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

Currently there are three Member States from the WHO South-East Asia Region (Bhutan, Nepal and Maldives) that are Members of PCC in Category 2, while India and Thailand continue to be Members of PCC in Category 1. Since the term of office of Bhutan ends on 31 December 2020, representatives at the High-Level Preparatory Meeting were requested to consider electing one Member State of the WHO SEA Region to serve on the PCC for a three-year term of office starting 1 January 2021.

The HLP Meeting recommended that Bangladesh serve on the PCC for a three-year term starting 1 January 2021 in place of Bhutan whose term ends on 31 December 2020. The recommendations made by the HLP Meeting for consideration by the Seventy-third Session of the WHO Regional Committee for South-East Asia are as follows:

**Actions by WHO**

1. Document the nomination of Bangladesh based on the recommendations made at the HLP Meeting for inclusion in the Working Paper for the Seventy-third Session of the Regional Committee and update the HRP department at WHO headquarters after the Regional Committee Session.

2. Share the final report of the PCC meeting held on 25 March 2020 in Geneva as and when available.

This Working Paper and the HLP Meeting recommendations are submitted to the Seventy-third 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 Parties cooperating 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 arrangements for the 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 will 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 Policy and Coordination Committee consists of members from among the Cooperating Parties as follows (Annex 1):

   (1) Largest financial contributors (Category 1): Eleven 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 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, Nepal and Maldives. 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 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 currently. Nepal was a member in this category for the term 1 January 2012–31 December 2014.

(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 (2.2.2) and 3 (2.2.3) 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 in Dili, Timor-Leste, in 2015 had 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 draft Report of the 33rd Meeting (virtual) of the Policy and Coordination Committee (PCC), held on 25 March 2020 in Geneva, Switzerland, is attached (Annex 2) for the information of the Seventy-third Session of the Regional Committee.

**Membership from the South-East Asia Region under Category 1 and 2**

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>
<td>Bangladesh</td>
<td>1987–1989</td>
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<td>1990–1992</td>
<td>Regional Committee</td>
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<td>2000–2002</td>
<td>Regional Committee</td>
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<td>2006–2008</td>
<td>Regional Committee</td>
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<td></td>
<td>2012–2014</td>
<td>Regional Committee</td>
<td>2.2.2</td>
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<tr>
<td>Bhutan</td>
<td>2011–2013</td>
<td>Regional Committee</td>
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<td></td>
<td>2018–2020</td>
<td>Regional Committee</td>
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<tr>
<td>India</td>
<td>2005 onwards</td>
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<td>Indonesia</td>
<td>1992–1994</td>
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<td>1995–1997</td>
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<td>2015–2017</td>
<td>Regional Committee</td>
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<td>Maldives</td>
<td>2013–2015</td>
<td>Regional Committee</td>
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<td></td>
<td>2019–2021</td>
<td>Regional Committee</td>
<td>2.2.2</td>
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<tr>
<td>Country</td>
<td>Period</td>
<td>Elected by</td>
<td>Paragraph of the Memorandum on the administrative structure under which elected</td>
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<tr>
<td>Myanmar</td>
<td>2007–2009</td>
<td>Regional Committee</td>
<td>2.2.2</td>
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<td></td>
<td>2016–2018</td>
<td>Regional Committee</td>
<td>2.2.2</td>
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<tr>
<td>Nepal</td>
<td>1989–1991</td>
<td>Regional Committee</td>
<td>2.2.2</td>
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<td></td>
<td>2000–2002</td>
<td>PCC</td>
<td>2.2.3</td>
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<td>2005–2007</td>
<td>Regional Committee</td>
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<tr>
<td></td>
<td>2012–2014</td>
<td>PCC</td>
<td>2.2.3</td>
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<tr>
<td></td>
<td><strong>2019–2021</strong></td>
<td>Regional Committee</td>
<td><strong>2.2.2</strong></td>
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<td>Sri Lanka</td>
<td>1988–1990</td>
<td>Regional Committee</td>
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<td>1994–1996</td>
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<tr>
<td></td>
<td>2004–2006</td>
<td>Regional Committee</td>
<td>2.2.2</td>
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<tr>
<td></td>
<td>2009–2011</td>
<td>Regional Committee</td>
<td>2.2.2</td>
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<tr>
<td></td>
<td>2017–2019</td>
<td>Regional Committee</td>
<td>2.2.2</td>
</tr>
<tr>
<td>Thailand</td>
<td><strong>2016 onwards</strong></td>
<td>PCC</td>
<td><strong>Category 1</strong></td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>2014–2016</td>
<td>Regional Committee</td>
<td>2.2.2</td>
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</table>

6. At present, three Member States from the South-East Asia Region are members of the PCC: Bhutan, Maldives and Nepal. Since the term of office of Bhutan ends on 31 December 2020, the HLP Meeting recommended that Bangladesh serve on the Policy and Coordination Committee in Category 2 for a three-year term from 1 January 2021 to 31 December 2023.

7. While selecting Bangladesh for the membership of the Committee, 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 as a member of the PCC in the past under Category 2 during the period 2012–2014.

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

Category 1: Largest financial contributors in the previous biennium (2018–2019)

People’s Republic of China
Flemish Government, Belgium
France
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

Argentina 2019–2021
Bhutan 2018–2020
Czech Republic 2018–2020
Iran (Islamic Republic of) 2018–2020
Japan 2020–2022
Maldives 2020–2022
Mozambique 2018–2020
Namibia 2018–2020
Nepal 2019–2021
Niger 2019–2021
Nigeria 2019–2021
Philippines 2018–2020
Solomon Islands 2019–2021
Trinidad and Tobago 2019–2021

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
DRAFT REPORT
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## Abbreviations and acronyms

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CSO</td>
<td>civil society organization</td>
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<tr>
<td>ECHO</td>
<td>evidence for contraceptive options and HIV outcomes</td>
</tr>
<tr>
<td>GAP</td>
<td>Gender and Rights Advisory Panel</td>
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<tr>
<td>GBV</td>
<td>gender-based violence</td>
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<td>GPW13</td>
<td>WHO Thirteenth General Programme of Work</td>
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<td>HRP</td>
<td>Special Programme of Research, Development and Research Training in Human Reproduction</td>
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<tr>
<td>HRP-A</td>
<td>HRP Alliance</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<tr>
<td>PCC</td>
<td>Policy and Coordination Committee</td>
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<tr>
<td>RHR</td>
<td>Reproductive Health and Research (Department of)</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
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<tr>
<td>SGBV</td>
<td>sexual and gender-based violence</td>
</tr>
<tr>
<td>SRH</td>
<td>sexual and reproductive health</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health and Research (Department of)</td>
</tr>
<tr>
<td>STAG</td>
<td>Scientific and Technical Advisory Group</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
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<tr>
<td>UHC</td>
<td>universal health coverage</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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</table>
Executive summary

At its Thirty-third Meeting, a virtual meeting held on 25 March 2020, 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 (the “Programme” or HRP) took the following actions:

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

1. ELECTED Dr Teresa Soop, Sweden, as Chair of PCC.
2. ADOPTED the draft agenda without amendment.

Agenda item 2 Remarks by the WHO Chief Scientist

1. NOTED the remarks of the WHO Chief Scientist.

Agenda item 4 Adoption of the report of PCC(32), review of implementation of recommendations and remarks by the PCC Chair

1. ADOPTED the report of the 32nd meeting of the PCC and NOTED the follow-up actions in response to PCC recommendations.

Agenda item 5 Director’s annual report 2019

1. NOTED the Programme’s activities, as presented by the Director, and APPROVED the HRP Annual Report, 2019.
2. RECOMMENDED that the executing agency urgently accelerate recruitment of vacant HRP positions to bring staffing up to the level in the programme budget approved by PCC.

Agenda item 10 Financial matters

1. NOTED the HRP financial management analysis and outlook and the report on leveraged funding
2. APPROVED the HRP certified financial report 2018–2019
3. APPROVED the revised HRP budget for 2020–2021.

Agenda item 12 Follow-up to the HRP external evaluation 2013–2017

Agenda item 13   HRP theory of change
1. ENDORSED the proposed theory of change and the continued support of the sub-committee in its ongoing development.

Agenda item 14   Any other business
1. AGREED to task HRP to prepare an evidence-based statement on the impact of COVID-19 on access to safe abortion and other SRH services, to be considered for endorsement by PCC.

Agenda item 15   Date and venue of the 2021 meeting and tentative date for 2022
1. AGREED to hold the 34th meeting of the PCC on 24 and 25 March 2021 in Geneva and proposed 23 and 24 March 2022 as tentative dates for the 35th meeting of the PCC.
Introduction

In the unprecedented circumstances of the COVID-19 pandemic, the 33rd Meeting of the Policy and Coordination Committee (PCC) was held on 25 March 2020 as a virtual meeting. There were two online sessions, the first from 8am to 10am (CET) and the second from 4pm to 6pm (CET). Close to 100 participants logged into each session (the participants are listed in Annex 1).

Prior to the meeting, participants were invited to post comments on agenda items via the meeting app. This report synthesizes the proceedings of both sessions, along with comments submitted prior to the meeting. All decisions included in this report represent the consensus of participants in both sessions of the meeting.

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

The Chair of the PCC, Mr Sander Spanoghe, opened the meeting. As outgoing Chair, he expressed his gratitude for the fruitful collaboration among the Special Programme of Research, Development and Research Training in Human Reproduction (HRP), Scientific and Technical Advisory Group (STAG), Gender and Rights Advisory Panel (GAP), Standing Committee (SC) and PCC, and his pride in the achievements of the previous five years.

The Chair advised that the SC had endorsed Dr Teresa Soop, the delegate of Sweden, as candidate for Chair. Dr Soop had also been nominated by the United Kingdom of Great Britain and Northern Ireland. As there were no objections to her appointment, Dr Soop was invited to take the Chair. Expressing her sincere gratitude to her predecessor for his dedicated work, she acknowledged the great honour it was for Sweden to hold the Chair and to work with the Programme’s cosponsors.

On behalf of the PCC, the Chair expressed her condolences on the untimely death of Dr Peter Salama, Executive Director, Universal Health Coverage / Life Course, who had been a great champion of the poor, vulnerable and marginalized. She thanked all PCC Member States and HRP for convening in the extraordinary circumstances.

The Chair invited the PCC to adopt the draft agenda (see Annex 2). The agenda was adopted without amendment.

PCC:

1. ELECTED Dr Teresa Soop, Sweden, as Chair of PCC.
2. ADOPTED the draft agenda without amendment.

2. Remarks by the WHO Chief Scientist

In her remarks to the first session, Dr Soumya Swaminathan, WHO Chief Scientist, stated that in these very unusual times WHO was learning to work in different ways and its work must go on. WHO had been focused on leading efforts to tackle COVID-19. Research and innovation were of great importance as data and evidence were critical to inform response and impacts on health systems and programmes and the health of women, children and families. How to maintain sexual and reproductive health and rights (SRHR) services was all the more critical at this time. The risky impact of the COVID-19 virus on others may bring about some decline in services. There needed to be clear messaging of support to health workers, researchers, etc. One work stream of the Science Division was evidence synthesis, which required methodological expertise. Human rights and gender equity issues were integral to this. It was critical to be alert to any stigmatization or discrimination, which presented a real risk; hence the
heightened importance of messaging. She reiterated the particular importance of equity and service provision to the marginalized and most vulnerable.

Dr Swaminathan was unable to attend the second session.

**PCC:**

1. NOTED the remarks of the WHO Chief Scientist.

**3. Remarks by the Executive Director, Universal Health Coverage / Life Course**

Dr Zsuzsanna Jakab, Acting Executive Director, Universal Health Coverage / Life Course, expressed her regret at not being able to attend, due to the rapidly evolving COVID-19 situation.

**4. Adoption of the report of PCC(32), review of implementation of recommendations and remarks by the PCC Chair**

The Chair thanked HRP for the comprehensive report of PCC(32), noting increased collaboration with cosponsors, other implementing partners on the ground, decision-makers, civil society organizations (CSOs), etc., including joint work on innovation and digital health. She commended the work of the HRP Alliance (HRP-A) and increased efforts to collaborate with the Office of the United Nations High Commissioner for Human Rights (OHCHR). Since the last PCC meeting, WHO had undergone a transformation. As a consequence, HRP reports to both the Universal Health Coverage (UHC) / Life Course Division and the Science Division, “the best of both worlds” as it encompassed many synergies. She reemphasized the scientific independence of HRP and proposed that PCC request that WHO ensure the maintenance of the full integrity of HRP. She reported Sweden’s concern with the slow recruitment of HRP staff and desire to see WHO accelerate the process. She stated that PCC would appreciate an overview of the staffing situation.

In respect of HRP’s follow-up to the recommendations of PCC(32), the delegate of Belgium hoped that WHO guidelines would continue to acknowledge the contribution of HRP through co-branding and asked how HRP’s leading role on digital innovation in health would relate to work within the new WHO Division.

The Chair noted the increasingly harsh climate around SRHR, stating that the rights-holder must continue to be the individual, that PCC supported HRP pushing a rights-based agenda and that it was important to work on equity and services to the most vulnerable. The delegate of Switzerland noted that PCC had recommended (recommendation 8.2) that an updated report on SRHR in UHC become a standing agenda item. Given the importance of WHO engagement at the country level, the representative of Marie Stopes International asked whether there had been collaboration with Global Financing Facility (GFF) mechanisms in determining resource allocation for SRHR. The delegate of Belgium commended HRP for its sterling performance in having achieved the large-scale ECHO (evidence for contraceptive options and HIV outcomes) trial. The Chair reported that Sweden appreciated communications on the outcome of the trial, in particular the useful webinars, and suggested that HRP continue holding webinars as part of its communications strategy.

The Chair then invited members to adopt the report of the Thirty-second Meeting of the Committee. The report was adopted without amendment.

**PCC:**

1. ADOPTED the report of the 32nd meeting of the PCC and NOTED the follow-up actions in response to PCC recommendations.
5. Director’s annual report 2019

Dr Ian Askew, Director, Sexual and Reproductive Health and Research (SRH) Department, thanked the outgoing Chair for his strong performance in the role, noting that his commitment over the last five years had ensured that HRP functioned highly effectively. He thanked Sweden and its delegate Dr Teresa Soop for assuming the Chair, noting that Sweden had been a strong supporter of the Programme since its inception.

In reporting on the productivity and impact of HRP over the previous two years and the transformation of WHO, the Director highlighted two statistics: (i) 118 research centres (in more than 70 countries) had been strengthened through HRP grants; and (ii) 54.5 per cent of those trained through HRP-A were women, putting HRP on track to achieving gender parity in its training programme.

The Director identified exciting opportunities for 2020: (i) the production of global estimates for: violence against women; incidence of unintended pregnancy, abortion and abortion safety; causes of maternal death; burden of infertility; herpes simplex virus (HSV) and health promotion — these new data will be of use to both the global and national sexual and reproductive health (SRH) communities; (ii) the launch of guidelines on: infertility; safe abortion; cervical cancer; maternal health; (iii) support to new countries for policy and health systems strengthening to reduce maternal mortality due to unsafe abortion; (iv) reporting on and promoting the ACTION trial on use of antenatal corticosteroids for prevention of preterm, perinatal and neonatal mortality in hospitals in low-resource countries; (v) reporting on and promoting the ground-breaking CAPSAI study on impact and implementation of social accountability interventions in family planning programmes, which is already moving the rhetoric on social accountability; (vi) operationalizing the electronic repository for HRP research essential documents, study meta-data, analytic data sets and publications highlighted by the external evaluation of HRP 2013–2019; and (vii) production of multiple implementation tools based on best practices for UHC, human rights, digital health, family planning, infertility, maternal health, cervical cancer, self-care and adolescents. A substantial grant to the programme to prevent unsafe abortion will enable a response to country requests, for example for health system strengthening.

The Director then reported on work currently under way in response to the COVID-19 pandemic, which included ongoing work on norms and standards. A working group had been formed within the Department to address the research needs of SRHR during the pandemic situation. A WHO Essential Health Services guideline on management of SRH services during the pandemic-induced lockdowns was forthcoming, which integrates SRH service delivery, addressing in particular pregnant women and breastfeeding and refugees and migrants. HRP was working with WHO to supply the data skills needed to respond to the COVID-19 pandemic and staff had been deployed already to work in WHO Regional Offices. HRP was adapting generic research protocols around three areas to address the pandemic. It was also undertaking communications and advocacy work to ensure that SRHR issues were fully integrated into WHO messaging, as well as messaging by UN agencies and non-State actors. It was also liaising with the Inter-Parliamentary Union (IPU) and European Parliamentary Forum (EPF) to promote parliamentary actions. The Director emphasized the importance of uniform messaging.

The WHO transformation, which was very intensive, thorough and ongoing for two years, had resulted in a new strategy, the WHO Thirteenth General Programme of Work (GPW13). In line with the three strategic shifts made by WHO, HRP had been encouraged by the WHO Director-General to: (i) step up its leadership; (ii) drive impact in every country; and (iii) ensure that global public goods have impact on the ground where they are needed.

The Director presented an overall impact framework aligning HRP with WHO outputs and outcomes for impact at country level. All HRP units would henceforth report explicitly on results, as reflected in the new structure of WHO Headquarters. As HRP sits within the SRH department in the UHC / Life Course Division, this ensures full integration of SRHR issues throughout this Division, and reports to its Executive Director (currently Acting Executive Director, WHO Deputy-Director Dr Zsuzsanna Jakab). One element of the transformation is the change of the Department’s name from Reproductive Health and Research (RHR) to Sexual and Reproductive Health and Research (SRH), reflecting the essence of HRP’s work and the intersection of human reproduction and sexual health and rights. The Department (including HRP) is also aligned with and reports directly to the WHO Chief Scientist, Science Division.
The Director identified advantages in being situated in both science and policy management streams: HRP is integrated into the UHC work programme while also benefiting from and contributing to WHO’s global role as a scientific research leader.

The SRH Department had been restructured into seven thematic/programmatic units plus the HRP Secretariat. Each unit contained relevant technical expertise and focused indicators guided and directed the work of the units to deliver on global Sustainable Development Goals (SDGs) and other indicators and outcomes. The overall work programme took an integrated approach: joint planning of activities was conducted by representatives of all units, taking all departmental perspectives into account. Two further positions — a Human Rights Adviser, already established in response to the external evaluation of HRP 2013–2019, and a Gender Equality Adviser, to be recruited shortly — were positioned in the Office of the Director, to whom they report directly. As HRP was until recently subject to the WHO recruitment freeze, there were 20 vacant posts (representing some 20–25 per cent of departmental capacity) at the time of the meeting. HRP had been actively recruiting for ten of those positions since January 2020 and would shortly recruit for the other ten.

The delegate of Sweden was one of many who welcomed the renaming of the Department. She expressed appreciation of HRP’s many achievements and commended the increased efforts under HRP-A and on comprehensive sexuality education, implementation research, activities at country level and SRHR in UHC and the establishment of the position of Gender Equality Adviser. The delegate of the Netherlands added her appreciation of the important progress made on work around HRP-A and its network and activities. She noted that the joint work by the three WHO-based research programmes was promising and asked whether HRP had planned for the impact of the network of researchers on implementation at country level. The delegate of Sweden also commended HRP’s impact in presenting a strategy for strengthening not only the involvement but also the leadership of low-income countries’ researchers in HRP projects. For transparency, she would appreciate a description of how research project teams are selected.

The delegate of Sweden went on to state that Sweden and its partners greatly appreciated HRP’s work on evidence synthesis. She stressed the importance of not only focusing on harmful norms around masculinity but also those around femininity that enforce female subordination and control of women, and recommended that end-users and target groups be increasingly and directly involved in both normative work and research projects.

The delegate of the Netherlands noted that there seemed to have been difficulty in implementing a small number of HRP’s thematic activities, in particular contraception/fertility, safe abortion and services to adolescents and at-risk groups, where HRP is the most important source of progress in knowledge, guidance and policy dialogue. This indicated a worrying long-term trend. She requested renewed focus on those themes and suggested special planning or recruitment to ensure their delivery in full. Over-spending in certain other thematic areas was also noted.

The Director explained that apparent under- or over-spending was due to the mechanics of budgeting. This was in part a question of financial allocation and in part due to the specific nature of certain activities. For example, abortion services had been delivered as per the work plan but at a lower cost. The recruitment freeze had also had an impact, reducing resources for delivery. The family planning team had faced a major challenge with one large study and as the study could not proceed, the funding was reallocated. He noted that products were always delivered to the extent possible, but the budget allocation process had an impact.

The delegate of Belgium echoed the concern expressed about under-expenditure. He made the point that HRP is an autonomous programme within WHO, with an autonomous staff ceiling and suggested HRP communicate to WHO that its recruitment freeze contradicted HRP’s ability to perform. The Director advised that, while HRP was in fact able to recruit, it would be helpful if PCC, its governing body, were to make such a point. The delegate of Belgium made further suggestions to improve the structure of the annual report to be considered for next year. He expressed interest in the shared maternal health strategy of HRP and the Department of Maternal, Newborn, Child and Adolescent Health and Ageing, how the work would be allocated and where synergies might be found and requested that HRP report to the next PCC meeting in detail on the strategy. The Director advised that the joint maternal health working group was in the process of drafting a joint strategy, which would be shared with the PCC and more widely.
The delegate of Switzerland commended HRP for the very impressive results achieved in the reporting year, highlighting the establishment of a Gender Equality Adviser position and work on COVID-19. She requested that the Director’s annual report provide a comprehensive overview and analysis of the previous year’s performance to enable PCC to provide strategic guidance to HRP and suggested that results contained in different reports be further coordinated so as to be more readily accessible. Commenting on the summary of indicators and achievement values, a representative of the United Nations Population Fund (UNFPA) noted that two fifths of outputs related to capacity-strengthening and suggested that indicators be more granular in future reports.

The representative of the International Planned Parenthood Federation (IPPF) congratulated HRP for an excellent report and achievements in 2019, acknowledging the in-depth and quality research and guidance provided for programming, especially on key SRHR issues such as comprehensive abortion care, violence against women, female genital mutilation (FGM), fertility, sexually transmitted infections (STIs), cervical cancer prevention and adolescent SRH. IPPF was happy to collaborate with HRP to conduct implementation research and disseminate guidance for delivery of quality SRH services.

Responding to questions on whether there were any emerging features of the COVID-19 pandemic in terms of SRHR, in particular any that would impact on HRP’s work, the Director explained that, while anecdotal reports were emerging from WHO Country Offices and WHO was taking a health systems perspective, nothing concrete was yet known at the time of meeting. Asked to elaborate, the Director stated that he anticipated all HRP primary data collection would be put on hold. This would be discussed internally following the meeting and subsequently with donor partners. He noted how quickly the Department was having to adjust to the situation. The Department was considering alternative ways of providing services in family planning, maternal health, etc., such as home delivery, online resources and digital guidelines, when women’s ability to access them was compromised. The introduction of physical distancing and closedown of facilities made it difficult to go beyond the delivery of global guidance.

Two participants advised that the COVID-19 pandemic was being used by some Member States as a pretext to limit access to abortion. The representative of the Centre for Reproductive Rights urged that abortion be included as a critical aspect of the WHO Essential Health Services guideline. The representative of Women Deliver asked whether abortion services were not considered “essential services” and urged that HRP’s norms and standards also encompass birth attendants.

The delegate of Sweden appreciated the use of the term “comprehensive abortion services” and emphasized the aspects of access to safe abortion in the theme of “prevention of unsafe abortion”. She commended HRP for connecting “task-sharing” to access, which is of particular interest regarding medical abortion. She emphasized the great importance of finalizing the update of “Safe abortion: technical and policy guidance for health systems”.

The Director explained that HRP’s work with countries on access to abortion services was always determined by the laws of individual countries. HRP does consider abortion an essential service to the full extent of the law and uses an evidence base to assert that position. Given the evolving situation with the COVID-19 pandemic, the draft WHO guidelines would be very high level, addressing health systems rather than specific services. He assured the meeting that HRP was very intensely engaged with other key actors in WHO. He would report back separately on the question of inclusion of birth attendants.

The representatives of both the International Women’s Health Coalition (IWHC) and the International Campaign for Women’s Right to Safe Abortion requested that a statement be made urgently on safe abortion being an essential service. It was not a matter of legality, she said, as laws were being overridden. She also called on HRP to provide guidance urgently via telehealth while access to abortion was restricted; guidance on contraception would also be useful. The Director agreed that HRP advice must be made as widely available as possible and suggested that a statement be discussed under agenda item 14, Any other business.

A representative of UNFPA stressed the importance of the underlying messages at country level. He echoed the concerns of midwives and pregnant women on how services might be delivered given the impact of the pandemic. As was the case during the Ebola outbreak, women are avoiding going to
service centres. He asked what lessons might be learned from other countries’ experiences, for instance on innovation. On the supply side, there was the risk that the right commodities would not be available and there was also an impact on data collection as state systems were being disrupted. Acknowledging these points, the Director stated his appreciation of the resource materials produced by UNFPA.

The representative of the World Bank advised that the Bank was working to deliver funds to country teams. The Bank was very concerned to witness the supplanting of SRH programmes. The Director thanked her for raising this issue.

The representative of PATH emphasized the importance of the gender dimension to the entire response to COVID-19, which mainly impacts on women. HRP must be aware of addressing women at the centre of all programmes, particularly in this International Year of the Nurse and the Midwife.

A number of other participants made a range of practical suggestions to strengthen annual reporting, in particular to enhance the results focus. Thanking them, the Director took note of these suggestions.

In inviting the meeting to approve the Director’s annual report, the Chair made special note of the “phenomenal effort” that had been made in delivering the ECHO trial.

PCC:

1. NOTED the Programme’s activities, as presented by the Director, and APPROVED the HRP Annual Report, 2019.

2. RECOMMENDED that the executing agency urgently accelerate recruitment of vacant HRP positions to bring staffing up to the level in the programme budget approved by PCC.

10. Financial matters

Mr Craig Lissner, Unit Head, HRP Secretariat, presented the RHR financial report 2018–2019 (provisional) and the SRH projections and current financial situation. The biennial budgets and revenues showed an upswing in recent years. HRP would continue to adapt to increases and decreases in revenue, which was now reasonably stable. Income was in line with budget. Mr Lissner noted the generous support of the Susan Thompson Buffett Foundation for programmes to reduce maternal mortality and reduce unsafe abortion at country level. Governments remained the most important contributors to revenue (52 per cent), especially those that contribute multi-year funding. Non-State actors also contributed significantly (38 per cent).

Under-expenditure in certain programmes was primarily due to under-staffing as a result of the WHO transformation (which was being addressed, e.g. by the current recruitment of five Unit Heads). Within the preventing unsafe abortion programme, the case study on the rollout of services in the Republic of Ireland was delayed, as was support for the medical abortion combi-pack, and the WINGS and self-injection studies. Dr Bela Ganatra, Acting Unit Head, Prevention of Unsafe Abortion (PUA), expanded on several other issues that had impacted on programme expenditure. Activities had to be reprogrammed to enable HRP to initiate access in countries and the freeze on recruitment of dedicated staff had also delayed activities. Under-expenditure in the contraception programme was attributable to the considerable cost savings made on the ECHO trial, allowing funds to be carried over, and to some delays in gaining ethical approval. The acceleration of some work on STIs has resulted in over-expenditure in that area. The representative of the United Nations Children’s Fund (UNICEF) remarked on HRP’s collaboration with the Department of Maternal, Newborn, Child and Adolescent Health and Ageing, which UNICEF recognized as a positive transition. He expressed concern that, despite reported over-expenditure, momentum was being lost in the area of maternal health globally. In response, Mr Lissner reported that the over-expenditure was not specific to the maternal mortality project but to HRP’s focus on research on maternal and perinatal health and success in raising specified funds, e.g. for the carbetocin and ACTION trials. HRP was collaborating closely with the MCA department, with HRP focusing on research and normative products and MPH on country impact.
Mr Lissner reminded members that, at its previous meeting, PCC had expressed concern at the rate of implementation of activities by HRP-A. He reported that, in the current reporting year, this now stood at 94 per cent. While expenditure on staffing was below the approved 40 percent ceiling, renewed recruitment would raise it to that level by the end of the year.

The projected budget shortfall of $18.8 million for the 20-21 biennium was not of immediate concern, but underscored the importance of sustained fundraising. Notably, HRP had not lost any of its major flexible funding donors in its previous four years of operation. HRP would work with PCC members to recruit new donors. Mr Lissner stated that HRP was in a very good position at the end of 2018–2019 and the outlook was positive.

Some members noted that there had been under-expenditure in the flagship areas of safe abortion, contraception and fertility care, and adolescent and at-risk populations for the last three years. The delegate of the Netherlands requested a conscious effort be made to recruit more support for PUA. Continued vigilance of the maternal mortality project was needed to maintain a balance in funds. Some members suggested that a separate strategy for increased or accelerated spending in these areas was warranted, given the huge influx of funding for the maternal mortality project. Mr Lissner stated that concerted efforts would be made to bring these areas back on target and to increase PUA staffing.

The delegate of the Netherlands stated that the conclusion of the financial management analysis was that funding for the 2018–2019 biennium was up to 52 per cent undesignated and did not look to be higher for 2020–2021. The implementation rate of the overall budget was 74 per cent (89 per cent excluding the maternal mortality project). She noted that PCC would remain vigilant on designated funding and levels of implementation.

The delegates of Belgium and Sweden noted that both designated and undesignated revenue had fallen in 2019. The delegate of Sweden noted the reduction of funds from the Bill and Melinda Gates Foundation in 2019. The delegate of Belgium asked whether the downturn was a trend in the second year of every biennium and how deferred revenue was treated. Mr Lissner explained that there was no underlying trend; in 2019 the downturn was attributable solely to the end of the specified grant for the large-scale carboplatin project, which concluded in 2019. HRP was well positioned to attract other very large project-specific funding in 2020, including from the Bill and Melinda Gates Foundation. He reiterated that projections based on multi-year donors are on track, that no multi-year donors had been lost in the previous four years and that new donors would be sought vigorously. He also underscored the importance of considering income over the full biennium, and comparing with previous biennia, in order to assess long-term trends. In this regard, the delegate of Belgium stressed the importance of securing donors willing to support HRP with fewer strings attached, in order to reduce the amount of designated as opposed to undesignated funding.

There was no significant change in the revised programme budget for 2020–2021 as a consequence of the WHO transformation in terms of distribution across thematic areas and bottom-line totals; however, the budget was now broken down by budget section in line with the new unit structures for the department. Five new products had been added to the revised version: (i) evidence-based packages linked to SRHR within the WHO UHC compendium; (ii) products related to COVID-19; (iii) a new STI research agenda to be undertaken jointly with the Department of Global HIV, Hepatitis and STIs Programmes (HHS) (to which responsibility for the STI guidelines had been transferred); (iv) studies for modelling a reversible male contraceptive method; and (v) networking with countries, with a critical focus on incorporating HRP outputs into WHO Country Office support plans. Responding to an earlier question (raised under agenda item 4), Mr Lissner stated that all HRP outputs would henceforth be co-branded with WHO, which would raise the visibility of HRP.

The delegate of Belgium noted that, while responsibility for the STI guidelines had been transferred from HRP, funding for STI and cervical cancer activities had been increased. He asked whether additional activities had been prioritized following the important resolution on the cervical cancer strategy. He also noted that the budget for HRP-A activities remained lower than in the previous budget. The Director stated that in 2018–2019 there had been over-expenditure on both STIs and cervical cancer and that this would continue through 2020–2021, with a slight increase in allocation. The delegate of the United Kingdom of Great Britain and Northern Ireland asked whether it was possible to
predict the likely implications of the COVID-19 pandemic on the implementation of HRP work, timelines and expenditure and how it proposed to mitigate the impact.

PCC:

1. NOTED the HRP financial management analysis and outlook and the report on leveraged funding
2. APPROVED the HRP certified financial report 2018–2019
3. APPROVED the revised HRP budget for 2020–2021.

12. Follow-up to the HRP external evaluation 2013–2017

The Director stated that the external evaluation had been very helpful to the Department and guided its ongoing work. He thanked those members who had provided specific comments on the management response prior to the meeting. The Chair noted that some of the recommendations made by management concerned PCC itself.

Representatives of IPPF expressed the organization’s support for HRP continuing to drive the policy dialogue on gender equity and human rights, the creation of the role of Gender Equality Advisor and the inclusion of GAP in the research process, which would strengthen research results and inform design of gender transformative programmes. They appreciated the quality of the external evaluation and detailed management response. Particularly welcome was the focus on implementation research, which provided further opportunities for IPPF, national organizations, local partners and CSOs, especially in low- and middle-income countries (LMICs), to contribute to the evidence base. This was echoed by the delegate of Sweden. In that regard, IPPF had developed a joint action plan with HRP for implementation in 2020, with an emphasis on expanding work to document access to safe abortion and human rights in humanitarian settings, adolescents in humanitarian settings and linkages between SRH and sexual and gender-based violence (SGBV). They noted also the importance of assessing gaps and identifying relevant research partners outside the SRHR “box”, such as the large humanitarian actors, and developing synthesized research-based communications for target audiences in multiple languages. IPPF strongly supported HRP’s engagement in global and regional policy fora and dialogues and alliance-building to ensure national/regional progress in SRHR and gender-based violence (GBV) and youth programmes, which might require strengthening the capacity of WHO Regional and Country Offices in these areas. The IPPF representatives recommended that the new maternal and perinatal health strategy be discussed at the 34th Meeting of the PCC.

The delegate of Switzerland remarked that the management response document was extremely useful, demonstrating that the external evaluation was very helpful to HRP. She suggested retaining the document as a standard reporting device. The delegate of the United Kingdom of Great Britain and Northern Ireland agreed, suggesting that management respond to the external evaluation annually, including a review of the past year and projection into the coming year. The delegate of Belgium, in his capacity as Co-Chair of the PCC sub-committee on the external evaluation, advised that the sub-committee would discuss further the external evaluators’ observations of governance issues and would emphasize governance-related and financial issues in its report to the PCC. Regrettably, because of the pandemic, it was not able to report to the current meeting of the PCC and pilot the new approach to governance dialogue. The Chair noted that the work of the sub-committee would continue, with several PCC members willing to support its work following up on the external evaluation.

PCC:

13. HRP theory of change

Mr Craig Lissner, Unit Head, HRP Secretariat, reported that an intensive process to completely revise the theory of change (ToC) had been undertaken during the course of the year. Consultation had been comprehensive, with input from co-sponsors, HRP staff, WHO, Member States, PCC members and the SC, STAG and GAP. Presenting a flowchart of the new ToC, Mr Lissner drew attention to: the new outcome statement; explicit causal pathway; integration of impact indicators from the GPW13 and SDGs; a new “intermediate outcomes” stage; and a new results framework, which includes existing and new indicators. He highlighted the new stage of intermediate outcomes (uptake and use of HRP guidance), which distinguishes between international (WHO, co-sponsors) and country level while demonstrating the interaction between them. Intermediate outcomes would be measured by marker indicators, with each HRP team systematically collecting data on each to provide quantified information on uptake. Specific intermediate outcome indicators were included in the revised results framework. The new ToC, which represents a major change in direction, would be implemented immediately and used as a framework for reporting henceforth.

The delegate of Flanders/Belgium, in his capacity as Chair of the sub-committee on revision of the ToC, stated that the sub-committee regarded the revised ToC as very well thought through, not overly complex, appropriately incorporating gender and human rights dimensions and usefully focused on the main goals. He noted, however, that it failed to incorporate HRP’s contribution to UHC at country level. His various suggestions to further improve the ToC included further refining the indicators, strengthening the emphasis on specific rights holders, striking a balance between a science-based rationale and a moral imperative, and incorporating linkages with co-sponsors’ programmes. He proposed the sub-committee continue to work with the Secretariat on ongoing revision of the ToC as a “living document” guiding the work of HRP. This was supported by the delegate of the United Kingdom of Great Britain and Northern Ireland, who suggested PCC discuss the ToC further throughout the coming year, with a focus on improving the indicators and the governance of HRP. He added that PCC members are required to report back to their own constituencies. A representative of UNFPA agreed, noting also the need to explicitly link country capacity to implementation. The delegate of the Netherlands noted that more work was also required on defining HRP-A as a tool for generating impact, and on partnerships.

A representative of IPPF encouraged HRP to extend the nature of evidence generated beyond technical and rights-based evidence to encompass costs and cost efficiency of SRHR issues and guidance on monitoring, evaluation and research utilization. She encouraged HRP to institutionalize systems and processes for early engagement on the generation and synthesis of evidence. She sought feedback on strategies and mitigation measures, including CSOs, in the event that governments did not accede to activities in areas such as compulsory sexuality education, abortion and SGBV, which represented a critical risk to the programme.

A representative of UNFPA questioned how longer-term changes in norms, attitudes and behaviours would be measured. The representative of the Centre for Reproductive Rights welcomed the integration of gender equality and human rights throughout the ToC and emphasized the importance of qualitative data, for example, research on mistreatment of women in health-care settings. This was supported by the delegate of Sweden, who suggested looking at strategic partnerships as an intermediate outcome. In respect of the relative niche occupied by HRP, a representative of IPPF said it would welcome a discussion on levers/strategies and priorities in building partnerships with United Nations agencies focused on gender, youth and human rights and the framework for engagement/coordination being considered in these domains.

The delegate of the United Kingdom of Great Britain and Northern Ireland stressed the need, as a core element of the ToC, for HRP to commit to motivating the uptake of research by countries and to use its independence from WHO to liaise with governments on dissemination and uptake.

With regard to WHO’s monitoring of implementation, the Director advised that WHO is pushing hard at country level and expects to greatly strengthen its three-level working mechanism. Mr Lissner advised that the impact indicators are the same as those in the WHO framework.

Mr Lissner commented that all HRP’s work was underpinned by health, equity, gender and human rights imperatives. He stated that a more detailed indicators document was being developed and would be
shared with PCC. Improving the indicators’ alignment with cosponsors’ programmes would be discussed with co-sponsors in June 2020. HRP was working with PCC and the SC and would continue to share detailed indicators with the Chair and welcome input and guidance from PCC members. Work to improve the results framework would continue over the course of the year to better enable members to report back to their constituencies. The Chair emphasized the importance of maintaining the ToC as a useful tool for HRP and commended the willingness of HRP to incorporate the work of cosponsors into it.

PCC:

1. ENDORSED the proposed theory of change and the continued support of the sub-committee in its ongoing development.

15. Date and venue of the 2021 meeting and tentative date for 2022

The Chair advised members of the proposed meeting dates for the next two meetings and invited members to review and note them.

PCC:

1. AGREED to hold the 34th meeting of the PCC on 24 and 25 March 2021 in Geneva and proposed 23 and 24 March 2022 as tentative dates for the 35th meeting of the PCC.

14. Any other business

Following on from the earlier discussion of the COVID-19 pandemic and its impacts (see agenda item 5), the representative of the International Federation of Fertility Societies (IFFS) requested information on the impact of the pandemic on fertility treatment. Dr James Kiarie, Unit Head, Contraception and Fertility Care (CFC), responded that there was no evidence for clinical reasons that COVID-19 was harmful in the treatment context. The delegate of Belgium, noting that reference had been made to the pandemic throughout the meeting, advised that its impact would form a new workstream and requested that PCC mandate the Chair to enter dialogue with WHO on how that workstream would be organized and receive budget allocation inter-sessionally. An internal WHO working group was currently ensuring access to existing and additional responses. It was important to maintain a balance between ongoing work and emergency response.

In the second session of the meeting, extensive discussion took place on the request for a statement to be made urgently on safe abortion being an essential service (see agenda item 5). The representative of the International Women’s Health Coalition again emphasized the urgency of the situation on the ground. A representative of the IFFP, among other participants, supported the request, stressing the seriousness of the situation and the need for urgency. A representative of the International Campaign for Women’s Right to Safe Abortion advised that access to services was not possible under the lockdown imposed in many countries and women could no longer cross state borders. Denied the usual access routes to medicines, women were resorting to online pharmacies, many of which were unregulated, for medical abortion and contraceptive pills. Women’s mental health was at stake. In the current situation, a range of interlocking issues presented various public health risks.

Dr Askew advised that HRP was not able to issue such a statement autonomously. He was reluctant to see any such statement restricted to the issue of abortion alone and would prefer it to cover SRH more broadly. Restricting the statement to a particular service risked fragmenting the health systems approach to addressing COVID-19. The representative of the International Campaign for Women’s Right to Safe Abortion suggested WHO issue a statement identifying safe abortion as an essential SRH service. A representative of IPPF suggested broadening the statement to include associated issues such as GBV; she remarked that this was an opportunity not to be missed.
Those PCC members present at the meeting had no objection to a statement being prepared, but noted that agreement would have to be sought from absent Member States. It would be necessary to identify the most appropriate organization mandated to issue it.

**PCC:**

1. AGREED to task HRP to prepare an evidence-based statement on the impact of COVID-19 on access to safe abortion and other SRH services, to be considered for endorsement by PCC.

### 15. Date and venue of the 2021 meeting and tentative date for 2022

1. AGREED to hold the 34th meeting of the PCC on 24 and 25 March 2021 in Geneva and proposed 23 and 24 March 2022 as tentative dates for the 35th meeting of the PCC.

The Chair declared the meeting closed at 18:15 (CET).
Annex 1. List of participants

**MEMBERS**

**Argentina**

Sílvia Edith Ramos (*unable to participate*)
Technical Coordinator, National Ministry of Health, Sexual and Reproductive Health Department, National Plan for the Prevention of Adolescent Unwanted Pregnancy, Buenos Aires

**Belgium**

Sander Spanoghe
Policy Officer for Development Cooperation, Flanders Department of Foreign Affairs, Brussels

David Maenaut
Delegate-General, Permanent Mission of Flanders in Geneva PR of Belgium, Geneva

**Burkina Faso**

Ky Yolland
Director of Family Health, Ministry of Health, Ouagadougou

**Czech Republic**

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

**France**

Mathilde Mailfert
Health Expert, Ministry of Europe and Foreign Affairs, France, Paris

Morgan Jouy
Health Attaché, Représentation permanente de la France auprès de l’ONU à Genève, Genève

**Japan**

Mitsuyasu Yamada
Assistant Manager, Ministry of Health, Labour and Welfare, JAPAN GOVERNMENT, Tokyo

**Mozambique**

Elsa Nehemia (*unable to participate*)
Senior Technical Advisor for Maternal Health, MoH, Maputo

**Netherlands**

Ini Huijts
Thematic Expert Health / SRHR, DSO/GA, Ministry of Foreign Affairs, the Netherlands, The Hague

**Niger**

Garba Djibo (*unable to participate*)
Directeur des Etudes et de Programmation, Ministère de la Santé Publique, Niamey
Norway

Nina Strom  
Senior adviser, Norway, Oslo

Philippines

Jan Llevado  
Manager, National Family Planning Program, Department of Health, Manila

Sweden

Teresa Soop  
Senior Research Advisor, Sida, Stockholm

Mikaela Hildebrand  
Regional Advisor, Regional SRHR -Team for Sub-Saharan Africa, Sida, Stockholm

Sofia Norlin  
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Inga-Maj Andersson  
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Susanne Amsler  
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Adriane Martin Hilber  
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Thailand

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Manus Ramkiattisak  
Deputy Director of Bureau of Reproductive Health, Department of Health, Ministry of Public Health

Watcharakorn Riabroi  
Public Health Technical Officer, Bureau of Reproductive Health, Department of Health, Ministry of Public Health

United Kingdom of Great Britain and Northern Ireland

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Emily Weston  
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**Kristina Lod Castell**  
SR Sr Policy Adviser, IPPF/RFSU, Enskede Gård, Sweden

**Catarina Carvalho**  
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**Manuelle Hurwitz**  
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**Kartik Srinivasan**  
IPPF, London, United Kingdom of Great Britain and Northern Ireland

*UNDP*

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UNFPA, New York, United States of America

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UNFPA Office of Geneva, Switzerland

**Million Mekuria**  
UNFPA Office of Geneva, Switzerland

*UNICEF*

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Catherine Racowsky
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Sheryl Van Der Poel
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Bill & Melinda Gates Foundation

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Canada

Lina Sovani
Senior Analyst, Canada, Ottawa, Global Affairs Canada

Niloufar Zand
Senior Advisor, Canada, Geneva, Government of Canada

Center for Reproductive Rights

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Concept Foundation

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David and Lucile Packard Foundation

Tamara Kreinin
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FHI 360

Laneta Dorflinger
Director, Product Development and Introduction, FHI 360, Durham, United States of America

Geneva Foundation for Medical Education and Research (GFMER)

Raqibat Idris
Technical Officer, Geneva Foundation for Medical Education and Research (GFMER), Geneva, Switzerland
33rd Meeting of the Policy and Coordination Committee (PCC)

**Gynuity Health Projects**

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

**Institut de recherche pour le développement**

**Cecile Grimaldi**  
Chargée de mission - Service des partenaires et bailleurs internationaux, Institut de recherche pour le développement, Marseille, France

**Institute for Reproductive Health**

**Natacha Stevanovic-Fenn**  
Senior Research Officer, Institute for Reproductive Health, Washington, United States of America

**International Campaign for Women’s Right to Safe Abortion**

**Margaret Berer**  
Director, Publications & Meetings, International Campaign for Women’s Right to Safe Abortion, London, United Kingdom of Great Britain and Northern Ireland

**International Committee for Monitoring Assisted Reproductive Technologies**

**Geoffrey David Adamson**  
Chair, International Committee for Monitoring Assisted Reproductive Technologies, Cupertino, United States of America

**International Federation of Fertility Societies**

**Linda Giudice**  
Distinguished Professor, University of California, Los Altos Hills, United States of America

**Edgar Mocanu**  
President-Elect, International Federation of Fertility Societies, Dublin, Ireland

**International Federation of Gynecology and Obstetrics (FIGO)**

**Mary Ann Lumsden**  
FIGO Chief Executive, International Federation of Gynecology and Obstetrics (FIGO), London, United Kingdom of Great Britain and Northern Ireland

**Hani Fawzi**  
Director of Projects, International Federation of Gynecology and Obstetrics (FIGO), London, United Kingdom of Great Britain and Northern Ireland

**International Women’s Health Coalition**

**Françoise Girard**  
President, International Women’s Health Coalition, New York, United States of America

**Jhpiego**

**James Ricca**  
Director of Monitoring, Evaluation, and Learning, Jhpiego / MOMENTUM, Washington, United States of America
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<tr>
<td><strong>Karolinska Institutet</strong></td>
<td><strong>Amanda Cleeve</strong></td>
<td>Postdoc researcher, Karolinska Institutet, Stockholm, Sweden</td>
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<td><strong>March of Dimes</strong></td>
<td><strong>Salimah Walani</strong></td>
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<td><strong>Marie Stopes International</strong></td>
<td><strong>Bethan Cobley</strong></td>
<td>Director, Policy and Partnerships, Marie Stopes International, London, United Kingdom of Great Britain and Northern Ireland</td>
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<td><strong>Mexico</strong></td>
<td><strong>Sofia Varguez Villanueva</strong></td>
<td>Health Attache, Mexico, Geneva, Permanent Mission of Mexico in Geneva</td>
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<td><strong>PATH</strong></td>
<td><strong>Martha Brady</strong></td>
<td>Director, Sexual and Reproductive Health, PATH, Washington, United States of America</td>
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<td><strong>Sexual and Reproductive Health Matters</strong></td>
<td><strong>Jane Cottingham</strong></td>
<td>Chair of the Board of Trustees, Sexual and Reproductive Health Matters, Carouge, Switzerland</td>
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<td><strong>Eszter Kismodi</strong></td>
<td>Chief Executive, Sexual and Reproductive Health Matters, Geneva, Switzerland</td>
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<td><strong>The Population Council</strong></td>
<td><strong>Michelle Hindin</strong></td>
<td>Director, The Population Council, New York, United States of America</td>
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<td><strong>University of North Carolina</strong></td>
<td><strong>Herbert Peterson</strong></td>
<td>Director, WHO Collaborating Center, University of North Carolina, Chapel Hill, United States of America</td>
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<td></td>
<td><strong>Joumana Haidar</strong></td>
<td>Deputy Director/Implementation Lead WHO Collaborating Center, University of North Carolina, Chapel Hill, United States of America</td>
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<tr>
<td><strong>Women Deliver</strong></td>
<td><strong>Susan Papp</strong></td>
<td>Managing Director, Policy &amp; Advocacy, Women Deliver, New York, United States of America</td>
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</tr>
</tbody>
</table>
OTHER PARTICIPANTS

Gender and Rights Advisory Panel (GAP)

Dr Emma Fulu (unable to participate)
Director / Founder, The Equality Institute, Northcote, Australia

Scientific and Technical Advisory Group (STAG)

Professor Rob Stephenson (unable to participate)
Professor, University of Michigan, United States of America

HRP Alliance

Professor Elizabeth Bukusi
Assistant Principal Clinical Research Scientist, Kenya Medical Research Institute, Nairobi, Kenya
WHO Secretariat (as at 23 January 2020)

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Dr Soumya Swaminathan Chief Scientist

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Office of the Director
Lily Atutornu Assistant to Director
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Ndiougou Seck Project Officer
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Sami Gottlieb  
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Edna Kara  
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Igor Toskin  
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Jane Werunga-Ndanareh  
Assistant (Team)

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Briana Lucido  
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Garrett Mehl  
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Programmer Analyst

Thi My Huong Nguyen  
Technical Officer

Khursheed Nosirov  
Consultant

Soe Soe Thwin  
Manager (Quantitative Assessment and Data Management)
### Annex 2. Agenda

#### Provisional Programme

<table>
<thead>
<tr>
<th>Wednesday, 25 March</th>
<th>Presenter</th>
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<tbody>
<tr>
<td>1. Welcome, adoption of the agenda and election of presiding officers</td>
<td>Chair</td>
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<td>2. Remarks by the WHO Chief Scientist</td>
<td>S. Swaminathan</td>
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<td>3. Remarks by the Acting Executive Director, Universal Health Coverage / Life Course</td>
<td>S. Jakab (Deputy Director-General)</td>
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<td>4. Adoption of the report of PCC(32), review of implementation of recommendations and remarks by PCC Chair</td>
<td>Chair</td>
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<td>5. Director’s Annual Report 2019</td>
<td>I. Askew</td>
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<td>10. Financial matters</td>
<td>C. Lissner</td>
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<td>12. Follow up to the HRP external evaluation 2013-2017</td>
<td>Chair / I. Askew</td>
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<tr>
<td>13. HRP Theory of change</td>
<td>I. Askew / C. Lissner</td>
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<tr>
<td>15. Date and venue of the 2021 meeting and tentative date for 2022</td>
<td>Chair</td>
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<td>16. Any other business</td>
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