

Celebrating the Impact of the Human Reproduction Programme

HRP at 50

Sexual and reproductive health and rights across the life-course



Since 1972, the UN co-sponsored special programme, HRP, has pursued a vision of sexual and reproductive health and rights (SRHR) for all. This is the first in a series of stories to share key moments from HRP's history and the impact of its work on advancing the attainment of SRHR. Find out more about the Human Reproduction Programme [here](#).

From a call for research to impacting lives

Early adolescence is one of the most crucial stages in human development and one that has typically been understudied. In 2010, HRP organized a research priority-setting exercise on the sexual and reproductive health of very young adolescents, which led to the conception of the first global study of gender socialization in young adolescents – the Global Early Adolescent Study (GEAS). Starting in 2012, this 15-country longitudinal study, led by the Johns Hopkins Bloomberg School of Public Health in conjunction with HRP, explored how social constructions of gender influence adolescent health and wellbeing, including sexual and reproductive health, and how these processes unfold over time in different cultural, economic and geographical contexts.

During the first phase of the study, 2012–2016, researchers developed three new tools to assess gender norms and attitudes in 10-14 year olds. The tools were pilot-tested in 450 adolescent-carer dyads in 13 sites and quantitative surveys were carried out with around 2500 adolescents. As well as its technical contribution, HRP provided support to the Johns Hopkins Bloomberg School of Public Health and to study sites in Belgium, China, Ecuador, Egypt and India.

HRP was instrumental in drawing out and disseminating lessons learned from the first phase of the study, including the widespread nature of unequal gender attitudes and norms across geographic and sociocultural settings, different

personal and societal expectations of boys and girls, the influence of race, ethnicity, class, and immigrant status on gender norms and attitudes, and the key role parents and peers play in shaping gender norms and attitudes.

While the second phase of interventional and observational research is ongoing in ten countries, the large body of evidence generated since 2012 has helped to move gender socialization in young adolescents higher up the global agenda for action and investment.

HRP successfully used the findings from the first phase of the GEAS to advocate for the inclusion of content on building equitable gender norms in the 2018 update of the [UN International Technical Guidance on Comprehensive Sexuality Education](#), as a core member of the working group for the guidance.

Venkatraman Chandra-Mouli, Adolescent Sexual and Reproductive Health and Rights Lead at WHO/HRP, says “This guidance is informing the development and updating of national curricula on sexuality education around the world. It is heartening to see how a call for research by HRP led to a multi-country study, which generated evidence that was used to update global normative tools that are being rolled out globally. Building solid cognitive, emotional, and social skills in adolescence lays the foundation for sexual and reproductive health and well-being throughout the trajectory of boys and girls lives.”

“ The study shone a spotlight on how early inequitable gender attitudes and norms develop in different contexts. By exploring young people’s beliefs about gender, relationships, and social norms in their communities, we now better understand the factors that predispose them to future sexual health risks, ” says Venkatraman Chandra-Mouli, Adolescent Sexual and Reproductive Health and Rights Lead at WHO/HRP

Origins in family planning

As young people begin developing relationships and exploring their sexuality, contraception becomes a consideration for the first time. HRP was established in 1972 with a focus on fertility regulation and developing new approaches to family planning, following a resolution at the 1965 World Health Assembly recognizing that scientific knowledge on the biology of human reproduction and medical aspects of fertility control was insufficient, necessitating a programme on human reproduction within WHO. This later evolved into the HRP of today. Forty-five years later, in 2017, the use of modern contraceptives prevented an estimated 308 million unintended pregnancies worldwide.

HRP has conducted and coordinated a number of multi-centre trials on the safety and efficacy of various contraceptive methods over the years, providing important evidence to prevent unplanned pregnancies and provide greater choice to couples and individuals. This research has contributed to the development of methods such as combined monthly hormonal injectable contraception, contraceptive implants, and emergency contraception regimens using levonorgestrel that have gone on to be registered in over 100 countries and included as one of 13 life-saving commodities by the UN Commission on Life-saving Commodities for Women and Children.

HRP has channelled the evidence from its research on contraceptives into improving the quality of care in family planning – one example is the [Medical Eligibility Criteria for Contraceptive Use](#) (MEC). First published in 1996, the document presents the latest WHO guidance on the safety of different contraceptive methods for women with specific health conditions and characteristics. The



fourth edition was awarded first prize in the 2011 British Medical Association Book awards under the category of obstetrics and gynaecology.

Now in its fifth edition, the MEC has been shared thousands of times with each update, and remains one of HRP's longest standing achievements for its impact on the lives of women and their families by strengthening family planning care.

One of its derivatives, the Medical Eligibility Criteria Wheel for Contraceptive Use (or [MEC wheel](#)) provides the information in summary form, allowing family planning providers to quickly assess a woman's medical eligibility to begin using contraceptives. Since 2019, the wheel has been available digitally in the form of an app.

Kiarie added "Contraceptive needs and choice change over time depending on individual economic, medical, and social circumstances. Despite the availability of effective interventions, certain groups, including adolescent girls, unmarried women, the poor, and people with disabilities can face barriers to accessing contraceptives when they need them."

“ Family planning sustainably addresses people’s and the planet’s need for health, peace, and prosperity by enabling the delaying and spacing of pregnancies, and by preventing unintended pregnancies and unsafe abortions, ” says James Kiarie, Head of the Contraception and Fertility Care Unit at WHO/HRP



International Conference on Population Development (ICPD) Programme of Action underscored the importance of preventing and managing unsafe abortion and providing services for safe abortion.

Starting in the 1980s, HRP conducted several randomized controlled trials that were critical for the development of medical abortion regimens, including collaboration with numerous medical centres and academic institutions around the world, to explore the safety and efficacy of misoprostol and mifepristone in combination and misoprostol alone for the medical management of abortion.

The results of these trials contributed to the inclusion of these medications in WHO's first technical [guidance](#) on abortion, published in 2002. This subsequently supported the decision to add the combination of mifepristone followed by misoprostol to the WHO complementary list of essential medicines in 2005, as a medical abortion regimen and important reproductive health medication to decrease maternal mortality and morbidity.

In the years that followed, new evidence, including that generated by HRP, proved that these medications are very safe and can be provided by a range of health workers, including nurses and midwives, and can also be self-managed in early pregnancy. New recommendations reflecting these findings were made in the [2015](#) and [2018](#) WHO abortion care guidelines and, following subsequent review by the Essential Medicines List (EML) Committee, these medications were moved from the complementary to the WHO [core list](#) of essential medicines in June 2019, with the indication that the combination regimen should be available everywhere and it removed the stipulation that direct supervision was needed.

Defining and preventing unsafe abortion

There were an estimated 121 million unintended pregnancies in women aged 15-49 years each year between 2015 and 2019, and 61% of these ended in abortion, according to HRP research. Further, 45% of these abortions were unsafe in 2017.

HRP first coined the widely used definition of unsafe abortion in 1992 and began publishing estimates of abortion safety thereafter. The 1994

“ Access to safe abortion enhances reproductive autonomy during a woman’s child-bearing years. HRP’s work on the development of medical abortion regimens as an additional option to surgical abortion was central to improving the safety of abortion procedures, ” says Bela Ganatra, Head of the Prevention of Unsafe Abortion Unit at WHO/HRP

Generating evidence to galvanize an end to FGM

In some countries, particularly in parts of Africa, Asia and the Middle East, social conventions and cultural ideals of femininity dictate that girls from infancy through to the age of about 15 years undergo female genital mutilation (FGM) as preparation for adulthood and marriage. The procedure involves removing part or all of the external female genitalia or other injury to the female genital organs for non-medical reasons.

According to estimates, over 200 million girls between the ages of 15 and 19 years alive today have undergone FGM. The practice comes with risks to women's health over the course of their lives, including their uro-gynaecological and obstetric health, as well as their mental and sexual health. In 2006, HRP led a prospective [study](#) examining the effects of three different types of FGM on obstetric outcomes in over 28 000 women in Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan, and found that FGM was associated with significantly greater risk of complications during childbirth and higher death rates among infants.

On the basis of these findings and other evidence, in 2008 HRP coordinated an inter-agency [statement](#) with ten UN agencies (OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM and WHO) calling all states, international and national organizations, civil society and communities to uphold the rights of girls and women and end FGM. This statement led the World Health Assembly to pass a resolution that same year denouncing FGM as a human rights violation and a public health issue and calling on countries to accelerate their efforts to eliminate FGM and ensure affected girls and women received the care they need.

These global commitments, along with the available evidence, led to the development of the [Global Strategy Against Medicalization of FGM](#) in 2010 and a comprehensive package of evidence-based resources to support the health sector to prevent FGM and provide high quality care in the management of its complications. According to estimates, the prevalence of FGM decreased from 49% in 1991 to 34% of girls aged 15-19 years in 2021.

“ HRP's evidence and resources are the foundation for countries implementing zero tolerance policies, engaging the health sector in multisectoral prevention and care efforts, and supporting health workers to be advocates for change, ”

says Christina Pallitto,
FGM lead at WHO/HRP

Shaping quality of care during pregnancy

The journey through pregnancy and childbirth is greatly impacted by the care and communication that women receive. Many adverse outcomes for mothers and babies can be prevented with quality healthcare during pregnancy and childbirth, including implementing timely and appropriate evidence-based health promotion, disease prevention, screening and treatment practices during antenatal care (ANC).

HRP has been instrumental in shaping quality of care through pregnancy. In 2001, the results of HRP's cluster-randomized controlled trial investigating whether a model of antenatal care based on a four-visit schedule with evidence-based education, screening, and therapeutic interventions, was as effective as the standard of care, were published. The findings, based on over 24 000 women attending 53 ANC clinics in Argentina, Cuba, Saudi Arabia and Thailand, led to WHO recommending a focused approach to antenatal care (FANC) in 2002. This approach was widely adopted until reports of an increased risk of perinatal

mortality with the reduced-visit model in low- and middle-income countries. In 2013, HRP's secondary analysis of ANC trial data found an increased risk of fetal death between 32 and 36 weeks' gestation for women who received the FANC package.

HRP has been instrumental in shaping quality of care through pregnancy.

Taking this new evidence on perinatal death, alongside other developments across the scope of ANC, including an emerging body of evidence on ANC interventions and health systems, HRP/WHO convened a group of global experts to develop a new comprehensive guideline on ANC. Capturing the complex issues surrounding ANC practices and prioritizing person-centred health and well-being of pregnant women, the '*2016 WHO recommendations on antenatal care for a positive pregnancy experience*' set out 49 recommendations guiding countries on providing evidence-based





“ The journey from the ANC trial to the SMART Antenatal Care Guidelines demonstrates the key role HRP plays in the end-to-end process from conducting research, to synthesising evidence, developing recommendations, and supporting implementation at national level, ”
says Özge Tunçalp, Medical Officer, WHO/HRP

ANC services. The guidelines also replaced the FANC model with the new 2016 WHO ANC model, recommending a minimum of eight antenatal contacts during pregnancy, with an emphasis on enhancing the quality of the contact to prevent and effectively manage complications.

These recommendations were one of HRP's first to follow a 'living guidelines' approach, using a combination of continuous surveillance of the literature, rapid updating of systematic reviews, and virtual consultations with expert panels to ensure the latest evidence and up-to-date recommendations reach end users. Since 2016 updates were published on multiple micronutrient supplements and vitamin D supplements during pregnancy in 2020, an update on zinc supplements during pregnancy in 2021, and updated recommendations on imaging ultrasound before 24 weeks of pregnancy, including implementation guidance for countries, in 2022.

Several tools were developed to support

adaptation and implementation of the recommendations, including the antenatal care recommendations [adaptation toolkit](#), developed by HRP in collaboration with Ministries of Health, WHO regional and country offices, implementation experts and country stakeholders, facilitating tailoring of context-specific recommendations to local situations. In February 2021, a dynamic repackaging of the guidance in the form of the WHO SMART Antenatal Care Guidelines was [launched](#) - the first WHO guidelines to use the SMART (Standards-based, Machine-readable, Adaptive, Requirements-based, and Testable) approach to support countries to integrate the recommendations into their national digital systems to accelerate adoption.

The 2016 ANC guideline includes a recommendation for health care providers to consider clinical enquiry about the possibility of intimate partner violence during ANC visits while assessing conditions that could be caused or complicated by intimate partner violence.

Building the evidence base on violence against women

Nearly one in three women globally has experienced physical and/or sexual violence from a partner or sexual violence from a non-partner in their lifetime. This figure, published by WHO/HRP in 2021, has remained more or less the same since WHO/HRP produced the first global and regional estimates of violence against women in 2013, in collaboration with the London School of Hygiene & Tropical Medicine and the South African Medical Research Council.

The first internationally comparable prevalence data on women's health and domestic violence were published in 2005, in a project led by WHO with support from HRP. The study, based on interviews with 24 000 women in 15 sites across ten countries, revealed widespread violence by male partners in all ten countries. It also established a gold-standard method for ethical, safe, and standardized ways to gather information on violence against women.

Claudia García Moreno, Unit Head of the Addressing the Needs of Vulnerable Populations Unit at WHO/HRP, coordinated the WHO multicountry study. She said "the study would not have been possible without the support of HRP."

Starting with the multicountry study, WHO/HRP has strived to build equal partnerships with and meaningfully engage women's rights organizations in research processes.

HRP's work on building the evidence base has generated data that have been instrumental in elevating violence against women as a global public health and development priority. The 2015 Sustainable Development Goals Agenda included an explicit target on the elimination of violence

against women and girls, SDG 5.2, with indicators for governments to track progress and report on the prevalence of intimate partner violence and non-sexual partner violence – indicators which were adopted based on the technical work and consensus building efforts of WHO/SRH with the UN and other partners. HRP and WHO now lead efforts to help track these indicators in partnership with UN Women and working closely with UNFPA, UNICEF and UNSD.

Furthermore, in 2016 SRH/HRP used data and evidence on the prevention and response to violence against women to build consensus that culminated in the [global plan of action to strengthen the role of the health system in the multisectoral response to interpersonal violence](#), in particular against women and girls and against children (resolution 69.5) which was endorsed by the Ministries of Health of 194 WHO Member States. It included improving the evidence and collection and use of robust data as one of its four strategic directions.

HRP continues to strengthen the measurement of violence experienced by specific groups, including adolescent girls, women with disabilities and older women.



Nearly 1 in 3 women globally have experienced physical and/or sexual violence from a partner or sexual violence from a non-partner in their lifetime.

“ Gathering epidemiological evidence to help understand the nature of violence against women and the prevalence and health impacts of intimate partner violence in different settings and age groups over time has been essential to put the issue on the public health agenda, ” says Claudia García Moreno, Unit Head of the Addressing the Needs of Vulnerable Populations Unit at WHO/HRP





Providing global leadership on sexual health

Freedom from violence and coercion is key to positive, pleasurable, and safe sexual relationships and good sexual health. Sexuality is a fundamental part of being human, reflecting individual desires, values and practices in the context of a complex interplay between physiological, psychological, social, economic, cultural, political, religious and spiritual factors. The concept of sexual health was first articulated by WHO in 1975 as 'the integration of the somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love.'

In 2002, HRP and the WHO Department of Reproductive Health and Research recognized the need to revisit this definition in a globally changing environment and, in collaboration with the WHO Department of Child and Adolescent Health and Development, as well as the Department of HIV/AIDS, convened a group of over 60 international experts to define sexual health and related issues. The resulting

working definitions of 'sexual health', 'sex', 'sexuality' and 'sexual rights' were published in 2006, reasserting sexual health as a key part of the human experience throughout the life-course, and remain in use today.

In 2010, HRP reviewed the working definition of sexual health and published a [framework](#) operationalizing the approach to sexual health to raise awareness in programming and research. The framework, [updated](#) in 2017, outlines six cross-cutting principles that should be incorporated into the design of all sexual health interventions, including consideration of the diversity of sexual health needs across the life-course in different settings and situations.

The definitions and framework have served to inform research, guidance, and measurement work across the world, for example, contributing to the components of SRHR described in the 2018 [report](#) of the "Guttmacher–Lancet Commission on sexual and reproductive health and rights for all".

“ Maintaining sexual health is a lifelong process with important implications far beyond the reproductive years. More work is needed to elaborate and develop interventions and guidance for improving sexual health and well-being across the life-course that go beyond a focus on specific problems, such as sexually transmitted infections or sexual violence. HRP will continue to research in this area, ” says Lale Say, Head of the SRH Integration in Health Systems Unit at WHO/HRP

Improving one's own sexual and reproductive health and well-being

HRP continues to lead the way in identifying and acting upon new priority topics, including acknowledging the essential role that laypeople play in managing their own sexual and reproductive health and in their role as caregivers. On average, individuals spend less than one hour each year with a health worker compared with over 8700 hours each year in [self-care](#). After conceptualizing the health systems and people-centred aspects of self-care and reviewing the available evidence, in 2019 HRP/WHO published the [first consolidated guideline](#) on self-care interventions for health and well-being, to support access to, uptake and use of self-care interventions for SRHR. This included recommendations for new uses of existing interventions, such as self-administration of injectable contraception, and improving access to and coverage of effective interventions that are not widely available in some settings, such as self-testing for pregnancy.

The importance of interventions that can increase autonomy and self-determination at every stage of people's lives became even more apparent during the COVID-19 pandemic. The 'living' guideline on self-care interventions was [updated](#) in 2022, outlining guidance across the spectrum of SRHR – including over-the-counter contraceptives, self-management of medical abortion, self-monitoring of blood pressure during pregnancy, self-testing for HIV, self-sampling to screen for cervical cancer, self-use of lubricants to promote sexual health – and across the life-course, from pre-conception, adolescence to older age.



To better understand the lived experiences of end users, HRP conducted an online global values and preferences [survey](#) and in-person focus group discussions with underserved communities and adolescents and young people. The feedback from 1350 health workers and lay people in 113 countries on the knowledge, use, and uptake of 17 different self-care interventions for SRHR was an essential part of the [qualitative input](#) to the global guidance.

The weight of the evidence accumulated thus far demonstrates that being able to access and use self-care interventions has a positive effect on health decision-making, health actions, and health outcomes.

By generating evidence and guidance to prevent unintended pregnancies, unsafe abortion, FGM, and violence against women, as well as articulating what quality, respectful SRH care, comprehensive sexuality education, and self-care can achieve, HRP is leading the way in helping people attain the best SRHR outcomes, throughout their lives and wherever they are in the world.

“ By considering the needs of different age groups and people's changing priorities over time, self-care interventions have the potential to improve sexual and reproductive health and rights at each stage in life, ”
says Manjulaa Narasimhan, Self-Care Lead at WHO/HRP

Contact us: Department of Sexual and Reproductive Health and Research, World Health Organization
Avenue Appia 20, 1211 Geneva 27, Switzerland • Email: srhrp@who.int
[www.who.int/teams/sexual-and-reproductive-health-and-research-\(srh\)/human-reproduction-programme](http://www.who.int/teams/sexual-and-reproductive-health-and-research-(srh)/human-reproduction-programme)

Page 10



HRP at 50: sexual and reproductive health and rights across the life-course
(Celebrating the impact of the Human Reproduction Programme)

ISBN 978-92-4-007064-6 (electronic version)

ISBN 978-92-4-007065-3 (print version)

© World Health Organization 2023. Some rights reserved.

This work is available under the [CC BY-NC-SA 3.0 IGO](#) licence.

9789240070646



9

789240 070646

March 2023