has more than 60,000 service delivery points, and 59 per cent of them are located in rural or peri-urban areas. This enables Member Associations to provide information and services to people in hard-to-reach areas where there are few, if any, other service providers. Member Associations also provide services to under-served groups that other providers – government, public or private – are unwilling to work with, or do not have the specialized skills required. These marginalized groups include young people, sex workers, men who have sex with men, people who inject drugs, prisoners and sexually diverse populations.

IPPF is continuing to roll out a methodology that assesses the poverty status and the sexual and reproductive health vulnerability of clients. Once Member Associations know if they are reaching those most in need, they are able to make programmatic and financial decisions to reach more people who are poor and under-served.

Following training on the methodology, Family Health Options Kenya (FHOK) carried out an assessment in its Nairobi West clinic. The results demonstrated that the proportion of poor and vulnerable clients was only 19 per cent, compared to FHOK's overall estimated proportion of vulnerable clients of 72 per cent. In an effort to reach more vulnerable clients at its Nairobi West clinic, FHOK increased the number of outreach activities from two to six per month. As a result, the number of clients reached per month through outreach services increased by almost 150 per cent. This will in turn increase the number of vulnerable clients as all the outreach areas serve the poorest and most vulnerable communities in the city.

81%

of IPPF's clients are poor and vulnerable

Focusing on people with disabilities

People with disabilities are among the most vulnerable and under-served in terms of their sexual and reproductive health and rights. They are more likely to experience sexual violence than their non-disabled peers, and their sexual and reproductive health needs are often denied, ignored or overlooked. A common misconception is that people with disabilities are unable to enjoy sexual pleasure and that they do not have sexual and reproductive health needs. The result is a lack of specialized sexual and reproductive health information, education and services for people with disabilities.

IPPF is challenging these myths and misconceptions, and using a range of strategies to provide information and services to people with disabilities, as illustrated here for Mozambique, Samoa and the United Kingdom.

Providing information and services to people with disabilities


Associação Moçambicana para Desenvolvimento da Família (AMODEFA)


Samoa Family Health Association (SFHA)


United Kingdom Family Planning Association (FPA UK)

Mozambique

In Mozambique, the Member Association is responding to the needs of the deaf community with sexual and reproductive health counselling and service provision. The Associação Moçambicana para Desenvolvimento da Família (AMODEFA) has trained nine community health workers who use sign language to provide HIV counselling and testing for deaf people. If clients need additional sexual and reproductive health information or services, the counsellors refer them to AMODEFA's health centre where service providers are trained in sign language. In 2013, the community health workers provided voluntary HIV counselling and testing for 142 deaf people and made 407 referrals to the health centre.

Samoa

Working in partnership with organizations that are specialized in supporting people with disabilities is an effective strategy for increasing access to sexual and reproductive health and rights information and services for people with disabilities.

The Samoa Family Health Association (SFHA) provided comprehensive training on sexual and reproductive health for a national disability organization that advocates for the rights of people with disabilities. The organization, Nuanua O Le Alofa (NOLA), provides support and counselling to people with disabilities, which now includes accurate and relevant information about sexuality, sexually transmitted infections, HIV and contraception, and on how to safeguard against violence. NOLA is managed by people with disabilities, and they have requested that SFHA train them as trainers so that they can train others to provide sexual and reproductive health information to disabled peers in their communities.

> Sexuality is the result of the whole person's life situation. Without the prerequisites for self-esteem and personal independence there can be no sound sexuality.[8]

United Kingdom

The United Kingdom Family Planning Association (FPA UK) takes a comprehensive approach to training and support related to the sexual and reproductive health and rights of people with learning disabilities. FPA UK supports people with learning disabilities to exercise their right to fulfilling sexual lives. The Association has a range of training materials and information leaflets which promote sexual health as opposed to focusing only on prevention of sexual ill health. The Association trains adults and young people with learning disabilities to understand sexual health issues, and to improve their confidence and self-esteem.

Parents, carers, schools and support workers also need support in providing information about sexual and reproductive health in a way that is understood by people with learning disabilities. In 2013, FPA UK focused on its successful collaboration with a special needs secondary school where Association staff taught comprehensive sexuality education classes. The classes covered safeguarding issues, consent, good and bad touch, healthy sexual behaviour, contraception and sexually transmitted infections. FPA UK provided training to the teachers so that they can teach these classes in the future.

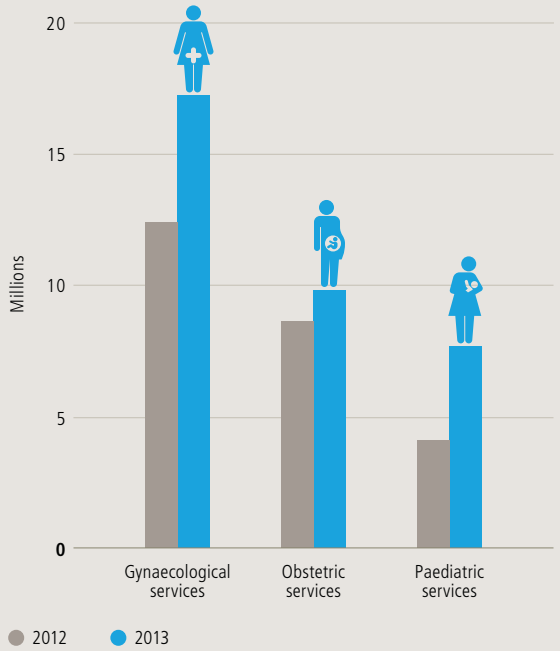
FPA UK is also supporting other Member Associations in Europe to build and strengthen their work with people with learning disabilities (page 30).

Focusing on the needs of women and girls

The majority (78 per cent) of IPPF's clients are women and girls. In many countries, women do not have control over their own bodies, including making decisions about childbearing, contraception or terminating a pregnancy, and their sexual and reproductive health needs often go unmet.

In addition to contraceptive and abortion-related services that benefit women and girls, IPPF also provided 17.3 million gynaecological and 9.9 million obstetric services in 2013 (Figure 9). In terms of child health, IPPF provided 7.7 million paediatric services. The combined number of gynaecological, obstetric and paediatric services provided in 2013 increased by 9.8 million, or 37 per cent, from 2012.

Figure 9: Number of gynaecological, obstetric and paediatric services provided, 2012–2013



Providing education and services to young people

IPPF provided 66.2 million sexual and reproductive health services to young people in 2013; this represents 48 per cent of all services provided and illustrates our commitment to increasing access to services for the largest generation of young people ever. The greatest increases between 2012 and 2013 were in contraceptive services (63 per cent), gynaecological services (57 per cent) and services related to sexually transmitted infections (44 per cent).

IPPF has been committed to providing youth-friendly services for many years, and has focused on community-based approaches with peer educators providing information and contraception to ensure accessibility of services for young people. This presence in the community, and the reputation of Member Associations as leaders in providing youth-friendly services in safe spaces, means that many young clients access services for the first time at our service delivery points.

IPPF understands the critical need to strengthen national health systems to provide sexual and reproductive health services to young people. In many countries, Member Associations have the convening power to work with civil society organizations, government agencies, including Ministries of Health and Education, and other stakeholders to ensure that young people can access the services they need. Associations also work with local partners to gain insight into the services young people use and where they are, and to improve referral systems between health care facilities.

Supporting and enabling service provision for young people by other providers is vital in meeting the unmet needs of young people globally. Recently, IPPF has partnered with UNESCO to identify good practices linking comprehensive sexuality education with services that support the scale-up of youth-friendly service provision by others in West and Southern Africa. This partnership has brought together civil society and health and education ministries for joint discussions and in-country planning to better coordinate efforts to provide youth-friendly services for as many young people as possible.

Responding to sexual and gender-based violence

Globally, 35 per cent of women experience either intimate partner violence or non-partner sexual violence during their lifetime.[9] In 2013, Member Associations provided 1.8 million prevention, screening and counselling services related to sexual and gender-based violence, a 73 per cent increase from 2012.

Women and girls are particularly vulnerable to sexual violence during humanitarian crises. During conflict, sexual violence is often used systematically as a method of warfare. Following natural disasters, women and girls are often left unaccompanied and in open areas or temporary shelters. Sexual violence, including rape, can cause a range of sexual and reproductive health problems such as unwanted pregnancy, fistula and sexually transmitted infections, including HIV. It also causes post-traumatic stress and psychosocial distress.[10]

Recognizing the need to respond to sexual violence during humanitarian crises, Member Associations that work in disaster-prone areas or in countries in conflict provide the Minimum Initial Service Package (MISP) for sexual and reproductive health in crises. The service package includes prevention and management of the consequences of sexual violence. Reproductive Health Uganda, for example, has begun to implement the MISP in two refugee camps in the southwest region. To respond to the high prevalence of rape in the camps, the Member Association provided training to service providers to support and care for rape survivors in both locations.

In early 2013, an undersea earthquake generated a destructive tsunami that hit the Solomon Islands, affecting a coastal community in the Santa Cruz Islands. The Solomon Islands Planned Parenthood Association's MISP team worked with local volunteers and nurses in the temporary camps to address a range of health needs of the community, including sexual and reproductive health, and particularly the needs of women and girls who had experienced sexual and gender-based violence.

Providing comprehensive care to survivors of sexual and gender-based violence

Afghan Family Guidance Association (AFGA)

Sexual and gender-based violence is pervasive in Afghanistan with up to 82 per cent of women having experienced at least one form of domestic violence, and 62 per cent having faced multiple forms of violence.[11] Despite recent legislation criminalizing violent acts against women and girls – such as domestic violence, early and forced marriage and rape – the violence continues, often unreported, and perpetrators are not being penalized to the full extent of the law. Many women do not report incidents because of cultural and social norms and taboos, religious beliefs, fear of being stigmatized and sometimes even threats to their lives.[12] The silence on sexual and gender-based violence in Afghanistan needs to be broken, and services and support for survivors are essential.

There is a direct and cyclical link between HIV and sexual and gender-based violence: women who experience intimate partner violence are 50 per cent more likely to acquire HIV,[13] and women living with HIV are more likely to experience sexual, physical and psychological violence.[14] Comprehensive services and support for survivors of sexual and gender-based violence must include HIV services; likewise, comprehensive HIV services need to include screening, treatment and support for survivors of sexual and gender-based violence.

The Afghan Family Guidance Association (AFGA) is responding to this critical demand and has increased access to integrated HIV and sexual and gender-based violence services in its family welfare centres in three cities. Sexual and gender-based violence tools developed by the IPPF South Asia Regional Office were adapted by AFGA to the Afghan context, and they include modules for health care professionals on screening and counselling. Subsequently, in 2012 and 2013, AFGA improved its programming by training staff, establishing effective referral networks and working with religious leaders and police. While it has taken some time to build the trust of clients to disclose information related to sexual violence, the number of screening and counselling services provided has recently increased dramatically (Figure 10).

AFGA provided training to doctors, nurses, midwives and counsellors on screening and providing integrated HIV and sexual and gender-based violence services. This integration means that clients visiting the clinics for HIV-related services are also screened for sexual and gender-based violence, and all survivors who come to AFGA's centres are offered psychosocial counselling, voluntary counselling and testing for HIV, and other services or referrals as needed.

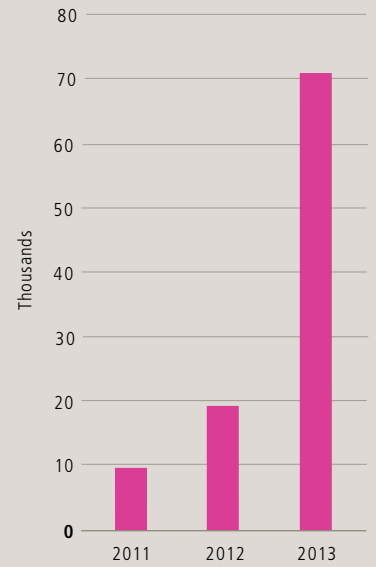
AFGA has established effective referral systems with seven non-governmental organizations that work on sexual and gender-based violence issues, ensuring clients get all the assistance they need, including legal support. These organizations also refer clients to AFGA for psychosocial counselling, and other sexual and reproductive health services.

In Afghanistan, religious leaders carry enormous weight in terms of influencing communities about issues such as domestic violence and reducing stigma and discrimination related to HIV. Since 2006, AFGA has trained 159 religious leaders on HIV and sexual and gender-based violence, and gained their support as community change agents. AFGA also wrote and distributed a book on Islam and contraception, which religious leaders use to condemn sexual and gender-based violence from an Islamic perspective.

As a result, 79 religious leaders have included sexual and gender-based violence issues in their Friday speeches in the recent past, and they have promoted accurate interpretation of the Quran, dispelling myths that link sexual and gender-based violence to Islamic teachings.

Cultural sensitivity and the lack of a secure environment prevent many women and girls from reporting sexual and gender-based violence to the police. It is common for police to automatically label women who do report incidents as criminals or immoral. AFGA trained 157 police personnel on sexual and gender-based violence, HIV, the effects of stigma and discrimination, and the need for police to be non-judgemental. As a result of the training, the police now refer survivors of sexual and gender-based violence to AFGA clinics immediately, where they can access psychosocial support, voluntary counselling and testing for HIV, and emergency contraception if needed.

Figure 10: Sexual and gender-based violence screening and counselling services provided by AFGA, 2011–2013



Explaining performance trends

IPPF is achieving impressive results in all six of its regions, Africa (AR), the Arab World (AWR), the European Network (EN), East and South East Asia and Oceania (ESEAOR), South Asia (SAR) and the Western Hemisphere (WHR). Table 3 provides an overview of the achievements made since the beginning of IPPF's Strategic Framework 2005–2015, with nine-year cumulative totals for the main sexual and reproductive health service categories. Annual results for 2013, including information on additional key performance indicators, are presented in Table 4.

Many of the highlights presented in this section illustrate IPPF's programme strategies to support growth in service numbers. Some of the increases are also due to better data quality. IPPF has invested in improved data systems and reporting frameworks to support Member Associations to collect data, including data that were not previously captured. There are numerous reasons for the previously unreported data, including the challenges of reporting data from geographically isolated locations, service categories missing on registers or data collection forms, and service packages previously counted as one service when the package included multiple services.

Service growth for many Member Associations is also due to increased performance following the implementation of strategies aimed at reaching more people with more services, and in more locations. The major drivers of growth included demand generation for services, marketing and promotional work; expanding outreach and mobile programmes to reach under-served populations; the provision of new service types such as cervical cancer screening and treatment, vasectomy services and sexual and gender-based violence services; and addressing internal barriers – such as client flow to reduce waiting times and service provider attitudes – to ensure quality service provision. Approaches focusing on young people included rolling out school-based service provision, integrating youth promoters in Member Association static clinics, and using educational activities to link with clinical services.

Table 3: Cumulative results by region, 2005–2013

Indicator	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of sexual and reproductive health services (including contraception) provided	199,846,223	21,246,494	13,386,397	81,798,422	122,000,656	239,695,985	**677,974,177**
Number of couple years of protection	11,464,852	2,559,167	420,800	5,879,568	18,217,304	44,453,809	**82,995,499**
Number of sexual and reproductive health services (including contraception) provided to young people under 25 years	89,243,625	6,986,377	5,702,017	22,612,387	56,199,732	78,891,535	**259,635,673**
Number of HIV-related services provided	32,470,434	2,505,638	1,978,677	12,970,484	11,861,354	34,694,588	**96,481,175**
Number of condoms distributed	281,734,249	6,959,061	8,827,709	182,160,932	274,260,065	580,194,730	**1,334,136,746**
Number of abortion-related services provided	1,644,329	353,777	749,322	1,401,893	2,900,316	5,811,298	**12,860,935**

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

678 million
SRH services provided

83 million
couple years of protection

1.3 billion*
condoms distributed

* 1 billion = 1,000,000,000

IPPF/Graeme Robertson/Kenya

Table 4: Results by region, 2013

Indicator	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of sexual and reproductive health services (including contraception) provided	56,380,418	5,324,138	1,514,277	18,503,828	22,781,156	32,137,245	**136,641,062**
Number of couple years of protection	2,612,058	236,825	44,087	720,455	2,778,010	5,687,013	**12,078,447**
Number of sexual and reproductive health services (including contraception) provided to young people under 25 years	31,648,478	2,469,046	741,829	7,491,076	10,619,393	13,264,128	**66,233,950**
Number of HIV-related services provided	10,846,534	927,296	294,622	2,831,038	3,041,772	6,820,059	**24,761,321**
Number of condoms distributed	54,157,674	612,132	920,568	26,898,017	41,821,592	39,780,758	**164,190,741**
Number of abortion-related services provided	542,659	84,603	107,591	278,138	382,454	1,561,332	**2,956,777**
Estimated percentage of Member Association clients who are poor and/or vulnerable	83%	85%	60%	76%	88%	78%	**81%**
Proportion of Member Associations providing the Integrated Package of Essential Services*	13%	45%	n/a†	0%	56%	50%	**26%**

* 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. 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 (see Annex C for details).

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

Programme successes: adolescents

Vaccinating girls to prevent cervical cancer

Asociación Hondureña de Planificación Familiar (ASHONPLAFA)

Human papillomavirus (HPV) vaccines can prevent approximately 70 per cent of cervical cancer cases and provide an opportunity to significantly reduce the incidence of morbidity and mortality due to cervical cancer.[15] However, more women die of cervical cancer in the developing world than in wealthier countries where effective screening programmes help to identify pre-cancerous lesions when they can easily be treated. In contrast, a lack of screening programmes in developing countries results in later or no diagnosis, and increased mortality.[16] In Latin America and the Caribbean, cervical cancer causes about three times as many more deaths than in neighbouring North America.[17]

In Honduras, the Asociación Hondureña de Planificación Familiar (ASHONPLAFA) partnered with the Ministry of Health's Immunization Programme to secure a donation of the Human Papillomavirus Quadrivalent Recombinant (GARDASIL®) vaccine, and to implement a school-based programme of vaccination for 10- and 11-year-old girls in the Comayagua and La Paz regions.

To ensure success, ASHONPLAFA and the Immunization Programme invested in strategic alliances with local authorities, developed materials to educate girls and the general public, and discussed the importance of HPV vaccination with parents and teachers. ASHONPLAFA also supported the development and implementation of a training programme for medical teams providing the vaccination. This type of community mobilization and educational approach is vital to the success of a vaccination programme as three doses are required over a six-month period for the vaccine to be effective.

ASHONPLAFA and the Immunization Programme conducted a school census to obtain an accurate number of 10- and 11-year-old girls to be vaccinated in each school. This meant that exact numbers of doses could be taken to the schools. Working with the government at all levels was crucial in contributing to success. The programme benefited from the government's cold chain infrastructure, as well as its existing distribution networks and personnel already trained in administering the vaccine.

The programme vaccinated 8,338 girls with three doses, reaching more than 95 per cent of the coverage target. This experience has given the Ministry of Health an HPV vaccination model that works and can be used when rolling out the vaccine at the national level. IPPF is exploring how the model could be replicated by Member Associations in Africa and Asia that are eligible for support from the GAVI Alliance to procure low-cost vaccines.

Investing in youth-led programmes

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

IPPF partners with young people to achieve social change, promote sexual rights, and build capacity to manage projects. For the past two years, IPPF has supported young people through the MYX Fund, providing small grants for youth-initiated and youth-led projects in Member Associations.

In Pakistan, a grant was given to support tea parties that gave girls the opportunity to talk about sexual and reproductive health with their peers, often for the first time. Young women who volunteer for Rahnuma-Family Planning Association of Pakistan (Rahnuma-FPAP) organized 144 tea parties at local youth resource centres, attended by 2,570 girls, a quarter of whom have subsequently accessed services from Rahnuma-FPAP.

At the beginning of the tea party project, the community was reluctant to participate as girls and women in Pakistan are raised to believe these issues should never be discussed with others. However, the tea parties provided an informal and safe space for young women and girls, who found the confidence to share their issues and discuss their concerns, and the tea parties became popular in the community.

Rahnuma-FPAP volunteers used a toolkit on running tea parties that was developed by young volunteers in Europe, and that will soon be available online. By adapting it to their local context, this provided a cost-effective approach for the young volunteers, and illustrates the benefit of cross-Federation collaboration and knowledge sharing.

> The tea parties have had a massive impact on me and my community. Without them, women and girls in the community would not have realized that sexual and reproductive health issues are concerns and that it is their right to seek redress.
>
> Young volunteer, Pakistan

Other MYX-supported projects included the creation of webinars on gender equality in Barbados and Peru; services, education and training for a group of young mothers in Burkina Faso; and the development of a magazine and website on young people's sexual health in Poland.

The MYX Fund has demonstrated that small funding schemes can breathe new life into youth networks and build momentum and support for youth leadership on sexual and reproductive health and rights issues.

Programme successes: HIV and AIDS

Improving the quality of life of young Kenyans affected by HIV

Family Health Options Kenya (FHOK)

Family Health Options Kenya (FHOK) has improved the health, education, nutrition and economic status of 10- to 19-year-olds living with HIV, and their families. The Adolescents Count Today project's 36 youth mentors worked with in- and out-of-school adolescents to raise awareness about sexual and reproductive health and HIV, and provided referrals to FHOK's youth-friendly clinics. FHOK also provided home-based care to adolescents and families affected by HIV, which included nutritional support, contraceptive and HIV counselling, care for those who are unwell, and support with treatment adherence.

An important and unique aspect of the project was engaging with young people's families. Parents and guardians were trained on how to communicate with their children on issues relating to HIV, sex and sexuality. Support groups were established for young people living with HIV and for parents.

From 2010 to 2013, the Adolescents Count Today project provided nearly 19,000 youth-friendly sexual and reproductive health and HIV services to young people, free of charge. Adolescents involved in the project now have comprehensive and accurate knowledge of HIV transmission, and many of those who are sexually active are now using condoms consistently.

The number of bed-ridden young people has fallen significantly as they and their parents seek medical attention at the earliest opportunity. Households now have an average of 2.5 meals per day, compared to 1.8 before the project. Access to treatment and nutritional support has led to improved health, and as a result, increased school attendance. The proportion of adolescents who were not in school has fallen from 40 to 16 per cent.

Training for parents has created more openness and dialogue on sexual and reproductive health and HIV issues, and improved relationships between parents and children. The support groups have provided a much needed platform for adolescents living with HIV to share experiences with each other and to find support to disclose their status and adhere to their treatment.

> My life changed since I have been touched by the project. My health has improved and I can take my medicine without skipping my doses. I can now live life like other kids.
>
> Young male project beneficiary

Providing integrated services to the most under-served and at-risk groups

Cameroon National Association for Family Welfare (CAMNAFAW)

Family Planning Association of India (FPA India)

Reproductive Health Uganda (RHU)

IPPF is addressing the sexual and reproductive health needs of groups that are disproportionately affected by HIV, including men who have sex with men, sex workers, people who use drugs and transgender people. In most countries, there is limited availability of stigma-free, integrated HIV and sexual and reproductive health services for these groups.

Member Associations in Cameroon, India and Uganda have trained their staff and equipped their clinics to ensure HIV services are available for everyone, including key populations, as part of sexual and reproductive health service provision. The Cameroon National Association for Family Welfare (CAMNAFAW) provides integrated services to men who have sex with men, whose service needs are largely ignored due to political sensitivity and discrimination, and whose HIV prevalence is as high as 37 per cent.[18] CAMNAFAW has strengthened partnerships with other organizations that work with men who have sex with men. The Association also provides integrated services to people of diverse sexual orientations and gender identities.

Taking a client-centred approach, the Family Planning Association of India (FPA India) is responding to the needs of transgender people by providing gender identity counselling, as well as information on HIV and other sexually transmitted infections, hormone therapy and breast augmentation procedures. FPA India has recruited counsellors from the transgender community, with positive feedback from service users. FPA India has started to offer laser therapy for facial hair removal, which has proved to be a key entry point for clients to access other sexual and reproductive health services.

Reproductive Health Uganda provides integrated services to male and female sex workers. Stigma associated with stand-alone HIV health facilities is still a major barrier to uptake, and sex workers prefer a 'one-stop centre' where they can access a range of integrated sexual and reproductive health and HIV services. The Member Association has trained 90 peer educators to reach these groups with sexual and reproductive health and HIV information and services.

> I love coming here because I can be myself without fear of discrimination.
>
> 18-year-old FPA India client

Programme successes: abortion

Shifting tasks to increase access to safe abortion services

Family Planning Association of Nepal (FPAN)

In many countries, the limited number and availability of doctors poses a serious barrier to the provision of sexual and reproductive health services, including safe abortion. The World Health Organization recommends that governments review national health guidelines and policy to support a more rational distribution of tasks and responsibilities among types of health workers.[19] Shifting certain tasks from doctors to mid-level health providers is a promising strategy for improving access and cost-effectiveness within health systems.

In Nepal, a large proportion of the population live in isolated and hard-to-reach areas. To provide services to these communities, the Family Planning Association of Nepal (FPAN) operates 102 community clinics in rural areas where there are no government health centres. They are staffed by a nurse, a community health worker and a clinic helper, and offer a comprehensive range of sexual and reproductive health services.

Following the introduction of a national task-shifting policy in 2011 that allows nurses to provide medical and surgical abortion, FPAN advocated for government approval for nurses to provide abortion in the community clinics. In early 2014, this approval was granted for seven clinics, with a further four currently being assessed.

Nurses in the approved clinics have received training and are now providing medical abortion services in under-served communities, thereby increasing access to safe abortion services at low cost for poor and rural women. Initial client feedback has been favourable with women expressing their satisfaction with the services and fees.

FPAN is looking to scale up this approach to reach even more rural women with safe abortion services throughout the country.

> Human resource shortages in the health services are widely acknowledged as a threat to the attainment of the health-related Millennium Development Goals. Attempts to optimize the potential of the existing health workforce are therefore crucial.[20]

Increasing access to quality medical abortion services

Association Burkinabè pour le Bien-Etre Familial (ABBEF)
Family Health Options Kenya (FHOK)

IPPF is increasing access to safe abortion services by advocating for the registration of medical abortion commodities and increasing the range of methods available for an early induced abortion. The World Health Organization recommends the combination of mifepristone and misoprostol as a safe and effective method of early induced abortion.[21]

In 2013, the Member Association in Burkina Faso secured an import licence for Medabon® in partnership with the National Society for Obstetricians and Gynaecologists. The Association Burkinabè pour le Bien-Etre Familial (ABBEF) subsequently began offering medical abortion services using this combined regimen. Previously, ABBEF was providing misoprostol-only medical abortion, which is not as effective as the combined method. The misoprostol-only method has a lower success rate that can sometimes require additional surgical treatment. ABBEF is the only organization in Burkina Faso with a licence to import the combined medical abortion drug, and the first organization in the country to offer it to clients. ABBEF is currently collecting evidence on the safety and acceptability of Medabon® in collaboration with the National Society for Obstetricians and Gynaecologists in order to advocate for full registration in Burkina Faso.

Family Health Options Kenya (FHOK) has successfully advocated in partnership with the Concept Foundation and other organizations for the Ministry of Health to register Medabon®. The combined drug provides clients with the option of a non-surgical, private, highly effective and safe method to terminate a pregnancy.

The availability of this quality-controlled combination drug, in doses recommended by the World Health Organization, has already reduced the complication rates of medical abortion in FHOK. Following registration, FHOK was able to procure Medabon® at a competitive rate. Before, the Association was only able to provide medical abortion using local brands of mifepristone and misoprostol, which were not quality assured and which resulted in higher complication rates. Following the registration and procurement of Medabon®, the complication rate dropped from 4 per cent to 0.5 per cent. There has also been a 21 per cent increase in the number of clients adopting medical abortion in FHOK clinics since Medabon® was introduced.

Programme successes: access

Introducing non-scalpel vasectomy in Burundi

Association Burundaise pour le Bien-Etre Familial (ABUBEF)

In Burundi, the proportion of women using a modern method of contraception is 18 per cent;[22] the total fertility rate in the country remains high at 6.1;[23] and 79 per cent of parents feel that they do not have enough income to take care of their children.[24] Before 2011, the only method of male contraception available was condoms.

However, this changed when the Association Burundaise pour le Bien-Etre Familial (ABUBEF) introduced non-scalpel vasectomy for the first time in the country in 2011. ABUBEF successfully overcame initial disinterest and scepticism from local government and potential clients, as well as opposition from religious groups. The Association established effective partnerships with public hospitals, and trained service providers on counselling and provision of non-scalpel vasectomy in both its own clinics and in hospitals. ABUBEF established a pool of trainers who continue to train other service providers on the procedure.

The Association also trained community health workers and peer educators on raising awareness of non-scalpel vasectomy, attracting potential clients, and referring clients for the procedure. One important aspect of awareness raising focuses on dispelling myths associated with vasectomy. For example, many people thought that vasectomy was the same as castration. Men feared that it would cause erectile dysfunction, while women believed that it would lead to promiscuity among men. Clarifying these misconceptions was essential for gaining support from local government and creating demand among potential clients for the procedure.

From 2011 to 2013, ABUBEF provided 278 non-scalpel vasectomies, and the Association has noticed a marked increase in the attendance and involvement of men in its centres.

> Only 3 percent of couples worldwide use vasectomy as their primary contraceptive method, even though it is permanent, safe, and cost-effective – and the only long-acting contraception available for men. The rate is even lower in sub-Saharan Africa: less than 0.1 percent of married women rely on a partner's vasectomy as a contraceptive method.[25]

Providing displaced people with life-saving services

Syrian Family Planning Association (SFPA)

As a result of the conflict that began in 2011, 9.3 million people in Syria are in need of humanitarian assistance, including 6.5 million internally displaced people,[26] and 2.4 million women and girls of reproductive age.[27] Syria's health system has effectively collapsed due to a lack of medical personnel and health supplies, and damaged or destroyed health facilities. An estimated 200,000 women are pregnant, with 1,480 giving birth in dire conditions every day.[28]

When the conflict began, the Syrian Family Planning Association (SFPA) was one of the first organizations to respond. SFPA adapted its services and increased its network of mobile clinics and outreach teams to meet the needs of the growing displaced population and to help fill the gap left by the damaged health system.

In partnership with agencies such as UNFPA and UNICEF, SFPA is providing the Minimum Initial Service Package (MISP) for sexual and reproductive health in crises through mobile clinics and outreach teams, and referring clients to its static clinics for a wider range of services. MISP components include preventing and managing the consequences of sexual violence; reducing HIV transmission, and neonatal and maternal morbidity and mortality; and addressing other reproductive health needs.

Recognizing SFPA's ability to provide sexual and reproductive health services throughout Syria, United Nations agencies have relied on the Association to lead on the provision of MISP since the crisis began. SFPA trained volunteers and medical staff to respond to emergency cases. Young people were also trained to provide basic medical care and psychosocial support.

In 2013, SFPA provided 967,000 sexual and reproductive health services free of charge, primarily to displaced populations. This was over six times more than in 2012 when SFPA provided 147,000 services. In collaboration with UNICEF and the Ministry of Health, the Association increased its provision of services to children under the age of 15. Outreach teams have also provided medical care and malnutrition prevention services to displaced children in shelters.

> Many pregnant women in Syria suffer multiple challenges, such as psychological difficulties, gynaecological problems, nutritional shortages and complications from early pregnancies. Maternal deaths increase during disasters.[29]

perform a relevant and accountable Federation

IPPF's achievements in 2013 contribute to a strong performance culture where decisions are based on data, organizational learning happens at all levels, technical support is provided to increase effectiveness, and investments are made to support communities most in need.

IPPF is committed to a performance culture and to maintaining a triangle of accountability for the promises we have made – to ourselves, our donors and partners, and to public citizens around the world. In 2013, we continued to monitor, review and invest in our internal systems and business processes to support strategic planning, financial and information management, organizational learning, accreditation, capacity building and governance. We also made improvements to our funding mechanism for Member Associations, and invested in our capacity to raise and manage restricted grants successfully.

IPPF's 2013 achievements in the area of Perform are presented in Figure 11. The overall results are positive, with two indicators showing significant progress, and four showing progress compared to 2012 but remaining below their 2013 targets.

Total income raised by the Secretariat fell by US$8.7 million to US$136.1 million, primarily due to a one-off legacy donation of US$15.0 million received in 2012. Excluding this donation, income rose by 5 per cent, but the target of US$137.5 million was not met. Income raised by Member Associations grew by US$12.0 million from 2012 to US$384.1 million, but missed the target by US$9.2 million.

IPPF demonstrated good progress in implementing systems to support the utilization of data in 2013. The proportion of IPPF's unrestricted funding used to reward Member Associations through a performance-based funding system increased by 1 per cent from 2012 to 7 per cent. This is a good result but falls short of the target of 8 per cent. The proportion of Member Associations using sexual and reproductive health service costing data from static clinics increased significantly from 2012, from 13 to 27 per cent, and exceeded the target of 18 per cent. The number of Member Associations using the IPPF methodology to estimate the proportion of clients who are poor and vulnerable doubled from 10 in 2012 to 20 in 2013, again achieving the 2013 target.

The proportion of Member Associations that have 20 per cent or more young people on their governing board grew by 5 per cent to 63 per cent. This is good year-on-year progress but remains below the target of 75 per cent.

This section presents achievements in strengthening IPPF's performance culture, with a focus on improving data quality, data-driven decision making, learning and capacity building among Member Associations, and investing for results.

Figure 11: Perform – performance results in 2013

Target: US$137.5 million of IPPF income (unrestricted and restricted), raised by the Secretariat **P.1**	**Target:** US$393.3 million of Member Association income (minus IPPF income), supported by the Secretariat **P.2**	**Target:** 8% of IPPF's unrestricted funding is used to reward Member Associations through a performance-based funding system **P.3**
US$136.1m	US$384.1m	7%
Target: 18% of Member Associations use SRH service costing data from static clinics **P.4**	**Target:** 20 Member Associations collect data on poverty and vulnerability status (using the IPPF Vulnerability Assessment methodology) **P.5**	**Target:** 75% of Member Associations have 20% or more young people under 25 years of age on their governing board **P.6**
27%	20	63%

Using client feedback to drive decisions

Member Associations collect feedback from their clients and use this information to inform decisions about how to improve the quality of their service provision and clinical care.

Reproductive Health Alliance Kyrgyzstan (RHAK) collects feedback from client satisfaction questionnaires and a comments book. Service providers analyse this feedback on a monthly basis and use the findings to improve the quality of care in the clinics. Following analysis of the feedback, RHAK made a post-abortion care leaflet available in the recovery room so clients can read it before their post-abortion counselling, and discuss with the counsellor if anything is unclear.

In Australia, Family Planning New South Wales (FPNSW) seeks feedback from client satisfaction surveys available on the Association's website and in waiting rooms, as well as a feedback and complaints form on the website. The information received is used to make quality improvements. Client feedback led FPNSW to introduce strategies to reduce waiting times and keep clients informed of possible waiting times; to alter clinic hours to better meet client needs; and to improve access to its telephone information and referral service. The Association started providing client parking on site, and introduced online and text message appointment systems. FPNSW also established a youth advisory group to design service delivery models for young people, including drop-in clinics.

The Family Planning Association of Hong Kong (FPAHK) collects feedback from client exit surveys. Findings from the surveys are shared with clinic and youth centre staff and are used to make decisions about how to improve clinics and the quality of services. As a result of analysing client feedback, FPAHK has reduced waiting times and improved its telephone answering services. The Association has also recruited doctors to fill vacancies and meet demand.

> I was very happy with the way the [counsellor] explained what I should expect from the procedure. Even after the abortion, the doctor explained how I should take care of myself and return back in one week for a check-up.
>
> 25-year-old client, FPA India

Member Associations in Nepal and Sri Lanka used the rapid PEER (Participatory Ethnographic Evaluation and Research) methodology[30] to gather feedback from clients on the accessibility of integrated sexual and reproductive health and HIV services. In Nepal, the target group was young people whereas in Sri Lanka, it was men who have sex with men. The objectives of the research were to identify barriers to accessing integrated services and propose ways to increase access.

Young beneficiaries in Nepal recommended making integrated services available in schools, establishing standards for private providers, and providing information in the community on the availability of services. Recommendations from men who have sex with men in Sri Lanka focused on ensuring services are confidential and providers are non-judgemental; involving men who have sex with men in planning service delivery programmes; training clinic staff to provide specialized services; and educating other stakeholders, including the judiciary, police and religious leaders.

Improving data quality

Capturing quality data is essential for data-driven decision making. In 2013, IPPF worked with MEASURE Evaluation to adapt its routine data quality assessment tool for use by Member Associations. IPPF and MEASURE Evaluation also developed a user guide for the tool which is available online.[31]

The tool enables Member Associations to rapidly verify the quality of data for selected indicators and to assess how well their data management systems collect, manage and report data. It contains a series of data collection worksheets that are completed at various service provision levels. These worksheets assess if data match reported numbers from each source, and whether service delivery and intermediate aggregation sites are collecting and reporting data accurately, completely and on time.

The tool is designed to generate specific outputs when data from the various reporting levels have been supplied. It then supports Member Associations to develop and implement action plans based on the results of the assessment to strengthen data management and reporting systems. Finally, by using the tool, Member Associations can monitor capacity improvements and performance of their data management and reporting systems to produce quality data over time.

IPPF piloted the adapted routine data quality assessment tool with the Family Planning Association of Malawi (FPAM). As a result, FPAM made a number of changes to address issues raised during the application of the tool. For example, some services were redefined, and clear guidelines were given to service providers on how data should be captured and reported. FPAM also established and circulated a data collection, reporting and management procedure for each level of aggregation. Data quality feedback has been incorporated into FPAM's quarterly management meetings, and the Association is now using the tool on a quarterly basis to conduct routine data quality checks as part of ongoing monitoring and supervision.

Federation-wide learning and improvement: capitalizing on the expertise of Member Associations

One of the benefits of being a member of IPPF is the opportunity to learn from and share with other members. While Regional Offices provide technical support to Member Associations in their regions, a growing trend is to decentralize this capacity building and call on Member Associations, who are experts in implementing sexual and reproductive health and rights programmes, to provide this support directly to each other.

In 2013, 40 Member Associations received direct technical support from another Member Association, and 41 Associations participated in knowledge sharing events with others. Due to national context, cost and language, most of the technical support between Member Associations is provided within the same regions, as illustrated by the examples below. Building on the success of these regional initiatives, IPPF is currently piloting a global mechanism to support inter-regional provision of technical support between Member Associations.

Strengthening capacity to work with young people with learning disabilities in Europe

Young people with learning disabilities face a number of obstacles to enjoying their sexual rights and are nearly five times more likely to experience sexual violence than non-disabled youth.[32] For young people with learning disabilities to be empowered to protect themselves against sexual abuse and violence, carers need to acknowledge and respect their sexuality and to provide guidance on protection and behaviour. Carers, however, are often not adequately trained to deal with sexuality issues, and many see sexuality as a problem.

Twelve European Member Associations have created a network to support each other in their efforts to prevent sexual abuse and violence against young people with learning disabilities. The group is divided into three categories: five 'expert' Associations with strong skills in the field, three 'learning' Associations with some expertise, and four 'entry-level' Associations that do not have any experience.[33]

The IPPF European Network Regional Office developed three manuals based on input from the expert Member Associations to provide a comprehensive resource pack that is used as the basis for training and capacity building. The manuals, which have been translated into numerous languages, are available for use by other Member Associations, and as a global good to all who are supporting young people with learning disabilities and their families.[34] The manuals are:

- a training manual for organizations that work directly with young people with learning disabilities
- a training manual for organizations that work with families and institutions
- a best practice manual for setting up a programme

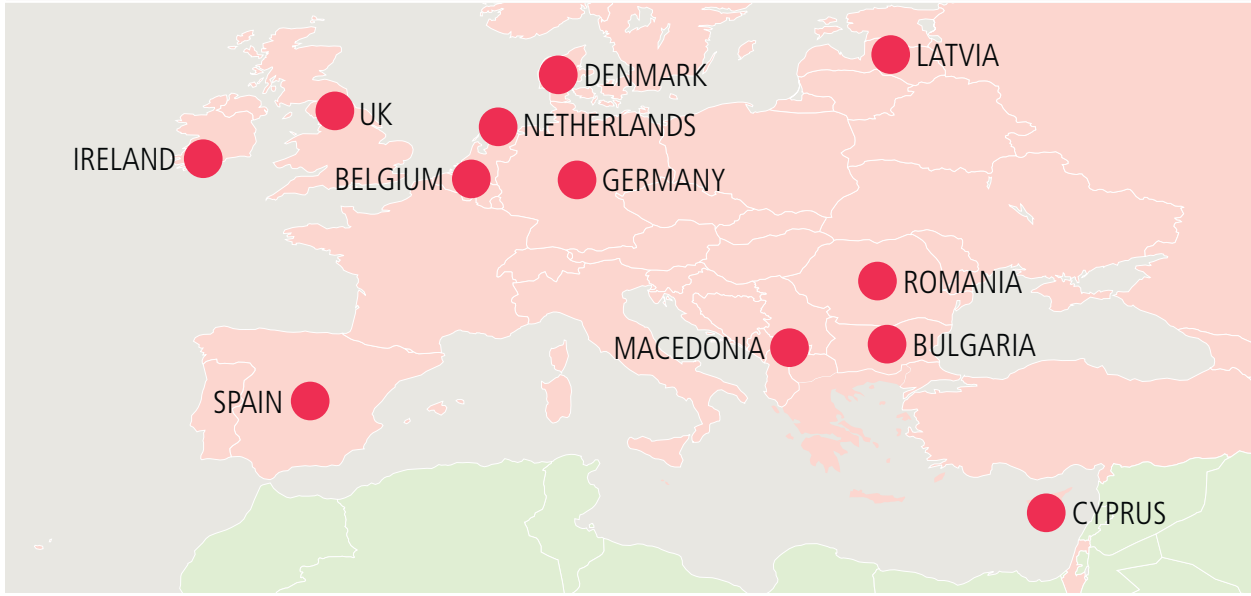
40

Member Associations received direct technical support from another Member Association

41

Member Associations participated in a knowledge sharing event with other IPPF members

Preventing sexual abuse and violence against young people with learning difficulties



The network uses a range of experiential learning methods to ensure good practice is shared. Staff from the expert Member Associations have provided training to others, and three technical support exchange visits involving seven Member Associations have taken place, with more planned for 2014. Distance mentoring is being provided on a continuous basis, and other non-IPPF partners have been identified, with regional and national promotion of the programme generating interest from others working directly with young people with learning disabilities.

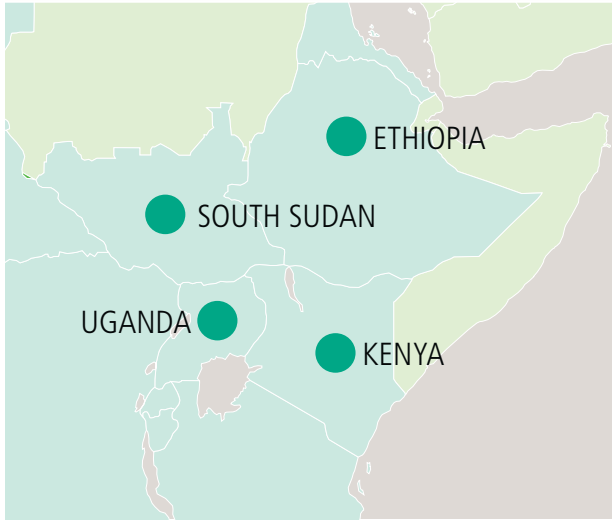
Supporting the new collaborative partner in South Sudan

IPPF's collaborative partner in the new country of South Sudan was established by a group of volunteers in December 2011. The Reproductive Health Association of South Sudan (RHASS) operates one static clinic in the country's capital Juba, but aims to expand coverage nationwide. The partner has received direct technical support from three African Member Associations.

Board members from RHASS travelled to Ethiopia to hear how the Family Guidance Association of Ethiopia expanded from one clinic to become the leading sexual and reproductive health organization in the country. RHASS saw the importance of building strong partnerships with the government, donors and the community. Service providers from RHASS visited Family Health Options Kenya, where they learned about contraceptive technology, providing quality sexual and reproductive health services, and data collection. Administrative staff visited Reproductive Health Uganda to look at its accounting and other administrative systems and processes.

Following the visits, RHASS began providing youth-friendly sexual and reproductive health services. Africa Regional Office staff trained service providers on monitoring and evaluation, and data collection systems in the clinic in Juba were strengthened. This experience illustrates the effectiveness of experienced Member Associations providing support to newly established partners, and highlights one of the benefits of being part of IPPF's network.

Technical assistance for the new collaborating partner in South Sudan



Building capacity on cost analysis in the Western Hemisphere region

In 2013, the IPPF Western Hemisphere Regional Office (WHRO) organized a regional workshop in Honduras, where the Bolivian Member Association, Centro de Investigación, Educación y Servicios (CIES), provided technical assistance on cost analysis to Member Associations in Honduras, Puerto Rico and Venezuela.

CIES trained the three Associations to use the Cost Revenue Analysis Tool Plus (CORE Plus), developed by Management Sciences for Health, to estimate the cost of services in static clinics, and to strengthen their cost analysis structures. They discussed strategies and established protocols to minimize costs and maximize the use of existing resources without compromising the quality of services. Following the workshop, CIES and IPPF WHRO staff visited each of the three Associations and supported them to develop action plans.

As a result of this capacity building, the Puerto Rican Member Association, Asociación Puertorriqueña Pro-bienestar de la Familia, conducted an analysis of pricing, productivity levels and the fixed cost base in its two main clinics. Using results from the analyses, the Association developed a plan to introduce new services in those clinics as part of a financial feasibility assessment. In Honduras, Asociación Hondureña de Planificación de Familia conducted a similar analysis in its six main clinics and is developing an action plan to address issues identified. In Venezuela, Asociación Civil de Planificación Familiar reviewed its service list, revised its fee structure, and established new pricing in its clinics.

Member Associations sharing skills on cost analysis

This work has helped the Member Associations to develop meaningful cross-subsidization strategies. Having a clear sense of what their costs are enables them to charge prices that will yield a profit which can then be used to subsidize services for clients who do not have adequate means to pay.

IPPF volunteers: change agents in their communities

In 2013, IPPF undertook a study to demonstrate the contribution of IPPF's volunteers to our vision, mission and values. This study documented the difference that volunteering makes to the lives of the volunteers themselves, and to their communities. To collect the qualitative information, IPPF conducted six rapid PEER (Participatory Ethnographic Evaluation and Research) reviews, one in each region.[35]

Using the PEER methodology, volunteers were trained in interviewing skills and then conducted conversational interviews with other people in their social networks who also volunteer for the Member Associations to gather their stories and perspectives. This yielded an immediate and authentic account of how volunteering has changed lives. IPPF worked with multiple types of volunteers: young volunteers in Belize and Kyrgyzstan; community-based volunteers in Burkina Faso and the Philippines; and reproductive health volunteers and peer educators in Nepal. In Tunisia, the PEER interviewer group comprised visually impaired young volunteers, a midwife, a social worker, a clinic coordinator, and a former youth programme coordinator.

Despite the range of volunteer types and ages, there were commonalities among them all in terms of how volunteering has changed their lives. Volunteers involved in the rapid PEER reviews value the sexual and reproductive health and rights knowledge they have acquired. This has led to positive behaviour change as well as the opportunity to share this knowledge with their peers. Volunteering has given the volunteers increased confidence and self-esteem, and they are driven by a shared desire to help their communities. Their role as change agents has made a significant difference to their communities. For example, young volunteers in Belize and Kyrgyzstan share sexual and reproductive health information with their peers and refer them to the Association clinics. They have contact with young people that the Member Associations would otherwise be unlikely to reach.

Volunteers in Tunisia are driven by a desire to improve women's rights and sexual and reproductive health and rights in their communities. Community outreach workers run sensitization and information sharing activities on sexual and reproductive health and rights in villages, and refer clients to health facilities for services.

Community-based volunteers in Burkina Faso are improving the health and well-being of their communities by acting as intermediaries between the Member Association and the communities, providing sexual and reproductive health and rights information and counselling. They are seen as role models because of the positive changes made in their own lives, including increased uptake of contraception and a willingness to discuss sexual and reproductive health and rights issues. As a result, volunteers have noticed that use of contraception and birth spacing have increased in their communities.

In the Philippines, community-based volunteers feel responsible for the well-being of their communities and for sharing accurate information about sexual and reproductive health. They have played an important role in dispelling myths about sexual and reproductive health, for example, that condom use is linked to promiscuity among women and girls; sexually transmitted infections are carried by mosquitos; drinking bleach cures sexually transmitted infections; and the oral contraceptive pill can lead to birth defects.

The sustained presence of volunteers in their communities has led to increased uptake of contraception and an increased client load for the Family Planning Organization of the Philippines (FPOP). The volunteers are able to reach geographically isolated populations with information, services, counselling and contraception, and to make referrals to FPOP clinics.

> Volunteers are not paid – not because they are worthless, but because they are priceless

Reproductive health volunteers in Nepal raise awareness in their communities about sexual and reproductive health and rights. They also provide contraceptive counselling, as well as contraception, including injectables in some cases. Like the volunteers in the Philippines, they feel responsible for educating their communities about sexual and reproductive health and dispelling myths. They are an important link between rural communities and the Family Planning Association of Nepal (FPAN), and contribute significantly to the client flow at FPAN clinics.

Before, I had an ancestral view [on female genital mutilation], but I saw all the negative aspects with the information I learned. Now, I am the first to speak out against female genital mutilation.

50-year-old male governance volunteer, Burkina Faso

I made the choice [to become a volunteer] to help women and couples meet their reproductive health needs, to help make sexuality more recognized as part of life.

27-year-old female clinical volunteer, Tunisia

When a girl has an unwanted pregnancy, you can't tell the parents because to them you have to stay a virgin. Everything turns upside down for the family in such situations. Volunteers are valuable. They accompany her to the clinic.

20-year-old female volunteer, Kyrgyzstan

When I first got involved with FPOP, it was common in my area to have seven to eight children. People were guided by priests who spoke publicly against any sort of contraception. Now, even people who are religious use contraception and do not have more than three kids.

47-year-old female community-based volunteer, Philippines

We make FPAN visible in the communities. We explain what FPAN does and what services are available at the branch.

25-year-old female reproductive health volunteer, Nepal

He feels that it's important, the information we're passing on, because both of his sisters are teen mothers [at ages 13 and 15]. If our information had reached his family faster, we would have prevented his sisters from being teen mothers.

*17-year-old male volunteer, Belize**

* The attribution refers to the person who the quotation is about, rather than the PEER interviewer who reported the statement.

MOVING FORWARD TOGETHER

Developing IPPF's Strategic Framework 2016–2022

In 2013, IPPF developed an inclusive and collaborative process to identify the next strategy that will guide the Federation when the current Strategic Framework ends in 2015. As a globally connected, locally-owned civil society movement that champions and advances sexual and reproductive health and rights for all, our desire is to agree clear and focused priorities that will help us build on past achievements and respond to the changing global and local landscapes.

122 Member Associations and collaborative partners responded to electronic questionnaires

17 strategy meetings were held with volunteers, staff and young people

20 donors provided feedback and suggestions

Engage

We have consulted widely, both within the Federation and with external stakeholders, to generate valuable feedback. This process has involved reflecting on our past and identifying challenges and opportunities for the next seven years – for the Federation as a whole and taking into consideration the rich diversity of Member Associations and the country contexts in which they work.

Focus

A dedicated group of Member Association and Secretariat staff analysed the feedback and drafted a new Strategic Framework for further consultation at all levels of the Federation. A draft outline was approved by IPPF's Governing Council in May 2014, and final approval is expected to follow in November. Work is progressing to develop the expected results that will be used to monitor implementation of the strategy.

Implement

Implementation of the new Strategic Framework will begin in 2016. To prepare, we will revise country level strategies and update our internal systems and performance mechanisms in 2015. This will enable us to move forward as a united Federation working toward a world free from discrimination, and where all people are empowered to make choices about their sexuality and well-being.

Investing for results

In 2013, total IPPF income raised by the Secretariat from governments, foundations and other sources fell by 6 per cent (US$8.7 million) to US$136.1 million. This net fall was due to a one-off legacy donation of US$15.0 million received in 2012 to support youth programming in Mexico. Excluding this donation, total income rose by US$6.3 million. The proportion of unrestricted income raised by the Secretariat was 62 per cent of total funding in 2013, compared to 53 per cent in 2012 due to the legacy donation, but is comparable with previous years (Figure 12).

Unrestricted funding can be allocated quickly and is essential to IPPF's effectiveness, innovation and sustainability. This type of funding is critical as it enables Member Associations to develop and maintain partnerships with governments and other stakeholders, deliver ongoing programmes and build on lessons learned. The increase in unrestricted grants from US$77.4 million to US$84.7 million enabled IPPF to raise the amount of grants to Member Associations and other partners by 12 per cent in 2013 to a total of US$80.1 million.

Analysis of expenditure by programme area shows that access, abortion, capacity building and adolescents received the greatest amount of funding in 2013, closely followed by advocacy and HIV and AIDS (Figure 13). Overall, 77 per cent of funding was invested in programmes across IPPF's five strategic priorities of adolescents, abortion, HIV and AIDS, access and advocacy, with the remaining 23 per cent in supporting strategies.

IPPF continues to invest in countries with the lowest levels of development and the greatest unmet needs for sexual and reproductive health and rights. In 2013, 85 per cent of grants to Member Associations and other partners went to those working in countries with low or medium human development.[36] Member Associations and partners in countries with the highest development needs are located in Africa and South Asia; they received 36 per cent and 19 per cent of the grants awarded, respectively.

The international development aid architecture is continuing to shift, with bilateral donors and other international funding agencies increasingly granting funds directly to partner organizations in countries where activities are implemented. It is becoming increasingly more important, therefore, for Member Associations to invest in fundraising strategies and identify potential sources of income in country. Member Association income (minus IPPF grants) in 2013 increased by US$12.0 million, to US$384.1 million. This represents 83 per cent of overall Member Association funding. Detailed information on IPPF finances is available in the IPPF Financial Statements 2013.[37]

IPPF's performance-based funding system was used in five of the six regions in 2013 to make data-driven decisions about resource allocation to Member Associations. In each case, there is a maximum of +/- 10 per cent of unrestricted funds awarded to Associations, depending on their performance. In 2014, the Arab World region started to implement performance-based funding, which means all six regions are now using the system.

Figure 12: Income raised by the Secretariat, by type, 2010–2013

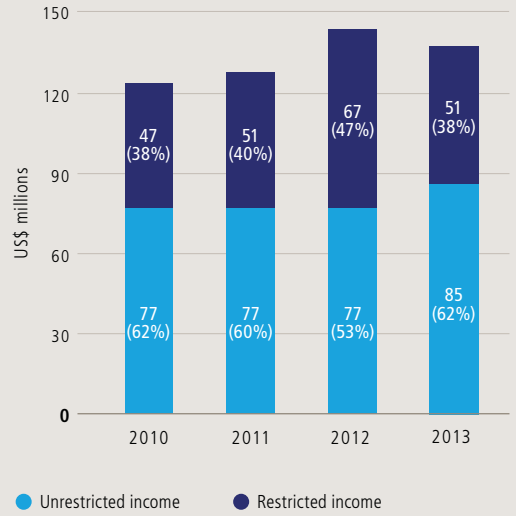
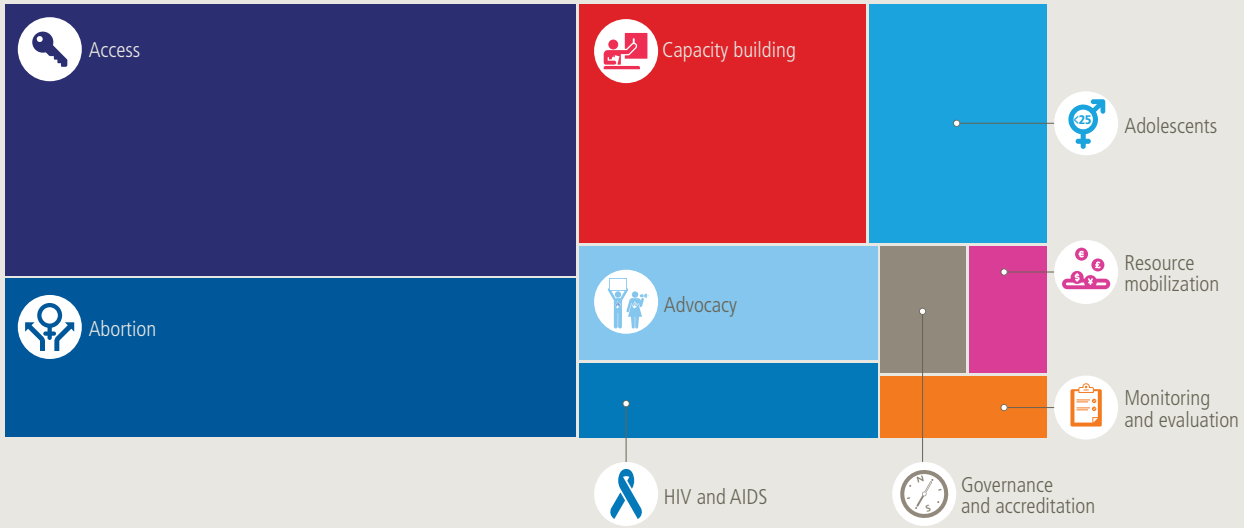


Figure 13: Expenditure, by programme area, 2013



Programme successes: Perform

Learning about the provision of community-based injectables

Association de Bien-Etre Familial – Naissances Désirables (ABEF-ND)
Association Togolaise pour le Bien-Etre Familial (ATBEF)

The Democratic Republic of Congo has one of the lowest contraceptive prevalence rates in the world, with only 5 per cent of married women using a modern method.[38] The Member Association in the Democratic Republic of Congo, Association de Bien-Etre Familial – Naissances Désirables (ABEF-ND), is committed to increasing access to modern methods of contraception.

ABEF-ND has received technical support from the Member Association in Togo, Association Togolaise pour le Bien-Etre Familial (ATBEF), on the provision of injectable contraceptives by community workers. After the government of Togo gave permission for non-medical personnel to provide injectable contraceptives, ATBEF trained and equipped community health workers to provide a range of contraception, including injectables. This High Impact Practice in Family Planning[39] has enabled ATBEF to increase access for poor and vulnerable clients in Togo.

ABEF-ND staff visited ATBEF to learn about this initiative and understand how they could replicate something similar. Following the visit, ABEF-ND initiated a pilot programme in its Bandundu branch. The Association trained 20 nurses on providing injectables in the community setting and equipped them with the necessary supplies and revised reporting tools.

The Democratic Republic of Congo does not have a task shifting policy like the one in Togo. ABEF-ND, therefore, will use the results from Bandundu to advocate for national policy change. It will argue that nurses should provide injectable contraceptives as part of community-based distribution to reach more under-served people, and that non-medical personnel should also be trained, equipped and supported to provide injectables in the community, as is the case in Togo.

ABEF-ND's advocacy plans are aligned with the government's recent Family Planning 2020 commitment to increase access to modern methods of contraception. The commitment includes the first-ever allocation of national budget for the purchase of contraceptives, as well as increasing the modern contraceptive prevalence rate to 19 per cent by 2020.[40]

During the exchange visit, ABEF-ND staff noticed that ATBEF's user fees were lower than those of other clinics and hospitals, leading to increased access for poor and vulnerable clients. ABEF-ND is currently looking into the possibility of lowering its user fees, and the Association has also started to provide free contraceptive services, including long-acting, reversible methods, during community outreach.

Using cost analysis to increase efficiency

Association Mauritanienne pour la Promotion de la Famille (AMPF)
Palestinian Family Planning and Protection Association (PFPPA)
Sudan Family Planning Association (SFPA)

Three Member Associations in the Arab World region have used the Cost Revenue Analysis Tool Plus (CORE Plus) to increase efficiency. The tool helps determine projected and actual costs of services, by type. Costs can be compared for different numbers of clients and different service delivery models. The tool analyses the time taken to provide each type of service and provides data that can be used to improve efficiency.

In Mauritania, CORE Plus was used to support the Association Mauritanienne pour la Promotion de la Famille to design strategies to address the needs of under-served communities. This included expanding the package of services provided, training midwives to use ultrasound, increasing demand generation activities, and better utilization of service providers' time. Results of the analyses also supported revision of the supply management system for improved efficiency.

The Palestinian Family Planning and Protection Association has used CORE Plus to estimate the cost of each service and then compare performance, including the costs of services, across its service delivery points. Changes made as a result of CORE Plus analyses included switching from the use of latex gloves to rubber ones by cleaners, contracting laboratory technicians instead of operating laboratories, and working with specialists on a part-time basis to free other medical personnel without reducing client flow. Lastly, new services were introduced to support cost recovery.

Based on analyses using CORE Plus, the Sudan Family Planning Association has revised its pricing system and opening hours, and reflected on where services need to be provided in areas with an absence of health coverage by the state. Analyses also highlighted the efficiency of the work of community-based service providers and mobile clinics in reaching those with greatest needs, including internally displaced populations. Financial systems were reviewed to identify cost drivers and to include costs of donations that had previously been omitted, such as commodities.

Preventing cervical cancer with low resource screening methods

Reproductive and Family Health Association of Fiji (RFHAF)
Sexual Health and Family Planning Australia (SH&FPA)

Cervical cancer is the most common cancer and leading cause of cancer death in Fiji.[41] Screening and treatment of pre-cancerous lesions could prevent most cases of cervical cancer death.[42] However, in Fiji, only 10 per cent of women get regular Pap tests.[43] Family Planning New South Wales (FPNSW), a member of the Australian Member Association and its lead agency in the international development arena, partnered with the Reproductive and Family Health Association of Fiji (RFHAF), the Fiji Ministry of Health and the Fiji Nursing Association to provide a cervical cancer screening and treatment programme.

The programme piloted visual inspection of the cervix with acetic acid (VIA) which is a safe, effective and low-cost way to screen for cervical cancer. It also included treatment of pre-cancerous lesions by cryotherapy, a fast and pain-free method. This single visit approach, with no waiting for treatment and no need for referrals, is recognized by the World Health Organization and is appropriate for low-resource settings such as Fiji.

FPNSW worked with the Ministry of Health to review the possibility of nurses providing VIA and cryotherapy. Initially, doctors did not support the initiative, meaning that women needed to travel long distances to a health centre to see a doctor to obtain these services and that many women were being lost to follow-up. FPNSW reviewed data with Ministry of Health staff, convincing them of the importance of allowing nurses to perform the procedure. FPNSW developed and delivered training on VIA and cryotherapy to nurses in Fiji, which qualified them to carry out the procedures.

The Fijian Member Association played a key role in creating a demand for the screening services. RFHAF was chosen as a partner because of its connection with community members and its skills in providing information and education. RFHAF held awareness raising sessions with community and church groups, market vendors, garment factory workers, and in schools. The Association conducted door-to-door outreach in squatter settlements, and developed information, education and communication materials. During follow-up, RFHAF found that 70 per cent of women engaged during community outreach activities attended the health centres and hospitals for screening services.

During the two-year pilot, more than 3,700 women were screened using VIA; 7 per cent of those screened had a pre-cancerous or cancerous lesion detected. The 2 per cent that required further treatment received cryotherapy. In 2013, this single visit screening and treatment approach was endorsed for national implementation across Fiji.


Family Planning New South Wales/Roneel Lal/Fiji

Throughout the development of the programme, FPNSW worked closely with Ministry of Health clinicians to ensure ownership and implementation, and the Ministry is now in the process of training clinicians in all regions of Fiji to increase access to screening across the country. FPNSW continues to provide mentoring and support to the nursing staff implementing the training.

> “It has given me peace of mind that I can confidently say that I have no symptoms of developing cervical cancer, especially at my age.
>
> 55-year-old woman who had never had a Pap test

Next steps

Our three Change Goals continue to guide us in making best use of resources to maximize progress from now to 2015. Our immediate plans focus on ensuring sexual and reproductive health and rights are reflected in the post-2015 development framework, and delivering on our commitment to double services.

Unite

As the United Nations Member States begin to finalize the details of the new development goals, and working alongside the Open Working Group and other United Nations processes, IPPF will focus on securing sexual and reproductive health and rights in the post-2015 development framework. We will also advocate for global level targets and indicators on sexual and reproductive health and rights, and at the national level, Member Associations will encourage governments to set their own ambitious targets for each country.

IPPF will intensify engagement with regional and international institutions, such as the African Union. Across the globe, we will hold policy makers accountable to the promises they have made on sexual and reproductive health and rights, and Member Associations will work at national level to ensure that global policy commitments are translated into national policy and programme priorities. Using the I Decide petition, IPPF will unite Member Associations to focus on Goal 3 of IPPF's Vision 2020 – to eliminate discrimination against women and girls.

IPPF will continue to press governments to keep the promises they made on contraception at the 2012 London Summit on Family Planning or subsequently to Family Planning 2020 (FP2020), while encouraging other countries to make new pledges. We will amplify civil society's voice within the FP2020 initiative by reaching out to the wider civil society constituency, and through IPPF representation on the FP2020 Reference Group and Working Groups.

Deliver

Our strategic approach to trebling services by 2020 identified a number of service delivery channels and service areas with high potential for scale-up. In mid-2014, IPPF set aside US$3.0 million in unrestricted funds to strengthen work in three critical areas: sexual and gender-based violence (US$1.5 million); cervical cancer (US$1.0 million); and social franchising, including the provision of long-acting contraceptives (US$0.5 million). Small working groups comprising staff from across the Secretariat have been established to learn from IPPF's experience to date, develop tools and guidelines to enhance future work, and provide targeted support to the subset of 42 Member Associations that have been identified as focus countries for increasing comprehensive service provision. We have also begun to identify opportunities to increase sexually transmitted infection services, and we will develop a longer-term plan by the end of 2014 and seek additional resources to support this vital work.

Our commitment to increasing services, particularly for poor and vulnerable people, is coupled with a focus on quality assurance and quality improvement. We have strengthened Secretariat capacity to support quality of care and are working to pull together good practice from across the Federation and to update and strengthen existing assessment tools and guidelines. We are also working to improve supplies management to avoid stock outs and discontinuity of services in Member Associations. These investments in quality of care will increase the acceptability and accessibility of services and enhance client satisfaction.

Perform

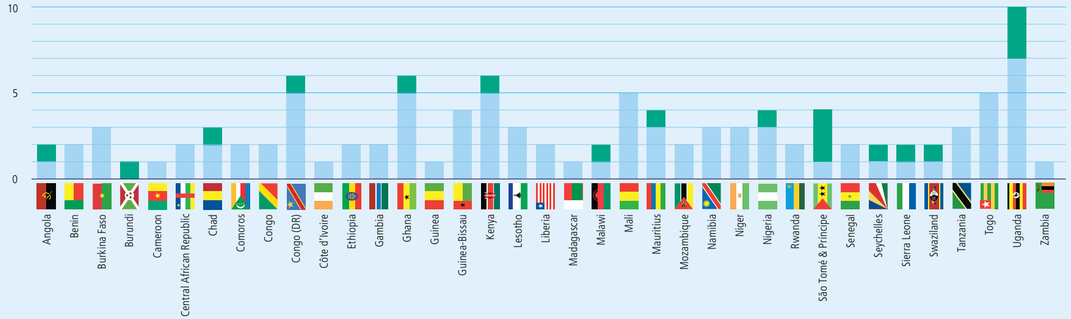
IPPF's commitment to organizational effectiveness means investing in our internal systems and business processes to support financial and information management, organizational learning, capacity building and governance. In 2015, we will ensure that all systems are ready for the beginning of the next Strategic Framework (2016–2022), including a performance dashboard to monitor progress. We will also assist Member Associations in developing their own strategic plans to align with the global framework.

An increasing focus on performance culture is supported by a number of systems and tools that support data analysis and utilization. In 2015, IPPF will begin using a health management information system to collect, analyse and report data on sexual and reproductive health services and to drive decision making for improved programmes. This system will also support the move toward capturing real-time data from all service delivery points. Client-centred clinic management information systems will continue to be at the heart of promoting meaningful use of information to improve client health outcomes and support service providers in their work.

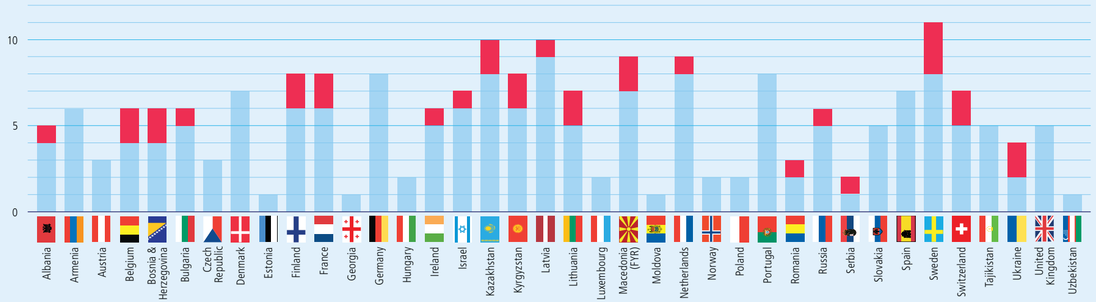
Future plans for learning between Member Associations focus on capacity building and using a range of approaches such as in-country visits, workshops, training courses and virtual mentoring. 'Expert' Member Associations are increasingly recognized as being optimal partners to provide technical support, and are using these opportunities to act as invaluable resources for other Member Associations as well as for government and partners external to IPPF.

Annex A: Number of policy and/or legislative changes, by country, 2005–2013

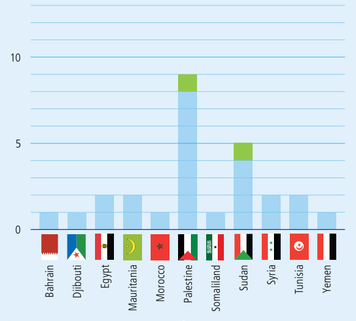
Africa



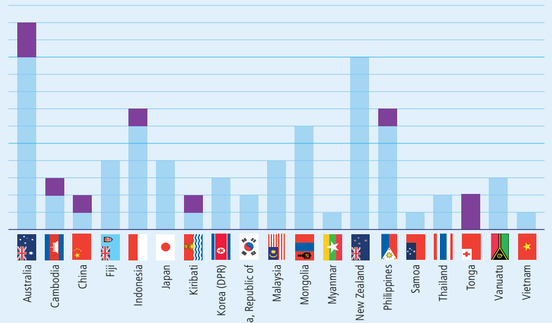
European Network



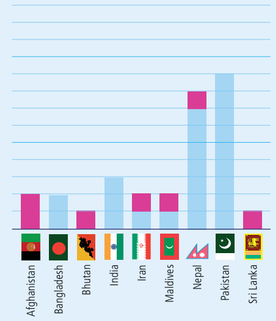
Arab World



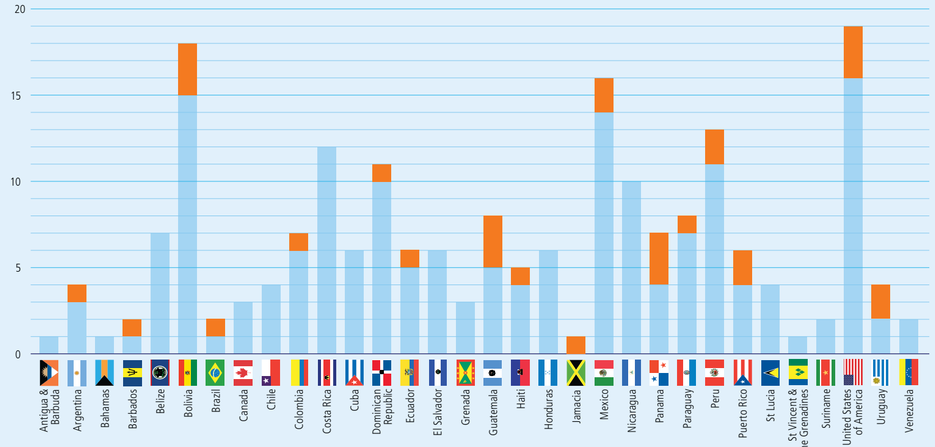
East and South East Asia and Oceania



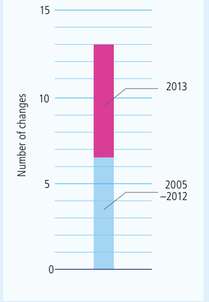
South Asia



Western Hemisphere



Key



Annex B: Global performance results, by region, 2010–2013

Table B.1: Online survey response rate, 2010 and 2013

IPPF region	Year	Total number of Member Associations/ collaborative partners	Number of Member Associations/ collaborative partners that responded	Response rate (per cent)
Africa	2013	42	39	93%
	2010	37	37	100%
Arab World	2013	15	14	93%
	2010	15	13	87%
European Network	2013	39	38	97%
	2010	41	41	100%
East and South East Asia and Oceania	2013	26	26	100%
	2010	22	22	100%
South Asia	2013	9	9	100%
	2010	9	9	100%
Western Hemisphere	2013	30	30	100%
	2010	29	29	100%
Total	2013	161	156	97%
	2010	153	151	99%

Table B.2: Online service statistics module response rate, 2010 and 2013

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	2013	42	39	93%
	2010	37	37	100%
Arab World	2013	12	11	92%
	2010	13	9	69%
European Network	2013	24	20	83%
	2010	22	18	82%
East and South East Asia and Oceania	2013	26	26	100%
	2010	22	22	100%
South Asia	2013	9	9	100%
	2010	8	8	100%
Western Hemisphere	2013	29	29	100%
	2010	28	27	96%
Total	2013	142	134	94%
	2010	130	121	93%

Table B.3: IPPF's performance dashboard – global performance results, 2010–2013

Indicator	2010 baseline (actual, if available)	2011 (actual, if available)	2012 (actual)	2013 (target)	2013 (actual)	% of target achieved	2014 target	2015 target
Unite*								
U.1 Number of successful policy initiatives and/or positive legislative changes in support or defence of SRHR to which Member Associations' advocacy contributed	47	116	105	**50**	**97**	**194%**	50	50
U.2 Number of successful global and regional policy initiatives and/or positive legislative changes in support or defence of SRHR to which IPPF's advocacy contributed	n/a	5	11†	**5**	**13**	**260%**	5	5
U.3 Proportion of Member Associations monitoring obligations made by government in the international human rights treaties that they have ratified	n/a	n/a	42%	**n/a**	**55%**	**n/a**	58%	61%
Deliver								
D.1 Number of SRH services provided	88.2m	89.6m	112.7m	**125.8m**	**136.6m**	**109%**	149.0m	176.4m
D.2 Number of couple years of protection	8.9m	9.1m	11.8m	**12.7m**	**12.1m**	**95%**	15.1m	17.8m
D.3 Number of SRH services provided to young people (under 25 years) (as a % of all services provided)	31.0m (35%)	37.4m (42%)	45.1m (40%)	**57.9m** (46%)	**66.2m** (48%)	**114%** (104%)	71.5m (48%)	88.2m (50%)
D.4 Number of abortion-related services provided	1.8m	1.9m	2.4m	**3.4m**	**3.0m**	**87%**	4.9m	7.1m
D.5 Number of HIV-related services provided	12.3m	15.2m	19.2m	**21.2m**	**24.8m**	**117%**	25.1m	29.7m
D.6 Estimated number of IPPF clients who are poor and vulnerable (as a % of all clients)	23.9m (72%)	24.9m (73%)	36.1m (81%)	**35.3m** (77%)	**48.8m** (81%)	**138%** (106%)	41.8m (79%)	49.5m (80%)
D.7 Proportion of Member Associations providing the Integrated Package of Essential Services	7%	14%	21%	**33%**	**26%**	**80%**	44%	55%
D.8 Number of young people (below 25 years of age) who completed a comprehensive sexuality education programme delivered by Member Association staff	n/a	4.4m	18.2m	**20.0m**	**25.1m**	**126%**	27.6m	30.4m
Perform								
P.1 Total IPPF income (unrestricted and restricted), raised by the Secretariat (US$)‡	124.2m	127.6m	144.8m≠	**137.5m**	**136.1m**	**99%**	145.7m	154.3m
P.2 Total Member Association income (minus IPPF income), supported by the Secretariat (US$)‡	289.9m	324.3m	372.1m	**393.3m**	**384.1m**	**98%**	415.6m	439.3m
P.3 Proportion of IPPF's unrestricted funding used to reward Member Associations through a performance-based funding system	n/a	1%	6%	**8%**	**7%**	**88%**	10%	10%
P.4 Proportion of Member Associations using SRH service costing data from static clinics	n/a	n/a	13%	**18%**	**27%**	**150%**	25%	30%
P.5 Number of Member Associations collecting client data on poverty and vulnerability status (using the IPPF Vulnerability Assessment methodology)	n/a	1	10	**20**	**20**	**100%**	35	45
P.6 Proportion of Member Associations that have 20 per cent or more young people under 25 years of age on their governing board	57%	58%	58%	**75%**	**63%**	**84%**	90%	100%

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

† The 2012 value of U.2 was revised following a change in the reporting dates to be consistent with other indicators (January to December).

‡ Targets have been revised to double income between 2010 and 2020, instead of 2015.

≠ The 2012 income was increased by a one-off legacy donation of US$15.0 million in the Western Hemisphere region.

Table B.4: Change Goal UNITE – performance results, by region, 2010–2013

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	**2013**	**18**	**2**	**32**	**9**	**7**	**29**	**97**
	2012	12	8	27	10	3	45	105
	2010	9	2	12	8	2	14	47
U.2 Number of successful regional and global policy initiatives and/or positive legislative changes in support or defence of SRHR to which IPPF's advocacy contributed	**2013**	**1**	**1**	**5**	**1**	**1**	**1**	**13**†
	2012	1	0	3	1	0	2	11‡
	2010	n/a	n/a	n/a	n/a	n/a	n/a	5≠
U.3 Proportion of Member Associations monitoring obligations made by government in the international human rights treaties that they have ratified	**2013**	**51%**	**29%**	**61%**	**46%**	**44%**	**77%**	**55%**
	2012	62%	29%	49%	12%	22%	48%	42%
	2010	n/a	n/a	n/a	n/a	n/a	n/a	n/a

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

† Includes four global advocacy successes; the wins in ESEAOR and SAR were counted as one (page 7).

‡ Includes four global advocacy successes; the 2012 value of U.2 was revised following a change in the reporting dates to be consistent with other indicators (January to December).

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

Table B.5: Change Goal DELIVER – performance results, by region, 2010–2013

Indicator	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
D.1 Number of SRH services provided	**2013**	**56,380,418**	**5,324,138**	**1,514,277**	**18,503,828**	**22,781,156**	**32,137,245**	**136,641,062**
	2012	39,473,382	2,821,454	1,730,329	15,616,282	18,576,517	34,491,529	112,709,493
	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	**2013**	**2,612,058**	**236,825**	**44,087**	**720,455**	**2,778,010**	**5,687,013**	**12,078,447**
	2012	**2,370,768**	**287,345**	**41,068**	**755,973**	**2,304,131**	**6,046,977**	11,806,262
	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)	**2013**	**31,648,478 (56%)**	**2,469,046 (46%)**	**741,829 (49%)**	**7,491,076 (40%)**	**10,619,393 (47%)**	**13,264,128 (41%)**	**66,233,950 (48%)**
	2012	14,581,128 (37%)	1,303,746 (46%)	841,979 (49%)	5,395,490 (35%)	8,779,415 (47%)	14,168,895 (41%)	45,070,653 (40%)
	2010	11,317,560 (38%)	424,714 (22%)	779,239 (52%)	2,382,796 (25%)	6,882,495 (47%)	9,214,640 (30%)	31,001,444 (35%)
D.4 Number of abortion-related services provided	**2013**	**542,659**	**84,603**	**107,591**	**278,138**	**382,454**	**1,561,332**	**2,956,777**
	2012	345,682	46,763	106,969	208,578	505,856	1,172,877	2,386,725
	2010	165,161	40,149	101,806	169,098	500,816	793,869	1,770,899
D.5 Number of HIV-related services provided	**2013**	**10,846,534**	**927,296**	**294,622**	**2,831,038**	**3,041,772**	**6,820,059**	**24,761,321**
	2012	7,110,125	439,801	203,697	3,269,967	1,865,541	6,279,162	19,168,293
	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)	**2013**	**21,647,085 (83%)**	**2,354,933 (85%)**	**1,391,101 (60%)**	**8,378,044 (76%)**	**9,422,826 (88%)**	**5,655,969 (78%)**	**48,849,958 (81%)**
	2012	7,822,183 (89%)	834,261 (76%)	1,205,521 (59%)	12,225,537 (83%)	7,081,260 (82%)	6,973,234 (75%)	36,141,996 (81%)
	2010	4,640,396 (73%)	347,441 (49%)	478,508 (30%)	6,894,071 (77%)	5,780,588 (82%)	5,746,949 (68%)	23,887,953 (72%)
D.7 Proportion of Member Associations providing the Integrated Package of Essential Services*	**2013**	**13%**	**45%**	**n/a†**	**0%**	**56%**	**50%**	**26%**
	2012	8%	9%	n/a†	9%	33%	52%	21%
	2010	5%	0%	n/a†	4%	13%	15%	7%
D.8 Number of young people (below 25 years of age) who completed a comprehensive sexuality education programme delivered by Member Association staff	**2013**	**873,340**	**1,689**	**437,939**	**22,447,386**	**162,712**	**1,176,516**	**25,099,582**
	2012	560,086	2,286	489,591	15,632,261	261,541	1,204,440	18,150,205
	2010	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* There are eight components in the Integrated Package of Essential Services: sexuality counselling; contraception; safe abortion care; and STI/RTI, HIV, gynaecological, obstetric and gender-based violence services. 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 (see Annex C for details).

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

Table B.6: Change Goal PERFORM – performance results, by region, 2010–2013

Indicator	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
P.1 Total IPPF income (unrestricted and restricted), raised by the Secretariat, in US$ millions	**2013**							**136.1**
	2012			[Not applicable by regional breakdown]*				144.8
	2010							124.2
P.2 Total Member Association income (minus IPPF income), supported by the Secretariat, in US$ millions	**2013**	**55.2**	**4.6**	**4.9**	**142.5**	**17.9**	**159.0**	**384.1**
	2012	50.3	4.2	4.5	142.2	16.9	153.9	372.1
	2010	34.3	4.4	4.6	88.5	14.3	143.8	289.6
P.3 Proportion of IPPF's unrestricted funding used to reward Member Associations through a performance-based funding system	**2013**	**5%**	**0%**	**10%**	**10%**	**10%**	**6%**	**7%**
	2012	5%	0%	0%	10%	10%	6%	6%
	2010	n/a	n/a	n/a	n/a	n/a	n/a	n/a
P.4 Proportion of Member Associations using SRH service costing data from static clinics	**2013**	**31%**	**30%**	**0%**	**18%**	**56%**	**36%**	**27%**
	2012	20%	0%	0%	10%	56%	8%	13%
	2010	n/a	n/a	n/a	n/a	n/a	n/a	n/a
P.5 Number of Member Associations collecting client data on poverty and vulnerability status (using the IPPF Vulnerability Assessment methodology)	**2013**	**5**	**0**	**0**	**3**	**5**	**7**	**20**
	2012	2	0	0	0	5	3	10
	2010	n/a	n/a	n/a	n/a	n/a	n/a	n/a
P.6 Proportion of Member Associations that have 20 per cent or more young people under 25 years of age on their governing board	**2013**	**77%**	**71%**	**63%**	**62%**	**44%**	**47%**	**63%**
	2012	72%	64%	49%	58%	56%	52%	58%
	2010	73%	39%	42%	59%	44%	69%	57%

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

Table B.7: Number of couple years of protection provided, by region, by method, 2010–2013

Type of method	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of responses	**2013**	**(n=39)**	**(n=11)**	**(n=20)**	**(n=26)**	**(n=9)**	**(n=29)**	**(n=134)**
	2012	(n=39)	(n=12)	(n=21)	(n=26)	(n=9)	(n=28)	(n=135)
	2010	(n=37)	(n=9)	(n=18)	(n=22)	(n=8)	(n=27)	(n=121)
Intrauterine devices	**2013**	**396,051**	**192,349**	**22,209**	**207,166**	**797,980**	**1,746,698**	**3,362,453**
	2012	330,013	253,832	20,140	263,485	636,440	2,216,463	3,720,374
	2010	236,998	235,258	9,531	213,573	443,213	1,604,423	2,742,996
Oral contraceptive pill	**2013**	**578,948**	**18,826**	**6,369**	**152,463**	**455,862**	**800,430**	**2,012,899**
	2012	526,687	16,511	2,857	109,471	433,806	886,824	1,976,156
	2010	156,677	20,214	2,191	125,498	370,609	545,658	1,220,887
Voluntary surgical contraception (vasectomy and tubal ligation)	**2013**	**40,670**	**-**	**180**	**32,450**	**757,805**	**1,199,120**	**2,030,225**
	2012	37,280	-	3,880	37,140	588,814	1,215,420	1,882,534
	2010	13,210	-	3,760	33,220	530,833	1,258,620	1,839,643
Condoms	**2013**	**451,314**	**5,101**	**7,671**	**224,150**	**348,513**	**331,506**	**1,368,256**
	2012	485,751	3,299	8,206	250,223	298,631	537,388	1,583,498
	2010	261,970	5,247	15,613	368,052	311,215	622,026	1,584,122
Injectables	**2013**	**658,311**	**10,342**	**29**	**63,257**	**237,221**	**636,373**	**1,605,534**
	2012	406,676	8,584	19	70,324	231,422	628,958	1,345,984
	2010	289,276	7,271	46	75,021	171,968	428,810	972,398
Implants	**2013**	**481,480**	**9,339**	**6,799**	**39,251**	**99,745**	**758,851**	**1,395,465**
	2012	576,906	4,682	5,589	22,838	42,346	379,037	1,031,398
	2010	133,076	385	3,477	16,610	13,911	197,905	365,363
Emergency contraception	**2013**	**3,868**	**41**	**365**	**1,093**	**80,883**	**120,467**	**206,717**
	2012	3,226	132	49	1,037	72,671	106,876	183,991
	2010	1,303	391	86	1,287	61,825	122,960	187,852
Other barrier methods	**2013**	**1,396**	**827**	**200**	**578**	**-**	**179**	**3,180**
	2012	4,080	305	305	1,374	-	513	6,576
	2010	9,816	1,022	1,434	1,375	-	907	14,553
Other hormonal methods	**2013**	**19**	**-**	**265**	**46**	**-**	**93,388**	**93,718**
	2012	150	-	22	81	-	75,498	75,752
	2010	15	-	-	90	-	689	794
Total	**2013**	**2,612,058**	**236,825**	**44,087**	**720,455**	**2,778,010**	**5,687,013**	**12,078,447**
	2012	2,370,768	287,345	41,068	755,973	2,304,131	6,046,977	11,806,262
	2010	1,102,342	269,789	36,136	834,726	1,903,573	4,781,999	8,928,609

Table B.8: Number of sexual and reproductive health services provided, by region, by service type, 2010–2013

Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of responses	2013	(n=39)	(n=11)	(n=20)	(n=26)	(n=9)	(n=29)	(n=134)
	2012	(n=39)	(n=12)	(n=21)	(n=26)	(n=9)	(n=28)	(n=135)
	2010	(n=37)	(n=9)	(n=18)	(n=22)	(n=8)	(n=27)	(n=121)
Contraceptive (including counselling)	2013	30,683,682	795,843	413,738	6,886,842	10,810,137	10,277,515	59,867,757
	2012	24,256,982	758,047	285,762	4,639,660	9,299,951	13,427,888	52,668,290
	2010	16,817,092	634,570	324,929	4,621,885	7,909,074	13,506,032	43,813,582
Gynaecological	2013	3,893,087	1,192,493	194,226	1,722,947	1,844,284	8,419,721	17,266,758
	2012	947,646	446,491	86,209	1,543,071	1,434,226	7,964,894	12,422,537
	2010	450,223	381,383	88,872	1,115,931	900,651	7,023,958	9,961,018
HIV and AIDS (excluding STI/RTI)	2013	7,650,001	458,587	149,064	1,067,736	1,642,622	1,620,985	12,588,995
	2012	5,966,380	210,578	119,946	1,143,883	948,929	1,392,629	9,782,345
	2010	3,341,702	172,768	129,205	639,068	830,626	1,123,855	6,237,224
STI/RTI	2013	3,196,533	468,709	145,558	1,763,302	1,399,150	5,199,074	12,172,326
	2012	1,143,745	229,223	83,751	2,126,084	916,612	4,886,533	9,385,948
	2010	444,918	111,195	74,734	741,253	756,790	3,924,661	6,053,551
Specialized counselling	2013	2,234,894	292,024	439,247	1,306,892	1,338,975	1,091,275	6,703,307
	2012	3,399,512	314,389	1,007,219	1,804,734	1,119,874	1,607,640	9,253,368
	2010	3,082,671	223,702	753,106	914,430	867,061	802,455	6,643,425
Obstetric	2013	2,392,887	1,013,722	48,505	1,542,596	2,504,194	2,436,815	9,938,719
	2012	1,191,286	659,007	22,820	1,764,777	1,985,955	3,004,459	8,628,304
	2010	770,240	289,563	19,428	810,009	1,450,436	2,836,314	6,175,990
Paediatric	2013	1,571,734	739,501	234	3,185,489	1,735,221	516,930	7,749,109
	2012	402,754	52,966	-	1,912,806	1,476,766	296,674	4,141,966
	2010	261,267	35,891	230	77,559	856,439	277,427	1,508,813
SRH medical	2013	3,757,942	177,395	3,431	646,304	958,808	541,399	6,085,279
	2012	1,701,551	63,431	10,437	398,363	759,896	496,513	3,430,191
	2010	4,561,180	28,891	10,208	336,304	497,681	106,808	5,541,072
Abortion-related	2013	542,659	84,603	107,591	278,138	382,454	1,561,332	2,956,777
	2012	345,682	46,763	106,969	208,578	505,856	1,172,877	2,386,725
	2010	165,161	40,149	101,806	169,098	500,816	793,869	1,770,899
Infertility	2013	155,311	47,489	2,841	44,408	29,384	400,850	680,283
	2012	16,367	5,294	789	16,619	7,891	178,027	224,987
	2010	9,370	2,448	202	31,370	2,594	221,708	267,692
Urological	2013	301,688	53,772	9,842	59,174	135,927	71,349	631,752
	2012	101,477	35,265	6,427	57,707	120,561	63,395	384,832
	2010	64,207	10,186	3,857	37,015	92,775	51,073	259,113
Total	2013	56,380,418	5,324,138	1,514,277	18,503,828	22,781,156	32,137,245	136,641,062
	2012	39,473,382	2,821,454	1,730,329	15,616,282	18,576,517	34,491,529	112,709,493
	2010	29,968,031	1,930,746	1,506,577	9,493,922	14,664,943	30,668,160	88,232,379

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

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 exam (auto-qualify if provides Pap smear)

and

B: Manual breast exam

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

ABBEF	Association Burkinabè pour le Bien-Etre Familial
ABEF-ND	Association de Bien-Etre Familial – Naissances Désirables
ABPF	Association Béninoise pour la Promotion de la Famille
ABUBEF	Association Burundaise pour le Bien-Etre Familial
ACT	Adolescents Count Today
AFGA	Afghan Family Guidance Association
AIDS	Acquired immune deficiency syndrome
AMODEFA	Associação Moçambicana para Desenvolvimento da Família
AMPF	Association Marocaine de Planification Familiale
AR	Africa region, IPPF
ASHONPLAFA	Asociación Hondureña de Planificación Familiar
ATBEF	Association Togolaise pour le Bien-Etre Familial
AWR	Arab World region, IPPF
CAMNAFAW	Cameroon National Association for Family Welfare
CFPA	China Family Planning Association
CIES	Centro de Investigación, Educación y Servicios
CORE Plus	Cost Revenue Analysis Tool Plus
CYP	Couple years of protection
EN	European Network, IPPF
ESEAOR	East and South East Asia and Oceania region, IPPF
FHOK	Family Health Options Kenya
FP2020	Family Planning 2020
FPAHK	Family Planning Association of Hong Kong
FPA India	Family Planning Association of India
FPAM	Family Planning Association of Malawi
FPAN	Family Planning Association of Nepal
FPA UK	United Kingdom Family Planning Association
FPNSW	Family Planning New South Wales
FPOP	Family Planning Organization of the Philippines
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
ICPD	International Conference on Population and Development
IFPA	Irish Family Planning Association
INPPARES	Instituto Peruano de Paternidad Responsable
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
MCH	Maternal and child health
MISP	Minimum Initial Service Package for sexual and reproductive health
NOLA	Nuanua O Le Alofa
PEER	Participatory Ethnographic Evaluation and Research
PPAG	Planned Parenthood Association of Ghana
PPAZ	Planned Parenthood Association of Zambia
PPFN	Planned Parenthood Federation of Nigeria
Rahnuma-FPAP	Rahnuma-Family Planning Association of Pakistan
RFHAF	Reproductive and Family Health Association of Fiji
RHAC	Reproductive Health Association of Cambodia
RHAK	Reproductive Health Alliance Kyrgyzstan
RHASS	Reproductive Health Association of South Sudan
RHU	Reproductive Health Uganda
RTI	Reproductive tract infection
SAAF	Safe Abortion Action Fund
SAR	South Asia region, IPPF
SFHA	Samoa Family Health Association
SFPA	Syrian Family Planning Association
SHE	Society for Health Education
SH&FPA	Sexual Health and Family Planning Australia
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TICAD	Tokyo International Conference on African Development
UK	United Kingdom
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VIA	Visual inspection with acetic acid
WHO	World Health Organization
WHR	Western Hemisphere region, IPPF

Thank you

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