

Sexual and reproductive health work at WHO

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Department of Reproductive Health and Research
World Health Organization

Training Course in Sexual and Reproductive Health Research
Geneva, 16 February 2009



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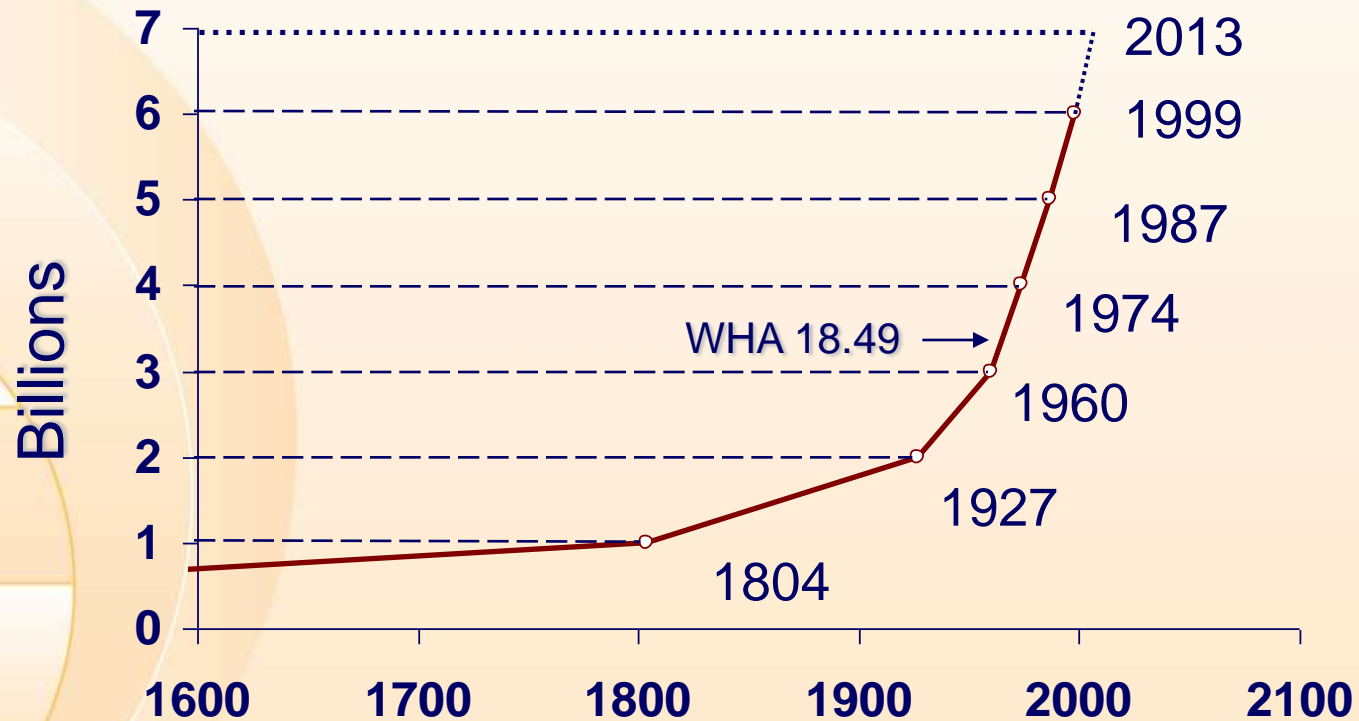


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How it began...



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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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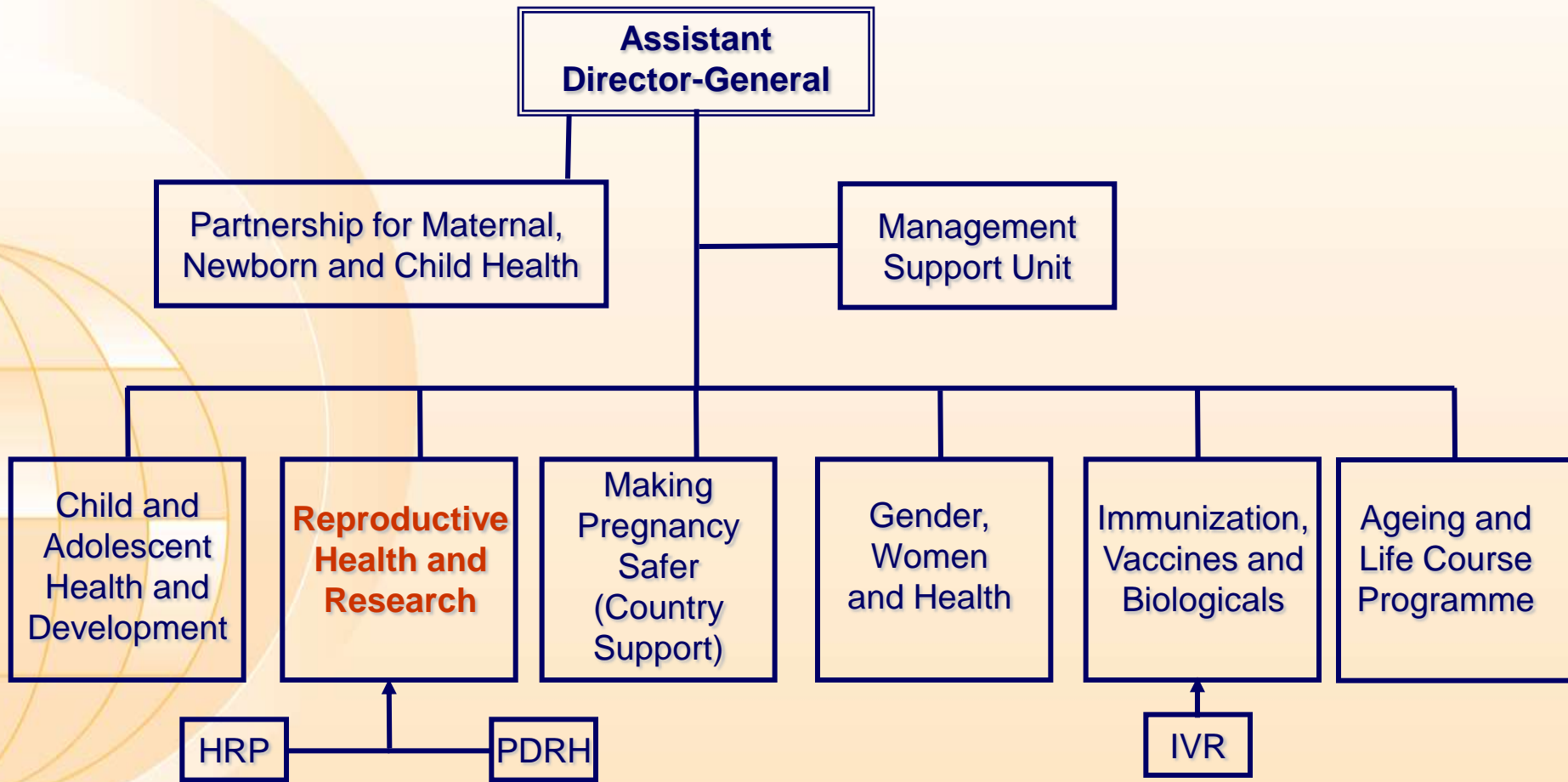


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Family and Community Health Cluster



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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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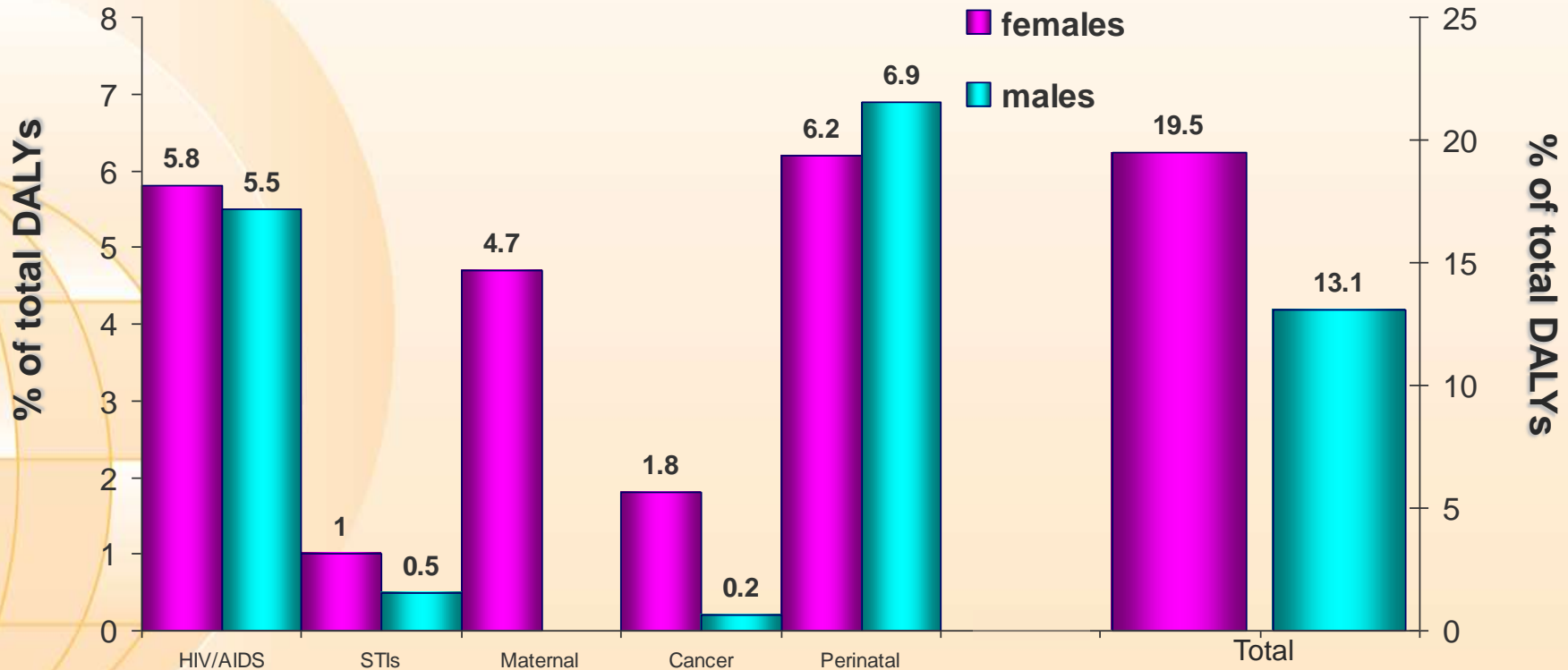


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Reproductive ill-health accounts for substantial portions of global burden of disease



(Source: World Health Report, 2004)



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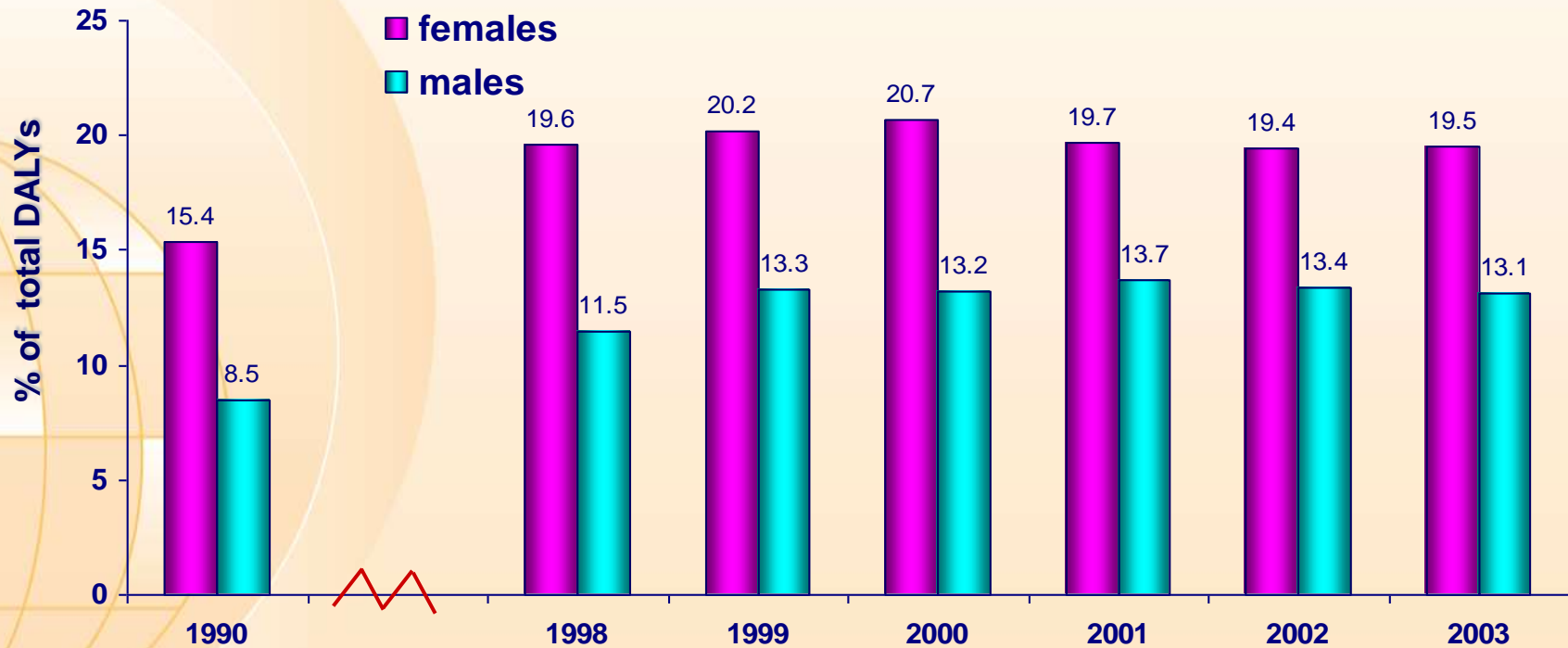


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Reproductive ill-health as proportion of global burden of disease shows no sign of declining



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



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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



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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)



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"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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2007

Indicators for monitoring MDG 5 recommended by the Inter-Agency and Expert Group on MDG Indicators

Goal 5: Improve maternal health

- Target 5.A.: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
 - 5.1 Maternal mortality ratio
 - 5.2 Proportion of births attended by skilled health personnel
 - 5.3 Contraceptive prevalence rate
 - 5.4 Adolescent birth rate
 - 5.5 Antenatal care coverage (at least one visit and at least four visits)
 - 5.6 Unmet need for family planning
- Target 5.B.: Achieve, by 2015, universal access to reproductive health

(Source: 12th Inter-Agency and Expert Group meeting on MDG indicators, Paris, November 2007)



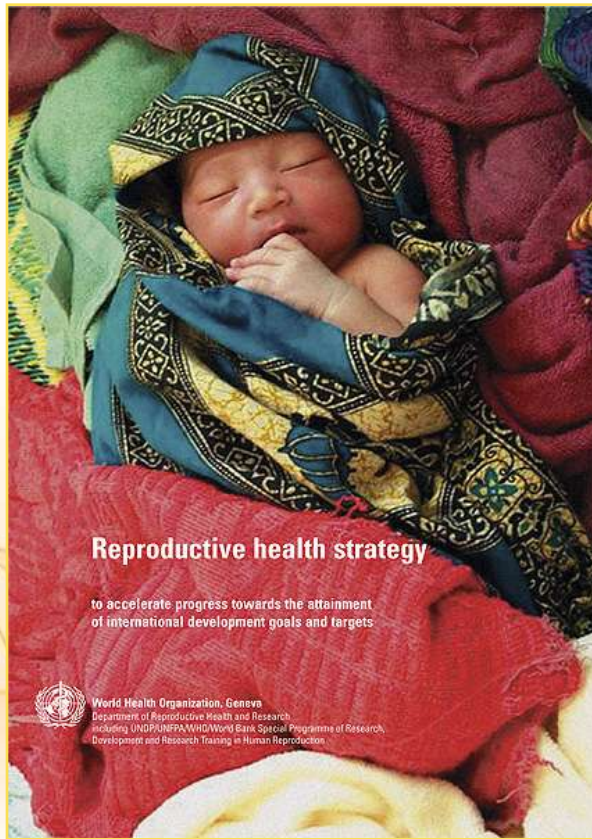
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The WHO global reproductive health strategy adopted by WHO's 192 Member States in May 2004



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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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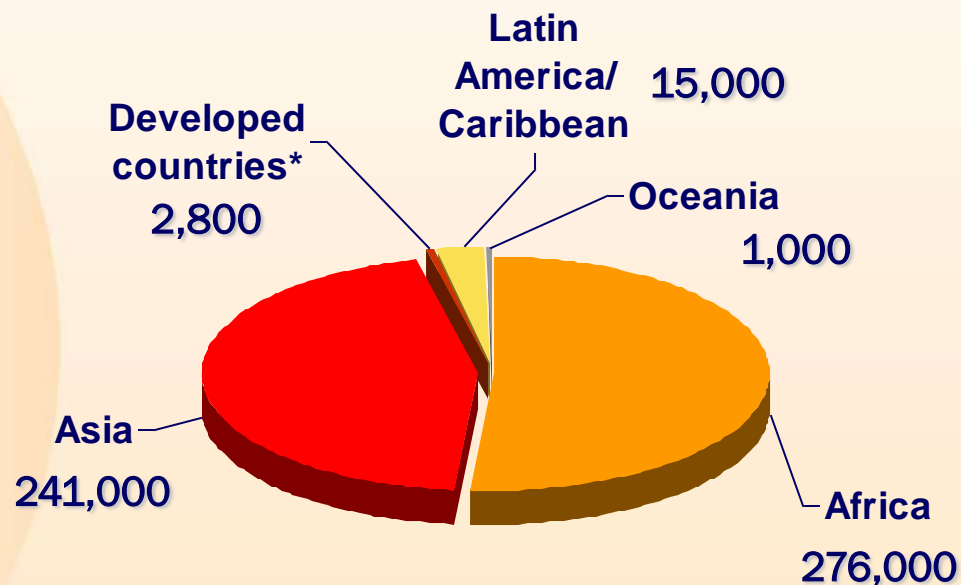
Maternal and perinatal health today

- 536,000 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)



Maternal mortality — the silent epidemic

Total maternal deaths in 2005 = 536,000



* includes countries of the Commonwealth of Independent States (CIS)

(Source: WHO/UNICEF/UNFPA/The World Bank, 2007)



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Comparison of 1990 and 2005 regional and global estimates of maternal mortality*

	1990		2005		% Change in MMR 1990-2005
	MMR	Maternal deaths	MMR	Maternal deaths	
WORLD TOTAL	430	576,000	400	536,000	-5.4
DEVELOPED REGIONS	11	1,300	9	960	-23.6
Countries of the CIS	58	2,800	51	1,800	-12.5
DEVELOPING REGIONS	480	572,000	450	533,000	-6.6
Africa	830	221,000	820	276,000	-0.6
<i>North Africa</i>	250	8,900	160	5,700	-36.3
<i>Sub-Saharan Africa</i>	920	212,000	900	270,000	-1.8
Asia	410	329,000	330	241,000	-19.7
Latin America and the Caribbean	180	21,000	130	15,000	-26.3
Oceania	550	1,000	430	890	-22.2

* Numbers are rounded

(Source: WHO/UNICEF/UNFPA/The World Bank, 2007)



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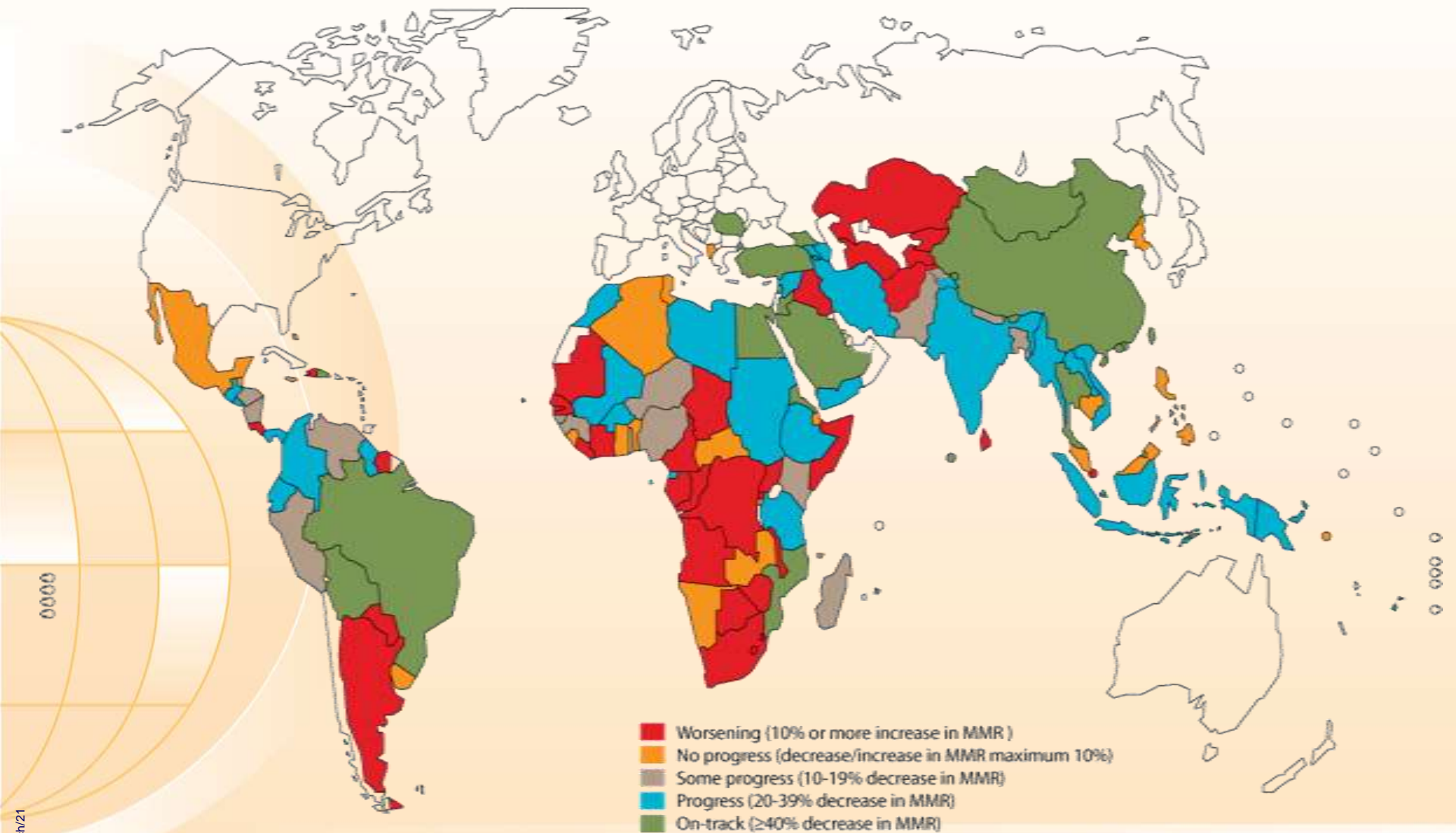


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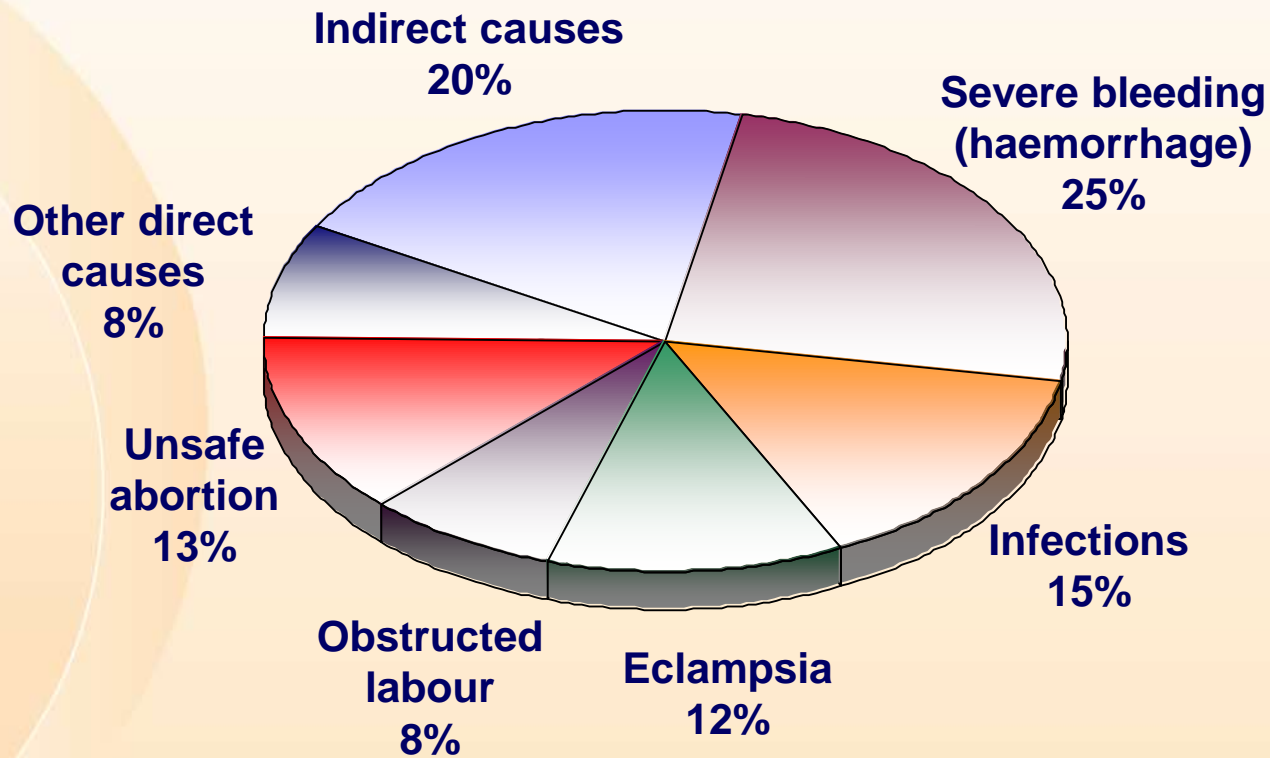
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Progress (or lack of it) in maternal mortality reduction



Note: Developed countries and developing countries with baseline MMR < 50 and decrease in MMR between 1990-2005 are excluded from this categorization.

Causes of maternal deaths^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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Maternal and perinatal health research ongoing with leading participation of WHO

	Countries	Women	Status
Prevention of preeclampsia (anti oxidants)	4	1365	Completed
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



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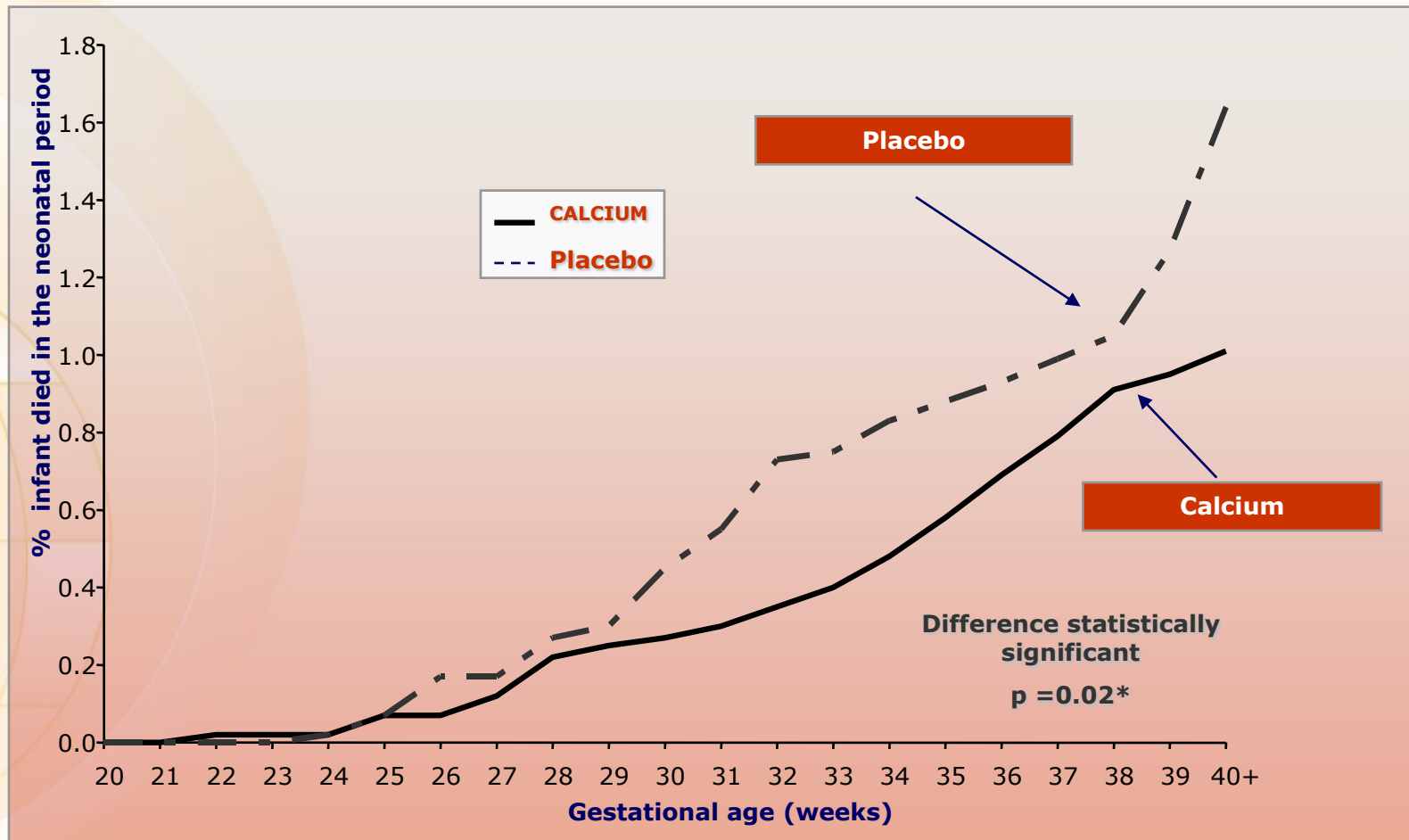


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Cumulative risk of neonatal mortality, by treatment group overall RR=0.70 (0.56-0.88)



Villar J, Abdel-Aleem H, Meriardi M et al, Am J Obstet Gynecol 2006



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WHO Global Survey of Maternal and Perinatal Health

- Short term (3 months) data collection surveys in randomly selected health facilities in randomly selected countries
- On line data collection system (real time)
- Simple data collection forms (2 pages) focusing on specific topic of interest
- In 2005: Data collected on ~180,000 deliveries in 8 countries in Africa and 8 in Latin America (mode of delivery and mortality and morbidity – Villar et al, The Lancet, 2006)
- Allows for moving from estimates to real data



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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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Address http://www.medsinet.com/who/ Go Links

Google Search Web 82 blocked AutoFill Options

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

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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, registrese 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](#)

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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).



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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.



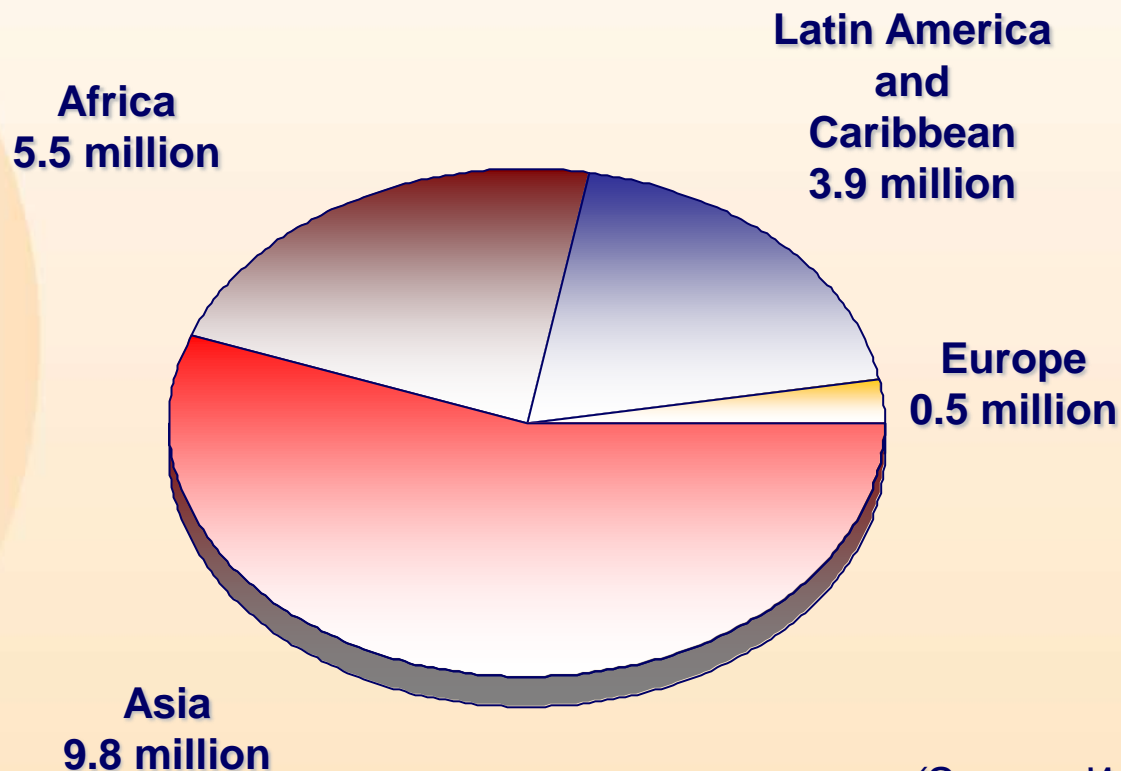
New collaborative projects (2008-9)

- Pre-eclampsia
 - screening
 - prediction of outcome
 - treatment of moderate hypertension
- Delivery/Postpartum care
 - Management of third stage of labour
 - Anti-shock garment
- Perinatal/Newborn health
 - develop standards of fetal growth for international applications
 - preterm birth (genetics, prevention of mortality)
 - diagnosis of birth asphyxia at community level
- Epidemiology
 - WHO multicountry study on MPH: preterm, stillbirths, birth defects
- Research synthesis
 - Systematic reviews: Continuum of care, Ultrasounds, Diabetes, Preterm birth rates, Sepsis rates, Preeclampsia rates
- Operations research
 - Obstetric fistula: clinical and socio-cultural aspects
 - Detection and management of anaemia in pregnancy
 - Birth plans
 - Integration of maternal and newborn health services with HIV/Malaria
 - Antenatal care (web based training module and avatar simulation)



Estimated annual numbers of unsafe abortion, around the year 2003

Total number of unsafe abortions = 20 million
(Total number of abortions = 42 million)



(Source: WHO, 2007)



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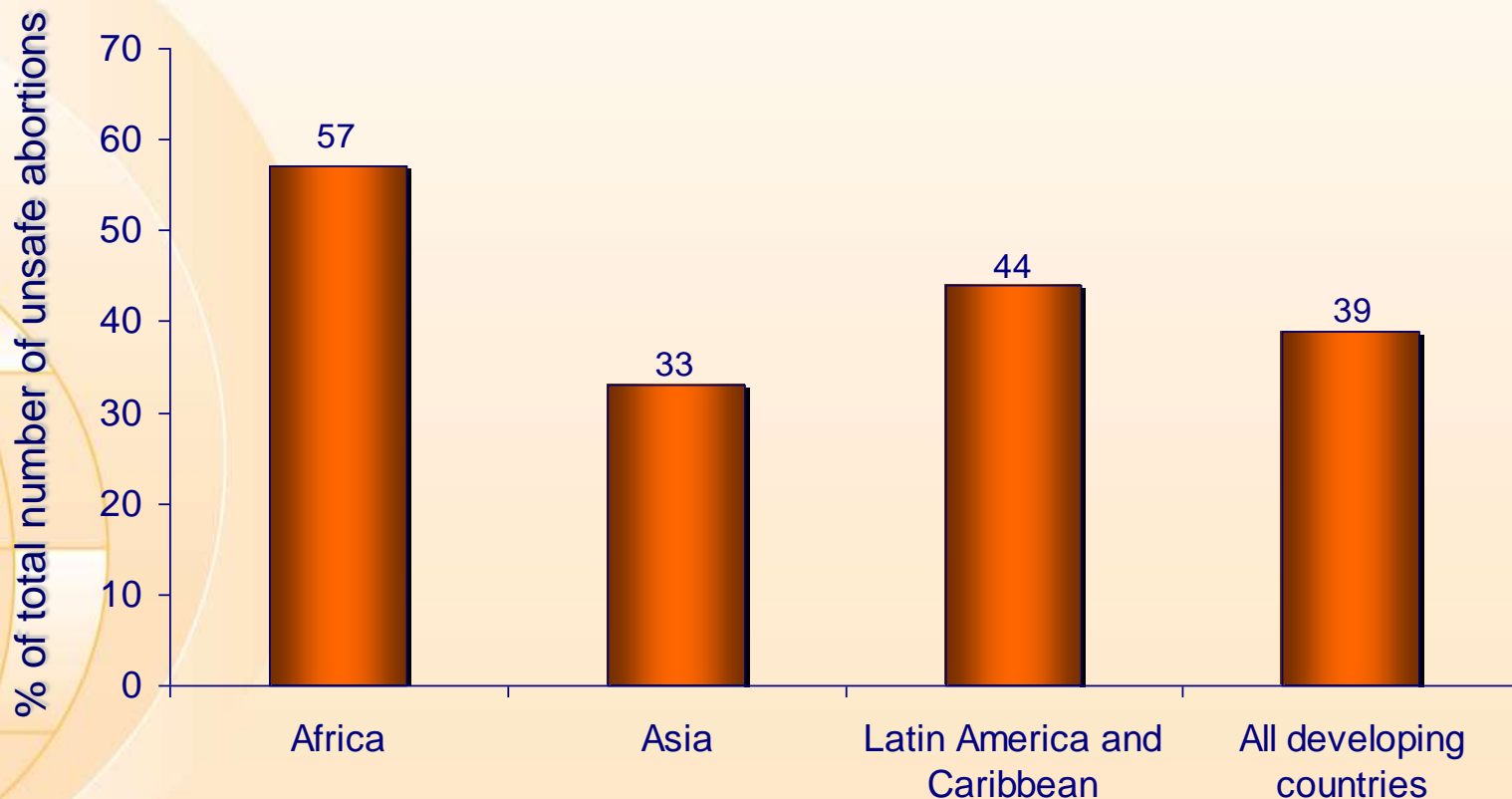
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Estimated proportions of unsafe abortions among 15-24 year olds, around the year 2003

Total number of unsafe abortions = 20 million



(Source: WHO, 2007)



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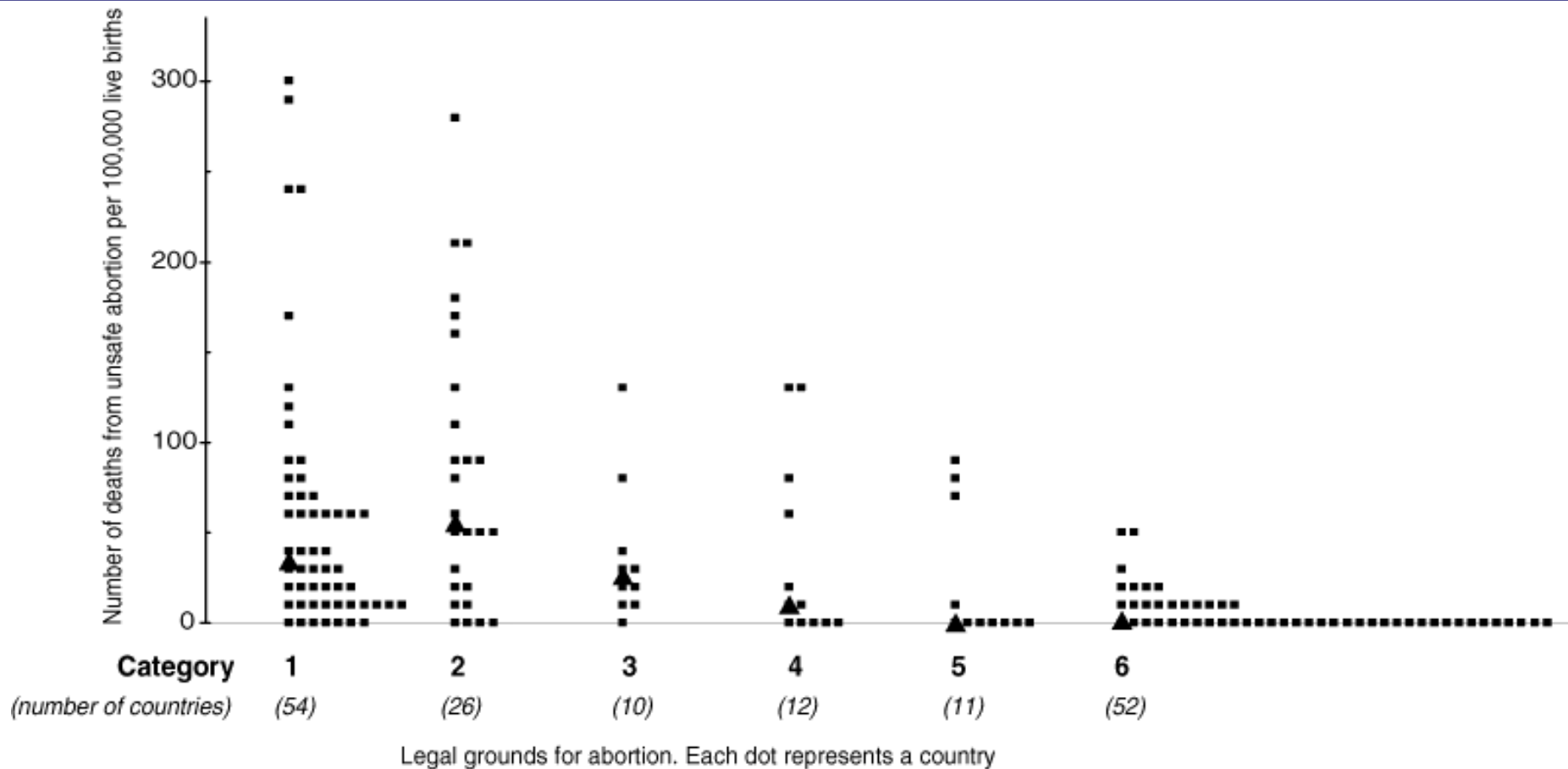


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Deaths from unsafe abortion in countries with different legal grounds for abortion



- Category
1. To save the woman's life only, or no grounds
 2. Same as category 1, and also to preserve health (physical and mental)
 3. Same as category 2, and also in cases of rape and/or incest
 4. Same as category 3, and also in cases of fetal impairment
 5. Same as category 4, and also for economic or social reasons
 6. Same as category 5, and also on request

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

Frequently asked clinical questions
about **medical abortion**

Conclusions of an International consensus
conference on medical abortion in early first
trimester, 1-5 November 2004, Bellagio, Italy



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Organization

Combipack of Mifepristone Tablets
and Misoprostol Tablets

MEDABON*

Warning: Keep out of reach of children.
FOR CLINICAL TRIAL USE ONLY

Each blister pack contains:
(A) Yellow uncoated tablet containing
Mifepristone 200 mg
(B) White uncoated tablet containing
Misoprostol 200 mcg

Dosage and Administration:
200 mg of Mifepristone (1x200mg Tablet)
in a single oral dose, followed 36 - 48 hours
later by 800mcg of misoprostol
(4x200 mcg Tablets) in a single dose given
vaginally. The dosage is independent of
body weight. If the patient vomits shortly
after administration of the mifepristone,
she should inform the doctor.

Storage: Store at or below 25°C
(77°F), in a dry area.

GUJ/DRUGS/25/789

Return empty packaging and unused
products

* Trade Mark

Manufactured by:
Sun Pharmaceutical Industries Limited,
Halol-Baroda Highway,
Halol : 389 350, Gujarat, INDIA,

PAULB0636

MASTER BATCH NO. JKTC080
MFG. DATE: 03/08/08, NO. B. JKTC085
EXP. DATE: 03/08/10
EXPIRY DATE TO BE DETERMINED 01/2007

Mifepristone 200 mg

Misoprostol 200 mcg

Misoprostol 200 mcg

DAY 1
FIRST DOSE ORALLY

36-48-HOURS AFTER FIRST DOSE-VAGINALLY

soprostol 200 mcg



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Misoprostol (3 x 0.8mg) for termination of early pregnancy

Two routes and two intervals

Treatment group	Outcome - n (%)		
	Complete abortion	Continuing pregnancy	Others*
Sublingual 3-hour (n=512)	431 (84.2%)	29 (5.7%)	52 (10.1%)
Sublingual 12-hour (n=509)	399 (78.4%)	47 (9.2%)	63 (12.4%)
Vaginal 3-hour (n=513)	434 (84.6%)	20 (3.9%)	59 (11.5%)
Vaginal 12-hour (n=512)	425 (83.0%)	25 (4.9%)	62 (12.1%)

* incomplete abortion, missed abortion, undetermined outcome

(Source: Lancet, 2007)



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"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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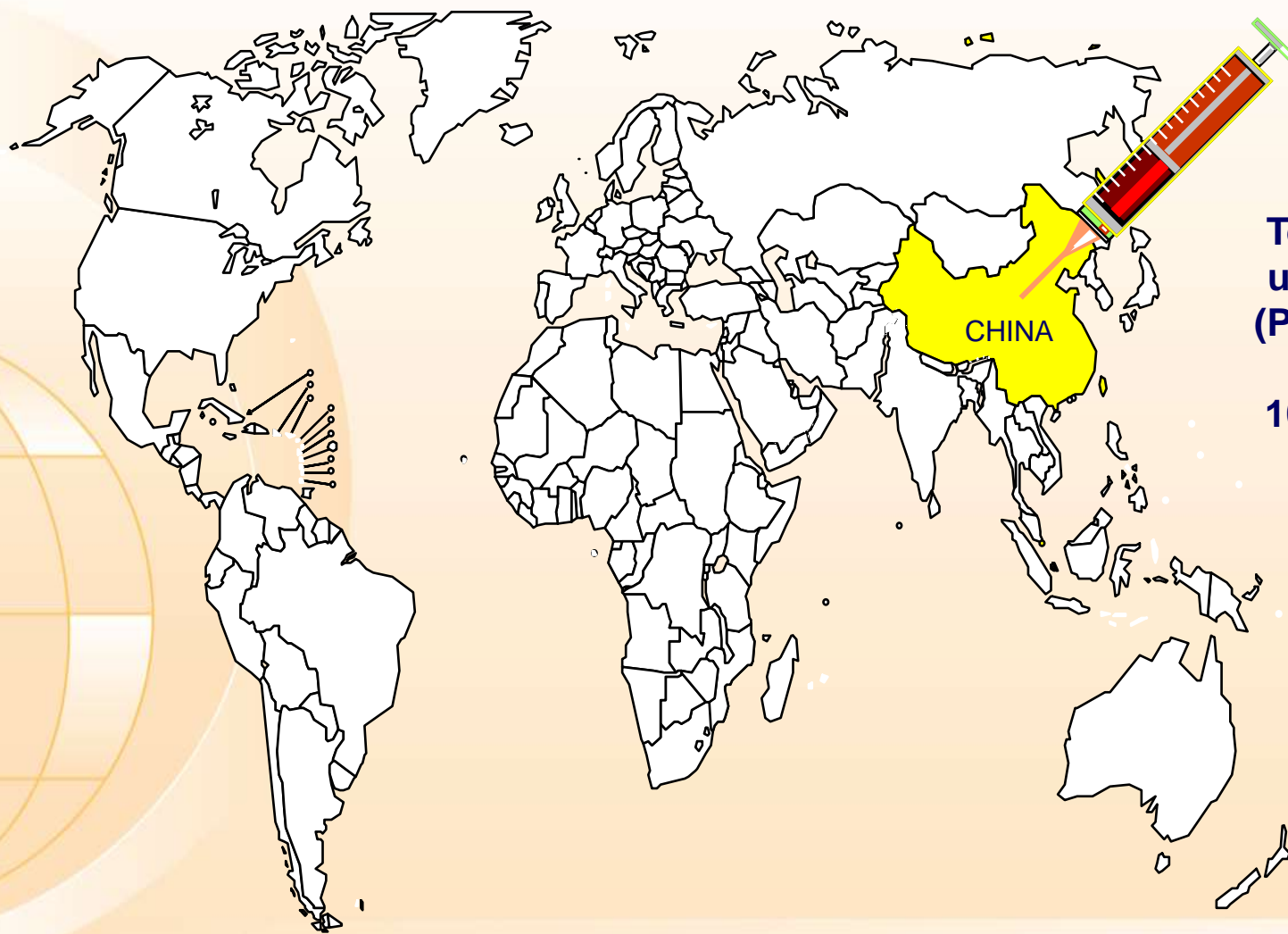
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Unmet needs in contraceptive hardware

- 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



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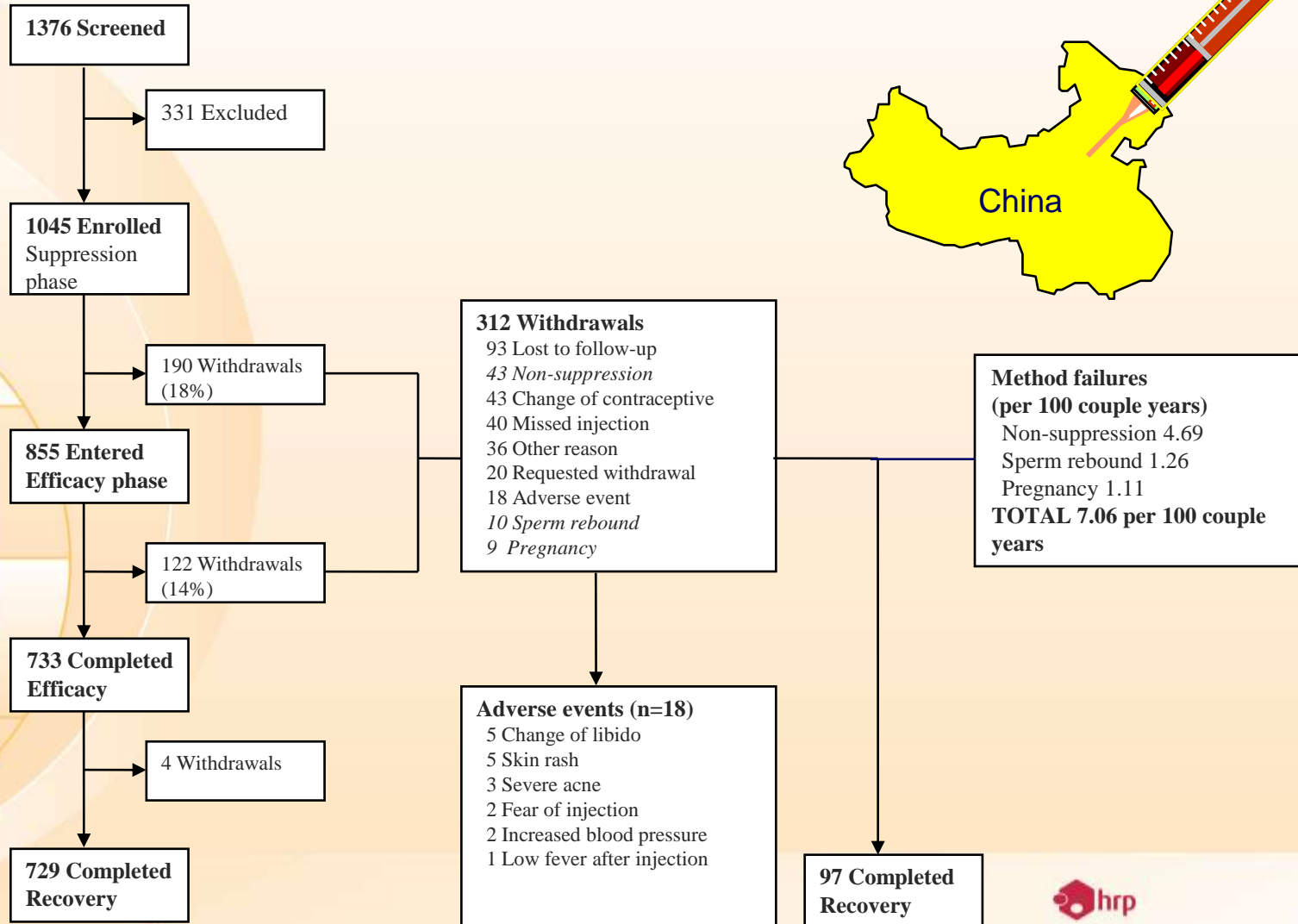


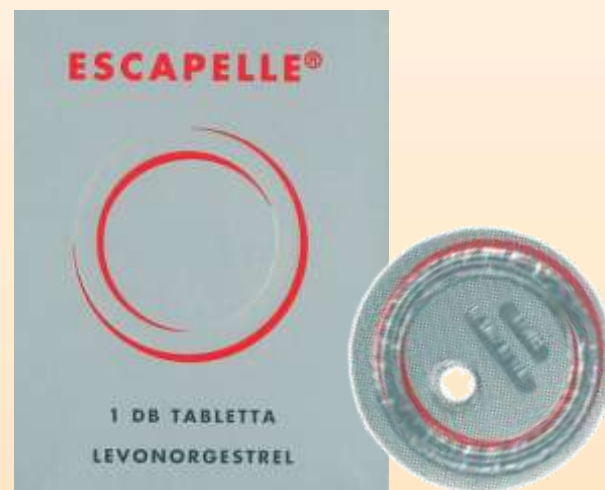
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Phase III study of testosterone undecanoate for male contraception





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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
- 2.5 million [1.8 million - 4.1 million] people became newly infected with HIV in 2007 (more than half of them were young people, 15-24 years; progressive "feminisation" of epidemic)
- 2.1 million [1.9 million - 2.4 million] people died of AIDS in 2007
- 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**
- **Introduction of HPV vaccine**



Setting the scene for HPV vaccine introduction ...

Preparing for the introduction of HPV vaccines

Policy and programme guidance for countries

World Health Organization UNFPA

This cover features a green background with a red star icon at the top left, a purple icon of a person with a headband, a yellow globe icon, and a cluster of orange star icons at the bottom. Logos for the World Health Organization and UNFPA are at the bottom.

Human Papillomavirus and HPV vaccines

Technical information for policy-makers and health professionals

World Health Organization Department of Immunization, Vaccines and Biologicals

This cover has a blue background with a red star icon at the top left, a purple icon of a person with a headband, a yellow globe icon, and a cluster of orange star icons at the bottom. Logos for the World Health Organization and the Department of Immunization, Vaccines and Biologicals are at the bottom.

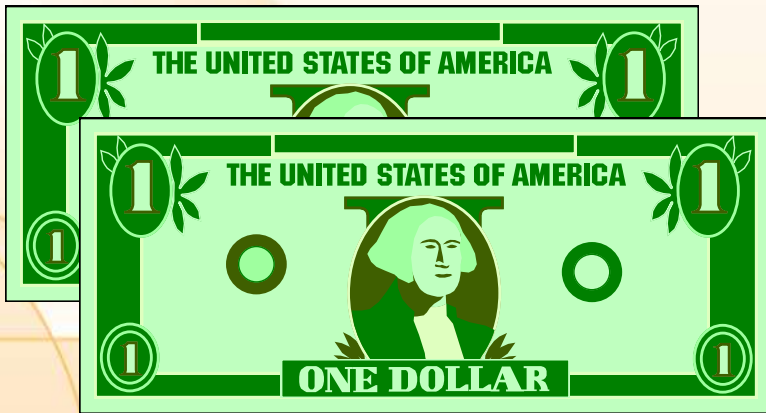
Cervical cancer, human papillomavirus (HPV) and HPV vaccines

Key points for policy-makers and health professionals

World Health Organization PATH UNFPA

This cover is red with a red star icon at the top left, a white icon of a person with a headband, a red globe icon, and a cluster of white star icons at the bottom. Logos for the World Health Organization, PATH, and UNFPA are at the bottom.

Our commitment to research capacity strengthening



US\$ 2

Research and development



US\$ 1

Research capacity
strengthening



World Health Organization

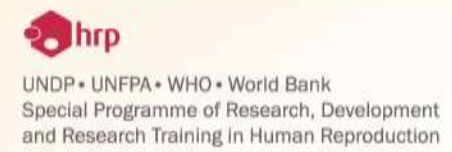
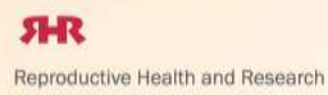
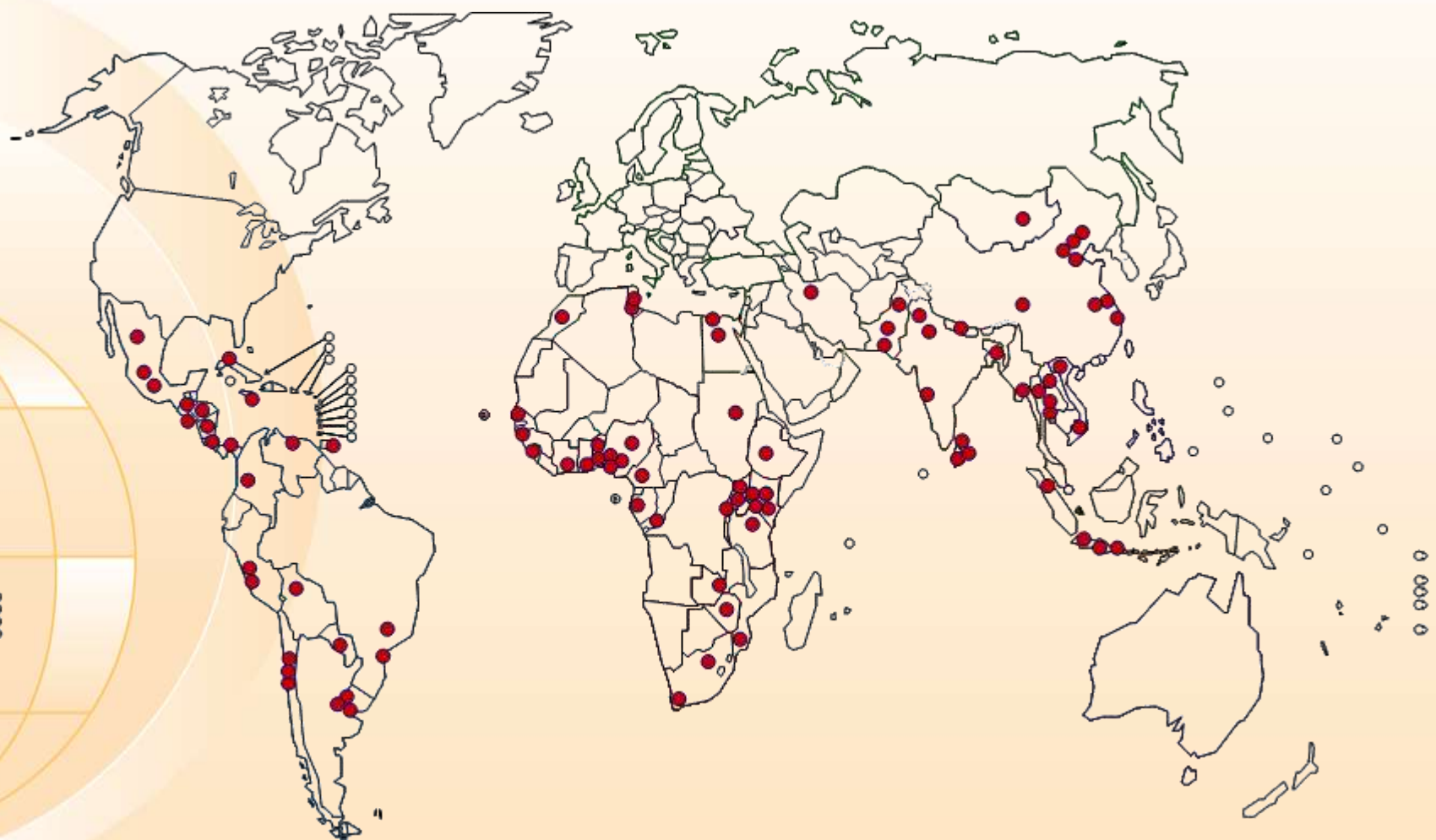


Reproductive Health and Research



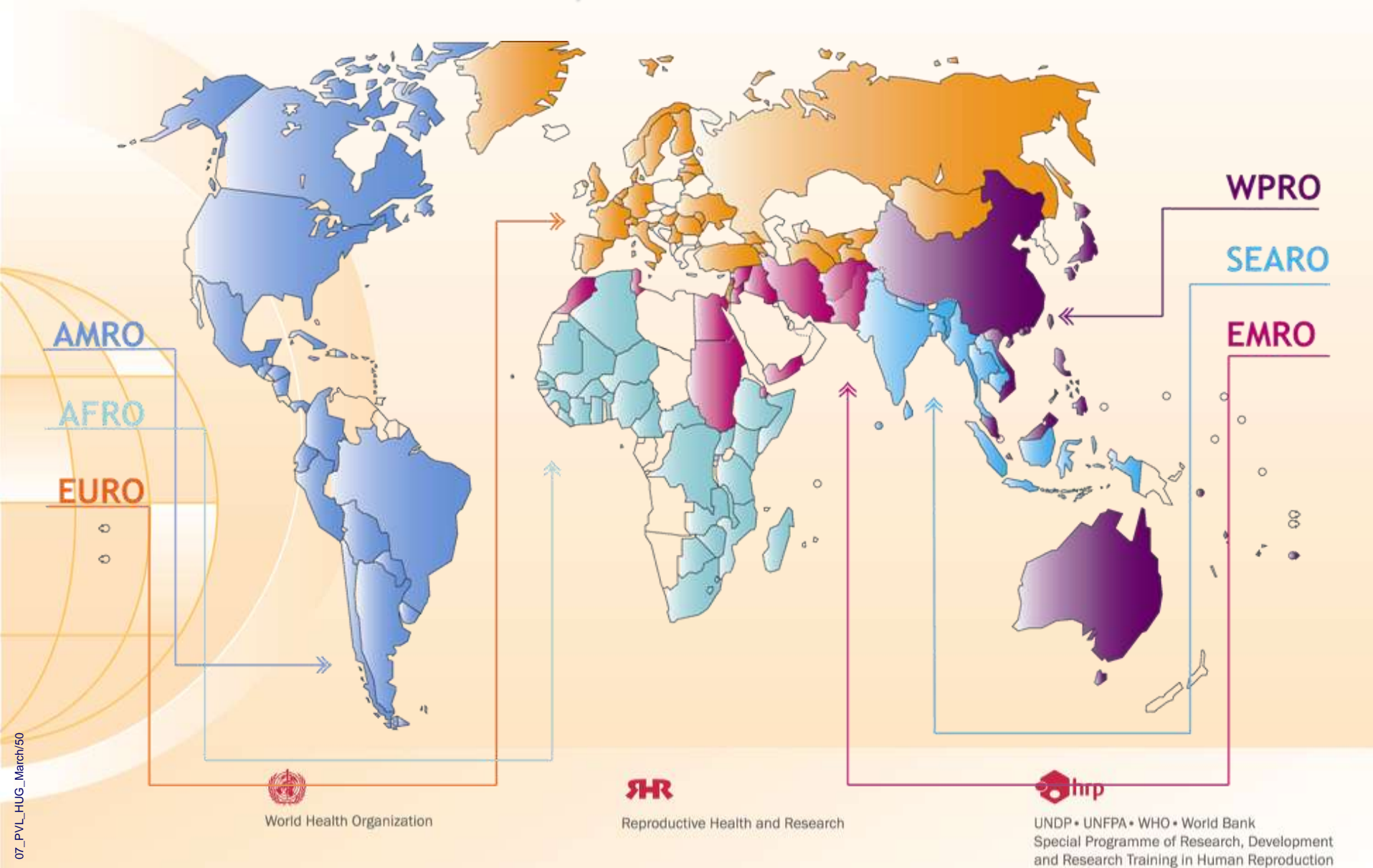
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Distribution of research capacity strengthening grants awarded since 1990

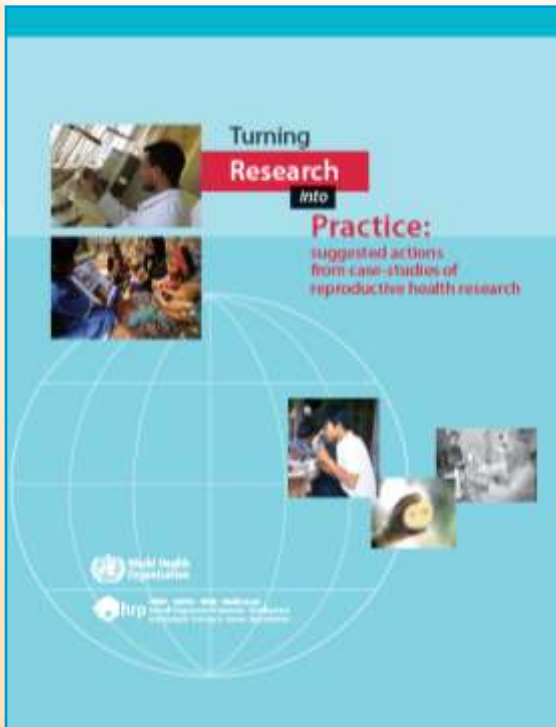


Countries collaborating with the Programme

2007, n=115 countries



Bridging the know-do gap



Turning
Research
Into
Practice



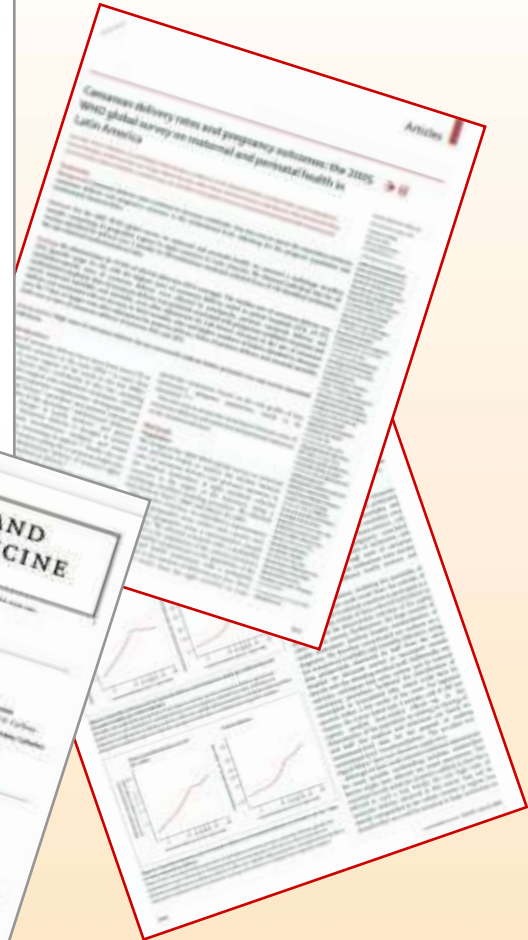
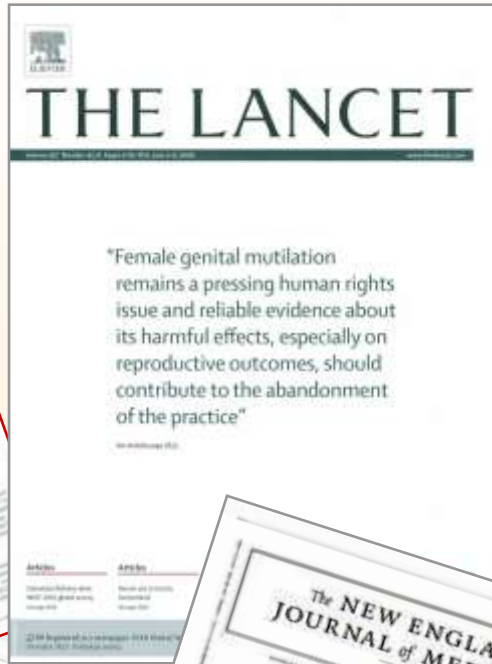
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The policy brief - the essence of research findings and their policy implications

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

The image shows the cover of a policy brief. The top left features the World Health Organization logo and name. Below it, the title 'The internet is an effective means of providing sex and reproductive health education to young people in Shanghai, China' is displayed in blue. The date 'November 2006' is in the top right. A vertical label on the left side reads 'Adolescents and reproductive health'. The cover includes a map of China with Shanghai highlighted. The bottom section contains the WHO logo and the name of the department: 'Department of Reproductive Health and Research'. The main text area on the right contains the title, context, objective, and methods sections.

World Health Organization

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

Adolescents and reproductive health

Shanghai

Context

An increasing number of young people in China is engaging in sexual relations before marriage and the age at 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 behaviour. The intervention group was then introduced to a specially designed web site entitled (literal translation) "Fighting youthhood", which offered sexual and reproductive health knowledge and service information, low 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 10-month intervention period. The control group did not have access to the special 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 behaviour.

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Authoritative responses to concerns of Member States



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 hormonal contraceptives (COCs) and combined estrogen-progestin menopausal therapy. The outcome will be an IARC Monograph to be published.

This was an update of a similar review undertaken in 1999-2000. At that time, COCs were categorized as "possibly carcinogenic to humans" (Group 2B). On the basis of the subsequent data, this review makes a definite classification of COCs and changed the classification from "possibly carcinogenic to humans" (Group 2B) to "not classifiable as to its carcinogenicity" (Group 3).

A summary of the new risks to IARC was given in the WHO Weekly Bulletin. The evidence in this report makes it clear that, over the past years, age and use were assessed by scientific bodies and widely discussed in the media. It is striking of the IARC Classification that it is new.

IARC regularly convenes groups of experts to evaluate the carcinogenic risks to human beings of agents, combinations of agents or their metabolites or derivatives as published in the IARC Monographs. It is important to note that IARC uses the overall risk-benefit profile of complex health terms, even in terms of overall cancer burden that have a positive effect on cancer control or the risk of some others.

Combined oral contraceptives
As stated in IARC's review, the use of COCs slightly decreases the risk of cervical cancer, but increases the risk of breast, liver, and stroke (if smoked). Some of these risks refer to older



WHO STATEMENT ON HORMONAL CONTRACEPTION AND BONE HEALTH
July 2008

Several 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 oral hormonal contraception, especially progestin-only methods (POPs), and the risk of bone loss. In response, WHO convened a consultation in Geneva on 23-25 June 2008, to assess current evidence on the relationship between the use of oral 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 fractures. Bone mineral density (BMD) measurements are commonly used to diagnose 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, but 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 use 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.

Progestin-only methods of contraception

With regard to progestin-only methods, data on longitudinal impacts suggest no adverse effect on BMD. Other low-dose progestin-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 OMRs 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 OMR 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 lesser across a variety of studies. Cross-sectional studies show lower BMD in long-term OMR users by approximately 0.5 SD at hip and spine compared with non-users. In longitudinal studies, adults (25-50 years) and adolescents (premenarche to $+10$ years) both lost around 1 to 2 percent (approximately 0.5 SD) of BMD in the same sites after 2 years of continuous use of OMRs. The rate of loss appeared to increase over time.

When OMR 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-OMR users with a period of 2 to 3 years. It is not clear whether the loss in BMD among adolescent users of OMRs prevents attainment of potential peak bone mass. There remains a concern that older women who reach the menopause while still using OMRs may no longer have the opportunity to regain BMD before entering the period of bone loss normally associated with the postmenopause.



Statement on hormonal contraception and risk of STI acquisition
July 2005

A study published by Morrison et al. in transmitted infection (STI) among sexually transmitted infections (STI) among sexually active women using hormonal methods of contraception (Morrison et al., 2005). Results did not suggest chlamydia or gonococcal infection as hormonal contraception. For women chlamydia infection (95% confidence contraceptive methods. However, the difference in populations of users at finding.

Subsequently, WHO's systematic review modifies the risk of acquiring a STI in the Guidance Steering Group who conclude guidance, namely: there are no contraindications to using hormonal methods of contraception for women who are at risk of acquiring a STI.

Reference:
1. Morrison GS, Singh P, Wong EL, Kwak C. Hormonal contraceptive use, seroviral etiology, and STI acquisition. *Sexual Transm Infect* 2004; 80: 561-567.



Hormonal Contraception and HIV: Science and Policy
Africa Regional Meeting
Nairobi 16-21 September 2006

STATEMENT

The World Health Organization Headquarters Office and Regional Office for Africa, in partnership with the Reproductive Health and Family Research Unit of the University of Witwatersrand in South Africa in WHO Collaborating Centre, International Planned Parenthood Federation Africa Region and Family Health International (FHI), convened a meeting of 73 representatives from 17 reproductive, biological and epidemiological 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 seronegative sex partners, together with family planning experts. 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 as a subset of an intervention trial from Kenya/Morogoro, Kenya, showed that users of hormonal contraceptives have a 1.5-fold increased risk of acquiring HIV infection compared with non-users. Other studies conducted among

sex workers have found similarly elevated rates. However, it is not known whether such risks also apply to users 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 Cambodia, 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 restriction on the use of COCs and POPs by women at risk of acquiring HIV, consistent with the current WHO Medical Eligibility Criteria for Contraceptive Use guidelines. However, participants supported 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 POPs to prevent unwanted 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 unwanted 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.

Reproductive health home page - Microsoft Internet Explorer provided by WHO

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

Reproductive health home page

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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

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- 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 Kaen 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/



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 (STI/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, STI/RTIs, and maternal health

Evidence-based tools

Family planning



Maternal and newborn health



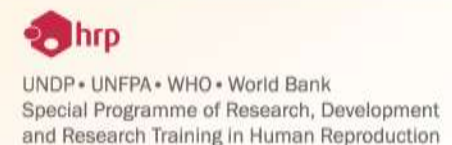
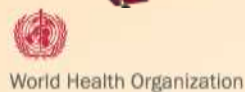
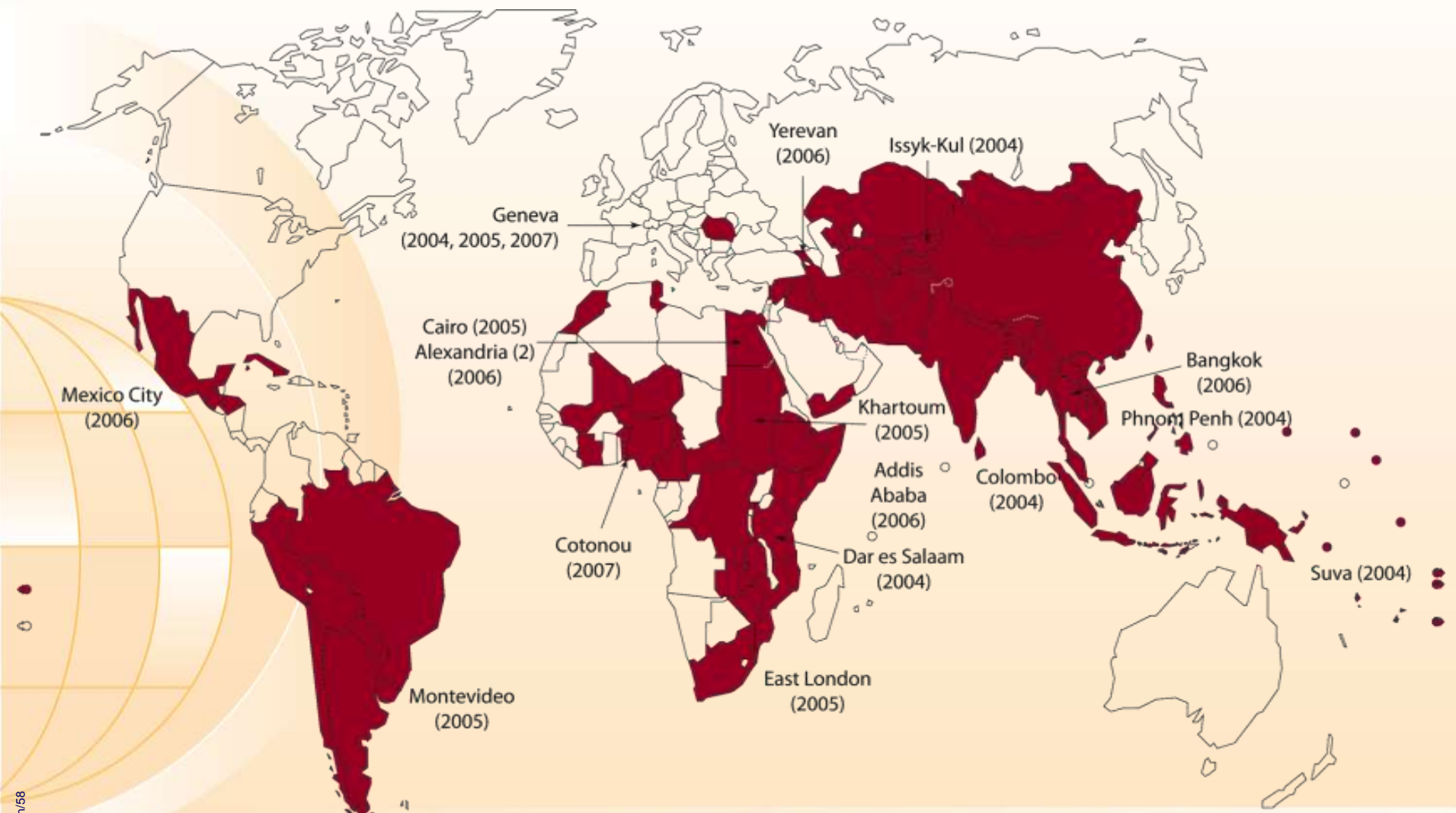
STI/RTI control



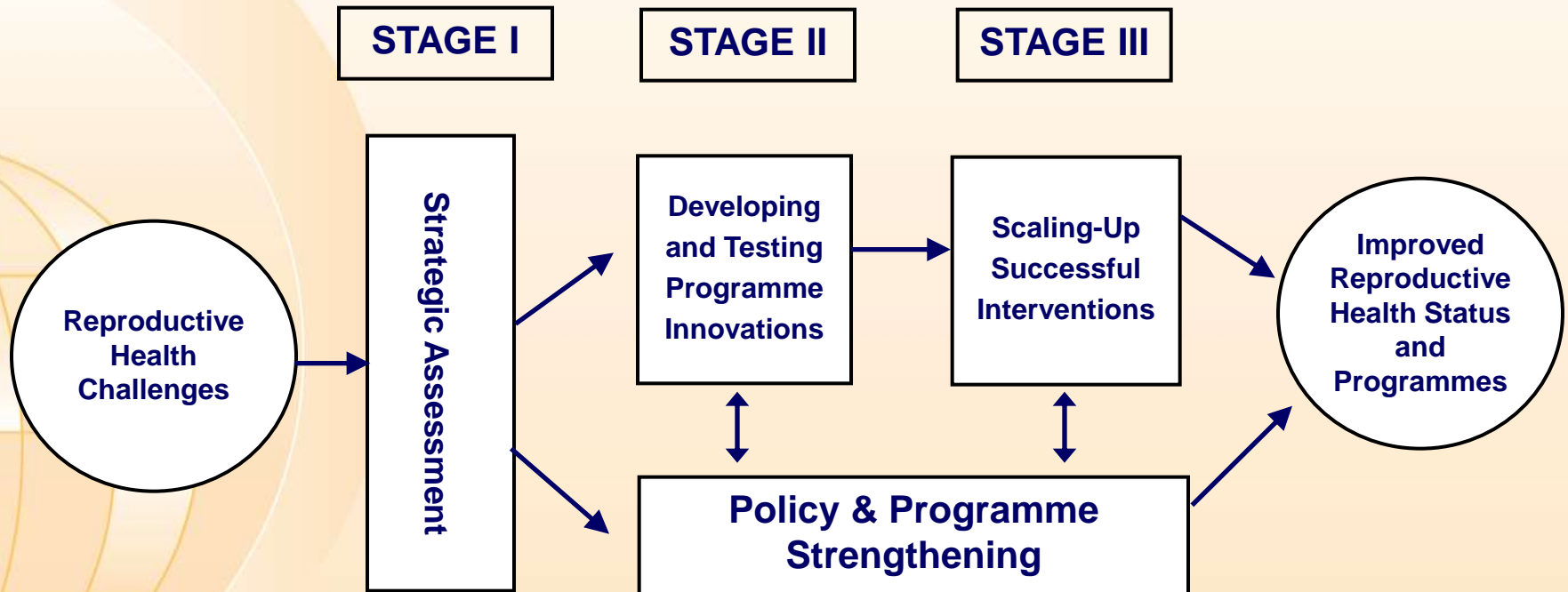
Further information on SRH guidelines including online electronic versions: www.who.int/reproductive-health - Further information on SPP activities: mbizvom@who.int



The UNFPA/WHO Strategic Partnership Programme



The Strategic Approach Implementation Process



Using the Strategic Approach in Countries to Strengthen Reproductive Health Programmes



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Support to countries

- Repositioning family planning
- Strengthening linkages between sexual and reproductive health and HIV/AIDS services (incl. submission to the Global Fund to Fight AIDS, TB and Malaria)
- VIA for cervical cancer prevention
- Screening for congenital syphilis
- Promoting gender and human rights



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Lancet series on sexual and reproductive health



Main papers

1. Epidemiology of sexual and reproductive ill-health: Glasier et al. (4 November 2006)
2. Sexual behaviour: Wellings et al. (11 November 2006)
3. Family planning: Cleland et al. (18 November 2006)
4. Unsafe abortion: Grimes et al. (25 November 2006)
5. Sexually transmitted infections: Low et al. (2 December 2006)
6. Call to action: Fathalla et al. (9 December 2006)

Commentaries (4 November 2006)

- ICPD – looking back: Langer
- Sexual health: rights and responsibilities: Shaw
- Sex, politics and money: Thomas



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Art for health

Comment

1. Lengua T, Iversen A. Inequalities in health and justice for promoting malaria. *Current Opinion in Infectious Diseases* 2004; 9: 200-203.
2. Lengua T, Iversen A. Inequalities in health and justice for promoting malaria. *Current Opinion in Infectious Diseases* 2004; 9: 200-203.
3. Lengua T, Iversen A, Wadhvani S, Iversen A. Reducing malaria's burden: evidence of effectiveness for education in India. *Washington, DC: Global Health Council*; 2002: 17-24.
4. Report of a WHO study group. Malaria vector control and personal protection. 2006. <http://www.who.int/malaria/files/WHO-TS-2006.pdf>
5. Elong J, Chabrie F, Guille P, Mounji L. Reducing the efficacy of personal protective equipment against an insecticide resistance strain with outdoor-based pyrethroid resistance. *Malaria* 2004; 5: 40.

Art for women's health

The difference in the sexual and reproductive health status of women in developed and developing countries is vast. This disparity represents one of the starkest examples of social injustice of our time. About 530,000 pregnant women and 3 million newborn babies die every year because of complications related to pregnancy and childbirth. Almost all these deaths happen in developing countries. Similarly, sexually transmitted infections, reproductive tract infections, cervical cancer induced by the human papillomavirus, and other gynaecological disorders disproportionately affect the most vulnerable and disenfranchised populations of women.

Much could be done to rectify these situations if more people were informed about and mobilised to act towards the improvement of global sexual and reproductive health. Greater advocacy and support for sexual and reproductive health interventions—including information-based campaigns, for example—could lead to substantial changes in the dire conditions many women and their newborn babies currently endure. The intention of the Art for Health project is to contribute to these efforts in an innovative way. Specifically, the project uses contemporary art as a medium to increase people's awareness of sexual and reproductive health issues around the world, particularly those that negatively affect the lives of women and their families.

Participants at the XVIII World Congress of the International Federation of Gynecology and Obstetrics (FIGO)—in Kuala Lumpur, Malaysia, Nov 5-10, 2006—will be able to view the first set of contemporary artworks produced for the Art for Health project at WHO's stand. The project is actively endorsed by the WHO Department of Reproductive Health and Research (RHR), which has commissioned 18 paintings and is sponsoring the first exhibition of a selection of the congress. The department is also using the artwork for promotional material and publications.

The paintings that will be featured at the congress portray women from diverse ethnic and social back-

grounds. Within the images are messages by the women themselves that call on the viewer to join them in a unified effort to better their lives and those of future generations. The statements incorporated into the two generations. The statements incorporated into this Comment are representative pieces accompanying this Comment are modifications of famous quotes of outspoken women's agency, and collective action. "Same sky, same women", for example, promotes awareness of an underlying tie connecting women around the world (figure 1). "I want to fight with dreams in my soul, with you" furthers this sentiment by asking viewers to engage in partnerships with women living in low-resource nations, partnerships that are characterised by mutual respect and shared



Published online November 1, 2006
DOI:10.1016/S1473-3099(06)70044-4



Figure 1: Same sky, same women. Shobita Farooq, 2006, acrylic on canvas.

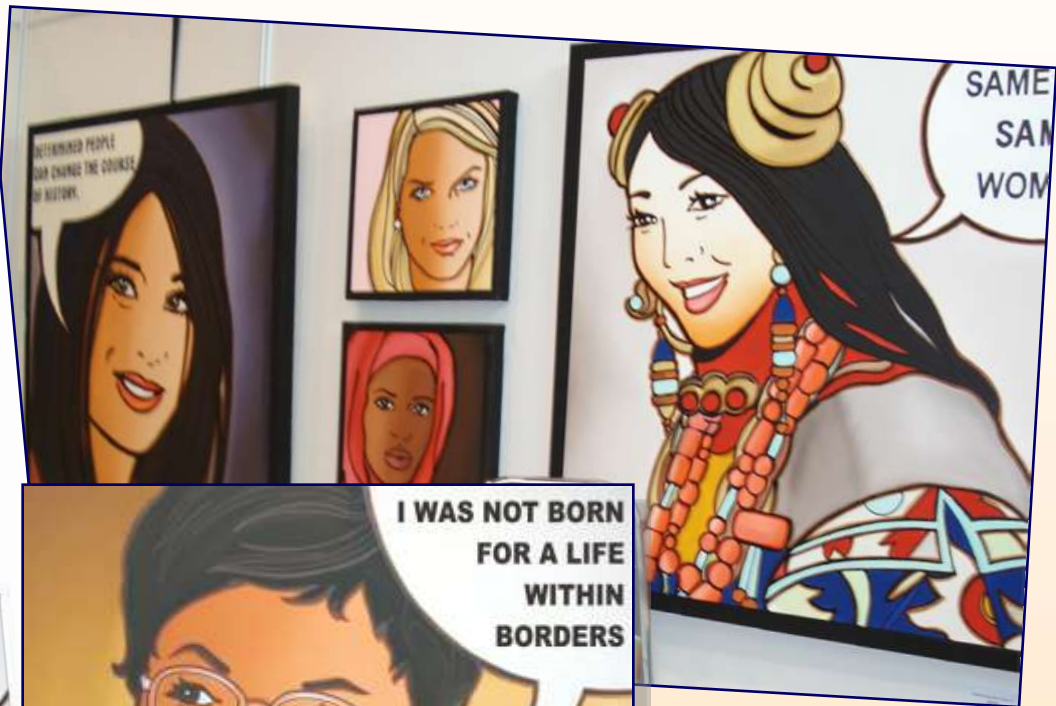


Figure 2: I was not born for a life within borders. Shobita Farooq, 2006, acrylic on canvas.

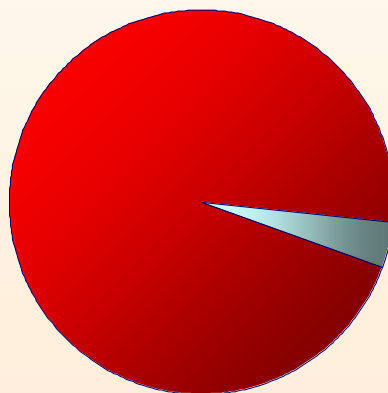
www.thelancet.com Vol 368 December 16, 2006

Departmental budget 2008-2009

RHR

■ Extrabudgetary funds ■ Regular budget funds

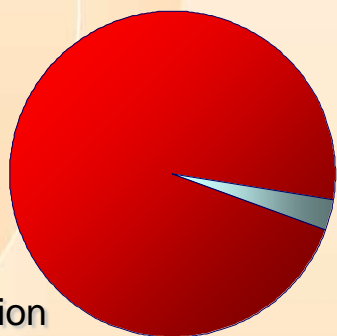
US\$ 73 million
(96%)



US\$ 3 million
(4%)

HRP

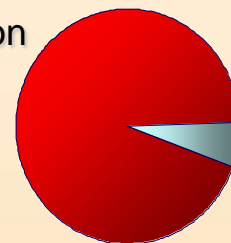
US\$ 48.4 million
(97%)



US\$ 1.5 million
(3%)

PDRH

US\$ 24.6 million
(94%)



US\$ 1.5 million
(6%)



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"If you think research is expensive, try disease."

(Mary Lasker)



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