REGIONAL COMMITTEE

Seventy-first Session
New Delhi, India
3–7 September 2018

Special Programmes:
UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP): Policy and Coordination Committee (PCC) – Report on the attendance at PCC in 2018 and nomination of a Member in place of Myanmar whose term expires on 31 December 2018

The Policy and Coordination Committee (PCC) acts as the Governing Body of the Special Programme of Research, Development and Research Training in Human Reproduction.

At present, three Member States from the WHO South-East Asia Region (Bhutan, Myanmar and Sri Lanka) are Members of the PCC in Category 2, while India and Thailand continue to be Members of the PCC in Category 1. Since the term of office of Myanmar ends on 31 December 2018, representatives at the High-Level Preparatory (HLP) Meeting were requested to consider proposing one of the Member States of the WHO SEA Region to serve on the PCC for a three-year term of office from 1 January 2019.

The attached working paper was presented to the HLP Meeting which recommended that, since the term of Myanmar ends on 31 December 2018, Nepal serve on the PCC for a three-year term of office from 1 January 2019. The recommendations made by the HLP meeting for consideration by the Seventy-first Session of the Regional Committee are as follows:

Actions by WHO

- Document the nomination of Nepal based on the recommendations made at the HLP Meeting for inclusion in the Regional Committee Working Paper and update the Department of Reproductive Health and Research (RHR) at WHO headquarters after the Regional Committee Session.
- Share the finalized report of the PCC meeting held during 20-21 March 2018 in Geneva as and when available.

This Working Paper and the HLP Meeting recommendations are submitted to the Seventy-first Session of the WHO Regional Committee for South-East Asia for its consideration and decision.
**Introduction**

1. The Policy and Coordination Committee (PCC) of the Special Programme of Research, Development and Research Training in Human Reproduction acts as the Governing Body of the Special Programme and is responsible for its overall policy and strategy. For coordinating the interests and responsibilities of the Cooperating Parties in the Special Programme, it:

   - reviews and decides upon the planning and execution of the Special Programme;
   - reviews and approves the plan of action and budget for the coming financial period prepared by the Executing Agency and reviewed by the Scientific and Technical Advisory Group (STAG) and the Standing Committee;
   - reviews the proposals of the Standing Committee and approves the arrangements for financing of the Special Programme;
   - reviews the proposed longer-term plans of action and their financial implications;
   - reviews the annual financial statements submitted by the Executing Agency, and the audit report thereon, submitted by the external auditor of the Executing Agency;
   - reviews periodic reports that evaluate the progress of the Special Programme towards the achievement of its objectives;
   - reviews and endorses the selection of members of STAG by the Executing Agency in consultation with the Standing Committee; and
   - considers such other matters relating to the Special Programme as may be referred to it by any Cooperating Party.

**Composition**

2. The PCC consists of members from among the Cooperating Parties as follows (Annex 1):

   (1) Largest financial contributors (Category 1): 11 government representatives from countries that are the largest financial contributors to the Special Programme, including India and Thailand.

   (2) Countries elected by WHO regional committees: 14 Member States are elected by the WHO regional committees for three-year terms according to population distribution and regional needs. The three countries currently representing the South-East Asia Region under this category (Category 2) are: Bhutan, Myanmar and Sri Lanka. In its election, due account is taken of a country's financial and/or technical support to the Special Programme, as well as its interest in the fields of family planning, and research and development in human reproduction and fertility regulation, as demonstrated by its national policies and programmes.

   (3) Other interested Cooperating Parties (Category 3): Two members are elected by the PCC for three-year terms from the remaining Cooperating Parties. None of the countries from the South-East Asia Region falls within this category.
(4) Permanent members: These comprise the cosponsors of the Special Programme, namely, UNAIDS, UNDP, UNFPA, UNICEF, WHO, the World Bank, and the International Planned Parenthood Federation (IPPF).

(5) Observers: Other Cooperating Parties may be represented as observers upon approval of the Executing Agency, which is the World Health Organization, after consultation with the Standing Committee. Observers may attend sessions of the PCC at their own expense.

3. Members of the PCC in Categories 2 and 3 may be re-elected.

**Action to be taken by the Regional Committee**

**Report on the PCC session**

4. The Regional Committee at its Sixty-eighth session recommended that the PCC members elected by it should report to the next session of the Regional Committee, giving a summary of the deliberations of the last PCC session attended by them. The report of the PCC meeting held during 20–21 March 2018 in Geneva, Switzerland, has been received from WHO Headquarters on 20 August 2018 and attached (Annex 2) for information at the Seventy-first Session of the Regional Committee.

**Membership from the South-East Asia Region under Categories 1, 2 and 3**

5. The following table depicts PCC membership from the South-East Asia Region over the past years.

<table>
<thead>
<tr>
<th>Country</th>
<th>Period</th>
<th>Elected by</th>
<th>Paragraph of the Memorandum on the administrative structure under which elected</th>
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<tr>
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<td>India</td>
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<td>Country</td>
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<td>Indonesia</td>
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<td>Sri Lanka</td>
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<td>Regional Committee</td>
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<td>1994–1996</td>
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<td>2017–2019</td>
<td>Regional Committee</td>
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<td>1986</td>
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<td>PCC</td>
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<td>1991–1993</td>
<td>Regional Committee</td>
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<td>Regional Committee</td>
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<td></td>
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<td>Timor-Leste</td>
<td>2014–2016</td>
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6. At present, three Member States from the South-East Asia Region are members of the PCC: Bhutan, Myanmar and Sri Lanka. Since the term of office of Myanmar ends on 31 December 2018, the HLP Meeting recommended that Nepal serve on the PCC in Category 2 for a three-year term from 1 January 2019 to 31 December 2021.

7. While selecting Nepal as the Member State, the HLP Meeting took into account the country’s financial and/or technical support to the Special Programme, its interest in the fields of family planning, and research and development in human reproduction and fertility regulation, as demonstrated by its national policies and programmes. It also considered the country’s track record of being a member of the PCC in the past under Categories 2 and 3 during 2005–2007 and 2012–2014, respectively.

8. The recommendation of the HLP Meeting is being submitted to the Seventy-first Session of the Regional Committee for its consideration.
Annex 1

Category 1: Largest financial contributors in the previous biennium (2016–2017)

- China
- Flemish Government, Belgium
- Germany
- India
- Netherlands
- Norway
- Sweden
- Switzerland
- Thailand
- United Kingdom of Great Britain and Northern Ireland
- United States of America

Category 2: Countries elected by WHO regional committees

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
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<tbody>
<tr>
<td>Bhutan</td>
<td>2018–2020</td>
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<td>Czech Republic</td>
<td>2018–2020</td>
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<tr>
<td>Fiji</td>
<td>2017–2019</td>
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<tr>
<td>Iran (Islamic Republic of)</td>
<td>2018–2020</td>
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<td>Mauritius</td>
<td>2016–2018</td>
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<td>Mozambique</td>
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<td>Myanmar</td>
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<td>Namibia</td>
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<td>Papua New Guinea</td>
<td>2016–2018</td>
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<td>Peru</td>
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<td>Philippines</td>
<td>2018–2020</td>
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<td>Sri Lanka</td>
<td>2017–2019</td>
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<td>Venezuela (Bolivarian Republic of)</td>
<td>2016–2018</td>
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</tbody>
</table>

Category 3: Other interested Cooperating Parties

- Burkina Faso                  | 2018–2020  |
- Uruguay                       | 2018–2020  |

Category 4: Permanent members

- UNDP                           |
- UNFPA                          |
- UNICEF                         | Co-sponsors |
- WHO                            |
- The World Bank                 |
- IPPF                           |
- UNAIDS                         |
THIRTY-FIRST MEETING OF THE POLICY AND COORDINATION COMMITTEE (PCC)

20-21 MARCH 2018

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

ECHO  evidence for contraceptive options and HIV outcomes
FIGO  International Federation of Gynecology and Obstetrics
GAP  Gender and Rights Advisory Panel
H6  UNAIDS, UNPA, UNICEF, UN Women, WHO and The World Bank Group
HRP  Special Programme of Research, Development and Research Training in Human Reproduction
ICD  International Classification of Diseases
IPPF  International Planned Parenthood Federation
IPU  Inter-Parliamentary Union
LMIC  low- and middle-income countries
MISP  minimum initial service package
OHCHR  Office of the High Commissioner for Human Rights
PCC  Policy and Coordination Committee
RHR  Reproductive Health and Research
SDG  Sustainable Development Goal
SRH  sexual and reproductive health
SRHR  sexual and reproductive health and rights
STAG  Scientific and Technical Advisory Group
STI  sexually transmitted infection
TDR  Special Programme for Research and Training in Tropical Diseases
UHC  universal health coverage
UNDP  United Nations Development Programme
UNESCO  United Nations Economic, Social and Cultural Organisation
UNFPA  United Nations Population Fund
UNHCR  United Nations High Commissioner for Refugees
UNICEF  United Nations Children’s Fund
WHO  World Health Organization
Executive summary

At its Thirty-first meeting, held in Geneva on 20 and 21 March 2018, the Policy and Coordination Committee (PCC) of the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) took the following actions:

Agenda item 1. Welcome, adoption of the agenda and election of presiding officers

1. APPOINTED Dr Eric Rafai, Fiji, as Vice-Chair of the 31st PCC.
2. APPOINTED Dr Petr Velebil, Czech Republic, as rapporteur of the 31st PCC.
3. ADOPTED the agenda.

Agenda item 2. Remarks of the Assistant Director-General, Family, Women, Children and Adolescents cluster

1. EXPRESSED THANKS to the Assistant Director-General for her support to HRP.
2. RECOMMENDED consideration of a high-level working group to promote integration of education and health, especially for the sexual and reproductive health and rights of all adolescents.
3. EXPRESSED THANKS to the Assistant Director-General for her assurance that the specialized needs of HRP would be taken into account in application of the WHO rotation and mobility policy.

Agenda item 3. Adoption of the report of PCC(30), review of implementation of recommendations and remarks by the Chair

1. ADOPTED the report of the 30th meeting of the PCC, and NOTED the follow-up actions in response to PCC recommendations.
2. RECOMMENDED the use of "push" notifications when documents become available for upcoming PCC meetings.

Agenda item 4. Director’s annual report 2017

1. CONGRATULATED HRP on the extensive work portfolio and the achievement of the targets.
2. RECOMMENDED that certain themes of the portfolio could be grouped strategically for reporting on achievements and to inform future directions for HRP’s research and normative and implementation work.
3. RECOMMENDED that emphasis on adolescent sexual and reproductive health and rights be sustained, including country-level implementation research and a focus on comprehensive sexuality education.
4. RECOMMENDED more explicit reporting on how gender and rights are incorporated in HRP’s portfolio.

Agenda item 5. Financial reports

1. NOTED the financial reports and WELCOMED the new format of financial reporting.
3. REQUESTED that HRP include in future financial reports: (i) staff cost expenditure against the ceiling set by the PCC, (ii) expenditure analysis for all the budget sections and (iii) expenditure by the World Bank income groupings.
4. NOTED the lower carry-over funds than in previous years and EXPECTED that HRP would continue to reduce the carry-over.

5. EXPRESSED CONCERN about the potential effect of designated funding on human resources for other projects.

6. APPROVED the proposal for a new HRP policy on budget revision.

**Agenda item 6. External evaluation**

1. RECOMMENDED that the external evaluation specifically consider and assess the structure and efficiency of the PCC as part of the governance process and management.

**Agenda item 7. How can HRP’s research strengthen health systems for universal health coverage**

1. WELCOMED the important discussion on strengthening HRP’s contribution to universal health coverage and invited HRP to consider the remarks made during the discussion and to report at the next meeting of the PCC on progress made and the way forward.

**Agenda item 8. Reports of the committees**

**Sub-item 8.1 Standing Committee**

1. CONGRATULATED the Standing Committee on the strong engagement of cosponsors in a large number of activities, including those on estimating maternal mortality, skilled birth attendance and links between SRHR and HIV.

2. RECOMMENDED that a more strategic approach or framework be presented to highlight the planning for cosponsor engagement and collaboration in various activities.

3. RECOMMENDED that engagement with the H6 partnership be strengthened to better connect and update HRP’s research.

4. NOTED that engagement from UNDP had been limited and welcomed UNDP’s commitment to a more robust engagement henceforth.

5. ENCOURAGED continued engagement from cosponsors.

**Sub-item 8.2 Scientific and Technical Advisory Group (STAG)**

1. NOTED and ADOPTED the report and recommendations of the Scientific and Technical Advisory Group (STAG).

2. ENDORSED the appointments of Dr Asha George (South Africa) and Dr Tari Turner (Australia) to STAG and the reappointment for a second term of Dr Ulysses Panisset (Brazil), for three-year terms starting on 1 January 2019.

3. ENDORSED the appointment of Dr Anita Hardon (Netherlands) as Chair of STAG.

**Sub-item 8.3 Gender and Rights Advisory Panel (GAP)**

1. WELCOMED and ENDORSED the report of the Gender and Rights Advisory Panel (GAP) and recommendations, and commended the strategic approach in GAP interventions.
2. RECOMMENDED that HRP ensure integration of gender equality and human rights in all its portfolios of work, and further RECOMMENDED that it continue to develop its work on accountability, remedies and redress for sexual and health and rights.

3. ENDORSED the reappointment of Dr Pascale Allotey (Ghana), Dr Sheena Hadi (Pakistan) and Dr Kaye Wellings (United Kingdom) for a second three-year term starting on 1 January 2019.

Sub-item 8.4 HRP Alliance Advisory Board

1. NOTED and WELCOMED the progress of the work of the HRP Alliance.

Agenda item 9. SRHR, human rights, and HRP’s research agenda following the WHO-OHCHR recommendations

1. THANKED the panellists for their presentations, and UNDERSCORED the importance of continued work on sexual and reproductive health and rights in the research agenda.

Agenda item 10. Innovation and roadmaps – HRP’s roles along the pathway from research and development to registration to scaling up

1. NOTED and WELCOMED the diverse portfolio of innovations and research, which were at various stages of maturity towards becoming global public goods.

2. RECOMMENDED that HRP highlight “end-to-end thinking” for innovation introduction, and ENCOURAGED the Department to report on research to improve uptake of existing innovations in addition to the development of new products.

3. NOTED concerns about the poor availability of “combi-packs” for medical abortion and other essential medicines, including monitoring the quality standards of the drugs, inclusion for prequalification and sustainable financing approaches.

4. RECOMMENDED that HRP increase its focus on the availability and accessibility of innovations in low- and middle-income country (LMIC) markets, particularly by addressing barriers related to commercial pricing and intellectual property.

5. RECOMMENDED that end-users and communities be included in the design and development of innovations, including in the identification of gaps and market failures and in research on social innovations.

Agenda item 11. Sexual and reproductive health and rights in humanitarian settings: HRP’s work in partnership

1. THANKED the panellists for their presentations, and UNDERSCORED the importance of continued work on sexual and reproductive health and rights in humanitarian settings.

Agenda item 12. Pledging for 2018 and subsequent years

1. NOTED and THANKED all donors for their generous contributions.

Agenda item 13. Date and venue of the 2019 meeting and tentative date for 2020

1. AGREED to hold the 32nd meeting of the PCC on 20 and 21 March 2019 in Geneva and proposed 25 and 26 March 2020 as tentative dates for the 33rd meeting of the PCC.
Agenda item 14.  Review and approval of the draft report of the meeting

1.  APPROVED the draft summary report of the meeting.
1. Welcome, adoption of the agenda and election of presiding officers

Mr Sander Spanoghe, Chair of the Policy and Coordination Committee (PCC), opened the meeting. He welcomed the strong presence of cosponsors, the high-level representation from countries and the two Member States that had newly been appointed to the PCC: Burkina Faso and Uruguay. He said that the order of the first few items would be changed.

He invited the PCC to adopt the draft agenda as revised orally.¹ The agenda was adopted.

He invited members to nominate a vice-chair for the session. The delegate from The Netherlands proposed that Fiji be appointed, and the delegate from the United States of America endorsed the proposal. Dr Eric Rafai, ² Fiji, was nominated as Vice-Chair.

The Chair invited members to nominate a rapporteur for the session. The delegate from Norway proposed that the Czech Republic be appointed. Dr Petr Velebil, Czech Republic, was appointed as rapporteur.

PCC:

1. APPOINTED Dr Eric Rafai, Fiji, as Vice-Chair of PCC.

2. APPOINTED Dr Petr Velebil, Czech Republic, as rapporteur of PCC.

3. ADOPTED the agenda.

¹ See Annex 2 for the agenda.

² See Annex 1 for the list of participants.
2. Remarks of the Assistant Director-General, Family, Women, Children and Adolescents cluster

Dr Princess Nothemba Simelela said that the PCC provided important oversight of HRP’s work. Observers in particular acted as a mirror, revealing blind spots that were not seen by others. Achieving UHC would require different “packages” at different levels of care and in different countries, and the content of the SRHR package should be defined. As some countries might be uncomfortable with certain aspects of SRH in primary health care, innovative pathways such as community organizations must be found to introduce them. Resources had been received to respond to humanitarian emergencies, and SRHR could be promoted in work on achieving Sustainable Development Goals (SDGs) 3 and 5.

Dr Simelela urged the team to consider the ultimate goals of their outputs, such as whether their estimates, publications or guidelines would reduce maternal mortality at country level. Guidelines were important, but countries should be strengthened to use them. More collaboration should be sought with other WHO programmes that affected women, children and adolescents, such as those on noncommunicable diseases, alcohol abuse and air pollution, especially through digital technology. WHO should be positioned as a critical player in countries. She urged the PCC to continue to challenge HRP staff and to offer their expertise to advise them.

Discussion

The delegate from Switzerland made a statement on behalf of Belgium, Germany, The Netherlands, Norway, Sweden, Switzerland and the United Kingdom. She said that the group firmly believed that policies and programmes should be based on human rights principles and scientific evidence. In view of the Director-General’s strong commitment to SRH, HRP had a strong role to play in achieving better health outcomes. They commended HRP on ensuring communication at strategic moments, such as the evidence briefs provided at the Family Planning 2020 summit in 2017. WHO and other cosponsors should continue to take opportunities to communicate HRP’s work, so that it was more widely known and used. While commending WHO’s rotation policy, the group considered that positions that required a highly specialized profile should be exempted, and she asked for clarification with regard to HRP’s research staff.

The representative of France welcomed the progress made in the past year. At a time when SRHR was regularly challenged and science was being superseded by ignorance, research on SRH should provide clear scientific information about the benefits of interventions to ensure the health and rights of women. The SRHR of women and young people were essential for sustainable development, and she called on WHO and HRP to continue to promote those rights. On International Women’s Day on 8 March, France had launched its new five-year international strategy for equality between women and men, centred on women’s rights and a gender approach.

The representative of the Global Fund for Women urged that partnerships with women’s groups and movements be strengthened to increase the impact of guidelines.

The representative of the International Federation of Gynecology and Obstetrics (FIGO) commented that, in view of the growing population of adolescents globally, SDG 4, for inclusive, equitable, high-quality education, was also relevant with regard to SRHR.

The representative of the International Women’s Health Coalition, noting that sustained opposition to SRHR was often based on ideology and not on evidence, urged WHO and HRP to ensure their presence at all high-level political events in order to debunk myths and clarify issues. The example of the Philippines showed that obstacles could be overcome with WHO technical assistance.

The representative of the Concept Foundation said that unsafe abortion was still a major cause of mortality worldwide, and the momentum established in HRP’s work on safe, high-quality abortion should be maintained.
The representative of Reproductive Health Matters asked for specific information on how HRP ensured that gender and rights were included in its research, normative work and technical support.

The representative of International Planned Parenthood Federation (IPPF) welcomed the strong partnership with her organization. HRP’s guidelines were extremely useful in service delivery and were the basis for the handbooks and guidance they produced.

The co-Chair of GAP, Dr Carmen Barroso, commented that integration of SRHR and HIV prevention and control were both part of UHC. She suggested that WHO call for a high-level group on education and health to provide political impetus for the area.

The representative of the International Committee for Monitoring Assisted Reproductive Technology stressed the importance of integrating infertility into general women’s health care. He supported HRP’s work on digitalization of data, which could promote self-care, bring people together and increase capacity.

The representative of Family Planning 2020 thanked HRP for its normative guidelines on SRHR, which increased technical capacity and provided standards for operationalizing a rights-based approach, especially for reaching adolescents and young people. She asked for guidance on how her organization could work more effectively with WHO.

Dr Simelela replied that WHO’s new mobility policy was intended to ensure a strong country presence, by continually interrogating the quality and competence of the staff of WHO country offices to ensure that they were responsive to the countries’ needs. She said that the scope of global health had changed, and a multisectoral structure was needed to sustain investment in health. WHO staff must therefore be conversant not only with health but also with education, finance, sanitation and the environment. WHO would be "fit for purpose" at all levels only if its focus was shifted to countries. Research teams would not necessarily be moved from headquarters to country offices, but they should have a deliberate, strategic approach to conceptualizing their work. In choosing collaborating centres, they might favour those that involved and built the capacity of young public health students, particularly from developing countries, rather than established academics. The first step was to strengthen WHO country and regional offices to respond better to country needs.

PCC:

1. EXPRESSED THANKS to the Assistant Director-General for her support to HRP.
2. RECOMMENDED consideration of a high-level working group to promote integration of education and health, especially for the sexual and reproductive health and rights of all adolescents.
3. EXPRESSED THANKS to the Assistant Director-General for her assurance that the specialized needs of HRP would be taken into account in application of the WHO rotation and mobility policy.
3. Adoption of the report of PCC(30), review of implementation of recommendations and remarks by PCC Chair

The Chair invited members to adopt the report of the thirtieth meeting of the Committee. The report was adopted without amendment.

The delegate from The Netherlands requested that documents for the meeting be sent to members earlier, so that they could provide high-quality feedback. Dr Askew, Director, Department of Reproductive Health and Research (RHR), replied that issuance of documents on financial matters depended on WHO’s accounting procedures. All other documents had been sent 10 days before the PCC meeting. Members would be informed as new documents became available on the WHO app.

In the discussion on implementation of recommendations, the delegate from Switzerland commented that the response to the Committee’s request for options for tracking the use of guidelines and research findings to show impact went beyond HRP’s mandate. More analytical, systematic solutions to such tracking had been expected.

The Chair said that the point would be a standing issue at each meeting of the PCC. He expressed concern about representation of sexual and reproductive health (SRH) at the various high-level forums that were held each year. Parts of the world were living in denial of SRH and rights (SRHR), which led to high morbidity and mortality. HRP should continue to monitor the situation and strengthen research into solutions.

PCC:

1. ADOPTED the report of the 30th meeting of the PCC, and NOTED the follow-up actions in response to PCC recommendations.

2. RECOMMENDED the use of “push” notifications when documents become available for upcoming PCC meetings.
4. Director’s annual report 2017

Dr Ian Askew, Director, RHR, welcomed Member States, organizations and the large number of observers. He recalled that 2017 had been a tumultuous, volatile year, with dynamic changes in the positions of Member States with regard to SRHR and gender equality and heightened engagement between governments and civil society. The work of HRP went beyond research and normative issues to global involvement, including in humanitarian settings as part of global alliances. HRP had had a large impact globally, regionally and nationally, and he described the impacts of his “top ten” research outcomes.

HRP had collaborated with a number of universities on a systematic review of research on how gender roles developed from early childhood, boys and girls having different social expectations. Another systematic review had been published on interventions to reduce rapid, repeated pregnancies among adolescents, which had implications not only for health but also for communities. Abortions had now been classified as “safe”, “less safe” and “least safe” for defining practices and for legal purposes; at least 45% of abortions were estimated to be less or least safe. The management of complications arising from female genital mutilation had also been addressed in systematic reviews. Maternal morbidity was considered a lower priority than mortality, and countries should be supported in defining, measuring and tracking morbidity and its effect on functioning and well-being. Engaging women and communities was crucial for improving the quality of care during childbirth, and research was under way into what women wanted to make childbirth a positive experience. Another project was ensuring that adequate commodities were available for antenatal care, and a study in Mozambique had shown that a simple focus on the supply system could have impressive results. HRP was leading research on policy and systems approaches for controlling and mitigating the effects of sexually transmitted infections (STIs) other than HIV, of which there were more than one million new cases per day. Strategies had been identified for advancing point-of-care diagnostics for prevention and control. The worldwide problem of antimicrobial resistance was, however, making gonorrhoea even more difficult and sometimes impossible to treat.

He emphasized the importance of data for designing and monitoring programmes and for accountability to decision-makers. A group of experts had met to find an operational definition of sexual health, from the perspective not only of disease but also sexual experiences and sexual health programmes. Work was being conducted on other definitions, including a new section on sexual health in the 11th revision of the International Classification of Diseases (ICD); a standard definition of maternal morbidity that included interventions; and regional and global trends in the timing of antenatal care visits, encouraging earlier, more frequent visits. HRP had issued four guidelines in 2017, on: responding to children and adolescents who had been sexually assaulted; use of tranexamic acid in the treatment of post-partum haemorrhage; screening and treatment for syphilis in pregnant women; and SRHR of women living with HIV, which reflected the perspectives of the affected community. HRP was designing tools to ensure that countries adopted the guidelines.

Dr Askew described how HRP was moving from defining global policy to local action, with its cosponsors. The approaches included clear communication of evidence and clear, usable guidelines that did not require extensive technical support; tools to support their adoption and scaling up by countries in partnership with WHO offices and technical assistance partners; implementation research to guide scaling up; strengthening health systems, especially through digital solutions; and meeting requests for normative advice. He gave an example of use of guidelines that did not require technical support, in which Afghanistan had been advised on preventing intimate partner violence, with positive results. Normative advice had been provided at the request of the Philippines, and a statement on the safety and efficacy of certain contraceptive commodities had been prepared to ensure their availability. In Ireland, guidance had been provided on safe abortion. A network had been set up to ensure quality, equity and dignity in maternal, newborn and child health care in all countries. Through a donor, grants were provided through regional offices to increase access to family planning products and advice. The Implementing Best Practices initiative for family planning and reproductive health had more than 50 partners, with 12 000 professionals to facilitate networking, including webinars.
He said that, in response to the request from the PCC, the Programme was conducting implementation research to guide national work on universal health coverage (UHC) by scaling up guidelines and interventions. The HRP Alliance was strengthening national research capacity by building a global, interactive network of research partners, embedding capacity-strengthening within research projects, strengthening regional and national capacity for conducting and using research and collaborating with other research partnerships. In response to the request from the PCC to clarify how HRP could benefit its cosponsors, he said that UNFPA had a new strategic plan for 2018–2021, with four goals relevant to all the cosponsors. UNICEF’s strategy for health 2016–2030 was to end preventable maternal, newborn and child deaths and to promote the health and development of all children, with a focus on adolescents. UNDP’s strategic plan 2018–2021 included collaborative planning with UNFPA, UNICEF and UN Women in improving adolescent and maternal health, achieving gender equality and the empowerment of women and girls and ensuring greater availability and use of disaggregated data. With regard to HIV, health and development, UNDP was promoting effective, inclusive governance for health, reducing inequality and social exclusion and building resilient, sustainable health systems. The priorities of the World Bank for 2016–2020 included assisting countries in accelerating their progress towards UHC to end extreme poverty and promote shared prosperity, including reproductive, maternal, adolescent health and gender and ageing and health. The mission of WHO’s 13th Global Programme of Work 2019–2032 was “to promote health, keep the world safe and serve the vulnerable”, with one billion more people leading healthier lives, with health coverage and made safer. Strategic shifts would be required in leadership, diplomacy and advocacy; gender equality, health equity and human rights; multisectoral action; and financing. The global goods would be normative guidance, agreements, data, research and innovation. The driving impact in each country depended on its capacity and its vulnerability.

Dr Askew said that, in 2018, the work of HRP would include ensuring that SRHR was integrated into responses to humanitarian emergencies and disease outbreaks, with the Health Emergencies office at WHO; integrating SRHR into national “packages” of interventions for UHC; moving towards elimination of cervical cancer; responding to countries’ requests for extending access to safe abortion; broadening work on digital data and health technology; leading user-initiated interventions in sexual and reproductive health care; and steering global work in increasing access to high-quality, affordable fertility care, for which a new post had been created within HRP. He thanked all HRP’s donors and partners.

**Discussion**

In response to a comment from Dr Pascale Allotey, co-Chair of GAP, that the PCC officers were all men, Dr Askew said that was not HRP’s policy. Furthermore, WHO was consulting the Department in its review of procedures to prevent and respond to incidents of sexual harassment. WHO and the Office of the High Commissioner for Human Rights (OHCHR) were launching a formal framework on gender, health and human rights, and he recalled that GAP and STAG had issued a joint statement on the political challenges to such a framework in 2017.

The delegate from the Philippines thanked HRP for facilitating access to a number of contraceptives by convincing its national Food and Drug Administration of their safety and efficacy. He looked forward to further cooperation.

The delegate from Belgium asked for clarification of the method used to estimate the number of people worldwide who were infertile. She welcomed the emphasis on adolescent SRHR and on comprehensive sex education and asked how that would be implemented in the projects in southern and eastern Africa.

The delegate from The Netherlands congratulated HRP on its work. She looked forward to the results of new work on abortion, SRHR in humanitarian settings and infertility and asked for more information on comprehensive sex education for adolescents and on intervention research. With regard to the impact of HRP’s research, it was not clear which results were associated with each theme; grouping of themes, projected outcomes and better linkages to partners would be useful.
The delegate from Sweden commented that the Director’s annual report would be a good advocacy tool with regard to antimicrobial resistance.

The delegate from Switzerland agreed that the report was a good communication tool. Most targets appeared to have been achieved, as the strategic approach allowed a large number of achievements; however, she requested greater clarity with regard to actual outcomes.

The delegate from Norway welcomed the timely, interesting work on increasing digitalization and use of webinars, which made the work of HRP more visible. She also welcomed the increasing number of partnerships, the work on application of guidelines and the integration of SRH.

The Chair of STAG said that the report to the Guttmacher–Lancet Commission on SRHR had been accepted and would be published in May 2018, after a launch in Johannesburg, South Africa. He suggested that the definition of SRHR in that paper would be useful to HRP.

The representative of UNFPA also welcomed the new emphasis on gender rights and adolescent sexual health and education, but also for ageing societies. Work on infertility was being encouraged in Member States. Comprehensive sex education should be seen as empowering.

Dr Askew thanked the group for their positive remarks. He said that comprehensive sex education and targeting adolescents were being integrated into virtually all HRP’s projects. HRP had been involved in formulating the international technical guidance on sex education from UNESCO. The work on infertility would be described at the next PCC meeting, when HRP would present its results more strategically, with timelines and showing how they fit together.

**PCC:**

1. CONGRATULATED HRP on the extensive work portfolio and the achievement of the targets.

2. RECOMMENDED that certain themes of the portfolio could be grouped strategically for reporting on achievements and to inform future directions for HRP’s research and normative and implementation work.

3. RECOMMENDED that emphasis on adolescent SRHR be sustained, including country-level implementation research and a focus on comprehensive sexuality education.

4. RECOMMENDED more explicit reporting on how gender and rights are incorporated in HRP’s portfolio.
5. Financial reports

Mr Craig Lissner, Programme Manager, described the new approach to financial reporting of HRP, which comprised a certified financial report for 2016–2017 and a financial management analysis and outlook. At the request of the PCC, both reports provided more detail on expenditure and an emphasis on operational support rather than operations and were harmonized with those of the Special Programme for Research and Training in Tropical Diseases (TDR) and the Alliance for Health Policy and Systems Research.

The current budget, approved by the PCC in 2017, was US$ 68.4 million. Revenue was US$ 62.1 million, with a lower carry-over cash balance than in the previous biennium. Income in 2016–2017 was derived overwhelmingly from governments and non-State actors, and two cosponsors had also contributed (WHO US$ 1.077 million and UNFPA US$ 0.255 million). He recalled that, in each biennium, the 11 Member States that contributed the most became “category 1” members of the PCC for the following biennium, in accordance with the memorandum on the administrative structure of HRP, and he thanked them all for their generous contributions. The only cosponsors and United Nations agencies that had made contributions had been UNFPA and WHO. Engagement with all cosponsors was being strengthened, and it was hoped that others would make contributions in 2018. Funds from non-State actors were an important source of revenue for HRP, and Mr Lissner recalled WHO’s procedure for engagement with non-State actors, which required due diligence and risk assessment for all such contributions. He mentioned the long-term support of the Bill & Melinda Gates Foundation and an agreement with Merck to fund a research project on the effectiveness of heat-stable carbetocin. The PCC had requested a report on designated funding, which could be accepted only according to the guidelines approved by the PCC in 2017: that it be only for work that was in the approved programme of work, that it did not affect HRP’s scientific independence and if it covered the full cost of implementation, including staff costs. The share of such contributions had increased over the past decade, to represent 38.8% of income in 2016–2017.

HRP’s expenditure had reached 99% of the approved budget in 2016–2017. Although expenditure was not entirely equivalent to the budget for all activities, as explained in detail in the analysis of financial management, the two were clearly converging. Designated funding had been raised to cover almost all Programme areas. In the area of maternal and perinatal health, which had overspent its budget, significant designated funding for the carbetocin project had been received, so that undesignated core contributions had not had to be used. HRP was respecting the request by the PCC to insist on full cost recovery in agreement with donors of designated funds.

Also in response to a request from the PCC, he presented a breakdown of the cost of operations (research, research capacity-strengthening, technical activities and cross-cutting work such as communication and human rights) and of operational support. Operations represented over 80% of costs, whereas operational support represented 12% of the total.

Funds for projects had also been leveraged directly. Thus, projects were supported not only by HRP but also by partners. For instance, in a multicentre study with a protocol and coordination provided by HRP, funding partners might pay for the study in one or more centres; or partners might pay for national or local participants in a training course organized by the Department. Such funds went directly to the activity or project. Each year, staff was asked to report activities in which such funding had been used. In 2016–2017, 31 projects had received a total of US$ 432 000 from HRP and an estimated US$ 1.8 million from implementing partners.

The financial outlook depended on the revenue requirements in the approved budget, the available resources and a projection of the resources to be received. After accounting for carry-over balances at the beginning and end of the biennium and outstanding commitments from 2017, on 1 January 2018 HRP had a net carry-over of US$ 17.2 million. The revenue received in 2018 was already US$ 18.5 million, for a total of US$ 35.7 million available. Although that represented a 48% budget shortfall, 21 months remained in the biennium, and, if conservative projection of income were included, the gap would be reduced to about 20%. Sustained fund-raising and donor stewardship would be important during the remainder of the biennium.
Mr Lissner said that he would welcome comments on the new analytical approach, as it was important that it respond to the Committee’s reporting requirements.

**Discussion**

Delegates welcomed the increased financial implementation. The delegate from The Netherlands noted, however, that the amount of carry-over funds was still high and should be reduced further. Her remarks were echoed by a number of participants, and by donating countries in particular.

The delegate from the United Kingdom asked why expenditure for equipment and supplies differed significantly each year and how much expenditure was for research partners.

The delegate from Switzerland asked for analyses of all thematic budget sections that deviated from their targets to better understand differences in execution. She and the delegate from Norway said that, if the short-fall persisted, the short-term funding strategy and prioritization defined previously should be used. If members tried to raise funds in their countries, as they had been asked to do, they should better understand the reasons for the short-fall. She asked that the time contributed by HRP staff be factored into estimates.

The delegate from Belgium asked for clarification of the unexpected pharmacovigilance cost in relation to the budget for the carbocin trial.

Responding to comments, Mr Lissner said that staff costs had amounted to 35% of the budget, which was under the ceiling of 40%. The budget was driven by designated funding, which accounted for the overspending on the research project on carbocation. Dr Gülmezoglu added that the project consisted of a very large trial on post-partum haemorrhage, with 30 000 samples, which had to be conducted at the regulatory level of rigor. The multinational contract research organization that had been contracted to conduct the trial had massively underestimated the number of site visits and medication coding and recording. The donor that was financing the trial had provided the additional funds required. Equipment and supplies represented less than 1% of the budget, as most was paid for by partners. He agreed that explanations could be provided for all budget sections that showed any variance. There was no procedure for budget revision during the year; however, a proposal for budget revisions had been distributed to members, that was based on WHO policies for internal budget increases, which gave the Chair the authority to reduce or increase the budget ceiling under certain conditions. For example, the budget might be increased by additional funding, such as for health emergencies. The proposal would allow HRP to make adjustments to the budget between meetings of the PCC.

**PCC:**

1. **NOTED** the financial reports and **WELCOMED** the new format of financial reporting.


3. **REQUESTED** that HRP include in future financial reports: (i) staff cost expenditure against the ceiling set by the PCC, (ii) expenditure analysis for all the budget sections and (iii) expenditure by the World Bank income groupings.

4. **NOTED** the lower carry-over funds than in previous years and **EXPECTED** that HRP would continue to reduce the carry-over.

5. **EXPRESSED CONCERN** about the potential effect of designated funding on human resources for other projects.

6. **APPROVED** the proposal for a new HRP policy on budget revision.
6. External evaluation

The Chair described the composition of the external evaluation subcommittee, which consisted of the chairs of STAG and GAP, UNFPA representing the Standing Committee (Anneka Knuts son), the Chair and the co-Chair of the PCC, The Netherlands (Ini Huijts) and Switzerland as back-up (Susanne Amsler). The terms of reference for the evaluation were being drawn up, with selection of case studies and a template to ensure well-structured, uniform outputs. A list of consultants and consultancy firms was being made. The next steps would be a limited call for proposals, selection of the winning bid and contracting; once the case studies had been completed, the subcommittee would report back to GAP, STAG and the PCC in 2019.

One of the case studies would be on HRP’s work in co-designing, monitoring and reporting on SRHR indicators, including in the context of implementation of the 2030 Agenda for Sustainable Development and of the Every Woman Every Child Global Strategy for Women’s, Children’s and Adolescents’ Health. Another would be on HRP’s work on comprehensive maternal and perinatal health, including postpartum contraceptive use. The third would be on HRP’s work on gender, equity and rights, including broader work from the perspective of “leave no one behind”. The fourth would be on the flexibility and fitness for purpose of more recent work streams, such as adolescent SRHR and SRHR in humanitarian settings and health emergencies.

The delegate from the United Kingdom proposed that the external evaluators also examine the structure and function of the PCC.

PCC:

1. RECOMMENDED that the external evaluation specifically consider and assess the structure and efficiency of the PCC as part of the governance process and management.
7. How can HRP’s research strengthen health systems for universal health coverage

Dr Askew said that the item would provide an opportunity for members to give HRP guidance on what more HRP could do in countries, regions and the world to achieve SHRH as part of UHC.

Dr Lale Say, RHR, said that at least half the world’s population still did not have full coverage of essential health services, about 100 million people were still being pushed into “extreme poverty” by health care costs, and almost 12% of the world’s population spent at least 10% of their household budget on health care. All United Nations Member States had agreed to achieve SDG target 3.8, which was to ensure UHC. WHO and the World Bank had identified two indicators for reaching that target, which were coverage of essential health services for both the general and the most disadvantaged populations and the proportion of the population with large household expenditure on health as a share of total household expenditure or income; however, there was currently no guidance on how they should be measured routinely. For operationalization of UHC, WHO had launched a call to action at the United Nations General Assembly in 2017, to protect populations of all ages with health services at different levels, from community to referral care; the framework also included social determinants of health and climate and environmental factors. A cross-cluster group at WHO was defining the health services required at each level and in different systems, so that individual countries could identify appropriate guidance. Achievement of UHC would be measured on the basis of its three dimensions: health services, health expenditure and quality. A robust method was required to measure the impact of UHC on health outcomes, and WHO had designed a framework for measuring health system strengthening for UHC.

The GAP had recommended consideration of a number of issues: people-centredness, with a focus on people as rights holders and not just as consumers; intersectionality, such as how income affected acute vulnerability; and ensuring that the poorest sections of the population did not experience a financial burden. UHC could be ensured only if all populations and services were recognized with governance and laws to safeguard the most vulnerable. Thus, financial protection was necessary but not sufficient, and strengthening health systems and assuring community engagement were essential. HRP contributed by providing guidelines on SRHR interventions in UHC and would provide minimal essential packages according to the type of health system. It conducted research on the effectiveness, access to, equity and acceptability of interventions, such as improving the quality and coverage of antenatal care, ensuring the availability and use of “combi-packs” for abortions, providing software to determine coverage, quality and equity at points of care and strengthening health system capacity to respond to gender-based violence. Dr Say asked the PCC to describe experiences from their countries that might guide others, to identify the research questions that should be priorities for HRP and to recommend actions that would help ensure that coverage of SRH was not seen as a low priority in countries.

Discussion

The representative of UNICEF said that UHC would be an important means of reducing the growing inequity in countries. Health insurance was increasingly being used in the growing number of middle-income countries, such as Ghana and the Philippines; in addition, the quality of care should be addressed cross-sectorally and not only at the level of ministries of health. HRP could use case studies to inform emerging middle-income countries about such initiatives. Measurement of the impact of UHC should distinguish between its actual contribution and attribution of impact.

The representative of IPPF said that comprehensive sex education for adolescents and young people was essential, while social norms and legislation often did not ensure that no one was left behind. The example of the Philippines showed how that HRP could bring about fundamental changes without political discussions.

The delegate from the Philippines described his country’s experience in developing essential packages for use at different levels. Post-abortion care could be proposed if it addressed less and least safe abortions, but could not be part of a package, because abortion was not allowed in his country. Provision of family planning was decided on the basis of an annual review of the health insurance database to determine the demand. As 10% of pregnancies in his country were among women under 20 years, he would be interested in knowing the mortality and morbidity outcomes of adolescent pregnancies for both the mother and the child. One way of ensuring that SRHR was not seen as a low priority was to engage economic managers to point out the early economic gain of family planning without waiting for a demographic dividend.

The delegate of Switzerland commented that HRP had formulated an explicit theory of change to show what HRP contributed to strengthening health systems for UHC and proposed that a theory of change be formulated for each research project. She agreed with the previous speaker that it was important to show the economic impact of good SRHR for general health and show how SRHR services can be linked to other services.

The delegate from Uruguay described the integrated health system introduced in 2017 that covered the entire population. Since 2011, abortion for certain conditions has been legal in Uruguay. This means abortions are carried out in safe conditions, and in the past three years no abortion-related deaths had been reported. The country has also adopted an act regarding assisted reproduction, which is partly funded by the State. In addition, a new system has been introduced to prevent unwanted pregnancies in adolescents, which had resulted in a sharp drop in teenage pregnancy. Research will be undertaken to see if free contraception should be provided to women. Furthermore, Uruguay still needs to address the issue of the transmission of human papillomavirus; the vaccine is available but assistance from the international community is needed to make it accessible to all who need it. Also, he highlighted the importance of legislation in reducing high mortality from cervical cancer.

The co-Chairs of GAP commented that HRP should advocate not only for SRHR but also for good governance for UHC, with inclusion of women’s and youth groups to advocate for SRHR in their countries. The focus tended to be on poverty and financing; however, other factors affected access, such as migrant and undocumented status.

The Chair of STAG described relevant experience in Egypt, where a reduction in contraception had led to increased fertility and maternal mortality. The Minister of Finance was therefore convinced that spending money on family planning would save health costs, and the fertility rate had decreased. WHO should therefore communicate with parliamentarians and ministries of finance and development in conducting programmes. Ownership of SRHR research by Member States was important to ensure the continuity. Research should also be conducted on the rising prevalence of caesarean section in some countries.

The delegate of Fiji called for capacity-building in small island developing states for research on the effect of climate change on the vulnerability of women and children.

The delegate from Belgium suggested that research be conducted on links with mental health. The experience of UNAIDS in involving communities could usefully be exploited.

The representative of UNDP commented on the effect of laws, customary laws, policies and the human rights environment on access to SRHR, including criminalization of behaviour.

The representative of UNFPA said that she agreed with the GAP co-Chair on the importance of accountability. She proposed that a life-course approach be used, rather than interventions and programmes for specific age groups. HRP could conduct research to find better UHC indicators, including on SRHR. Models should be developed for integration of adolescents, early abortion by midwives and people-centred care.
The delegate from Burkina Faso described SRHR care in her country, in which free treatment was given to pregnant women 42 days after birth and for children under five to reduce maternal and neonatal mortality. Health packages had increased the use of services. In a country in which children under five years represented 25% of the population, the programme was an important step towards UHC. It should be pursued further, documented properly and replicated in other countries.

The delegate from Mozambique described improved access to reproductive health in her country, in which information on family planning was provided at secondary schools, which had increased demand and access by adolescents. Community health workers enrolled new users of family planning, and coverage had increased from 33% in 2016 to 41% by the end of 2017. Research was needed on the social and cultural norms of SRH, and more data should be generated on morbidity and mortality rates of women and newborns associated with high fertility.

The delegate from Myanmar described experience in her country in use of an essential health package, which included SRHR. Health literacy was a priority of the Minister of Health, with good communication with ethnic group organizations, standard guidelines, distribution of reproductive health commodities and training. HRP research activities for achieving UHC included improving gender equity, preventing gender-based violence and promoting institutional rather than home deliveries. Myanmar is working on assessing maternal death surveillance and response, conduct cervical cancer screening and conduct a survey on knowledge, attitudes and skills to reduce adolescent pregnancy rates.

The delegate from The Netherlands said that research was needed on ways of communicating results, on the equity and health needs of girls in urban and rural areas and of younger and older women. The results should be easily understandable by governments so that they could take evidence-based decisions, and the delegate from Sweden added that whatever research was conducted should be synthesized and communicated in a user-friendly way for use by policy-makers, as UHC was ultimately a political decision.

The delegate from Norway commented that there was an overlap between SRH and the UHC agenda. UHC meant creating an effective health system, including in rural areas. Strategic collaboration was needed with actors outside SRHR to facilitate uptake.

The delegate from Peru said that health systems in Latin American countries were fragmented, with little primary health care. Research was needed on access to health services in urban and rural areas and according to social and cultural differences. The priorities for research included education of indigenous populations about SRHR.

The delegate from Mauritius said that health care in her country was free, but pockets of the population were not covered. Over 90% of the population attended public hospitals. Family planning had been so successful that a policy had been enacted to increase the fertility rate. Research should be conducted on adolescent pregnancy, reducing out-of-pocket payments for health and increasing fertility rates in certain situations.

The delegate from Bhutan said that the economic conditions in his country were very different from those elsewhere. The State provided free medical services, although there was currently a challenge to sustainable financing. A national SRHR strategy was being developed that was adapted to local norms.

The representative of the International Committee for Monitoring Assisted Reproductive Technology said that SRHR was often a low priority for policy-makers, for cultural reasons. The issue should be objectivized by reducing it to numbers of the burden of diseases associated with SRHR as compared with those of diseases for which there is public funding. Personal and social barriers could be reduced by the creation of programmes for mobile devices, on which people could express their opinions anonymously.

The representative of the International Federation of Fertility Societies commented on the huge inequity in fertility care in and between states and the harm that caused. The priorities were to collect robust data, implement evidence-based guidance, promote safe clinical practice and conduct research into cost-effective, scalable interventions.
The representative of the International Women’s Health Coalition expressed surprise that the slides shown on UHC did not include women or girls. Their needs affect analyses of health insurance, coverage and services. Insurance should be accessible directly by women and adolescents, and they should have autonomy in deciding to access the services they needed. Women, girls and people should be at the centre of UHC. Discussion on Millennium Goal 5 had identified essential obstetric care as a measure of a functioning health system, as the same emergency room could be used for other emergency care.

The representative of Jhpiego said that a comprehensive package should include not only curative but also preventive, promotion and diagnostic services. More detailed national and subnational data, rather than global or regional data, were required to track progress.

The representative of Women Deliver urged HRP and the cosponsors to take advantage of political events, such as the Tokyo Declaration in December 2017, where SRHR had not been mentioned, while vaccines, HIV, health emergencies and reducing out-of-pocket expenditure were. There was no mention of the significant reduction in out-of-pocket expenditure for contraceptives and supplies for women and adolescents. WHO, UNICEF and the World Bank were all co-signers of the declaration but had not taken advantage of the opportunity to mention SHRH.

PCC:

1. WELCOMED the important discussion on strengthening HRP’s contribution to universal health coverage and invited HRP to consider the remarks made during the discussion and to report at the next meeting of the PCC on progress made and the way forward.
8. Reports of the committees

8.1 Standing Committee

Dr Willibald Zeck, UNICEF, reported on the 85th meeting of the Standing Committee meeting in November 2017. He gave three examples of strengthened engagement of the cosponsors during the past year. Measurement of maternal mortality had attracted a high level of cosponsor engagement, with participation by UNICEF, WHO, UNFPA and the World Bank, each agency using its comparative advantages, and publication of a series of joint estimates and analyses, which were used as standards in many countries. WHO and UNICEF had formed a task force that had agreed on an updated definition of a “skilled birth attendant”. The third example was linkage between SRHR and HIV infection. An interagency working group had brought together cosponsors and representatives of communities of people living with HIV, donors, researchers and agencies that had been active since 2004. The index of SRHR–HIV linkages was used to monitor and assess impact and progress of policy, systems and service delivery. The innovative, participatory approach used in developing the global consolidated guideline on SRHR of women living with HIV had been commended by the WHO Director-General. The work on SRHR–HIV linkage had been particularly relevant for work in countries in eastern and southern Africa. In the coming months, the cosponsors would discuss how to strengthen their collaboration at country level.

The Standing Committee had commended the Secretariat on the new approach to identifying STAG members through an open call for expressions of interest and had approved it. The Committee had endorsed two candidates for membership of STAG for approval by the PCC: Dr Tari Turner, Cochrane Collaboration, Monash University, Australia; and Dr Asha George, University of the Western Cape, South Africa.

The Standing Committee had endorsed the proposed terms of reference for the external evaluation and had nominated Dr Anneka Knutsson of UNFPA to represent the cosponsors on the external evaluation subcommittee.

He thanked PCC members for their support of HRP, which contributed to achievement of the shared goals of all the cosponsors in SRH.

Discussion

The delegate from Switzerland requested a more strategic approach to annual planning on cosponsor collaboration rather than a list of ongoing activities. She asked for clarification of use of the H6 as a potential forum.

The delegate from the Philippines said that, while estimates of maternal mortality were important, countries used their own measures. His country was planning to use Civil Registration of Vital Statistics in order to meet the SDGs and provide annual data.

The delegate from Belgium said that, in view of the large number and complexity of the activities, a strategic framework might be drawn up, perhaps linked to the HRP programme and budget framework, with integrated priorities. He noted that, although participation of UNDP was still limited, it had an important role to play in coordination of United Nations agencies at country level.

Dr Zeck said that he could provide more detail, including strategic thinking, but would require more time for his presentation. H6 was very active, and HRP was discussed at H6 forums, making it more visible. He said that the lack of visibility of UNDP had been due largely to limited human resources. New staffing had reinforced UNDP’s commitment to HRP, and it was dedicated to remaining actively engaged.

The representative of the UNFPA also commented that H6 and HRP were strongly linked. H6 partners conduct joint programming in terms of equity, quality and dignity and multisectoral approaches, while results from HRP should be included in the toolbox for countries.
PCC:

1. CONGRATULATED the Standing Committee on the strong engagement of cosponsors on a large number of activities including those on estimating maternal mortality, skilled birth attendance and links between SRHR and HIV.

2. RECOMMENDED that a more strategic approach or framework be presented to highlight the planning for cosponsor engagement and collaboration in various activities.

3. RECOMMENDED that engagement with the H6 partnership be strengthened to better connect and update HRP’s research.

4. NOTED that engagement from UNDP had been limited and welcomed UNDP’s commitment to a more robust engagement henceforth.

5. ENCOURAGED continued engagement from cosponsors.

8.2 Scientific and Technical Advisory Group (STAG)

Professor Gamal Serour reported on the 35th meeting of the STAG. Professor Anita Hardon, the co-Chair, had been Chair of the meeting, Dr Jayantilal Satia was Vice-Chair and Dr Harriet Birungi was Rapporteur. One member had declared a possible conflict of interest. In response to the Director’s report on major achievements in 2017, the Group had recommended that RHR develop a plan to monitor the impact of its work at both national and global levels. In response to the report of the GAP, the Group had recommended that HRP address barriers to the uptake of vaccination against human papillomavirus, including misconceptions about girls’ sexual behaviour after vaccination. The seven general recommendations included analyses of the cost-effectiveness and costing of programmes, interventions and strategies and a recommendation that research include the social, behavioural, cognitive and decision-making processes that may influence and explain study outcomes.

The Group welcomed HRP’s strengthened programme of work on infertility and recommended continued support. It also recommended that programmes on STIs be strengthened with technical support and advocacy to translate research results into action at country level. Recommendations had also been made on the study of cervical cancer, measurement of the impact of guidelines on SRHR outcomes for women living with HIV, automated registration of cumulative data or scores during labour to assess the quality of care. With regard to safe abortion, HRP was asked to continue to fill in evidence gaps, including medical management of abortion and provider attitudes. The Group had also made recommendations on female genital mutilation, violence against women and SRHR in humanitarian settings and disease outbreaks. In its overview of new activities for 2018–2019 in the approved Programme Budget, the Group had made six recommendations.

During the meeting, six subgroups had met to discuss measurement of research outcomes for demonstrating impact on health status and behaviour, resulting in eight recommendations. On the topic of research design, reporting standards and guidelines for complex interventions for public health, the Group had recommended that HRP develop a research policy that included innovative methods for engaging with diverse stakeholders and provide guidance on research methods and strategies that catalysed the impact of HRP tools and guidelines. They strongly encouraged the Department to use multidisciplinary consultation and a systematic approach in collaboration with other relevant departments at WHO in scoping and developing guidelines on user-initiated interventions, cautioning that any work to increase such interventions should safeguard against the proliferation of substandard medicines or limited choice.
Discussion

In the discussion on the two reports, participants welcomed the guidance and recommendations but asked for a comprehensive report and a presentation that focused only on strategic areas.

The Chair of the PCC noted that one recommendation requested analyses of the cost-effectiveness of programmes, which would require the input of a health economist, implying another staff position.

The recommendation, that HRP measure adherence to guidelines, in addition to health outcomes, was very ambitious and would put excessive pressure on the Programme. Measurement of impact was now expected in many areas and would eventually have to be addressed. There was, however, no expectation that the method be extensive. HRP could ask country and regional offices for data.

Dr Askew said that donors were asking for demonstrations of impact. The external evaluation of the impact of HRP that was conducted every five years provided a good indication, whereas any systematic analysis of impact within HRP would require shifting of budgetary allocations from other areas.

It was suggested that the impact to be measured was that of WHO as a whole and not only of the HRP.

Dr Askew thanked Professor Serour, the outgoing Chair of the STAG, and thanked him for his ambitious, progressive view of HRP activities. He presented him with a certificate.

PCC:

1. NOTED and ADOPTED the report and recommendations of the Scientific and Technical Advisory Group (STAG).

2. ENDORSED the appointments of Dr Asha George (South Africa) and Dr Tari Turner (Australia) to STAG and the reappointment for a second term of Dr Ulysses Panisset (Brazil), for three-year terms starting on 1 January 2019.

3. ENDORSED the appointment of Dr Anita Hardon (Netherlands) as Chair of STAG.

8.3 Report of the Gender and Rights Advisory Panel (GAP)

Dr Carmen Barroso presented the report of the GAP retreat and its 22nd meeting, held in February. Fewer recommendations had been made than in previous years. She emphasized the role of the HRP Alliance in strengthening research capacity, to ensure that LMIC were not just sources of data but also led research. The Panel had recommended that the dissemination and implementation of HRP’s work be strengthened, with a strategic plan and resources to follow up publication of guidelines and tools by implementation in countries; for example, the guidelines on rights-based quality of care for contraception had had little uptake and should be promoted. HRP had a particular task to advocate and strengthen the response to sexual harassment across WHO and the United Nations. Another recommendation was to accelerate review protocols in crisis situations. With regard to the update of the safe abortion guidelines, laws and policy and human rights should be integrated throughout the document and also appear in a separate section.

Dr Pascale Allotey described the recommendations on UHC, user-initiated interventions and community engagement. The GAP recommendation was to ensure intersectorality and to ensure that not only income inequality was considered as a driver of UHC, so that some vulnerable populations were overlooked. Meaningful involvement of communities and women’s rights organizations should be integral to UHC planning, governance and advocacy. She described the work on user-initiated interventions and highlighted the importance of human rights and accountability frameworks for self-diagnosis, treatment and management in that regard.
Discussion

The participants congratulated GAP on its strategic, timely recommendations and recognized the importance of intersectorality in UHC, the safe abortion update and user-initiated interventions. It was suggested that parliamentarians and citizens’ hearings on health issues be used for advocacy, with a plan of action for dissemination. The discussion highlighted the central role of laws and policies and called for HRP to ensure their integration in all portfolios. Health systems should include accountability, remedy and redress. The updated safe abortion guidelines were described as an invaluable source for confronting regressive practices and in submissions to United Nations human rights bodies.

Dr Barroso replied that systemic redress was required to prevent future violations of human rights, improve management and obtain better results. Human rights were being integrated into all HRP projects, which could serve as a model for other departments.

PCC:

1. WELCOMED and ENDORSED the report of the Gender and Rights Advisory Panel (GAP) and recommendations, and commended the strategic approach in GAP interventions.

2. RECOMMENDED that HRP ensure integration of gender equality and human rights in all its portfolios of work, and further RECOMMENDED that it continue to develop its work on accountability, remedies and redress for sexual and health and rights.

3. ENDORSED the reappointment of Dr Pascale Allotey (Ghana), Dr Sheena Hadi (Pakistan) and Dr Kaye Wellings (United Kingdom) for a second three-year term starting on 1 January 2019.

8.4 HRP Alliance Advisory Board

The Chair of the HRP Alliance Advisory Board, Professor Elizabeth Bukusi, summarized the major achievements of the HRP Alliance during the past year. In its research capacity strengthening activities for SRHR, the focus had been on implementation research to link HRP Alliance grant recipients with HRP research from the time of research agenda setting, conceptualization, design, analysis and use of research. The work was extended to involve WHO collaborating centres and other research partners. Long-term institutional development was conducted at five institutions selected as regional knowledge transfer “hubs”: in Brazil, Burkina Faso, Thailand, Ghana and Kenya. Their work plans included training in research methods linked to SRHR research projects, maintaining links between research students and their home institutions so that they returned at the end of their training. They participated in HRP multi-country research projects and networking and support to institutions in low-resourced settings. Long-term institutional development grants had been awarded to institutions in Guinea, the occupied Palestinian territories, Pakistan and Paraguay. The projects in which they were participating were implementation of the WHO safe childbirth checklist in Burkina Faso and Côte d’Ivoire, mistreatment of women during labour and delivery in Guinea and intimate partner violence from the perspective of men in Paraguay. Small grants had also been given for community projects on Zika virus disease in collaboration with TDR.

Two researchers in LMICs had received scholarships to participate in a research capacity strengthening training workshop in sexual violence in Brazil. Three candidates from Burkina Faso and two from Guinea had received grants to study for master’s degrees in public health, and a researcher from Liberia was studying in Ghana. Other training courses included research synthesis and qualitative research methods training at the University of Lausanne, Switzerland; research methods used in studying gender-based violence in Paraguay; and a research methods training course in Kenya.

Planned activities for 2018 include creation and extending linkages among the hubs, HRP research and other regional research partners and to seek other grant mechanisms to fund their work. Thus, additional hubs
would be created in the WHO Eastern Mediterranean, European, South-East Asian and Western Pacific regions. The long-term institutional development grants would be continued, as would training and workshops in research capacity strengthening at the hubs and strengthening links and engagement with collaborating centres. Collaboration with APHSR and TDR is planned, such as at the Health System Global meeting in 2018.

The global meeting of the HRP Alliance partners had been held in November 2017 in Accra, Ghana; 15 partners, including collaborating centres, participated. The annual in-person meeting of the Advisory Board was held at the same event.

Discussion

The delegate from The Netherlands commented that the objectives of the Alliance were the responsibility of the whole Programme and of full members of HRP research teams based in their institutions.

Responding to questions, Professor Bukusi and Alliance members said that cooperation was not only south-south but also north-south, as in multi-country studies. Institutions were selected to participate in the programme after a call for interest and evaluation. She agreed with the comment that there was a gap between women and men in higher education and that future reports should be disaggregated by gender. In answer to a question from UNDP about whether the Alliance had a strategy for engaging communities and community organizations in research and strengthening their capacity, she said that there were mechanisms to embed communities in research projects, by ensuring that research was well grounded in the priorities of the country. Gender equity and human rights were covered in courses, with links to HRP studies and work in humanitarian settings. The Alliance did not have a formal interactive platform but communicated through various online groups and e-mail chains.

PCC:

1. NOTED and WELCOMED the progress of the work of the HRP Alliance.
9. Sexual and reproductive health and rights, human rights and HRP’s research agenda following the WHO-OHCHR recommendations: panel discussion

Dr Dirk Mueller, Senior Health Adviser, Research and Evidence, Department for International Development, United Kingdom, presented the three panel members: Mr Nicholas Fasel, adviser on human rights measurement at the OHCHR; Dr Carmen Barroso, co-Chair, Independent Accountability Panel Every Woman Every Child; and Ms Alexandra Blagojevic, programme manager for international development at the Inter-Parliamentary Union (IPU). Dr Mueller said that the report of the high-level working group on health and human rights of women, children and adolescents commissioned by WHO and OHCHR described the human right to health and through health. Important topics were the need to uphold health in national law, enabling and empowering people to claim and use those rights and monitoring and holding bodies accountable for upholding those rights, as defined at the Family Planning 2020 summit.

Mr Fasel presented the work of OHCHR on development of human rights indicators and a human rights approach to data. The pledge to leave no one behind and gender disaggregation provided opportunities to reduce discrimination and inequality, by collecting data with the necessary safeguards. Human rights standards had to be transformed into indicators of States’ conformity with human rights treaties that seek to measure commitments, acceptance of human rights by States, their implementation and the result on affected population groups. The indicators were then transformed into policy measures to strengthen monitoring and accountability. Guidance developed by OHCHR supports national work on data disaggregation to ensure that no one was left behind, including those not captured by traditional statistical methods. Six human rights principles should be observed in collecting and using data: disaggregation, ethnic and sexual self-identification, confidentiality, transparency, participation and accountability.

Dr Barroso said that the independent accountability panel of the United Nations Secretary-General had been set up to monitor gender equality and the human rights of adolescents, to assess progress on accountability in implementing the global strategy on women, children’s and adolescents’ health. Institutionalized accountability meant no corruption, efficient management, transparency, better data and sanctions. The report, Transformative accountability for adolescents, included a number of recommendations. Those included making adolescents more visible and measuring what matters, with better data, disaggregation and an “adolescent index”. Another was to foster whole-of-government accountability to adolescents by a focus on gender equality to harness demographic dividends, making schools work for adolescents’ overall well-being and teaching respect for others’ rights, ensuring effective human rights oversight and involving young people meaningfully in budgeting and implementing policies. A third recommendation was to ensure that UHC was relevant for adolescents, including those with disabilities, by providing a package of essential services that were free at points of care.

Ms Blagojevic said the functions of parliament were legislation, budget, representation and oversight. Parliaments exerted oversight, as they the only bodies that held government to account on behalf of the people. In accountability, the overseeing body accounted for its choices, actions and decisions. She said that the IPU had been founded in 1889 and had 179 members. Its first resolution in the field of SRHR had been on human rights in HIV/AIDS in 2006, addressing mainly discrepancy in access to services. HRP was part of the only IPU group that included technical advisers, which discussed the barriers to be addressed, including criminalization and discrimination in law, stigma and discrimination, traditional practices and customary laws. IPU–HRP cooperation involved engaging parliamentarians and provision of evidence at national, regional and global levels. A concrete example was parliamentary engagement in SRHR in Rwanda, which had resulted in a law on reproductive health.

Discussion

The Chair commented that many at-risk populations were illegal immigrants, and he asked how they could be included if officials could not legally identify and disaggregate them. Their exclusion had implications for
human rights, gender issues and access to services. Speakers replied that parliamentarians should be exposed to the reality of the health of such populations. HRP could provide such evidence and form strong partnerships with civil society to advocate for these groups. The context differed by country, the groups being recognized in some but not others. As half the countries in the world had a national human rights institution, they might indicate how such data could be collected.

In answer to the delegate from the Philippines, who reported that the Supreme Court in his country had ruled that the rights of the parents of adolescents under 18 who were themselves parents or pregnant superseded those of the adolescents, Dr Barroso said that OHCHR should have the authoritative word. The Convention on the Rights of the Child stipulated the right to autonomy, and adolescents’ rights should prevail when they were in conflict with those of their parents. The Convention implied the presumption that adolescents were competent to access services: If they could seek, understand and access services themselves, they should be presumed to have the competence to do so.

One representative commented that the definition of an adolescent varied by law, and adolescents of different ages had different problems. Dr Barroso replied that the *Lancet* Commission had defined adolescents as those over 14 years of age to differentiate them from children. Others commented that definitions were needed but they should evolve with time, as fixed definitions could result in fragmented approaches. Means should be found to assess adolescents’ capacity to make decisions and to give informed consent, and OHCHR was working with HRP on that issue. It was important to operationalize the best interests of the child. The age of consent had huge implications for SRHR. The best way to promote leadership by young people was to allow them to participate in meetings such as the present one. Adolescents were the least included of all groups, and HRP should find ways to ensure their participation, to empower them and ensure their contributions to discussions that affected them, as part of social accountability.

Mr Fasel said that the OHCHR was developing a common language on human rights. Data indicators helped to bridge policy with human rights at national and global level and with civil society.

**PCC:**

1. THANKED the panellists for their presentations, and UNDERSCORED the importance of continued work on sexual and reproductive health and rights in the research agenda.
10. Innovation and roadmaps - HRP’s roles along the pathway from research and development to registration to scale up: panel discussion

Dr Edward Kelley, Director, Service Delivery and Safety, WHO, said that the 13th General Programme of Work was forward-looking, driving innovation through regional centres of excellence, mobilizing political will and channelling resources. Evidence and guidance on the available tools were not available; HRP and WHO could coordinate collaboration and knowledge management.

Dr Garrett Mehl, Adolescents and At-risk Populations Team, described the role of HRP in the development and introduction of innovations. He introduced the Gartner “hype cycle” for mapping the role of HRP at various stages of the maturity of an innovation, from the trigger, to expectations and ultimately to productivity. It included assessment of the market for innovations, setting appropriate research questions, synthesizing evidence, conducting research on introduction of innovations and establishing pricing schemes to ensure the access of LMICs to the innovation. HRP had conducted research on various digital systems to improve service delivery and the quality of data. The THRIVE multisite study addressed operational processes for transitioning from paper registers to digital health records, which resulted in the Open Smart Register Platform software application. Subsequent research would investigate the impact of the application, and partners would be found to ensure its financial sustainability. HRP was also conducting research on a novel cuff-less blood pressure measuring device to be used on a smartphone. Current barriers to reliable blood pressure measurements included frequent calibration, bulkiness and cost. HRP was conducting validation research and working with the Legal Department at WHO to ensure preferential pricing for LMICs, while WHO would retain the license in perpetuity.

Dr Sami Gottlieb, Human Reproduction team, said that the global strategy on STIs called for innovations to improve SRH, including STI vaccines. In 2013, WHO and the US National Institutes of Health had organized a technical consultation on vaccines against herpes, chlamydia, gonorrhea, syphilis, and trichomoniasis, which resulted in a plan of action, from pre-vaccine development through vaccine introduction. To make vaccine development less risky and to accelerate introduction, the plan called for better epidemiological data were required on infection and disease burden, basic science and translational research should be advanced, the impact of STI vaccines should be measured and “preferred product characteristics” defined. Clinical evaluation and planning of vaccine introduction should be expedited and facilitated and investment in STI vaccine development should be encouraged. HRP was defining the value and public health need for vaccines, developing WHO’s preferred product characteristics and mapping clinical development pathways, including reducing barriers. HRP, with the WHO department for Immunization, Vaccines and Biologicals, was also mapping clinical development, to facilitate evaluation and licensing of vaccines. One example was development of herpes simplex virus vaccines, as their development was the most advanced and there was no other effective intervention for that common STI. An investment case was being prepared, providing the public health and financial rationale for the vaccines, which had revealed a number of gaps. The economic burden of the infections was being calculated, for both high-income countries and LMICs. Several candidate vaccines were in phase-I and -II studies, and a phase-I trial of the first candidate vaccine against chlamydia had been completed. Interest in gonorrhoea vaccines had increased substantially after the finding that licensed vaccines against Neisseria meningitis B may have activity against gonorrhoea. Vaccine development was also of renewed interest in WHO’s fight against antimicrobial resistance.

Dr Metin Gülmezoglu, Coordinator, Maternal and Perinatal Health team, described HRP’s role in the development and introduction of innovations. HRP collaborated with partners in funding innovations, providing scientific input and facilitating business expertise to bring innovations to LMIC markets. He gave three examples: development of a heat-stable uterotonic (carbetocin) in partnership with Merck4Mothers, the “combi-pack” for medical abortions, and the addition of tranexamic acid for the treatment of postpartum haemorrhage to the maternal health recommendations. In the case of carbetocin, HRP had collaborated in “end-to-end thinking” on conducting the research and ensuring a channel for ensuring the availability of carbetocin in LMICs. HRP had also synthesized evidence on use of tranexamic acid for the treatment of
postpartum haemorrhage and had updated its recommendations in October 2017; however, those were not yet used. Similarly, although the combi-packs for medical abortion were registered in 2008, none had been prequalified by WHO. Timely strategic planning was critical to early uptake, access to and use of innovations.

**Discussion**

Delegates remarked that HRP should also consider conducting research on product improvement, such as extended use of contraceptive implants, and countering the decrease in use of IUDs in recent years; research should also focus on sustaining and scaling up use of previous innovations. Although innovations were essential, the emphasis could lead to fragmentation and over proliferation of many new ideas. Innovations should be absorbed into the broader market and become global goods. One delegate asked about HRP’s work on social innovations. She mentioned the work of TDR in that area, which might be the basis for collaboration.

Pricing and accessibility in LMIC markets remained an issue. For example, the cost of the HIV vaccine had become prohibitive for LMICs, and pharmaceutical companies had limited incentive to extend the availability of this innovation. WHO should combat patent laws and intellectual property issues in dealing with those companies. Furthermore, innovations should be designed with communities and end-users. HRP could lend its leadership to global partners in making innovations accessible.

Representatives raised concern about the quality standards of the combi-packs obtained from the online medical commodities database, which was common. HRP had a role in guaranteeing their quality even when they were obtained otherwise than through WHO mechanisms.

Dr Gottlieb said that work on new vaccines was being done primarily with WHO and GAVI, the Vaccine Alliance, to ensure that they were accessible in the countries that needed them. WHO was also working on prequalification standards that would facilitate production of vaccines in countries such as China and India.

**PCC:**

1. **NOTED and WELCOMED** the diverse portfolio of innovations and research, which were at various stages of maturity towards becoming global public goods.

2. **RECOMMENDED** that HRP highlight “end-to-end thinking” for innovation introduction, and **ENCOURAGED** the Department to report on research to improve uptake of existing innovations in addition to the development of new products.

3. **NOTED** concerns about the poor availability of “combi-packs” for medical abortion and other essential medicines, including monitoring the quality standards of drugs, inclusion for prequalification and sustainable financing approaches.

4. **RECOMMENDED** that HRP increase its focus on the availability and accessibility of innovations in low- and middle-income country (LMIC) markets, particularly by addressing barriers related to commercial pricing and intellectual property.

5. **RECOMMENDED** that end-users and communities be included in the design and development of innovations, including in the identification of gaps and market failures and in research on social innovations.
11. Sexual and reproductive health and rights in humanitarian settings: HRP working in partnership

Ms Ini Huijts, Ministry of Foreign Affairs, The Netherlands, recalled that specific commitments to SRHR had been made at the World Humanitarian Summit, especially for adolescents and safe abortion services. SRHR services had to be included comprehensively in planning a response, including for local women. In the framework of the She Decides movement, some short-term funding had been provided to WHO by the Netherlands for SRHR in crises for developing capacity in the cluster. The recent spotlight on gender-based violence in humanitarian settings and a number of scandals called for stronger systems to prevent such situations proactively. The Ministry was investigating the possibility of integrity policies, an ombudsman and selection of partners.

Mr Andrew Harper, UNHCR, said that account must be taken of people who were not only a growing proportion of the world’s population but also the most vulnerable, with difficult access to services. Refugee crises were increasing, and most refugees were in countries that were the least able to absorb them, with significant stress on their health services. Refugee populations had often suffered significantly already and arrived in remote parts of other countries, without access to national health services, partners and authorities. UNHCR was examining existing policies and had identified some that are problematic, such as discrimination against people infected with HIV. In some European countries, contraceptive implants could be inserted only by surgeons; in others, emergency contraceptives were not registered, leading to long delays. The standards and regulations in countries that are expected to receive refugees should be studied to ensure sufficient planning and preparation, and government infrastructure should be strengthened: 74 000 refugees had arrived in Uganda in 2018, and the Government was finding it difficult just to register them.

The evidence base on the most effective interventions should be expanded, with examples of governments that have responded well with progressive stances, such as Jordan, South Sudan and Yemen, which should be supported. The total required to finance humanitarian crises in 2017 had been about US$ 20 billion, only half of which had been funded. The current level of interventions could not be continued. A holistic and not just an emergency response was required, so that humanitarian agencies were not left to deal with crises for decades. Almost all countries recognized that refugees should have access to SRH services; for example, only three countries did not give refugees the same as their citizens’ access to antiretroviral drugs.

Ms Peggy Hicks, OHCHR, called for a more person-centred approach to SRHR, not only because it was right but because it was more effective. She described the case of young woman who had suffered violations of her rights within her family and community and then became internally displaced and could no longer access contraception. With a violent husband, she had asked for termination of an unwanted pregnancy but was refused and had aborted herself. To build a more integrated approach to SRHR in humanitarian emergencies, all forms of violence at home and in the community should be included and also discrimination, which was exacerbated by crises. Another change should be in how SRHR services were viewed, including access to abortion and emergency contraception. Denial of abortion services had been recognized by the Committee for the Elimination of Discrimination against Women as a form of gender-based violence, and there was no doubt that policies and laws to prevent abortion could have long-lasting effects on both the mother’s development and her mental health. Thus, the case of a woman who died because services were not available would be investigated as a violation of the right to health and to life. Recent crises demonstrated a profound need for SRHR services, as among Rohingya refugees in Bangladesh, massive displacement in Yemen that has increased forced child marriage, prostitution and gender-based violence and the conflict in Syria which has also resulted in sexual violence and forced child marriage, domestic and intimate partner violence, early and unwanted pregnancies, isolation and psychological harm. Barriers to care included lack of clear referral mechanisms, lack of transport, inadequate information, family attitudes and stigma. She welcomed the new WHO–OHCHR cooperation for promoting and protecting human rights.

Dr Benoit Kalasa, UNFPA, said that conflict will remain the main driver of humanitarian needs in 2018. Of the 136 million people will need assistance and protection, an estimated 34 million were women of reproductive age and five million were pregnant. Crises exacerbated existing problems. In many countries, health
infrastructure was already weak, and crises entailed a breakdown of the health care system, which also affected health care staff. During the outbreak of Ebola virus disease, the health care structure could no longer take the pressure and staff was no longer available or were victims themselves. An additional challenge was financing of services, as reproductive health was not considered a priority. He described the minimum initial service package (MISP), which ensured feasible services of a good standard that were targeted to the population. MISP addressed gender-based violence, STIs, unplanned pregnancies and complications of abortions. Often, only one part of a package was used, resulting in wastage; in the MISP, all the components were useful. In 2017, UNFPA had reached 16 million people in humanitarian crises, including information on SRHR and services for 10.4 million people in 53 countries, 3.4 million people with regard to gender-based violence and 1.5 million adolescents with adolescent-friendly health services. The aim was to ensure that every woman and every adolescent girl, whether she was a refugee in her country or deprived of her basic rights when services broke down, could prevent an unintended pregnancy, give birth safely and live free from sexual violence.

Discussion

The delegate from Sri Lanka reported that, despite the severe 30-year internal conflict in his country, malaria had been eliminated in 2015, indicating that the health system had remained intact. Immediately after the conflict, in 2009, village hospitals were established that provided primary care and referral for secondary and tertiary care, including for refugees from Myanmar and Pakistan. He invited the Committee to study the positive case of Sri Lanka, in which conflict had not adversely affected the health service.

The representative of the World Bank said that programming of services should include consideration of the fact that fertility increased under displacement and stress, as a coping mechanism, which might include pregnancy. She asked how unwanted pregnancies were addressed in countries in which abortion was criminalized. She also urged consideration of sexual violence against boys and men. She stressed the political nature of the issue of displacement of populations to other countries and its health impact.

The representative of UNICEF described a new guideline on newborn care in humanitarian settings.

The representative of Ipas described the provision of services to Rohingya refugees in Bangladesh, bridging the gap between safe abortion and contraceptive care and development aid, indicating that it was not complex to provide safe abortion care. She said that, as abortion care was a means to protect right to health and life, there was legal support for its provision. The wide-scale provision of contraceptive care was, however, a challenge because of lack of funding.

The representative of Family Planning 2020 said that there were gaps in government planning. There had been continued uptake of contraceptive implants, but ethical issues had been raised about their use among displaced women. Provision of such devices was a critical opportunity to meet needs for long-acting contraception.

The representative of Women Deliver suggested that women and girls be involved in designing guidelines, knowing their rights and in accountability mechanisms.

The representative of France underscored the importance of integrating SRHR in humanitarian settings, with effective, innovative solutions. In her country’s strategy for 2022, “gender markers” would be used to measure the impact of humanitarian projects on gender equality.

The representative of the Centre for Reproductive Rights asked to what extent had UNFPA and UNHCR taken into account treaty body monitoring standards in developing holistic policies for responding to humanitarian crises.

The representative of FIGO asked whether WHO and HRP could identify and prioritize chronic and acute medical events globally, such as the reasons for deaths of women of reproductive age and the most cost-effective, immediately implementable interventions, which would help donors to identify projects that they
might consider worth funding. He suggested that donors set up an emergency fund so that human and pharmacological requirements could be mobilized immediately.

The representative of SRI said that a group most in need of SRHR care was sex workers, and means should be found to reach them effectively.

Mr Harper said that he would welcome ideas and suggestions on how his organization’s work could be improved. The High Commissioner had reiterated his commitment to refugee women and girls, with a new policy on age, gender and diversity. The global compact included gender markers to provide a better understanding of the impact of operations on the ground. No one had sufficient understanding of humanitarian settings, and the voices of the women, girls, boys and men concerned were not heard. A pragmatic, comprehensive system was required to hear those voices and to meet their requirements. Additional resources were needed; however, there were more and more restrictions and earmarking, and the resources required to help governments and people were not forthcoming.

Ms Hicks said that abortion was fully banned and criminalized in only a few countries. She agreed that sexual violence against boys and men should be included in programmes, as should the marginalized group of sex workers. Research was needed on accountability in humanitarian settings, in which human rights violations were investigated after the fact.

Dr Kalasa mentioned three types of innovation that might be used in humanitarian settings: remote-sensing satellites to identify the movement of people, so that their needs could be better targeted; strong supply chain delivery to ensure commodities and services in remote places; and new contraceptive methods in revised MISP kits.

Dr Askew described the work of HRP in SRHR in humanitarian settings. In collaboration with the department of Health Emergencies at WHO, the capacity of national health clusters was being strengthened in four ways: increasing access to key SRH services; broadening the approach to gender-based violence beyond medical care, to include social aspects and mental health; obtaining and using data for monitoring and accountability, including with digitizing systems; and setting up a research-to-practice consortium of researchers, implementers, policy-makers and donors to identify evidence gaps and to influence programmes and planning.

**PCC:**

1. THANKED the panellists for their presentations, and UNDERSCORED the importance of continued work on sexual and reproductive health and rights in humanitarian settings.
12. **Pledging for 2018 and subsequent years**

The Philippines said that a voluntary contribution for 2018 was subject to domestic clearance. The contribution might be made to UNFPA, as an official mandate would be required if it were given to HRP. A caveat would be attached that none of the amount be used for work on abortion, although US$ 20 000 would be given for post-abortion care in 2018 and perhaps a larger amount in 2019.

The United Kingdom was currently negotiating a new memorandum of understanding with HRP to provide £11 million over the next five years, starting in April, corresponding to £2.2 million per annum.

Switzerland announced an agreement with WHO that its core contributions in 2017–2019 would include a contribution to HRP of 1.25 million CHF per year.

Sweden announced an agreement with WHO for a contribution of 65 million SEK in 2018–2019 to the three special programmes.

Norway said that its contribution to HRP was part of its overall contribution to WHO. Negotiations would be held during the second or third quarter of 2018, and the amount would be communicated later.

The Netherlands said that a separate contract with HRP was to be signed in the second quarter of 2018. She expected that the contribution would be at the same level as in the previous two years and that the trust fund would be maintained.

Belgium announced a pledge by the Flanders Government of €750 000 per year in 2018–2021.

The representative of UNFPA accepted the proposal of the Philippines that UNFPA act as a third party to channel resources to HRP. It had agreed on programme of work for US$ 30 000 per year.

**PCC:**

1. NOTED and THANKED all donors for their generous contributions.

13. **Date and venue of the 2019 meeting and tentative date for 2020**

Several women’s organizations requested that the PCC meeting be planned so as not to conflict with the meeting of the Commission on the Status of Women.

**PCC:**

1. AGREED to hold the 32nd meeting of the PCC on 20 and 21 March 2019 in Geneva and proposed 25 and 26 March 2020 as tentative dates for the 33rd meeting of the PCC.

14. **Review and approval of the draft report of the meeting**

1. APPROVED the draft summary report of the meeting.
Annex 1. List of participants

Members

Belgium

Mr Sander Spanoghe
Policy Officer Development Cooperation, Flanders Department of Foreign Affairs, Government of Flanders

Mr Kris Dierckx (unable to attend)

Dr Thérèse Delvaux
Senior Researcher, Public Health Institute of Tropical Medicine, Brussels

Bhutan

Mr Tashi Penjor
Chief Planning Officer Policy, Planning Division, Ministry of Health, Thimphu

Burkina Faso

Dr Ramatou S. Sawadogo Windsouri
Director of Family Health, Ministry of Health, Ouagadougou

China

Mrs Yue Dai
Officer, Division of Women’s Health, Department of Maternal and Child Health, National Heath and Family Planning Commission, Beijing

Czech Republic

Dr Petr Velebil
Chief, Perinatal Centre, Institute for the Care of Mother and Child, Prague

Fiji

Dr Eric Rafai
Deputy Secretary for Public Health, Ministry of Health and Medical Services, Suva

Germany

Mr Martin Brechter
Adviser, Division of Economic and Social Development, Digitalisation, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH, Eschborn

India

Unable to attend
<table>
<thead>
<tr>
<th>Country</th>
<th>Name and Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iran (Islamic Republic of)</td>
<td>Dr Alireza Raeisi, Deputy Minister for Public Health, Ministry of Health and Medical Education, Tehran</td>
</tr>
<tr>
<td></td>
<td>Dr Payman Hemmati, Senior Expert, Ministry of Health and Medical Education, Tehran</td>
</tr>
<tr>
<td></td>
<td>Mr Tofigh Sedigh Mostahkam, Minister in charge of WHO, UNIAIDS, ILO, Permanent Mission of Iran to the United Nations at Geneva, Geneva</td>
</tr>
<tr>
<td>Mauritius</td>
<td>Mrs Mylavadee Mudaliar, Permanent Secretary, Ministry of Health and Quality of Life, Port Louis</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Dr Páscoa Alegria Herculano Zualo Wate, Head of Department, Woman and Child Health, Ministry of Health, Maputo</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Dr Hla Mya Thway Einda, Director, Maternal and Reproductive Health, Department of Public Health, Ministry of Health and Sports, Naypyidaw</td>
</tr>
<tr>
<td></td>
<td>Professor Khin Pyone Kyi, Clinical Professor, Obstetrics and Gynaecology Department, Central Women’s’ Hospital, Yangon, and Department of Health Services, Ministry of Health and Sports, Naypyidaw</td>
</tr>
<tr>
<td>Namibia</td>
<td>Unable to attend</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Mrs Ini Huijts, Thematic expert in health, SRHR, Directorate of Social Development, Division for Health and AIDS, Ministry of Foreign Affairs, The Hague</td>
</tr>
<tr>
<td>Norway</td>
<td>Mrs Nina Strøm, Senior Adviser, Department for Education and Global Health, Oslo</td>
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<tr>
<td></td>
<td>Dr Atle Fretheim, Director of Research and Innovation, Health Services Division, Norwegian Institute of Public Health, Oslo</td>
</tr>
<tr>
<td></td>
<td>Ms Kari Hoel, Minister, counsellor in global health, Permanent Mission of Norway in Geneva, Geneva</td>
</tr>
<tr>
<td>Country</td>
<td>Name</td>
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<tr>
<td>Nepal</td>
<td>Mr Nodin Ennals</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>Dr Edward Waramin</td>
</tr>
<tr>
<td>Peru</td>
<td>Mrs Gabriela Minaya Martinez</td>
</tr>
<tr>
<td>Philippines</td>
<td>Dr Juan Antonio Perez</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Dr Anil Jasinghe</td>
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<tr>
<td>Sweden</td>
<td>Professor Maria Teresa Bejarano</td>
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<tr>
<td>Switzerland</td>
<td>Ms Susanne Amsler</td>
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<td></td>
<td>Dr Adriane Martin Hilber</td>
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<tr>
<td></td>
<td>Ms Anne Hassberger</td>
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<tr>
<td>Thailand</td>
<td>Dr Wachira Pengjuntr</td>
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<tr>
<td></td>
<td>Dr Kittipong Saejeng</td>
</tr>
</tbody>
</table>
Mrs Suchada Saraboon  
Director, Department of Health, Ministry of Health, Bangkok

Dr Bunyarit Sukrat  
Deputy Director, Bureau of Reproductive Health, Bangkok

United Kingdom of Great Britain and Northern Ireland

Dr Sue Kinn *(unable to attend)*  
Head of Health Research, Research and Evidence Division, Department for International Development (DFID), Glasgow

Dr Dirk Mueller  
Senior Health Adviser, Research and Evidence Division, Department for International Development (DFID), London

Martin Smith  
Deputy Programme Manager, Research and Evidence Division, Department for International Development (DFID), London

United States of America

Ms Shawn Malarcher*  
Health Science Specialist, Office of Population and Reproductive Health, United States Agency for International Development, Washington DC

*The representative of the United States of America did not participate in discussions related to access to abortion.*

Dr Carolyn Deal  
Branch Chief, Sexually Transmitted Diseases, National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda

Dr Daniel Johnston  
Branch Chief, Contraception Research Branch, National Institute of Child Health and Human Development, Division of Extramural Research, National Institutes of Health, Bethesda

Dr Karen Pazol  
Deputy Associate Director for Science, Division of Reproductive Health, Centers for Disease Control and Prevention, Atlanta

Dr Gail Bolan  
Director, Division of STD Prevention, Centers for Disease Control and Prevention, Atlanta

Uruguay

Dr Jorge Quian  
Vice Health Minister, Ministry of Health, Montevideo

Mrs Cristina Gonzalez  
Minister, Counsellor Mission of Uruguay to the United Nations, Geneva
### Venezuela (Bolivarian Republic of)

*Unable to attend*

### PERMANENT MEMBERS

#### UNDP

**Mr Kene Esom**  
Policy Specialist, Human Rights, Law and Gender, HIV, Health and Development Group, New York, United States of America

#### UNFPA

**Dr Benoit Kalasa**  
Director, Technical Division, United Nations Population Fund (UNFPA), New York, United States of America

**Ms Anneka Knutsson**  
Chief, Sexual and Reproductive Health Technical Division, United Nations Population Fund (UNFPA), New York, United States of America

**Ms Monica Ferro**  
Director, Geneva Office, United Nations Population Fund (UNFPA), Geneva, Switzerland

**Ms Petra ten Hoope-Bender**  
Technical Adviser, Sexual and Reproductive Health Technical Division, United Nations Population Fund (UNFPA), Geneva, Switzerland

#### UNICEF

**Dr Willibald Zeck**  
Head, Global Maternal, Newborn and Adolescent Health Program, UNICEF, New York, United States of America

#### World Bank

**Dr Sameera Altuwaijri**  

#### International Planned Parenthood Federation (IPPF)

**Dr Sarah Onyango**  
Director, Technical Programmes, International Planned Parenthood Federation Central Office, London, United Kingdom of Great Britain and Northern Ireland

**Ms Catarina Carvalho**  
Representative, International Planned Parenthood Federation, Geneva, Switzerland
31st Meeting of the Policy and Coordination Committee (PCC)

UNAIDS

Luisa Cabal
Special Adviser, Human Rights and Gender, Joint United Nations Programme on HIV/AIDS (UNAIDS), Geneva, Switzerland

Observers

Action Canada for Sexual Health and Rights

Ms Meghan Doherty (unable to attend)
Director, Global Policy and Advocacy, Action Canada for Sexual Health and Rights Ottawa, Canada

Afghanistan

Dr Mohd Shouib Hashimi (unable to attend)
Data Analysis Manager, Health Management Information System

American Society for Reproductive Medicine

Dr Richard Reindollar
Chief Executive Officer, Administration, American Society for Reproductive Medicine, Birmingham, United States of America

Dr Christos Coutifaris
President, Board of Directors, American Society for Reproductive Medicine, Birmingham, United States of America

Dr Sheryl van der Poel
Consultant, American Society for Reproductive Medicine, Vésenaz, Geneva, Switzerland

Bill & Melinda Gates Foundation

Christine Galavotti
Senior Program Officer, Family Planning, Global Development

Brazil

Mrs Juliana De Moura Gomes
Second Secretary, Permanent Mission of Brazil to the United Nations Office and other international organizations in Geneva

Ms Gabriella Casanova
Health, Permanent Mission of Brazil to the United Nations Office and other international organizations in Geneva

Canada

Ms Niloofar Zand
Senior Adviser, Global Affairs, Canada Permanent Mission to the United Nations in Geneva, Switzerland
### Center for Reproductive Rights

**Ms Nancy Northup**  
President and Chief Executive Officer, Center for Reproductive Rights, New York, United Stated of America

**Ms Rebecca Brown**  
Director of Global Advocacy, Center for Reproductive Rights, New York, United Stated of America

**Ms Nina Sun**  
Global Advocacy Adviser, Center for Reproductive Rights, New York, United Stated of America

### Children’s Investment Fund Foundation

**Mr Miles Kemplay**  
Director, Adolescent Sexual and Reproductive Health, Children’s Investment Fund Foundation, London, United Kingdom of Great Britain and Northern Ireland

### Clinton Health Access Initiative

**Ms Christina Allain**  
Global Program Manager, Sexual Reproductive Maternal and Neonatal Health, Clinton Health Access Initiative, Arlington, United States of America

### Concept Foundation

**Dr Hans Vemer**  
CEO, Concept Foundation, Geneva, Switzerland

### David and Lucile Packard Foundation

**Ms Tamara Kreinin**  
Director, Population and Reproductive Health, David and Lucile Packard Foundation, Los Altos, United States of America

### Eritrea

**Dr Berhane Debru Beyin**  
Acting Director General of Research & Human Resources Development, Ministry of Health of the State of Eritrea, Asmara

### FHI 360

**Dr Laneta Dorflinger**  
Director, Contraceptive Technology Innovation, Family Health International (FHI 360), Durham, United States of America

### FP2020

**Ms Beth Schlatter**  
Executive Director, UN Foundation – FP2020, Washington DC, United States of America
France

Mrs Ariane Lathuille
Health Attaché, French Permanent Mission to the United Nations Office in Geneva, Chambésy, Switzerland

Mr Philippe Damie
Health Councillor, Permanent Mission of France to the United Nations in Geneva, Chambésy, Switzerland

Ghana

Laila Heward-Mills
Counsellor, Ghana Permanent Mission in Geneva...

Global Fund for Women

Dr Heli Bathija
Representative, Global Fund for Women, San Francisco, United States of America

Guttmacher Institute

Dr Ann Biddlecom
Director of International Research, Research Division, Guttmacher Institute, New York, United States of America

Gynuity Health Projects

Dr Beverly Winikoff
President, Gynuity Health Projects, New York, United States of America

International Committee for Monitoring Assisted Reproductive Technologies

Dr David Adamson
President, International Committee for Monitoring Assisted Reproductive Technologies, Palo Alto, United States of America

International Federation of Fertility Societies

Professor Richard Kennedy
President, International Federation of Fertility Societies, Mount Royal, United States of America

Dr Linda Giudice
Professor of Obstetrics, Gynecology and Reproductive Sciences, University of California at San Francisco, United States of America

International Federation of Gynecology and Obstetrics (FIGO)

Dr Edgar Mocanu
Chair, FIGO REI, International Federation of Gynecology and Obstetrics, Dublin, Ireland
<table>
<thead>
<tr>
<th>Organization</th>
<th>Name</th>
<th>Position</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>International Women’s Health Coalition</strong></td>
<td>Ms Françoise Girard</td>
<td>President, International Women’s Health Coalition</td>
<td>New York, United States of America</td>
</tr>
<tr>
<td><strong>Inter-Parliamentary Union</strong></td>
<td>Ms Aleksandra Blagojevic</td>
<td>Programme Manager, International Development, Inter-Parliamentary Union</td>
<td>Geneva, Switzerland</td>
</tr>
<tr>
<td><strong>Institute for Reproductive Health</strong></td>
<td>Dr Rebecka Lundgren</td>
<td>Research Director, Institute for Reproductive Health, Georgetown University</td>
<td>Washington DC, United States of America</td>
</tr>
<tr>
<td><strong>Ipas</strong></td>
<td>Dr Anu Kumar</td>
<td>Interim Chief Executive Officer, Ipas, Chapel Hill</td>
<td>United States of America</td>
</tr>
<tr>
<td><strong>Italy</strong></td>
<td>Dr Serena Battilomo</td>
<td>Head of Office, General Directorate for Health Prevention</td>
<td>Ministry of Health, Italy</td>
</tr>
<tr>
<td><strong>Jhpiego</strong></td>
<td>Dr Jeffrey Smith</td>
<td>Vice President, Technical Leadership Office</td>
<td>Baltimore, United States of America</td>
</tr>
<tr>
<td><strong>March of Dimes</strong></td>
<td>Dr Joe Leigh Simpson</td>
<td>Senior Vice President, Research and Global Programs</td>
<td>United States of America</td>
</tr>
<tr>
<td></td>
<td>Dr Salimah R. Walani</td>
<td>Vice-President, Global Programs, March of Dimes</td>
<td>United States of America</td>
</tr>
<tr>
<td><strong>Medicus Mundi</strong></td>
<td>Mrs Andrea Rajman</td>
<td>Responsible for Suisse Romande</td>
<td>Geneva, Switzerland</td>
</tr>
<tr>
<td><strong>Office of the United Nations High Commissioner for Human Rights</strong></td>
<td>Ms Peggy Hicks</td>
<td>Director, Thematic Engagement, Special Procedures and Right to Development Division</td>
<td>Office of the United Nations High Commissioner for Human Rights, Geneva, Switzerland</td>
</tr>
</tbody>
</table>
Ms Lucinda O’Hanlon  
Adviser on Women’s Rights, Women’s Rights and Gender Section, Office of the United Nations High Commissioner for Human Rights, Geneva, Switzerland

Mr Nicolas Fasel  

Pakistan

Dr Mariam Saeed  
First Secretary, Permanent Mission of Pakistan to the United Nations in Geneva, Switzerland

PATH

Dr Martha Brady (unable to attend)  
Director, Reproductive Health PATH, Seattle, United States of America

Mr Philippe Guinot  
Director Europe and West Africa, Geneva Office, Switzerland

Poland

Mr Adam Wojda  
Permanent Mission of the Republic of Poland to the United Nations Office in Geneva, Switzerland

Reproductive Health Matters

Ms Jane Cottingham  
Chair, Board of Trustees, Reproductive Health Matters, Geneva, Switzerland

Republic of Korea

Professor Juhwan Oh  
JW Lede Center for Global Heath, Seoul National University, Seoul, Republic of Korea

Sexual Rights Initiative

Stuart Halford  
Director, Geneva Office, Switzerland

Susan T. Buffett Foundation

Ms Elizabeth Bird  
Susan T. Buffett Foundation, Omaha, United States of America

Tunisia

Dr Rafia Tej Dellagi (unable to attend)  
President, Director-General’s Office, National Department for the Family and Population, Ministry of Health, Tunis, Tunisia
31st Meeting of the Policy and Coordination Committee (PCC)

**United Nations High Commissioner for Refugees (UNHCR)**

**Dr Ann Burton**
Chief, Public Health Section, UNHCR, Geneva, Switzerland

**Mr Andrew Harper**
Director, Division of Programme Support and Management, UNHCR, Geneva, Switzerland

**Josep Vargas Sr**
Reproductive and HIV Officer, Public Health, UNHCR, Geneva, Switzerland

**University of North Carolina**

**Dr Herbert Peterson**
Director, Department of Maternal and Child Health, University of North Carolina at Chapel Hill, Chapel Hill, United States of America

**Mrs Joumana Haidar**
Implementation Science Lead, Maternal and Child Health Department, University of North Carolina at Chapel Hill, Chapel Hill, United States of America

**United Nations Women**

**Ms Christine Loew**
Director, UN Women Liaison Office in Geneva, Switzerland

**WomenCare Global**

**Ms Shannon Bledsoe**
Executive Director, WomenCare Global, San Diego, United States of America

**Dr Kelly Culwell (unable to attend)**
Chief Medical Officer, WomenCare Global, San Diego, United States of America

**Women Deliver**

**Ms Susan Papp**
Director, Policy and Advocacy

**OTHER PARTICIPANTS**

**Scientific and Technical Advisory Group (STAG)**

**Professor Gamal I. Serour**
Professor of Obstetrics-Gynaecology, Director, International Islamic Center for Population Studies and Research, Al Azhar University, Egypt
Gender and Rights Advisory Panel (GAP)

Professor Pascale Adukwei ALLOTEY
Director, International Institute for Global Health (IIGH), United Nations University (UNU), Jalan Yaacob Latif, Malaysia

Dr Carmen Barroso
Co-Chair, Independent Accountability Panel Every Woman Every Child, United States of America

HRP Alliance

Dr Elizabeth Bukusi
Chief Research Officer, Center for Microbiology Research, KEMRI, Kenya
## HQ Secretariat (as at 12 February 2018)

### Family, Women, Children and Adolescents
- **Princess Nothemba Simelela**  
  Assistant Director-General

### Department of Reproductive Health and Research
- **Ian Askew**  
  Director

### Office of the Director
- **Rajat Khosla**  
  Human Rights Adviser
- **Elisa Scolaro**  
  Technical Officer

### Programme Management
- **Nicolas Gremion**  
  Finance and Budget Assistant
- **Catherine Hamill**  
  Technical Officer
- **Edin Karahasanovic**  
  Assistant (Team)
- **Svetlin Kolev**  
  Information Officer
- **Deborah Leydorf**  
  External Relations Officer
- **Craig Lissner**  
  Programme Manager
- **Christine Meynent**  
  Assistant (computer systems)
- **Jenny Murcott**  
  Administrative Assistant
- **Elizabeth Noble**  
  Information Officer
- **Vinod Unikkadath**  
  Information Officer

### Biostatistics and Data Management
- **Lucio Fersurella**  
  Technical Assistant
- **Ndema Habib**  
  Statistician
- **Sihem Landoulsi**  
  Programmer Analyst
- **Thi My Huong Nguyen**  
  Technical Officer
- **Soe Soe Thwin**  
  Manager, Quantitative Assessment and Data Management

### Human Reproduction Team
- **James Kiarie**  
  Coordinator
- **Moazzam Ali**  
  Medical Officer
- **Nathalie Brouzet**  
  Medical Officer
- **Elaine Caruana**  
  Assistant (Team)
- **Thérèse Curtin**  
  Assistant (Team)
- **Asa Cuzin-Kihl**  
  Technical Officer
- **Mario Festin**  
  Medical Officer
- **Mary Lyn Gaffield**  
  Scientist
- **Sami Gottlieb**  
  Medical Officer
- **Rita Kabra**  
  Technical Officer
- **Thabo Matsaseng**  
  Scientist
- **Natalie Maurer**  
  Assistant (Team)
- **Manjulaa Narasimhan**  
  Scientist
- **Stephen Nurse Findlay**  
  Technical Officer
- **Theresa Ryle**  
  Assistant (Coordinator)
- **Petrus Steyn**  
  Scientist
- **Melanie Taylor**  
  Medical Officer
- **Nandita Thatte**  
  Technical Officer
Igor Toskin  Scientist
Jane Werunga-Ndanareh  Assistant (Team)
Teodora Wi  Medical Officer

Maternal and Perinatal Health Team
Metin Gülmezoglu  Coordinator
Ferid Abubeker  Medical Officer
Lily Atutornu  Assistant (Coordinator)
Ana-Pilar Betran Lazaga  Medical Officer
Mercedes Bonet Semenas  Medical Officer
Claire Garabedian  Assistant (Team)
Bela Ganatra  Scientist
Ronnie Johnson  Scientist
Catherine Kiener  Assistant (Team)
Caron Kim  Medical Officer
Antonella Lavelanet  Medical Officer
Olufemi Oladapo  Medical Officer
Anna Thorson  Scientist (Research Manager)
Sarah Törnqvist de Masi  Medical Officer
Özge Tuncalp Mingard  Scientist
Anna Vasalaki  Assistant (Team)
Joshua Vogel  Technical Officer
Mariana Widmer  Technical Officer

Adolescents and At-risk Populations Team
Lale Say  Coordinator
Mohamed Ali  Scientist
Avni Amin  Technical Officer
Venkatraman Chandra-Mouli  Scientist
Doris Chou  Medical Officer
Lejla Gagic  Assistant (Team)
Claudia García-Moreno  Medical Officer
Lianne Gonsalves  Technical Officer
Lauri Jalanti  Assistant (Team)
Loulou Kobeissi  Scientist
Garrett Mehl  Scientist
Ann-Beth Moller  Technical Officer
Milly Nsekalije  Assistant (Team)
Christina Pallitto  Scientist
Megin Reijnders  Technical Officer
Joanne Simpson-Deprez  Assistant (Coordinator)
## Annex 2. Agenda

### Programme

**TUESDAY, 20 March (09:00-17:00)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Time</th>
<th>Presenter</th>
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<tbody>
<tr>
<td>1. Welcome, adoption of the agenda and election of presiding officers</td>
<td>09:00-09:20</td>
<td>Chair</td>
</tr>
<tr>
<td>2. Remarks of Assistant Director-General, Family, Women, Children and Adolescents Cluster</td>
<td>09:20-09:40</td>
<td>ADG/FWC</td>
</tr>
<tr>
<td>3. Adoption of the report of PCC(30), review of implementation of recommendations and remarks by PCC-Chair</td>
<td>09:40-10:15</td>
<td>Chair</td>
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<tr>
<td>4. Director's Annual Report 2017</td>
<td>10:15-10:45</td>
<td>I. Askew</td>
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<tr>
<td>5. Financial reports</td>
<td>10:45-11:45</td>
<td>C. Lissner</td>
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<tr>
<td>6. External Evaluations</td>
<td>11:45-12:05</td>
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<tr>
<td>7. How can HRP's research strengthen health systems for universal health coverage</td>
<td>12:05-12:30</td>
<td>C. Lissner</td>
</tr>
<tr>
<td>LUNCH</td>
<td>12:30-14:00</td>
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<tr>
<td>8. Reports of the committees</td>
<td>14:00-15:15</td>
<td>I. Askew</td>
</tr>
<tr>
<td>→ 8.1 Standing Committee</td>
<td>15:40-16:00</td>
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<tr>
<td>→ 8.2 Scientific and Technical Advisory Group (STAG)</td>
<td>16:00-16:20</td>
<td>G. Serour</td>
</tr>
<tr>
<td>→ 8.3 Gender and Rights Advisory Group (GAP)</td>
<td>16:20-16:40</td>
<td>P. Alleløy</td>
</tr>
<tr>
<td>→ 8.4 HRP Alliance Advisory Board</td>
<td>16:40-17:00</td>
<td>E. Bukusis</td>
</tr>
<tr>
<td><strong>TEA BREAK</strong></td>
<td>16:15-17:45</td>
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<tr>
<td><strong>RECEPTION (WINTER GARDEN, WHO RESTAURANT)</strong></td>
<td>17:15-20:00</td>
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<tr>
<td>WEDNESDAY, 21 MARCH (08:30-17:00)</td>
<td>TIME</td>
<td>PRESENTER</td>
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<tr>
<td>9. SRHR, human rights, and HRP’s research agenda following the WHO-OHCHR recommendations</td>
<td>08:30-10:00</td>
<td>D. Mueller</td>
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<tr>
<td></td>
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<td>A. Blagojevic</td>
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<td>N. Fasel</td>
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<td>C. Barrosso</td>
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<tr>
<td></td>
<td>PANEL DISCUSSION</td>
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</tr>
<tr>
<td>10. Innovation and roadmaps – HRP’s roles along the pathway from R&amp;D to registration to scale up</td>
<td>10:30-11:30</td>
<td>M. Gulmezoglu</td>
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<td>S. Gottlieb</td>
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<td>G. Mehl</td>
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<td>PRESENTATIONS OF HRP INNOVATIONS FOLLOWED BY PCC DISCUSSION</td>
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<tr>
<td>11. Sexual and reproductive health and rights in humanitarian settings: HRP working in partnership</td>
<td>11:30-12:30</td>
<td>I. Huljs</td>
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<td>A. Harper</td>
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<td>B. Kalasa</td>
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<td>PANEL DISCUSSION</td>
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<td>12. Pledging for 2018 and subsequent years</td>
<td>14:00-14:15</td>
<td>CHAIR</td>
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<td>13. Date and venue of the 2019 meeting and tentative date for 2020</td>
<td>14:15-14:25</td>
<td>CHAIR</td>
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<tr>
<td>14. Review and approval of the draft report of the meeting</td>
<td>14:25-15:00</td>
<td>RAPPORTEUR</td>
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<tr>
<td>14. Review and approval of the draft report of the meeting (continued)</td>
<td>15:30-16:50</td>
<td>RAPPORTEUR</td>
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<td>15. Any other business</td>
<td>16:50-17:00</td>
<td>CHAIR</td>
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