



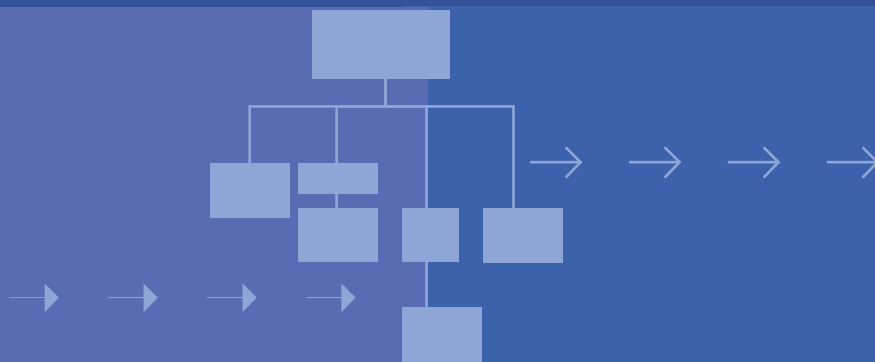
UNDP • UNFPA • UNICEF • WHO • World Bank
Special Programme of Research, Development
and Research Training in Human Reproduction

External evaluation 2008–2012

Executive summary



Advancing sexual and reproductive health





UNDP/UNFPA/UNICEF/WHO/WORLD BANK
Special Programme of Research, Development and
Research Training in Human Reproduction (HRP)

External evaluation 2008–2012

Executive summary



WHO/RHR/HRP/13.01

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Views expressed in this document are those of the 2008–2012 HRP External Evaluation Team.

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Abbreviations

CSO	civil society organization
ECS	elimination of congenital syphilis
ERC	Ethics Review Committee
GAP	Gender and Rights Advisory Panel
H4+	Health 4+ – partners UNFPA, UNICEF, WHO, World Bank, UNAIDS
HRP	UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
ICPD	International Conference on Population and Development
IRP	Implementation Research Platform
IPPF	International Planned Parenthood Federation
LID	long-term institutional development
MCA	WHO Department of Maternal, Newborn, Child and Adolescent Health
MDG	Millennium Development Goal
MEC	Medical eligibility criteria for contraceptive use
MTCT	mother-to-child transmission
NET-EN	norethisterone enantate
NGO	nongovernmental organization
OTC	over-the-counter
PCC	Policy and Coordination Committee
PDRH	Programme Development in Reproductive Health
PEEC	PCC External Evaluation Committee
PwC	Price WaterhouseCoopers SA
RHR	WHO Department of Reproductive Health and Research
RP2	Research Project Review Panel
SPP	Strategic Partnership Programme
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
TU	testosterone undecanoate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USA	United States of America
VIA	visual inspection with acetic acid
WHO	World Health Organization



Authors and acknowledgements



The 2008–2012 External Evaluation of the United Nations Development Programme (UNDP)/United Nations Population Fund (UNFPA)/World Health Organization (WHO)/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) was coordinated by Nicholas Dodd, Consultant, Sexual and Reproductive Health.

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1. Introduction and methods

1.1 Background

The Special Programme of Research, Development and Research Training in Human Reproduction (HRP) was established by the World Health Organization (WHO) in 1972 to coordinate, promote, conduct and evaluate international research in human reproduction. Sixteen years later, in 1988, HRP became a cosponsored programme, with an explicit mandate for:

- promoting and supporting research aimed at finding and developing safe and effective methods of fertility regulation, and identifying and eliminating obstacles to such research and development;
- identifying and evaluating health and safety problems associated with fertility regulation technology, analysing the behavioural and social determinants of fertility regulation, and testing cost-effective interventions to develop improved approaches to fertility regulation within the context of reproductive health services;
- strengthening the training and research capability of developing countries in the field of human reproduction;
- establishing a basis for collaboration with other programmes engaged in research and development in human reproduction, which will include the identification of priorities across the field and the coordination of activities in the light of such priorities.

The original four cosponsors were the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the World Bank and WHO, and the *Memorandum of Understanding* agreed to by these parties remains the document that guides HRP's overall purpose, as well as its governance. HRP is the only body within the United Nations system mandated to lead

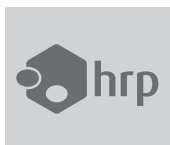
research in human reproduction. It works in close association with countries to provide the answers to critical SRH questions, thereby generating evidence-based research findings and the information needed to achieve universal access to effective services and to enable people to protect and promote their own SRH.

Since 1998, HRP has functioned as one of the two components in the Department of Reproductive Health and Research (RHR). The second component is Programme Development in Reproductive Health (PDRH), whose function became to facilitate the application of research results to policy and practice in SRH programmes in countries, thereby raising the value of HRP's outputs, and increasing the effectiveness of WHO's work in SRH.

HRP's modus operandi remains largely unchanged since its inception. It develops 5-year strategic plans and biennial workplans and budgets, to implement a prioritized global research agenda, and to provide support to strengthen research capacity in institutions in programme countries. Its budgetary support for these two items remains at 2:1, respectively, for research and for capacity strengthening. Its proposed programme of work is reviewed by its Scientific and Technical Advisory Group (STAG), and its Policy and Coordination Committee (PCC) provides oversight for funding, policy and programme management.

The content of HRP's work, however, has changed substantially over the years, from an early focus on developing new methods of fertility regulation and clinical studies on the safety and efficacy of new and existing methods of fertility regulation, to an agenda focused on the broader spectrum of SRH, including: family planning; maternal and perinatal health; sexually transmitted and reproductive tract infections; preventing unsafe abortion; and





gender, reproductive rights, sexual health and the SRH of adolescents; as well as research on implementation of the SRH products and tools the Programme produces. HRP's overriding vision is:

... the attainment by all peoples of the highest level of sexual and reproductive health. We strive for a world where all women's and men's rights to enjoy sexual and reproductive health are promoted and protected, and all women and men, including adolescents and those who are underserved and marginalized, have access to sexual and reproductive health information and services.

Over the last 20 years, the global landscape on SRH has progressively developed. HRP was a key resource to these processes and then incorporated their outcomes fully into its work. They included: the *Programme of action* of the 1994 International Conference on Population and Development (ICPD) in Cairo, and its various follow-up mechanisms; the *Beijing Declaration and platform for action of the Fourth World Conference on Women in 1995*, which reaffirmed the reproductive health agenda, and its follow-up mechanisms; the Millennium Development Goals (MDGs), including the new target 5B, on universal access to reproductive health; the United Nations Secretary-General's *Global strategy for women's and children's health*; the WHO Global reproductive health strategy, adopted at the World Health Assembly in 2004; the report of the WHO Commission on the Social Determinants of Health, which focused on health inequities; the WHO *Global strategy for the prevention and control of sexually transmitted diseases: 2006 – 2015*; and, most recently, the 2012 London Family Planning Summit. Many regional commitments also ensued, for example the Maputo *Plan of action on sexual and reproductive health and rights* for a continental

policy framework for sexual and reproductive health and rights in Africa.

By both helping to guide global change and then adapting its work to such change, HRP has continued to demonstrate that its business model functions very well, and that it remains relevant to the needs of programme countries. As well as conducting research, and building capacity to conduct research, the Programme also synthesizes research through systematic reviews of the literature, and develops tools that facilitate access, by countries and by individuals, to the latest research information.

1.2 A note on language

HRP is also referred to throughout this document as “the Programme”; those countries that are the main intended beneficiaries for HRP's work are collectively referred to as “programme countries”; and the various outputs of the Programme, whether they be physical devices or printed materials, are collectively referred to as “the products” of the Programme. Finally, the term “sexual and reproductive health” (SRH) is implicitly assumed to always include a component of sexual and reproductive rights.

1.3 Previous external evaluations of HRP

HRP has a long-standing culture of regularly submitting its work and functioning to external evaluations, of which the last two are briefly reviewed here.

In 2002, an external evaluation, jointly conducted by Management Sciences for Health and the Swiss Centre for International Health of the Swiss Tropical Institute, focused on four key issues. These were: the relevance and effectiveness of HRP-supported research in reproductive health; the dissemination, global use and impact of the results of HRP's

reproductive health research; reproductive health research-capacity strengthening by HRP and the use and impact of HRP's work at country level; and the HRP governance process, management, administration and efficiency. Two thematic case-studies were also undertaken, the first on emergency contraception and the second on mainstreaming gender and women's perspectives. The evaluation examined HRP's work between 1990 and 2002.

The overall conclusion of the 2002 evaluation was that:

HRP clearly met expectations in terms of its core mission to coordinate, promote, conduct and evaluate international research in reproductive health and achieved its major objectives. The Programme maintained its position as the global leader in generating research results and establishing the scientific consensus needed to advance reproductive health policies and practices, especially for developing countries.

The most recent external evaluation reviewed the period 2003 to 2007, and was conducted by a team of eight international experts during the course of 2006–2007. The overall focus of the evaluation was on the impact of the Programme on global public goods, and this was examined in more detail through five case-studies on: the long-term safety and effectiveness of the copper-releasing intrauterine devices; improving the quality of family planning care in China; medical (non-surgical) abortion; improving maternal and newborn health; and knowledge synthesis and transfer. In addition, the evaluation also reviewed

HRP's follow-up actions to the recommendations of the previous evaluation in the areas of governance, management, administration and efficiency.



The overall conclusion of the 2003–2007 evaluation was that:

HRP remains a global leader in sexual and reproductive health research and capacity building, with particular relevance to the needs of populations in resource-poor settings. The evidence base resulting from this research has been translated effectively into health policy changes and improved practice standards and has ultimately improved health outcomes.

1.4 The current external evaluation of HRP

The current evaluation of HRP covers the period 2008–2012 and was requested by the World Bank at the 71st meeting of the standing committee in June 2011. At this meeting, the cosponsors agreed on draft terms of reference, elaborating an approach that would review the comparative advantage of HRP and its impact in improving outcomes and influencing evidence-based changes in SRH policies and programmes, as well as carrying out a number of case-studies. The standing committee also recommended the establishment of a PCC External Evaluation Committee (PEEC), to include: the chair and vice-chair of PCC at its 24th meeting on 16–17 June 2011, one representative of the HRP financial contributors, the chair of RHR's STAG, and one representative of the four HRP cosponsors, in order to oversee the process of the evaluation. Terms of reference for the evaluation were subsequently shared with PCC members for feedback, and



finalized at the 72nd meeting of the standing committee in December 2011. The abbreviated terms of reference can be found in Annex 1.

1.4.1 Methods

The evaluation was carried out through a combination of desk reviews of documentation; interviews with key informants; questionnaires; and site visits. It aimed to be systematic, and to use an evidence-based approach, relying on quantitative data, supplemented, wherever possible and appropriate, by qualitative information.

The evaluation reviewed HRP's overall relevance and effectiveness, particularly in terms of producing global public health goods, and the efficiency and effectiveness of its governance, management and administration. Four case-studies were also conducted; these examined:

- evidence generation and synthesis to improve family planning, prevent unsafe abortion and prevent and control sexually transmitted diseases and reproductive tract infections;
- research-capacity strengthening and network building;
- strengthening implementation research;
- the status of, and opportunities for strengthening, engagement with the private sector and civil society.

The process for the evaluation began in Geneva in June 2012, with preliminary consultations and interviews with senior staff of the Programme, as well as WHO staff in many other related departments. The evaluation team also met with

the PCC subcommittee charged with overseeing the evaluation (PEEC), as well as the wider group of PCC members and observers. In response to an e-mail invitation, several RHR staff submitted information on their work and ideas for the evaluation process. This was followed by a review of all relevant documentation produced by the Programme over the past 5 years.

For the overall assessment of the efficiency and effectiveness of HRP's governance, administration and management, a 65-point questionnaire was then developed and sent out in full confidence to over 400 key informants; 166 (39.9%) responded and these are referred to in Sections 2 and 3 as "the respondents".

Subsequently, a much shorter questionnaire on the relevance and the use of HRP's products in national SRH programmes was sent to all UNFPA country offices, with a response rate of over 30%. The rationale here was that, of all the cosponsors, UNFPA's mandate in terms of substance coincides most directly with that of HRP.

Finally, a citation analysis of the Programme's peer-reviewed publications was also commissioned as part of the evaluation.

A timeline for the evaluation was agreed; the consultants shared chapter outlines for discussion and review in mid July, and then started working on the content of their respective assignments. Progress reports on the evaluation were submitted to PEEC in August and November 2012.

The full report was subsequently reviewed by PEEC and the standing committee and presented to PCC at its 26th meeting in June 2013.

2. Overall assessment of HRP's relevance and effectiveness

2.1 Introduction

This section reviews the overall relevance and effectiveness of HRP; its research; its comparative advantage and the value added by its location within WHO; its work on norms and standards; its monitoring of global trends in SRH; its work related to the SRH/HIV research agenda; and how it communicates its products to its clients.

Over the past 5 years, HRP has faced a number of serious challenges with regard to its management, administrative processes, staffing and funding, to name but a few. However, in the period 2008–2012, the Programme continued to produce many important global public goods in the area of SRH. This was largely due to three factors: the dedication and excellence of its staff; the leadership and determination of its directors in making the necessary decisions to ensure that HRP continued to move forward; and its fundamentally sound governance and technical oversight systems.

So, ultimately, because of a robust business model, and an ability to adapt to change, HRP was able to continue to function very effectively.

Findings

As the evaluation progressed, it became apparent that it was not always easy to distinguish between the outputs of HRP and the outputs of PDRH.

Publications citing achievements of HRP often appeared to include work carried out by PDRH.

Recommendation

- HRP needs to clearly identify in its reporting mechanisms the results it achieves, as distinct from the results achieved by PDRH.

2.2 Global public health goods

Does HRP continue to be a relevant and effective instrument for research in SRH? Does it continue to produce outputs that are consistent with its overall goals and objectives? What has been the outcome/impact of these public goods in programme countries?

Global public goods can be defined as those “goods” that are freely available to all, and are non-rival in consumption; that is, consumption by one person does not affect the availability for consumption by others. Global public health goods can be in the form of health knowledge and technologies; health policy and regulatory guidance; and public health systems, including any “good” that makes such systems more effective, more efficient or more accessible.

Public health goods created by the Programme include: the results of its research published in peer-reviewed journals; guidelines; policy briefs; programmatic and policy documents; technical guidelines; systematic evidence reviews; global trend analyses in the area of SRH; an electronic journal for the dissemination of evidence and guidance; and new methods of fertility regulation and new technologies in other areas of SRH.

2.2.1 Priority setting

Does HRP continue to use sufficiently robust mechanisms to determine its priorities?

Relevance and effectiveness require a sound and systematic approach to priority setting. HRP periodically reviews and assesses its priorities, by engaging groups of experts to assist in identifying, categorizing and ranking research issues. This process, along with the WHO Global reproductive health strategy, adopted at the World Health Assembly in 2004, informs the Programme's





medium-term strategies and biennial budgets and workplans, which are then reviewed by STAG and approved by PCC.

The Programme's research proposals also include three separate levels of priority (V: vital; E: essential; and I: important), which enable a more detailed review and are also used to guide the disbursement of programme funds by the secretariat as costs and income fluctuate over time.

Respondents were asked about the influence of programme countries and donors on HRP's priorities, as well as on the strength of its mechanisms for determining its research priorities, and whether opportunities had been missed.

Findings

In general, it appears that different thematic areas within the Programme use different methods to identify priorities, and some of these are more rigorous and more inclusive than others. These processes may need to be strengthened to enable the Programme to focus on a smaller number of critical policy- and programme-relevant questions. Respondents gave the general impression that programme countries should have more influence on the setting of HRP's research priorities and donors a little less, but that, overall, priorities were generally in line with what needed to be done. However, a number noted that it was important for the Programme to keep its ear to the ground and take note of what the real issues were. A number of respondents felt that the Programme might need to focus more on research that is likely to have an impact in the short term (for example prevention of sexually transmitted infection [STI], and its work on magnesium sulfate for pre-eclampsia and eclampsia), while maintaining at a more moderate level other areas of work that could have a major impact, but in the much longer term (for example,

male contraception). Respondents identified implementation research, research on adolescents, and research on the social determinants of SRH as three areas to which the Programme might wish to give greater attention.

Recommendations

- HRP needs to strengthen and take a more uniform approach to its priority-setting process, in order to identify those key research questions and knowledge gaps in SRH that are most likely to have an impact in programme countries. Criteria should include: a priority issue for countries furthest from the MDGs and other global targets; likely impact; implementability; sustainability; practicality; cost; risk; comparative advantage of HRP; and lead time.
- In its overall programme of work, HRP should consider giving higher priority to implementation research, research on adolescents, and research on the social determinants of SRH.

2.2.2 Geographical focus

Does HRP's work focus sufficiently on attainment of the MDGs and other global targets, and on the research needs of the least developed countries in overcoming barriers to improving access to SRH information and services?

One often-cited barrier to undertaking research in the poorest countries is the lack of both human and institutional resources. However, through its research-capacity-strengthening grants, and its Biostatistics and Data Management unit, HRP has been instrumental in developing methodologies to undertake research in resource-poor settings, supporting the process of design, implementation,

monitoring, data management and processing, and publication, while ensuring that good clinical practice guidelines, standard operating procedures, and data-quality standards are maintained.

HRP has identified a number of countries for “strategic focus”, using criteria such as high levels of maternal mortality and unmet need for family planning. These countries are not very well aligned with priority countries of other global initiatives such as the MDG “countdown to 2015”, and the H4+¹ initiative.

Recommendation

- For HRP to maximize its potential impact, it needs to strengthen its focus on research questions that will benefit the least developed countries and those furthest from the MDG targets, and, wherever possible, on undertaking this research in these countries. All proposed work should include a clear statement of how it contributes directly or indirectly to the achievement of MDG targets 4, 5 and 6 or any post-2015 global targets. This statement should be used by STAG as a major indicator of the relevance of the proposed research.

2.2.3 Coordination of research

Are coordination mechanisms for research both with outside partners and within WHO sufficiently strong?

1. UNFPA, the United Nations Children’s Fund (UNICEF), WHO, the World Bank and the Joint United Nations Programme on HIV/AIDS (UNAIDS), have joined forces as Health 4+ (H4+) to support countries with the highest rates of maternal and newborn mortality. The H4+ partners support emergency obstetric and neonatal care needs assessments and help to cost national maternal, newborn and child health plans, mobilize resources, increase the number of skilled birth workers, and improve access to reproductive health services.

Globally, HRP does not attempt to map the SRH research landscape in any systematic fashion, and neither does any other organization. It is generally agreed that this would be costly, labour intensive, and of little added value. The more informal strategy used by the Programme – maintaining a broad overview of the major areas of work being pursued by the global SRH research community through its many formal and informal contacts with them – appears to generally avoid unnecessary and costly duplication of efforts. Respondents gave HRP high ratings in terms of its effectiveness in coordinating its research agenda to avoid such overlaps.

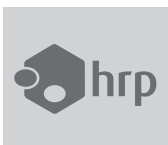
Within WHO, the Department of Maternal, Newborn, Child and Adolescent Health (MCA) is carrying out research and defining norms for maternal, newborn and adolescent health. The Special Programme for Research and Training in Tropical Diseases (TDR) is undergoing a major reorientation towards implementation research.

A number of respondents felt that coordination mechanisms between HRP and these two groups were not sufficient.

Recommendations

- HRP should consider developing an e-platform to enable organizations engaged in research on SRH to share information on their current work and future plans.
- There is a need for a more formal mechanism for coordination of research between HRP and MCA, particularly in the areas of maternal and perinatal research, and research on adolescent SRH; and between HRP and TDR on implementation research.





2.2.4 Selected highlights

What are some of the major global public goods produced by HRP between 2008 and 2012?

The evaluation reviewed a number of the outstanding products produced by the Programme over the last years in each of its five major thematic areas: promoting family planning; maternal and perinatal health; preventing unsafe abortion; prevention and control of sexually transmitted and reproductive tract infections including gynaecological cancers and infertility; and sexual health, including adolescents, gender and sexual and reproductive rights.

These included:

- the *Medical eligibility criteria for contraceptive use* (MEC), which won the first prize in the Obstetrics and Gynecology category of the 2011 British Medical Association Book Awards;
- the MEC wheel, which has been adapted and translated into 24 languages, and is in use in over 80 countries;
- the *WHO laboratory manual for the examination and processing of human semen*, which is available in six languages, with over 4500 copies sold and 500 copies distributed free in programme countries; and is the document most frequently downloaded from the WHO web site, totalling over 27 500 downloads as of the end of 2012;
- guidelines for optimizing maternal and newborn care, already being implemented in more than 15 countries;
- research on the effectiveness of magnesium sulfate for the treatment of eclampsia and pre-eclampsia, now included in the *WHO Model list of essential medicines*; a 2011 survey of programme countries revealed that 95% had

included magnesium sulfate in their national lists of essential medicines;

- *Safe abortion: technical and policy guidance for health systems*; over 20 countries are currently using this document to strengthen national norms and standards and over 80% of respondents felt that safe abortion guidance had strengthened SRH programmes or policies;
- research on mid-level providers for abortion care and other HRP guidance on safe abortion are currently being used in an operations research initiative in 30 countries to expand access to medical abortion;
- *Sexually transmitted and other reproductive tract infections – a guide to essential practice*; over 75% of respondents felt that this document had been used to strengthen SRH programmes or policies in countries;
- the HRP guideline on gender and rights in reproductive health; over 60% of respondents indicated that this had been used to strengthen SRH programmes and policies in countries.

The UNFPA country office enquiry found that more than two thirds of countries had used four of the Programme's products: MEC; maternal mortality estimates; optimizing delivery of maternal and newborn health interventions; and the STI guide to essential practice, to strengthen national SRH programmes. A further five products, the MEC wheel; maternal near-miss definition; safe abortion guidance; the Reproductive Health Library; and the gender and rights training manual had been used to strengthen SRH programmes in over 50% of countries.

Findings

A review of just a sample of the Programme's products revealed evidence of their use in over

130 countries. It would appear that many countries are thus making very good use of HRP's products in strengthening their SRH programmes, but that even more could be benefiting. This will require investment in a new communication and uptake strategy for all the Programme's products, and investment in an introductory strategy, to be able to demonstrate, in a limited number of countries, how HRP's products can be incorporated into SRH programmes (see Section 2.5). These "success story" examples can then be used to leverage the larger funds of multilateral and bilateral donors, including the cosponsors and foundations, for use in additional countries for similar purposes.

Conclusion

HRP continues to ensure its relevance by being the unique global resource that generates the research findings, synthesizes the evidence and develops the products to support policy formulation and programme strengthening to improve SRH. HRP's outputs continue to be consistent with its overall goals and objectives. It continues to provide global leadership on sensitive SRH issues, and it continues to generate global public health goods of the highest quality and utility.

Recommendation

- The Programme should commission a periodic review of the utilization of its products in programme countries, and estimates of their potential or actual impact. Such a review will demonstrate the value of investing in HRP, and thus further strengthen its fundraising ability.

2.3 Comparative advantage

Does HRP have a comparative advantage and does it continue to utilize it?

WHO provides a forum that is unique in many ways. It is universally owned by countries; it is inclusive and neutral; it has the ability to work on the widest spectrum of health issues however sensitive, and to convene health authorities and experts to deliberate on health topics; and when WHO speaks, its "imprimatur" or seal of approval is universally recognized. HRP benefits from this mantle and adds to it a commitment to the highest quality of research, science and evidence.

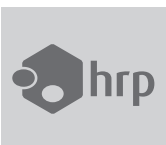
Respondents gave very high ratings in relation to WHO/HRP's neutrality, convening ability, seal of approval, ability to address any SRH issue however sensitive, and commitment to the highest standards or research. A number of respondents felt that preventing unsafe abortion was one very specific area where HRP had a major comparative advantage over other organizations.

Eighty-seven per cent of respondents felt that no other organization existed that could fulfil the function of HRP.

Conclusion

The Programme continues to demonstrate its comparative advantage through its ground-breaking work in areas such as unsafe abortion, adolescent SRH, and violence against women. It continues to exploit its neutrality, its inclusiveness and its ability to convene the broadest array of interested parties to discuss and provide guidance on sensitive technical and policy issues in the area of SRH. The value of its guidance and other products is maximized by its position within WHO.





2.4 Norms and standards

Does HRP continue to set policy and programme norms and standards?

HRP's work in the area of norms and standards results in various types of publication, including: technical (clinical) guidelines, programmatic and policy documents and policy briefs. These set global standards for policies, programmes and clinical practice in SRH. In the past 5 years, the Programme has produced 86 such documents, including 16 clinical guides, 51 programmatic and policy documents and 19 policy briefs.

In addition, HRP, in collaboration with its partners, standardizes SRH terminology, contributes to relevant sections of the *WHO model list of essential medicines*, ensures that essential reproductive health commodities are added to the WHO Essential Medicines Prequalification Scheme, provides global reference standards in the area of SRH, and updates relevant sections of the *International statistical classification of diseases and related health problems*.

Respondents gave very high ratings to HRP's work on norms and standards, and many respondents felt that the work undertaken by HRP in this area was essential, and an area that was uniquely appropriate for WHO.

Conclusion

HRP continues to be the gold standard for developing, monitoring and updating the evidence-based norms and standards required to guide SRH policies, strategies, programmes and clinical practice. Policy statements, programme guides, clinical guidance, and evidence summaries issued by WHO/HRP are key reference materials for governments when developing or revising SRH policies and programmes. As an entity within WHO,

the credibility of HRP among Member States is assured, and its materials thus receive far greater attention, and have a larger global health impact than similar issuances by any other institution.

2.5 Monitoring of global trends in sexual and reproductive health

Does HRP continue to monitor important global trends in SRH?

HRP continues to monitor important global trends in SRH, in collaboration with diverse partners. These include: global maternal mortality estimates developed in collaboration with the WHO Health Information and Statistics Department, UNICEF, UNFPA and The World Bank; and the global estimates of unsafe abortion and associated mortality, the sixth edition of which was published in 2011.

The Programme was also a key partner, with the London School of Hygiene and Tropical Medicine and Save the Children, of the scientific team that developed preterm birth estimates. HRP also contributed to the development of publications covering global estimates of stillbirths – *National, regional, and worldwide estimates of stillbirth rates in 2009 with trends since 1995* – and of the global burden of STIs, in 2010.

More than 70% of respondents gave HRP very high ratings on its effectiveness in monitoring global trends.

Conclusion

HRP continues to play a vital role in the monitoring and assessment of global trends in SRH, and this work is instrumental for evidence-based advocacy, the monitoring of progress towards the achievement of the MDGs and other global targets and goals, and the initiation of national campaigns to address specific SRH issues.

2.6 The sexual and reproductive health/ HIV research agenda

What is HRP's involvement in the SRH/HIV research agenda?

There are clear bidirectional links between SRH and HIV-prevention policies and programmes, and HRP has been actively pursuing collaborative work in this area over the last 5 years, including development of policy and programmatic guidance to address the SRH of people living with HIV; planning a multicountry study on the fertility intentions and unmet need for family planning among women living with HIV; and implementation research on integrated approaches for strengthening SRH and HIV services (see Section 6).

HRP collaborated with the International Planned Parenthood Federation (IPPF), UNFPA, WHO, UNAIDS, the Global Network for People Living with HIV/AIDS, the International Community of Women with HIV/AIDS, and Young Positives, to develop a rapid assessment tool for SRH and HIV linkages at policy, system and service levels. This has already been used in over 45 countries.

The Kesho Bora Study was a landmark piece of research led by HRP, using its own funds and leveraging additional funds from partners. It showed that giving mothers a combination of antiretroviral drugs during pregnancy, delivery and breastfeeding cuts HIV infection in infants by 42%. The findings have changed WHO's recommendations on infant feeding and led to new drug-combination approaches in global efforts to eliminate mother-to-child transmission (MTCT) of HIV.

HRP continues to advocate for and provide assistance to programme countries in preparing

proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria, particularly in the areas of: unmet needs and opportunities for linking SRH and HIV prevention and care; and opportunities to address violence against women and girls. As a result, the proportion of proposals with an element of SRH has increased in the last two rounds.

2.6.1 Collaboration with the WHO HIV/AIDS department

Current and future work of the WHO HIV/AIDS department includes specific deliverables that require contributions from HRP. These include: a generic protocol for operational research to understand the performance and impact of use of dual point-of-care tests for HIV and syphilis; guidance on the evaluation, specifications and procurement of female condoms; tools for monitoring condom quality during storage; technical guidance on microbicides; and clinical guides and tools for family planning for persons living with HIV, to name just a few.

2.6.2 Collaboration with UNAIDS

Collaboration between HRP and UNAIDS includes areas such as: a discussion paper on male involvement in the prevention of MTCT of HIV, which also identified gaps in knowledge and areas for further research; the technical meeting on hormonal contraception and HIV risk, which provided clear guidance on this issue; development of a counselling tool on reproductive choices and family planning for people living with HIV; and guidance on issues such as male circumcision and HIV.

Two thirds of respondents gave HRP highly positive ratings on its work on the SRH/HIV agenda.





Conclusion

The Programme continues to play an important role in shaping and implementing the SRH/HIV research agenda and should continue to strengthen links with HIV/AIDS research partners.

2.7 Efficiency and effectiveness of HRP's communication

HRP communicates with its clients in a number of ways and through a number of mechanisms. Most of these involve its publications, which can be classified into a number of separate categories. For the main six categories (clinical guidelines, programme and policy documents, policy briefs, monitoring and evaluation reports, advocacy documents and peer-reviewed articles), the Programme has produced 477 such documents over the past 5 years. By far the largest output of HRP is its peer-reviewed articles, and these increased from 52 in 2008 to 127 in 2011 and 80 in 2012. Respondents cited peer-reviewed publications and clinical guidelines as the most effective channels for communicating HRP's results.

HRP continues to undertake high-impact randomized trials – the type of research that answers key questions and provides the core evidence for clinical practice guidelines. This research is vital in determining the standards for the practice of evidence-based medicine and public health.

Peer-reviewed publications are generated by both the Programme's global research agenda and the support it provides to research-capacity strengthening. Some research papers are highly country specific. The undertaking of research is an essential element of research-capacity strengthening, but such research cannot always be expected to reflect global research needs.

Recommendation

- In future reporting, HRP should distinguish between peer-reviewed articles generated through its global agenda, and those generated from research-capacity-strengthening activities. This would provide more transparency and permit a greater understanding of the impact of the Programme's work at both global and regional levels.

2.7.1 Bibliometric analysis of HRP's papers

To provide more evidence of the quality and impact of the HRP's work, the evaluation team requested the Programme to commission a bibliometric analysis of its peer-reviewed publications. The analysis was contracted out to Thomson Reuters in the UK and the report is briefly summarized in this section.

The analysis was able to identify and match 1842 HRP publications in its database, of which the majority (89.6%) were peer-reviewed articles and reviews. The most frequent type of journal in which HRP research is published is journals focusing on contraception, obstetrics and gynaecology, and andrology. Obstetrics and gynaecology accounts for the highest share, at 40.9% of all papers published, and the citation impact for these articles is twice the world average.

HRP articles published in journals dealing with general and internal medicine (such as *The Lancet* and *The New England Journal of Medicine*) and oncology had a citation impact of between two and three times the world average.

Overall, the normalized citation impact of HRP publications has risen from an already impressive level of 1.42 during the period 1990 to 2007,

to 2.14 between 2008 and 2011, indicating a significant improvement in the impact of the Programme's research. The proportion of papers that are highly cited (those papers that belong to the world's top 10% of most cited papers relative to the journal category and year), also increased between these two periods, from 16.5% to 18.3%.

The analysis also provides clear evidence of the increased involvement, particularly of low-income countries, in the Programme's work over the past 5 years. The proportion of papers where any author was from a programme country increased from 43.4% to 63.9%, and 40% of all papers had a first author from a programme country. This last figure is below the 2011 level for TDR, which currently stands at 61%, and reflects the need for the Programme to strengthen its efforts to involve institutions in programme countries.

Conclusion

All indicators of HRP's research performance in the citation analysis are significantly above world averages and clearly reflect high-quality research that is well regarded among the international research community.

Recommendation

- The Programme needs to continue to increase the level of involvement of researchers from programme countries.

2.7.2 HRP's channels of communication

The questionnaire asked for opinions about the effectiveness of various groups in communicating HRP's products, including: WHO country offices; WHO regional offices; WHO headquarters; regional advisory panels; cosponsors; and donors. Ratings for all these groups were poor, indicating considerable room for improvement.

Many respondents felt that HRP needed to strengthen the advocacy, communication and dissemination of its products, in particular by developing a strategy that specifically targets end-users in programme countries and involves the regional and country offices of WHO, as well as the other cosponsors, donors and civil society organizations (CSOs), amongst others. There was also an indication that the strategy should be linked to a stronger focus in the Programme on programmatic, implementation and social science research, to better understand the introductory process and its barriers.

Findings from the UNFPA survey included a number of suggestions, such as the need to develop and keep up-to-date lists of key stakeholders at country level, including national SRH managers, national NGOs, universities, training schools, CSOs and professional associations, and to ensure that these groups were systematically kept informed of all new developments and products. The overall clear message was the need for HRP to strengthen its communication strategy to guide the dissemination of its products at country level, to better ensure their use.

2.7.3 Changes in RHR over the last 5 years and how these have affected HRP's research communication and uptake

HRP creates many valuable global SRH goods, but the ultimate value of these goods is in their utilization to improve the quality of SRH policies and programmes in countries, so that individuals can benefit. There is a continuum from research to action, of which research communication and uptake is an integral and essential component.

Up until 2007, HRP had two direct mechanisms for promoting the use of its products in countries. These were: a well-funded PDRH, and a well-funded Strategic Partnership Programme (SPP)





with UNFPA, in the amount of over US\$ 6 million between 2003 and 2007.

With the end of the SPP in 2008, and the funding constraints in PDRH that followed from 2008 to 2011, brought about by changes in WHO core funding policies, the introduction of HRP's products in countries waned, and the potential impact of its products was compromised. HRP started to lose a substantial amount of its ability to ensure that its products were translated into use at country level.

Overall funding to PDRH has declined since the 2006–2007 biennium, and flexible funding to PDRH has fallen dramatically, from 56.0% of total income in 2006–2007 to 26.3% of total income in 2010–2011. Specified funds now make up almost three quarters of income to PDRH.

Since 2010, all flexible PDRH funding has been used to pay staff salaries. A further consequence of the loss of core PDRH funding is that while, up until 2008, the costs of STAG and GAP were shared between HRP and PDRH, since 2009 this has not been possible, and the full cost has been underwritten by HRP.

Respondents gave a very strong indication of the negative impact of the reduction in PDRH funding on the promotion and utilization of HRP's products.

Conclusion

HRP continues to carry out the research and systematic reviews that enable the production of evidence-based policies, programme interventions and clinical guidelines for SRH.

The Programme also needs to be a global leader in efforts to develop and evaluate more effective ways of communicating and introducing the knowledge it produces into SRH policies and programmes. However, with the end of the SPP and the severe

cutback in funding to PDRH, the Programme has lost a substantial portion of its ability to ensure the communication and uptake of its products. Over the past few years, some ad hoc solutions have been used to address this issue, but none of them were universally acceptable or viable in the longer term. It is thus a matter of urgency that donors and cosponsors find a more permanent solution.

The responsibilities of HRP are: first to do the research, review the evidence and prepare the products; second, to have an effective communication strategy that ensures that all its products are communicated to all those who need to be aware of them; and third, to have an uptake strategy that enables the Programme to demonstrate how to introduce some of its more critical products into a limited number of programme countries, and to assess their potential or actual impact on SRH. In order to be accountable for this work, HRP needs sufficient funds in its budget to implement all these activities.

This could be achieved in a number of ways. Donors could return to earmarking contributions to PDRH, thus restoring its "lost" funding, or they could request the Programme to use, say, 20% of the funds for research on "research communication and uptake". HRP has a long-established practice of spending one dollar on strengthening research capacity for every two dollars spent on research; it may now need to review these proportions and include a percentage of the budget for "research communication and uptake".

The larger task of introduction and uptake falls to national governments, the cosponsors, donors, foundations, CSOs and other. All these groups have internal responsibilities to use the uptake "success stories" demonstrated by HRP, and to channel their own funds for the same purpose in the countries

where they work, to ensure wider and greater impact of the Programme's products, as well as greater value of their own investments.

Such a process would ensure that the value of HRP's products is maximized. It would also enable

the Programme to more clearly demonstrate the relationship between the funds invested in a particular area of the work and the results of that investment at country level.



Recommendations

- There is a need for HRP to develop and invest in a new communication strategy, which explores innovative ways of packaging and disseminating HRP's research findings and other products for use in strengthening national SRH policies and programmes. The strategy should consider the role of knowledge intermediaries and gatekeepers of change, and that different products will require very different approaches. Subsequent communication workplans should identify clear deliverables and associated indicators.
- HRP needs to develop, invest in, and implement a strategy for the utilization of its key products into a limited number of countries, to demonstrate their potential or actual impact, and to thereby leverage and guide the use of the funds of national governments, cosponsors, bilateral agencies, CSOs, foundations and others in their support to national SRH programmes.
- The PCC will need to provide guidance on the source of funding for HRP's communication and utilization work.
- HRP donors and cosponsors need to review and strengthen their systems and processes for utilizing HRP's products in their own programmes of development assistance, in order to maximize the value of HRP's global goods.

3. Efficiency and effectiveness of HRP's governance, management and administration



3.1 Introduction

This section does not attempt to review and evaluate all aspects of the governance, management and administration of HRP, but examines funding and fundraising; financial management; cosponsorship; the functioning of the main governance bodies of HRP: PCC, STAG, the Gender and Rights Advisory Panel (GAP), and the Research Project Review Panel (RP2); and selected aspects of programme management, including managing for results, managing research grants and managing research.

3.2 Funding and fundraising

3.2.1 Overall funding

The Programme's income reached a peak of US\$ 45 million in the 2006–2007 biennium; since then, it declined to a little in excess of US\$ 40 million for the following two biennia. Current income projections for the 2012–2013 biennium predict an increase to over US\$ 45 million.

Governments continued to provide the major portion of HRP's income, and in the most recent biennium, 2010–2011, this reached 72% of total income. Funding from cosponsors has declined by 50%, from around US\$ 14 million in the mid 1990s to around US\$ 7 million in 2010–2011. Contributions from foundations have become a significant source of HRP's income.

3.2.2 Designated funding

Over the years, designated funding has continue to increase, and continues to be an important source of HRP's income, currently running at around 20% of total income.

In the 2000–2001 biennium, HRP had an income of US\$ 33.3 million, of which US\$ 858 248 (2.6%) was designated funding. After deducting costs

for staff salaries, general technical activities and programme management (US\$ 13.0 million), the Programme had around US\$ 20 million for research activities, of which more than 95% was undesignated.

In the 2010–2011 biennium, HRP had an income of US\$ 41.7 million, of which US\$ 7.6 million (18.2 %) was designated. After again deducting costs for salaries, general technical activities and programme management (US\$ 28.0 million), the Programme had around US\$ 13.7 million for research activities, of which US\$ 5.1 million (37.2%) was designated.

Thus, the total funds available for HRP research activities have decreased by 31.5% over the last 10 years; undesignated funding for research activities has decreased by 58%, and designated funding for research activities has increased by a factor of almost six.

In 2000–2001, every staff dollar implemented US\$ 1.50 of activities; in 2010–2011, every staff dollar implemented US\$ 0.50 of activities.

Findings

Core funding and core funds available for research have both declined significantly. Core funding enables the HRP research agenda to be driven by needs and priorities that are independently and consensually identified. The number of HRP staff has remained virtually unchanged over the period of the evaluation, and respondents gave the Programme high ratings on the effectiveness of managing its human resources. However, the unavoidable increases in the costs of staffing, compounded by the weakening of the US dollar against the Swiss Franc have reduced the efficiency of the Programme over the last 10 years. Designated income causes the Programme additional work.

Conclusion

To regain its efficiency, the Programme needs an increase in undesignated funding, and needs to contract out a greater proportion of its work (see also Section 3.6.3).

Recommendation

- All donors to HRP should reflect on the importance of providing the Programme with undesignated funding, and, wherever possible, provide such funding on a multiyear basis. Where this is not possible, the current practice of providing designated funds for specific items of HRP's already approved workplan and budget should continue. The Programme should explore the possibility of additional funding from new foundations located outside the United States of America (USA).

3.2.3 Leveraged funding

Over the period of the evaluation, leveraged funding continued to run at a ratio of between 3 and 4 to 1. Between 2008 and 2011, the Programme's partners contributed US\$ 19.6 million in leveraged funding to projects for which HRP contributed US\$ 5.6 million.

Conclusion

The catalytic role the Programme can play by providing support to initiatives in SRH that are funded or implemented by partners demonstrates an added value for every dollar invested in HRP.

3.2.4 Income from royalties

HRP income from royalties continues at a little under 3% of total income.

3.2.5 HRP fundraising initiatives and achievements, 2008–2012

Findings

Over the period of the evaluation, the Programme developed and implemented a resource-mobilization strategy. The Programme is also currently in the process of consolidating funding initiatives with a number of governments and foundations. Income for the 2012–2013 biennium is predicted to reach a level in excess of all previous biennia.

Respondents gave positive views on the Programme's fundraising work. In commenting on their ratings, a large number of respondents indicated that the single most important way for the Programme to secure additional funding was to document and communicate the utilization, and thus potential impact, of its products in programme countries, and particularly how these help achieve global goals in SRH. A number of other respondents felt that the Programme needed to continue its outreach and engagement with foundations and global health initiatives to seek additional funds.

Conclusion

The Programme should be commended on its resource-mobilization efforts. During a period of global financial crisis, when many organizations have experienced severe funding cuts, the Programme's resource-mobilization initiatives have enabled it to maintain income at over US\$ 40 million for the last two biennia.





Recommendation

- HRP needs to continue to build on the success of its resource-mobilization work and strengthen it further by demonstrating and communicating the utilization of its products in programme countries, their potential impact, and how this helps the achievement of global targets in SRH.

3.3 Financial management

PCC generally views HRP's management of funds very positively, and more than two thirds of respondents gave high ratings for the efficiency of the Programme's management of its financial resources. Some respondents felt that more communication on financial matters should take place between PCC meetings (though this is already being done with the standing committee), and that HRP needed to continue to be very transparent in distinguishing between financial reporting of HRP and PDRH.

Conclusion

The Programme has continued to manage its financial resources in an efficient and effective manner.

3.4 Cosponsorship

HRP cosponsorship is defined in the *Memorandum of Understanding* as an expression of commitment rather than a legally binding relationship. The original cosponsors were UNDP, UNFPA, WHO and the World Bank, and these have remained so since HRP became a cosponsored programme in 1988.

Over the period of the evaluation, UNDP has returned as a financial contributor and has begun to play a more active cosponsor role. UNICEF became a new cosponsor as of December 2012. In

addition, the Joint United Nations Programme on HIV/AIDS (UNAIDS) was accepted by PCC in 2012 as a new permanent member of PCC, joining the IPPF in that capacity.

These developments strengthen the Programme's sphere of partnership and influence; facilitate opportunities for synergies in both basic and programme research; and expand opportunities for the promotion and use of HRP's products in programme countries.

The cosponsors of HRP make up the standing committee, which meets three times a year. The costs of the standing committee are less than 1% of the total governance costs. The standing committee provides an important advisory function to the HRP director in between meetings of the PCC. Meetings of the standing committee also provide the opportunity to discuss stronger cosponsor engagement in advising on future research priorities; stronger support from cosponsors for use of the Programme's products in countries; and future financial contributions from cosponsors, which have waned considerably in recent years.

The World Bank has been the most consistent and strongest financial supporter of HRP. In the last two biennia, 2008–2009 and 2010–2011, the World Bank provided 55% of income from cosponsors, and UNFPA and WHO each provided 22%.

While a number of respondents felt that the political and financial support provided by cosponsors was sufficient, a larger number felt that it could be much improved. This group felt that financial support to the Programme from cosponsors should be increased and that cosponsors should also become stronger champions for HRP and its products.

On the possibility of additional cosponsors, responses were somewhat mixed. A number

of respondents voiced caution. However, the majority was in favour of increasing the number of cosponsors, providing they were willing to commit funds and the necessary time to help guide the Programme.

Finally, respondents felt that the Programme needed to further strengthen and continue its direct communication with the executive directors and senior management of the cosponsors, in order to promote all aspects of cosponsorship: funding, political support and partnerships.

Conclusion

Cosponsorship continues to be considered a very important element of the fundamental structure of HRP. However, it needs to be reinvigorated, as much by the cosponsors themselves as by the Programme.

Recommendation

- HRP and the cosponsors need to strengthen their engagement, developing clear plans and mechanisms to use the programmatic experience and networks of the cosponsors to help identify key research questions and needs for policy, programmatic and technical guidance, and to use their programmes and networks to promote and expand the use of HRP's products in countries. A progress report should be presented to PCC after 2 years. The Programme should, somewhat cautiously, explore additional cosponsors.

3.5 Governance

This section of the evaluation examines the functioning of PCC, STAG, GAP and RP2.

The governance of HRP is laid down in its *Memorandum of Understanding*, which defines

the composition and role of PCC and STAG. PCC provides overall programme monitoring, strategic guidance and financial oversight, while STAG provides overall scientific and technical guidance on the Programme's work.

These are supplemented by two other important mechanisms, GAP and RP2. GAP advises the Programme on issues of gender equity and equality and human rights, and ensures a gender orientation in all its work. Reports of GAP are presented at both STAG and PCC meetings. RP2 reviews every research project proposed for support, and no project can be funded unless RP2 provides a positive scientific, technical and ethical review.

3.5.1 The Policy and Coordination Committee

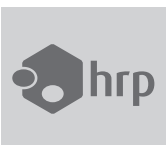
PCC is made up of various categories of members. Category 1 members of PCC are the 11 largest donors to the Programme in the previous biennium; category 2 members are 12 representatives from programme countries selected by the WHO regional offices; and category 3 members are two additional members elected by a ballot of category 1 and 2 members every 3 years.

A continuing issue from previous evaluations of the Programme has been the participation of members from programme countries. The Programme itself has little say over either which countries are selected or the individual participants chosen to attend.

Findings

Respondents gave high ratings on the effectiveness of PCC, but four out of five indicated that its effectiveness could be improved, and in doing so made a number of suggestions. These included the following: that more time should be allowed for discussion; that presentations should be





shortened; that there should be more involvement of category 2 members; that the Programme should strengthen its reporting to PCC to include outcomes and impact as well as outputs; and that more time should be given to policy, strategic, and financial issues for PCC's discussion, advice and agreement.

A number of respondents felt that direct involvement of PCC in areas such as priority setting and communication was not appropriate, since the job of PCC was more to ensure that sufficiently robust priority-setting mechanisms and communication strategies were in place.

Recommendations

- PCC needs to ensure that its agenda gives sufficient space for the discussion of policy, strategic and financial issues central to the well-being, growth and development of the Programme, as well as receiving reports on progress, outcomes and impact.
- PCC may wish to consider adding an agenda item every other year that would provide an opportunity for donors, cosponsors and programme countries to report on their use of the Programme's products.

3.5.2 The Scientific and Technical Advisory Group

STAG provides an overall scientific and technical review of "the content, scope and dimensions of the Special Programme, including the research areas covered and approaches to be adopted, and to recommend priorities within the Special Programme".

As of 2012, STAG had a full complement of 18 members, 10 of whom are female. The majority of

members, 11, are from programme countries, and all WHO regions are well represented.

In 1999, PCC endorsed the recommendation of STAG to expand its mandate to review the activities of RHR as a whole, rather than just HRP, as long as there were no financial implications for HRP. The cost of STAG, and also GAP, were to be paid in alternate years out of the budgets of PDRH and HRP. However, because of core budget reductions in PDRH, the costs of STAG and GAP have been borne entirely by HRP since 2009.

Respondents gave very high ratings for the effectiveness of STAG, but again the vast majority indicated that it could be improved. Suggestions included: that STAG should take on a stronger strategic role in shaping the Programme's priorities; that STAG agendas were too crowded, allowing insufficient time for in-depth discussions, and that periodic in-depth reviews of each area of the Programme's work by a subgroup of STAG, with one or two coopted experts in the area, would put to better use the expertise that STAG contains. Respondents also felt that STAG meetings often resulted in rather long "to do" lists – an average of more than 35 recommendations per meeting – which put an additional burden on programme staff in following them up.

Conclusion

The guidance and advice provided to the Programme by STAG continues to be appreciated and viewed as very important. Since 2000, STAG has substantially increased its workload. Its meetings already lasted 4 days, so there was little margin for compensation here. The anticipated benefit of reviewing the totality of RHR's work has, perhaps somewhat inevitably, led to less detailed STAG reviews of some aspects of HRP's work. Since 2009, PDRH flexible funds have been used entirely to pay for staff salaries, thus further

bringing into question the added value of STAG's review of PDRH activities, which are largely driven by specified funds from various donors.

Recommendation

- PCC may wish to consider a number of different options, including the following: STAG could revert to its original function as the scientific and technical review body for HRP, and could receive and review a report only on the overall work of PDRH on a biennial basis; STAG could undertake in-depth reviews, perhaps in alternate years, of two to three of the main areas of the Programme's work; in other years, it could focus on more strategic, policy and forward-looking issues, as well as reviewing and advising on overall workplans and budgets.

3.5.3 The Gender and Rights Advisory Panel

The Gender Advisory Panel (GAP) was established in 1995, and renamed the Gender and Rights Advisory Panel in 2007. Its terms of reference include reviewing all aspects of the department's work, with attention to gender equity and equality, as well as human rights; proposing mechanisms through which gender and rights concerns can be brought to bear across the department; and examining and giving guidance to the department on key concepts currently under debate in the area of SRH.

As of 2012, GAP had eight members, two of whom are male, from five of the six WHO regions. Currently, the WHO Regional Office for South-

East Asia is not represented as a member, though two temporary advisers from the region attended GAP in 2012. Three members come from donor countries and five from programme countries.

Respondents gave similar very high ratings on the effectiveness of the GAP, and again the majority indicated ways in which it could be improved.

Some respondents felt that GAP operated somewhat in isolation and needed to find a way of bringing its concerns more into the mainstream of HRP; other respondents felt that STAG has a degree of gender and rights expertise, and that there was thus the potential for some duplication. A number of respondents felt that GAP should be congratulated for having largely achieved its original goal of mainstreaming gender and rights into the work of HRP. As with STAG, GAP issues a large number of recommendations, averaging around 30 per meeting, all of which expect a response from the Programme.

Conclusion

The guidance and advice provided to the Programme by GAP continues to be appreciated, and GAP continues to be viewed as having a very important role to play. GAP is perceived as having largely achieved the objective of mainstreaming gender and rights issues into HRP's work. It is also perceived as remaining somewhat isolated from the mainstream of HRP. A proportion of its meetings cover similar agenda items to STAG, and part of the function of GAP is to provide a gender review of the Programme's work. A simultaneous scientific, technical and gender review of HRP's work would enrich and add value to the process of providing guidance to the Programme, and, at the same time, further reduce direct and indirect governance costs.





Recommendation

- HRP should examine the feasibility of merging GAP into STAG. This would require ensuring that STAG maintains adequate gender and SRH rights expertise; carries out biennial reviews of HRP's full programme of work from a gender and rights perspective; and commissions an independent review of its approach to gender and human rights after 5 years.

3.5.4 The Research Project Review Panel

RP2 is tasked with providing a technical, scientific, financial and ethical review for every research project the Programme proposes to undertake. No research proposal can receive funding from HRP without final approval following RP2 review. RP2 is a vital mechanism and resource for the Programme, in ensuring the quality and integrity of its research.

As of 2008, the five previous specialist panels were integrated with the Scientific and Ethics Review Group, essentially coalescing six panels into one new mechanism – RP2.

Findings

The creation of RP2 has resulted in a review process that is simpler but retains its original rigor; a process that has dramatically reduced, since 2008, the average time for review and approval from 18 months to 3 months; an updated, simplified electronic HRP research application form; and preparation of new ethical guidance for social science and implementation research.

The creation of RP2 has resulted in an estimated biennial saving in excess of US\$ 250 000 in terms of meeting costs, and savings estimated at somewhere between US\$ 450 000 and

US\$ 500 000 each biennium in terms of staff servicing costs.

Despite the rigorous RP2 review process, all HRP research projects also have to be submitted to and approved by the WHO Research Ethics Review Committee (ERC), though a number of respondents questioned the value added of this additional procedure, and perceived it as a process of duplication.

ERC is financed through appropriations from WHO research programmes such as HRP. Between 2010 and 2012, the Programme has had to pay almost US\$ 250 000 for this additional review process, thereby offsetting a considerable proportion of the savings discussed above.

Respondents gave very high ratings for the effectiveness of RP2. Many felt the timeliness of the review process had been improved, but that proposals sometimes needed more prescreening, review and revision by HRP staff before being submitted; and some felt that the Programme may have lost some capacity in scientific research direction and monitoring oversight, with the loss of the strategic committees.

Conclusion

RP2 performs an essential function in the technical, scientific, financial and ethical review and approval of HRP's research proposals. The creation of RP2 has strengthened and harmonized the research-proposal review process, and is significantly more efficient, in terms of time and money, than the multilevel review process it replaced. The ERC ethical review essentially duplicates the ethical review already carried out by RP2 and costs HRP additional time and money. One of the more common reasons for delays in the approval process is the submission to RP2 of research proposals that are incomplete, or that do not meet the required scientific and technical standards.

Recommendations

- The Programme should renegotiate its relationship with regard to the overlapping functions that exist between RP2 and ERC. Ideally, a way needs to be found for WHO senior management to entrust the ethical review of HRP's research to RP2. This will most likely require a number of actions, including investment in a more robust RP2 database with support for data management, and application by RP2 for FWA-OHRP accreditation (Federal Wide Assurance for the Protection of Human Subjects – Office for Human Research Protections Database), which would include a system of periodic external reviews of RP2.
- When submitting research proposals to RP2 for final assessment and approval, programme staff should ensure that the proposals are complete and conform to the required technical and scientific standards.
- In addition to the regular annual review of ongoing research proposals, programme staff should consult RP2 at any point after a research proposal has been approved, if any scientific, technical, ethical or management issues arise during the lifetime of the project until its completion.
- For its major areas of work, the Programme needs to develop mechanisms for identifying research needs and priorities, as well as planning and monitoring research studies, utilizing external expertise.

3.5.5 Costs of HRP governance

The overall total direct costs of governance have decreased considerably, by 22.5% over the period of the current evaluation. There are additional

savings attributable to the reduction in HRP staff time spent contributing to, supporting and attending the reduced number of meetings that now take place.

During the period 2008–2012, one meeting of PCC was held outside Geneva in a programme country, which allowed PCC members to visit the sites of several research projects and to see first-hand the results of HRP's work. While this had clear advantages in terms of underscoring the relevance of HRP's work and putting PCC in context, it also had a significant financial implication, increasing the cost of the meeting by a factor of four, as compared to PCC meetings held in Geneva.

Conclusion

The Programme should be commended on continuing to carefully manage, and indeed reduce, its governance costs, and there remain few opportunities for further savings. An eventual merging of GAP with STAG would bring some additional savings and a further reduction in servicing costs.

Recommendation

- The Programme should consider periodically holding a PCC meeting outside Geneva, but only after prenegotiating a cost-sharing agreement with the host government.

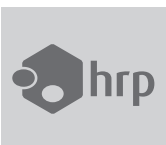
3.6 Management and administration

3.6.1 Managing for results

Did HRP achieve its objectives as laid down in its biennial workplans?

HRP's workplan is developed within the overall context of the WHO workplan and budget, in order to show how the work of the Programme relates





and contributes to the achievement of WHO's overall expected results.

HRP's expected results are also clearly identified in its biennial workplans. These are largely quantitative, in terms of, for example, numbers of studies to be carried out and numbers of reports to be published. A review of the 2012–2011 biennium revealed that HRP clearly exceeded its targets in some areas, such as published research papers, training activities and grants, and countries implementing interventions based on HRP research. In other areas, such as evidence-based studies and tools, and countries supported to test HRP's SRH guidelines, achievement was less than expected. Overall, the Programme clearly exceeded the targets for its quantitative indicators. However, such reporting captures neither the potential nor the actual impact of the Programme's work.

HRP has some control over potential impact, by ensuring that its work focuses on those areas and questions that are most relevant in assisting programme countries to improve the SRH of their populations, and it does have the mandate to undertake research on the introduction of its products, and research on barriers to the uptake of its products. This is essential in demonstrating to its clients and constituents both the value of its products and how they can be scaled up for use in countries, so that the much larger funds available to multilateral, bilateral and other donors can be guided towards being used for interventions that HRP has shown are evidence based, and thus interventions with an almost "guaranteed" impact.

Two thirds of respondents gave a very high ratings for the Programme's effectiveness in setting its workplan targets, but respondents felt that the Programme should strengthen its reporting of results to PCC, providing more data on outcomes, and more information on the impact in programme

countries, particularly examples of implementation research and research to overcome barriers to introducing evidence-based policies and programming.

Conclusion

Respondents gave a very positive assessment of HRP's effectiveness in managing for results. The evaluation took note of the dual reporting requirements for the HRP secretariat. On the one hand, HRP is required to condense its entire programme of work under three indicators, for the WHO Organization-Wide Expected Result, OWER 4.2, while on the other hand, its cosponsors, donors and governing and advisory bodies reasonably expect a far more comprehensive results framework. For the current 2012–2013 biennium, the Programme is continuing to use the same framework.

Recommendation

- For future biennia, starting in 2014–2015, HRP should develop a new results framework which, in addition to a simplified approach to counting outputs, should identify and monitor utilization of its products in programme countries, and, wherever possible, identify potential and/or actual impact.

3.6.2 Managing research grants

How effective is HRP in awarding, processing and monitoring research grants?

Findings

More than three quarters of respondents gave very high ratings for the Programme's effectiveness in awarding, processing and monitoring research grants. Some respondents noted that the awarding

of grants was sometimes slow, but that time was needed for the necessary scientific, technical and ethical review. Others again noted the need for HRP staff to prescreen and make sure that proposals were sufficiently strong, particularly from a scientific and technical point of view, before being submitted to RP2, and that this would help speed up the awarding of grants. Income flows were also noted as sometimes affecting the Programme's ability to award and process grants.

Respondents did not give high ratings to a question regarding how changes in WHO administrative processes had affected the processing of research grants. They felt problems had been caused by staff reductions; the additional requirement for passing proposals through the WHO ERC; communication and processing difficulties with the new WHO administration unit in Kuala Lumpur, although some problems, such as the ability to continue processing advance payments, have been subsequently resolved; overburdened programme staff; lack of resources; and unclear links with individual performance-assessment mechanisms, which needed strengthening and linking to clear deliverables.

Conclusion

The Programme is viewed as performing efficiently the processing, awarding and monitoring of research grants.

3.6.3 Managing research

Was the Programme implemented in the most efficient way?

Findings

A total of 46.5% of respondents felt that the balance between research work undertaken by programme staff, and research work commissioned by HRP but contracted out, was

about right. However, an almost equal proportion, 45.3%, felt that the balance should shift towards work contracted out.

In elaborating on their responses, a number of informants felt that while it was essential for HRP to continue to set the research agenda, the Programme should use more institutions, particularly in programme countries, to carry out a greater proportion of the research, systematic reviews and methodological work, thus enabling the Programme to manage a larger portfolio of work and thus become more efficient.

Many respondents related their answers to this question to the issue of HRP staffing costs, which are considerably higher than, for example, in TDR and the Global Alliance, where they are, respectively, around 20% and 30% of overall budgets.

Some respondents felt that changes in the functions of the statistical and data-processing group in HRP over the years, from processing data to overseeing the process of data management was a good example of how the Programme had become more efficient in one area of its work.



Recommendation

- In order to gain further efficiencies, the Programme may need to re-examine the balance between the proportion of research being done by programme staff and the proportion being managed by programme staff but implemented by outside institutions.

4 Evidence generation and synthesis to improve family planning, prevent unsafe abortion and prevent and control sexually transmitted and reproductive tract infections



4.1 Introduction

This 2008–2012 case-study highlights HRP activities in the areas of (a) family planning, (b) unsafe abortion and (c) sexually transmitted and reproductive tract infections, by demonstrating HRP's unique process of addressing SRH issues, from problem identification to generating new knowledge, to global roll-out of solutions.

4.2 Methods

Meetings were held with team leaders in Geneva (18–20 April and 19–22 June 2012), to identify focal activities of the professional clusters. A desk audit of peer-reviewed publications and WHO reports was complemented by e-mail contact with collaborators. Highlighted work includes the development of a male contraceptive, marketing of emergency contraceptives and HRP's response to evidence about hormonal contraceptive use and HIV risk. The application of the WHO strategic approach to reducing unsafe abortion and the initiative to eliminate congenital syphilis are also summarized.

4.3 Findings

4.3.1 Developing a male contraceptive

A phase II, eight-country trial of two long-acting injectable hormones, testosterone undecyloate (TU), an androgen, and norethisterone enanthate (NET-EN), a progestin, was undertaken to determine their safety, effectiveness and acceptability as a male contraceptive. While the regimen was effective in suppressing spermatogenesis, higher than expected rates of mood changes and increased libido led to a decision to stop the trial in April 2012. All sites should complete "close-out" visits by November 2012 and reporting is expected in 2013. While further testing of this drug combination is not

expected to continue, the study will inform future development of a male contraceptive. The side-effects apply to the 1000 mg TU/200 mg NET-EN combination, and not to the drugs used alone for their approved indications.

4.3.2 Getting a new product to market – emergency contraception

The emergency contraceptive levonorgestrel can prevent pregnancy if taken within 120 hours of unprotected sexual intercourse. As it cannot terminate an established pregnancy, it is also acceptable where abortion is not. It is safe for over-the-counter (OTC) use and HRP has promoted its distribution through social marketing. As of 2010, 126 of 189 countries worldwide have an emergency contraception product registered, and of these, in 103 countries, no prescription is required. Successful programmes (based on high-volume sales) were supported and/or promoted by governments. OTC sale at affordable prices, with discrete access through educated shop owners, pharmacists and health-care providers, facilitated sales. Barriers included lack of public-sector support; negative campaigns suggesting that emergency contraception acts as an abortifacient; prescription requirement; and limited public education.

4.3.3 Monitoring product safety – hormonal contraception and risk of HIV acquisition

The WHO *Medical eligibility criteria for contraceptive use* (2009) indicate that hormonal contraceptives are safe for use by women at high risk of HIV or living with HIV; however, emerging evidence of associations between hormonal contraceptive use and risk of HIV infection, disease progression and transmission, suggested the need to review the current guidance. In early 2012, HRP

convened a team of 75 experts to review the new evidence. They concluded that:

- the available evidence did not establish a clear causal association between injectable contraceptives and HIV acquisition, but did not rule out a possible effect; therefore, use of hormonal contraceptives should remain unrestricted but further evidence should be closely monitored;
- women at high risk of HIV infection can use all existing hormonal contraceptive methods without restriction, but should use condoms and other measures to prevent and reduce their risk of HIV/STIs;
- women living with HIV infection can also use all hormonal contraceptive methods without restriction but should consistently use condoms to prevent HIV transmission to non-infected sexual partners.

4.3.4 Safe abortion services: application of the WHO strategic approach to unsafe abortion – experience in sub-Saharan Africa, eastern Europe and Asia

Worldwide, 55% of abortions are classified as unsafe, more so in Africa (97%). In eastern Europe, where abortion is legal for a broad range of indications, limited use of contraceptives results in a high rate of abortion. In 2011, Bangladesh requested HRP technical assistance² to revise their national menstrual regulation² guidelines in line with WHO safe abortion guidance. The WHO strategic approach is a useful tool for tackling sensitive problems and has been applied to the prevention of unsafe abortion. The experiences of 11 countries that applied the approach to

address unsafe abortion during 2008–2012 are summarized.

National strategic assessments were carried out by country assessment teams, using qualitative methods with a range of stakeholders. Findings were presented at national dissemination workshops, where recommendations were reviewed and refined and interventions prioritized. Common barriers to safe abortion care across all settings included the lack of standards and guidelines for comprehensive abortion care, and inadequate training of abortion providers. Some African countries that had ratified the 2003 Maputo Protocol on safe abortion reported that laws were in conflict with this protocol. Where laws had been revised, the public was generally unaware of the changes. Other challenges included poor access to, and availability of, contraception; gender inequality; limited access to sexual education for girls; and girls being expelled from school when they become pregnant.

Follow-up activities in African countries included the development of national guidelines for abortion care; dissemination of information on legal indications for abortion; and strengthening of family planning programmes, adolescent SRH services and sexuality education. In the Republic of Moldova, a comprehensive abortion care programme was piloted in two perinatal centres, which were later designated as training sites for the stage 3 roll-out. In 2011, the WHO *Safe abortion: technical and policy guidance for health systems* was adapted for use in Bangladesh, with HRP assistance. The nature and pace of scaling-up depends on a health system's readiness for change and available resources. Resistance to change has been reported where institutions or individuals benefited from the status quo.

Lessons learnt included the following:



2. Defined as “a procedure to make the menstrual cycle regular if menstruation is absent for a short duration” (*National menstrual regulation services guidelines*. Dhaka, Ministry of Health and Family Welfare, People's Republic of Bangladesh, 2011).



- the participatory process of the strategic approach helps catalyse change through early engagement of stakeholders;
- ministry of health participation is essential to enable the integration of recommendations into health policy and programmes;
- the process helps build local skills in planning, quantitative and qualitative data collection and analysis, intersectoral collaboration, evaluation and implementation;
- engaging financial partners early is critical, so that implementation does not lose momentum;
- the need for each country to adapt the strategic assessment tool to the local context, with each intervention providing lessons for other country teams seeking ideas of where to begin.

4.3.5 Controlling sexually transmitted and reproductive tract infections: initiative to eliminate mother-to-child transmission of congenital syphilis

Untreated syphilis in pregnancy can cause late abortion, stillbirth, prematurity/low birth weight, neonatal deaths and congenital infection. These adverse outcomes may be avoided by antenatal screening and treatment. In 2007, WHO launched the global initiative to eliminate congenital syphilis by at least 80% in 10 high-burden countries (Bangladesh, India, Indonesia, Kenya, Madagascar, Mozambique, Rwanda, South Africa, United Republic of Tanzania and Zambia) by 2015. Specific targets are that, by 2015, at least 90% of pregnant women will be screened for syphilis and at least 90% of women who are syphilis seropositive will be appropriately treated.

A strategy toolkit has been developed to provide technical support for screening, case identification and contact tracing and includes protocols for monitoring and surveillance. Core data on annual elimination of congenital syphilis (ECS)

are submitted to WHO or UNAIDS, through WHO regional offices. Programme impact is measured by the progress toward the target incidence of congenital syphilis (≤ 0.5 per 1000 live births). An ECS website provides tools and information, at http://www.who.int/reproductivehealth/topics/rtis/cs_global_updates/en/index.html.

Progress on the initiative has been variable across regions. Because of their pre-existing infrastructure, Latin American and the Caribbean countries were best prepared to embrace the initiative, and adopted a plan of action in 2010. Separate guidelines have been developed for these countries and have been integrated into national plans in 22 countries. Given its pre-existing health infrastructure and organization, Cuba has made the most progress; however, 11 countries report having achieved target incidence rates for congenital syphilis of less than 0.5 per 1000 live births. In Africa, progress has been slower, as more work needs to be done to develop systems to deliver the services and change the culture of late attendance for antenatal care. In 2011, the initiative was launched in the Asia-Pacific region, with some success already reported in India, Malaysia and Myanmar.

Continuing challenges include the persistence of vertical programmes (e.g. antenatal care, HIV), weak mid-level human resources skills, and inefficient logistical support. Technology transfer is needed to help scale up services, including strengthening of laboratory facilities, laboratory information systems, surveillance and programme evaluation. Cultural and legal barriers, inconsistent funding and weak political will are threats to sustainability. The willingness of development partners like the Global Fund to Fight AIDS, Tuberculosis and Malaria to support the integration of ECS into the HIV portfolio will help promote the initiative.

The ECS campaign strengthens the integration of STI and SRH services based on a country's level of readiness, by promoting the elimination of both congenital syphilis and mother-to-child transmission of HIV. This campaign is an excellent example of the public good created by HRP, which brings new technology to bear on a persistent problem, resulting in improvements in health and survival. Partnerships with academic institutions, NGOs and other international agencies enable high-quality research to inform decision-making about what works, marrying skills in high-income countries to the needs of low- and middle-income countries, while building inter-country collaboration between low- and middle-income countries so they can help each other. The achievement of target incidence rates for congenital syphilis of ≤ 0.5 per 1000 live births in 11 countries in Latin America and the Caribbean is encouragement that the goal is not unrealistic.

4.4 Conclusions and recommendations

Although it is relatively small, the HRP team in Geneva is impressive in its capacity to identify and coordinate a large network of investigators, collaborators and experts, drawn from academic and research institutions across all the WHO/United Nations regions of the world, capable of addressing acute problems and developing long-term solutions to global SRH challenges.

The cases in this section demonstrate the global value of HRP, from problem identification (unsafe abortion) and problem clarification (the strategic approach), to generating new knowledge (male contraception) and marketing new products (emergency contraception), to piloting and roll-out of solutions to global problems (safe abortion; ECS), while monitoring the emergence of new knowledge (hormonal contraceptives and HIV) to maintain public trust in WHO/HRP as a reliable source of global SRH advice.

Recommendations

- **Male contraception**
A clear policy framework is needed to guide research regarding male reproductive health, including the development of male contraceptives. Within this framework, it may be necessary to revisit the costs and benefits of a male contraceptive. Currently, while the health risks of a new male contraceptive are likely to be borne almost entirely by the user, the health benefits appear to be largely to the partner, in terms of avoidance of the risks of unwanted pregnancy. In addition, there are social and economic benefits which accrue to the family unit. The economic costs of an unwanted pregnancy are often the responsibility of the male partner and need to be factored into the equation.
- **Emergency contraception**
Efforts are needed to advance the social marketing and promotion of emergency contraception, including among adolescents. Strategies are needed to measure access to emergency contraception, and its utilization and impact. Integration of indicators into demographic and health surveys or other reproductive health surveys may be a place to start.
- **Monitoring product safety**
This continues to be a critical role for HRP because of its neutrality, its convening ability, and its dedication to science and evidence.
- **Safe abortion services and eliminating congenital syphilis**
To support the safe abortion and ECS goals moving forward, monitoring indicators should be incorporated into universally accepted international country reporting frameworks.



5 Research-capacity strengthening and network building



5.1 Introduction

WHO's Global reproductive health strategy includes supporting action-oriented research and research-capacity strengthening that contribute to the overarching goal of achieving universal access to quality SRH services. The goal of HRP in research-capacity strengthening is "to improve reproductive health in countries and regions through support to priority national/regional research, in particular that which is linked to improved operations of reproductive health programmes".

The strategies to achieve a sustainable local resource for national governments and countries of evidence on policy and programme interventions to advance SRH include provision of various forms of grants, including long-term institutional development (LID) grants to institutions to develop the infrastructure for research. After the period of the LID grants, institutions are monitored and become eligible for resource maintenance and capital grants to sustain the gains made.

HRP has established and convenes regional advisory panels that serve as regional scientific and technical advisory bodies to HRP on priority national/regional research, capacity-building and programmatic activities in SRH.

5.2 Methods

The methodology and process for this case study involved desk review of relevant documents related to HRP's work during the period of the evaluation. A global e-mail questionnaire was also sent to 25 institutions that have benefited from LID grants. The objective of the questionnaire was to assess the performance of the collaborating centres in relation to the support given by HRP. Site visits were made for verification of reports and to assess the extent of national and regional outcomes.

Discussions were also held with the ministries of health and other national institutions that worked with the collaborating centres, in order to assess the impact of these partnerships.

5.3 Findings

HRP is currently funding and collaborating with 103 research centres in 55 countries around the world (11 in the Region of the Americas, 10 in the European Region, 23 in the African and Eastern Mediterranean Regions, and 11 in the South-East Asia and Western Pacific Regions). The questionnaire was sent to 25 LID grant recipients in the Americas, Africa, Asia and the Pacific, and Eastern Mediterranean. The heads of 23 collaborating institutions responded (5 in Latin America; 10 in Africa; 7 in Asia and the Pacific, and 1 in the Eastern Mediterranean), which represented a 92% response. HRP assists such institutions to identify their needs and makes site visits to provide expertise on the implementation process for the agreed activities. Such visits are also used to encourage the institutions to adopt corrective interventions for any shortcomings, to further improve their research orientation. Sixty-four per cent of the centres felt that these HRP visits were frequent enough to provide the support that the centres needed.

The extent to which HRP objectives related to capacity building for research were still valid can be deduced from the fact that, in most countries, heads of the HRP-supported centres sit on bodies that set the national research agenda for SRH, and WHO/HRP guidelines and handbooks for SRH programmes are universally used to guide national programmes. In most institutions, the number of courses offered by the centres and the number of presentations at scientific meetings increased after the HRP support.

5.3.1 Regional networks

Through network building, HRP has promoted interregional collaboration. Eighty-nine per cent of the centres collaborated with other institutions: of these, 63% collaborated with other local institutions, thereby cascading the knowledge and skills benefit from HRP support, while 37% collaborated with regional institutions and with global/international institutions. In some countries, this collaboration has enhanced the capacity to attract funding from other institutions.

5.3.2 Research-capacity strengthening and the global research agenda

Institutions that have benefited from research-capacity strengthening have subsequently been able to participate in implementation of the global research agenda. HRP has been very effective in developing the research capacity of institutions, leading to increased high-quality output from the collaborating centres published in peer-reviewed journals. There are many examples that reveal that supported institutions have conducted studies that influenced national health policy, and that in turn led to improvement in the health of women in all regions. Satisfaction with HRP support among the countries is high; 74% of the centres surveyed indicated that HRP had fully met their expectations. Through training and provision of logistics support by HRP, a culture of research has been established in many low- and middle-income countries.

5.3.3 Research outputs

There are many examples where the outputs of HRP-strengthened research centres have resulted in improvements in women's lives. For example, a study that concluded that controlled cord traction can be omitted with little increase in the risk of postpartum haemorrhage in settings where skilled birth attendants are not available, has potential

to save many lives in low- and middle-income countries where postpartum haemorrhage remains the top cause of maternal death. A multicountry survey, in 29 countries, on maternal and newborn health, with a focus on the management of severe complications in pregnancy and childbirth, has the potential to reduce case-fatality rates from obstetric complications and save many lives.

Other policy and practice changes resulting from HRP's research include the adoption of the use of magnesium sulfate in the management of pregnancy-induced hypertension; use of misoprostol in the management of postpartum haemorrhage and incomplete abortion; and replacement of dilatation and evacuation with manual vacuum aspiration. These all have the potential to significantly reduce maternal mortality and morbidity and to create significant cost savings in the delivery of health care.

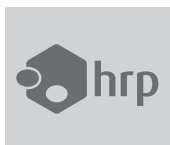
The Sichuan Family Planning Research Institute in Chengdu, China, carried out the research on non-scalpel vasectomy, supported by HRP. This method is now practised worldwide and has made vasectomy more acceptable and accessible to many individuals.

Implementation research is also increasing, and a number of countries took part in the (ReproNet) visual inspection with acetic acid (VIA) study for cervical cancer screening. VIA has since been adopted in these countries, leading to scaling up of screening services for cervical cancer, the commonest cancer in women in low- and middle-income countries.

5.3.4 The relevance of research-capacity strengthening for national agendas

WHO remains the organization that countries look up to for guidance on health promotion, and countries are more likely to adopt HRP





guidelines, which are informed by HRP-supported studies globally, than those produced by other partners. Studies funded by HRP, by being focused on country needs, have led to the development of national treatment guidelines, as well as contributing to global standards for SRH programmes. Many research staff from the collaborating centres sit on national SRH research policy planning bodies,

Seventy-five per cent of the institutions felt that this advantage was because HRP work was more specific to SRH research issues; 45% also felt that this was related to the high-quality training provided through sponsorship to good institutions and the provision of experts for local training. One third reported that HRP promoted studies that were more specific to national needs, which was greatly appreciated by the countries.

5.3.5 Sustainability

As an integral part of the LID grant approach, institutions are encouraged to develop a sustainability plan to allow them to continue thriving beyond the period of support. A number of institutions in many countries have since been weaned off HRP support, including in Argentina, Brazil, Kenya, Senegal, Tunisia and Zimbabwe. These institutions have continued to produce substantial amounts of good-quality research. However, not all institutions become fully independent at the end of the LID grant period.

5.3.6 The research capacity strengthening legacy

HRP has funded the training of a large number of scientists in research methodology, as well as postgraduate education for senior researchers, which has influenced policy and programmes in low- and middle-income countries and promoted

evidence-based treatment and programming of health care in low- and middle-income countries. This is promoting universal coverage of SRH services, while also improving the quality of care.

HRP has been very effective in developing the research capacity of collaborating institutions. The major outputs attributable to HRP in the collaborating centres include an increase in high-quality research proposals and publications, and the development, or revision, of national guidelines that contribute to the achievement of national MDGs.

5.4 Conclusions and recommendations

There is sufficient evidence that HRP objectives to strengthen capacity for research are achieved or are likely to be achieved. Testimonials from institutions consider the HRP support as the only real possibility to train with first-line researchers in the area of reproductive health. Workshops and seminars were found to be enriching experiences that create a scientific frame of mind. HRP provides one of the few opportunities for most researchers in low- and middle-income countries to travel to training centres. The result is a greatly increased output of publications in peer-reviewed journals that have worldwide influence on policy and practice for the improvement of women's and children's health.

There is evidence that work by supported centres has contributed to the achievement of MDGs in their countries and promoted the ICPD agenda.

However, gaps still remain in the needs of individual countries, as a result of inadequate funding to satisfy the needs of the centres. In the face of reduced funding to HRP, it remains to be seen whether reductions in the amounts of research-capacity strengthening grants and lengths of study will result in a slower pace of research-capacity strengthening by HRP.

Some institutions are still not able to stand on their own after the 10-year LID grant. Many centres in low-income countries will still not have adequate numbers of research staff at the end of the 10-year support for institutional development.

This is partly because of staff mobility and partly due to countries' dependence on HRP support. The ending of LID grants in some institutions has led to significant weakening of those centres.



Recommendations

- The process of LID grant application and processing should be simplified, in order to reduce delays.
- To promote sustainability, LID grant support should have a clear exit strategy, which should be continuously monitored, including lobbying with national governments and other potential donors to sustain the centres when the HRP support comes to an end.
- Training, whether it be long-term scholarships, short-term attachments to research centres, or travel to scientific meetings, conferences and seminars, is an essential component of research-capacity strengthening and should be a central component of all LID grants.
- The objectives of research studies should include deliberate steps to influence policy and programmes, with clear methodologies on how that is to be achieved.
- Research grants should include a budget for dissemination and follow-up on the utilization of the research results. Appropriate dissemination processes targeting policy-makers and programme managers should be clearly outlined. University departments of obstetrics and gynaecology are critical in changing clinical practice and should be a target of meetings for dissemination of research results.
- More studies designed to promote MDG 5B should be encouraged in low- and middle-income countries, to accelerate improvements in women's reproductive health and neonatal health.
- Support to regional networks should include funding that ensures that every country in the supported region can participate in the network.

6 Strengthening implementation research



6.1 Introduction

The focus of this case-study is work on implementation research carried out by HRP and RHR. Implementation research is research aiming to develop strategies for available or new health interventions, in order to improve access to, and the use of, these interventions by the populations in need. As such, it intends to create generalizable knowledge that can be applied across settings and contexts.

This section focuses on examining what HRP has done since 2008 on implementation research specifically, and how this can be strengthened in the future. That means reviewing HRP research activities aiming to create strategic knowledge to improve the use of effective health interventions by the populations in need.

6.2 Methods

To conduct this external evaluation, the reviewer visited the HRP offices at WHO Geneva and interviewed HRP staff, members of STAG, staff involved in implementation research projects, WHO staff in other departments, and experts in implementation research. HRP research studies that have gone through ethical review since 2008 were reviewed, as well as all HRP publications in the same period, pertinent HRP governance documents (working plans, reports to STAG, annual internal reports) and the strategic plan for 2010–2015. Staff suggestions and shared experiences were also incorporated.

The HRP list of projects was reviewed to identify projects related to implementation research. Lead officers for each of these projects were contacted by e-mail and asked to share relevant information: the final approved protocol, actual state of the project, intermediate and final evaluations, published manuscripts and any additional

information that would be useful to get a better understanding of the project. The HRP web site was used as a source of information to identify activities related to the Implementation Research Platform (IRP).

The reviewer also received a list of titles of all HRP manuscripts published in a peer-reviewed journal from 2008 to 2012. This list was examined in sequential steps, in order to highlight only those publications that referred to implementation research.

6.3 Findings

Implementation research has gained attention in recent years, owing to the large underuse of several life-saving interventions in low- and middle-income countries. Since 2009, HRP has made substantial efforts to raise the priority of implementation research within the department, and made substantial contributions to include implementation research as a major topic in funding agencies.

6.3.1 Prioritization of implementation research within the Programme and WHO

HRP assembled the interteam working group that adopted a common definition of implementation research, and contributed to the conceptual approach that several WHO departments adopted in 2010. Implementation research was prioritized in the HRP strategic plan for 2010–2015, including products and activities in progress or to be conducted by each HRP team.

6.3.2 Contribution to implementation research funding

HRP prioritization of implementation research contributed to the decisions of funding agencies to allocate funds to implementation research initiatives and specific projects, specifically the

IRP, funded by the Norwegian Government Agency for Development Cooperation, the Department for International Development of the United Kingdom of Great Britain and Northern Ireland, and the Swedish International Development Cooperation Agency; and the implementation research study of antenatal care in Mozambique, funded by the Flanders International Cooperation Agency.

6.3.3 The Implementation Research Platform

This initiative has an excellent conceptual approach. It provides funding for implementation research proposals developed in low- and middle-income countries, with the technical and methodological support of HRP and TDR. However, the potential global impact is limited by the relatively low funding and the short time frame, which will only allow small studies at country or subregional level.

6.3.4 HRP resources for implementation research

HRP has high-quality resources that should facilitate implementation research studies: the *Reproductive Health Library* as a source of effective health interventions and implementation strategies in reproductive health; the WHO guidelines system; The Global Survey; and the GREAT Project (Guideline development, Research priorities, Evidence synthesis, Applicability of evidence, Transfer of knowledge). All these resources put HRP in an advantageous position to design and conduct global implementation research studies effectively and efficiently.

6.3.5 High-quality implementation research studies

The eight studies identified are all high-quality implementation research studies, addressing

priority questions. As most of these studies are still ongoing, no impact can be expected at this time. However, the findings of these studies will probably impact public health decision-making in the countries where they are being conducted.

The eight studies are in the areas of maternal and perinatal care and safe abortion. The main aims include increasing skilled birth attendance; improving the quality of maternal, neonatal and emergency obstetric care; improving antenatal care and antenatal screening of syphilis; and task-shifting for medical abortion. Six are single-country studies conducted in Guatemala, Mongolia, Mozambique, Nepal, the United Republic of Tanzania and Uganda, and two are multicountry studies conducted in the Middle East region (Egypt, Lebanon, Occupied Palestinian Territories, Syria), and in Latin America (Argentina, Brazil), Africa (Democratic Republic of the Congo, South Africa) and Asia (India, the Philippines, Thailand). Most of the interventions under study are multifaceted, mainly including components orientated toward health-care workers' capacity building or knowledge transfer, but also involving different models of organization of care and community-level interventions. The design of the interventions has been based on, or refined by, formative research in five of them. All are prospective intervention studies, most of them with experimental designs: cluster randomized controlled trial (4); individual randomized trial (1); stepwedge design (1); interrupted time series (1); and a non-randomized intervention study (1).

6.3.6 Collaboration with other global implementation research studies

Providing support to other relevant initiatives, such as the National Institute of Child Health and Human Development's Global Network Antenatal Corticosteroids Trial, is an efficient way to





contribute to answering global implementation research questions that are being studied by other groups or agencies.

6.3.7 Lack of large-scale implementation research studies on priority issues

HRP is still not conducting implementation research studies addressing reproductive priority questions on a large scale. That means designing implementation interventions that may overcome common barriers in several countries; and evaluating them in large-scale studies in several countries. Such studies are essential to gain generalizable knowledge in an efficient way and in a relatively short time.

6.4 Conclusions and recommendations

Implementation research has gained attention in recent years, owing to the large underuse of several life-saving interventions in low- and middle-income countries. Since 2009, HRP has made substantial efforts to raise the priority of implementation research within WHO departments, and made substantial contributions to include it as a major topic in funding agencies. It prioritized implementation research in its own strategic plan for 2010–2015.

HRP continues to collaborate with other global implementation research studies and was a key part of the team that facilitated the decisions of funding agencies to allocate funds to implementation research initiatives and specific projects. The knowledge created by these studies will be very relevant for the included countries. However, because most have been small scale, their potential global impact is limited.

As discussed in Section 6.3.5, the eight HRP studies identified in this section are all ongoing high-quality implementation research studies, with an anticipated impact on public health decision-making in the countries where they are being conducted. One of these studies may have direct implications on regional policies in the Middle East, as it is ongoing in four countries.

Although, some of the HRP projects took place in different countries of the same region (mainly Asia), HRP work is primarily orientated towards specific countries' needs and there is still much work to do regarding interventions that may be useful to overcome common barriers in several countries.

Studies that use a global approach are essential to gain generalizable knowledge in an efficient way and in a relatively short time period. HRP has extensive experience in conducting large-scale studies investigating new interventions in maternal health, family planning, and methods for safe abortion. It has done a good job in creating generalizable knowledge regarding interventions to improve health in the same period, but has not done anything comparable regarding implementation research. Studies of this magnitude and potential impact are much needed.

The Programme has high-quality resources that put it in an advantageous position to design and conduct large-scale global implementation research studies effectively and efficiently. Such studies will provide answers to scale up priority reproductive interventions at a global level.

Recommendations

- HRP should design and conduct implementation research studies addressing reproductive priority questions, on a large scale. Large-scale studies should evaluate strategies for scaling up family planning and improving emergency obstetric health care (i.e. scaling up the use of magnesium sulfate for eclampsia treatment, task-shifting in the provision of health care, integration of onsite contraceptive services with abortion and puerperal care, and scaling up the uptake of emergency contraception).
- Active participation of HRP in the IRP should continue. Advocacy to expand future calls for proposals, in order to award larger-scale research projects, would be an asset.
- HRP should continue the support and participation in other large-scale research studies focusing on low- and middle-income countries, initiated by other agencies or research groups. These collaborative efforts are an efficient use of resources.
- Setting up a transdisciplinary team of scientists in implementation research may facilitate HRP activities in implementation research. This team should ideally include expertise in the design of implementation strategies, design and conduct of implementation intervention studies, qualitative approaches for assessment of barriers, statistical expertise in design and analysis of implementation research trials, and behavioural sciences. This team, assembled with either existing or new staff, would work with all thematic teams in a cross-cutting way, providing up-to-date standard methods for implementation science.



7 The status of, and opportunities for strengthening, engagement with the private sector and civil society



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7.1 Introduction

This section presents the findings, conclusions and recommendations that result from the case-study carried out by PricewaterhouseCoopers SA (PwC), within the framework of the HRP external evaluation 2008–2012. The study focuses on “the status of, and opportunities for strengthening, engagement with the private sector and civil society”.

PwC agreed with HRP to undertake the following tasks: to analyse the HRP Programme and its structure from a governance perspective and within the broader framework of WHO; to map existing relationships between HRP, the private sector and organizations representing civil society; to assess the role of key stakeholders (private sector/civil society) and their involvement in HRP’s activities; to assess existing relationships with both the private

sector and civil society, within the framework of WHO, in order to identify legal limitations and room for opportunities; and to identify best practices and opportunities to strengthen engagement with the private sector and civil society.

In the context of this study, the term “private sector” refers to private enterprises that pursue a commercial and financial interest and that will contribute to HRP’s efforts in the field of reproductive health research. By civil society, the report refers to not-for-profit NGOs, which in this case have a particular interest in entering into a collaborative initiative with HRP on the basis of a particular research project.

7.2 Methods

The approach used in the study was to:

- enhance understanding of HRP from a governance perspective;
- identify key HRP drivers for engaging in collaborations with the private sector and civil society;
- review the existing collaborations between HRP and the private sector and civil society;
- analyse existing collaborations on the basis of the key drivers identified;
- draw conclusions and propose recommendations for the way forward.

To carry out the study, the team reviewed all relevant WHO and HRP documents, and conducted interviews with both WHO and HRP staff, as well as with representatives of the private sector and civil society.

The process followed enabled the identification of key HRP drivers for engaging in collaborations with the private sector and civil society; the identification and review of the existing

collaborations between HRP and the private sector and civil society; and an analysis of those existing collaborations on the basis of the key drivers identified.

7.3 Findings

Key drivers for HRP's engagement with the private sector and civil society were extracted from a number of WHO and HRP documents including HRP/WHO's *Memorandum of Understanding* (1998, revised in 2012); the *HRP programme budget for 2012–2013 (including medium-term strategic plan for 2012–2015)*; the United Nations Secretary-General's *Global strategy for women's and children's health* (2010); WHO's *Guidelines on working with the private sector to achieve health outcomes*; and the *WHO policy framework for engaging and working with the commercial private sector*.

The key drivers identified were as follows:

- alignment with HRP's key goal of "promoting, coordinating, supporting, conducting and evaluating research in human reproduction, with particular reference to the needs of developing countries";
- contribution towards the Secretary-General's call for action to "generate and synthesize research-derived evidence, and provide a platform for sharing best practices, evidence on cost-effective interventions and research findings";
- contribution to WHO call for "National research capacity (to be) strengthened as necessary, and new evidence, products technologies, interventions and delivery approaches of global and/or national relevance (to be) available to improve maternal, newborn, child and adolescent health";
- promotion of wide availability of new health-related products to the public at large;
- promotion of availability of products to the public sector of low- and middle-income countries in sufficient quantities to meet the demand, and at an affordable, or at least preferential, price;
- negotiation, collection and reinvestment of royalties when new products or technologies can generate revenues from their commercialization;
- "compliance with the WHO principles, policies and guidelines on working with the private sector to achieve health outcomes".

It is noted that the proposed drivers represent a set of principles that can be further discussed and defined by HRP on the basis of additional internal consultations.

Existing collaborations were analysed to identify patterns and trends, while also seeking to make a distinction between the private sector and civil society. On the basis of the analysis, the existing collaborations were regrouped into four main categories that share common key goals, themes or activities. These were:

- identification of new products or technologies;
- dissemination of information, tools and policies;
- management of research projects;
- fundraising through commercial activities.

7.4 Conclusions

HRP has a key role to play in supporting the implementation of the UN Secretary-General's *Global strategy for women's and children's health*, particularly in order to generate and synthesize research-derived evidence, and to provide a





platform for sharing best practices, evidence on cost-effective interventions and research findings.

HRP has engaged in a number of collaborations with the private sector and civil society over the years, and has hence been able to leverage the strengths and expertise of these sectors to further its objectives. However, these collaborations have taken place in an ad hoc manner and on opportunistic basis. Moreover, teams within HRP have not tended to coordinate its activities when collaborating with the same CSO, particularly with international NGOs that work with different HRP teams.

No clear vision or specific strategy has been put forward to engage with those sectors that are active or willing to be active in the field of reproductive health. Although the collaborations have overall been in line with HRP's key goal of enhancing research in human reproduction, some cases were identified where the primary aim was to raise additional funds, rather than to support research, thus only indirectly contributing to HRP's main goal.

In addition, the two objectives of providing a platform for sharing best practices, evidence on cost-effective interventions and research findings, and contributing to the strengthening of national research capacity have not been part of any of the existing collaborations.

Some collaborations with CSOs were set up by HRP's teams on an informal basis without a legal framework formalizing the commitments of the parties involved. In some instances, this has led to unclear roles and responsibilities and lack of accountability, which could challenge successful collaborations. No monitoring and evaluation framework has been put in place to assess the extent to which each of the collaborations has met the objectives. Nor is there any post-ante evaluation of the Programme's achievement and value for money provided.

Some difficulties were experienced in gaining access to updated financial information regarding the collaborations identified and reviewed, in particular regarding the collection of royalties. Therefore, it was not possible to assess value for money of the different collaborations.

HRP is currently raising funds through the royalties received on the basis on the commercialization of new products or technologies resulting from the research projects conducted in collaboration with the private sector or civil society. However, HRP is considering raising additional funds through new innovative mechanisms, particularly in collaboration with the private sector, which would entail the production and marketing of goods featuring images of HRP initiatives. However, these types of collaborations go beyond the core mandate of HRP and WHO, and may thus not be eligible within the current HRP structure.



Recommendations

- To strengthen engagement with the private sector and civil society, HRP needs to develop a clear vision, accompanied by a detailed strategic plan to realize it. This vision and strategy should stipulate HRP's specific goals for engagement with the private sector and civil society. A beginning point could be a concept paper for further discussion.
- HRP should agree on a set of criteria for selection of the type of collaborations that would best serve its needs, and in order to assess new opportunities. A more structured process would increase transparency and accountability.
- In order to become a key platform for sharing best practices, evidence and cost-effective interventions, HRP should strive to develop and strengthen a sense of community among all stakeholders dedicated to research on human reproduction, by convening an annual global meeting on reproductive health, in collaboration with interested parties from the private sector and civil society. Moreover, to better meet the needs of the private sector and civil society, and in order to promote and ensure easy and wide access to best practices, HRP should consider further developing the existing web site to make it a live web platform (e-discussion and social media).
- In order to facilitate and further leverage relations with CSOs, particularly with the international NGOs, HRP should appoint an individual to act as a focal point, and who would work closely with the Programme director. In addition, HRP should also consider the possibility of adopting framework agreements with these organizations.
- To better monitor the engagement with private and civil society, HRP should also consider the possibility of adopting a performance framework when engaging with the private sector and civil society (objectives, indicators and targets). As a first step towards this, HRP should start gathering all financial and nonfinancial information regarding the existing collaborations.
- Alternative options regarding the best structure to achieve HRP's strategic goals related to the private sector and civil society may be explored through a feasibility study. However, for research projects, HRP should continue directly to engage with the private sector and civil society through its current mandate and executing agency (WHO).
- When products or technologies resulting from the research projects are proven to be effective for use in the field, and can be commercialized by a private-sector collaborating party, HRP should make sure that royalties are properly negotiated and that funds received are properly monitored and reinvested.
- If the collaborating party is a CSO entering into commercial agreements with the private sector for the production and commercialization of a new product or technology, HRP needs to ensure that the collaborative agreement provides for public sector pricing to ensure availability of new products or technology in low- and middle-income countries; and ensures a fair compensation is received, based on the investment made for development of the new product or technology.

8 Summary of major conclusions and recommendations



8.1 General conclusions

- HRP continues to ensure its relevance by being the unique global resource that generates the research findings, synthesizes the evidence and develops the products to support policy formulation and programme strengthening to improve SRH. HRP's outputs continue to be consistent with its overall goals and objectives. It continues to provide global leadership on sensitive SRH issues, and it continues to generate global public health goods of the highest quality and utility.
- The Programme continues to demonstrate its comparative advantage through its ground-breaking work in areas such as unsafe abortion, adolescent SRH and violence against women. The value of its guidance is maximized by its neutrality, inclusiveness, convening ability and position in WHO.
- HRP continues to be the gold standard for developing, monitoring and updating evidence-based norms and standards. These are the key reference materials used by governments to guide SRH policies, strategies, programmes and clinical practice.
- The Programme continues to play a vital role in the monitoring and assessment of global trends in SRH. These outputs are widely used for evidence-based advocacy and monitoring progress on national and global SRH targets.
- The Programme's products are in use in over 130 countries.
- Objective indicators of HRP's research performance are significantly above world averages and clearly reflect high-quality research, and research that is well regarded among the international research community.
- The Programme has continued to manage its financial resources in an efficient and effective manner, and should be commended on its resource-mobilization efforts during a period of global financial constraint. Governance costs have been reduced, but overall funds available for research have declined as a result of escalating overhead costs.
- HRP's cosponsorship and governance mechanisms are considered robust and efficient, but have clear scope to improve their effectiveness.
- The case-studies in the external evaluation demonstrate that HRP is highly effective in strengthening research capacity in individual countries and continues to generate global public health goods of the highest quality and utility. In view of the underuse of several life-saving SRH interventions in low- and middle-income countries, a strengthened focus on large-scale implementation research studies, whose findings will be generalizable to many countries, is recommended. The Programme should further explore how to strengthen its engagement with the private sector and civil society.

8.2 Recommendations



8.2.1 Results

- For future biennia, starting in 2014–2015, HRP should develop a new results framework which, in addition to a simplified approach to quantifying outputs, should identify and monitor utilization of its products in programme countries, and, wherever possible, identify their potential and/or actual impact.
- The Programme should commission a periodic review of the utilization of its products in programme countries, and estimates of their potential or actual impact. Such a review will demonstrate the value of investing in HRP and thus further strengthen its fundraising ability.
- HRP needs to clearly identify in its reporting mechanisms the results it achieves, as distinct from the results achieved by PDRH.
- In future reporting, HRP should distinguish between peer-reviewed articles generated through its global agenda, and those generated from research-capacity strengthening activities. This would provide more transparency and permit a greater understanding of the impact of the Programme's work at both global and regional levels.

8.2.2 Research

- For its major areas of work, the Programme needs to develop mechanisms for identifying research needs and priorities, as well as planning and monitoring research studies, utilizing external expertise.
- HRP needs to strengthen and take a more uniform approach to its priority-setting process, in order to identify those key research questions and knowledge gaps in SRH that are most likely to have an impact in programme countries. Criteria should include: a priority issue for countries furthest from the MDGs and other global targets; likely impact; implementability; sustainability; practicality; cost; risk; comparative advantage of HRP; and lead time.
- For HRP to maximize its potential impact, it needs to strengthen its focus on research questions that will benefit the least developed countries and those furthest from the MDG targets, and, wherever possible, on undertaking this research in these countries. All proposed work should include a clear statement of how it contributes directly or indirectly to the achievement of MDG targets 4, 5 and 6 or any post-2015 global targets. This statement should be used by STAG as a major indicator of the relevance of the proposed research.
- In its overall programme of work, HRP should consider giving higher priority to implementation research, research on adolescents and research on the social determinants of SRH.
- The Programme should renegotiate its relationship with regard to the overlapping functions that exist between RP2 and ERC. Ideally, a way needs to be found for WHO senior management to entrust the ethical review of HRP's research to RP2. This will most likely require a number of actions, including investment in a more robust RP2 database with support for data management, and application by RP2 for FWA-OHRP accreditation (Federal Wide Assurance for the Protection of Human Subjects – Office for Human Research Protections Database), which would include a system of periodic external reviews of RP2.

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- In order to gain further efficiencies, the Programme may need to re-examine the balance between the proportion of research being done by programme staff and the proportion being managed by programme staff but implemented by outside institutions.
- The Programme needs to continue to increase the level of involvement of researchers from programme countries.
- When submitting research proposals to RP2 for final assessment and approval, programme staff should ensure that the proposals are complete and conform to the required technical and scientific standards.
- In addition to the regular annual review of ongoing research proposals, programme staff should consult RP2 at any point after a research proposal has been approved, if any scientific, technical, ethical or management issues arise during the lifetime of the project until its completion.
- HRP should consider developing an e-platform to enable organizations engaged in research on SRH to share information on their current work and future plans.
- There is a need for a more formal mechanism for coordination of research between HRP and MCA, particularly in the areas of maternal and perinatal research, and research on adolescent SRH; and between HRP and TDR on implementation research.

8.2.3 Finance

- All donors to HRP should reflect on the importance of providing the Programme with undesignated funding, and, wherever possible, provide such funding on a multiyear basis. Where this is not possible, the current practice of providing designated funds for specific items of HRP's already approved workplan and budget should continue. The Programme should explore the possibility of additional funding from new foundations located outside the United States of America (USA).
- HRP needs to continue to build on the success of its resource-mobilization work and strengthen it further by demonstrating and communicating the utilization of its products in programme countries, their potential impact, and how this helps the achievement of global targets in SRH.

8.2.4 Communication and utilization

- There is a need for HRP to develop and invest in a new communication strategy, which explores innovative ways of packaging and disseminating HRP's research findings and other products for use in strengthening national SRH policies and programmes. The strategy should consider the role of knowledge intermediaries and gatekeepers of change, and that different products will require very different approaches. Subsequent communication workplans should identify clear deliverables and associated indicators.

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- HRP needs to develop, invest in, and implement a strategy for the utilization of its key products in a limited number of countries, to demonstrate their potential or actual impact, and to thereby leverage and guide use of the funds of national governments, cosponsors, bilateral agencies, CSOs, foundations and others, in their support to national SRH programmes.
- The PCC will need to provide guidance on the source of funding for HRP's communication and utilization work.
- HRP donors and cosponsors need to review and strengthen their systems and processes for utilizing HRP's products in their own programmes of development assistance.

8.2.5 Governance and cosponsorship

- HRP and the cosponsors need to strengthen their engagement, developing clear plans and mechanisms to use the programmatic experience and networks of the cosponsors to help identify key research questions and needs for policy, programmatic and technical guidance, and to use their programmes and networks to promote and expand the use of HRP's products in countries. A progress report should be presented to PCC after 2 years. The Programme should, somewhat cautiously, explore additional cosponsors.
- PCC needs to ensure that its agenda gives sufficient space for the discussion of policy, strategic and financial issues central to the well-being, growth and development of the Programme, as well as receiving reports on progress, outcomes and impact.
- PCC may wish to consider adding an agenda item every other year that would provide an opportunity for donors, cosponsors and programme countries to report on their use of the Programme's products.
- PCC may wish to consider a number of different options for STAG, including the following: STAG could revert to its original function as the scientific and technical review body for HRP, and could receive and review a report only on the overall work of PDRH on a biennial basis; STAG could undertake in-depth reviews, perhaps in alternate years, of two to three of the main areas of the Programme's work; in other years, it could focus on more strategic, policy and forward-looking issues, as well as reviewing and advising on overall workplans and budgets.
- HRP should examine the feasibility of merging GAP into STAG. This would require ensuring that STAG maintains adequate gender and sexual and reproductive health rights expertise; carries out biennial reviews of HRP's full programme of work from a gender and rights perspective; and commissions an independent review of its approach to gender and human rights after 5 years.
- The Programme should consider periodically holding a PCC meeting outside Geneva, but only after prenegotiating a cost-sharing agreement with the host government.



8.3 Final conclusions

The HRP team in Geneva, though relatively small, is highly impressive in its capacity to identify and coordinate a large network of investigators, collaborators and experts, from academic and research institutions all over the world, capable of addressing and developing long-term solutions to global SRH challenges.

In the period 2008–2012, the Programme continued to produce many important global public goods in the area of SRH. This was largely due to three factors: the dedication and excellence of its staff; the leadership and determination of its directors in making the necessary decisions to ensure that HRP continued to move forward; and its fundamentally sound governance and technical oversight systems.

By helping to lead and guide global developments in SRH, and then adapting to the changing environment, HRP continues to demonstrate that its business model is robust, and that its work remains highly relevant to the needs of programme countries.

Annex 1: Abbreviated terms of reference for the 2008–2012 external evaluation of HRP

Proposal for HRP external evaluation 2008–2012 (to be presented in June 2013)

The 2008–2012 HRP external evaluation will aim to provide information on (1) the relevance and fulfilment of HRP's objectives; (2) its efficiency and effectiveness; (3) its comparative advantage; and (4) the impact and sustainability of its work. In doing so, it will provide information that is credible and will enable the continued incorporation of lessons learnt into the decision-making process of both the Special Programme and its constituents.

In view of the positive feedback received from PCC on the process followed in the previous evaluation, it is proposed to follow a similar process in 2012–2013, in order to examine in depth a number of the critical programme areas and outputs that have not been examined recently.

Method of work

It is envisaged that the external evaluation report would consist of an introductory, overview chapter followed by seven chapters that would provide in-depth studies of the selected topics. The introductory chapter would give the background to the Programme as well as a brief overall assessment of the Programme's contribution to global public good as it relates to sexual and reproductive health and rights (SRHR). It would also evaluate the Programme's *modus operandi*, including its governance and the consultative mechanisms it employs for defining and prioritizing its work programmes and for the scientific and ethical review of planned, ongoing and completed activities. Furthermore, it would also describe the overall frame of reference that the Programme uses in pursuing its mission and vision, and thus would address such issues as the UN Secretary-General's *Global strategy for women's and children's health*, the Millennium Development Goals, including

poverty reduction, the Global reproductive health strategy, and the means by which it collects, manages and applies evidence to improve sexual and reproductive health in countries. The chapter would specifically address the following issues:

1. a brief overall assessment of the Programme's contribution to global public good, as well as its comparative advantage, as it relates to SRHR, in terms of its mandate, *modus operandi* and output. This assessment will include considerations on the uptake and utilization of HRP guidance, tools and strategic approaches:
 - does HRP continue to provide leadership on SRHR global health matters and to be important to the international community, to low-, middle- and high-income countries?
 - does it address key SRHR issues that will not typically be adequately addressed by individual countries or entities acting alone?
 - does it shape the SRHR-HIV research agenda, reflecting key programmatic and policy questions and needs?
 - does it set norms and standards, and articulate evidence-based policy and practices at the national and global levels?
 - does it monitor and assess effectively reproductive health trends, and conduct important evaluation?
 - does it identify, promote and evaluate innovative strategies and technologies?
 - does it communicate effectively within and beyond WHO?

The in-depth studies will focus on the following areas of major interest in relation to the Programme's mandate and plan of work:

2. overall efficiency and effectiveness of HRP's governance, management and administration;



3. evidence generation and synthesis to improve family planning, prevent unsafe abortion and prevent and control sexually transmitted and reproductive tract infections;
4. research-capacity strengthening and network building;
5. strengthening implementation research;
6. the status of and opportunities for strengthening engagement with the private sector and civil society.

For more information, please contact:

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