

HRP at 40: what they say

A history of scientific achievement to
advance sexual and reproductive health



40  hrp
years of innovation



40  hrp
years of innovation

UNDP · UNFPA · WHO · World Bank
Special Programme of Research, Development
and Research Training in Human Reproduction

40 years of innovation

For 40 years, HRP – the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction – has been the main instrument within the United Nations system for research in human reproduction, bringing together policy-makers, scientists, health care providers, clinicians, consumers and community representatives to identify and address priorities for research to improve sexual and reproductive health.



HRP...remains the global leader in SRH research and capacity-building, with particular relevance to the needs of populations in resource-poor settings. ... The evidence base resulting from this research has been translated effectively into health policy changes and improved practice and standards and ultimately improved outcomes. [HRP] is in a good position to continue advancing global public goods in a cost-effective way.

*Conclusions of an independent
External Evaluation of HRP 2003–2007*

ACKNOWLEDGEMENTS

This publication is about HRP – the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction – at its 40th anniversary, in 40 pages. Over the years, HRP has contributed in many ways to advancing sexual and reproductive health. These various contributions and reflections on the Special Programme cannot all be captured in 40 pages. Certainly much more could be highlighted, and many more would have something to say. This publication is an attempt to synthesize and share highlights of some of the landmark achievements. It is dedicated to all those who have contributed their time and effort to the work of HRP over the years. Many experts have served in various roles, in many technical and advisory committees. We cite some of these eminent people who have served in various capacities, in this publication. It is also dedicated to those who provide financial resources to the Special Programme.

Over the years, HRP has attracted expert staff from different parts of the world. Their dedication, commitment and innovative ideas make it possible to have a Special Programme that can continue to conduct research that addresses the evolving needs of diverse populations.

A special thanks to our partners, cosponsors and the global network of collaborating centres and experts who are helping to ensure these efforts contribute to making a difference to the women, men, children, adolescents and various communities we are committed to serve.

Dr Michael T. Mbizvo
Director

Department of Reproductive Health and Research (RHR)
including the UNDP/UNFPA/WHO/World Bank Special
Programme of Research, Development and Research
Training in Human Reproduction (HRP).



FOREWORD

I join other cosponsors, Member States, development partners, in particular the dedicated community of donors to HRP, to reaffirm the support of WHO to the founding vision of HRP.

Accomplishments by HRP in the past 40 years have been shaped by various international development goals and targets, including those in the International Conference on Population and Development (ICPD) Programme of Action, the Millennium Development Goals (MDGs), and the United Nations Secretary-General's Global Strategy for Women's and Children's Health. HRP's work contributes to these goals by supporting and coordinating research on a global scale and conducting research in partnership with countries to provide the high-quality information needed to achieve universal access to effective care and to enable people to protect and promote their own health.

HRP has an important role in following up on recommendations from the United Nations Human Rights Council Resolution, adopted in September 2011, on Preventable Maternal Mortality and Morbidity and Human Rights, in its work to address root causes of maternal mortality and morbidity – such as lack of accessible and appropriate health-care services, information and education, unmet need for family planning, harmful practices, and gender inequality – and in its efforts towards eliminating sexual violence against women and girls.

HRP is a Programme we are all proud of. It is making a significant contribution to saving lives, and its research to advance sexual and reproductive health, over the years, has had a global impact as reported by successive external evaluations of HRP and experts cited in this publication.

Dr Flavia Bustreo
Assistant Director-General

Family, Women's and Children's Health,
World Health Organization



Photographs

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Governance

HRP is governed by the Policy and Coordination Committee (PCC), which meets annually to review progress and achievements of the Special Programme. PCC reviews HRP's programme of work and the budget, and is made up of the 11 top donor countries, 14 Member States selected by WHO's regional committees, the cosponsors of HRP and IPPF, and cooperating parties voted for by PCC following an open nomination process. Former PCC members, other donors, foundations, representatives of civil society and professional bodies attend meetings of PCC as observers. PCC brings together Member States, donors and other stakeholders to shape the global research agenda towards improving sexual and reproductive health and rights. More than 95% of HRP income is from voluntary contributions. Being a PCC member helps to contribute to shaping the global sexual and reproductive health research agenda. During its annual meetings, PCC is apprised on progress of the Special Programme by the Director, the Chair of the Scientific and Technical Advisory Group (STAG) and the Chair of the Gender and Rights Advisory Panel (GAP). In addition, highlights are shared and panel presentations are made on a theme of special interest to the Special Programme and the global effort to advance sexual and reproductive health and rights. Themes recently discussed by PCC include:

"A decade in perspective" – vignettes of HRP's achievements towards improving sexual and reproductive health (in 2008). Improving sexual and reproductive health through research and research training by HRP (in 2009). Strengthening health systems through operations research to improve sexual and reproductive health, with a panel presentation on "Research, policy and practices for improving sexual and reproductive health: context and strategies at country and global levels" (in 2010). The role of human rights in improving sexual and reproductive health, with a panel presentation on "Partnerships in implementing best practices (IBP) to improve sexual and reproductive health" (in 2011). In 2012, the technical presentation will focus on the theme of working to improve adolescent sexual and reproductive health, with a panel presentation on "HRP at 40: a history of achievement".

"HRP has continued to deliver high-quality research evidence responding to changing needs and priorities in global health and especially to those of low-resource settings. The innovations it has developed and tested during 40 years of its life led to interventions that have improved sexual and reproductive health care and impacted on improving health of millions of people throughout the world. This represents a best return for investment by development partners and agencies concerned with improving health and development of populations. Notably HRP works to deliver on the promise of universal access to sexual and reproductive health and its contribution to serving women's and children's lives."



Helga Fogstad,
Chair, Policy and Coordination Committee from 2010

Helga Fogstad is Head, Health Section, Health Education and Research (HUF), at the Norwegian Agency for Development Cooperation.

Our vision

HRP's vision is the attainment of all peoples of the highest possible level of sexual and reproductive health. It strives for a world where all women's and men's rights to enjoy sexual and reproductive health are promoted and protected, and all women and men, including adolescents and those who are underserved and marginalized, have access to sexual and reproductive health information and services.

"During four decades this programme has made an outstanding contribution to sexual and reproductive health throughout the world. HRP brings together scientists, practitioners and policy-makers from both developing and developed countries. Its committees assess evidence to determine priorities, plan and commission research, and develop guidelines for promoting sexual and reproductive health. Over the years the programme has broadened from basic biomedical and clinical research, to epidemiological and social science research, and to research on the implementation of existing knowledge. Always the emphasis is on reproductive health in the developing world, where the needs are greatest."



Dr David Skegg,
Chair, HRP Scientific and Technical
Advisory Group from 2011

David Skegg is a medical epidemiologist and professor at the University of Otago, Dunedin, New Zealand. From 2004 to 2011 he was Vice-Chancellor (President) of the University. In 2009 he was knighted for services to medicine.

Our mission

HRP research helps people lead healthy sexual and reproductive lives, by strengthening capacities of countries to provide quality information and services that enable people to protect their own sexual and reproductive health and that of their partners.

“It is the fervent hope and dream of researchers to see their research making an impact on improving the health and lives of people. HRP is a shining example of the ability to conduct highly relevant and rigorous scientific studies that directly inform treatment guidelines and public health practice with concomitant impact on global health. Having served on HRP’s Scientific and Technical Advisory Group for a decade, I have been thoroughly impressed with HRP’s approach of establishing evidence-based priorities of the highest burden conditions adversely impacting global reproductive health and then systematically generating and collating data to identify best possible solutions. HRP has been particularly successful in translating these solutions to widely acknowledged and utilized international guidelines and thereafter, in supporting the worst affected countries of the world to translate these into practice. During my tenure, some of the most notable contributions were in contraception guidelines, safe approaches for medical abortion, improved and streamlined antenatal care, antiretroviral therapy to prevent mother-to-child transmission of HIV and its contributions to assisting countries attain the Millennium Development Goals.”



Dr Salim Abdool Karim,
Chair, HRP Scientific and Technical
Advisory Group, 2009–2010

Salim S. Abdool Karim is Pro Vice-Chancellor (Research), University of KwaZulu-Natal and Director of CAPRISA - Centre for the AIDS Program of Research in South Africa. He is also Professor of Clinical Epidemiology at Columbia University and Adjunct Professor of Medicine at Cornell University, New York.

About HRP

HRP was established in 1972 by WHO following a World Health Assembly Resolution that, among other things, provided a mandate for “...promoting scientific and technical cooperation between developed and developing countries” and “coordinating the global research efforts in the field of reproductive health.” In 1988, the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), and The World Bank joined WHO as the Programme’s cosponsors. The four cosponsoring agencies, and IPPF, together with the major financial contributors and other interested parties, make up the Programme’s governing body, the Policy and Coordination Committee (PCC), which sets policy, assesses progress, and reviews and approves the Programme’s budget and programme of work. PCC shapes the global agenda for research to advance sexual and reproductive health.

Administratively, HRP is the research arm of the WHO Department of Reproductive Health and Research (RHR). RHR’s work is premised on the need to achieve access to and quality of sexual and reproductive health care, in order to meet the needs of diverse populations, particularly the most vulnerable. It is shaped around the five components of WHO’s *Global reproductive health strategy*:

- improving antenatal, perinatal, postpartum and newborn care;
- providing high-quality services for family planning, including infertility services;
- eliminating unsafe abortion;
- combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer and other sexual and reproductive health morbidities;
- promoting sexual health, with gender, reproductive rights and adolescents, as cross-cutting.

This work further contributes to achievement of the 1994 ICPD Programme of Action, the Millennium Development Goals and the UN Secretary-General’s *Global Strategy for Women’s and Children’s Health*, among others.

Capacity strengthening for research and programme development is a sixth main component of the work. Within the WHO *Global reproductive health strategy*, key areas of action and partnership include the need for: strengthening health systems’ capacity; improving the information base for priority-setting; mobilizing political will; creating supportive legislative and regulatory frameworks; and strengthening monitoring, evaluation and accountability.

Three overarching themes form part of the mission of RHR’s work: universal access to sexual and reproductive health including addressing unmet needs; the renewal of primary health care; and fostering programmatic and policy linkages between services and interventions for HIV and for sexual and reproductive health.

Advisory Panels

Work by HRP/RHR is subject to constant review by advisory groups and periodic external evaluation by independent experts.

Broad strategic technical advice on HRP’s work is provided by the Scientific and Technical Advisory Group (STAG). In 1999, STAG assumed the responsibility for reviewing, and advising on, the work of the whole Department.

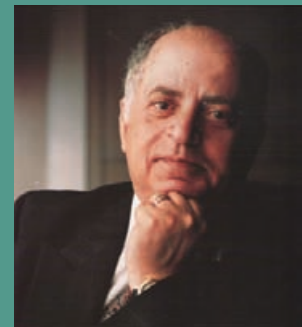
Regional Advisory Panels (RAPs) monitor and evaluate the work in their respective geographical regions. At an annual meeting, progress is reviewed and evaluated, and joint plans for the coming year are made for headquarters and for each region.

The Research Project Review Panel (RP2) reviews all HRP projects involving human subjects and research in animals and contributes to ethical debate on matters relating to sexual and reproductive health.

The Gender and Rights Advisory Panel (GAP) aims to ensure that considerations of gender equity and equality as well as reproductive rights are brought into all of the Department's work, and provides guidance to the Department on the ongoing work of integrating women's perspectives and experiences, particularly those from developing countries, into all its activities. It also advises on research on gender and human rights related to sexual and reproductive health.

The Toxicology Panel is a complementary review body to the RP2. It provides expertise in the evaluation of pharmacokinetic, metabolic, endocrinological, toxicological, teratogenicity, carcinogenicity and mutagenicity studies of drugs or devices developed or studied by HRP or referred to it for advice. In addition, the Programme has several strategic review committees and specialist panels that advise on detailed research strategies.

“What to me was wonderful in my days at HRP was the sight of groups of scientists from North and South, East and West, brought together by the Programme, putting their great minds together and volunteering their time and expertise, to find solutions that can help women in developing countries achieve the better sexual and reproductive life they deserve and they have been denied. HRP, a global collaborative scientific enterprise for such a noble cause, and with an impressive track record, deserves continued support from all who care. Women have made good progress almost everywhere, but they still have some steep mountains to climb. Scientific research can provide them with valuable ammunition they need in their march forward.”



Dr Mahmoud F. Fathalla,
Former Director of HRP

Professor of Obstetrics and Gynaecology,
former Dean of the Medical School,
Assiut University, Egypt, and former Chairman of the
International Planned Parenthood Foundation.

“HRP is an exceptional leader in global sexual and reproductive health. Its team consistently conducts innovative, high-quality research that impacts science, policy and public health norms, standards and programs worldwide. I have found HRP to be unsurpassed in its capacity to convene scientific and technical leaders from multiple disciplines, countries and institutions. In collaboration with multiple stakeholders, priority setting for research, training, advocacy and consultation is achieved using systematic and transparent approaches.



“Having served as RAP Chair for the Americas for over six years, I have been impressed by HRP’s commitment to funding and mentoring researchers in Latin America and the Caribbean. Additionally, HRP has bolstered multiple institutions that advance the sexual and reproductive health agenda at national and regional levels while addressing the Millennium Development goals. By building sustainable partnerships and networks that identify, monitor and justify reproductive health and health care needs to the wider public, and by seeking pathways through which to achieve improvements, HRP works tirelessly towards the mission of better health for all.”

Dr Sylvia Guendelman,
HRP Regional Advisory Panel Chair
for the Americas, 2000–2007

Sylvia Guendelman is Professor of
Public Health at the University of California, Berkeley, and
Chair of the Maternal and Child Health Program.



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Thanks to the high credibility of the Programme and of WHO in general, HRP's research results have a greater influence on reproductive health policies and standards than the research of any other reproductive health organization.

External Evaluation of HRP,
1990–2002

HRP research breakthroughs contributing to saving women's and children's lives

HRP is a global leader in reproductive health research. The Programme:

- conducts, generates and coordinates research to identify interventions and technologies and to generate the knowledge necessary to improve sexual and reproductive health;
- synthesizes research evidence to establish global norms and standards, and develops tools and guidelines that address evolving needs and problems in sexual and reproductive health;
- contributes to strengthening research and technical capacity in countries through support to and collaboration with relevant academic and research institutions, which contributes to country efforts to promote and protect people's sexual and reproductive health, and to have access to and receive high-quality sexual and reproductive health services when needed;
- seeks to stimulate support and action at international level by disseminating evidence on the prevalence and impact of poor sexual and reproductive health issues.

The following highlights selected key achievements by the Programme towards the attainment of international development goals and targets.

"The credibility that the work of HRP contributes to global efforts to advance sexual and reproductive health and rights cannot be overstated. In a part of the international health field where political, social and cultural sensitivities connect and often collide, the consistently high standards that HRP sets itself, in terms of the research it undertakes allows those of us who rely on its findings and recommendations a rare degree of confidence that our claims are robust, evidence-based, and in line with global best practice. HRP demonstrates the convening power of the UN at its best; it brings together some of the world's most widely respected researchers, collaboratively establishing and working within best practice standards, pioneering research on difficult topics and maintaining a commitment to capacity-building for research throughout the developing world. I have been proud to be associated, albeit tangentially, with the work of HRP, and I wish it every continued success for the future."



Karen Newman,
Chair/Co-Chair, Gender and Rights
Advisory Panel, 2007, 2008 and 2010

Karen Newman is Coordinator of the
Population Sustainable Network, London, United Kingdom.

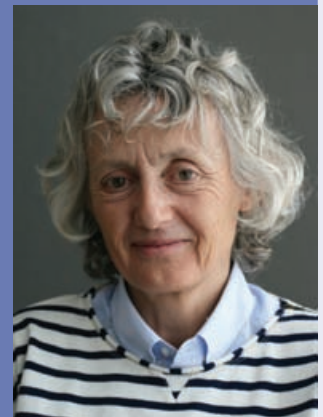
Widening choice and access to family planning

In the developing world, 215 million women have an unmet need for contraception, and another 64 million have an unmet need for a modern method. Up to a third of maternal deaths can be averted by use of effective contraception by women wishing to postpone or cease further childbearing. There is a high unmet need for family planning, particularly for some selected populations such as adolescents, those in low socioeconomic classes, and in conflict and disaster situations.

HRP has led, conducted and coordinated a large number of multicentre trials on the safety and efficacy of a variety of contraceptive methods, providing important tools and conclusive evidence that contribute significantly in prevention of unplanned pregnancies, thus reducing maternal deaths and morbidities, decreasing the numbers of unsafe abortions, and leading to stronger and healthier families and communities. HRP research results have been applied towards improving quality of care in service delivery and improving access to family planning and reproductive health services.

HRP has contributed to the development of new methods of contraception with the goal of providing expanded choices to couples, an indicator of quality of care, which is also linked to method uptake and continuation. Methods such as the contraceptive vaginal ring, a monthly injectable, and emergency contraception regimens have been made available to couples worldwide, thanks in part to HRP global research initiatives.

“HRP excels at undertaking large clinical trials in many countries often working in partnership with other agencies. Over the years HRP has investigated subjects which would be considered by most researchers to be rather mundane. What other organization would continue to study the effectiveness of IUDs for 12 years and longer? Yet the observation that the IUD lasts a very long time has transformed the perception, safety and cost of this method of contraception.”



Dr Anna Glasier,
Chair, HRP Scientific and
Technical Advisory Group, 2004–2008

Anna Glasier was the Lead Clinician for Sexual Health in NHS Lothian, Scotland, until May 2010.

She holds honorary professorships at the University of Edinburgh (Department of Obstetrics and Gynaecology) and the University of London School of Hygiene and Tropical Medicine (Department of Public Health and Policy). In 2006 she was awarded an OBE for her services to Women's Health.

Intrauterine device (IUD)

From the 1970s, a number of different kinds of IUDs were produced and marketed for use, necessitating rigorous evidence to guide decisions on choosing the safest, most effective, reversible long-acting method. Through a series of international trials in impressively large cohorts of women, HRP has, over the past three decades, monitored the performance and safety record of many popular IUDs. Thanks to these trials, HRP has been able to provide data on the safety and efficacy of a variety of IUDs, which facilitate informed choices by programme managers and providers, significantly contributing to prevention of unintended pregnancies.

Hormonal contraceptive implants

These are also long-acting methods using slow-releasing mechanism for hormones that produce a contraceptive effect over several years. Currently there are studies looking into the effectiveness of implants that work for longer periods, requiring fewer implants, and with fewer side-effects. Due to the work of HRP, these studies are being conducted in many countries with promising results that could lead to facilitated access to more long-acting methods that may be more easily provided to a wider group of women.

Guidelines and tools

HRP develops and disseminates evidence-based family planning guidelines and tools, among which The WHO *Medical eligibility criteria for contraceptive use* (4th edition), or “MEC”, was awarded the first prize in the Obstetrics and Gynaecology category in the 2011 British Medical Association Book Awards. This family planning guidance tool has been a pillar of the work of HRP since its inception 40 years ago. It has been shared thousands of times over in countries, with each update, and it remains one of our most long-standing and flagship achievements for its impact on the lives of women and their families in countries, by its role in strengthening family planning care.



The goals of the HRP research agenda, established in 1972, to provide relevant information to country programmes on the long-term safety and effectiveness of IUDs have been fully and successfully achieved.

*Conclusion of the External Evaluation of HRP,
2003–2007*

Reducing unintended pregnancies through emergency contraception

Emergency contraception (EC) contributes to reducing unintended pregnancies following an unprotected act of intercourse. HRP has played a pioneering role in the development of emergency contraception, in making it easier and safer to use, and more widely available to women worldwide.

HRP conducted a large multicentre randomized trial demonstrating the safety and efficacy of levonorgestrel as an emergency contraceptive. Subsequent work from HRP has contributed to supporting the successful registration and increased utilization of single-dose levonorgestrel as an emergency contraceptive in several countries.

An HRP review of scientific literature elucidated the primary mechanism of action of levonorgestrel to be the disruption of normal ovulation. Its use may also prevent the sperm and egg from meeting. Levonorgestrel emergency contraceptives do not interrupt an established pregnancy or harm a developing embryo.

Today, emergency contraception is a registered product and used by women in 140 countries.



EC has spread, from being registered in only six European countries with 3% of the world population in 1995, to 96 countries with over 5 billion people (82% of the world population) in 2002. HRP had a central role in this success through its research, its partnership with other reproductive health agencies and industry, development of service guidelines, introduction of EC in countries, and its many professional presentations and publications.

External Evaluation of HRP, 1990–2002



Preventing unsafe abortion to reduce maternal mortality and morbidity

Unsafe abortion continues to be a major public health problem and a serious obstacle to achieving Millennium Development Goal 5 in many countries. About 22 million unsafe abortions occur each year causing close to 50 000 maternal deaths, almost all in developing countries. In addition, approximately 5 million women suffer short-term or lifelong disabilities due to complications resulting from unsafe abortion. Preventing unsafe abortion is, therefore, critical to reducing maternal mortality and morbidity. WHO plays the lead role among the UN Health Four (H4+) in preventing unsafe abortion and related mortality.

“Since being part of GAP I have been edified by the breadth of work undertaken by a small but committed and talented team at HRP that strives to be responsive to emerging needs while adhering to standards of excellence. The team recently demonstrated its leadership in facilitating the inter agency guidance on sex selection and safe abortion at a very critical time when concerned members states may have been misguided by extreme ideological posturing on these very difficult issues. As the only UN agency that has since ICPD stayed committed to reducing unsafe abortion, WHO’s HRP team has boldly advanced the agenda of making abortions safer for women across the world through its research and evidence-informed technical/policy guidance. In a world where women’s health is continually compromised by the complexity of politics and ideology, HRP must continue playing a role that focuses on high-quality research and transparency in processes of policy/technical guidance development.”



Lester Coutinho,
Co-Chair, Gender and Rights
Advisory Panel, 2011, 2012

Lester Coutinho is Programme Officer,
The David and Lucile Packard Foundation.

HRP's work in promoting family planning has been critical in addressing unmet need for family planning and in reducing unplanned pregnancies and, consequently, abortion and unwanted births. However, continuing lack of access to effective contraceptives combined with contraceptive- or user-failure result in estimated 33 million unplanned pregnancies each year.

Improving access to surgical and non-surgical (medical) abortion care

Two randomized clinical trials by HRP, published in *The Lancet*, have established that trained nurse and auxiliary nurse-midwives can provide surgical and non-surgical (medical) abortion as safely as physicians. This finding has major implications for expanding access to safe abortion in resource-poor settings with shortage of physicians or where they are overloaded.

Non-surgical (medical) abortion

HRP played a catalytic role in the development of medical abortion care offering millions of women a choice of safe medical abortion technology. The most recent external evaluation of HRP showed that HRP trials have been instrumental in developing a low-cost formulation of safe and effective medical abortion regimen for the first-trimester (comprising mifepristone and misoprostol). The same evaluation showed that this development can potentially reduce unsafe abortions by 1 million and save 3600 lives annually if medical abortion is registered and available in countries where abortion is legally permitted on request.

WHO/HRP Safe abortion technical and policy guidelines

These guidelines serve as a reference document for UN organizations, NGOs, professional associations, programme managers and health care providers. These have been published in several languages and are one of the most widely used Guidelines. An update of the Guidelines is currently in production.

HRP is currently undertaking a series of operations research studies aimed at providing programmatic evidence to expand access to safer services in resource-poor settings using medical abortion and, where it is not against the law, focusing on the role of mid-level providers.



As the only UN agency that has since ICPD stayed committed to reducing unsafe abortion, WHO's HRP team has boldly advanced the agenda of making abortions safer for women across the world through its research and evidence-informed technical/policy guidance.

*Dr Anna Glasier,
Chair, HRP Scientific and Technical Advisory Group,
2004–2008*

Reducing maternal deaths by preventing postpartum haemorrhage

Postpartum haemorrhage is one of the most important causes of maternal mortality accounting for at least 25% of the maternal deaths occurring each year. HRP is currently conducting a multicountry survey in 26 countries to establish the causes and prevalence of severe morbidity and near-miss morbidity as a proxy for maternal death.

HRP conducted a large multicentre randomized trial that showed that oxytocin is the drug of choice for prevention of postpartum haemorrhage. HRP is collaborating with external partners to evaluate the safety and efficacy of misoprostol for prevention and early treatment of postpartum haemorrhage in settings where oxytocin is not available.

Between 2009 and 2010, HRP conducted a large multicentre randomized trial to determine the best way to manage the third stage of labour with the objective of reducing the risk of postpartum haemorrhage. It has been shown that a strategy of active management of third stage of labour (AMTSL) significantly reduces the risk of developing postpartum haemorrhage. However, it has been difficult to implement this strategy due to the special training needs to apply one of its components (controlled cord traction). The HRP study, in which more than 24 000 women participated, showed that omitting controlled cord traction has little effect on the risk of severe bleeding and indicates that effective prevention of postpartum haemorrhage could be accomplished with just a uterotonic agent (primarily oxytocin). The study findings have important implications for expanding access to effective care and could have a substantial impact on maternal survival in places where access to skilled medical staff is difficult.

Due to emerging new evidence, WHO is currently updating its evidence-based recommendations for prevention of postpartum haemorrhage and management of postpartum haemorrhage and retained placenta. Thirty-five questions on interventions and a list of possible outcomes in the treatment of atonic postpartum haemorrhage and retained placenta were identified by HRP and partners; these questions required 45 recommendations. The editorial base of the Cochrane Pregnancy and Childbirth Group designed and ran search strategies and carried out the initial screening of results and coordinated the production of relevant Cochrane reviews. Centro Rosarino de Estudios Perinatales (CREP) a WHO Collaborating Centre in Argentina, prepared GRADE tables and helped to update Cochrane reviews if needed. As a result of this close collaboration, within 12 months, 22 Cochrane reviews were conducted or updated for the guideline. Of these 11 are already published in *The Cochrane Library* and four are in the editorial process. The updated guideline will be published in the second half of 2012.

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In the period 1990–2002, HRP clearly met expectations in terms of its core mission to coordinate, promote, conduct and evaluate international research in reproductive health. HRP fulfils a uniquely important role that cannot be taken up by another existing agency or organization in the world ... no other reproductive health research organization collaborates with an equivalent network of research institutions.

External Evaluation of HRP, 1990–2002

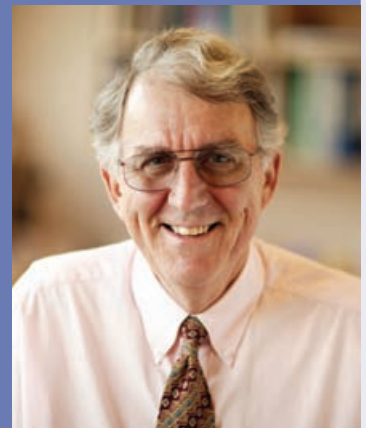


Research into hypertension during pregnancy to improve maternal and newborn health

Pre-eclampsia and eclampsia are responsible for 12% of maternal deaths worldwide and for a considerable proportion of maternal morbidity. In addition, they significantly contribute to perinatal mortality and morbidity.

HRP conducted a large multicentre randomized trial in six developing countries that showed that calcium supplementation in pregnant women with low-calcium intake reduced the risk of most severe complications in cases of hypertensive disorders of pregnancy. The study showed a trend towards reduced maternal mortality. Importantly calcium supplementation in pregnancy was associated with a 30% reduction in neonatal mortality. Calcium supplementation is an effective preventive intervention which is affordable, acceptable and feasible for use in low-resource settings.

“A highlight for me was the opportunity to work with a dedicated group of individuals in Geneva and in developed and developing countries whose purpose was to improve the reproductive health of those less fortunate than many of us, particularly women. There was a great sense of satisfaction to observe the difference made by the work of HRP and RHR, guided by STAG, on policies in many different areas of reproductive health as well as the improvements in lifestyle and occupation of many people in developing countries. The great strength of WHO, and through it, RHR, is its political independence and its emphasis on only using evidence-based information to develop recommendations and guidelines. These principles remain as important today as they were in my time on STAG.”



Dr Jock Findlay,
Chair, Scientific and Technical
Advisory Group 1998–2003

Jock Findlay is Head of the Female Reproductive Biology Group of Prince Henry's Institute of Medical Research, and a Senior Principal Research Fellow of the National Health and Medical Research Council of Australia. He is also Director of Research at the Royal Women's Hospital, Victoria, Australia. He holds honorary professorships with the Departments of Obstetrics & Gynaecology at Monash and Melbourne Universities.

HRP has been involved in two major randomized clinical trials that have shown that magnesium sulfate:

- Reduces by half the risk of developing eclampsia in women with pre-eclampsia, as well as possibly reducing the risk of maternal death.
- Is the drug of choice and reduces mortality in women with eclampsia. The wider introduction of magnesium sulfate in country health care programmes will greatly improve pregnancy outcomes.

HRP has also led studies that have shown that in areas where dietary calcium intake is low, calcium supplementation during pregnancy is beneficial for the prevention of pre-eclampsia in all women, and especially those at high risk of developing pre-eclampsia.

WHO recommendations for prevention and treatment of pre-eclampsia and eclampsia were published in 2011.

HRP is currently conducting a multicentre study to test whether changes in serum and urinary angiogenic proteins, substances potentially involved in the genesis of hypertension in pregnancy, can be used as an effective method for identifying women at high risk of developing pre-eclampsia. If proven effective, dipsticks and other ready-to-use methods to detect angiogenic factors could be developed for use at point of care. The study is a collaboration with the Perinatal Research Branch of the National Institute of Child Health and Development (PRB/NICHD). This collaboration will allow HRP and PRB/NICHD to test rapidly new research hypotheses without having to establish new ad-hoc research protocols and infrastructures.

A pregnant woman's risk of an adverse outcome from pre-eclampsia can now be calculated with the aid of the six-component Pre-eclampsia Integrated Estimate of Risk (or PIERS) model that was developed by HRP and partners. The model uses clinical and laboratory data, such as gestational age on admission and measures of cardiorespiratory, renal, hepatic and haematological functions, to predict the 48-hour probability of an adverse maternal outcome.



Ensuring access to quality antenatal and intrapartum care

Three million newborns in the first week of life and 358 000 women die every year from complications of pregnancy and childbirth. Antenatal care reduces perinatal mortality and improves maternal health through detection and treatment of pregnancy-related conditions and facilitates the use of skilled care at childbirth. In addition, the antenatal period provides an opportunity to reach pregnant women with a number of additional interventions that may be vital to their health and well-being as well as the health of their unborn child (such as detection and appropriate treatment of HIV/AIDS, syphilis, malaria, and anaemia) and appropriate identification and response to cases of violence against women. Access to antenatal care at least once during pregnancy is relatively high even in low-resource settings; however it is important to make sure necessary components of antenatal care are adequately provided, of good quality and lead to increases in facility births.

In 2002, HRP conducted a multicentre clinical trial to test a new evidence-based model of antenatal care. The results of the study informed the development of the WHO Antenatal Care Model based upon components scientifically proven to improve maternal, perinatal and neonatal outcomes through four antenatal and one postpartum visit. The WHO Antenatal Care Model is currently being implemented in many resource-constrained settings around the world and HRP is following its adaptations in different settings.

HRP is currently conducting a study which aims to determine whether the implementation of an adapted version of the WHO Antenatal Care Model that integrates antenatal care services with other health services in antenatal clinics in Mozambique will improve: (1) health outcomes for women and infants; and (2) the capacity of these clinics to detect, treat, and prevent major conditions (e.g. violence against women and diseases such as HIV/AIDS, malaria, anaemia).

HRP is also coordinating and monitoring the conduct of three implementation research projects to improve the quality of and access to antenatal and intrapartum care. In Guatemala the evaluation is conducted in villages and first-level facilities interacting with traditional birth attendants to increase antenatal care and facility childbirth. In the Four-country Study in the Middle-East (Egypt, Lebanon, West Bank and Gaza Strip and Syria) a multifaceted intervention aims to reduce severe maternal morbidity. In Uganda and the Philippines, multiple strategies involving service quality improvement, demand-side financing, facilities' renovations, and increasing facility births through community health worker-mediated interventions, are being evaluated.

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HRP research has set the global standard for antenatal care. The framework for monitoring attainment of MDG5 now includes the HRP recommendation of using the proportion of pregnant women worldwide who attend for four antenatal visits as an indicator of antenatal care use.

*External Evaluation of HRP,
2003–2007*



Preventing mother-to-child transmission of HIV

An estimated 230 000 babies are infected with HIV each year, almost all of them in resource-limited settings. In many developing countries, mothers living with HIV have a tough choice: either breastfeed their babies and risk transmitting the virus through their milk, or give them formula. The latter deprives infants of the natural immunity passed on through breast milk, which helps protect against diarrhoea, malnutrition and other potentially deadly diseases. Sanitation can also be an issue, with a scarcity of clean water with which to mix the formula. Many families cannot afford infant formula.

The Kesho Bora study – or a ‘Better Future’ in Swahili – aimed to assess whether the risk of passing on HIV during breastfeeding could be reduced. The study, led by HRP, was carried out between 2005 and 2008, involving over 800 women in Burkina Faso, Kenya and South Africa.

The study found that giving mothers with HIV a combination of antiretroviral medication (ARVs) during pregnancy, delivery and breastfeeding dramatically cuts HIV infections in infants compared with the standard WHO recommendations at the time of the study.

The very clear results from the Kesho Bora study demonstrated a 43% reduction in transmission risk. Women whose virus was suppressed to undetectable levels by the time of delivery had only a 2.7% chance of transmitting HIV to their babies up to one year of age, even if they breastfed. For the first time, there was enough evidence for WHO to recommend use of ARVs during breastfeeding.

The revised guidelines are now being considered by countries and incorporated into national policies on preventing mother-to-child transmission. Several countries have already adopted the approach pioneered in Kesho Bora of providing priority access to triple-combination ARVs to pregnant women with HIV infection and continuing the medications after breastfeeding has ceased. This not only substantially reduces the risk of HIV infection in the baby, but also preserves the health of the mother so she is better able to provide for her family.

The efficacy of this new therapy led WHO, UNAIDS, UNICEF and PEPFAR (The United States President’s Emergency Plan for AIDS Relief) to launch an initiative to eliminate mother-to-child transmission of HIV. Offering pregnant women with HIV infection priority access to treatment and the means to go safely through pregnancy and breastfeed their new baby are essential steps in increasing the acceptability of and participation in programmes to prevent mother-to-child transmission of HIV.



The overall conclusion was that, during the period 1990–2002, HRP clearly met expectations in terms of its core mission to coordinate, promote, conduct and evaluate international research in reproductive health and achieved its major objectives. The Programme maintained its position as the global leader in generating research results and establishing the scientific consensus needed to advance reproductive health policies and practices, especially for developing countries.

External Evaluation of HRP, 1990–2002

Eliminating congenital syphilis

Congenital syphilis continues to be a major public health problem, causing stillbirths, prematurity, neonatal deaths, and congenital disease. An estimated 2.65 million stillbirths occur yearly, of which 98% occur in low and middle-income countries. Maternal infections such as syphilis are one of the top five major causes of stillbirth. In addition, genital ulcer diseases such as syphilis increase the risk of HIV transmission by three- to five-fold.

Elimination of congenital syphilis as a public health problem is feasible with a relatively simple set of existing interventions focusing on maternal and newborn care. Universal screening for syphilis among antenatal care attendees and treatment of positive women is cost-effective even in low-prevalence settings. Syphilis screening in pregnancy is more effective in preventing stillbirths than any other pregnancy intervention besides comprehensive emergency obstetric care, and costs less per pregnant woman treated than nearly any other intervention. Interventions to improve screening programmes for antenatal syphilis could reduce syphilis-attributable stillbirths and perinatal deaths by 50%.

“HRP is uniquely important in supporting national health administrations’ efforts to improve reproductive health through research, research training, setting of standards and guidelines, and promoting the use of research results in policy-making and planning. While other organizations carry out some of these functions, none comes close to the breadth, capacity, prestige and credibility of HRP, with its base in WHO, international composition and links to governments.

External Evaluation of HRP, 2003–2007

The building blocks for congenital prevention are already in place in many countries: policy guidelines for universal antenatal syphilis screening exist in most countries; levels of antenatal attendance are high; screening tests are low-cost and technically feasible even at the primary health-care level; and treatment with penicillin is inexpensive and is on the essential medicines list of all countries. Despite these numerous facilitating factors, the majority of pregnant women are not screened for syphilis as there is a great under-appreciation of the burden of congenital syphilis and syphilis screening of pregnant women is often not a priority public health intervention.

HRP is leading the Global Elimination of Congenital Syphilis Initiative to highlight the importance of congenital syphilis as a key issue for maternal and newborn health, as well as emphasize how efforts to improve antenatal syphilis screening can be used to strengthen underlying antenatal care systems. In addition, HRP is working with partners to support regions and countries in dual elimination of mother-to-child transmission of HIV and syphilis, and strengthen surveillance, monitoring, and evaluation systems. HRP is finalizing an advocacy tool to outline the rationale for investing in elimination of congenital syphilis efforts: the Investment case for eliminating congenital syphilis: promoting better maternal and child health and stronger health systems.

HRP is collaborating with countries and external partners to identify how to best monitor elimination of congenital syphilis efforts, and to understand better the importance of early treatment for syphilis in pregnancy.



Eliminating female genital mutilation

Worldwide, there are around 140 million girls and women who have been subjected to female genital mutilation (FGM). Every day, 8000 girls are at risk of undergoing the procedure. In collaboration with partners, HRP is working with countries towards elimination of the practice.

Female genital mutilation includes all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs, for non-medical reasons. FGM has no health benefits, causes severe pain and has several immediate and long-term health consequences. A landmark HRP study, reported in *The Lancet*, showed that FGM is associated with increased risk of complications during childbirth and significantly higher death rates among infants.

HRP is also supporting research to look more in-depth at the reasons for the persistence as well as abandonment of FGM.

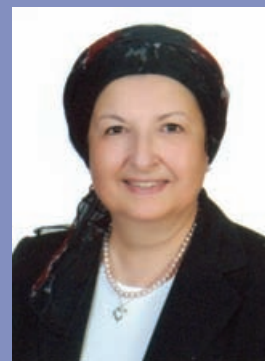
In 2008, HRP coordinated an interagency statement on the elimination of FGM that was signed by OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, and WHO. The statement highlights the evidence from the HRP-sponsored research.

Following this statement, the World Health Assembly passed a resolution denouncing FGM as a violation of human rights and a barrier to achievement of the Millennium Development Goals. Through this resolution, all countries have committed to increase their efforts to support the elimination of FGM.

FGM performed by health professionals is increasing, yet it does not necessarily lead to harm reduction, and creates implied approval of the practice. With HRP's lead, in 2010, a global strategy to stop health-care providers performing FGM was developed.

A key role for health professionals is, however, providing care for girls and women suffering negative health consequences from FGM, as well as support for its abandonment. HRP has developed a series of training courses, and technical tools for health-care workers, including guidance videos for counselling training. HRP works closely with UNICEF and UNFPA to disseminate these tools and research results on FGM to health professionals and policy-makers.

“HRP has continued to provide high-quality scientific and technical advice, which takes into account the role of gender equality and human rights. Sexual and reproductive health is central to the health of women, men and children, and to achieving the Millennium Development Goals. Ill-health from causes related to sexuality and reproduction remains a major cause of preventable death, disability, and suffering among women, particularly in middle-and low-income countries.



“During my involvement in the RAP, I worked very hard with the other members to encourage reproductive health research in our Region. Alternation of the meetings between African countries and Eastern Mediterranean countries allows the group to realize the different problems and the different circumstances the scientists are working with. It also gave us opportunity to interact with the decision-makers and scientists from different countries and know their priorities.

“An example of the research activities was that dealing with female genital mutilation, which was a major problem in Africa and some countries of the Eastern Mediterranean Region.

“Capacity-building of scientists was also considered and South Africa demonstrated a success, which deserves continuous financial support from the programme. Attention was also given to Operational Research and encouraging collaborating centres to propose long-term studies.

“In order to follow up with activities in the region, several site visits were done. I was involved in visits to Yemen, Sudan, Syria and Nigeria. These visits enriched our knowledge and helped the local scientists to interact with experts for exchange of experience. ”

Dr Wagida A. Anwar,
HRP Regional Advisory Panel Chair for Africa
and Eastern Mediterranean, 2007–2009

Agida A. Anwar is Professor at the Department of Community,
Environmental and Occupational Medicine, Faculty of Medicine,
Ain Shams University, Cairo, Egypt.

Strengthening national cervical cancer prevention and control programmes in countries

Cervical cancer is the second most common cancer in women worldwide, with about 529 000 new cases and 275 000 deaths each year, more than 85% of which are in developing countries. The lack of effective prevention and control programmes aimed at detecting and treating precancerous lesions in low-resource countries is one of the factors underlying the striking differences between industrialized and developing countries in cervical cancer morbidity and mortality rates. The use of an appropriate screening method is important to correctly identify women needing further follow-up, as early as possible, and to allow as many women as possible with precancerous lesions to be treated to prevent the development of cervical cancer.

HRP has assessed the acceptability and feasibility of implementing a cervical cancer prevention programme based on a “see and treat” approach using visual inspection with acetic acid (VIA) and cryotherapy, through the implementation of operations research in defined areas of six African countries (Madagascar, Malawi, Nigeria, Uganda, United Republic of Tanzania and Zambia).

Based on the results of this research and lessons learnt, services are now being scaled-up by countries because: (1) nurses and midwives can do the tests with minimal equipment and supplies; (2) training of personnel can be accomplished quickly; and (3) test results are available immediately, thus allowing for prompt management and follow-up of women.

HRP is key member of the Intercluster working group on HPV and cervical cancer that coordinates global activities on cervical cancer including support to programmes and research in countries, and development of a global research agenda.

HRP is currently supporting the United Republic of Tanzania to generate evidence of the operational capacity of careHPV, a rapid screening test. This evidence will permit consideration of scaling-up the introduction of this new test in the United Republic of Tanzania and to strengthen its cervical cancer prevention and control programme.



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HRP is a unique Programme and the international leader in reproductive health research. It needs to be supported further to enable it to continue its role effectively in response to evolving reproductive health problems and practices.

External Evaluation of HRP, 1990–2002

Strengthening research capacity to improve sexual and reproductive health in low- and middle-income countries

There is need for locally relevant research for formulation of policies and implementation of effective interventions for addressing sexual and reproductive health problems in low- and middle-income countries. A critical mass of scientists and institutions of scientific excellence are therefore needed to respond to this challenge.

Since its inception in 1972, a key activity of HRP has been the provision of support to countries to strengthen their research and technical capacities in sexual and reproductive health. Institutional and individual grants are provided to research institutions and junior researchers in low- and middle-income countries in the form of various structured schemes ranging from long-term institutional development grants, resource maintenance grants, to research training grants. This long-term effort has led researchers and institutions in developing countries to participate more effectively in strengthening health systems and policies in their countries.

“HRP is the programme that conducts and supports very excellent research in reproductive health. This research improves women’s health particularly in the developing world. The *Reproductive Health Library* (RHL) is a very successful database that has practical use worldwide. Serving as RAP chairperson of Asia and Pacific regions and as a STAG member, I have been impressed with the works of HRP in terms of implementing research and practical guidelines. The workshops about reproductive health in Thailand, Laos, Viet Nam, Cambodia, Myanmar and so on improved women health in this Region. These works of HRP assisted the countries in Asia and Pacific to attain the Millennium Development Goals.”



Dr Surasak Taneepanichskul,
HRP Regional Advisory Panel Chair for
the Asia-Pacific Region, 2009-2011

Surasak Taneepanichskul is Professor,
Department of Obstetrics & Gynaecology, and
Dean, College of Public Health Sciences,
Chulalongkorn University, Bangkok, Thailand.

“HRP studies have contributed to establishing safety and practice standards for various contraceptives. Other studies include those on post-abortal and post placental IUD insertion as well as tubal sterilization.



“As an expert in assisted reproductive technology (ART) I have presented papers and written chapters for an HRP book on the subject of ART and have been involved in the move to find a cheaper way of doing IVF to increase access to IVF for clients. These approaches have been addressed by special group workshops including those in Tanzania and at WHO headquarters.

“The RAP reviewed proposals for projects in reproductive health in the Regions and built capacity in reproductive health in various countries through training and involvement in projects. Significant support and progress have been made in Nigeria. Through the RAP assistance, several new centres for collaboration with HRP were recognized, including in East London, South Africa, and the Kilimanjaro Medical Centre in Tanzania.

“HRP has provided a forum for showcasing objective scientific evidence and translating it to action in a sustainable manner across the Globe but with special attention to developing countries. As it adapted to regional and gender sensitivities, it became more relevant to a greater proportion of the world. Unfortunately, these adaptations were occurring as donor reluctance, and maybe fatigue reduced HRPs funds. HRP then found that it has been operating within a tighter and tighter financial jacket.

“There is a way out of this. Those very countries in Africa, Asia, South America and Middle East and emergent eastern Europe that, WHO, quite rightly, has become more sensitive to, must put their money where their mouths are and donate to HRP. Such gestures should indicate to traditional sources of WHO funds that support for WHO/HRP is from across the world.

“My experience with WHO HRP has been very positive. I wish WHO/HRP yet better times to come.”

Dr Osato Ona Frank Giwa-Osagie,
former HRP Regional Advisory Panel Chair for
Africa and the Eastern Mediterranean

Osato Giwa-Osagie, is Distinguished Professor of the Department of Obstetrics and Gynaecology, College of Medicine, University of Lagos, Nigeria, and Officer of the Order of the Niger.

Collaborating institution perspective

"The collaboration between the Epidemiology Unit, Prince of Songkla University (PSU), a major university in southern Thailand and HRP, started in 1986. For six years, I joined the Steering Committee of the Taskforce for Safety and Efficacy of Fertility Regulation which allowed me to develop my own expertise in reproductive health epidemiology.

In 1991, a team comprising HRP staff and myself conducted site visits to over ten research institutes

in Asia to review the development of human resources. The following year, the International Programme for Graduate Study in Epidemiology started at PSU. With Research Training grants (scholarships) from HRP, our University became a regional centre to improve the research capacity of for mid-level staff. Later on, the International Programme received grants from Ford Foundation, the Norwegian and Thai governments, Thailand Research Fund and Thai Health Foundation.

"Over the years, more than 60 PhD and 50 MSc students graduated. Their theses led to changes in reproductive health policy and implementation of programmes in their respective countries. These include, among others, measures to improve the health of migrants; interventions to increase access to emergency obstetric care in remote areas and reduction in reliance on induced abortion for fertility regulation.

"The Epidemiology Unit provided assistance to centres receiving HRP's Long-term Institution Development (LID) grants; and in the past few years, received Research Project Mentoring Grants from HRP. Substantial progress has been made in the research centres in Viet nam, Myanmar and Mongolia starting from the LID grant periods.

"In summary, over two and a half decades, our joint efforts with HRP have made a difference to reproductive health research in Asia."



Dr Virasakdi Chongsuvivatwong,
Professor of Community Medicine
at Prince of Songkla University, Hatyai, Thailand

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Research capacity strengthening is one of HRP's major achievements...The research centres that have benefited from HRP's research capacity strengthening efforts have contributed to shaping national policies and programmes in their countries.

External Evaluation of HRP, 1990–2002



Protecting and promoting human rights and gender equality in sexual and reproductive health

HRP aims to ensure that research, policies and programmes in sexual and reproductive health protect and promote human rights and equality between women and men, including adolescents. Specifically HRP works to provide evidence to guide health policies, programmes and systems, through, for example, research to assess ways in which sexual and reproductive health services can address violence against women; developing guidance for the promotion of sexual health and healthy sexuality; generating evidence on ways to prevent intimate partner and sexual violence against women; and helping governments and their partners to ensure that sexual and reproductive health policies and laws are grounded in human rights.

HRP has: (1) worked on global research to document how human rights standards have been specifically applied to sexual health and sexuality in international, regional and national laws and jurisprudence as a basis for developing international standards on sexual health, sexuality and human rights; (2) worked with regions to assist countries to assess and improve their policy and legal frameworks to better support sexual and reproductive health and ensure they are in line with human rights commitments; (3) built capacity in regions and countries to use human rights to advance sexual and reproductive health in different ways; (4) contributed to international, regional and national human rights monitoring mechanisms; and (5) provided expert opinions to national legislative processes.

From the WHO Multicountry Study on Women's Health and Domestic Violence Against Women, HRP has generated a database with information from over 24 000 women from 15 sites in 10 countries, containing a wealth of information that has been analysed and widely used at the national and international levels. HRP and its partners continue to move forward with cross-country analysis as part of their research-to-action agenda. To date, the study findings have been used to illustrate the extensive burden of intimate partner violence and its associations with poor physical, mental and reproductive health and they have been very instrumental in bringing attention to this problem.

HRP also participates in various partnerships, interagency processes and with the international human rights machinery for the promotion of gender equality, reproductive rights and sexual and reproductive health. Various interagency statements have been initiated by HRP and published, including in the areas of preventing sex-selection and female genital mutilation. The statements reaffirm the commitment of United Nations agencies to encourage and support efforts by States, international and national organizations, civil society and communities to uphold the rights of girls and women and to address the multiple manifestations of gender discrimination. They thus seek to highlight the public health and human rights dimensions and implications of such problem and to provide recommendations on how best to take effective action.

“HRP in WHO is a model and leader within the United Nations of integrating gender equality and human rights into sexual and reproductive policy and program development. Through HRP, WHO is building the key evidence, the cutting-edge research agenda and the standards that governments, public health professionals and advocates alike are using to advance SRH and rights and to promote good health outcomes.”



Luisa Cabal,
Co-Chair Gender and Rights
Advisory Panel, 2011, 2012

Luisa Cabal is the Director of the International Legal Program at the Center for Reproductive Rights, where she leads the Center’s legal and advocacy efforts in Africa, Asia, Latin America, and Europe.

Promoting the health of adolescents

Adolescents, especially young women, are particularly vulnerable to sexual and reproductive ill-health. Lack of knowledge, inability to negotiate no sex or safe sex, and cultural demands for marriage at a young age combine to yield alarming incidences among adolescents of sexual coercion, especially at first sexual intercourse, sexually transmitted infections, including HIV/AIDS, low use of contraception and hence high pregnancy and birth rates, and nearly half of all unsafe abortions are performed in girls aged 15–24 years.

HRP supports research to help countries understand what adolescents need and how best to reach them to encourage responsible sexual behaviour and help them protect and promote their sexual and reproductive health.

The Senegal Ministry of Health used results from HRP's research in creating its first action plan for improving adolescent sexual and reproductive health services.

HRP researchers in Shanghai, China, found that young people considered a dedicated web site to be a responsive, effective means to improve their knowledge about sexual and reproductive health. HRP also confirmed that sex education via the Internet does not increase sexual activity. The web site is now part of the 'life education' programme for Shanghai's secondary schools, and the mass media have given it wide coverage.

The national education policy in Panama changed when an HRP collaborating centre showed that a significant proportion of adolescent girls is sexually active, leading to unintended pregnancies and withdrawal from school. Teachers are now trained to discuss issues of sexuality with students, and pregnant schoolgirls are allowed to continue their studies.

HRP constructed approaches to empower married adolescents in Bangladesh to make informed decisions about their sexual and reproductive health and to reduce the negative impacts of poverty, social and cultural norms and lack of information demonstrated by our research.

An HRP systematic review of risk-taking behaviours among adolescents in developing countries found that adolescents were generally poorly informed about ways to prevent such unwanted outcomes as STIs and pregnancy. Their knowledge of safe sexual activity was generally weak, misperceptions of risk were common, and many had limited or non-existent access to condoms and contraception so they could do little (apart from abstinence) to engage in preventive safe sexual behaviours. Based on the findings from the systematic review, HRP made recommendations to: (1) encourage open dialogue about adolescent sexual and reproductive health within families; (2) challenge gender norms among youth and parents; (3) implement programmes in early adolescence; (4) incorporate peer networks into adolescent sexual and reproductive health programmes; (5) increase programmes for vulnerable adolescents in marginalized communities; (6) target misinformation and misperceptions about risk; and (7) conduct further research on effective intervention strategies.



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Reaching adolescents is critical to improving maternal health and achieving other Millennium Development Goals.

Millennium Development Goals Report 2011

Helping men take responsibility

Despite the influence men may have on their partner's health, they are often largely unaware of women's sexual and reproductive issues or the risks of childbearing because their involvement in the care of their wives and newborn infants is so limited. Men may nevertheless make most of the decisions about health matters in the family. Men also have sexual and reproductive health issues of their own, but services often ignore men entirely.

Many men would be willing to take greater responsibility for the sexual and reproductive health of their partners and the well-being of their families. HRP research led to a policy brief to the Kenyan Ministry of Health, advising that men want access to information and services yet are often ignored or disregarded in current health programmes.

An effective contraceptive method for men would be one means for men to share responsibility. HRP's work related to men and family planning has included biomedical research to develop methods of male fertility regulation as well as social science studies to examine male roles and perceptions in family and contraception.

HRP studies in South Africa and Uganda indicate that both men and women make decisions about condom use within a marriage and that the use is higher than expected. Such information helps programme managers to design services that are appropriate for clients.



HRP is uniquely important in supporting the efforts of national health administrations to improve reproductive health. It does this through research, research training, setting of standards and guidelines, and promotion of the use of research results in policy-making and planning. While other organizations carry out some of these functions, none comes close to having the breadth, capacity, prestige and credibility of HRP with its base in WHO, international composition, and links with national governments.

External Evaluation of HRP, 1990–2002

HRP has demonstrated proof of concept for an injectable, hormonal contraceptive for men, and is conducting a detailed investigation into side-effects and their possible causes. A strategy will be developed that incorporates method development with social science research and behaviour change interventions to increase positive male engagement in family planning initiatives.

The *WHO laboratory manual for the examination and processing of human semen*, first published by HRP in 1980, has become the world standard for clinical andrology and infertility laboratories. The fifth edition was published in 2010 and is HRP's most downloaded document. It has also been translated into several languages.

In late 2011 HRP provided support to a UNAIDS interagency workshop on integrating gender-based violence and engaging men and boys for gender equality into national AIDS plans. A programming guide to address gender-based violence in the context of HIV is in preparation that situates male involvement in a conceptual framework that promotes engagement and involvement of men and boys in the context of promoting gender equality and uses the terminology "engaging men and boys for gender equality".



The WHO semen manual appears to be established as the world authority over other USA and European manuals and handbooks. It was cited 2384 times in references of scientific journals compared with only 79 citations for the next most widely cited manual... The 30-fold greater number of citations is strong evidence that the WHO manual is truly the global standard.

External Evaluation of HRP, 1990–2002

Improving information for accountability in women's health

In 2008, 358 000 women were estimated to die from complications of pregnancy and childbirth. In order to address adequately the clinical causes and contributing factors of these deaths, a standard system by which these causes are correctly identified is necessary. Research evidence shows inconsistencies of both clinical records and research studies in identification of conditions causing or contributing to maternal deaths.

HRP synthesized all available evidence and published the first-ever systematic review of causes of maternal deaths for all countries and regions, showing variability in cause-distribution of maternal deaths across regions as well as misclassifications in registration and cause-attribution of maternal deaths. Such misclassification might misinform programmatic actions to prevent and mitigate maternal deaths.

HRP has developed a standard classification system for deaths during pregnancy, childbirth, and the 6-week period following birth, that aims to support studies to better understand the burden and causes of maternal mortality and facilitate accurate certification of deaths.

HRP is contributing to improve information and accountability for women's health by both: (i) monitoring the global and regional cause-attribution of maternal deaths to ensure availability of accurate and up-to-date information on preventable causes of deaths; and (ii) supporting researchers, clinicians, and programme implementers in accurate identification of the causes of and contributing conditions to maternal deaths through the new WHO classification system.



“All our debates and discussions have meaning only when they improve the health of people and relieve their suffering.” –

World Health Assembly 2011

WHO Director-General,
Dr Margaret Chan



Contribution towards achievement of universal access to sexual and reproductive health

“Achieving universal access to reproductive health” was integrated as the second target for tracking progress towards attainment of the Millennium Development Goal (MDG) 5, following a recommendation at the 2005 World Summit. This recommendation was based on the recognition that universal access to reproductive health is key to achievement of all the MDGs, especially MDGs 3 and 5. There are gaps in reproductive health access in many low-income countries. For example, in sub-Saharan Africa, one in four women who wish to stop or delay childbearing does not have access to a family planning method.

HRP generates, synthesizes, and supports implementation of effective interventions to address the determinants of access (availability, information, cost/affordability, quality) in all key aspects of sexual and reproductive health, including family planning and maternal health. Countries are supported in incorporation of evidence-based interventions in policies and programmes, and monitoring of inputs, processes and results, to make informed decisions on health service needs, priorities and outcomes, and ensure accountability for accelerated progress in achievement of universal access to reproductive health, thus MDG5.

Case-studies from countries that have used policy and programmatic innovations for advancing reproductive health are analysed and discussed at relevant forums, with potential applicability to other countries. A recent result is the initiation of a Policy Dialogue Series supported by Global Leaders Council and in collaboration with the Aspen Institute. An annual “Reproductive Health Resolve Award”, to be given to a country that made progress in reproductive health using innovative policies, was announced at the first of these Series at a high-level event at the United States Mission during the time of the World Health Assembly in 2011.

“...for the first time governments acknowledged that every person has the *right* to sexual and reproductive health. They agreed to put *gender equality*, *reproductive health* and *reproductive rights* at the *centre of development* ... recognized the need to make sure that all people who want reproductive health care can get it.” – ICPD 15th Anniversary, 2009

“When we work together, we succeed” – Women Deliver, June 2010



Ban Ki-moon
United Nations Secretary-General

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