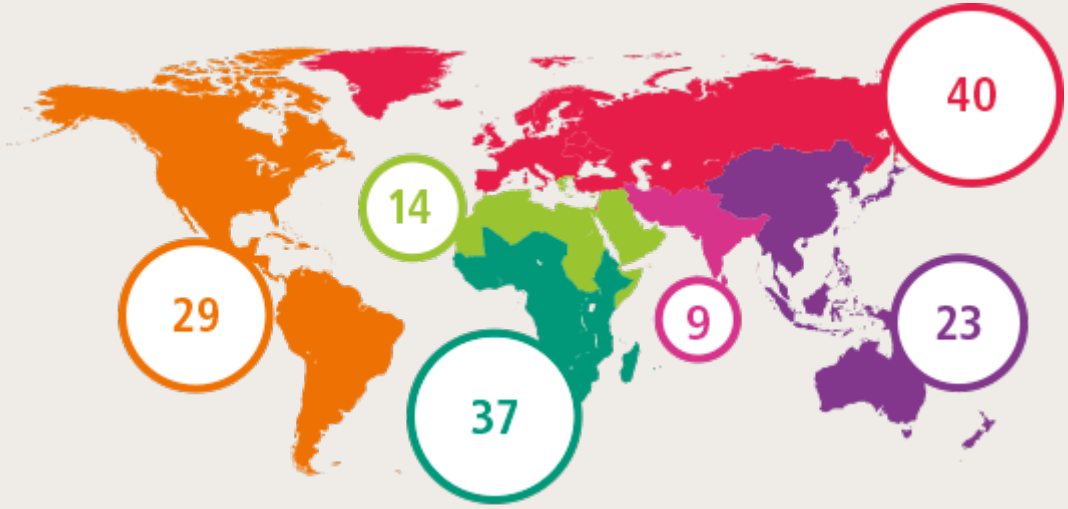
IPPF

From choice, a world of possibilities

Annual Performance Report 2012–2013

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.



152 Member Associations

Millions of volunteers

33,000+ staff

80% of Member Associations have at least one young person on their governing board

73% of Member Associations have at least one staff member who is under 25 years old

49% of Member Associations have volunteers and/or staff openly living with HIV

Acknowledgements

We would like to express thanks to Member Association, Regional Office and Central Office volunteers and staff who have contributed to this report. Special thanks to Mahua Sen and James Newton for data analysis.

Editorial

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IPPF's results in 2012

190m condoms distributed

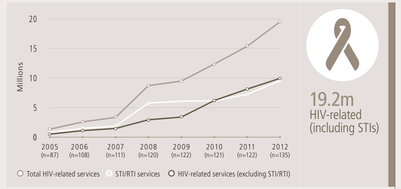
13% Condoms

45m people received services from IPPF

8 out of 10 people we serve are poor, marginalized, socially-excluded and/or under-served.

We provide comprehensive services to the most vulnerable groups.

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



19.2m HIV-related (including STIs)

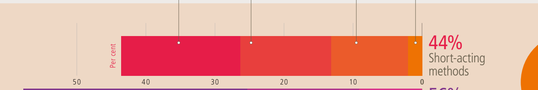
4 out of 10 of our services are provided to young people under 25 years old.

4.9m unintended pregnancies averted*

550,000 unsafe abortions averted

11.8m Couple years of protection,* by method

17% Oral contraceptive pills · 11% Injectables · 2% Others



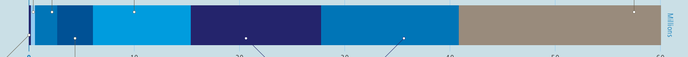
32% Intrauterine devices (IUDs) · 16% Voluntary surgical contraception (vasectomy and tubal ligation) · 9% Implants

52.7m contraceptive services provided

112.7m sexual and reproductive health services provided

60.0m non-contraceptive services provided

0.4m Infertility · 2.1m Abortion-related · 9.3m Specialized counselling



0.2m Urological · 3.4m SRH medical

Advocacy successes, by theme

59 Member Associations contributed to

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

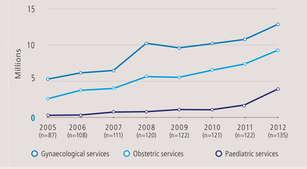
28	Access to SRH services
27	Education and services for young people
20	Access to safe and legal abortion
09	Prevention of gender-based violence
09	National budget allocations for SRH
06	Support for people living with HIV
03	Cervical cancer prevention
03	Assisted conception

Location of our 65,491 service delivery points

44% Urban · 56% Peri-urban and rural

12.4m Gynaecological

13.1m Maternal and child health



* 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.

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Foreword

> The eight women who founded IPPF in 1952 were brave and angry. Sixty years on, we commit to honour their memory, to be as brave and angry now as they were then in our collective movement towards universal sexual and reproductive health and rights.

2012 marked the first year implementing IPPF's three Change Goals – Unite, Deliver and Perform. The Change Goals focus and prioritize our work in delivering our Strategic Framework 2005–2015, and guide us to maximize impact for those people who have the greatest unmet needs for sexual and reproductive health.

To monitor progress against a set of annual targets for each of the three Change Goals, we developed a Performance Dashboard of indicators, the results of which are presented in this report. I am pleased to say that with the majority of targets surpassed, we have made significant progress in many areas and will continue to closely monitor progress in implementing our Strategic Framework.

In 2012, we finalized our Vision 2020 for Sexual and Reproductive Health and Rights (Vision 2020), a manifesto of what we are demanding of governments by 2020. Vision 2020 allows us to clearly articulate IPPF's demands in relation to the post-2015 development agenda, and will support us in our work to ensure that sexual and reproductive health remain central to global health and sustainable development.

IPPF Member Associations continued to play a leadership role in advocating at the national level for changes to policy and legislation that support sexual and reproductive health and rights, often overcoming barriers including opposition driven by conservative political, religious, cultural and social forces. In 2012, our unwavering commitment led to a remarkable 105 legal or policy changes in 59 countries around the world. These changes build on IPPF's long and successful history of promoting sexual and reproductive health and rights through a global network that engages grassroots voices at all levels.

With the provision of 112.7 million sexual and reproductive health services in 2012, we are on target to achieve our goal of doubling services by 2015. Our dedication to serving those most in need is stronger than ever: a record eight in every ten of IPPF clients are either poor or vulnerable, and four in ten are under 25 years old. IPPF's contraceptive services provided 11.8 million couple years of protection in 2012, which means that nearly 5 million unintended pregnancies and over half a million unsafe abortions were averted.

IPPF's quality of care strategy ensures that services are provided within a client-centred approach with an underlying mandate that all clients have the right to access sexual and reproductive health services and information. We support those that others may be reluctant or unable to work with, including vulnerable groups – such as sex workers, prisoners, displaced populations, people who use drugs, sexually diverse groups or young people – as well as those who cannot pay. Clients who visit IPPF's clinics are assured that an integrated package of essential services will be available, a 'one-stop shop' providing sexuality counselling; contraception; safe abortion care; and STI/RTI, HIV, gynaecological, obstetric and gender-based violence services.

IPPF continues to invest in robust systems and business processes to optimize organizational effectiveness. In 2012, progress was made in implementing our performance-based funding system with four out of six regions allocating proportionately more resources to reward high performing Member Associations. Data are increasingly viewed as an asset to the Federation, supporting decision making at all levels of the Federation and in many different areas of our work including governance, management, finance, clinic performance and costing analyses, and evidence-based advocacy. This investment in a strong performance culture provides us with a solid basis from which we are continuously learning and improving our programmes, as well as remaining accountable to our stakeholders.

In November 2012, IPPF commemorated its 60th Anniversary in South Africa, and took the opportunity to discuss the future of the sexual and reproductive health and rights movement, particularly IPPF's role, with key partners including community-based and civil society organizations, donors and United Nations (UN) agencies. Listening to our partners also supported us in our initial discussions on the development of a successor strategy for the Federation for 2016 onwards.

I would like to take this opportunity to thank the IPPF volunteers, staff and our partners around the world, whose tireless efforts are improving the lives of millions of people. We will continue to use the powerful force of our global commitment to build public, political and financial support for sexual and reproductive health and rights.

Tewodros Melesse, Director-General, IPPF

One Member Association's work in implementing IPPF's Change Goals

Family Planning Association of India (FPA India)

Unite

At the London Summit on Family Planning, civil society and governments committed to meeting the contraceptive needs of an additional 120 million women and girls in the world's poorest countries. The Family Planning Association of India (FPA India) played an important role in convening civil society during the lead-up to the Summit. The Association initiated a platform for grassroots, state and national level civil society organizations in India to discuss and debate issues that could be raised at the Summit with one unified national voice.

FPA India engaged the support of civil society organizations in each of India's 13 states to convene state level consultations on contraceptive programmes. These meetings captured commonalities and gaps in policy, systems and service delivery. The discussions led to recommendations that were drafted into reports. These state level gaps and recommendations were then synthesized and presented at the national consultation, where civil society participants along with representatives from international organizations, UN agencies, donors and the Indian government, agreed national level recommendations to present at the London Family Planning Summit.

Deliver

FPA India provided 36 per cent more sexual and reproductive health services in 2012 than 2011. One of the strategies to increase the number of services, particularly to under-served clients, is the use of satellite clinics.

The Association has built satellite clinics in rural areas and urban slums to reach poor and vulnerable clients who are under-served by both public and private health systems. These small clinics have two or three rooms and are staffed by a full-time nurse, counsellor, laboratory assistant and support staff. The satellite clinics are connected to FPA India's main clinics so clients can be referred for advanced care such as surgical procedures and then have follow-up care at the more conveniently located satellite clinics.

Services include clinical examinations, contraception, management of sexually transmitted infections (STIs), medical abortion, antenatal and post-natal care, gynaecology, counselling and referrals. The start-up and maintenance costs of these satellite clinics are low, which enables FPA India to reach a higher number of poor and under-served clients with affordable services close to their homes. This approach also uses staff more efficiently at both the satellite and primary static clinics.

Perform

Effective service delivery is closely linked to analysis of service data and evidence-based decision making. In FPA India, a wealth of information was being collected but only a fragment of it was being utilized to improve performance. This was recognized as a missed opportunity, so clinic staff were trained on data collection, analysis, interpretation and utilization. Service data were reviewed and the following programmatic decisions were made:

- increase special service sessions in remote areas
- involve pharmacists and rural medical practitioners for abortion referrals
- increase referrals from community-based distributors

Association headquarters staff analysed and used service statistics data to improve performance by:

- providing values clarification training to staff at low performing clinics to increase the number of abortion-related services provided
- upgrading clinics with a high number of referrals for second trimester abortions to enable them to provide these services
- training doctors on STI syndromic management to increase the number of STI services provided

IPPF/Peter Caton/India

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

In 2012, 59 Member Associations contributed to 105 policy and/or legislative changes in support of a wide range of sexual and reproductive health and rights issues. This success results from expertise in raising public awareness, holding governments to account and bringing grassroots voices to the table.

In 2009–2010, IPPF conducted a midterm review of its Strategic Framework 2005–2015, and one of the critical issues identified was the need to strengthen our advocacy and communications, with a focus on ensuring that sexual and reproductive health and rights are central to global health and development.

IPPF is resolute in its efforts to build public, political and financial support for sexual and reproductive health and rights. We work on some of the most controversial issues that others shy away from, and we are well recognized for our global leadership role, especially on behalf of those who are most marginalized. We continue to resist those who oppose our work, challenging their attempts to bring about legislative or policy changes that would be harmful to sexual and reproductive health and rights.

To increase the effectiveness of our advocacy, we work in partnership with civil society, engaging public and media agencies at local, national, regional and global levels to convince decision makers to respect, promote and protect the sexual and reproductive rights of women, men and young people.

Figure 1 presents IPPF's advocacy performance in 2012 against targets. The results are positive with two indicators surpassing their targets; the third indicator is new and targets will be set to assess future performance. In 2012, Member Associations' advocacy efforts contributed to 105 policy and/or legislative changes in support of sexual and reproductive health and rights issues (Figure 2). This is more than double the annual target of 50 and reflects our commitment to and continued success in making a significant difference to the lives of millions of people with improved sexual and reproductive health.

Figure 1: Unite – performance results in 2012

Target: 50 successful policy initiatives and/or positive legislative changes in support or defence of SRHR to which the Member Association's advocacy contributed **U.1**	**Target:** 5 successful global and regional policy initiatives and/or positive legislative changes in support or defence of SRHR to which IPPF's advocacy contributed **U.2**	**Target:** Proportion of Member Associations monitoring obligations made by government in the international human rights treaties that they have ratified (baseline data) **U.3**
105	15	42%

In the year of the London Summit on Family Planning, Member Associations contributed to seven national policy or legislative changes related specifically to access to contraception. A further nine have resulted in an increase in government budgetary allocation to sexual and reproductive health, including family planning.

At regional or global levels, IPPF's advocacy contributed to a further 15 policy or legislative changes in support of sexual and reproductive health and rights, exceeding the target of five.

The third indicator relates specifically to the watchdog role of Member Associations to hold their governments to account on promises they have made. In 2012, 42 per cent of Member Associations monitored the obligations made by their governments in the international human rights treaties that they have ratified.

This section presents global advocacy successes, including IPPF's involvement in the London Summit on Family Planning and our work to ensure that sexual and reproductive health and rights are not forgotten in the post-2015 development agenda. It also highlights the advocacy work of Member Associations around the world which has resulted in successful policy and legal changes and social change at the community level.

Figure 2: Number of policy and/or legislative changes by theme, 2012

28 Access to SRH services

27 Education and services for young people

20 Access to safe and legal abortion

09 Prevention of gender-based violence

09 National budget allocations for SRH

06 Support for people living with HIV

03 Cervical cancer prevention

03 Assisted conception

In 2012, Member Associations contributed to 105 changes in policies and legislation in support of sexual and reproductive health and rights in

59 countries

Uniting regionally and globally

IPPF uses its extensive network and presence in the majority of the world's countries to work at regional and international levels. As a united Federation, we are able to convene leaders from multiple stakeholders, including government, civil society and technical agencies, to influence high level political will and to ensure that sexual and reproductive health and rights are central to global health and development.

In 2012, IPPF finalized Vision 2020 for Sexual and Reproductive Health and Rights, a manifesto of what IPPF is demanding of governments by 2020. This document was approved at IPPF's 60th Anniversary commemorative event in South Africa in November 2012, enabling us to reach Federation-wide agreement and ownership. Vision 2020 was publicly launched on 22 April 2013 at the United Nations Commission on Population and Development, with other launch events organized by 46 Member Associations taking place around the globe.

Influencing the post-2015 development agenda

IPPF has successfully contributed to ensuring that sexual and reproductive health and rights are included in the post-2015 development agenda. UN Secretary-General Ban Ki-moon established the High Level Panel of Eminent Persons from 29 countries to advise on the global development framework beyond the Millennium Development Goals (MDGs); this was the first of three main elements of the post-2015 development process. In May 2013, the Panel submitted its final report with recommendations, which reflected specific IPPF requests.

A senior volunteer of the Planned Parenthood Association of Liberia (PPAL) was on the steering committee of the High Level Panel's formal meeting in Monrovia, Liberia, in February 2013. She set up a meeting between the Association and the President of Liberia, who is a co-chair of the Panel. Through these links, PPAL was able to build the case for sexual and reproductive health to be recognized as a cornerstone of poverty alleviation.

Likewise, the President of IPPF attended the High Level Dialogue on Health in the Post-2015 Development Agenda in Botswana in March 2013. Working with key allies, the President requested the addition of the language 'securing universal access to reproductive health' within the specific health goals that were submitted to the High Level Panel and included in the final report.

Prior to the drafting phase of the final report, each Member Association in the 29 countries with a High Level Panel Member informed them of IPPF's requests for the next development framework. At the same time, at the global level, IPPF mobilized the international development community to sign on to a letter to Panel members encouraging them to protect gender equality and sexual and reproductive health and rights in the final report.

As a result of IPPF's advocacy efforts, the final High Level Panel report included a specific target on universal sexual and reproductive health and rights. The report also called for a stand-alone gender goal with targets on preventing violence against women and girls; forced marriage; equal legal rights; and equality in political, public and economic life. The report called for indicators to be disaggregated by income, gender, disability, age and those living in different localities to enable monitoring against targets.

In addition to influencing the High Level Panel, IPPF has also successfully engaged in other strategic processes to ensure sexual and reproductive health and rights are central to global development. We submitted responses to the UN's online consultations on the post-2015 framework in the areas of health; population dynamics; gender inequality; lesbian, gay, bisexual, transgender and intersex issues; and disability issues. We also submitted a comprehensive response to an open consultation on the post-2015 framework held by the International Development Committee of the UK Parliament.

Vision 2020 for Sexual and Reproductive Health and Rights: a manifesto

Vision 2020 was developed to ensure that sexual and reproductive health and rights are at the core of the development agenda. We are partnering with the wider sexual and reproductive health and rights community – including civil society organizations, UN agencies and the private sector – to call on governments to commit to 10 targets, each of which highlights priority actions and policy recommendations:

- establish by 2015 a new international development framework that includes sexual and reproductive health and rights as essential priorities
- increase access to sexual and reproductive health and rights in order to close the gap between the top and bottom wealth quintiles by 50 per cent by 2020
- eliminate all forms of discrimination against women and girls to achieve de facto equality of opportunity for both women and men by 2020
- recognize sexual rights and reproductive rights as human rights by 2020
- engage young people in all policy decisions affecting their lives
- provide comprehensive and integrated sexual and reproductive health and HIV services within public, private and not-for-profit health systems by 2020
- reduce by at least 50 per cent the current unmet need for family planning by 2020
- make comprehensive sexuality education available to all by 2020
- reduce maternal mortality due to unsafe abortion by 75 per cent by 2020
- allocate sufficient resources to make all nine targets achievable by 2020

Uniting at the UN to stop violence against women and girls

IPPF played a key role in shaping the outcome document of the 57th session of the Commission on the Status of Women in March 2013. The theme of the Commission was violence against women and girls, and its agreed conclusions promoted sexual and reproductive health and rights. The text included:

- the first ever reference in a UN consensus document to emergency contraception
- reference to safe abortion where permitted by law
- reference to comprehensive sexuality education
- reference to sexual violence as a war crime
- an explicit link between violence against women and sexual and reproductive health and rights
- reference to disabled women and older women

Twelve Member Associations attended the Commission, where they met with their respective governments and engaged the media. The diversity of their voices and experience gave credibility to IPPF's issues and enabled greater access to individual state conversations.

IPPF formed a coalition with other sexual and reproductive health and rights organizations, and together we were regarded as expert partners throughout the negotiation process. The coalition partners trained UN mission staff on sexual and reproductive health and rights, how to advocate for them and how to respond to arguments from opposition groups. During negotiations, delegates used the exact language learned at the training to make a point or raise an issue that needed to be addressed.

Equally important was IPPF's creation of partnerships with other development organizations, including those with broad mandates as well as those working specifically on violence against women. IPPF will continue to work with these partners to integrate sexual and reproductive health and rights issues into broader development dialogues, particularly those related to the post-2015 development framework.

Engaging with emerging leaders

IPPF is engaging in a long-term initiative to develop and sustain a network of young emerging leaders to advance the sexual and reproductive health and rights agenda. IPPF and its Norwegian Member Association Sex og Politikk launched this initiative in Oslo in September 2012 with the Emerging Leaders' Summit. The Summit engaged young opinion leaders and decision makers from around the world who were not previously active in sexual and reproductive health and rights.

Participants discussed the most pressing issues that are limiting the lives and opportunities of young people around the world. They translated those challenges into specific requests for national and international action to feed into the Summit's outcome document, the Roadmap for the 21st Century.

The diversity of the participants – activists, politicians, media experts, musicians, artists and members of minority communities – ensured that the discussions and outcomes took into consideration the wide range of realities and contexts that young people experience around the world. It also meant that the Roadmap is relevant across regions, genders, religions and sexual orientations. The young leaders have committed to taking the Roadmap for the 21st Century forward.

The Summit's most powerful outcome was engaging committed and articulate emerging leaders in the sexual and reproductive health and rights agenda, many for the first time. Their increased awareness and support will add strength and weight to the global movement in the years to come.

Promoting women's health and rights among Muslim populations

In 2012, IPPF convened a meeting in Kuala Lumpur with health experts, Sharia scholars, parliamentarians and health practitioners from 30 countries with large Muslim populations to discuss and debate women's health. Although participants represented a wide range of cultural backgrounds, the group agreed on some fundamental principles that need to be at the heart of future work to promote women's health and rights in Muslim countries.

These principles aim to:

- reduce violence against women and girls, including female genital mutilation
- reduce maternal mortality and morbidity
- advocate against child marriage
- address HIV and the vulnerabilities that increase the risk of HIV transmission, especially for women and girls
- strengthen the response to women's health issues during humanitarian crises
- address cervical cancer and infertility

Participants developed an action plan to support religious, political and financial decision makers in Muslim countries to work together to improve the health and lives of women and girls. The commitment and enthusiasm to debate issues and collaboratively identify responses clarified for IPPF that this remains a critically important area and one that will receive increased focus in the years ahead.

> Women have a special place in Islam... Interpretations of the Quran are commonly compounded by cultural norms, rituals and traditions, which affect women's access to health and their health-seeking behaviour.
>
> YABhg Tun Dr. Mahathir Mohamad,
> Perdana Leadership Foundation[1]

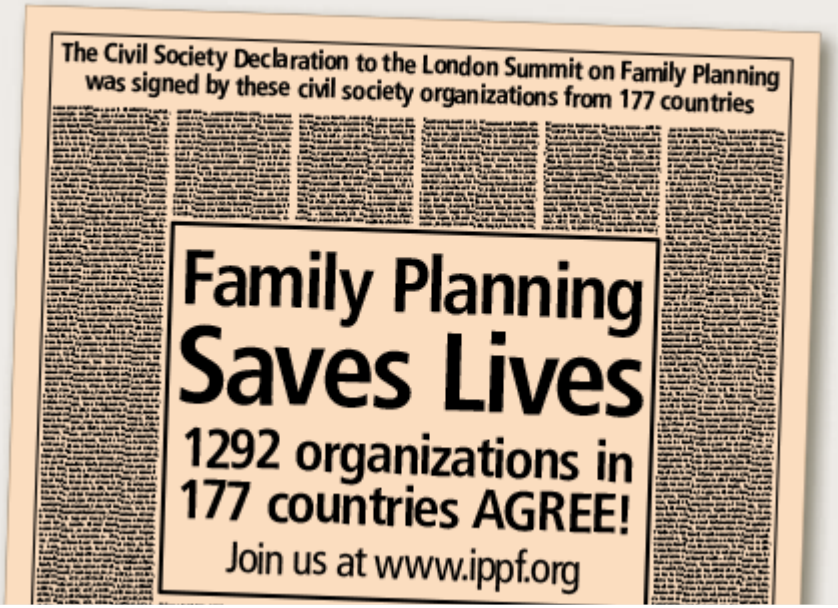
IPPF and the London Summit on Family Planning

Globally, more than 200 million women and girls have an unmet need for contraception. The London Summit on Family Planning mobilized global commitment to make affordable, lifesaving contraceptive services and information available to 120 million women and girls in the world's poorest countries by 2020. The Summit was co-hosted by the UK government and the Bill & Melinda Gates Foundation, in partnership with UNFPA, USAID and national governments.

Before the Summit, IPPF's Director-General was appointed as Co-Vice Chair of the Stakeholder Group representing civil society. IPPF engaged civil society and communicated their perspectives and concerns with the Summit's conveners; organized four public consultations; and created an email account to collect feedback from civil society. We also established a steering committee largely made up of developing country members outside the Federation and selected because of their extensive regional and national reach.

As a result, IPPF gathered feedback from thousands of civil society organizations, and incorporated it into a declaration from civil society, which was signed by nearly 1,300* organizations from 177 countries. The declaration was sent to the UK Prime Minister and Melinda Gates, and was published in the UK newspaper, the Financial Times.

Member Associations were also involved in garnering support from civil society in their respective countries and convincing their governments to make commitments at the Summit. Rahnuma-Family Planning Association of Pakistan (Rahnuma-FPAP), for example, worked with UNFPA to mobilize the media, and civil society and public sector organizations and parliamentarians to convince the government to take part in the Summit and commit more political and financial resources for sexual and reproductive health. Rahnuma-FPAP also engaged civil society through a national advocacy alliance, holding a series of regional and national meetings that resulted in a position paper that was submitted to federal and provincial governments, asking them to maximize resource allocation for sexual and reproductive health.


The Civil Society Declaration to the London Summit on Family Planning was signed by these civil society organizations from 177 countries

Family Planning Saves Lives

1292 organizations in 177 countries AGREE!

Join us at www.ippf.org

FINANCIAL TIMES

Monday 9 July 2012

> Women should be empowered to decide whether and when they want to become pregnant, as well as how many children they want to have. This is at the core of our mandate and work at country level.
>
> Dr Babatunde Osotimehin, UNFPA Executive Director[2]

At the Summit, IPPF made an unprecedented commitment to treble the number of sexual and reproductive health services provided by 2020, through a comprehensive package of rights-based services, including a range of contraceptive methods and safe abortion. We also made a commitment to establish civil society networks in the poorest countries and support their efforts to hold governments to account for providing services and committing financial resources. IPPF's Director-General participated in a high level panel on integrating family planning with women's and children's health services, including HIV. IPPF co-hosted two debates: 'Accounting for rights: an enabling environment for improved results' and 'Helping young people overcome reproductive health challenges'.

After the Summit, IPPF's Director-General was invited to participate in the Reference Group for Family Planning 2020. This was a key outcome of the Summit and the group will be responsible for providing strategic direction and coordination among partners to improve women's and girls' access to contraception. The group will also track resources and results, ensuring that the US$2.6 billion committed is invested so that an additional 120 million women in the poorest countries can access contraception.

* Following publication, additional signatures were received before the London Summit on Family Planning.

Programme successes: Member Association advocacy

Winning the 14-year battle for reproductive health legislation in the Philippines

Family Planning Organization of the Philippines (FPOP)

Advocating for policy and legislative change at the national level can take years – even decades – and is often accompanied by fierce religious and political opposition. After more than a decade of courageous and tireless advocacy by the Family Planning Organization of the Philippines (FPOP) and civil society partners, a national reproductive health bill was finally passed in 2012. Filipinos now have increased access to reproductive health information and services, including the provision of free contraceptive services to the poor and vulnerable.

Under the new bill, all government health care facilities must be staffed with reproductive health care professionals, and include basic emergency obstetric and newborn care facilities. Women now have access to safe and legal post-abortion care. The bill also requires the national education curriculum to include reproductive health.

About 80 per cent of the Filipino population are Catholic, and the bill faced robust opposition from the Catholic Church, which has strong political influence. This opposition kept the bill blocked in Congress for 14 years. FPOP began advocating for legislative change in 1998. The Member Association helped form the Reproductive Health Advocacy Network, which drafted the first proposed reproductive health bill in 2001, and continued fighting for legal change until the end of 2012. In the year leading up to the passing of the bill, FPOP stepped up its efforts to mobilize more support for the legislation from influential people, including artists who publicly supported the bill.

The Philippines was one of nine countries that had their human rights records reviewed in 2012 as part of the UN's annual Universal Periodic Review process. FPOP took this opportunity to file a joint submission with the Sexual Rights Initiative on the right to sexual and reproductive health in the Philippines. The submission states that the government's failure to provide access to a full range of sexual and reproductive health information and services has resulted in high numbers of maternal deaths, unplanned pregnancies and unsafe abortions.

The submission urged the government to pass the reproductive health bill. It also reminded the government that it had signed international agreements recognizing its duty to promote, protect and fulfil the sexual and reproductive health and rights of Filipinos.

Despite its success in pushing through the bill, FPOP's advocacy efforts must continue. Religious groups have already mobilized to urge the Supreme Court to overturn the bill, which it has the power to do. A decision is expected in July 2013.

Funding civil society partners

Legislative change requires coordinated work among multiple partners, including civil society organizations. Through the NGO Forum Small Grants Facility, IPPF funded civil society organizations globally to advocate at the national level for increased access to sexual and reproductive health services. The maximum grant was US$10,000, and results showed that relatively small amounts of money can make a big difference in advocacy work.

IPPF funded two organizations in the Philippines that helped support the reproductive health bill and neutralize opposition. The Forum for Family Planning and Development worked with a group of supportive Catholic civil society organization leaders and legislators to help address opposition from the Catholic community. The Foundation for Adolescent Development built the capacity of young people to advocate for the bill.

> FPOP sees the urgent need for a comprehensive reproductive health law to enable [an] adequate number of midwives ... and a full range of family planning methods and services.
>
> FPOP and the Sexual Rights Initiative[3]

Promoting women's reproductive rights in Somaliland

Somaliland Family Health Association (SOFHA)

In many countries, sexual and reproductive health and rights are not respected, protected or fulfilled, particularly for women and girls. Member Associations in these countries work hard to convince their governments to support policy and legislation that uphold the rights of everyone, including women and girls.

Before 2012, women in Somaliland needed consent from their husbands or fathers before undergoing emergency obstetric procedures, including Caesarean sections. As a result, many women died when a male relative could not reach the hospital in time to give permission.

For years, Somaliland Family Health Association (SOFHA) worked with Ministry of Health officials to convince them of the importance of having a written policy or law in place to allow women to give their own consent. Association staff and volunteers advocated for this at meetings, conferences and workshops. Last year, the Ministry of Health issued a written policy on Caesarean sections, which includes a protocol that allows women to give their consent if a male relative is not present. While this is a significant and lifesaving achievement, SOFHA still considers it a partial victory and will continue its tireless efforts toward full consent rights for women.

Decriminalizing abortion in Mauritius

Mauritius Family Planning and Welfare Association (MFPWA)

Each year, unsafe abortion causes 47,000 deaths around the world and ill health for a further 5 million women.[4] Restrictive legislation does not reduce the number of abortions, but instead drives millions of women to seek unsafe, clandestine abortions.

The Mauritius Family Planning and Welfare Association (MFPWA) estimates that about 20,000 women seek illegal and unsafe abortions every year in Mauritius. Until last year, abortion in Mauritius was highly restrictive and only allowed to save the life of the pregnant woman. MFPWA worked for years to convince the government to amend the criminal code, and its work has contributed to liberalizing the country's abortion laws with an expansion of indications for safe, legal abortion.

The Association held meetings with policy makers and politicians, organized a public conference, carried out a successful media campaign and attended parliamentary sessions. It built a coalition with other non-governmental organizations and trade unions to form an advocacy platform from which they also supported legislators in amending the code.

MFPWA joined two other organizations to form the Common Front on Abortion, which advocated for three years for this amendment and met with government officials to discuss the importance of decriminalizing abortion in certain cases. In his speech about this amendment to the National Assembly, the Honorary Attorney General thanked the Common Front on Abortion – specifically naming MFPWA – for its support throughout the process and for meeting with him to make recommendations.

Previously, the criminal code penalized anyone seeking or providing an abortion with a minimum of 10 years' imprisonment. The code was amended to authorize abortion under four circumstances: if the pregnant woman's life is in danger, if the woman's health is at risk of 'grave injury', if the fetus is at risk of severe malformation, or if the pregnancy is a result of rape or sex with a minor.

The revised criminal code makes it clear that abortion in these specific cases must be carried out by a specialist in obstetrics and gynaecology and in a prescribed institution. The revision means that thousands of women can avoid unsafe abortions.

Ending gender-based violence in Bhutan

Respect, Educate, Nurture, Empower Women (RENEW)

Domestic violence is common in Bhutan, where 68 per cent of women believe that their partner is justified in hitting or beating them in certain circumstances.[5] Since its creation in 2004, the Member Association in Bhutan has been campaigning to prevent gender-based violence. The Association – Respect, Educate, Nurture, Empower Women (RENEW) – played a major role in the development and passing of Bhutan's domestic violence bill.

The bill, which passed in the National Assembly in 2012, proposed the criminalization of domestic violence and specified the legal grounds for prosecuting perpetrators. RENEW participated as the only gender-based violence service provider on the consultative board during the drafting of the bill, and continued to advocate for important amendments after the drafting stage. The Association met with parliamentarians throughout the process.

RENEW secured support from the media to document the bill's discussion in Parliament, which included heated debates and strong opposition to the bill. RENEW put so much pressure on parliamentarians that the Association was featured on the national news. In 2013, the bill was voted on and became law.

> I remain thankful to agencies like RENEW for their dedicated service rendered to the [survivors] of domestic violence, even in the absence of such legislative support.
>
> Parliamentarian Dorji Tshering[6]

> Prior to the establishment of RENEW in 2004, nobody talked about domestic violence or protection of women's rights.
>
> UNDP[7]

Changing social norms: Abandoning female genital mutilation in Côte d'Ivoire

Association Ivoirienne pour le Bien-Etre Familial (AIBEF)

Having a supportive legal environment does not automatically result in improved health or the protection of rights. The relationship between law and social change is complex. While law can act as an instrument of change, it can also be impeded due to values, customs, and social or economic factors. For law to carry weight, societal attitudes need to adapt. This requires advocacy at the community level, engaging religious and other traditional leaders, raising awareness and engaging citizens in the political process.

Female genital mutilation has been outlawed in Côte d'Ivoire since 1998 but is still practised in many parts of the country. It is deeply rooted in centuries of tradition and is a normal part of many women's and girls' lives. Those who have not undergone the practice are often stigmatized and considered to be unacceptable for marriage. In the Séguela district, the percentage of women that had undergone female genital mutilation in 2006 was a staggering 88 per cent – the highest in the country.[8]

> I remind people about the harmful effects of female genital mutilation in the mosque and other public gatherings.
>
> Imam

To support the existing legal framework, the Association Ivoirienne pour le Bien-Etre Familial (AIBEF) implemented a project to advocate at the community level for the elimination of the practice in Séguela.

AIBEF invested a year gaining the trust of local authorities, educating them on the negative consequences of female genital mutilation and supporting them in their role to prevent it. Developing a relationship with local authorities and including them in the project gave AIBEF access to the villages, and encouraged local authorities to sensitize their own communities and enforce the law banning the practice.

A significant component of the project involved changing attitudes at the community level. At the beginning of the project, AIBEF conducted focus group discussions in 20 villages to determine perceptions and knowledge of female genital mutilation, and to discuss how the practice could be eradicated.

Based on these discussions, the Association trained religious and community leaders, journalists, community health workers, local authorities and ex-practitioners on the negative health and rights consequences of the practice, as well as the law forbidding it. Once trained, AIBEF engaged these groups as peer educators in the communities.

Project staff worked with practitioners of female genital mutilation. Despite the law banning the practice, AIBEF decided not to report them to the authorities. Two practitioners agreed to receive training on the health risks of female genital mutilation. As a result, they abandoned the practice and became peer educators to convince other practitioners to stop. A further 16 practitioners abandoned the practice because of the advice and sensitization from peer educators. AIBEF compensated those who stopped the practice with funds to start alternative businesses.

AIBEF produced a documentary film that included a representation of a female genital mutilation ceremony, as well as testimonies from women who had undergone the procedure and spoke of the consequences they had suffered. The film was extremely successful and convinced practitioners to stop the practice.

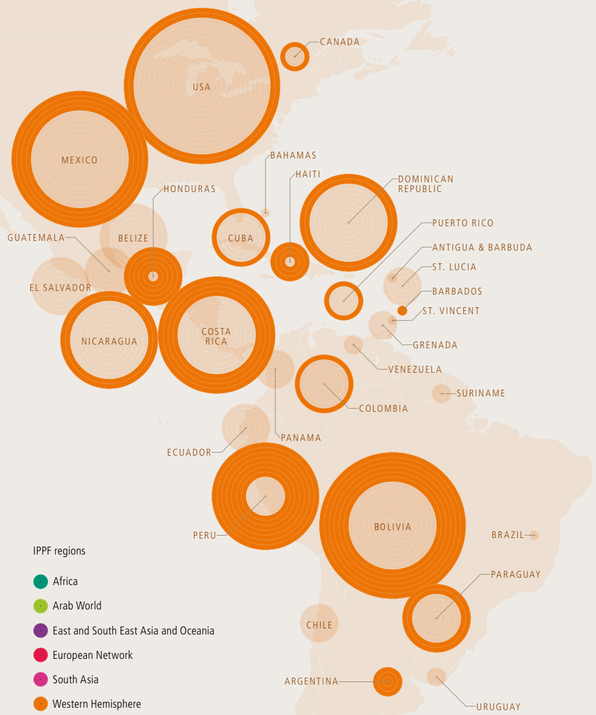
The project established committees at village and provincial levels to monitor activity, hand any practitioners over to the local authorities, and work with their communities to abandon the practice. These committees include village leaders, imams, presidents of women's groups, and presidents of youth groups.

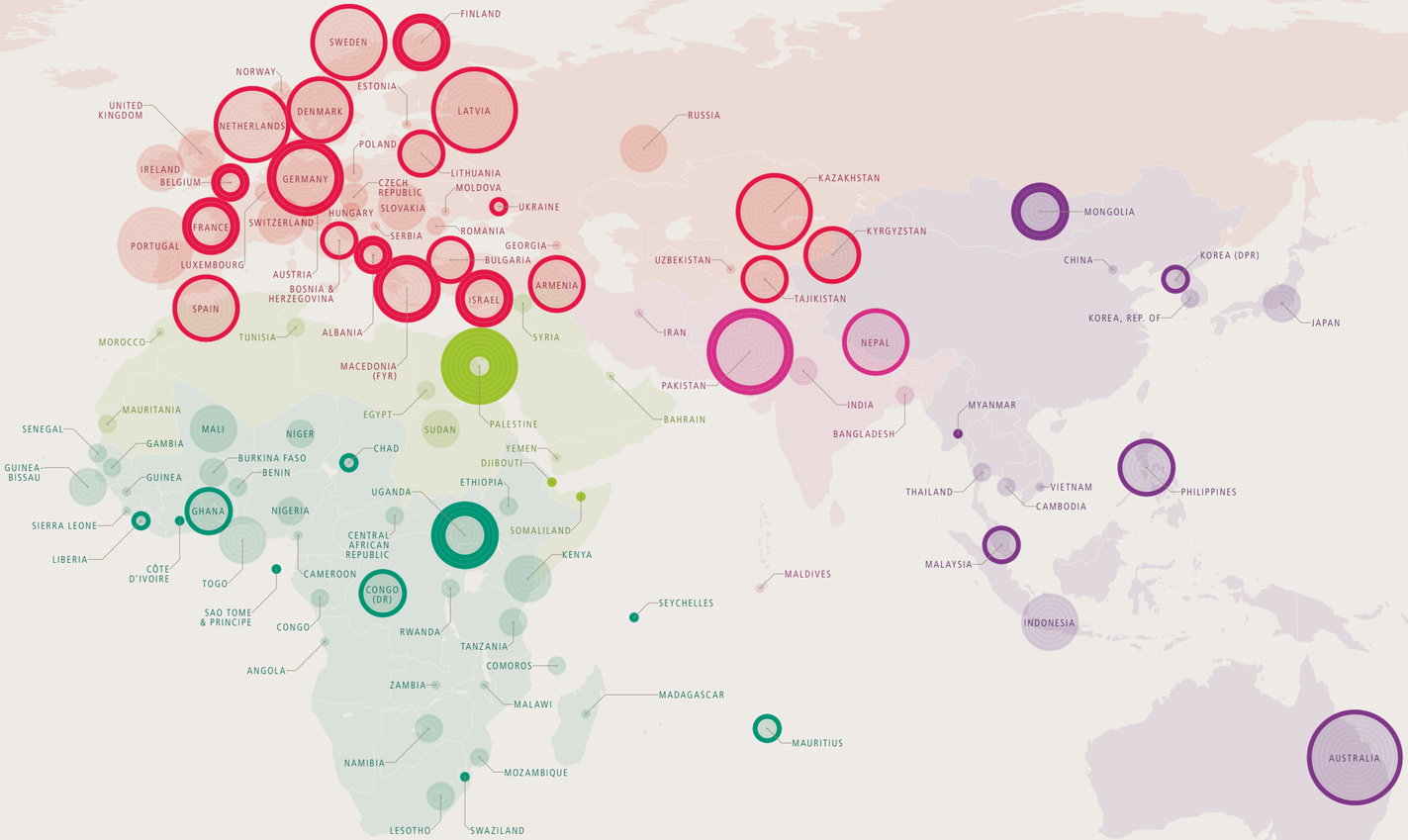
> I have eight daughters. The first two were circumcised but the other six girls were not because I know the consequences.
>
> Female project beneficiary

Women are seen as the primary perpetrators of female genital mutilation and the decision makers about whether their daughters undergo the practice. AIBEF, therefore, made a concerted effort to target women and girls through community advocacy efforts. One focus group participant explained, "It's the woman who takes the initiative to circumcise her daughter. Even if the husband doesn't approve, the young girl is circumcised unbeknownst to the head of the house."

At the end of the project, women and girls reported an increased knowledge and understanding of the health risks of female genital mutilation. Many women said that they do not intend to have their daughters undergo the practice, a hugely important indicator of the project's success. Moreover, in 2011, the percentage of women that had undergone female genital mutilation in Séguela had fallen to 75 per cent.[9]

IPPF's global achievements in advocacy: changing laws and policies to support sexual and reproductive health and rights around the world





From 2005 to 2012, Member Associations contributed to

556 policy and/or legislative changes

in support of sexual and reproductive health and rights in

140 countries*

Key

Number of policy and/or legislative changes

Year of policy and/or legislative change

* See Annex A for number of policy and/or legal changes, by country, 2005–2012.

unite

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

IPPF has committed to doubling the number of sexual and reproductive health services provided between 2010 and 2015. The results from 2012 show that significant progress has been made and that we are currently on target to achieve our goal.*

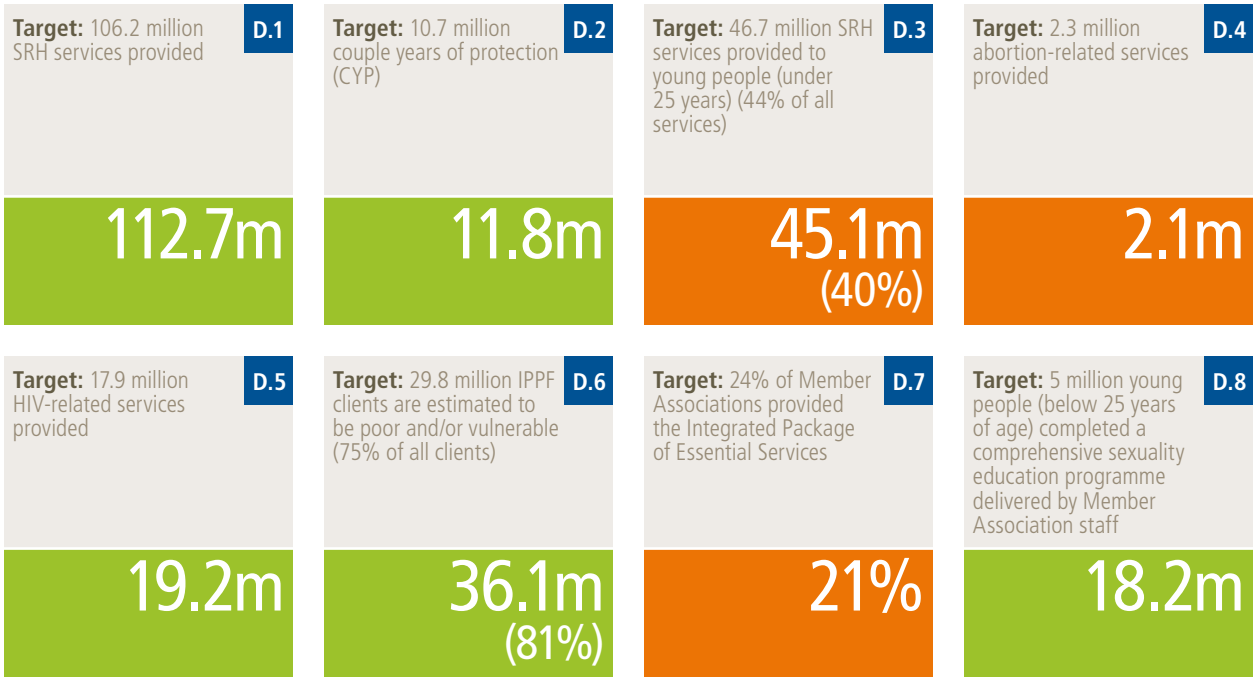
IPPF's performance in 2012 in the delivery of sexual and reproductive health services and sexuality education is presented in Figure 3. Overall, the results are positive, with five indicators showing significant progress, surpassing the targets for 2012, and the other three showing year-on-year progress but remaining slightly behind the targets.

The number of sexual and reproductive health services increased by 26 per cent from 2011, and exceeded the target by 6 per cent (Figure 4). Similarly, the number of couple years of protection (CYP) increased by 30 per cent from 2011, and was 10 per cent higher than the target. Significant progress was also made in the number of HIV-related services provided – an annual increase of 27 per cent – as well as in the number of young people completing a sexuality education programme delivered by IPPF. The numbers on sexuality education are inflated substantially by the major achievement in China, where 15 million young people completed a sexuality education programme delivered by the Family Planning Association of China. However, the global data, excluding China, also reveal an annual increase of 24 per cent.

IPPF's commitment to reaching the poorest and most vulnerable is reflected in the result that 81 per cent of clients were estimated to be poor, marginalized, socially-excluded and/or under-served. This is a record for IPPF, being an eight percentage point increase from 2011, and six percentage points higher than the target. The number of poor and/or vulnerable clients served rose significantly from 24.9 million in 2011 to 36.1 million in 2012, an increase of 45 per cent (Figure 5). The number of services provided to young people went up by 21 per cent from 2011 to 45.1 million in 2012, which is a good result but below the target set of 46.7 million. The provision of abortion-related services increased by 31 per cent from 2011 to 2.1 million in 2012; again, a good result, but one which did not achieve the 2012 target of 2.3 million.

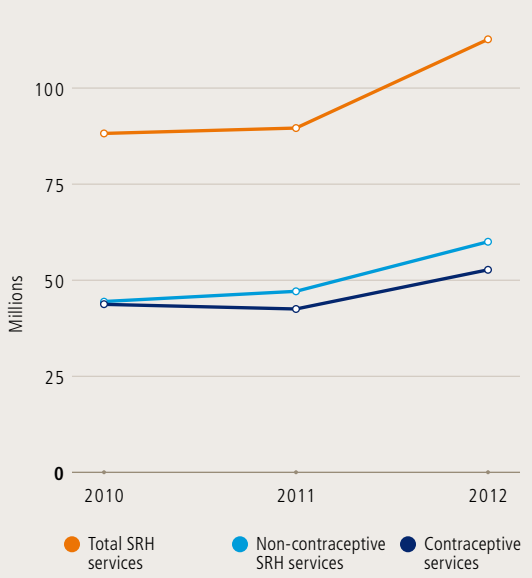
Finally, the proportion of Member Associations providing an integrated package of essential services improved, from 12 per cent to 21 per cent between 2011 and 2012, but did not meet the target of 24 per cent.

Figure 3: Deliver – performance results in 2012



* See Annex B for global performance results, by region, 2010–2012.

Figure 4: Number of SRH services provided, 2010–2012



Investing in the countries with greatest need

The majority of IPPF's core investments are made in countries with the greatest need 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.

In the 93 countries identified by the UNDP Human Development Index (HDI)[10] as having low or medium human development and where there is an IPPF Member Association or collaborating partner, the 2012 results for service provision showed significant increases in performance. Over 79 million sexual and reproductive health services were provided in these countries, an increase of 20.6 million since 2011. The most common categories of services provided were contraception, maternal and child health (MCH), and HIV-related services (Figure 6).

Figure 5: Estimated number and percentage of IPPF clients who are poor or vulnerable, 2010–2012

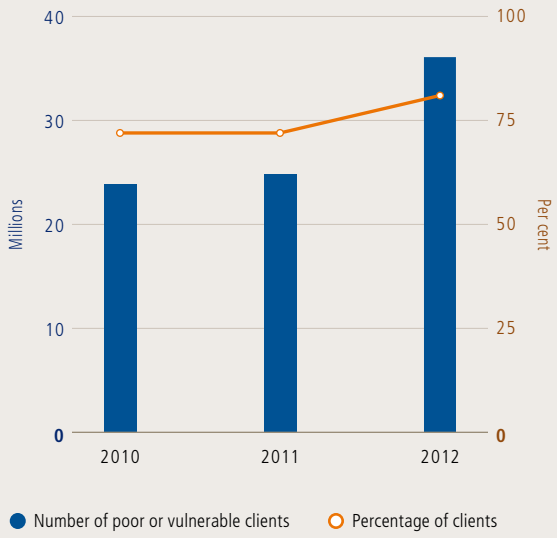
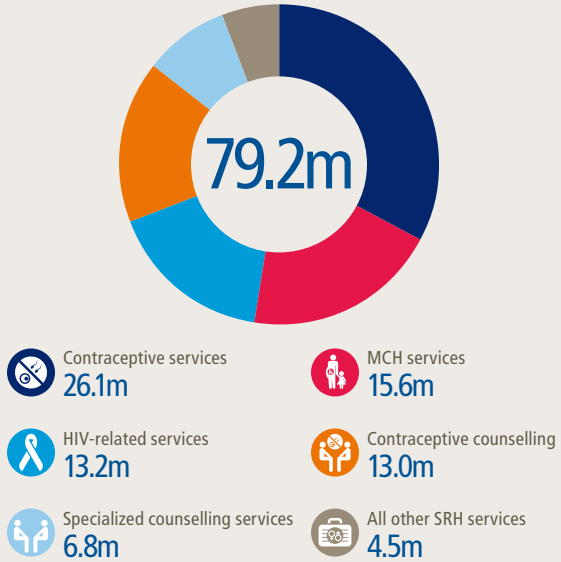


Figure 6: Number of SRH services provided, by type, in countries with low or medium human development, 2012



Expanding service provision in low resource settings

Planned Parenthood Federation of Nigeria (PPFN)

Following a performance review, PPFN recognized that it was not fulfilling its potential and that the geographical coverage of service provision was less than a sixth of the country. To increase performance, it adopted a cluster model focusing on large urban slums and reaching under-served populations.

The model involves a public-private partnership strategy to increase access to sexual and reproductive health services by creating a cluster of five clinics within a radius of 20 kilometres. The clinics include private, government, community-based distributors, faith-based organizations and PPFN. One of the clinics acts as a comprehensive health facility and the others serve as feeders, referring clients who need more specialized services. Each cluster has a leader who coordinates logistic supplies, data capture, management and handling of fees. Traditional, religious and social institutions play a role in generating demand for services in their communities.

As a result of PPFN's cluster model, the Member Association is now the leading sexual and reproductive health service provider in Nigeria with significant increases in performance in service provision. In low resource settings, the cluster model increases coverage of services with limited resources; reduces human resource constraints by using well-trained, lower level groups of health personnel; and benefits from community involvement to generate demand for services.

Contraception

The global trend for the number of CYP provided by IPPF showed a dramatic increase of 30 per cent in 2012, from 9.1 million in 2011 to 11.8 million in 2012. This overall increase results from significant rises in countries such as the Democratic Republic of Congo, Honduras, Pakistan and Uganda (Figure 7), and from overall increases in the Africa region (68 per cent), South Asia region (14 per cent) and Western Hemisphere region (33 per cent). IPPF adheres to a rights-based approach and provided 15.8 million contraceptive counselling services to women and couples. This supports informed decision making about when, if and how many children to have, and is a fundamental primary health care service which contributes significantly to reducing unmet need, raising awareness and ensuring that the chosen method of contraception is appropriate, reliable and safe for every woman.

Figure 7: Couple years of protection (CYP), selected countries, 2011–2012

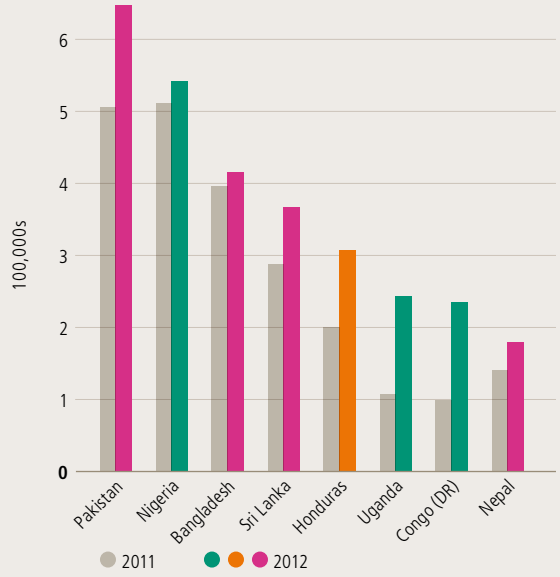
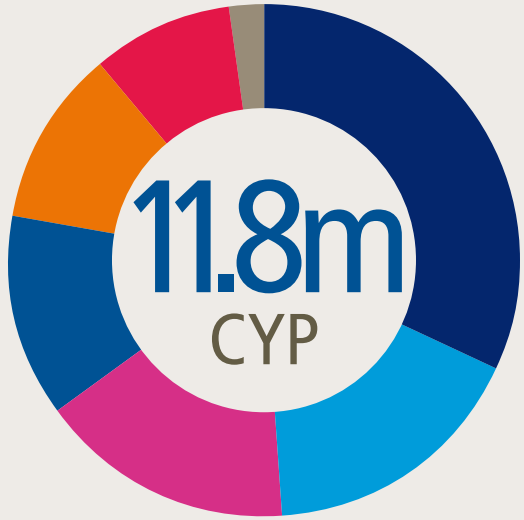


Figure 8: Couple years of protection (CYP), by method mix, 2012



- IUD 32%
- Oral contraceptive pill 17%
- Voluntary surgical contraception (vasectomy and tubal ligation) 16%
- Condoms 13%
- Injectables 11%
- Implants 9%
- Others, including emergency contraception 2%

4.9m

Unintended pregnancies averted

550,000

Unsafe abortions averted

IPPF's contraceptive services provided 11.8 million CYP in 2012. Using Marie Stopes International's Impact 2 estimation model, this averts 4.9 million unintended pregnancies and 550,000 unsafe abortions. Figure 8 illustrates the method mix of IPPF's CYP: 40 per cent of CYP was provided by long-acting methods, 44 per cent by short-acting, and 16 per cent by permanent methods. In comparison to 2011, proportionately more of IPPF's global CYP was provided by long-acting methods in 2012, with the number of CYP due to intrauterine devices increasing by 32 per cent to 3.7 million. Three other major increases in CYP from 2011 to 2012 involved oral contraceptive pills, rising by 49 per cent to just under 2 million; injectables, increasing by 35 per cent to more than 1.4 million; and implants, with more than 1 million provided – an increase of 151 per cent.

HIV-related services

The number of HIV-related services provided by IPPF continued to rise, from 15.1 million in 2011 to 19.2 million in 2012, an increase of 27 per cent. The greatest increases occurred in the provision of sexually transmitted infection/reproductive tract infection (STI/RTI) services, HIV opportunistic infection treatment, psychosocial support and antiretroviral treatment (Table 1). All six IPPF regions provided more HIV-related services in 2012 than in 2011. The Africa region in particular provided significantly more services: 5.2 million in 2011 and 7.1 million in 2012, an increase of 36 per cent. Member Associations with particularly strong performance include those in Cambodia, Honduras, India, Morocco, Swaziland and Uganda (Figure 9).

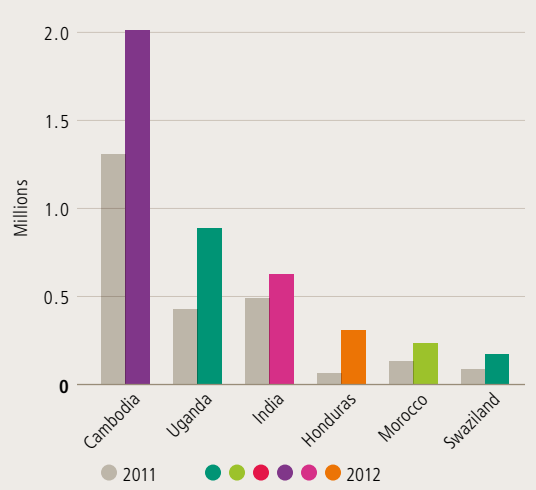
The proportion of Member Associations providing at least six of the nine services along the prevention-to-care continuum dropped slightly from 58 per cent in 2011 to 55 per cent in 2012. However, this still represents progress in comparison to previous years. In 2005, for example, only 32 per cent of Member Associations provided at least six of the nine services. The services most commonly provided in 2012 included condom distribution (92 per cent), behaviour change communication (90 per cent), and STI treatment and voluntary counselling and testing for HIV (both at 78 per cent). The services provided by the fewest Member Associations were palliative care and antiretroviral treatment (18 and 14 per cent respectively).

It is not only the quantity but also the quality of services provided that has been an important focus of IPPF's work. Member Association facilities and outreach services are committed to providing accessible, quality and stigma-free HIV and sexual and reproductive health services for all. They have made a concerted effort to operationalize stigma-free services by focusing on the attitudes and approaches of health care providers. They also focus on specific client expectations, experiences of people living with HIV and key populations most vulnerable to HIV, such as people who use drugs, men who have sex with men, transgender people and sex workers.

Table 1: Number of HIV-related services provided, by type, 2011–2012

Type of service provided	2011	2012
STI/RTI services	7,101,681	9,385,948
HIV voluntary counselling and testing	3,385,802	4,210,788
HIV serostatus lab tests	2,353,660	2,697,621
HIV prevention counselling	1,924,961	2,283,144
Antiretroviral treatment	27,836	113,076
Psychosocial support	62,938	112,915
HIV and AIDS home care treatment	86,682	51,028
HIV opportunistic infection treatment	52,411	69,211
Other lab tests	18,588	29,093
All other HIV services	69,615	198,138
Total	15,084,174	**19,150,962**

Figure 9: Number of HIV-related services provided, selected countries, 2011–2012



IPPF and the Global Fund in partnership

Fifty-six per cent of eligible Member Associations are working with the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) as a Country Coordinating Mechanism member, Principal Recipient or Sub-Recipient. This allows Member Associations to participate in decision making or receive funding to manage and implement programmes. The following examples highlight the variety of roles that Member Associations play in partnership with the Global Fund.

Principal Recipient

The Cameroon National Association for Family Welfare (CAMNAFAW) has been a Principal Recipient since 2011, after being a Country Coordinating Mechanism member for the three previous years. As a Principal Recipient, CAMNAFAW has been able to recruit more staff with different skills, and to strengthen its integrated work on sexual and reproductive health and HIV, raising its profile and credibility.

Sub-Recipient

During 2011, the Fundación Mexicana para la Planeación Familiar, A.C. (MEXFAM) was selected as one of four Sub-Recipients to implement a project serving men who have sex with men, and people who inject drugs. MEXFAM has strengthened its capacity in several areas such as designing and implementing new approaches to meet the needs of these vulnerable groups.

Country Coordinating Mechanism

Reproductive Health Uganda (RHU) has raised awareness of the benefits of linking HIV and sexual and reproductive health services among Sub-Recipients. As a Country Coordinating Mechanism member, RHU has been able to influence the content of proposals to ensure that the linkages agenda is prioritized, and subsequently implemented.

Abortion-related services

The number of abortion-related services increased by 31 per cent in 2012. The most common types of services included pre- and post-abortion counselling, post-abortion care, and surgical abortion (Table 2). The number of pre-abortion counselling services increased substantially in 2012 due to an increased emphasis placed on providing counselling to all clients who attend a Member Association clinic with an unplanned pregnancy to ensure that they are aware of all options available, including continuing the pregnancy, adoption or abortion – either provided by the Member Association or through referral to another service provider in cases where the Member Association does not have the capacity or the certification to perform the abortion procedure in their clinics.

If a client chooses an abortion, then post-abortion contraceptive options are discussed during pre- and post-abortion counselling. Clients who receive treatment for incomplete abortion also receive post-abortion counselling. Significant achievements have also been made across the Federation to increase the number of post-abortion clients adopting contraception. For the 12 Member Associations that are participating in the Global Comprehensive Abortion Care Initiative, the proportion of clients adopting a contraceptive method following an abortion procedure or treatment for incomplete abortion was 93 per cent in 2012, an increase of 4 per cent from 2011. Five of these Member Associations – in Bangladesh, Cameroon, India, Kyrgyzstan and Sudan – achieved a rate of 98 per cent or higher.

In January 2012, IPPF launched the Abortion Strategic Action Plan to accelerate performance. The plan reflects IPPF's commitment to expanding safe abortion services as well as strengthening abortion advocacy. It provides a set of clear deliverables and targets against which progress can be measured, and identifies specific areas of work for targeted support and investment.

The plan involves 73 participating Member Associations across the six regions. There are 33 intensive focus Member Associations which have the commitment and capacity to move forward quickly to produce results in a short timeframe and in line with IPPF's target of doubling sexual and reproductive health services by 2015; another 19 emergent Member Associations with the potential to scale up work on abortion but which, thus far, lack the initial training or infrastructure to do so; and finally, 21 Member Associations that have shown interest in providing abortion-related services or are in countries with high levels of unmet need.

An important component of IPPF's work on abortion involves improving quality of care. Approaches include:

- training service providers; for example, training medical officers, nurses and paramedics to provide manual vacuum aspiration, medical abortion, implants, tubal ligation, intrauterine devices and non-surgical vasectomy
- training on implementation of the World Health Organization's updated safe abortion guidelines
- responding to client satisfaction surveys; for example, reducing prices, increasing days when services are provided, and introducing appointment systems to reduce waiting times
- using information from mystery clients
- focusing on clients' rights, including the right to information, access, choice, security, privacy, confidentiality, comfort, dignity and continuity

Table 2: Number of abortion-related services, by type, 2011–2012

Type of service provided	2011	2012
Pre-abortion counselling	363,744*	739,275
Post-abortion counselling	434,910	462,564
Surgical abortion	382,174	387,327
Post-abortion care	223,845	277,193
Medical abortion	179,150	198,105
Treatment of incomplete abortion	31,303	50,365
Total	1,615,126	**2,114,829**

* Includes <3,000 consultation services.

Increasing access to safe abortion services

Association Burkinabé pour le Bien-Etre Familial (ABBEF)

The Member Association in Burkina Faso developed strategies to increase access to safe abortion services at its Bobo-Dioulasso youth centre and clinic. Association Burkinabé pour le Bien-Etre Familial (ABBEF) forged a new partnership with a public health centre close to its youth friendly clinic for the referral of clients seeking comprehensive abortion care. In addition, ABBEF organized talks for students, young women and girls visiting its youth centre to provide information about the services offered at the adjoining clinic. These strategies have been effective, resulting in a 20 per cent increase in the number of clients provided with a surgical or medical abortion.

ABBEF is also working with nine facilities to develop a social franchising programme to increase access to comprehensive abortion care and contraceptive services. The nine facilities are located in under-served areas where there are no ABBEF clinics.

High numbers of unplanned pregnancies end in abortions. Unsafely performed abortions account for 12 per cent of all maternal deaths in West Africa, equating to about 9,700 maternal deaths per year.

WHO[11]

Quality of care

Quality of care in IPPF means the delivery of services in a way that addresses the rights of clients as well as the needs of providers. Clients have the right to information and sexual and reproductive health services. They have the right to choice, safety, privacy, confidentiality, dignity and comfort when receiving services, continuity of care, and opinion. Providers also have certain needs that must be met to enable and empower them to provide quality services. These include training, information, adequate physical and organizational infrastructure, supplies, guidance, respect from clients and managers, encouragement from supervisors, feedback concerning their performance, and freedom to express their opinions concerning the quality of services they provide.

IPPF is implementing a quality of care strategy which involves:

- the provision of an integrated package of essential services in static clinics
- a system for quality improvement based on self-assessment and supportive supervision
- the use of data standards based on existing protocols and aimed at providing quality health care by analysing client-specific information

IPPF has set targets for Member Associations to provide an integrated package of essential services which includes eight components: sexuality counselling; contraception; safe abortion care; and STI/RTI, HIV, gynaecological, obstetric and gender-based violence services.* The integration of these services in a 'one-stop shop' approach can minimize missed opportunities, increase uptake of services, reduce costs, and facilitate efficiency in training, monitoring and supervision. Each of these types of service can be an entry point to identify other sexual and reproductive health needs that can then be addressed. IPPF's Integrated Package of Essential Services: Online Quality Assurance Toolkit offers a set of guidelines and resources from comprehensive, up-to-date and evidence-based scientific documentation.

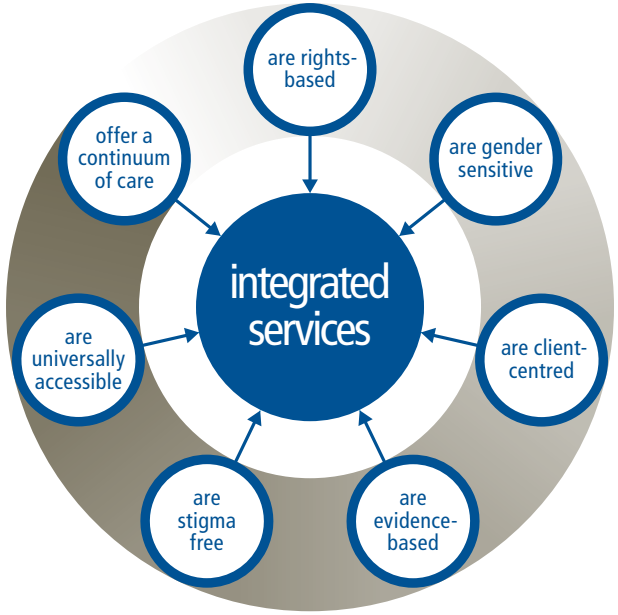
* See Annex C for details.

The IPPF approach to quality improvement is based on self-assessment, a participatory process whereby Member Association staff, at both the service delivery point and management levels, identify problems affecting the quality of services and then propose concrete solutions for improvement. Self-assessment is based on the premise that staff would like to know what is not working and what could be improved in their work. They would also like to have a say in addressing issues in their own working environment and want to feel responsible for addressing challenges and proposing solutions.

The effectiveness of the quality improvement process using self-assessment depends on the ability of Member Association staff to work together in teams. Staff teams should be multidisciplinary and undertake the self-assessment in a non-hierarchical environment where all members are equal and free to express their opinions without fear of being reprimanded. In this way, staff at all levels are empowered and have ownership over the quality improvement process.

The final component of the quality of care strategy involves using data standards for electronic client records to improve the quality, continuity and coordination of care. As part of the Western Hemisphere region's Evidence-based Practice Initiative, a list of clinical data standards for contraception and abortion-related services has been developed. Once integrated into the electronic clinical management information systems, service providers are guided by the standards to ensure delivery of high quality care to their clients. While manual client health records have long enabled a 'case management' approach to client care and data collection, the added benefits of using electronic systems include consistency and standardization of data, ease of aggregation and access to client level quality of care indicators.

Data standards are now used in a number of Member Associations in the Western Hemisphere region. Results show improved health outcomes and increased client satisfaction; improved coordination, continuity of care and clinical decision making for providers; better monitoring of provider performance; improved efficiency in medical audit and quality of care processes at the organizational level; and improved ability to design, monitor and evaluate programmes at a macro level [see page 30 for further information on this Initiative].



> Quality of care means striving for and reaching agreed levels of care that are accessible, equitable, affordable, acceptable, patient centred, effective, efficient and safe.
>
> WHO[12]

Reaching poor and vulnerable people

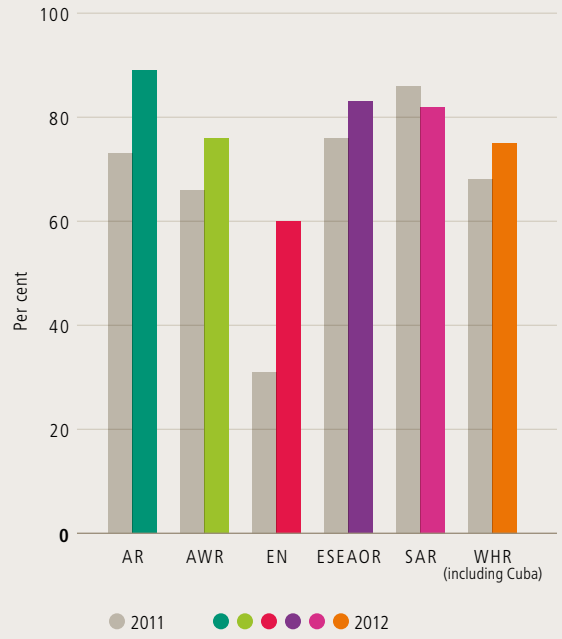
In 2012, the estimated proportion of IPPF clients identified as poor, marginalized, socially-excluded and/or under-served increased to 81 per cent from 73 per cent in 2011. This is a significant achievement, with five of IPPF's six regions increasing the proportion of poor and/or vulnerable clients served by Member Associations (Figure 10). This reflects IPPF's unwavering commitment to provide sexual and reproductive health services to those with the greatest needs.

Many Associations serve vulnerable people who are not reached by governments and other providers due to a reluctance to work with them and an inability to provide the specialized services needed. Under-served groups include sex workers, men who have sex with men, prisoners, people who use drugs, sexually diverse populations and people who have been trafficked. Young people's needs are often not adequately met by public or private providers who may be resistant to serving them because of their age and/or unmarried status.

Over half of IPPF's service delivery points are located in rural and peri-urban locations to ensure access to services for geographically isolated communities with limited health facilities and personnel. Overall, 70 per cent of IPPF's sexual and reproductive health services are provided in countries identified as having low or medium levels of human development, according to the UNDP's Human Development Index.[13]

IPPF is continuing to roll out a methodology which assesses the proportion of clients who are poor and/or vulnerable. This is based on Poverty Scorecards,[14] a tool that uses regression analyses of national survey questions to estimate the probability of a client being poor. In the questionnaire, Member Associations also include questions on sexual and reproductive health vulnerability. Each analysis is specific to country context. The data provide Member Associations with important information on the profile of clients they serve. Knowing if services are reaching those who may need them most supports decision making about how to manage programmes, staffing needs, where to target activities and where additional funding or reallocation of resources may be needed. A guide to collecting and analysing data to measure vulnerability will be published by IPPF in 2013. This will provide Member Associations with a consistent and peer-reviewed methodology to collect reliable data and be able to measure the success of their programmes in reaching those most in need.

Figure 10: Estimated percentage of Member Association clients who are poor and/or vulnerable, by region, 2011–2012



81%

of IPPF's clients are poor and/or vulnerable

Focusing on the needs of women and girls

The majority – eight out of ten – of IPPF's services are provided to women and girls who have the greatest morbidity and mortality risks associated with sexual and reproductive health. In many parts of the world, women do not have control over their own bodies, are unable to make decisions about childbearing, are prevented from ending an unwanted pregnancy, and are vulnerable to sexual violence, trafficking and exploitation.

In addition to contraceptive and abortion-related services that benefit women and girls, IPPF also provided 12.4 million gynaecological services (examinations, biopsy, imaging and cancer screening) and 8.9 million obstetric services (prenatal and post-natal care, pregnancy testing and deliveries) (Figure 11). Regarding child health, a further 4.1 million paediatric services were provided, including over 1.2 million immunizations, and 535,000 baby/infant health checks and neonatal screening services. Overall, the combined categories of gynaecological, obstetric and paediatric services increased by an additional 5.7 million, or 29 per cent, between 2011 and 2012.

Figure 11: Number of gynaecological, obstetric and paediatric services provided, 2011–2012

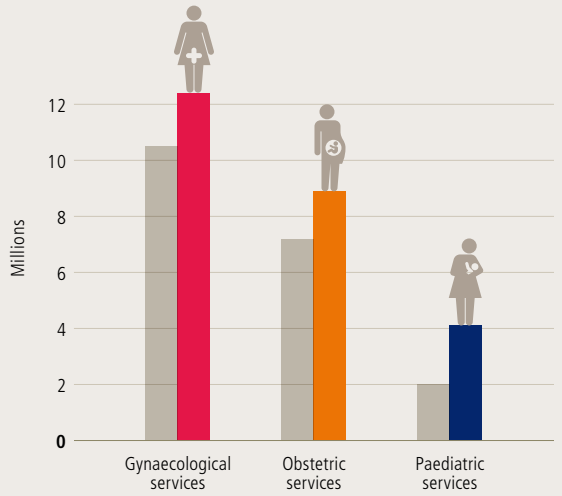
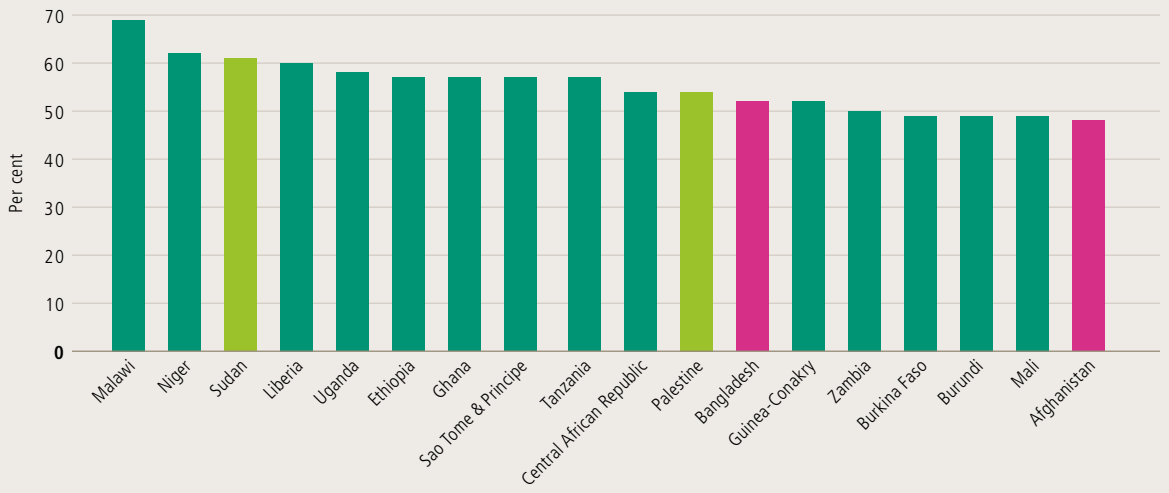


Figure 12: Percentage of SRH services provided to young people, selected countries, 2012



Providing services to young people

In 2012, 45.1 million sexual and reproductive health services were provided to young people, a rise of 7.7 million, or 21 per cent, from 2011. Globally, one-third of Member Associations provided more than half of their services to those aged under 25. On average, 40 per cent of all services provided by IPPF go to young people, although the percentage is greater in many countries with high proportions of young people in the population. Figure 12 highlights the proportion of services provided to youth for 18 Member Associations that are particularly effective in meeting young people's sexual and reproductive health needs. In all of these countries, the proportion of young people in the total population lies between 30 and 35 per cent, with an average of 32 per cent.

The focus on young people is critical to ensure the realization of the sexual and reproductive health and rights of the largest ever generation of young people who face stigma and discrimination, who may have no voice, and who have limited access to information. In addition to providing sexual and reproductive health information and services to young people, IPPF also works with ministries of education and school authorities in many countries to include comprehensive sexuality education in official school curricula. We also recognize that many young people, especially the most marginalized and vulnerable groups, cannot access school-based comprehensive sexuality education. We therefore provide other options including peer education, programmes for parents/guardians, online comprehensive sexuality education tools, and youth-centred programmes.

Comprehensive sexuality education helps young people to make informed choices. To translate these choices into realities, young people must also have access to confidential, non-judgemental and youth friendly services, and IPPF is in a unique position to strengthen the linkages between choice and reality. Evidence from interviews with young people across the globe shows that they visit Member Associations' service delivery points and participate in comprehensive sexuality education programmes, confident that they will be treated with respect, listened to, and able to access the sexual and reproductive health information and services that they need.

Supporting marginalized youth

Planned Parenthood Association of Zambia (PPAZ)

Advocacy efforts by the Planned Parenthood Association of Zambia (PPAZ), in partnership with UNESCO and others, have led to the inclusion of comprehensive sexuality education in the new school curriculum, which will provide much needed information to young Zambians in school.

To address the needs of out-of-school youth, and recognizing the link between substance abuse, poor sexual and reproductive health outcomes, and social exclusion for young people, PPAZ developed a peer education programme that includes information about the health-related consequences of substance abuse. The programme helps young people to recognize sexual and reproductive rights, and to be more tolerant towards sexual diversity. PPAZ is expanding its service delivery through new outreach sites and the provision of mobile services to peri-urban and rural young people. PPAZ has also established effective referral systems with partner organizations, including substance abuse support networks.

> I learned that people have the right to make their choices regarding their sexuality and their choices should be respected. I believe that they should access safe services without discrimination.
>
> 24-year-old female

Key results by region

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). The eight-year cumulative totals for the major categories of sexual and reproductive health services are presented in Table 3 and provide an overview of the achievements made since the beginning of IPPF's current Strategic Framework 2005–2015. Table 4 focuses on the annual results for 2012, with information on a number of additional key performance indicators.

Table 3: Cumulative results by region, 2005–2012

Indicator	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of sexual and reproductive health services (including contraception) provided	143,465,805	15,922,356	11,872,120	63,294,594	99,219,500	207,558,740	**541,333,115**
Number of couple years of protection (CYP)	8,852,794	2,322,342	376,713	5,159,113	15,439,294	38,766,796	**70,917,052**
Number of sexual and reproductive health services (including contraception) provided to young people under 25 years	57,595,147	4,517,331	4,960,188	15,121,311	45,580,339	65,627,407	**193,401,723**
Number of HIV-related services provided	21,566,874	1,572,653	1,682,145	9,966,788	8,731,550	27,867,207	**71,387,217**
Number of condoms distributed	227,576,575	6,346,929	7,907,141	155,262,915	232,438,473	540,413,972	**1,169,946,005**
Number of abortion-related services provided	1,011,268	265,568	639,909	1,038,711	1,927,522	4,248,672	**9,131,650**

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

Over half a billion*

SRH services provided

71m

couple years of protection

Nearly 1.2 billion*

condoms distributed

* 1 billion = 1,000,000,000

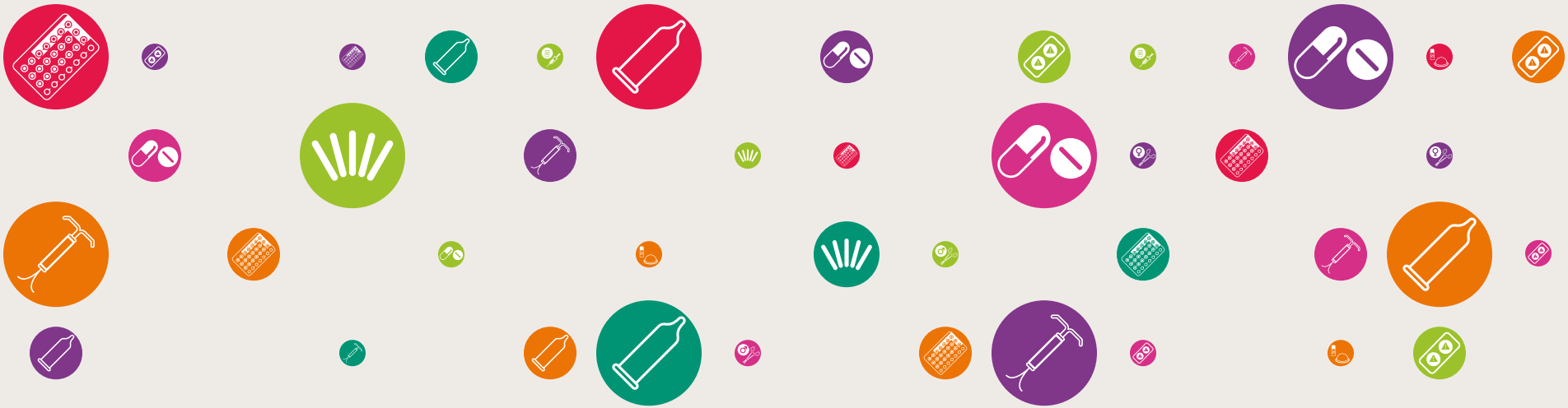


Table 4: Results by region, 2012

Indicator	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of sexual and reproductive health services (including contraception) provided	39,473,382	2,821,454	1,730,329	15,616,282	18,576,517	34,491,529	**112,709,493**
Number of couple years of protection (CYP)	2,370,768	287,345	41,068	755,973	2,304,131	6,046,977	**11,806,262**
Number of sexual and reproductive health services (including contraception) provided to young people under 25 years	14,581,128	1,303,746	841,979	5,395,490	8,779,415	14,168,895	**45,070,653**
Number of HIV-related services provided	7,107,781	439,801	203,697	3,267,370	1,853,655	6,278,658	**19,150,962**
Number of condoms distributed	58,290,104	395,845	984,747	30,026,771	35,835,701	64,486,539	**190,019,707**
Number of abortion-related services provided	316,693	46,763	106,969	173,408	298,303	1,172,693	**2,114,829**
Estimated percentage of Member Association clients who are poor and/or vulnerable	89%	76%	59%	83%	82%	75%	**81%**
Proportion of Member Associations providing the Integrated Package of Essential Services*	8%	9%	n/a†	9%	33%	52%	**21%**

* 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. Data for 2012 are based on a revised model which is significantly harder to achieve than previous models. 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

Changing lives of out-of-school youth with peer education

Family Health Options Kenya (FHOK)

In Kenya's Nyanza province, HIV prevalence, infant and child mortality rates, and unmet need for contraception are the highest in the country.[15] Substance abuse among young people is common, and girls often leave school early due to pregnancy or because sending boys to school is prioritized. Many of Nyanza's young people have nowhere to turn for accurate information and find it difficult to engage with existing services and clinics.

Family Health Options Kenya (FHOK) has responded with the Youth, Education and Sexuality project, which provided youth-led comprehensive sexuality education and outreach services to out-of-school young people. Peer educators distributed condoms and explained why and how they are used. They discussed HIV and the importance of getting tested, and referred young people to FHOK clinics for HIV voluntary counselling and testing. Peer educators raised awareness of the health-related consequences of substance abuse, and provided referrals for substance users to health services and support networks. They also helped girls return to school, and referred young women living with HIV or with unplanned pregnancies to health services. Volunteers spoke to parents about the importance of girls attending school.

Youth-led activities increased the demand for services among young people in Nyanza. The peer educators acted as an important link between out-of-school youth and health facilities in the community as they became recognized as trusted referral agents.

As a result of FHOK's project, young people's lives in Nyanza have improved significantly. Many were introduced to the project at a time when they were struggling with a sexual or reproductive health problem. FHOK's services, information and support helped them regain hope and feel that they were given a second chance. Condom use has increased and there has been a significant uptake of voluntary HIV counselling and testing. A number of young people have either reduced or entirely given up substance use.

> Before, honestly, I didn't even know how to use [condoms]. Checking the expiry date to me would have been the last thing which I came to learn that it should be the first thing. The project brought a great change in my life. I and my girl now use condoms.
>
> 17-year-old male

Reaching young people with information technology

Family Planning Association of Sri Lanka (FPASL)

In Sri Lanka, many young people, particularly those who are unmarried, lack access to reliable and accurate sexual and reproductive health information. Existing services and information are targeted at older married couples, and are often unaffordable for younger individuals. Sex and sexuality are generally not discussed at home or in school, and there is no compulsory sexuality education in Sri Lankan schools. The Family Planning Association of Sri Lanka (FPASL) is meeting this huge information gap for young people with technology.

FPASL launched a tri-lingual website to provide sexual and reproductive health information, with a particular focus on young people. Anyone needing advice or information can contact qualified doctors and counsellors through text messaging, instant messaging, web chat, voice calling or web forum. A Skype function on the website means that voice calls can be made to qualified personnel at no cost. People receiving support, advice and information remain anonymous, their discussions are confidential, and the service is completely free of charge.

FPASL was strategic in its use of information technology to reach young and unmarried Sri Lankans. The Association capitalized on the rising number of mobile phone and internet users, taking into consideration the fact that young Sri Lankans have embraced

communications technology. As a result, the website has registered 10,000 contacts by young people, covering a wide range of sexual and reproductive health topics. FPASL also engaged the support of the captain of the Sri Lankan national cricket team – popular among and respected by many young Sri Lankans – to advertise and promote the website.

Programme successes: HIV and AIDS

A perfect match: integrating sexual and reproductive health and HIV services

Family Health Options Kenya (FHOK)
Family Planning Association of Malawi (FPAM)
Family Life Association of Swaziland (FLAS)

HIV prevalence and poor sexual and reproductive health are driven by similar determinants. It has long been believed that integration of services can lead to improved health outcomes, better service experience for clients (including reduced stigma) and cost savings; however, there was little evidence to confirm these assumptions.

> Integrated services, provided by trusted and competent providers, can be a step in the right direction to ensuring access to more health services for all.
>
> Dr Joyce Banda, President of Malawi

The Integra Initiative was a five-year research project (2008–2012) to gather evidence on the benefits and costs of a range of models for delivering integrated HIV and sexual and reproductive health services in high and medium HIV prevalence settings, to reduce HIV infection (and associated stigma), and to reduce unintended pregnancies. Managed by IPPF, in partnership with the London School of Hygiene and Tropical Medicine and the Population Council, four models of integration were tested in real world settings in Kenya, Malawi and Swaziland, in both ministry of health and Member Association facilities. A study of the costs, savings and possible efficiency gains from integrating sexual and reproductive health and HIV services was also conducted in the three countries.

The Integra Initiative combined operations research with enhancing service provision, and the three Member Associations involved in the programme significantly increased the provision of HIV services during the project period (Table 5). In Kenya, the integration of HIV testing and counselling with post-natal care services has resulted in a reduction in unmet need for contraception and in unintended pregnancies.

The Integra intervention included mentoring and skills development for providers, which improved the quality of care for both contraceptive and post-natal care services in Kenya and Swaziland. In Malawi, the research showed that when offered a choice, young people prefer to have access to HIV-related services (such as counselling, testing and treatment) integrated in the same facility as other sexual health services.

Several of the research components highlighted an unmet need for sexual and reproductive health services for women living with HIV. In particular, analysis of data on a cohort of women living with HIV followed over time revealed that they had high needs for both contraception and HIV services which are better met through integrated service provision, and which support women living with HIV to realize their fertility intentions. The results also identified where investment is needed for integration and where efficiencies can be made to increase value for money. In particular, the results identified the need for better use of infrastructure and human resources, although drugs and supplies made up the greatest proportion of costs.

The Initiative developed an innovative measurement tool which assesses readiness for integration, as well as the extent to which a facility has already integrated sexual and reproductive health and HIV services. The tool can be used by ministries of health for national programmes to determine the readiness for or level of existing integration within facilities, to monitor the changes in integration over time, and to evaluate outcomes of integrated care.

Finally, the Integra Initiative has provided significant opportunities for learning. The Integra website showcases research findings, project reports and innovations, and interactive discussions about current questions, debates and good practice in linking sexual and reproductive health care and HIV.

Integra
Strengthening the evidence base for integrating HIV and SRH services

www.integrainitiative.org

Table 5: Number of HIV services provided, 2008 and 2012

Member Association	2008	2012
Family Health Options Kenya	38,122	184,567
Family Planning Association of Malawi	10,544	81,261
Family Life Association of Swaziland	17,939	132,268

Programme successes: abortion

Ensuring access to treatment for incomplete abortion

Sudan Family Planning Association (SFPA)

Abortion in Sudan is only legal under very limited circumstances and must be carried out in a government hospital. Many women resort to unsafe abortion because they do not know their legal rights, and because there is a lack of access to safe and legal abortion services in the country.[16]

To ensure clients have access to safe abortion services to the full extent of the law, the Sudan Family Planning Association (SFPA) has strengthened its partnership with government hospitals and improved its referral system. This resulted in an increase in referrals in 2012 of 84.6 per cent from 2011. SFPA staff accompany referred clients to the hospital for the procedure, and contact them afterwards to follow up and provide support where necessary.

To respond to the needs of women who have complications after an unsafe abortion, SFPA provides treatment for incomplete abortion and related counselling services in its clinics. In 2012, the Association provided training to community health workers, such as village midwives, about the dangers of unsafe abortion. These health workers raise awareness of and provide advice on the lifesaving incomplete abortion services that SFPA provides. Clients are referred by the community health workers to SFPA clinics to receive treatment for an incomplete abortion. In 2012, the number of referrals by community health workers to SFPA clinics increased by 42.3 per cent from 2011. The Association promotes accurate, effective and rights-based messaging about abortion, for example, that every client is equal and entitled to treatment for incomplete abortion. Health workers, therefore, are able to correct misinformation and reduce stigma surrounding abortion in their communities.

> Abortion is legally restricted in Sudan to circumstances where the woman's life is at risk or in cases of rape. Post-abortion care is not easily accessible. In a country struggling with poverty, internal displacement, rural dwelling, and a dearth of trained doctors, mid-level providers are not allowed to provide post-abortion care or prescribe contraception.[17]

Ensuring access to safe abortion

Asociación Pro-Bienestar de la Familia Colombiana (Profamilia)

The process of abortion law reform is lengthy and full of challenges. In many countries, even where abortion is permitted under certain conditions, few providers are willing to offer the service, and access to safe abortion services remains limited.

In Colombia, abortion has been permitted since 2006 in cases of fetal impairment, incest or rape, and to preserve a woman's physical or mental health.[18] However, there remain significant barriers to accessing legal abortion services, particularly in the public health sector, and high rates of unsafe abortion persist. An increasingly hostile political environment and ongoing efforts to overturn the abortion legislation contribute to uncertainty among health providers.

The Asociación Pro-Bienestar de la Familia Colombiana (Profamilia) has been working tirelessly to ensure women's access to legal abortion services. In 2012, Profamilia provided 2,267 legal abortions, an increase of 35 per cent from 2011, and a stark contrast to the 322 abortions reported nationwide in 2008.[19] Profamilia has also made significant progress in ensuring that young people have access to safe and legal abortion services with six in ten abortions provided to young women under the age of 25.

Profamilia monitors results closely and provides all necessary policy and administrative support for staff based on these results. New information systems have been implemented in 21 clinics, with training provided to administrative and medical staff, and reports developed to facilitate data analysis and decision making. Profamilia conducted monitoring visits in 17 clinics to provide follow-up on use of the clinic information system; to resolve provider concerns regarding processes for legal abortion cases related to sexual violence and fetal malformations; and to address issues related to informed consent, and provision of services to young people and women with disabilities.

Profamilia is well poised to contribute to the advancement of abortion service provision in Colombia and in the region, and to establish itself as an important leader for protecting abortion rights.

Programme successes: access

High impact practice in contraceptive service delivery

Association Togolaise pour le Bien-Etre Familial (ATBEF)

At 41 per cent, Togo has one of the highest rates of unmet need for contraception in the world, with only 12 per cent of women currently using a modern method of contraception.[20] The Association Togolaise pour le Bien-Etre Familial (ATBEF) responded to this need for increased access to modern contraception, particularly among the poorest and most under-served communities, by training, equipping and supporting community health workers to provide a range of family planning methods.

After years of strong advocacy by ATBEF, the government of Togo gave permission for non-medical personnel to be trained to perform certain medical procedures, including the provision of injectable contraception. In close collaboration with the Ministry of Health, ATBEF responded by selecting community health workers in remote areas of one district to provide comprehensive contraceptive services, including injectables. Medical personnel trained, certified and supervised these health workers; provided coaching and ongoing technical support; and assessed them on a quarterly basis. This strong element of monitoring and quality control contributed significantly to the success of this project.

To ensure access for rural, hard-to-reach clients, ATBEF gave the community health workers bicycles that could cope with rough terrain, enabling them to travel to clients' homes in villages that are situated far from health facilities. ATBEF also held meetings in communities, and with religious and community leaders to build support for the project. The health workers collaborated with other health service providers to offer sexual and reproductive health information and services to even more women.

To alleviate fear among women of the possible side-effects of some contraceptive methods, ATBEF carried out awareness raising activities and enlisted the help of 15 contraceptive champions to help dispel myths and correct misinformation. For example, some women had previously believed that intrauterine devices caused illnesses or that they were permanent methods of contraception.

As a result of this work, ATBEF has been able to reach people in remote and under-served areas where a lack of access to family planning resulted in low contraceptive prevalence rates. ATBEF has significantly increased the number of poor, marginalized, socially-excluded and/or under-served clients that it serves (91 per cent, compared to 70 per cent in 2011). This 23 per cent increase in ATBEF's couple years of protection (CYP) in 2012 was largely due to injectable contraceptives. ATBEF contributed to 19 per cent of Togo's national CYP.

> In my village, this project has greatly contributed to the reduction of marital disputes and early pregnancies among students. Maternal deaths are no longer recorded in my community.
>
> Village chief

The project's success was built on strong partnerships with the Ministry of Health, local imams and community leaders. The government has expanded the model to seven other districts, with ATBEF providing technical support to other organizations implementing this approach.

91%

of ATBEF's clients are poor and/or vulnerable

perform a relevant and accountable Federation

In 2012, IPPF invested in organizational systems and business processes to ensure that the principles of economy, efficiency, effectiveness and equity are applied. Our evidence-based approach supports better programme design, maximizes performance, facilitates learning, and enables us to remain accountable to our clients, donors and partners.

One of the critical issues identified by the midterm review of IPPF's Strategic Framework 2005–2015 was performance culture. Significant achievements had already been made since the beginning of the Framework in the areas of IPPF's accreditation system, governance reform and measurement of global performance. However, a need was identified to strengthen systems for monitoring performance, accountability, effectiveness and transparency to ensure maximum impact, value for money and continuous improvement throughout the Federation.

Figure 13 presents IPPF's achievements in 2012 in the area of Perform against targets. Overall, the results are positive, with three indicators showing significant progress, two showing progress but remaining slightly behind the targets set for 2012, and one making no progress since 2011 and not achieving the target.

The income raised by the IPPF Secretariat went up by 13 per cent from 2011, to US$144.8 million. This is a good result but falls below the target of US$157.8 million. Income raised by Member Associations also showed an increase – 15 per cent from 2011, to US$372.1 million – a good result but below the target of US$374.6 million.

Figure 13: Perform – performance results in 2012

Target: US$157.8 million of IPPF income (unrestricted and restricted) **P.1**	**Target:** US$374.6 million of Member Association income (minus IPPF income), supported by the Secretariat **P.2**	**Target:** 5% of IPPF's unrestricted funding is used to reward Member Associations through a performance-based funding system **P.3**
US$144.8m	US$372.1m	6%
Target: 5% of Member Associations use SRH service costing data from static clinics **P.4**	**Target:** 10 Member Associations collect data on poverty and vulnerability status (using the IPPF Vulnerability Assessment methodology) **P.5**	**Target:** 65% of Member Associations have 20% or more young people under 25 years of age on their governing board **P.6**
13%	10	58%

Three indicators monitor progress in implementing systems to support the utilization of data (P.3, P.4 and P.5). The proportion of IPPF's unrestricted funding used to reward Member Associations through a performance-based funding system was 6 per cent in 2012, above the target of 5 per cent. The overall aim is to reach 10 per cent by 2015, as agreed by IPPF's Governing Council, and we are making good progress towards this. With 13 per cent of Member Associations using sexual and reproductive health service costing data in static clinics, the target of 5 per cent was exceeded. Similarly, the methodology developed (by IPPF in partnership with MEASURE Evaluation and based on Poverty Scorecards*)[21] to estimate the proportion of IPPF's clients who are poor and vulnerable has now been implemented by 10 Member Associations, equalling the 2012 target.

Finally, the proportion of Member Associations that have 20 per cent or more young people on their governing board remained static between 2011 and 2012 at 58 per cent, and did not meet the target of 65 per cent.

This section presents major initiatives to strengthen the Federation's performance culture with a focus on data driven decision making, learning, improving systems and business processes, and investing for results.

* Poverty Scorecards were available for 43 countries where there are IPPF Member Associations at the beginning of 2012.

Data driven decision making

IPPF is harnessing the potential of data to improve performance and make financial savings. The value of data to IPPF is not viewed solely in terms of accountability to donors but also in terms of providing the evidence needed to make decisions. The following examples illustrate how IPPF is increasingly seeing data as an asset that supports operational, financial and strategic management, and governance.

IPPF's Branch Performance Tool enables management of Member Associations to use existing data to internally review performance across different static clinics and outreach facilities, and to identify those that are performing most efficiently. The comparisons use efficiency scores consisting of a range of data, such as the ratio of clients to staff per day, services and CYP provided, cost per services/CYP, and overheads as a percentage of total cost. The analyses support management to review performance, taking into consideration the context in terms of location, size, different client profiles and staffing, and to make decisions that have the greatest potential for operational improvements. Examples of such decisions in 2012 included reallocating desk work from frontline medical professionals to less expensive administrative staff, conducting community outreach to increase knowledge of and demand for services, and relocating service delivery points to areas with greater unmet need for sexual and reproductive health services.

The learning gained from implementing the Branch Performance Tool, both within and across Member Associations, has been invaluable. Comparing across similar clinics that have significantly different levels of performance guides management decisions to improve performance, or to close the clinic and use the resources elsewhere. For the Federation, the increased body of learning about how clinics operate efficiently provides vital information and encouragement to others in supporting change.

In 2012, the Branch Performance Tool was introduced in 13 Member Associations, including the Reproductive Health Association of Cambodia (RHAC) which used the process to guide its sustainability improvements. Data on cost recovery were reviewed and used to divide each clinic into three categories: those that are financially sustainable; those that are partially supported by donors; and those that are completely funded by donors. For each type, RHAC developed strategies to improve performance and sustainability, including reviewing current staff capacity, strengthening existing service provision and expanding referral networks. Fee structures were also assessed and some clinics were able to increase the range of services provided and to charge higher fees to recover costs. Senior management now review data monthly and discuss the figures with clinic staff who recognize the importance of keeping accurate records and who are empowered to use the data to develop strategies that increase performance.

To improve the quality of care of abortion services, the Reproductive Health Alliance of Kyrgyzstan (RHAK) established a medical audit system to explore the causes of medical abortion-related complications. The Association reviewed and analysed all cases and used the information to develop refresher training courses for service providers on how to prevent and treat complications following medical abortion. The Member Association found that complications were often caused by the provision of medical abortion by unskilled and/or untrained providers in non-RHAK clinics, or because of poor quality and regulation of drugs.

RHAK's work contributed to the development of a database used by the medical abortion drugs supplier in Kyrgyzstan. To register, all service providers must complete a training programme on medical abortion procedures. Elements of training include counselling, selection criteria for medical abortion clients, required dosage and the route of administration. Service providers also have to report on the number of medical abortions performed which will support more realistic and reliable data at the national level. RHAK has trained service providers to become certified to purchase medical abortion drugs, a move that should help reduce the number of complications. RHAK is also working with a medical abortion manufacturer to ensure the correct dosage is supplied in each packet.

IPPF's accreditation system ensures adherence of all Member Associations to the standards and responsibilities of membership. Once every five years, Member Associations undergo an accreditation review involving the assessment of data on membership standards to confirm compliance and/or identify any areas of non-compliance. Prior to any accreditation review visit, a self-assessment is completed by each Member Association as well as an in depth desk review of various documentation. These contribute to the body of evidence which is used by the accreditation team, in consultation with Member Associations, to either confirm compliance, or draw up an action plan to address any outstanding issues. The data collected during reviews also provide IPPF's Governing Council with the information it needs to be able to confirm accreditation status, or to suspend or expel Member Associations that do not comply with IPPF's standards. This is done through IPPF's Membership Committee which thoroughly examines the outcomes of each accreditation review and makes the necessary recommendation to IPPF's Governing Council. Since the beginning of the accreditation system in 2003, five Member Associations have been expelled and two have been suspended.

IPPF invests substantial resources to support Member Associations to make the changes necessary to become fully accredited. The Solomon Islands Planned Parenthood Association worked hard to establish good governance practices following a governance crisis in 2008. New board members now receive orientation on their roles and responsibilities and are supported to become strong advocates for the Association. During an accreditation review visit in 2011, however, several areas of governance were identified that still required strengthening. The IPPF review team and the Association developed an action plan to address these areas. By December 2012, the Association had resolved all outstanding issues and was subsequently accredited at the May 2013 Governing Council.

Evidence-based Practice Initiative

With the overall goals of improving health outcomes and guaranteeing access for all to sexual and reproductive health services, the Western Hemisphere Regional Office launched its Evidence-based Practice Initiative to improve the use of client-based data for decision making. The Initiative aligns with international efforts to promote the meaningful use of information to improve service delivery, with the ultimate goal of improving client health outcomes. Specifically, the Initiative will develop standardized data sets for sexual and reproductive health services, support the implementation of clinical management systems using electronic health records, and stimulate evidence-based decision making by focusing at several levels on the data needed. The guiding principle of the Evidence-based Practice Initiative is to support a client-centred, rights-based service delivery approach by increasing access to services and improving quality of care. The Initiative provides the information needed to understand and increase sustainability, and supports the optimal use of clinic resources to meet institutional goals.

The Western Hemisphere region is spearheading the development of clinical data standards for abortion-related and contraceptive services. These data standards are based on authoritative medical sources (primarily the World Health Organization and IPPF's Medical and Service Delivery Guidelines). They were developed by a working group made up of evaluation, information technology and medical experts on a regional level, and medical and data experts from seven Member Associations. The clinical data standards were piloted in two Member Associations in Colombia and Peru. Through the Western Hemisphere region's Capacity Building Fund, the Member Associations in Bolivia, Brazil, Dominican Republic and Honduras are incorporating the clinical data standards into their electronic clinical management systems.

The use of standardized data collected through electronic health records provides multiple benefits at several levels (see below).

At the client level	At the provider level	At the Member Association level	At the Federation level
improved satisfaction, as clients' needs can be better documented and responded to	improved coordination of care with real-time client information from multiple providers and access to referral information	increased understanding of the health impact that services have on the community with more reliable, client-based data	improved ability to design programmes with stronger evidence to test approaches
improved transparency and information sharing, as clients have greater access to their own medical records	improved continuity of care with follow-up, review and analysis of client outcomes over time	improved medical audit and quality of care processes	improved efficiency in reporting with consolidated reporting systems using standardized, client-based data
increased efficiency, as waiting times are reduced	improved quality of care with information and alerts related to specific conditions	improved ability for management to make organizational decisions, as information can be analysed within and across clinics, providers and groups of clients	improved ability to conduct evidence-based advocacy, using data that describe client health needs and outcomes
better health outcomes, as clients receive improved coordinated care with different providers and on different health concerns		increased clinic performance, as detailed data can be easily accessed, analysed and used to improve service delivery	increased access to performance data to make resource allocation decisions
		increased potential to provide local/ national leadership on electronic health record and data standard initiatives	
		reduced reporting burden with reports that are generated from the system	

Learning to improve

IPPF recognizes the importance of learning from its own experience and that of others, and of using knowledge to increase organizational effectiveness. There are both formal and informal learning approaches throughout the Federation, including the provision of technical assistance; peer exchange; our online knowledge sharing platform, IPPF Exchange; annual performance reviews; monitoring and evaluation; skills training; development of methodologies, tools and policies; specialist publications; After Action Reviews; and communication initiatives. Our commitment to learning means that we continuously improve our ability to achieve our mission.

IPPF capitalizes on the wealth of expertise, knowledge and experience within the Federation, by hosting learning events and supporting peer exchange or South-to-South learning. The learning from this type of capacity building contributes to increased effectiveness and improved performance. For example, Rahnuma-Family Planning Association of Pakistan introduced a system of learning and sharing to improve the quality of care provided in its clinics. Staff members visit other clinics to observe all aspects of clinic management, to learn from the experience of their colleagues, and to conduct audits of standards and practice. This has led to improved skills and an increase in client flow.

A learning exchange visit between the Family Guidance Association of Ethiopia and Family Health Options Kenya provided the opportunity to share experiences on integrating comprehensive abortion care and sexual and reproductive health services. The exchange resulted in the identification of effective strategies such as the use of resource mobilization schemes to secure local funding and increase sustainability; holding open day sessions to raise awareness, create demand and attract more clients; and holding values clarification workshops to strengthen the involvement of volunteers.

IPPF Exchange is a knowledge sharing website open to all volunteers and staff across the Federation. It is a place where people can go to learn, share experiences, communicate with each other, have discussions, ask questions, and read about IPPF policies and standards. Volunteers and staff can also upload and download a range of tools, guides, reports and other resources. In 2012, the site was redeveloped in response to user feedback on how to improve it.

IPPF often provides technical expertise to other agencies and organizations working on sexual and reproductive health and rights; likewise, we build on learning that comes from outside the Federation to improve our own programmes. IPPF is active in a number of global health partnerships. Our Director-General is on the Board of the Partnership for Maternal, Newborn and Child Health and the Family Planning 2020 Reference Group, and IPPF chairs the Board of the Reproductive Health Supplies Coalition and the Safe Abortion Action Fund. IPPF also has a seat on the Family Planning 2020 Performance Monitoring and Accountability Working Group. We have a number of formalized strategic partnerships with FIGO, WHO and various UN agencies. We participate in technical groups such as the High Impact Practices in Family Planning Group; the International Best Practices Steering Committee; the UN Commission on Life-Saving Commodities, particularly the Implant Technical Reference Team; Cervical Cancer Action; and the UK Consortium on AIDS and International Development. With UNFPA, IPPF is co-convenor of the steering group to develop a compendium of sexual and reproductive health and HIV linkages indicators.

> After Action Reviews are used to assess our work and identify successes and failures through open and honest discussions. They help us to improve specific areas of our work and have resulted in more efficient business processes.

Strengthening systems

IPPF is a large and complex organization with multiple levels of management. Global systems and processes are required to enable IPPF to function effectively, including planning, budgeting, implementing and evaluating programmes, and reporting results. It is important that the systems allow information to flow logically between Member Associations, Regional Offices and the Central Office. In 2012, IPPF carried out an internal review of systems and business processes to identify areas for improvement. The aim was to ensure that a sufficiently robust system was in place that provides necessary controls for a well managed organization, but that also reduces the burden of bureaucracy on both Member Associations and the Secretariat. IPPF is now implementing the systems review's recommendations.

The review highlighted service statistics data quality as an area for improvement, echoing the recommendations made in the 2009–2010 midterm review of IPPF's Strategic Framework 2005–2015. The service statistics module was developed in 2005 to capture the profile and volume of clinical services provided by Member Associations. The module has undergone modifications over the years to respond to changing data capture and reporting requirements, but this was not done systematically or with extensive consultation.

A revision of the service statistics module was carried out during 2012 involving programme and evaluation staff from IPPF's Member Associations and the Secretariat. The result is a revised module which aligns the services reported by Member Associations with those required by the Secretariat for performance monitoring and accountability. This significantly reduces the data reporting burden of Member Associations without compromising the ability of the Secretariat to utilize the data. The module also provides definitions and explanations for each service type to ensure more accurate data categorization. This is expected to improve the quality of data, in particular, its validity and completeness.

In 2013, training on the new module has been provided to Member Associations to ensure that their internal clinical data management systems and IPPF's service statistics are harmonized and compatible, and that all data collection needs are met. Data on sexual and reproductive health services will be reported on the new module for the reporting year 2013.

IPPF Africa Regional Office provided technical support to a number of West African Member Associations in 2012 to strengthen their data collection systems. As a result, many of the clinic management systems are now electronic, which has enabled the Associations to increase the accuracy of data, collect client-based data, and produce reports for donors and other stakeholders more quickly. The Associations use the data to make programmatic and management decisions; for example, managers in the Central African Republic Member Association now conduct quarterly meetings with service providers to review data, discuss any issues with the numbers and make changes to increase service provision.

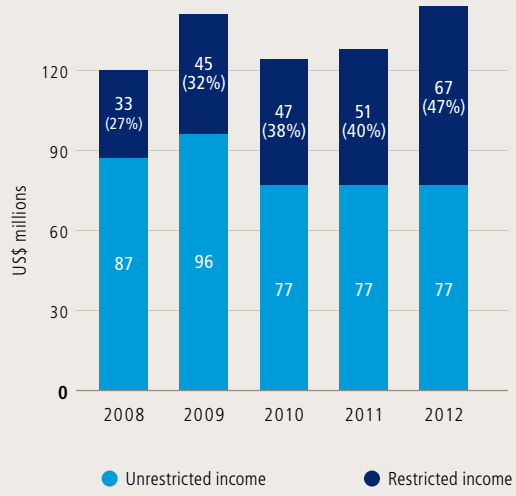
The improved systems have also prompted the Member Associations to revise and streamline their data capture forms. In Togo, the Member Association brought together all of its service providers to develop one data collection template, and the increased accuracy of the data led to a 15 per cent increase in the number of services reported in 2012 compared to 2011. After moving to an electronic data management system, the Association in Senegal revised its data capture forms in consultation with the Ministry of Health so that the data collected are in line with both IPPF's reporting templates and Senegal's national systems. This has enabled the Association to become a major contributor to national level data on sexual and reproductive health services.

Investing for results

Despite ongoing global economic difficulties, IPPF's total income from governments, foundations and other sources increased by US$17.2 million between 2011 and 2012 to US$144.8 million, a rise of 13 per cent. The primary factor contributing to the rise in overall funding was a 32 per cent increase in the amount of restricted funding that IPPF received. Restricted funding now represents 47 per cent of total funding, or US$67.4 million, compared to 27 per cent in 2008, reflecting the growing trend for donors to support distinct project areas and/or priority countries (Figure 14).

Restricted funding enables IPPF to deliver specific activities and contributes toward achieving our strategic goals. However, projects supported by restricted funding can be costly due to additional investment needed in their management and systems and due to onerous reporting requirements which are not streamlined among donors. To ensure sustainability and performance of these projects, planning and funding must include the support of management functions.

Figure 14: Total unrestricted and restricted income, 2008–2012

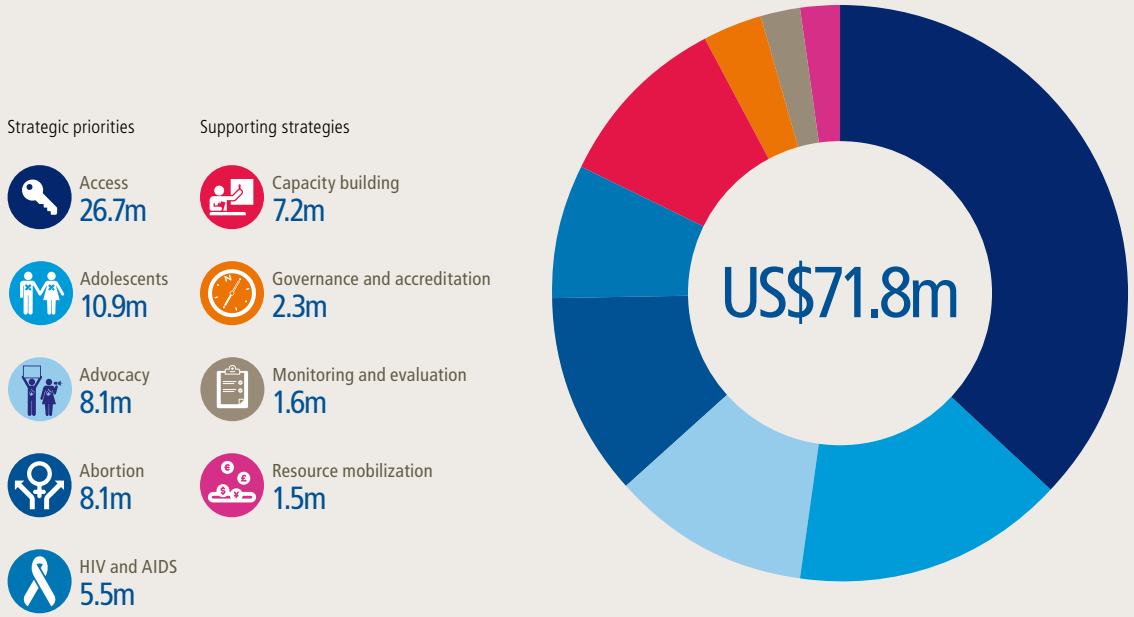


Unrestricted funding remained virtually unchanged, with a one per cent increase from 2011 to 2012. This type of funding, however, is essential for the sustainability and effectiveness of IPPF's programmes. Unrestricted funds can be allocated quickly and responsively, and help us avoid the high start-up and shut-down costs often associated with short-term projects. Unrestricted funding enables Member Associations to build and maintain important long-term partnerships with governments and other stakeholders which are essential to delivering effective and sustainable sexual and reproductive health programmes and to strengthening health systems. Ultimately, unrestricted funding provides the investment that is essential for the sustainable development of nationally-owned Member Associations.

IPPF's Governing Council allocates unrestricted funding across each of the six regions, with the highest priority regions of Africa and South Asia receiving 45 per cent and 16 per cent respectively. Regional Offices are then responsible for awarding these funds to Member Associations, with US$71.8 million in grants to Member Associations in 2012. Of these, 83 per cent were invested in projects across the five priority areas of IPPF's Strategic Framework 2005–2015, and a further 17 per cent in the four supporting strategies (Figure 15). Four of the six regions are currently using IPPF's performance-based funding system to make data driven decisions on resource allocation to Member Associations, with a maximum of +/–10 per cent of unrestricted funds awarded to Associations, depending on performance.

The majority of IPPF's resources continue to be allocated to countries with the lowest levels of development and the greatest unmet needs for sexual and reproductive health and rights. In 2012, 85 per cent of our direct grants to Member Associations went to those working in countries with low or medium human development, according to UNDP's Human Development Index (HDI).[22]

Figure 15: Grants to Member Associations, by IPPF strategic priorities and supporting strategies, 2012



In 2012, Member Associations continued to raise a significant amount of financial resources themselves, responding to the changing aid architecture by securing additional funding from bilateral donors and international sources, as well as identifying local sources of funding and investing in income generating strategies. The total Member Association income (excluding IPPF income) in 2012 was US$372.1 million, an increase of US$47.8 million from 2011. This represents 84 per cent of Member Associations' overall funding. A growing financial independence is vital for the sustainability of the Federation in the long term, and contributes significantly to our overall capacity to reach those most in need, to support sustainable programmes and to achieve our mission.

In 2012, a new IPPF policy to combat bribery was approved by the Governing Council. This is in line with the UK Bribery Act of 2010 and aims to support IPPF's zero tolerance approach to bribery and corruption and to ensure adherence to the highest legal and ethical standards throughout the Federation. Also in 2012, IPPF appointed an accountancy firm as internal auditor to provide assurance that there are effective processes in place to both identify and mitigate risks. The risk management system identifies, evaluates and manages significant risks faced by the Federation in the areas of governance; strategic, operational and financial compliance; and external risks. The internal auditor will support IPPF to understand risks more systematically, and to be able to respond to them in an effective way.

Performance successes

Improving infertility treatment through South-to-South learning

Centro de Investigación, Educación y Servicios (CIES)
Bem-Estar Familiar no Brasil (BEMFAM)
Asociación Pro-Bienestar de la Familia Colombiana (Profamilia)

Centro de Investigación, Educación y Servicios (CIES) will soon become a key provider of infertility treatment services in Bolivia following a South-to-South learning programme with two other Member Associations from the Western Hemisphere region. Bem-Estar Familiar no Brasil provided support to CIES on low complexity assisted reproduction techniques, including ovulation induction and intrauterine insemination. The Asociación Pro-Bienestar de la Familia Colombiana subsequently offered technical assistance in providing high complexity assisted reproduction treatment, including ovarian stimulation, ovarian function testing, fertilization, embryo cultivation and embryo transfer. During this programme, CIES was able to learn about both the medical and business perspectives of providing infertility services, including the financial and human resources that are needed.

> [Infertility] affects both men and women in approximately equal proportions, potentially causing considerable personal suffering and disruption of family life.
>
> IPPF and International Medical Advisory Panel[23]

CIES is currently building an in vitro fertilization unit in La Paz, as well as opening low complexity treatment clinics in three other Bolivian cities from which complex cases that require in vitro fertilization can be referred. Key members of staff have been trained and infertility protocols developed. CIES intends to provide 3,500 low cost consultations related to infertility treatment per year, thus closing the sexual and reproductive health gap for low and middle income groups that are traditionally not served by private practice. It is estimated that integrating infertility treatment with existing sexual and reproductive health services will increase the Association's financial sustainability by between 2 and 4 per cent.

Building capacity of remote health care workers in the Pacific

Pacific Member Associations

The geographic isolation of many communities in the Pacific makes the delivery of sexual and reproductive health services both financially and logistically challenging. Contraceptive commodity stock-outs are common in the region, and isolated health care workers have limited opportunity for skills training and capacity development. The Pacific has high rates of maternal and infant mortality, gender-based violence, sexually transmitted infections and unmet need for contraception.[24]

There are nine Member Associations in the Pacific – in the Cook Islands, Fiji, Kiribati, Papua New Guinea, Samoa, the Solomon Islands, Tonga, Tuvalu and Vanuatu.[25] They have all participated in a capacity building programme to strengthen their work in providing sexual and reproductive health information and services. Staff received training on comprehensive sexuality education, quality of care, clinical procedures (such as non-scalpel vasectomy), and on contraceptive commodity security. Community-based distributors have been selected and supported to reach remote communities with essential sexual and reproductive health information and services.

In 2012, the Pacific Associations more than trebled the number of sexual and reproductive health services they provided (519,000 services) compared to the pre-programme level in 2010. Most of the clients receiving these services (89 per cent) were poor, marginalized, socially-excluded and/or under-served, an increase of 11 per cent from 2011.

The Associations have also capitalized on the existing expertise of other Member Associations. Staff from Sexual Health and Family Planning Australia have been mentoring Pacific Association nurses in delivering quality sexual and reproductive health programmes. This sharing of learning and experience has been a valuable component of the programme.

89%

of Pacific Member Associations' clients are poor and/or vulnerable

Learning from a midterm review

Choices and Opportunities youth programme

IPPF carried out a midterm review of the multi-country Choices and Opportunities youth programme. The review enabled the 14 Member Associations[26] involved to make evidence-based decisions on the implementation of their projects.

Taking stock of progress at the mid-point encouraged Member Associations to assess their planned activities and focus more on the quality of implementation and effectiveness of strategies to reach vulnerable young people. It enabled them to learn from what was working well and what needed improving, and to act on that learning. The review also assessed institutional capacity and structure of the Member Associations' youth programming and helped establish how the IPPF Secretariat can best support them to achieve their goals.

> [The midterm review] gave direction to the overall implementation of the project. [It] will lead to increased services offered to young people. It will also lead to more engagement of the LGBTI community in the project. On comprehensive sexuality education, the evaluation has helped us to refocus on sexual rights. We now see the real value for this.
>
> Project staff member,
> Family Health Options Kenya

The outcomes of the review provided key recommendations at all levels that informed the development of 2013 and 2014 work plans. The review also acted as a powerful management tool at the Secretariat level to ensure that Member Associations are supported based on performance and need, as identified in the review.

The review identified six key themes that cut across the programme that will support Member Associations to strengthen their youth programming, including the need for South-to-South learning. Other key areas include reaching out to young lesbian, gay, bisexual, transgender and intersex groups; providing safe abortion services and care for young people; and advocating for comprehensive sexuality education and supporting its implementation.

Listening, building trust and responding to local needs

Reproductive Health Uganda (RHU)

There is a high HIV prevalence among female sex workers in Uganda, and yet this community remains marginalized and under-served in terms of sexual and reproductive health and rights. Reproductive Health Uganda (RHU) is one of the few organizations in the country that addresses the needs of sex workers, providing them with sexual and reproductive health information and services in a non-judgemental and stigma-free environment. A number of male sex workers and men who have sex with men also accessed RHU's services, so the Member Association expanded its work to include these high risk groups. RHU listened to men who have sex with men and collected information on their numbers, where they live, what they do, the various challenges they face, and their sexual and reproductive health needs. Throughout this process, trust gradually increased, as did the demand for information and services.

Peer education was identified as an essential approach to reach sex workers and men who have sex with men. RHU identified and trained 90 peer educators in Kampala (60 sex workers and 30 men who have sex with men). Topics included condom negotiation skills, accurate information about HIV and other sexually transmitted infections, contraception, post-abortion care, life planning skills, referral information and client records/data management skills. Peer educators and service providers reached out to groups in their households or at other private locations to offer services, such as HIV counselling and testing and the provision of contraceptives, including condoms. Peer educators were involved in the review and redesign of programmes to reach sex workers and men who have sex with men. Their recommendations responded to reports of low levels of trust in many referral points, and the need to provide a 'one-stop shop' for sexual and reproductive health services, including HIV-related services, for sex workers and men who have sex with men.

Next steps

IPPF plays a vital role in international development, providing sexual and reproductive health information and services, supporting health systems strengthening and holding governments accountable to promises they have made. IPPF's Change Goals will guide us in focusing limited time and resources to achieve accelerated results from now to 2015.

Unite

Vision 2020 for Sexual and Reproductive Health and Rights sets out IPPF's advocacy priorities and calls on governments to commit to 10 targets, one of which is to establish a new international development framework that includes sexual and reproductive health and rights. We will partner with civil society organizations, UN agencies, and the private sector to ensure that sexual and reproductive health and rights are reflected in the post-2015 development framework, and we have developed three 'asks':

- The post-2015 global development agenda must include sexual and reproductive health and rights as essential priorities.
- The unfinished business from the Millennium Development Goal MDG 5b on universal access to reproductive health must feature, along with MDG 6 on HIV and AIDS.
- The post-2015 global development agenda must include a specific gender goal to eliminate all forms of discrimination against women and girls.

We will continue to contribute to the next steps in this process by influencing national positions to support negotiations among UN Member States. We will convene civil society to participate in regional and global debates, including the ICPD+20 process. In addition, recognizing the importance of Brazil, Russia, India, China and South Africa (BRICS) in international negotiations, we will encourage their support for sexual and reproductive health and rights.

Deliver

Increasing service provision: The commitment to increase the number of sexual and reproductive health services provided is shared across IPPF. In order to focus our efforts, 42 Member Associations, covering all six regions, have been identified as priorities for support, and detailed roadmaps for how these Member Associations plan to increase service provision are in preparation. Early analysis reveals some key priorities, including: meeting the needs of young people; expanding mobile services to reach those who are under-served; reducing commodity stock-outs; and establishing social franchising networks to increase the range of services provided. Staff from across the Secretariat will work together to support efforts and share learning.

Partnership with UNFPA in support of Family Planning 2020: UNFPA and IPPF have a long history of successful collaboration supported by our complementary roles in working with governments and communities. In 2013, a new initiative between UNFPA and IPPF was launched at Women Deliver to bring a significant boost in investment to family planning, including increasing financial and political will for sexual and reproductive health in 12 countries and the Pacific Islands. A series of innovative approaches will help increase access to family planning, especially among hard-to-reach populations, and will make a significant contribution to the commitment made at the London Summit on Family Planning to enable 120 million more women and girls in the world's poorest countries to access contraception by 2020.

Perform

IPPF continues to strengthen its performance culture in order to optimize organizational effectiveness and support decision making at all levels of the Federation. We use a number of tools and systems to support data capture, analysis, demand and utilization, including the Branch Performance Tool, the Vulnerability Assessment Methodology and the Client Management Information System. The development of the Data Quality Assessment Tool will be complete in 2013 to support Member Associations to improve data quality and increase confidence in data.

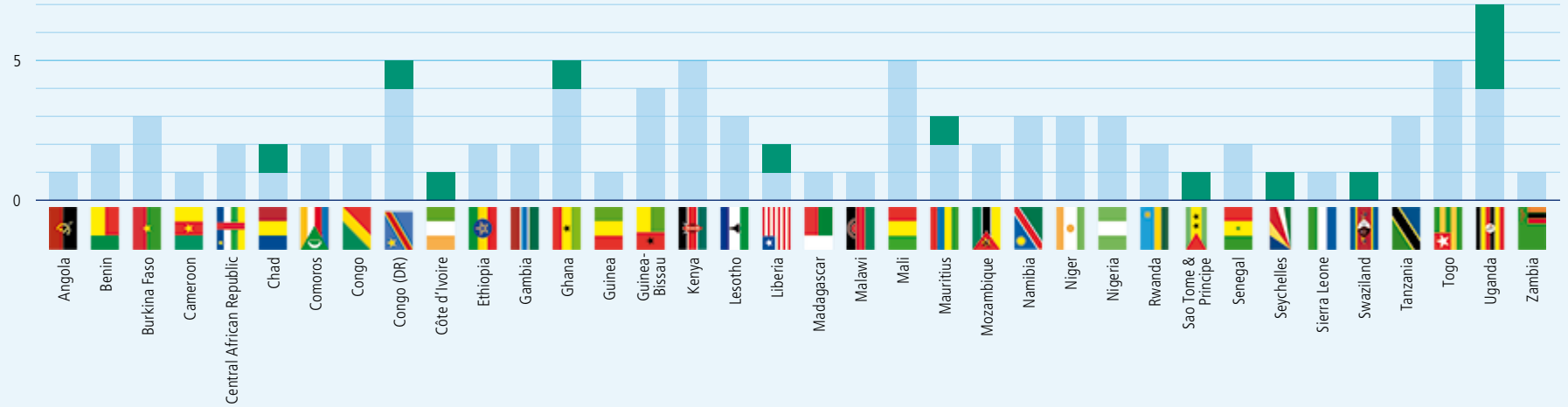
IPPF also remains committed to innovation and learning across the Federation, and in 2014, we will launch the Innovation Programme to build on the lessons learned from its predecessor, the Innovation Fund. While retaining the focus on testing innovative approaches to increase access to services for the poorest and most vulnerable, this new phase will emphasize research, robust evaluation design and systematic documentation to expand the potential for the replication and scale up of successful innovations, and to contribute to learning in the wider sexual and reproductive health sector.

We will foster a culture of collaborative learning, including participation and knowledge sharing in global health partnerships, and we will use evidence to implement a programme of continuous improvement, and to remain accountable to our stakeholders.

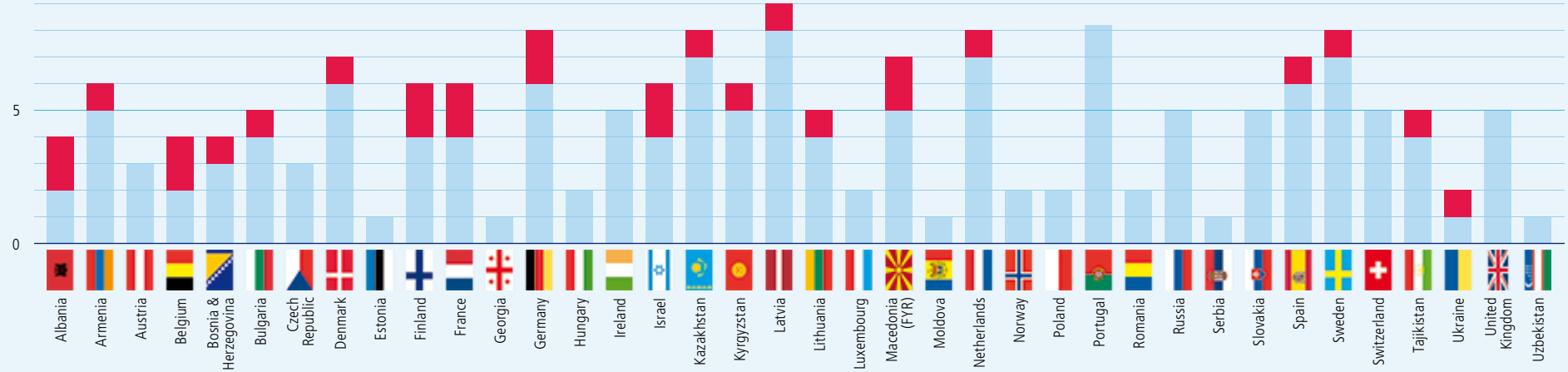
IPPF/Jennifer Woodside/Senegal

Annex A: Number of policy and/or legal changes, by country, 2005–2012

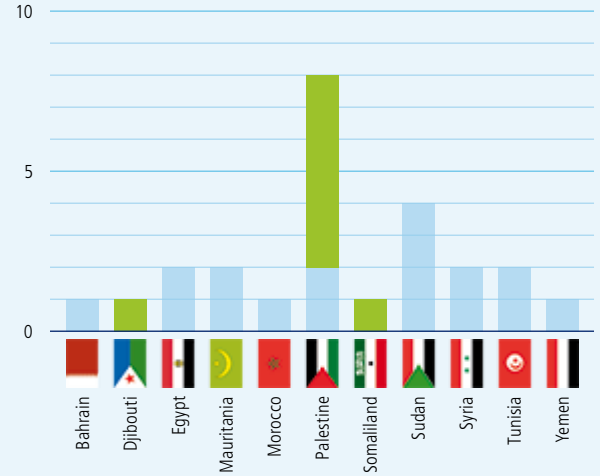
Africa



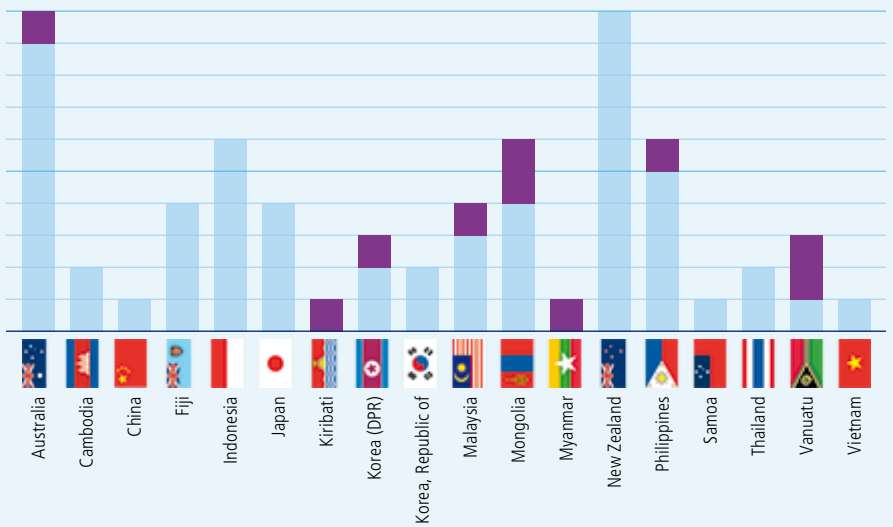
European Network



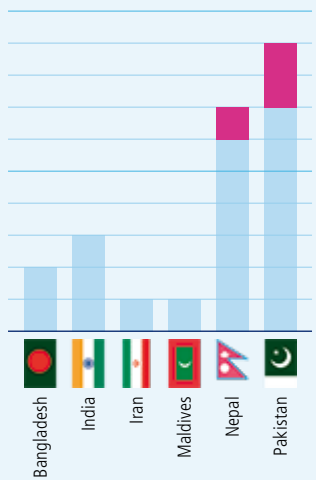
Arab World



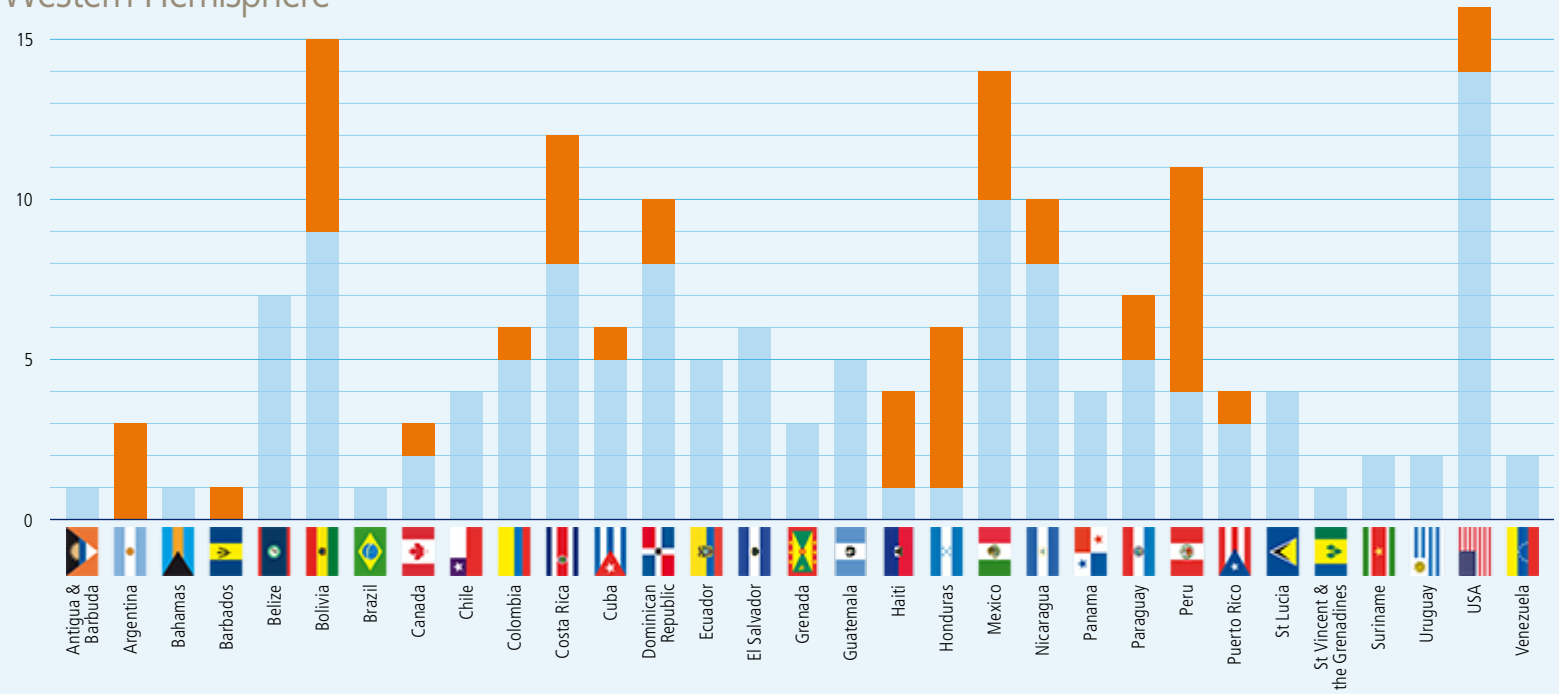
East and South East Asia and Oceania

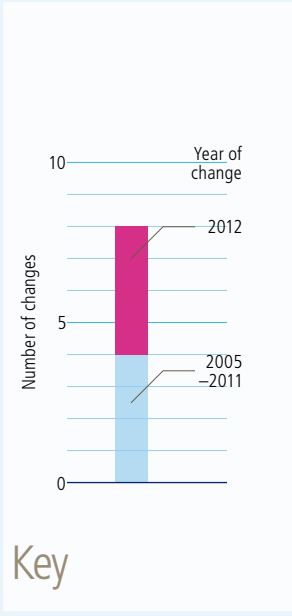


South Asia



Western Hemisphere





Annex B: Global performance results, by region, 2010–2012

Table B.1: Online survey response rate

IPPF region	Year	Total number of Member Associations/ collaborative partners	Number of Member Associations/ collaborative partners that responded	Response rate (per cent)
Africa	2012	40	39	98%
	2010	37	37	100%
Arab World	2012	16	14	88%
	2010	15	13	87%
European Network	2012	40	39	98%
	2010	41	41	100%
East and South East Asia and Oceania	2012	26	26	100%
	2010	22	22	100%
South Asia	2012	9	9	100%
	2010	9	9	100%
Western Hemisphere	2012	29	29	100%
	2010	29	29	100%
Total	2012	160	156	98%
	2010	153	151	99%

Table B.2: Online service statistics module response rate

IPPF region	Year	Total number of Member Associations/ collaborative partners that provide services	Number of Member Associations/ collaborative partners that provided data	Response rate (per cent)
Africa	2012	40	39	98%
	2010	37	37	100%
Arab World	2012	14	12	86%
	2010	13	9	69%
European Network	2012	24	21	88%
	2010	22	18	82%
East and South East Asia and Oceania	2012	26	26	100%
	2010	22	22	100%
South Asia	2012	9	9	100%
	2010	8	8	100%
Western Hemisphere	2012	28	28	100%
	2010	28	27	96%
Total	2012	141	135	96%
	2010	130	121	93%

Table B.3: IPPF's performance dashboard – global performance results, 2010–2012

Target	2010 Baseline (actual, if available)	2011 (actual, if available)	2012 (target)	2012 (actual)	% of target achieved	2013 target	2014 target	2015 target
Unite*								
U.1 Each year, 50 successful policy initiatives and/or positive legislative changes in support or defence of SRHR to which the Member Association's advocacy contributed	47	116	**50**	**105**	**210%**	50	50	50
U.2 Each year, 5 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	**5**	**15**	**300%**	5	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	**n/a**	**42% (baseline)**	**n/a**	tbd	tbd	tbd
Deliver								
D.1 Number of SRH services provided	88.2m	89.6m	**106.2m**	**112.7m**	**106%**	125.8m	149.0m	176.4m
D.2 Couple years of protection (CYP)	8.9m	9.1m	**10.7m**	**11.8m**	**110%**	12.7m	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%)	**46.7m** (44%)	**45.1m** (40%)	**97%** (91%)	57.9m (46%)	71.5 (48%)	88.2m (50%)
D.4 Number of abortion-related services provided	1.5m	1.6m	**2.3m**	**2.1m**	**91%**	3.4m	4.9m	7.1m
D.5 Number of HIV-related services provided	12.1m	15.1m	**17.9m**	**19.2m**	**107%**	21.2m	25.1m	29.7m
D.6 Estimated number of IPPF clients who are poor and/or vulnerable (as a % of all clients)	23.9m (72%)	24.9m (73%)	**29.8m** (75%)	**34.2m** (81%)	**115%** (108%)	35.3m (77%)	41.8m (79%)	49.5m (80%)
D.7 Proportion of Member Associations providing the Integrated Package of Essential Services	7%	14%	**24%**	**21%**	**88%**	33%	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	**5.0m**	**18.2m**	**364%**	tbd	tbd	tbd
Perform								
P.1 Total IPPF income (unrestricted and restricted) (US$)	124.2m	127.6m	**157.8m**	**144.8m**	**92%**	188.0m	218.2m	248.4m
P.2 Total Member Association income (minus IPPF income), supported by the Secretariat (US$)	289.9m	324.3m	**374.6m**	**372.1m**	**99%**	433.4m	501.0m	579.2m
P.3 Proportion of IPPF's unrestricted funding used to reward Member Associations through a performance-based funding system	n/a	1%	**5%**	**6%**	**120%**	8%	10%	10%
P.4 Proportion of Member Associations using SRH service costing data from static clinics	n/a	n/a	**5%**	**13%**	**260%**	18%	25%	30%
P.5 Number of Member Associations collecting data on poverty and vulnerability status (using the IPPF Vulnerability Assessment methodology)	n/a	1	**10**	**10**	**100%**	20	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%	**65%**	**58%**	**89%**	75%	90%	100%

* There is an additional target for Unite (U.4): the inclusion of SRHR or components of SRHR in the post-2015 global 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.

Table B.4: Unite performance results, by region, 2010–2012

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 the Member Association's advocacy contributed	**2012**	**12**	**8**	**27**	**10**	**3**	**45**	**105**
	2011	11	3	42	10	6	44	116
	2010	9	2	12	8	2	14	47
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	**2012**	**1**	**0**	**3**	**1**	**0**	**2**	**15†**
	2011	0	0	1	0	0	0	5‡
	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	**2012**	**62%**	**29%**	**49%**	**12%**	**22%**	**48%**	**42%**
	2011	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	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 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 eight global advocacy successes

‡ includes four global advocacy successes

Table B.5: Deliver performance results, by region, 2010–2012

Indicator	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
D.1 Number of SRH services provided	**2012**	**39,473,382**	**2,821,454**	**1,730,329**	**15,616,282**	**18,576,517**	**34,491,529**	**112,709,493**
	2011	27,504,525	2,259,940	1,514,091	12,333,732	15,386,102	30,618,062	89,616,452
	2010	29,968,031	1,930,746	1,506,577	9,493,922	14,664,943	30,668,160	88,232,379
D.2 Couple years of protection (CYP)	**2012**	**2,370,768**	**287,345**	**41,068**	**755,973**	**2,304,131**	**6,046,977**	**11,806,262**
	2011	1,406,890	246,417	37,238	822,688	2,019,072	4,530,351	9,062,656
	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)	**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%
	2011	12,830,721 47%	932,796 41%	784,141 52%	2,738,103 22%	7,058,298 46%	13,080,277 43%	37,424,336 42%
	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	**2012**	**316,693**	**46,763**	**106,969**	**173,408**	**298,303**	**1,172,693**	**2,114,829**
	2011	233,780	45,430	97,331	173,258	254,418	810,909	1,615,126
	2010	132,580	38,401	101,222	149,821	333,630	793,465	1,549,119
D.5 Number of HIV-related services provided	**2012**	**7,107,781**	**439,801**	**203,697**	**3,267,370**	**1,853,655**	**6,278,658**	**19,150,962**
	2011	5,205,127	345,768	165,421	2,034,137	1,714,285	5,619,436	15,084,174
	2010	3,742,379	280,621	203,157	1,337,781	1,525,087	5,043,725	12,132,750
D.6 Estimated number of IPPF clients who are poor and/or vulnerable (as a % of all clients)	**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%
	2011	4,273,983 73%	473,665 66%	490,183 31%	6,991,511 76%	6,503,768 86%	6,207,819 68%	24,940,929 73%
	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*	**2012**	**8%**	**9%**	**n/a†**	**9%**	**33%**	**52%**	**21%**
	2011	8%	0%	n/a†	12%	14%	30%	14%
	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	**2012**	**560,086**	**2,286**	**489,591**	**15,632,261**	**261,541**	**1,204,440**	**18,150,205**
	2011	218,454	6,366	473,634	2,444,751	143,843	1,161,261	4,448,309
	2010	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* There are eight components in the Essential Services Package: Integrated Package of Essential Services: sexuality counselling; contraception; safe abortion care; and STI/RTI, HIV, gynaecological, obstetric and gender-based violence services. Data for 2012 are based on a revised model which is significantly harder to achieve than previous models. Exceptions are permitted in relation to the context in which the Member Associations are working (for example, legislative constraints or other providers offering accessible, quality and affordable services).

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

Table B.6: Perform performance results, by region, 2010–2012

Indicator		Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
P.1	Total IPPF income (unrestricted and restricted), in US$ millions	**2012**							**144.8**
		2011				[Not applicable by regional breakdown]*			127.6
		2010							124.2
P.2	Total Member Association income (minus IPPF income), supported by the Secretariat, in US$ millions	**2012**	**50.3**	**4.2**	**4.5**	**142.2**	**16.9**	**153.9**	**372.1**
		2011	54.3	3.5	4.4	101.7	17.4	143.0	324.3
		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	**2012**	**5%**	**0%**	**0%**	**10%**	**10%**	**6%**	**6%**
		2011	0.3%	0%	0%	0.2%	0%	5%	1%
		2010	n/a	n/a	n/a	n/a	n/a	n/a	n/a
P.4	Number of Member Associations using SRH service costing data from static clinics	**2012**	**6**	**0**	**0**	**2**	**5**	**2**	**15**
		2011	n/a	n/a	n/a	n/a	n/a	n/a	n/a
		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)	**2012**	**2**	**0**	**0**	**0**	**5**	**3**	**10**
		2011	0	0	0	0	0	1	1
		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	**2012**	**72%**	**64%**	**49%**	**58%**	**56%**	**52%**	**58%**
		2011	76%	39%	45%	65%	44%	62%	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 (CYP) provided by region, and method, 2010–2012

Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of responses	2012	(n=40)	(n=11)	(n=21)	(n=26)	(n=9)	(n=28)	(n=135)
	2011	(n=37)	(n=9)	(n=19)	(n=23)	(n=7)	(n=27)	(n=122)
	2010	(n=37)	(n=9)	(n=18)	(n=22)	(n=8)	(n=27)	(n=121)
IUD	2012	330,013	253,832	20,140	263,485	636,440	2,216,463	3,720,374
	2011	272,214	208,784	11,700	241,687	501,765	1,572,064	2,808,214
	2010	236,998	235,258	9,531	213,573	443,213	1,604,423	2,742,996
Oral contraceptive pill	2012	526,687	16,511	2,857	109,471	433,806	886,824	1,976,156
	2011	291,872	21,401	2,464	115,002	400,429	497,912	1,329,079
	2010	156,677	20,214	2,191	125,498	370,609	545,658	1,220,887
Voluntary surgical contraception (vasectomy and tubal ligation)	2012	37,280	-	3,880	37,140	588,814	1,215,420	1,882,534
	2011	17,310	-	3,890	41,200	575,342	1,265,840	1,903,582
	2010	13,210	-	3,760	33,220	530,833	1,258,620	1,839,643
Condoms	2012	485,751	3,299	8,206	250,223	298,631	537,388	1,583,498
	2011	340,504	4,801	13,889	324,542	282,354	440,817	1,406,907
	2010	261,970	5,247	15,613	368,052	311,215	622,026	1,584,122
Injectables	2012	406,676	8,584	19	70,324	231,422	628,958	1,345,984
	2011	290,822	7,569	4	70,486	171,025	454,571	994,477
	2010	289,276	7,271	46	75,021	171,968	428,810	972,398
Implants	2012	576,906	4,682	5,589	22,838	42,346	379,037	1,031,398
	2011	182,683	3,370	4,453	24,331	18,899	177,227	410,961
	2010	133,076	385	3,477	16,610	13,911	197,905	365,363
Emergency contraception	2012	3,226	132	49	1,037	72,671	106,876	183,991
	2011	1,428	8	67	1,199	69,258	119,873	191,833
	2010	1,303	391	86	1,287	61,825	122,960	187,852
Other barrier methods	2012	4,080	305	305	1,374	-	513	6,576
	2011	10,051	485	753	4,150	-	1,183	16,622
	2010	9,816	1,022	1,434	1,375	-	907	14,553
Other hormonal methods	2012	150	-	22	81	-	75,498	75,752
	2011	6	-	19	90	-	865	980
	2010	15	-	-	90	-	689	794
Total	2012	2,370,768	287,345	41,068	755,973	2,304,131	6,046,977	11,806,262
	2011	1,406,890	246,417	37,238	822,688	2,019,072	4,530,351	9,062,656
	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, 2010–2012

Type of service	Year	AR	AWR	EN	ESEAOR	SAR	WHR	Total
Number of responses	2012	(n=40)	(n=11)	(n=21)	(n=26)	(n=9)	(n=28)	(n=135)
	2011	(n=37)	(n=9)	(n=19)	(n=23)	(n=7)	(n=27)	(n=122)
	2010	(n=37)	(n=9)	(n=18)	(n=22)	(n=8)	(n=27)	(n=121)
Contraceptive (including counselling)	2012	24,256,982	758,047	285,762	4,639,660	9,299,951	13,427,888	52,668,290
	2011	15,854,386	802,635	298,389	5,134,421	7,702,355	12,701,170	42,493,356
	2010	16,817,092	634,570	324,929	4,621,885	7,909,074	13,506,032	43,813,582
Gynaecological	2012	947,646	446,491	86,209	1,543,071	1,434,226	7,964,894	12,422,537
	2011	522,276	336,207	61,332	1,445,092	1,209,347	6,958,108	10,532,362
	2010	450,223	381,383	88,872	1,115,931	900,651	7,023,958	9,961,018
HIV and AIDS (excluding STI/RTI)	2012	5,964,036	210,578	119,946	1,141,286	937,043	1,392,125	9,765,014
	2011	4,627,279	245,148	98,150	859,606	958,200	1,194,110	7,982,493
	2010	3,297,461	169,426	128,423	596,528	768,297	1,119,064	6,079,199
STI/RTI	2012	1,143,745	229,223	83,751	2,126,084	916,612	4,886,533	9,385,948
	2011	577,848	100,620	67,271	1,174,531	756,085	4,425,326	7,101,681
	2010	444,918	111,195	74,734	741,253	756,790	3,924,661	6,053,551
Specialized counselling	2012	3,399,512	314,389	1,007,219	1,804,734	1,119,874	1,607,640	9,253,368
	2011	3,366,313	390,644	852,574	1,399,468	799,614	1,012,258	7,820,871
	2010	3,082,671	223,702	753,106	914,430	867,061	802,455	6,643,425
Obstetric	2012	1,222,619	659,007	22,820	1,802,544	2,205,394	3,005,147	8,917,531
	2011	760,462	223,126	23,250	1,621,893	1,783,262	2,805,643	7,217,636
	2010	847,062	294,653	20,794	871,826	1,679,951	2,841,509	6,555,795
Paediatric	2012	402,754	52,966	-	1,912,806	1,476,766	296,674	4,141,966
	2011	349,599	29,967	78	120,932	1,198,333	291,133	1,990,042
	2010	261,267	35,891	230	77,559	856,439	277,427	1,508,813
SRH medical	2012	1,701,551	63,431	10,437	398,363	759,896	496,513	3,430,191
	2011	1,111,955	69,248	10,708	344,731	623,174	165,679	2,325,495
	2010	4,561,180	28,891	10,208	336,304	497,681	106,808	5,541,072
Abortion-related	2012	316,693	46,763	106,969	173,408	298,303	1,172,693	2,114,829
	2011	233,780	45,430	97,331	173,258	254,418	810,909	1,615,126
	2010	132,580	38,401	101,222	149,821	333,630	793,465	1,549,119
Infertility	2012	101,477	35,265	6,427	57,707	120,561	63,395	384,832
	2011	96,108	14,189	4,923	49,817	95,216	59,992	320,245
	2010	64,207	10,186	3,857	37,015	92,775	51,073	259,113
Urological	2012	16,367	5,294	789	16,619	7,891	178,027	224,987
	2011	4,519	2,726	85	9,983	6,098	193,734	217,145
	2010	9,370	2,448	202	31,370	2,594	221,708	267,692
Total	2012	39,473,382	2,821,454	1,730,329	15,616,282	18,576,517	34,491,529	112,709,493
	2011	27,504,525	2,259,940	1,514,091	12,333,732	15,386,102	30,618,062	89,616,452
	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

and

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 Prenatal care

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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26 Qêndra pêr Popullsinë dhe Zhvillimin (Albania); Association for Sexual and Reproductive Health XY (Bosnia and Herzegovina); Asociación Dominicana Pro-Bienestar de la Familia (Dominican Republic); Egyptian Family Planning Association; Family Guidance Association of Ethiopia; Asociación Pro-Bienestar de la Familia de Guatemala; Family Planning Association of India; Indonesian Planned Parenthood Association; Family Health Options Kenya; Rahnuma-Family Planning Association of Pakistan; Family Planning Organization of the Philippines; Association Sénégalaise pour le Bien-Etre Familial (Senegal); Vietnam Family Planning Association; and Planned Parenthood Association of Zambia.

Key abbreviations

ABBEF	Association Burkinabé pour le Bien-Etre Familial
AIBEF	Association Ivoirienne pour le Bien-Etre Familial
AIDS	Acquired immune deficiency syndrome
AR	Africa region, IPPF
ATBEF	Association Togolaise pour le Bien-Etre Familial
AWR	Arab World region, IPPF
BEMFAM	Bem-Estar Familiar no Brasil
BRICS	Brazil, Russia, India, China and South Africa
CAMNAFAW	Cameroon National Association for Family Welfare
CIES	Centro de Investigación, Educación y Servicios
CYP	Couple years of protection
EN	European Network, IPPF
EPI	Evidence-based Practice Initiative
ESEAOR	East and South East Asia and Oceania region, IPPF
FHOK	Family Health Options Kenya
FIGO	International Federation of Gynaecology and Obstetrics
FLAS	Family Life Association of Swaziland
FPA India	Family Planning Association of India
FPAM	Family Planning Association of Malawi
FPASL	Family Planning Association of Sri Lanka
FPOP	Family Planning Organization of the Philippines
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HDI	Human Development Index
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MCH	Maternal and child health
MDG	Millennium Development Goal
MEXFAM	Fundación Mexicana para la Planeación Familiar, A.C.
MFPWA	Mauritius Family Planning and Welfare Association
NGO	Non-governmental organization
PPAL	Planned Parenthood Association of Liberia
PPAZ	Planned Parenthood Association of Zambia
PPFN	Planned Parenthood Federation of Nigeria
Profamilia	Asociación Pro-Bienestar de la Familia Colombiana
Rahnuma-FPAP	Rahnuma-Family Planning Association of Pakistan
RENEW	Respect, Educate, Nurture, Empower Women
RHAC	Reproductive Health Association of Cambodia
RHAK	Reproductive Health Alliance of Kyrgyzstan
RHU	Reproductive Health Uganda
RTI	Reproductive tract infection
SAR	South Asia region, IPPF
SFPA	Sudan Family Planning Association
SOFHA	Somaliland Family Health Association
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
Vision 2020	Vision 2020 for Sexual and Reproductive Health and Rights
WHO	World Health Organization
WHR	Western Hemisphere region, IPPF

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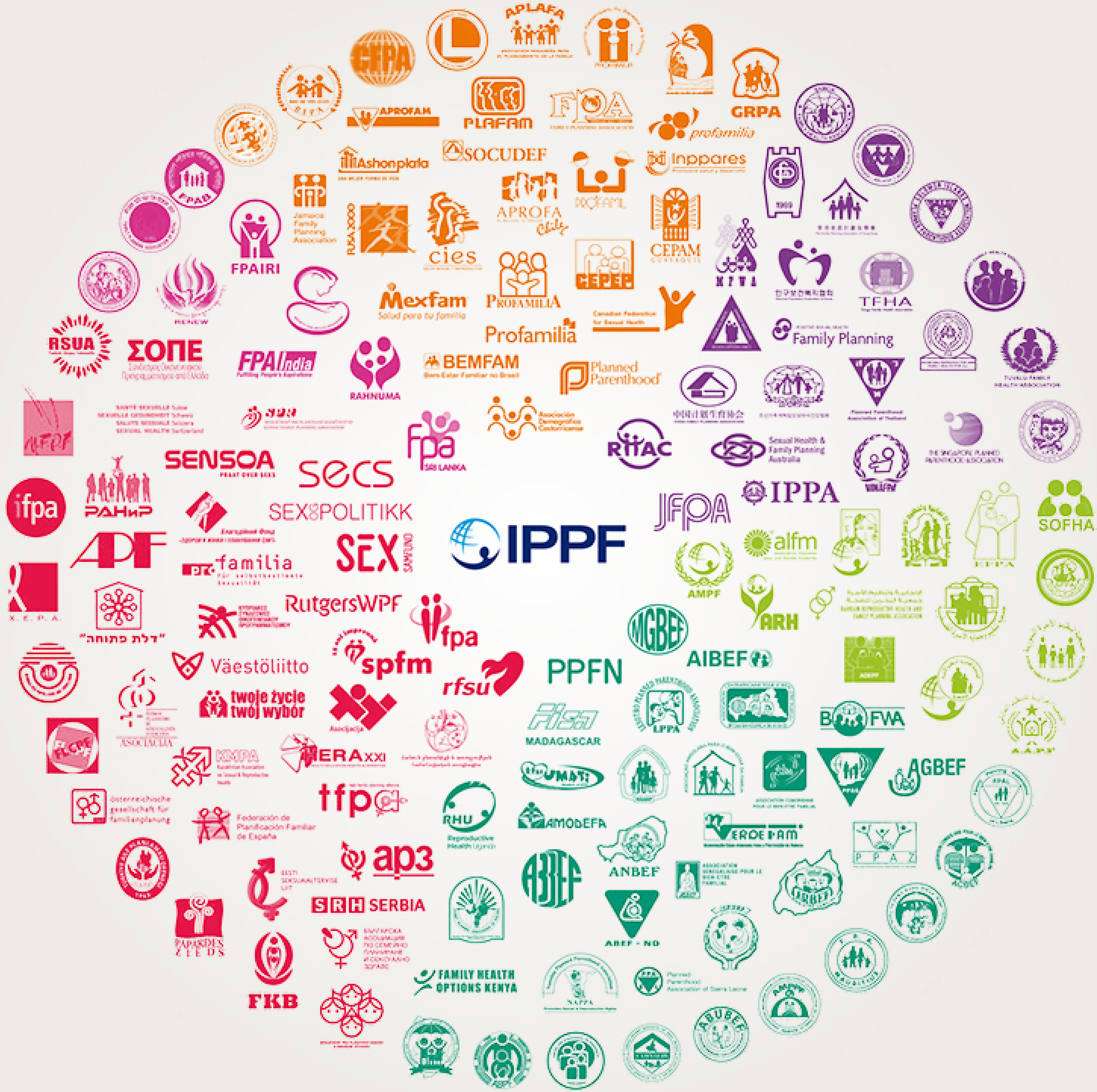

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