

HRP ANNUAL REPORT 2016

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



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01


ABOUT US

HRP has been providing leadership on sexual and reproductive health and rights for over 40 years. Founded in 1972, we have a unique mandate within the United Nations (UN) system to lead research and to build research capacity for improving sexual and reproductive health and rights through generating high-quality evidence.

HRP is based at the World Health Organization (WHO) headquarters in Geneva, Switzerland, within the Department of Reproductive Health and Research. We work collaboratively with partners across the world to shape global thinking on sexual and reproductive health and rights by providing new ideas and insights.

We support high-impact research, inform WHO norms and standards, support research capacity strengthening in low-income settings, and facilitate uptake of innovations and new information – including through digital and mobile technologies. An ethical, human-rights-based approach is integrated throughout our work.

HRP's vision is the attainment of the highest possible level of sexual and reproductive health for every single person across the globe. We strive for a world where human rights that enable sexual and reproductive health are safeguarded, and where all people have access to quality sexual and reproductive health information and services.

A group of people, including children and adults, are holding hands in a circle, suggesting a community or support group. The image is overlaid with a large circular graphic that has a teal-to-dark-blue gradient. Inside this graphic, white text states the organization's vision. The background is slightly blurred, focusing attention on the hands and the text.

HRP'S VISION IS THE
ATTAINMENT BY ALL PEOPLE
OF THE HIGHEST POSSIBLE
LEVEL OF SEXUAL AND
REPRODUCTIVE HEALTH

02

WHY SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS?

The importance of universal sexual and reproductive health for sustainable development and for the well-being of individuals, families, communities and countries has been internationally recognized.

The Sustainable Development Goals, the Millennium Development Goals before them, the UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health, and the aims of the Programme of Action of the 1994 International Conference on Population and Development all reflect a collective vision, which underlines the importance of protecting all people's human rights to access sexual and reproductive health information and services – in order to ensure physical and mental health, as well as economic development.

While great progress has been made, huge challenges remain. Too many women and infants continue to die in childbirth and in the first few days and weeks thereafter. Violence against women and girls, including harmful traditional practices, is a major global health challenge and human rights violation. Many individuals and couples are still unable to access information and services for sexual, reproductive, maternal and perinatal health services, putting their lives and well-being at risk. Humanitarian crises threaten lives, livelihoods, health and access to services for millions. And there are now more adolescents than at any period in history, greatly increasing demand for quality services that meet their needs.

Better data are key. Accurate service statistics help front-line health workers better care for their patients; rigorously collected evidence improves estimates of health conditions; and information from research on interventions informs policy, budgeting and health programming. Without continuing investments in research, as well as in improving capacity of countries to conduct research, it is unlikely that national health systems will be able to effectively implement global initiatives and strategies, or achieve the goal of universal health coverage.

For over 45 years, HRP has been conducting research on a global scale to improve sexual and reproductive health and to safeguard the human rights of people worldwide. We invite you to join with us in our efforts – with your help, we can continue to reach people and communities, and improve lives worldwide.

03

HELPING PEOPLE REALIZE THEIR DESIRED FAMILY SIZE

Contraception and family planning information, in addition to the prevention and treatment of infertility, allows people to attain their desired number of children and determine the timing of pregnancies.

These services and information are therefore crucial for securing the well-being and autonomy of women, while supporting the health and development of communities.

An estimated 225 million women in developing countries have an unmet need for contraception. Reasons for this include: fear or experience of side-effects; limited access and choice; cultural or religious opposition; and poor quality of available services. Satisfying unmet need for contraception would significantly reduce unintended pregnancies, unplanned births and induced abortions.

Infertility affects over 50 million people globally, many of whom cannot access the essential interventions they need.



Two sisters in Antsirabe, Madagascar, discuss their options for family planning methods.



SELECTED ACHIEVEMENTS IN FAMILY PLANNING AND CONTRACEPTION

- 1** HRP developed new and updated recommendations on the provision and use of contraception for the third edition of WHO's *Selected practice recommendations for contraceptive use (SPR)*. As a companion to WHO's *Medical eligibility criteria for contraceptive use (MEC)* – which focuses on who can use contraceptive methods safely in the context of specific health conditions and characteristics – the SPR provides guidance for policy- and decision-makers and the scientific community on how contraceptive methods can be used safely and effectively.



 The SPR is available [here](#)

- 2** Using guidance from both the MEC and the SPR, HRP supported more than 40 countries through the training of national decision-makers, to strengthen their national health systems so as to improve the safe and effective provision and use of contraception.

- 3** HRP completed a five-year study which demonstrated that the single-rod etonogestrel-releasing subdermal contraceptive implant (ENG implant), which is currently approved for up to three years of use, can be effective for up to five years. Extending the approved duration of use for the ENG implant could improve safe protection from unintended pregnancy for users and reduce costs and save resources for health systems. These findings will be valuable for regulatory authorities, policy-makers, supply chain managers and procurement advisers, family planning programme managers and clinicians.

- 4** For their Medical Book Awards 2016, the British Medical Association (BMA) rated the fifth edition of the MEC (2015) as “highly commended” in the Obstetrics and Gynaecology category.



- 5** The Training Resource Package for Family Planning offers essential resources that can be used by family planning and reproductive health trainers, supervisors and programme managers to design, implement and evaluate training programmes. Using evidence-based technical information from WHO publications, we updated the package in 2016 to include training modules on tubal ligation and vasectomy.



 All materials can be freely downloaded [here](#)

6



Does use of hormonal contraceptive methods increase a woman's risk of acquiring HIV? Since 1991, evidence on this issue has been inconclusive, and HRP has continuously monitored the available evidence. In 2016, HRP commissioned a systematic review of the latest evidence and held a consultation with a wide range of stakeholders to review the existing guidance on this risk. Subsequently, in early 2017, WHO updated its guidance statement on *Hormonal contraceptive eligibility for women at high risk of HIV*, confirming that women at high risk of acquiring HIV can use progestogen-only injectable contraceptives but should be advised about (i) concerns that these methods may increase risk of HIV acquisition, (ii) the uncertainty over whether there is a causal relationship, and (iii) how to minimize their risk of acquiring HIV.



The guidance statement is available [here](#)

More information is available [here](#)

7

To identify and outline various financing options for countries to achieve universal access to effective contraception, HRP commissioned five systematic reviews on alternative financing mechanisms for contraceptive programmes, which were published in December 2016 as a special supplement of *Studies in Family Planning*. The most striking finding from all the reviews was the lack of strong evidence on contraceptive financing; out of 17 000 articles identified, only 38 studies met the eligibility criteria, and after analysis it was not possible to make any strong recommendations on which financing mechanisms were more impactful.



Further information and links to the reviews are available [here](#)

SELECTED 2016 ACHIEVEMENTS IN INFERTILITY:

1

HRP developed a new fertility care assessment guide to help low- and middle-income countries determine how to incorporate fertility care services into existing policies, systems and reproductive health programmes while making the best use of existing resources to ensure delivery of quality clinical and laboratory services. In 2016, the guide was pilot-tested in Sudan and Zambia.

04

ENSURING THE HEALTH OF PREGNANT WOMEN AND GIRLS AND THEIR NEWBORN INFANTS

Complications of pregnancy and childbirth, including unsafe abortion, continue to pose great risks to the health and lives of hundreds of thousands of women.

Each day, about 800 women across the world die from pregnancy- or childbirth-related complications, most of which are preventable or treatable. The vast majority of maternal deaths – around 99% – occur in low- and middle-income countries, and young adolescents face a higher risk of complications and death as a result of pregnancy than older women.

The major complications that account for nearly 75% of all maternal deaths are severe bleeding, infections, high blood pressure during pregnancy (pre-eclampsia and eclampsia), complications during delivery, and unsafe abortion. Other maternal deaths are caused by or associated with diseases such as malaria and AIDS. In addition, morbidity due to complications of pregnancy and childbirth includes many debilitating conditions, such as obstetric fistula. More than two million women across sub-Saharan Africa and Asia live with untreated obstetric fistula, and up to 100 000 more develop this condition every year.

Ensuring good quality of care throughout pregnancy, childbirth and the postnatal period is recognized worldwide as essential to reducing the rates of complications and deaths related to pregnancy and childbirth.



A young woman makes a four-day journey with her father to Niamey, Niger with the hope of finding treatment for her fistula



SELECTED 2016 ACHIEVEMENTS IN MATERNAL AND PERINATAL HEALTH

1



HRP led the development of WHO's new comprehensive guideline on routine antenatal care for pregnant women and adolescent girls, *WHO recommendations on antenatal care for a positive pregnancy experience*. This guideline, which also introduces the 2016 WHO antenatal care model, incorporates relevant recommendations on antenatal care, and aims to complement existing WHO guidelines on the management of specific pregnancy-related complications. The guideline focuses on enhancing the quality of antenatal care to prevent and effectively manage any complications, and ensuring that more women can enjoy a healthy pregnancy, an effective transition to positive labour and childbirth, and ultimately a positive experience of motherhood – improving well-being for both women and their newborn infants.



The recommendations are available [here](#)

2

Due to poor care practices and insufficient infrastructure, equipment and supplies, many women and infants die, or suffer from life-long disabilities, even after reaching a health-care facility. Improving the quality of care provided at health facilities is therefore crucial to end preventable illness and deaths of women and their newborn infants, as well as to improve people's experience of care. As part of collaborative efforts across WHO to improve the quality of care for women and newborn infants, we worked with the WHO Department of Maternal, Newborn, Child and Adolescent Health to publish new *WHO Standards for improving quality of maternal and newborn care in health facilities*.



The new standards are available [here](#)

3



Every day, hundreds of women die during childbirth and thousands of infants are stillborn. With quality health care throughout pregnancy and childbirth, many of these deaths can be prevented, but countries often lack the knowledge and capacity to take the necessary actions. To address this, HRP supported the development of a new tool, *The WHO application of the International Classification of Disease to deaths during the perinatal period ICD-PM*, which is a standardized system for classifying stillbirths and neonatal deaths. It enables countries to link stillbirths and neonatal deaths to contributing conditions in pregnant women, and thus identify interventions that could prevent such deaths. This system also enables comparison of data within and between diverse settings.



More information and links to publications are available [here](#)

4

To accelerate the reduction of childbirth related maternal, fetal and newborn mortality and morbidity, in 2014 HRP initiated the Better Outcomes in Labour Difficulty (BOLD) project to address weaknesses in labour care processes and to better connect health systems and communities. In 2016, data collection for the BOLD project in Nigeria and Uganda was completed, including:

- a prospective cohort study following more than 10 000 women from hospital admission for childbirth through to discharge;
- a qualitative study including 205 in-depth interviews and 36 focus group discussions with women, midwives, doctors and administrators;
- a service design research project to develop and design the "Passport to Safer Birth", together with community members and health-care providers.

In 2017 the key findings of this research will be published in a number of peer-reviewed papers, as a special supplement to a scientific journal.



05

PREVENTING UNSAFE ABORTION

Women and adolescents with unwanted pregnancies who cannot access safe abortion are at risk of unsafe abortion.

Unsafe abortion occurs when a pregnancy is terminated either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

The rate of unsafe abortions is higher where access to effective contraception and safe abortion is limited or unavailable. Around 22 million unsafe abortions are estimated to take place worldwide each year, and 22,000 women die from abortion-related complications.

The major life-threatening complications resulting from unsafe abortion are haemorrhage, infection, and injury to the genital tract and internal organs. In addition to the deaths and disabilities caused by unsafe abortion, there are major social and financial costs to women, families, communities and health systems.



SELECTED 2016 ACHIEVEMENTS IN PREVENTING UNSAFE ABORTION

- 1** “Making greater investments in quality family planning services, providing safe abortion to the full extent of the law and ensuring post-abortion care including post-abortion contraception are essential public health strategies.”

Bela Ganatra, Scientist, WHO

Alongside researchers from the Guttmacher Institute, HRP co-authored new estimates on the incidence of abortion from 1990 to 2014, which were published in *The Lancet* in July 2016. The findings show a major decline of 41% in the incidence of abortion in developed regions in the past 25 years, from 46 down to 27 abortions per 1000 women annually, while there was a non-significant 5% reduction in developing countries (where 88% of the world’s abortions occur), from 39 down to 37 abortions per 1000 women annually. Globally, the rate has reduced from 40 to 35 abortions per 1000 women annually in that time span.



More information is available [here](#)

- 2** Training and preparatory work were completed for the launch of a multicountry, facility-based survey of abortion complications in 11 countries in Africa. This included finalization of the data-collection instruments, and two regional training workshops – one for Anglophone countries and one for Francophone countries. This survey aims to better measure the extent of the burden and severity of abortion-related complications, as well as capturing information about their management among women presenting to health-care facilities.

3



Medicine can be prescribed to help alleviate the physical pain that women may experience during and after abortion. In many contexts however, such medication can be expensive and difficult to access. So that health-care providers can be better informed about inexpensive and accessible medication options, HRP initiated a randomized controlled trial to determine the best pain control medication regimen for first-trimester medical abortion in three countries: Nepal, South Africa and Viet Nam.



The article is available [here](#)

4

When people lack awareness of national laws or misunderstand how they are applied, it can influence how they access health services. In recognition of this, HRP conducted a systematic review of women’s awareness of abortion laws in their own countries and the specific legal grounds and restrictions outlined in the laws. The findings, showed that correct general awareness among women about abortion laws was limited, even in countries where laws are less restrictive.



The article is available [here](#)

06

PROMOTING SEXUAL HEALTH AND WELL-BEING

Sexual health is much more than the absence of disease or infirmity. The current working definition of sexual health describes this as a “...a state of physical, emotional, mental and social well-being in relation to sexuality...; Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence”.

A wide range of issues affect people's sexual health and well-being worldwide, including reproductive tract and sexually transmitted infections (STIs), HIV and cervical cancer, in addition to sexuality-related human rights abuses, such as sexual coercion.

STIs represent a massive global burden of disease – more than one million people acquire an STI every day, which can have serious consequences beyond the immediate impact of infection itself. STIs like herpes and syphilis can increase the risk of HIV acquisition threefold or more, and mother-to-child transmission of STIs can result in a number of negative health outcomes for newborn infants, including stillbirth, congenital deformities and neonatal death. STIs can lead to social stigma and psychological distress, and can have an important impact on quality of life and sexual relationships. Cervical cancer, which is caused by sexually acquired infection with certain types of the human papillomavirus (HPV), is the second most common cancer in women living in low- and middle-income countries, and has a high rate of mortality.

A number of barriers prevent or deter people from receiving prompt and appropriate testing, diagnosis and care, and the most at risk – including adolescents – often do not have access to adequate health services. Sensitivities surrounding discussions of sexuality present challenges for the promotion of sexual health and well-being. More and better-quality research and data are needed to plan effective interventions and to advocate for resources to promote sexual health and well-being for couples and individuals.

SELECTED 2016 ACHIEVEMENTS IN SEXUALLY TRANSMITTED INFECTIONS (STIs)

1



The health sector response to STI epidemics is critical to the achievement of universal access to sexual and reproductive health services. Through HRP's leadership, WHO's new *Global health sector strategy on sexually transmitted infections 2016–2021* was adopted by the 69th World Health Assembly in May 2016. The strategy aims to end epidemics of STIs as major public health concerns through five strategic directions: information for focused action, interventions for impact, delivering for equity, financing for sustainability, and innovation for acceleration. The strategy prioritizes three STIs: gonorrhoea, syphilis and human papillomavirus.



The strategy is available [here](#)

2

Chlamydia, gonorrhoea and syphilis are three STIs that are all caused by bacteria and which can potentially be cured by antibiotics. Unfortunately, these STIs often go undiagnosed, and due to antibiotic resistance they are also becoming increasingly difficult to treat. Another STI, genital herpes, is caused by the herpes simplex virus, and can have a devastating effect on the social and psychological well-being of people who are infected. In addition, it can cause neonatal herpes when the virus is transmitted by a mother to a newborn infant during labour through shedding of the virus. In 2016, HRP led the launch of new WHO guidelines for treatment of these four STIs.



The treatment guidelines are available here:

[Gonorrhoea, chlamydia and syphilis](#)
[Genital herpes simplex virus](#)

3



A major barrier to the prevention and control of STIs is the unavailability of reliable, low-cost, rapid, point-of-care tests, which allow testing, diagnosis and treatment to be provided at a single visit to a health-care facility. In 2016, HRP completed nine research protocols to evaluate point-of-care tests for STIs, three of which were developed to evaluate the use of dual HIV and syphilis screening tests in clinics, among men who have sex with men.



More information about point-of-care diagnostic tests is available [here](#)

4

HRP has been part of major efforts in recent years to ensure that women get the treatment they need to keep themselves well and their children free from HIV and syphilis. Five countries were validated by WHO as having eliminated mother-to-child transmission of HIV and/or syphilis during 2015–2016: Cuba (both HIV and syphilis), Armenia (HIV only), Belarus (both), Republic of Moldova (syphilis only) and Thailand (both).




More information is available here:

[Cuba \(2015\)](#)
[Armenia, Belarus, Republic of Moldova and Thailand \(2016\)](#)


SELECTED 2016 ACHIEVEMENTS IN HUMAN PAPILOMAVIRUS (HPV) AND CERVICAL CANCER

- 1** In 2012, approximately 270 000 women died from cervical cancer, with more than 85% of these deaths occurring in low- and middle-income countries. Deaths from cervical cancer can be prevented if adolescent girls are immunized against HPV, and if cervical screening and treatment of precancerous lesions are available to women. With the vision of the elimination of cervical cancer as a global public health concern, the UN Joint Global Programme on Cervical Cancer Prevention and Control was formed by seven UN agencies, including WHO and HRP. This Global Programme aims to support governments in the development and implementation of sustainable, high-quality, national comprehensive cervical cancer control programmes.

 **More information on the UN Joint Global Programme on Cervical Cancer Prevention and Control is available [here](#)**

Young girl receives vaccination against HPV, in São Paulo, Brazil

- 2** HPV testing for primary cervical cancer screening of women over 30 years of age is likely to become the standard of care in the near future in many parts of the world. A single HPV test, however, has low positive predictive value (high rate of false positives), which can lead to unnecessary work and overtreatment and generate unnecessary distress. Thus, in areas where HPV testing is used for primary cervical screening, either with or without concomitant cytology, there is a need to define effective triage methods for women who test positive for HPV. HRP participates in the ESTAMPA multicentre study, which is being conducted at 11 sites in Latin America to compare visual, cytological and molecular triage methods, or combinations of these methods, in terms of their performance and cost-effectiveness among women participating in HPV-based screening programmes who test positive for HPV. So far, 16 500 women aged 30–45 years (of a total sample size of 50 000 women) have been enrolled and over 80% of HPV-positive women have undergone colposcopy procedures.

 **More information on the ESTAMPA multicentre study is available [here](#)**



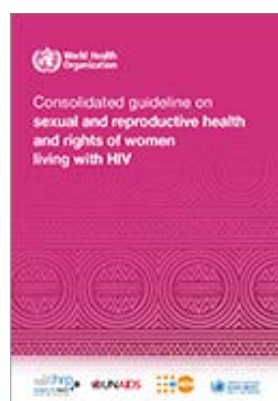
SELECTED 2016 ACHIEVEMENTS IN SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND HIV LINKAGES

1 In 2015, there were an estimated 17.8 million women and girls aged 15 and older living with HIV, constituting 51% of all adults living with HIV. HIV acquisition is driven by gender inequality, and HIV also further entrenches inequalities, leaving girls and women more vulnerable to its impact. In recognition of the need to prioritize the principles of gender equality and human rights to ensure the well-being of women living with HIV, in 2016 HRP finalized the *WHO Consolidated guideline on sexual and reproductive health and rights of women living with HIV*, which has been published in early 2017. This innovative guideline takes a woman-centred approach throughout to effectively address and represent the needs of girls and women living with HIV, as well as the needs of their families and communities.



More information about these linkages is available [here](#)

More information and a link to the guideline is available [here](#)



SELECTED 2016 ACHIEVEMENTS IN SEXUAL ORIENTATION AND GENDER IDENTITY

1 A review of systematic reviews was conducted by HRP researchers to identify evidence and knowledge gaps on the disease burden – including communicable and noncommunicable diseases, mental health conditions and violence – among individuals with a wide range of sexual orientations, physical characteristics, and gender identities and expressions. The review indicated that “there is a high burden of disease for certain subpopulations of SGM [sexual and gender minorities] in HIV, STIs, STI-related cancers and mental health conditions, and that they also face high rates of violence”. The knowledge gaps revealed are due to a lack of both original research and systematic and literature reviews about the disease burden in sexual and gender minorities. More information is also needed on the barriers that these minorities face in accessing health services.



07

SEXUAL AND REPRODUCTIVE HEALTH IN DISEASE OUTBREAKS

The urgent and coordinated responses to Ebola and Zika virus diseases have shown that disease outbreaks and their associated consequences present a number of significant challenges to sexual and reproductive health and rights.

During 2014–2015, countries affected by the Ebola outbreak struggled to control the escalating outbreak against an existing backdrop of high maternal, newborn and child mortality, and a low rate of skilled birth attendance. Fragmented health systems significantly reduced access to routine health services, in particular to essential maternal and newborn care.

A growing volume of data from careful clinical observation and testing of people who have recovered from acute Ebola virus disease indicates that the Ebola virus can persist at various sites in the body for many months in some people. Such sites include the inside of the eye, semen, amniotic fluid, breast-milk, the placenta and the central nervous system. Sexual transmission of the Ebola virus, from males to females, is a strong possibility, but has not yet been proven. Less probable, but theoretically possible, is female-to-male transmission.

More information is available [here](#)

While Zika virus infection in pregnancy is typically a mild disease, an unusual increase in cases of congenital microcephaly, Guillain-Barré syndrome and other neurological complications in areas where outbreaks have occurred has raised concerns about the health and safety of pregnant women and their families. In addition, while Zika virus is primarily transmitted to people through the bite of an infected mosquito from the *Aedes* genus, mainly *Aedes aegypti* in tropical regions, a growing body of evidence shows that sexual transmission of Zika virus is also possible. This is of concern due to an association between Zika virus infection and adverse pregnancy and fetal outcomes.

More information is available [here](#)

SELECTED 2016 ACHIEVEMENTS IN EBOLA VIRUS DISEASE

1

More surveillance data and research are needed on the risks of sexual transmission of Ebola virus disease, and particularly on the prevalence of viable and transmissible virus in semen over time. HRP and WHO updated the *Interim advice on the sexual transmission of the Ebola virus disease*.



The updated advice is available [here](#)



SELECTED 2016 ACHIEVEMENTS IN ZIKA VIRUS DISEASE

1



WHO published new interim guidance, *Pregnancy management in the context of Zika virus infection*, developed by HRP. This guidance recommends actions for preventing Zika virus infection, antenatal care and management of women with Zika infection, including interventions to manage potential complications during pregnancy, and care for all pregnant women living in Zika-affected areas, with the aim of optimizing health outcomes for mothers and newborns.



The interim guidance is available [here](#)

2



HRP led the development and update of the interim WHO guidance *Prevention of sexual transmission of Zika virus*, including new evidence and advice. Published with the aim of helping to inform the general public, the guidance can also be used by health workers and policy-makers to provide advice on safer sexual practices in the context of Zika virus.



Updated interim guidance is available [here](#)

3



HRP collaborates with other researchers to understand the causal links between Zika virus and a range of neurological disorders, within a rigorous research framework. In 2016, a statement was published and updated: *Zika virus infection: update on the evidence for a causal link to congenital brain abnormalities and Guillain-Barré syndrome*.



The statement is available [here](#)

4

The causal link between Zika virus infection and congenital malformations and occurrences of Guillain-Barré syndrome has been established, yet many key research and public health questions related to these issues need further investigation. With the aim of inspiring researchers to follow a common approach and to reduce bias in research, HRP led WHO in publishing seven research protocols. Specifically, data collected under the standardized protocols will be used: to refine and update recommendations for preventing the spread of the Zika virus; for surveillance and case definitions for microcephaly; to help understand the spread and severity of the virus, as well as its impact on the community; and to guide public health measures, particularly for pregnant women and couples planning a pregnancy. These protocols have also been designed to maximize the likelihood that data and biological samples are systematically collected and shared rapidly in a format that can be easily aggregated, tabulated and analysed across many different settings globally.



The generic protocols are available [here](#)



08

HEALTHY ADOLESCENCE FOR A HEALTHY FUTURE

Adolescence is the period of life that encompasses the transition from childhood to adulthood. WHO defines adolescents as people aged between 10 and 19 years old, while recognizing that age is only one characteristic that defines this critical period of rapid human development.

Behaviour and choices made during this time can determine a person's future health and well-being.

Adolescents across the world face considerable challenges to their sexual and reproductive health and rights. These include a lack of education and information; high rates of early and unwanted pregnancy; lack of access to health services, especially for contraception and safe abortion; gender inequalities and harmful traditional practices, such as female genital mutilation, and child, early and forced marriage; risk of infection with sexually transmitted infections (including HIV); sexual coercion and intimate partner violence.

More research is needed to develop and test adolescent sexual and reproductive health interventions, and to rigorously evaluate ongoing projects and programmes.



SELECTED 2016 ACHIEVEMENTS IN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

1



An improved understanding of adolescents' sexual and reproductive health needs can contribute to better safeguarding of adolescents' well-being. There is a particular need for data on adolescents' contraceptive service and information needs, and these data should be broken down by age and marital status, wherever possible, to be most useful for programme planning and monitoring. In recognition of this, HRP launched a set of fact sheets which disaggregate existing data to highlight key information on the use and non-use of contraceptives by adolescents aged 15–19, by marital status, in 58 low- and middle-income countries across the world.



The fact sheets are available [here](#)

2



A systematic review and synthesis of evidence on pharmacy provision of sexual and reproductive health commodities to young people was published. Key findings showed that with training and support, pharmacy personnel can serve as critical resources to young people. The lead author, an HRP staff member, won the Young Scientist Award for her presentation of the findings at the 2nd Global Conference of the European Society of Contraception and Reproductive Health in Basel, Switzerland, in May 2016.

3



New research by HRP, published as a set of systematic reviews, showed that there is a range of different interventions that can help to improve sexual and reproductive health outcomes in young people aged 10–24, but there is no single action or intervention which works for all young people everywhere, to address all of their needs.



More information is available [here](#)

4



Since May 2014, HRP has supported the adaptation in Brazil of a prototype online version of the *Quality assessment guidebook: a guide to assessing health services for adolescent clients*, originally published by WHO in 2009. This version of the guidebook allows data to be collected digitally to assess the quality and youth-friendliness of health services for adolescents. In 2015–2016, 45 health-care facilities in five states undertook a study to determine how often the quality assessment tool should be implemented. The results indicated that an annual cycle of assessment and feedback would be the best option.



09


PREVENTING AND RESPONDING TO VIOLENCE AGAINST WOMEN AND GIRLS

Violence against women and girls constitutes a major public health concern, and is a grave violation of human rights. WHO estimates indicate that, worldwide, about one woman in every three has experienced physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.

Violence against women takes multiple forms, and includes intimate partner violence; sexual violence; female genital mutilation; child, early and forced marriage; femicide; and trafficking.

Violence against women and girls can lead to a range of adverse physical, mental and psychosocial health outcomes, including negative impacts on sexual and reproductive health. Intimate partner violence and sexual violence can lead to unintended pregnancies, induced abortions, gynaecological problems, and sexually transmitted infections, including HIV. Intimate partner violence in pregnancy also increases the likelihood of miscarriage, stillbirth, preterm delivery and low-birth-weight infants. Conflict and post-conflict situations, including displacement, can exacerbate violence against women and girls and may present the risk of additional forms of violence.



 **More infographics
are available [here](#)**

SELECTED 2016 ACHIEVEMENTS IN VIOLENCE AGAINST WOMEN AND GIRLS

1

Global Plan of Action: Health systems address violence against women and girls



When health systems and health-care providers are strengthened, this can have a significant positive impact on the health and well-being of girls and women. HRP led the development of the *Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children*, which was endorsed by WHO Member States at the 69th World Health Assembly in May 2016. Four strategic directions are proposed that address both the health system mandate of the plan and the public health approach to addressing interpersonal violence: strengthen health system leadership and governance; strengthen health service delivery and health workers' capacity to respond; strengthen programming to prevent interpersonal violence; and improve information and evidence. The implementation of this global plan of action is expected both to improve the provision of care and support to girls and women who are survivors of violence, and to better facilitate cross-sectoral work to prevent violence.



The global plan of action is available here:

[Full version](#)
[Booklet](#)

Other resources on violence against women are available [here](#)

2

Ethical and safety recommendations for intervention research on violence against women

Building on lessons from the WHO publication *Putting women first: ethical and safety recommendations for research on domestic violence against women*



The sensitive nature of research on violence against women and girls requires special ethical and safety considerations. In recognition of this, as well as the need to provide guidance for research into the interventions that work to address violence against women and girls, HRP published new *Ethical and safety recommendations for intervention research on violence against women: building on lessons from the WHO publication "Putting women first: ethical and safety recommendations for research on domestic violence against women"*.



The new recommendations are available [here](#)

3

HRP tested a counselling intervention for pregnant women who have experienced recent intimate partner violence, using a randomized controlled trial implemented in the context of antenatal care services in Johannesburg, South Africa. More than a quarter of all the antenatal care attendees screened positive for such violence and were subsequently enrolled in the *Safe and Sound* study in 2014 and 2015. Preliminary results show that the intervention was effective: at follow-up (6–14 weeks after birth), women who had received the empowerment counselling were significantly less likely to have experienced intimate partner violence during the study period, and also had improved scores on anxiety, depression, uptake of community resources and self-efficacy, compared to women in the control group.



The article is available [here](#)

SELECTED 2016 ACHIEVEMENTS IN FEMALE GENITAL MUTILATION

1 Health-care providers across the world need to be prepared to provide care to girls and women who have undergone female genital mutilation (FGM). Many providers are unaware of the potential negative physical and mental health consequences of FGM, and are often inadequately trained to recognize and properly treat these conditions. As a result, girls and women can suffer needlessly from the negative physical and mental health consequences of this harmful practice. In recognition of this, HRP published new *WHO guidelines on the management of health complications from female genital mutilation* to equip health-care providers with the necessary information, and to ensure that the millions of women and girls who have undergone this harmful practice get the help they need.

An accompanying policy brief was also published, to reach policy-makers and ministry of health professionals and health systems managers in addition to health-care professionals, with current, evidence-based recommendations and best practice statements on the management of health complications among girls and women living with FGM.



The guidelines and policy brief are available [here](#)

More information is available [here](#)

According to new WHO guidelines, health-care providers need to know:

Female genital mutilation is:

- ✓ a **violation of human rights**
- ✓ **must never be performed** Not even by a health-care provider.

#endFGM

According to new WHO guidelines, health-care providers need to know:

How to provide **accurate and clear information** to clients with female genital mutilation

What to do when **asked to perform** female genital mutilation on a client

#endFGM

According to new WHO guidelines, health-care providers need to know how to:

Treat the health conditions that may affect women with female genital mutilation

- Gynecological complications** such as menstrual problems, pelvic pain
- Obstetric complications** such as difficult labour
- Mental health disorders** such as depression, anxiety
- Sexual dysfunction** such as painful intercourse

#endFGM

Health-care providers play an important role in the treatment and care of the **200 million girls and women** around the world living with **female genital mutilation**.

World Health Organization → Share to care. Learn more at www.who.int/reproductivehealth

10

PROTECTING AND SECURING HEALTH WITH HUMAN RIGHTS

Human rights are fundamental to the health of individuals, couples and families, and to the social and economic development of communities and nations. Human rights abuses continue to seriously undermine health, particularly for women and girls. Such abuses include harmful traditional and cultural practices such as female genital mutilation and child, early and forced marriage.

Violence against women and girls remains the most frequent human rights abuse worldwide.

Persistent inequalities mean that women, adolescents and children – particularly those who are poorer and living in hard-to-reach areas, and those living in emergency or crisis situations – often do not have equal access to key sexual and reproductive health services. This can have grave consequences for health and well-being, and can even result in death.

There are now over 125 million people in need of humanitarian assistance, a fivefold increase from only a decade ago. Of some 100 million people who were targeted in 2015 with humanitarian aid, an estimated 26 million were women and girls of reproductive age. Women and girls are affected disproportionately in both sudden and slow-onset emergencies, and they face diverse challenges to their sexual and reproductive health and well-being.

The Global Strategy for Women's, Children's and Adolescents' Health underlines how, in order to achieve the vision of the Sustainable Development Goals to "leave no one behind", it is imperative to protect and improve women's, children's and adolescents' health and well-being at times of emergencies and in the context of humanitarian settings.



SELECTED 2016 ACHIEVEMENTS IN HUMAN RIGHTS AND GENDER EQUALITY

1



In working to help expand access to health and human rights for women, children and adolescents everywhere, HRP helped to establish the High-Level Working Group for the Health and Human Rights of Women, Children and Adolescents. Housed by WHO and the Office of the United Nations High Commissioner for Human Rights (OHCHR), the Working Group responds to the call of the Sustainable Development Goals to “leave no one behind”.



More information on the Working Group is available [here](#)

2

The importance of promoting gender equality and human rights in sexual and reproductive health programmes and policies has been highlighted in the agenda of the Sustainable Development Goals. In recognition of the critical role played by research in determining what works, HRP staff co-authored a systematic review aimed at identifying research gaps relating to gender equality and human rights in sexual and reproductive health programmes and policies. The review highlighted that while progress has been made over the past 15 years, fundamental gaps remain, which include, among others, a need for more research on human-rights-based interventions, as well as a need to strengthen research methods and measurement of outcomes to capture long-term, sustained changes in sexual and reproductive health behaviours and outcomes.



More information is available [here](#)

3

Identifying human rights norms and standards related to the mistreatment of women during facility-based childbirth is a first step towards ensuring respectful and humane treatment, and is crucial for improving the overall quality of maternal care. In November 2016, researchers at HRP published “International human rights and the mistreatment of women during childbirth” in the *Health and Human Rights Journal*. This review of relevant international and regional human rights standards and laws also lays out an agenda for further research and action.



More information is available [here](#)

4

HRP undertook successful pilot-testing in Kenya, Nigeria and the United Republic of Tanzania of new tools supporting rights-based quality of care for family planning and new tools for monitoring of family planning programmes and services. Based on the results of the pilot-testing, the tools were further revised and finalized. Workshops are planned for implementation and dissemination of the tools in 2017.

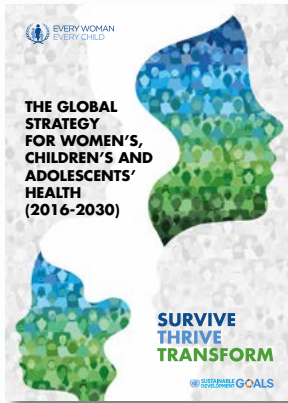
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HRP worked with the UNFPA country offices in Kazakhstan and Kyrgyzstan and the WHO Regional Office to build capacity of officials at the ministries of health to ensure human rights in family planning services. The meeting, which was held in Bishkek in November 2016, led to the development of national plans for implementation of a rights-based approach to family planning.



SELECTED 2016 ACHIEVEMENTS IN HUMANITARIAN SETTINGS

- 1** HRP is providing leadership and expertise on humanitarian settings for the Global Strategy on Women's, Children's and Adolescents' Health and its five-year implementation plan.



- 2** The *Inter-agency field manual on reproductive health in humanitarian settings*, published in 2010, was the result of a collaborative and consultative process engaging over 100 members of the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises, representing UN agencies and nongovernmental organizations. In 2016, the IAWG led a review of the field manual, to which HRP contributed. In particular, HRP provided expert input for the Minimum Initial Service Package (MISP) for Reproductive Health, as well as to the chapter on newborn care.



The manual is available [here](#)



11

SUPPORTING AND STRENGTHENING NATIONAL HEALTH SYSTEMS

Many countries across the world lack the necessary human resources and infrastructure to undertake crucial research in sexual and reproductive health and rights.

As the only body within the United Nations system with a global mandate to work on strengthening research capacity in sexual and reproductive health and rights, the HRP Alliance promotes and funds research, training, institutional development and networking to increase the capacity of low- and middle-income countries, with the aim of creating new knowledge on sexual and reproductive health and rights.

In addition, HRP ensures that scientific evidence is developed, shared and used by decision-makers to inform best practice in national health systems. Rigorous measuring and monitoring are essential to develop scientifically accurate evidence. This is required to inform norms and standards to guide provision of safe, effective, equitable and acceptable sexual and reproductive health services. Digital and mobile health innovations research and tools are increasingly needed to improve the efficacy, accuracy and ease of data collection, as well as the delivery of sexual and reproductive health interventions.

HRP continues to work with parliamentarians in recognition of their critical role in bridging the gaps between research, best practices, policy and resource allocations. Parliamentarians represent the interests of people and government, help to formulate and scrutinize legislation, and influence the use of resources. They can therefore act as powerful advocates for sexual and reproductive health and human rights.

Parliamentary forums, such as the Inter-Parliamentary Union (IPU), and regional platforms, including the Pan African Parliament and the European Parliamentary Forum, continue to provide valuable opportunities for engaging parliamentarians in global initiatives to improve health and well-being. Parliamentarians continue to be crucial advocates for promoting the health of women, children and adolescents, including sexual and reproductive health, and for holding national governments to account.

SELECTED 2016 ACHIEVEMENTS IN RESEARCH CAPACITY STRENGTHENING

1 Five institutions located in Brazil, Burkina Faso, Lithuania, Morocco and Thailand were endorsed by the HRP Alliance as the first resource centres (regional hubs) to lead regional research capacity strengthening. These regional hubs will be supported to reach the status of independent regional leaders in sexual and reproductive health and rights implementation research and knowledge translation.

2 Collaboration with the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) has been expanded to include a joint call for applications for small research grants supporting community-based research on Zika virus, linked to research capacity strengthening, as well as joint activities and student exchanges related to education and training in implementation research.

3 Donors and stakeholders are increasingly recognizing the value and impact of funding for health research. To ensure alignment of the efforts of all the donors and stakeholders active in research capacity strengthening, the ESSENCE on Health Research initiative was established in 2008. In acknowledgement of our work in this area, HRP is now represented on the Steering Committee for ESSENCE.



More information on ESSENCE on Health Research is available [here](#)



SELECTED 2016 ACHIEVEMENTS IN MEASURING AND MONITORING

1



Systematic measurement is needed to support a better understanding of the negative, yet non-life-threatening, complications that can affect women's health and well-being during and after pregnancy and childbirth. This will give countries the necessary information to improve health systems and services, so that women and their infants receive good-quality health care. In recognition of this, HRP developed a measurement tool – a novel approach to describe and quantify maternal morbidity – which was subsequently tested at health-care facilities. The pilot study was carried out in three sites (one each in Jamaica, Kenya and Malawi) and involved 1490 pregnant and postpartum women.

2

The Mother and Newborn Information for Tracking Outcomes and Results (MONITOR) technical advisory group was established jointly by HRP and the WHO Department of Maternal, Newborn, Child and Adolescent Health. The first MONITOR meeting was convened 8–9 November 2016 in Geneva, Switzerland, and included a group of 14 technical experts in the measurement of maternal and newborn health outcomes. Working with key stakeholders, the MONITOR technical advisory group will act as an advisory body to WHO on matters of measurement, metrics and monitoring of maternal and newborn health for the two departments. In addition, the technical advisory group will recommend strategies for harmonization of maternal and newborn health measurement efforts and provide a forum for sharing the latest strategies for improving national capacities for monitoring and evaluation of maternal and newborn health, and for the use of the data.

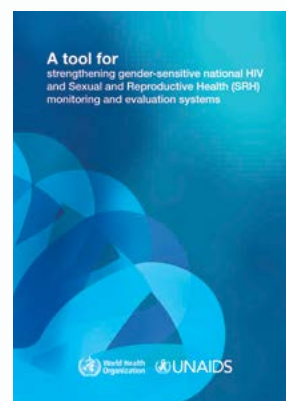
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As part of monitoring efforts for the Sustainable Development Goals, HRP harmonized the WHO and UNICEF databases and developed a joint global database for monitoring the proportion of births attended by skilled health personnel, which is one of the indicators for target 3.1: "By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births". To achieve this harmonization, WHO and UNICEF have come to an agreement on the methods of analysis and the interpretation of data obtained from various sources. This means that, although in the past discrepancies were noted, from now on the figures for this indicator that are published by UNICEF and WHO (and reported across the UN system) will be the same, per country and per reporting cycle.

4

While gender inequality affects many health conditions and outcomes, nowhere is it more pronounced than in matters of sexuality and reproduction. Hence, programmes and policies to address the health of women and girls, particularly their sexual and reproductive health and HIV status, must be informed by evidence and must address gender inequality. In recognition of this, HRP published *A tool for strengthening gender-sensitive national HIV and sexual and reproductive health (SRH) monitoring and evaluation systems*.



The tool is available [here](#)

SELECTED 2016 ACHIEVEMENTS IN DIGITAL HEALTH

1



The Open Smart Register Platform (OpenSRP) is a software system that supports front-line health workers to electronically register and monitor data on the health of their clients. Using mobile phones or tablets, the system frees health workers from cumbersome paperwork and helps to ensure that every individual is reached with essential health interventions appropriate to their needs. HRP's OpenSRP is being developed by a consortium of partners, led by the WHO Department of Reproductive Health and Research, including HRP, as a component of the THRIVE research study. mPower Social Enterprises Ltd, based in Dhaka, Bangladesh, uses OpenSRP (branded locally as "mTika") to help health workers better manage their clients by using real-time information to ensure timely vaccination. In recognition of the potential of this free and open-source software to improve the health of children, UNICEF has awarded the Bangladesh-based enterprise with an Innovation Fund in support of their pioneering efforts on vaccination.



More information on the award is available [here](#)

OpenSRP [website](#)

2

Adequate documentation and effective coordination of digital health tools are increasingly important in efforts to systematically plan for digital health investments. The Ebola outbreak of 2014 highlighted the potentially severe consequences of uncoordinated digital investments, which resulted in failure to provide needed data, misalignment with health system needs, and duplication of effort and investments. To address this problem, HRP developed the Digital Health Atlas – a web-based inventory tool for curating digital health implementations, detailing the health issues addressed, and graphically mapping the availability of different digital tools in each country.

3



A major obstacle to the scale-up and widespread adoption of mobile health (mHealth) innovations has been a lack of standard criteria for reporting findings from mHealth research and implementation. To address this need, HRP collaborated with Johns Hopkins Global mHealth Initiative to develop a checklist of standard criteria for reporting interventions using mobile phones: the mobile health (mHealth) evidence reporting and assessment (mERA) checklist.



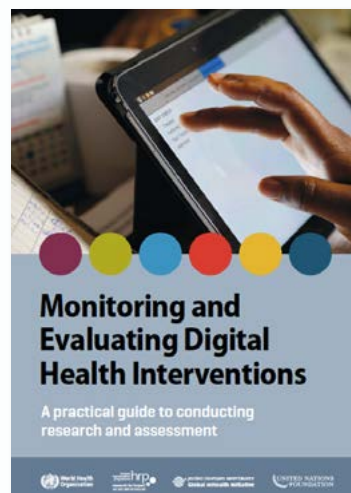
More information on the mERA checklist is available [here](#)

4

In 2016, HRP launched new step-by-step guidance to improve the quality and value of monitoring and evaluation efforts in the context of digital health interventions: *Monitoring and evaluating digital health interventions: a practical guide to conducting research and assessment*.



All materials can be freely downloaded [here](#)




5



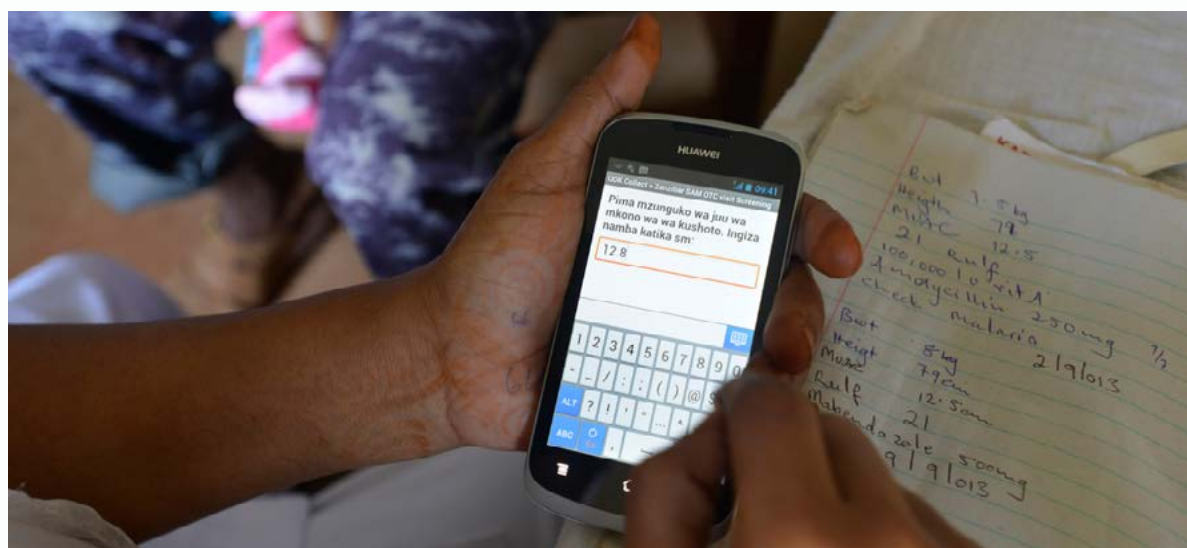
6



The Health Data Collaborative is a global initiative aimed at improving coordination of investments for monitoring the health-related Sustainable Development Goals. HRP co-chairs the Digital Health and Interoperability Working Group within the Health Data Collaborative, which comprises over 100 participants from dozens of UN and donor agencies, implementation partners and private sector groups. This Working Group helps countries make well informed investments in interoperable digital health information systems that have a proven impact on health, as well as investments to ensure monitoring and accountability. This work contributes to coordinated investments, reduction in duplication of effort, and wider adoption of digital health systems that are effective and sustainable.

 More information is available at the [Health Data Collaborative website](#)

HRP published a series of articles on the value and role of digital reproductive health registers, which provide an overview of how they work, which software is required, details of their value, a synthesis of the evidence in support of them, and what is required to implement them.



SELECTED 2016 ACHIEVEMENTS IN WORKING WITH DECISION-MAKERS

1



With the aim of assisting parliamentarians in their efforts to end child, early and forced marriage through legislation, and in order to improve the health of children and young girls in their countries, HRP collaborated with the IPU to review legislation on child, early and forced marriage in 37 countries in the Asia-Pacific region. The review, which was published in 2016, identified both good practices and barriers to implementing laws against child, early and forced marriage. It also introduced important findings and recommendations for further advancing parliamentary engagement in efforts to end child, early and forced marriage.



The publication can be downloaded [here](#)

2

HRP represents WHO as a member of the IPU Advisory Group on Health. This group has a specific focus on women's, children's and adolescents' health, and aims to improve understanding of parliamentary processes that can help to improve global health, and to increase national investment in health. Through this collaboration, HRP provides technical support to parliamentarians in the development and implementation of health-related multilateral agreements, resolutions, declarations and other legislative tools.

3

HRP has been instrumental in improving engagement with parliamentarians through the World Health Assembly. The annual World Health Assembly provides a unique opportunity for parliamentarians to acquire information on the latest scientific evidence and global health priorities, to help guide their political activity. Under the leadership of HRP, the first ever event for parliamentarians was organized within the context of the 69th World Health Assembly in May 2016, which was attended by parliamentarians from more than 50 countries.

4



Thanks to HRP's collaboration with IPU, an addendum was adopted by the IPU General Assembly to the 2012 resolution titled *Access to health as a basic right: The role of parliaments in addressing key challenges to securing the health of women and children* on the role of Parliaments in securing women's and children's health as a basic right – the addendum brings the resolution into alignment with the UN's Global Strategy for Women's, Children's and Adolescents' Health.



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