

Sexual and reproductive health work at WHO

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World Health Organization

Geneva, 21 March 2007



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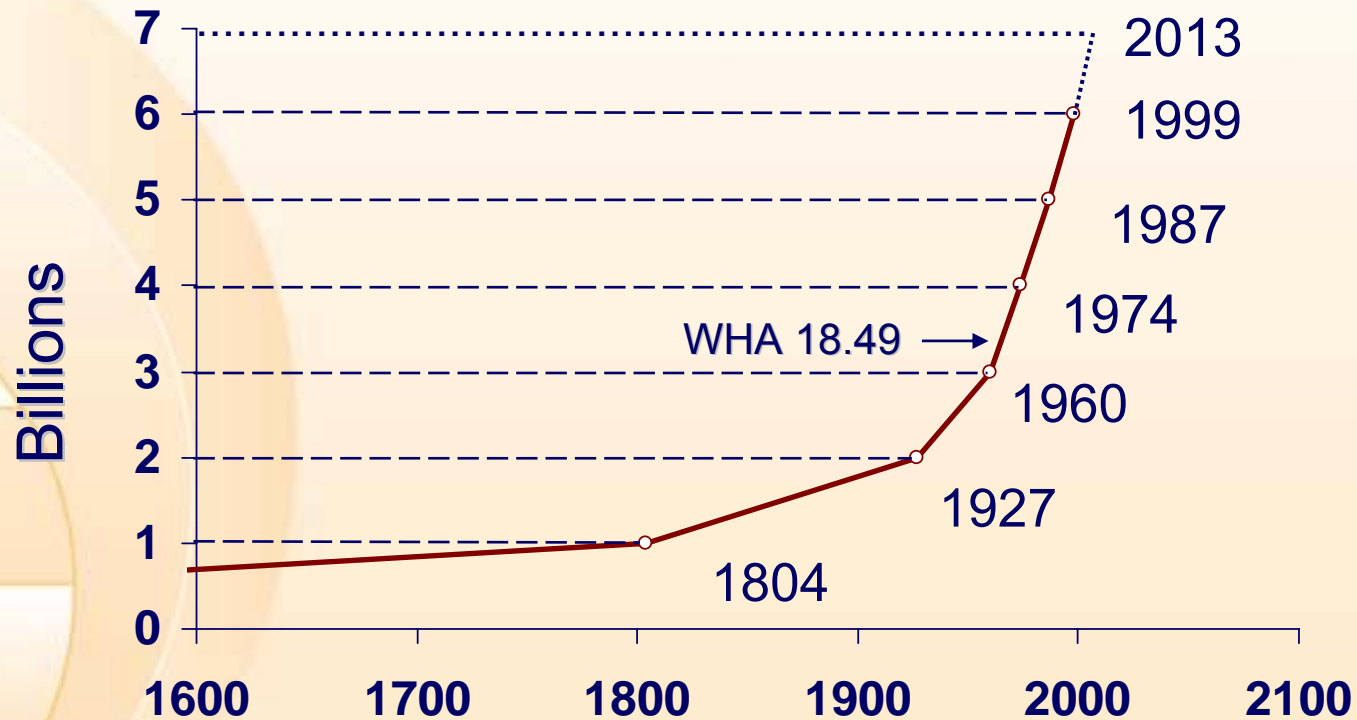


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How it began...



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HRP's history [1]

“REQUESTS the Director-General to develop further the programme proposed:

(a) in the fields of reference services, studies on medical aspects of sterility and fertility control methods and health aspects of population dynamics; ...”

(WHA Resolution 18.49; 1965)



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HRP's history [2]

- 1965:** Human Reproduction Unit within existing Division of Family Health (*WHA Resolution 18.49; 1965*)
- 1972-1988:** WHO (Expanded) Special Programme of Research, Development and Research Training in Human Reproduction
- 1988-present:** UNDP/UNFPA/WHO/World Bank cosponsored Special Programme (*WHA Resolution 41.9; 1988*)



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Department of Reproductive Health and Research (RHR)

- Created in November 1998
- Composed of two pre-existing entities
 - UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP)
 - WHO Division of Reproductive Health (Technical Support) (RHT)

$RHR = RHT (PDRH) + HRP$



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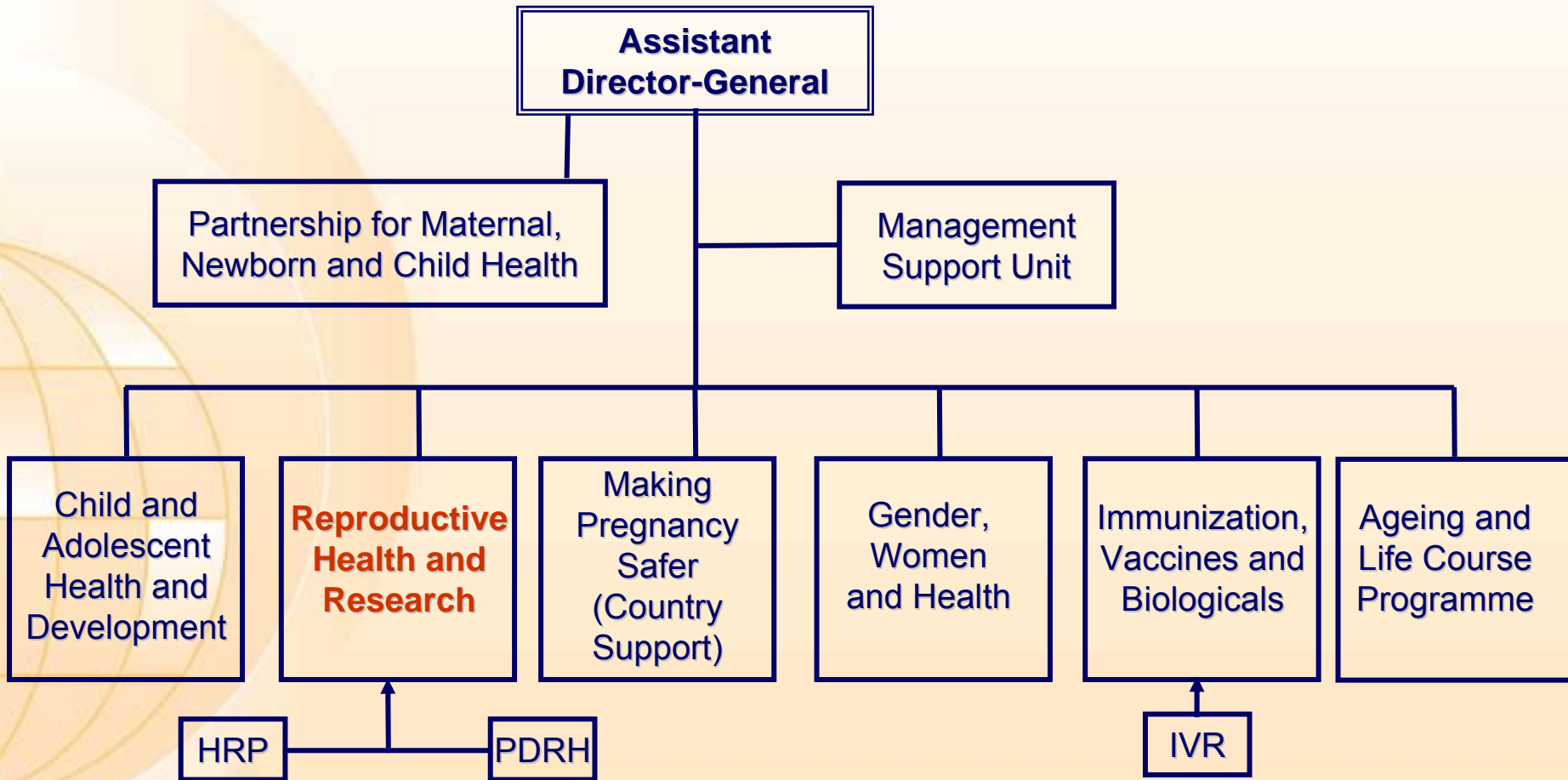


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Family and Community Health Cluster



The International Conference on Population and Development (Cairo, 1994)

The new conceptual framework

“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes...”

(ICPD Programme of Action, paragraph 7.2)



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Overall goal

“All countries should strive to make accessible through the primary health-care systems, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015.”

(ICPD Programme of Action, para. 7.6)



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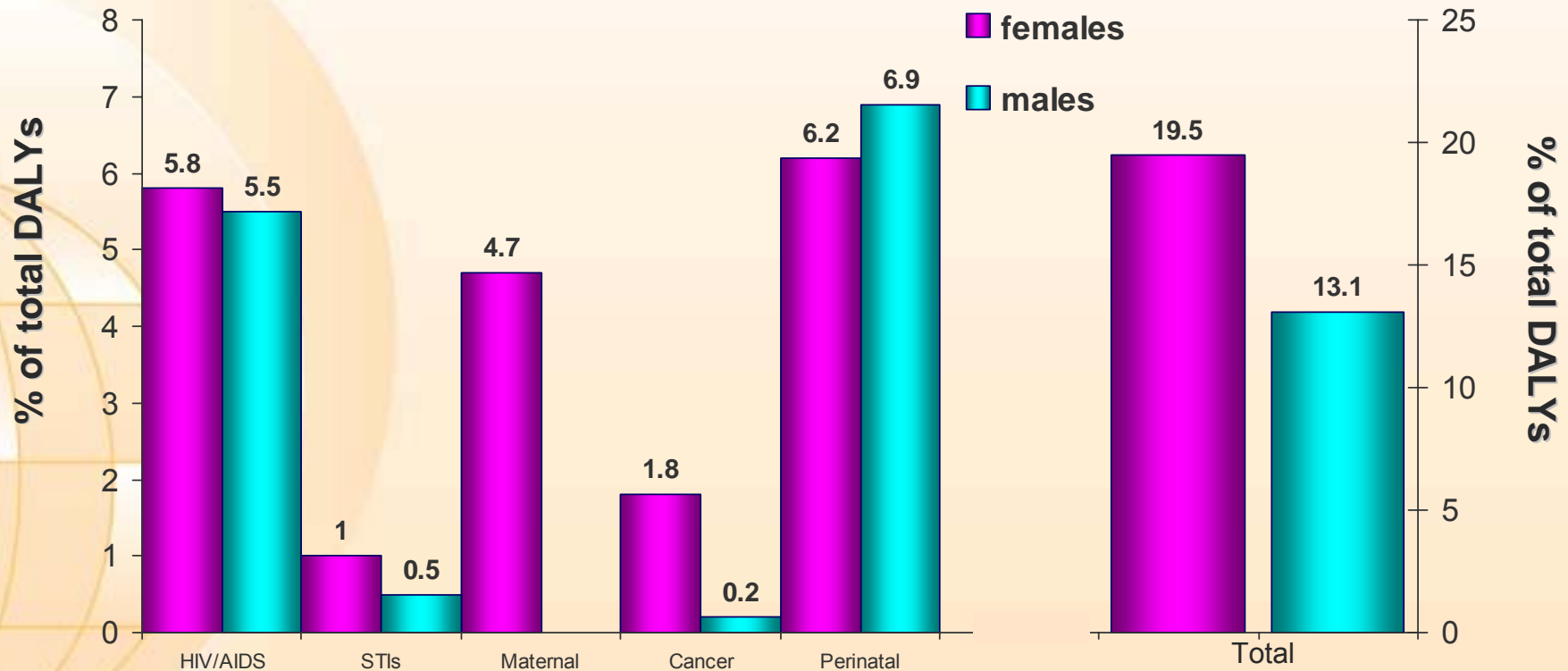


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Reproductive ill-health accounts for substantial portions of global burden of disease



(Source: World Health Report, 2004)



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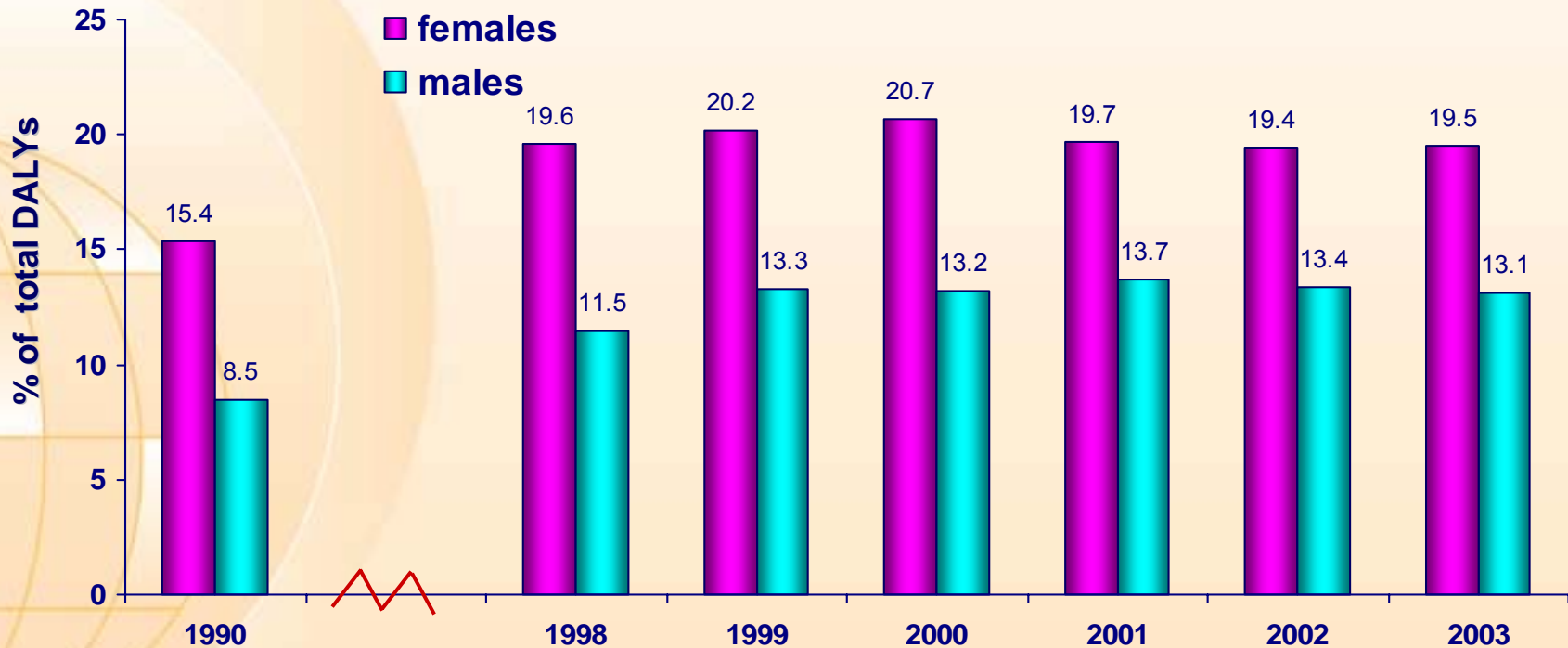


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Reproductive ill-health as proportion of global burden of disease shows no sign of declining



(Source: *The Global Burden of Disease, 1996 and World Health Reports, 1999-2004*)



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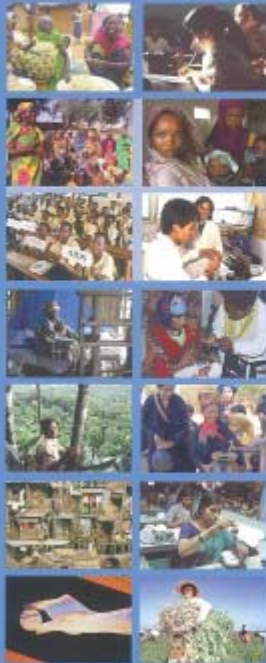


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Millennium Development Goals

- I. Eradicate extreme poverty and hunger
- II. Achieve universal primary education
- III. Promote gender equity and empowerment of women
- IV. Reduce child mortality
- V. Improve maternal health
- VI. Combat HIV/AIDS, malaria and other diseases
- VII. Ensure environmental sustainability
- VIII. Develop a global partnership for development





Investing in Development
A Practical Plan to Achieve the
Millennium Development Goals

Overview

"Sexual and reproductive health
– essential for reaching the Goals"

(pages 82-84)





"To this end we commit ourselves to:

...

- (g) Achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development, integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, ..."



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The final recognition of the role of sexual and reproductive health in achieving MDGs

“...I am therefore recommending the incorporation of these commitments [*i.e. those agreed at the 2005 World Summit*] into the set of targets used to follow up on the Millennium Declaration. This includes: ... a new target under Goal 5: to achieve universal access to reproductive health by 2015; ...”

Report of the Secretary-General on the work of the Organization,
General Assembly Sixty-first Session, 2 October 2006



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The WHO global reproductive health strategy was adopted by WHO's Member States in May 2004

An overview of the strategy paper

Guiding principle: human rights

Core aspects of reproductive and sexual health services

1. Improving antenatal, perinatal, postpartum and newborn care
2. Providing high-quality services for family planning, including infertility services
3. Eliminating unsafe abortion
4. Combating sexually transmitted infections including HIV, reproductive tract infections, and cervical cancer
5. Promoting sexual health



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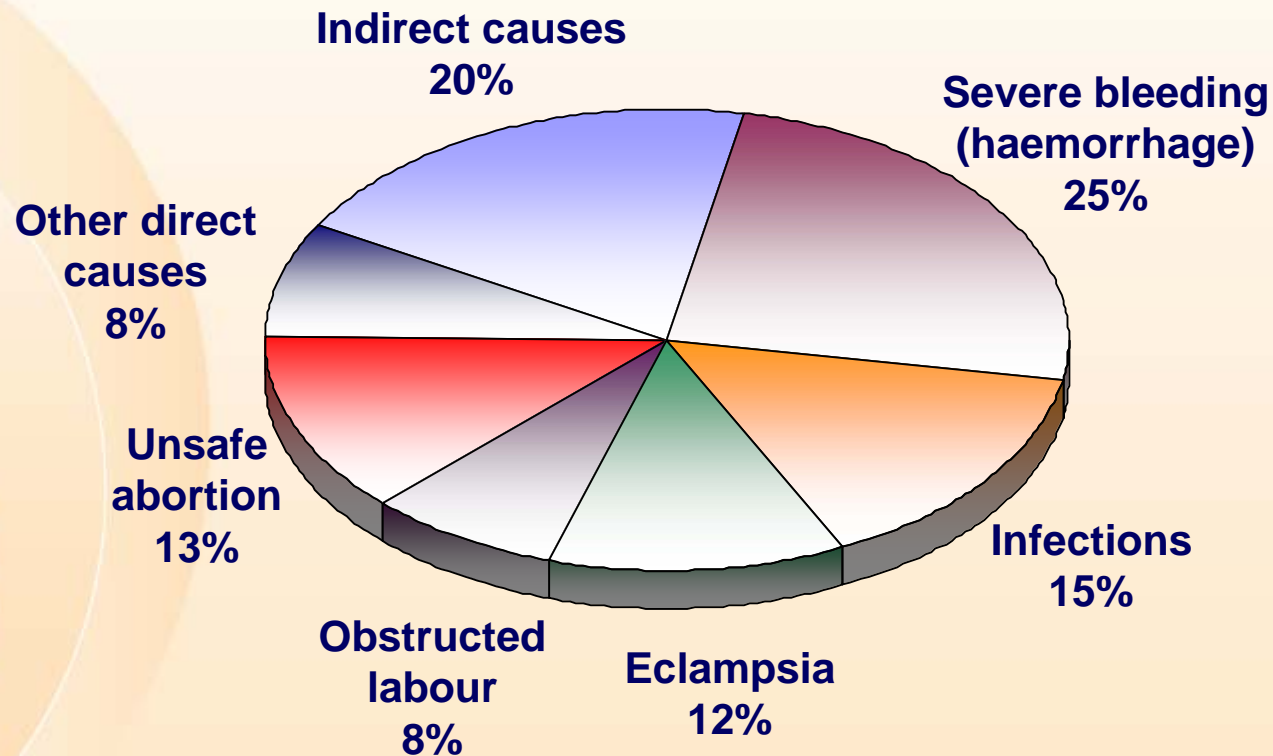
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Maternal and perinatal health today

- 529,000 women die each year during pregnancy, childbirth and postpartum period (> 99% in developing countries)
- over 300 million women suffer from short-term or long-term illness brought about by pregnancy and childbirth
- lifetime risk of maternal death in Africa is 1 in 16
- each year nearly 3.3 million babies are stillborn
- 4 million babies die during first 28 days of life (three quarters in the first 7 days)



Causes of maternal death^a



^a Total is more than 100% due to rounding.

(Source: World Health Report, 2005)



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Maternal and perinatal health research completed during 1995-2005 with leading participation of WHO

	Countries	Women	Status
Antenatal care	5	24 678	Published (2001)
Prevention of postpartum haemorrhage	9	18 530	Published (2001)
Treatment of pre-eclampsia (MAGPIE trial)	28	10 141	Published (2002)
Caesarean section	5	149 206	Published (2004)
Epidemiology of preterm delivery and IUGR	4	38 319	Published (2004)
Prevention of pre-eclampsia (calcium supplementation)	6	8 325	Published (2006)
WHO Reproductive Health Library	2	77 765	Published (2007)
<i>Long term follow-up of infants:</i>			
Calcium trial I	1	591	Published (1997)
Magpie trial	19	3 283	Published (2007)
Calcium trial II	2	800	Submitted
Total	25 *	331 638	

* Some countries have been involved in more than one study



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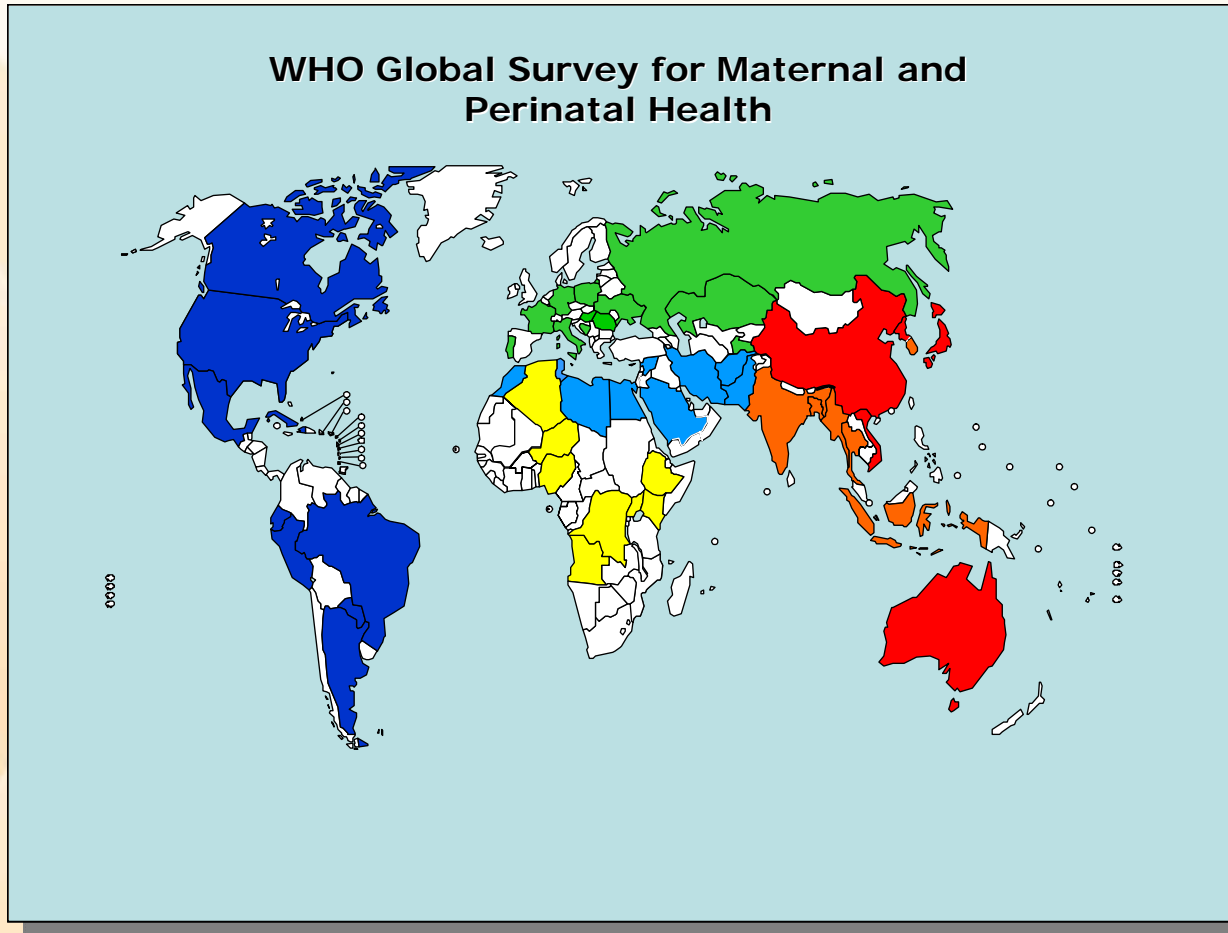
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Maternal and perinatal health research ongoing with leading participation of WHO

	Countries	Women	Status
Prevention of preeclampsia (anti oxidants)	4	1365	Data analysis
Treatment of asymptomatic bacteriuria	4	1500	Ongoing
Treatment of postpartum haemorrhage	4	900	Ongoing
Prevention of preeclampsia (treatment of hypertension)	6	2000	Initiated
WHO Global Survey of Maternal and Perinatal Health			
- Latin America	8	97 184	Published and further analysis ongoing
- Africa	7	81 961	Data analysis



WHO Global survey



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WHO Global Survey - Microsoft Internet Explorer provided by WHO

File Edit View Favorites Tools Help

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Y! Search Web NEW Toolbar Update Mail My Yahoo! Games Basketball Personals Music

mywebsearch Search Screensavers Cursor Mania PopSwatter Games My Info Customize My Button 1



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WHO Global Survey on Maternal and Perinatal Health



Login form for all regions

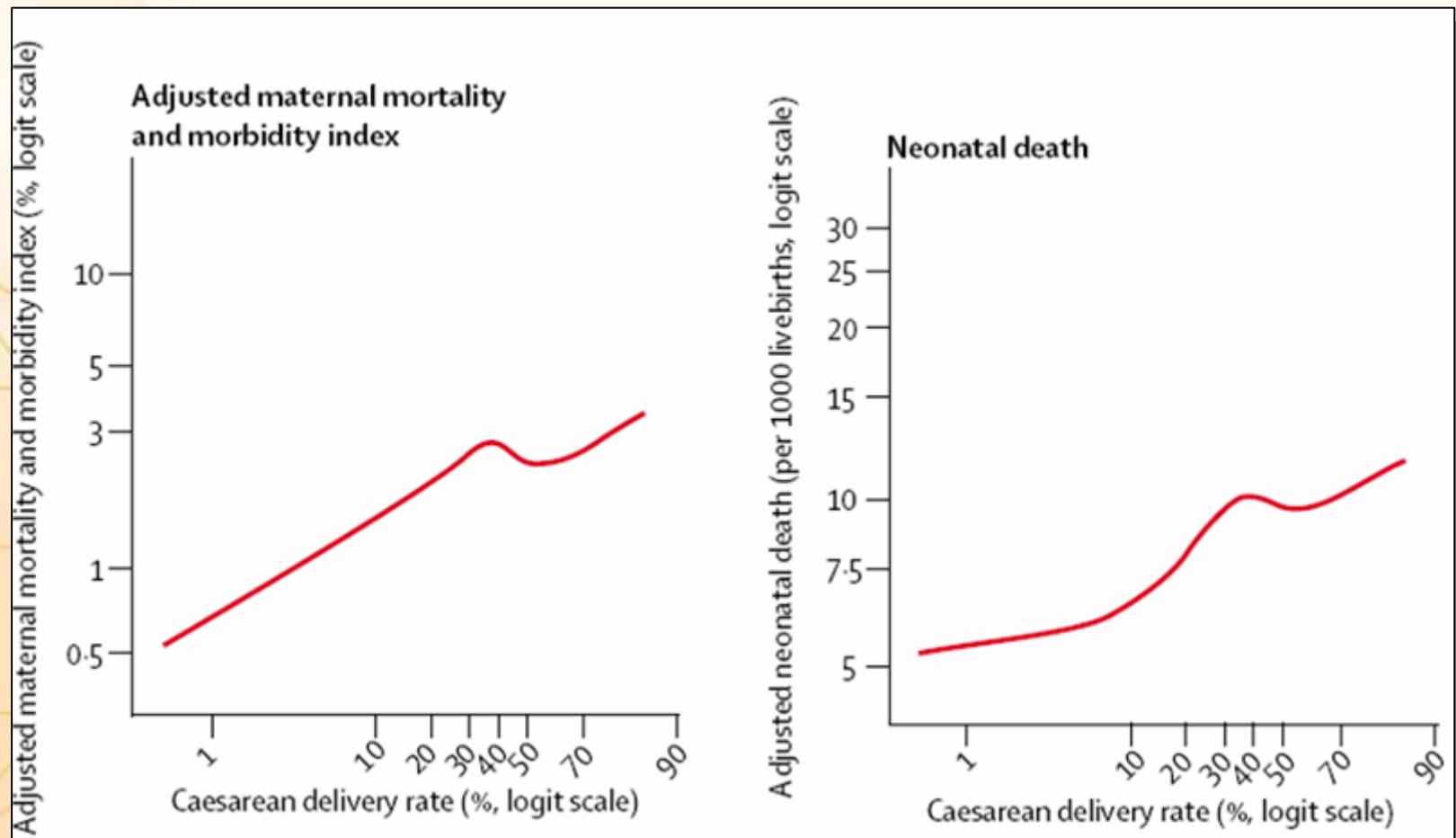
 Please login here if your favorite language is English. After logging in, you will have access to the WHO survey database. All information will be presented in the language you were registered in by your regional coordinator. [Login](#)

 Entrez ici s'il vous plaît si votre langue préférée est le français. Vous aurez accès à la banque de données sur l'enquête de l'O.M.S. Toutes les informations vous seront présentées dans la langue à laquelle vous avez été enregistré par votre coordonnateur régional. [Entrez](#)

 Por favor, regístrate aquí si su idioma de preferencia es el español. Luego de registrarse, tendrá acceso a la base de datos de la encuesta de la OMS. Toda la información estará en el idioma en el que [Entre](#)

start | Internet | Inbox - Microsoft O... | M & E MPS present... | Microsoft PowerPoi... | WHO Global Survey... | EN

2005 Global Survey results – Latin America (n= 97095 deliveries)



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Relationship between caesarean delivery and intrapartum fetal death according to fetal presentation

	n / N	OR (95% CI)
Cephalic Presentation		
Vaginal delivery (Reference level)	242/61870	1.0 ⁽¹⁾
Elective CD vs. Vaginal delivery	35/11300	0.7 (0.4 – 1.0)
Intrapartum CD vs. Vaginal delivery	73/16543	1.3 (0.9 – 1.7)
Breech and Other Presentations		
Vaginal delivery (Reference level)	53/547	1.0 ⁽²⁾
Elective CD vs. Vaginal delivery	18/1874	0.3 (0.1 – 0.5)
Intrapartum CD vs. Vaginal delivery	14/2043	0.2 (0.1 – 0.4)

(1) odds ratios adjusted by gestational age, maternal age, education, previous stillbirth or neonatal death, vaginal bleeding in 2nd half of pregnancy, other medical conditions, type of onset of labour (induced/not induced) and country.

(2) odds ratios adjusted by gestational age and type of onset of labour (induced/not induced).



Relationship between caesarean delivery and neonatal death according to fetal presentation at delivery

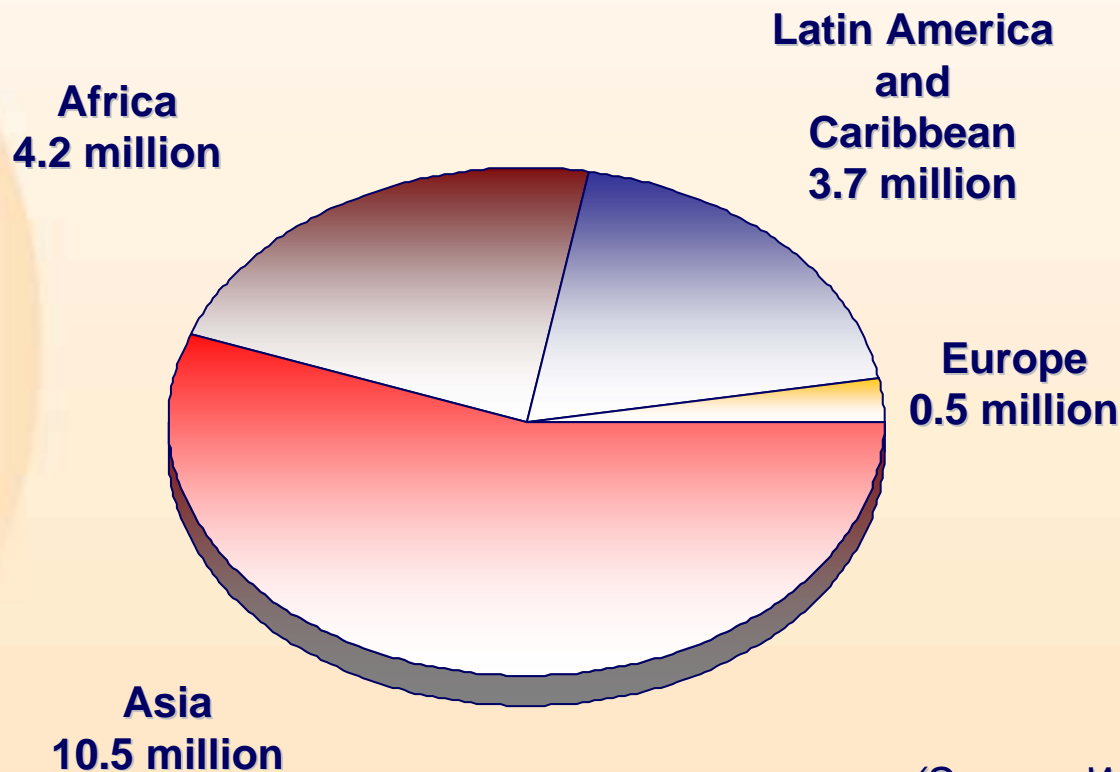
	n / N	OR (95% CI)
Cephalic Presentation		
Vaginal delivery (Reference level)	231/61299	1.0 ⁽¹⁾
Elective CD vs. Vaginal delivery	87/11237	1.7 (1.3 – 2.2)
Intrapartum CD vs. Vaginal delivery	107/16434	2.0 (1.5 – 2.6)
Breech and Other Presentations		
Vaginal delivery (Reference level)	36/421	1.0 ⁽²⁾
Elective CD vs. Vaginal delivery	33/1846	0.7 (0.4 – 1.3)
Intrapartum CD vs. Vaginal delivery	33/2021	0.6 (0.3 – 1.0)

(1) Odds ratios adjusted by gestational age, hypertensive disorders, any anaesthesia during labour and type of facility. (2) Odds ratios adjusted by gestational age.



Estimated annual numbers of unsafe abortion, around the year 2000

Total number of unsafe abortions = 19 million
(Total number of abortions = 46 million)



(Source: WHO, 2004)



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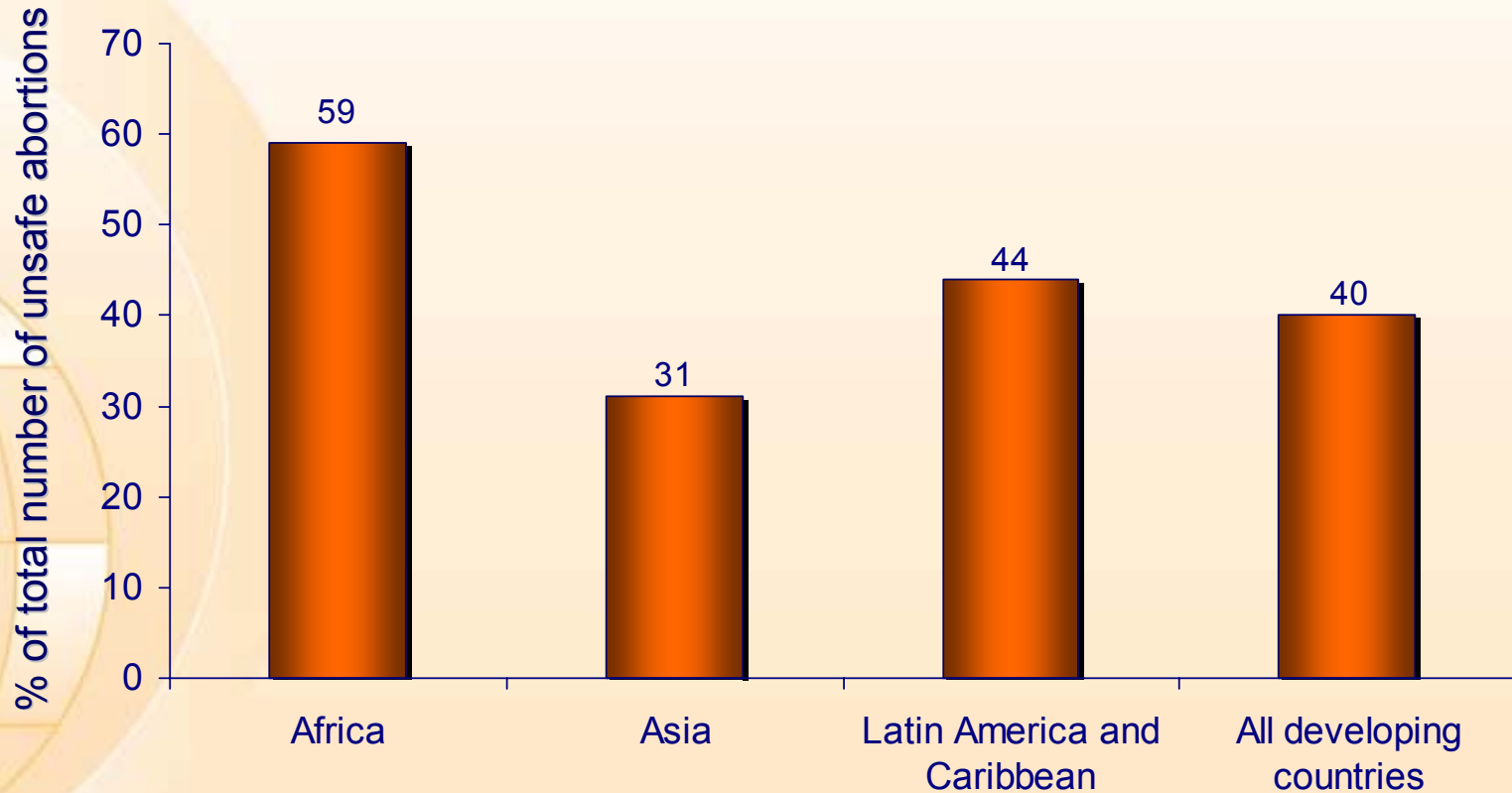
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Estimated proportions of unsafe abortions among 15-24 year olds, around the year 2000

Total number of unsafe abortions = 19 million



(Source: WHO, 2004)



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Preventing unsafe abortion

- Estimating incidence of abortion (jointly with Guttmacher Institute) and public health impact of unsafe abortion (mortality and morbidity)
- Providing guidance on management of complications of unsafe abortion, including guidance on post-abortion contraception
- Improving technologies and interventions for provision of safe abortion
- Assisting implementation of technical and policy guidance on safe abortion for health systems
- Supporting countries in the development of policies and programmes to reduce unsafe abortion and improve access to safe abortion and quality post-abortion care



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Getting research into practice



Cambodia
Ethiopia
Ghana
India
Moldova
Mongolia
Nepal
Romania
Russia
South Africa
Tunisia
Turkey
Ukraine
Viet Nam



"It is estimated that up to 100 000 maternal deaths could be avoided each year if women who did not want children used effective contraception."

(Marston and Cleland, 2003, quoted in World Health Report 2005)



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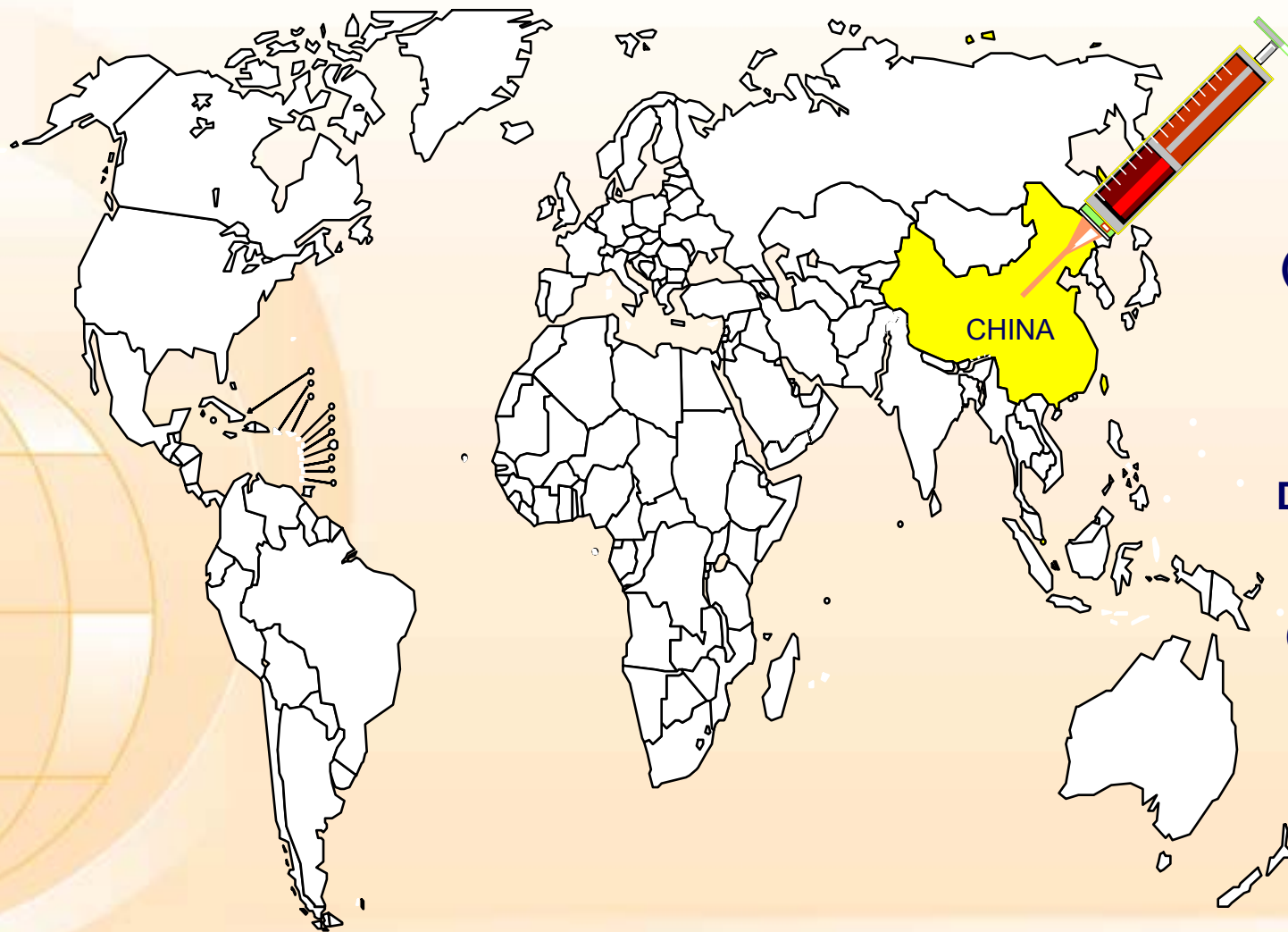
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Unmet needs in contraceptive hardware

- Methods for dual protection (including improved barrier methods)
- Reversible methods for men
- Postcoital methods for repeated use during the cycle
- Improved hormonal methods for women
- Long-acting, non-hormonal methods for women



Towards a male hormonal contraceptive



Testosterone undecanoate (Phase III trial)

1045 couples recruited

Data collection completed in mid-2006 (data analysis ongoing)



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Important new knowledge about safety/efficacy of hormonal fertility-regulating methods

- Oral contraceptives and cancer (benefits and risks)
- Oral contraceptives and cardiovascular disease
- Oral contraceptives and breast cancer
- DMPA and breast cancer
- Safety and efficacy of mifepristone
- Third-generation oral contraceptives and venous thromboembolism
- Long-term safety and efficacy of contraceptive implants (Norplant[®], Jadelle[®] and Implanon[®])



The epidemic of sexually transmitted diseases

- 340 million new cases of curable STIs annually
- more than 186 million ever-married women (15-49 years) in developing countries are infertile
- over 500,000 deaths (fetal and neonatal) due to syphilis each year
- 4.1 million [3.4 million - 6.2 million] people became newly infected with HIV in 2006 (more than half of them were young people, 15-24 years; progressive "feminisation" of epidemic)
- 2.8 million [2.4 million - 3.3 million] people died of AIDS in 2006
- cervical cancer is most common cause of cancer deaths among women in developing countries (some 200,000 deaths each year)

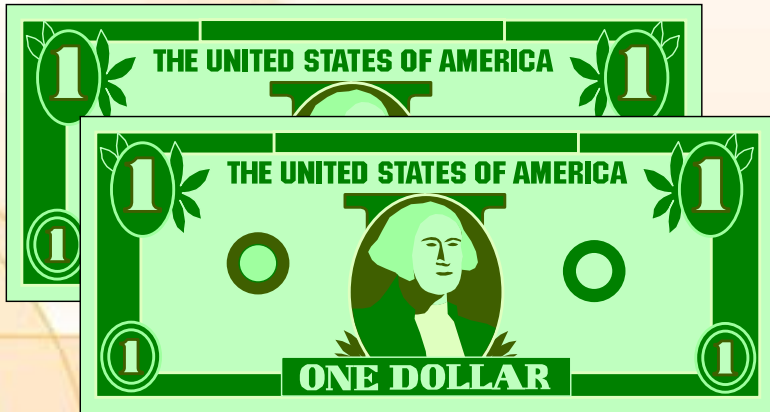


Research on the prevention of sexually transmitted infections – Selected examples

- **Female condoms:** comparative effectiveness for pregnancy prevention with male condoms (China, Nigeria, Panama, South Africa)
- **Microbicides:**
 - product development (identification of potential new products; safety monitoring of trials of potential microbicides)
 - capacity building for microbicide research and for regulatory decision-making
- **Mother-to-child transmission of HIV**



Our commitment to research capacity strengthening



US\$ 2

Research and development



US\$ 1

Research capacity
strengthening



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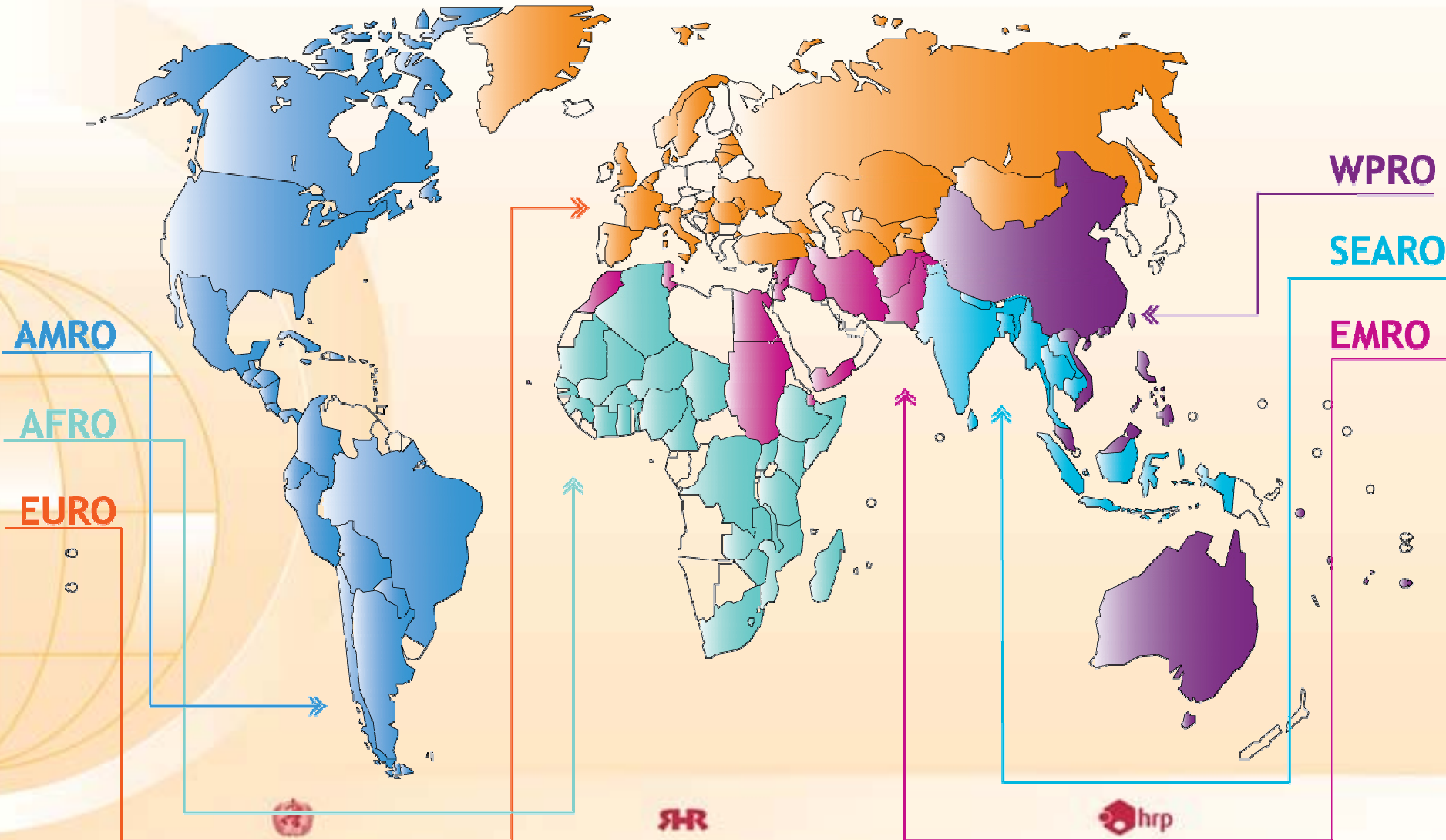
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Distribution of research capacity strengthening grants awarded since 1990



Countries collaborating with the Programme

2006, n=107 countries

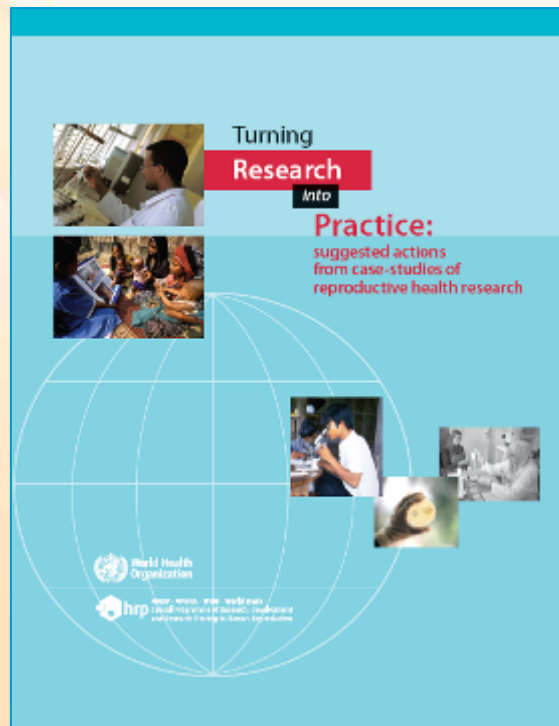



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Bridging the know-do gap



Turning
Research
Into
Practice



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THE LANCET

Volume 32, Number 10, September 2008 www.thelancet.com

“Female genital mutilation remains a pressing human rights issue and reliable evidence about its harmful effects, especially on reproductive outcomes, should contribute to the abandonment of the practice”

by Anthea King (12)

Articles
Obstetricians who
oppose the global
strategy

Articles
Risks of HIV
transmission
in sex
workers

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WHO analysis of causes of maternal death: a systematic review

Summary

Background

Methods

Results

Conclusions

The NEW ENGLAND JOURNAL of MEDICINE

September 8, 2008

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Case-control study of maternal death in the United States

WHO global survey on maternal and perinatal health in Latin America

Articles

Summary

Background

Methods

Results

Conclusions

The policy brief - the essence of research findings and their policy implications

"The internet is an effective means of providing sex and reproductive health education to young people in China"



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Adolescents and reproductive health

Social science research policy briefs

November 2006

The internet is an effective means of providing sex and reproductive health education to young people in Shanghai, China

Context

An increasing number of young people in China is engaging in sexual relations before marriage and the age of sexual debut in the country is declining. However, most young people (10–24 years) continue to lack basic sexual and reproductive health knowledge and skills to negotiate safe sexual practices. Moreover, sex education itself, and the channels of communication that are best suited for providing it for unmarried young people, remain controversial in China.

In recent years, the Internet has emerged as an important medium in China for information dissemination, especially for young people. In 2004, an estimated 87 million people used the Internet in China; 54% of them were below the age of 25 years. In large cities such as Beijing and Shanghai, the percentage of young people using the Internet is even higher. This pioneering study evaluated the potential of the Internet as a means of providing sex and reproductive health education to young people in China.

Objective

Launched in 2003, the study aimed to assess the feasibility and effectiveness of sex and reproductive health education for young people conducted through the Internet.

Methods

The research was conducted in two high schools and four colleges in a science and engineering university in Shanghai. One high school and two colleges were selected as the intervention group and the rest served as the control group. Baseline surveys were conducted among students in the two groups to assess individual sexual and reproductive health knowledge, attitude to contraception, and sexual behavior. The intervention group was then introduced to a specially designed web site entitled (Chinese translation) "Fighting youth hood", which offered sexual and reproductive health knowledge and service information, for educational videos, professional counselling through email and a bulletin board for group discussions and exchange of information and experiences. The web site was password-protected to ensure that only the intervention group could access it. Students in the intervention group were invited to visit the web site as often as they wanted during the 30-month intervention period. The control group did not have access to the social web site, but received information on sexual and reproductive health in school and/or through other media available to the general public. At the end of the intervention period, a follow-up survey was conducted, which re-evaluated the two groups' knowledge, attitudes and behavior.



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Authoritative responses to concerns of Member States



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WHO Statement Carcinogenicity of combined hormonal contraceptives and combined menopausal treatment

September 2005

In June 2005, the International Agency for Research on Cancer (IARC) convened a meeting of experts to review the scientific evidence on the carcinogenic risks to humans posed by combined estrogen-progestogen contraceptives (COCs) and combined estrogen-progestin menopausal therapy. The outcome of the meeting will be an IARC Monograph, to be published in 2006.

COC preparations. Assessments based on risk-benefit calculations are carried out by different teams within WHO. Several WHO committees work on creating evidence-based

This was an update of a similar review under the same formulations and published as a monograph in 1999.² At that time, COCs were "carcinogenic to humans" (Group 1) and combined hormonal menopausal therapy as "possibly carcinogenic to humans" (Group 2B). On the basis of the cumulative evidence, this new review reclassification of COCs and changed the classification of combined hormonal menopausal therapy to "possibly carcinogenic to humans" (Group 1).

A summary of the new review by IARC was published in *Lancet Oncology* this month.³ The evidence in this recent review is not new, but was published years ago and was assessed by scientific time and widely discussed in the media. It is important to note that IARC's classification of agents is not a statement of the overall risk-benefit profile of complex health terms, even in terms of overall cancer burden that have a protective effect on some increase the risk of some others.

IARC regularly convenes groups of international experts to evaluate the carcinogenic risks to humans of various agents, combinations of agents and their interactions. It is important to note that IARC's classification of agents is not a statement of the overall risk-benefit profile of complex health terms, even in terms of overall cancer burden that have a protective effect on some increase the risk of some others.

Combined oral contraceptives
As stated in IARC's review, the use of COCs slightly increases the risk of cancer, increasing it in some sites (breast, liver), decreasing it in others (ovary). Some of these data refer to older



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WHO STATEMENT ON HORMONAL CONTRACEPTION AND BONE HEALTH

July 2005

Steroid hormonal contraceptives, including oral contraceptives, injectables and implants, are highly effective and widely used. These contraceptives have important health benefits, including contraceptive and non-contraceptive benefits, and some health risks. For most women, the health benefits of use clearly exceed the health risks. Questions have been raised regarding the association between use of one particular hormonal contraceptive, depot medroxyprogesterone acetate (DMPA), and the risk of bone loss. In response, WHO convened a consultation in Geneva, on 20-21 June 2005, to assess current evidence on the relationship between the use of steroid hormonal contraceptives and bone health.

Bone health may be influenced by many factors including pregnancy, breastfeeding and use of hormonal contraceptives. The principal clinical outcome of interest with regard to bone health is the occurrence of fracture. Bone mineral density (BMD) measurements are commonly used to assess fracture risk, but the accuracy of measurements can be influenced by changes in body composition, including changes in lean body mass and fat. Furthermore, fracture risk is related to many factors, BMD being only one of them. The relationship between decrease in BMD and increase in fracture risk has been best studied in postmenopausal women, among whom the risk of any fracture increases approximately 1.5 fold for each standard deviation (SD) decrease in BMD. There is little information on the impact of BMD changes in young age groups on fracture risk later in life.

Combined methods of contraception

The use of current formulations of combined oral contraceptives (COCs) may have some small effects on BMD that are unlikely to be of clinical significance. Adolescent COC users may gain less BMD compared with adolescent non-users while perimenopausal users generally have increased BMD compared with perimenopausal non-users. A number of studies have investigated the risk of fracture among postmenopausal women in relation to past use

of COCs, but the findings are inconsistent. Data for other combined hormonal contraceptives, such as combined injectables, vaginal rings and skin patches, are scarce or non-existent.

Progestogen-only methods of contraception

With regard to progestogen-only methods, data on levonorgestrel implants suggest no adverse effect on BMD. Other low-dose progestogen-only contraceptives such as pills, other implants and the levonorgestrel-releasing intrauterine device do not appear to have an effect on BMD, although data for these methods are limited.

The use of DMPA for contraception produces a hypo-estrogenic state in women; some studies have shown that this is associated with a decrease in BMD. The weight of data indicates that DMPA use reduces BMD in women who have attained peak bone mass, and impairs the acquisition of bone mineral among those who have not yet attained peak bone mass. The magnitude of effect on BMD is similar across a variety of studies. Cross-sectional studies show lower BMD in longer-term DMPA users by approximately 0.5 SD at hip and spine compared with non-users. In longitudinal studies, adults (≥ 18 years) and adolescents (menarche to < 18 years) both lost around 5 to 7 percent (approximately 0.5 SD) of BMD at the same sites, after 2 years of continuous use of DMPA. The rate of loss appeared to decrease over time.

When DMPA use is discontinued, BMD increases again in women, regardless of age, except for those who have reached menopause. Among adults, BMD values appear to return to those of comparable non-DMPA users over a period of 2 to 3 years. It is not clear whether the loss in BMD among adolescent users of DMPA prevents attainment of potential peak bone mass. There remains a concern that older women who reach the menopause while still using DMPA may no longer have the opportunity to regain BMD before entering the period of bone loss normally associated with the postmenopause.



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Statement on hormonal contraception and risk of STI acquisition

July 2005

A study published by Morrison et al in *Sexually Transmitted Infection* (STI) among women using medroxyprogesterone acetate (DMPA) using hormonal methods of contraception in Maryland, USA. Results did not suggest chlamydia or gonococcal infection a hormonal contraception. For women chlamydia infection (95% confidence interval) was not significantly different between users and non-users of hormonal contraception. However, the differences in populations of users at finding.

Subsequently, WHO's systematic review modifies the risk of acquiring a STI via hormonal methods of contraception. The WHO Guideline Steering Group who conclude that the evidence is inconclusive, namely: there are no restrictions on using hormonal methods of contraception to reduce the risk of acquiring a STI.

Reference:

1. Morrison CS, Bright P, Wong EL, Kwok C. Hormonal contraception, cervical ectopy, and HIV risk. *Sexually Transmitted Infection* 2004;31:561-567.



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Hormonal Contraception and HIV: Science and Policy Africa Regional Meeting Nairobi 19-21 September 2005

STATEMENT

The World Health Organization Headquarters Office and Regional Office for Africa, in partnership with the Reproductive Health and HIV Research Unit of the University of Witwatersrand and the South African Collaborating Centre, International Planned Parenthood Federation Africa Region and Family Health International (FHI), convened a meeting of 72 representatives from 17 francophone, lusophone and anglophone sub-Saharan African countries on "Hormonal Contraception and HIV: Science and Policy".

The participants included policymakers and programme managers involved with family planning, sexual and reproductive health, and HIV/AIDS, women's health advocates, people living with HIV and scientists and clinicians involved with family planning and HIV research. They were joined by 13 representatives from international donor and non-governmental organizations and agencies. The goal of the meeting was to promote evidence-based discussion and decision-making in response to new information on any potential association between hormonal contraceptive use and the acquisition of HIV.

The meeting reviewed data and information on the association between use of hormonal contraception and the risk of acquiring HIV infection. This included a review of previously published information as well as new data that are expected to be made public in the next few months.

* A study published in 2004 on a cohort of sex workers followed over many years in Mombasa, Kenya, showed that users of hormonal contraception have a 1.5-fold (combined oral contraceptives [COCs]) to 1.8-fold (depot-medroxyprogesterone acetate [DMPA]) higher risk of acquiring HIV infection compared with non-users. Other studies conducted among

sex workers have found similarly elevated risks. However, it is not known whether such risks also apply to clients of family planning services, whose overall risk of acquiring HIV is typically lower than that of sex workers.

* Two new studies (one in Uganda, Thailand and Zimbabwe, the other in South Africa) pending publication conducted among clients of family planning services found no overall increase in risk of acquiring HIV infection in women who used hormonal contraception compared with women who used non-hormonal contraception or no contraceptive method.

The following recommendations were made by the meeting:

1. There should be no restrictions on the use of COCs and DMPA by women at risk of acquiring HIV, consistent with the current WHO *Medical Eligibility Criteria for Contraceptive Use* guidelines. However, participants suggested that the WHO Family Planning Working Group at its next meeting review the classification regarding women at high individual risk of HIV infection to assess whether some caution on use of these methods may be appropriate, though the participants acknowledged that the benefits of using COCs or DMPA to prevent unintended pregnancy would in the majority of cases offset any excess risk of acquiring HIV infection.

2. Women and their partners are strongly encouraged to protect against unintended pregnancy, STIs and HIV, using condoms alone or in addition to another contraceptive method ("dual protection"). The use of male or female condoms is recommended whenever there is any possibility of exposure to STIs, including HIV. Programmes to promote dual protection should be actively supported.



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Reproductive health home page - Microsoft Internet Explorer provided by WHO

http://www.who.int/reproductive-health/

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Sexual and reproductive health

Health topics

- Adolescence
- Ageing
- Cancers
- Family planning
- FGM/Harmful practices
- Infertility
- Maternal/perinatal health
- RTIs, STIs, HIV/AIDS
- Unsafe abortion
- Cross-cutting issues**
- Economics and finance
- Emergency situations
- Ethics
- Gender
- Linkages between sexual and reproductive health and HIV
- Monitoring & evaluation
- Working with countries
- About us**
- Strategy
- Highlights
- Governance
- Regional offices**
- Africa
- Americas
- Eastern Mediterranean
- Europe
- South East Asia
- Western Pacific

Sexual & reproductive health Lancet series
HRP coordinated this series by gathering accomplished researchers to look at critical issues including family planning, sexually transmitted infections, preventing unsafe abortion and sexual behaviour. [More information](#)

Art for Health
The intention of the Art for Health project is to contribute to the improvement of global sexual and reproductive health in an innovative way. Specifically, the project uses contemporary art as a medium to increase people's awareness of sexual and reproductive health issues prevalent around the world, particularly those that negatively affect the lives of women and their families. [More info](#)

Linkages between sexual and reproductive health (SRH) and HIV
Universal access to sexual and reproductive health information and services would have far-reaching effects for both the maternal health and child health Goals and for virtually every other Goal, including those for HIV/AIDS, gender, education, environment, hunger and income poverty. [More information](#)

New study shows Female Genital Mutilation exposes women and babies to significant risk at childbirth - [More information](#)

HRP SPECIAL PROGRAMME
UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP)
HRP is the main instrument within the United Nations system for research in human reproduction. HRP brings together health care providers, policy-makers, scientists, clinicians and consumer and community representatives to identify and address priorities for research aimed at improving sexual and reproductive health. [More information on HRP](#)

International meeting to celebrate the 10th anniversary of the WHO Reproductive Health Library (RHL)
27-29 April 2007
Under the auspices of Khon Keen University and the Thai Cochrane Network, this international meeting will provide an opportunity for exchange of ideas between international and Thai experts on sexual and reproductive health, research synthesis, utilization of research findings and innovative approaches to capacity-building including e-learning. [More information](#)

www.who.int/reproductive-health/

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Reproductive Health and Research

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Strategic Partnership Programme



Goal

to improve support to countries through the implementation of evidence-based norms and tools for reproductive health

Overall objective

to promote sexual and reproductive health through the application of evidence-based practices and informed policy and decision-making in health interventions



What the partnership should achieve

- 1 introduce systematically selected practice guides to improve sexual and reproductive health (SRH), initially in family planning and sexually transmitted and reproductive tract infections (STIs/RTIs)
support dissemination, adaptation and adoption of guidelines within countries through UNFPA Country Technical Services Teams (CSTs) and Country Offices, WHO Regional Offices and Country Offices
- 2 strengthen technical capacity through orientation and backstopping in SRH, including maternal health
enhance linkages between creation of evidence-based tools and implementation to improve programmes and service delivery

Expected outcomes

1. Adoption of tools and up-scaling of evidence-based practices
2. Improved quality of reproductive health care services, particularly in family planning, STIs/RTIs, and maternal health

Evidence-based tools

Family planning



Maternal and newborn health



ST/RTI control



Further information on SRH guidelines including online electronic versions:
www.who.int/reproductive-health - Further information on SPP activities: mbizvom@who.int





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