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Special Programme of Research, Development and
Research Training in Human Reproduction (HRP)

Follow-up on governance, management, administration and efficiency: a case-study

Reviewers

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Executive summary

Objectives and methods

The aim of this case-study is to assess progress on implementing the recommendations of the previous external evaluation of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) with regard to governance. Both document reviews and interviews with various stakeholders were used to collect information.

Findings

Implementation of recommendations of previous external evaluation

HRP has responded well to the recommendations of the previous evaluation, creating a task force for that purpose. Adequate, rapid action was taken, and the transparent reporting to HRP's Policy and Coordination Committee (PCC) was remarkable. Much progress has been made following up on the conclusions and recommendations of the previous external evaluation. A main finding of this case-study is that many of the weaknesses have been addressed and a number of problems solved.

Funding base

The most notable positive change is the much improved financial situation of the Programme in 2007, including greater diversity of income sources. HRP designed resource mobilization strategies that attracted new funding, and several existing donors increased their financial contributions. Income from country donors increased considerably. While new foundations are supporting HRP's work, overall their share has decreased. After a period of significant funding shortages, the income for the 2006–2007 biennium is greater than the budget, allowing the Programme to cover all three levels of priorities.

Advocacy

HRP has strengthened collaboration with its partners in advocating for implementation of the agenda of the International Conference on Population and Development (Cairo, 1994) and a greater role for sexual and reproductive health in achieving the Millennium Development Goals (MDGs), thus contributing to integration of a new reproductive health target under MDG5.

WHO and Programme management

When WHO urged bilateral donors to shift from earmarking funds for projects and programmes, such as HRP, to core funding, the Programme suffered a significant loss of income. As a result, the United Kingdom, one of the most important bilateral donors to the Programme, reverted to earmarked funding. Under the new WHO leadership and in view of structural and administrative changes within the Organization, HRP is in a stronger position and is better integrated into WHO in 2007–2008 than in 2002. Strengthening collaboration between HRP at headquarters and WHO at country level remains an area for improvement, as found in 2003. Decentralization is progressing, albeit at a slow pace. Ultimately, it may prove not to be a crucial goal for a global programme such as HRP. Measures have been introduced to improve the efficiency of governance committees and to accelerate grant processing; however, while these measures are useful, the tangible, objectively verifiable effect on efficiency remains limited.

Cosponsorship

Cosponsorship has remained similar to that in 2002–2003. UNDP did not make donations to the Programme during the period evaluated. Current efforts for 'one United Nations' at country

level represent an opportunity for revitalizing cosponsorship, strengthening HRP's efforts to translate research into policy and practice and advocating for greater emphasis on sexual and reproductive health for achieving the MDGs.

Benchmarks, monitoring and evaluation

HRP's reporting on benchmarks shows that the Programme is progressing well towards the main indicators guiding its work. The serious funding shortage during 2002–2006, however, reduced the number of completed research projects, as these are costly, long-term and recover only slowly from a financial crisis. At the same time, increased demand for evidence-based guidance led to a higher output of systematic reviews by HRP. Nevertheless, the current monitoring system remains complex, and various areas of work lack clear indicators of outcome and impact, making it difficult to evaluate progress. HRP has a longstanding culture of regularly submitting the Programme to external evaluations.

Comparison to TDR's governance

The UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) and HRP are the two cosponsored research programmes hosted and executed by WHO. As the governance of the two programmes has many similarities, synergies and exchanges of information between them could be strengthened in view of continuous improvement of HRP's governance, while maintaining the Programme's links with the Programme Development in Reproductive Health (PDRH) component of the Department of Reproductive Health and Research (RHR)[1] in WHO. Similar to TDR, a major remaining challenge to HRP's governance is the limited contribution of beneficiary countries (categories 2 and 3) to discussions by the Policy and Coordination Committee on matters relevant to HRP's operation and progress on technical issues. This report presents suggestions additional to those already envisaged by HRP.

1. The Department of Reproductive Health and Research (RHR) inlucdes HRP and a component concerned with programmatic work in sexual and reproductive health (PDRH).

Selected conclusions

- HRP responded actively to the recommendations of the 1990–2002 external evaluation.
- The Programme's financial position has improved significantly after several years of serious funding shortages.
- Cosponsorship was maintained, remaining similar to the situation in 2002–2003. UNDP has become actively engaged in the work of HRP but has not yet resumed financial contributions.
- Incorporation of sexual and reproductive health into MDG5 received effective support from HRP and cosponsors including UNFPA, UNDP (within the context of the Millennium Project) and WHO.
- HRP's benchmarks were achieved or good progress was being made, except during the period of funding shortfalls.
- The monitoring system remains complex, and various areas lack clear indicators of outcome and impact.
- Decentralized grants management resulted in more local ownership but might have slowed the process.
- There is good potential for exchanges of information and mutual learning between HRP and TDR, the two WHO cosponsored programmes.
- Beneficiary country members should become more active participants in meetings of the

Policy and Coordination Committee. HRP has plans for improving their participation.

Selected recommendations for improving HRP governance

- Explore whether membership on the Policy and Coordination Committee could be expanded to include not only countries that contribute financially and cosponsors but also partners from multilateral organizations and selected foundations.
- Link HRP activities at global and country levels to the country programmes of cosponsors and bilateral agencies through sexual and reproductive health advisers at WHO regional and country offices and local research institutions.
- In the short term, maintain and increase earmarked funding from donor countries. In the long term, WHO must credibly demonstrate to donors that shifting to core voluntary funding will not result in loss of income to HRP and that WHO will ensure predictable, sustained financial support.
- Explore better alternative systems for grant application, processing, monitoring and management.
- Ask WHO's Research Ethics Review Committee (ERC) to delegate responsibility for ethical review of HRP's research to its Scientific and Ethical Review Group (SERG), and to designate SERG as a subcommittee of ERC.
- Strengthen the capacity for developing proposals, writing reports and conducting research on sexual and reproductive health at decentralized levels and systematically involve Regional Advisory Panels (RAPs) and area managers from the beginning.
- The Directors of TDR and HRP should meet formally and regularly to exchange experiences and ideas on governance.
- Develop a strategy and guidelines for greater involvement of categories 2 and 3 members in the deliberations of the Policy and Coordination Committee.
- In line with the new strategic framework of WHO and the related monitoring framework, find indicators, including impact measures, for various areas of work to allow evaluation of the Programme against baselines and set targets.
- Consider creating a monitoring and evaluation position or obtain temporary expert support to strengthen the monitoring framework and the collection and presentation of data to report more efficiently on the Programme's performance to partners, cosponsors and donors.
- Give the Programme a new name for clear recognition and public relations.

Introduction

The previous external evaluation (covering the period 1990–2003) made recommendations concerning governance, management, administration and efficiency. The main recommendations for action were (for complete text, see final report):

- Revitalize cosponsorship.
- Expand and diversify the active funding base, including foundations, public–private partnerships, government institutions and revenue from products.
- Increase the efficiency of governance committees by reducing the numbers of meetings and participants and combining functions, where possible.
- Strengthen Regional Advisory Panels, and encourage more direct involvement of reproductive health staff in regional offices.
- Members of HRP's advisory bodies, particularly the Policy and Coordination Committee and the Scientific and Technical Advisory Group, should advocate more for sexual and reproductive health at global events.
- Explore decentralization of some administration and monitoring to regional and country levels.
- Revise the procedures for grants processing to make them more efficient and rapid.
- Increase exchanges, involvement and collaboration between HRP staff and other staff at WHO headquarters and regional and country offices. Regional directors, their staff and country offices should have a stronger role in supporting HRP and strengthening partnerships at all levels of WHO in support of human reproduction and related research.

The aim of this case-study on governance, in line with the terms of reference of this external evaluation, is to document progress, comment on follow-up actions and highlight other main issues that might have arisen, focusing mainly on governance. The evaluators assessed the extent to which HRP implemented the 'On-going or proposed follow-up actions and possible solutions' in the 'Follow-up actions to the external evaluation of HRP for 1990–2002', presented to the Policy and Coordination Committee, 30 June–1 July 2004.

Methods

Document review, semi-structured face-to-face and telephone interviews conducted by Claudia Kessler and Douglas Huber, and a small e-mail survey among category 2[2] members of the Policy and Coordination Committee were used to collect information. Annex 1 shows the interview instrument with the leading questions used; the list of respondents is given in Annex 2. The main groups of respondents and the numbers of persons interviewed were:

- HRP secretariat and other staff at WHO headquarters (7);
- chairpersons of Regional Advisory Panels (RAPs) (3);
- chairpersons of the Scientific and Ethical Review Group (SERG), the Scientific and Technical Advisory Group (STAG), the Policy and Coordination Committee (PCC) and the Gender and Rights Advisory Panel (GAP) (4);
- representatives of cosponsors (6, including WHO);
- representatives of bilateral donors (4);
- representatives of donor foundations (2);
- representatives of category 2 members of the Policy and Coordination Committee (beneficiary countries) (3);
- representatives of WHO regional offices (1); and
- the Director of TDR and Manager, WHO External Relations and Governing Bodies.

Despite several attempts, the evaluators did not succeed in interviewing additional respondents from foundations, WHO regional offices and RAPs, as planned. To include the views and suggestions of the country representatives concerned, the evaluators conducted a small e-mail survey among categories 2 and 3 members of the Policy and Coordination Committee. On the basis of the list of participants in the 2007 meeting of the Committee, a one-page questionnaire was sent to 19 country representatives. Despite two reminders, only three completed the questionnaires. Although a quantitative evaluation could not be done, the answers provided valuable qualitative information. In the 2003 external evaluation, 249 respondents provided detailed information at interviews and an e-mail survey, representing a substantial sample of stakeholders who addressed governance questions.

Transcripts of most of the interviews were sent to the respondents for correction and validation. On the basis of the sources of information and our experience with the previous evaluation, we weighed and selected the most representative views and made recommendations.

2. Category 2: beneficiary countries selected by WHO regional committees; category 3: other interested partners, currently composed of beneficiary countries.

Main findings and recommendations

3.1 Cosponsorship

HRP is structured on the basis of cosponsorship. UNDP, UNFPA, WHO and the World Bank have been the four cosponsoring partners since 1988. At the time of the last evaluation, it was of particular concern that UNDP had not been an active cosponsor since 1996, neither financially nor in technical and governance exchanges. HRP's cosponsorship agreement, as defined in the Memorandum of Understanding, is an expression of commitment by the cosponsors rather than a legally binding contract.

In accordance with the recommendations of the previous evaluation, HRP published a brochure entitled *Improving sexual and reproductive health through research: an investment for the future*, which highlights the benefits of investing in the Programme. To reinforce this message, regular meetings, including at high levels, have been held with the cosponsors. These helped in addressing one of the challenges with which HRP is confronted. Maintaining the awareness and commitment of the cosponsors in a context of frequent staff rotation requires continuous and repeated contact.

The cosponsored structure has been maintained and has gained in importance with recent efforts towards 'one United Nations' at country level. Cosponsoring of the Programme helped the United Kingdom to make a case for returning to earmarked funding, as 'HRP is not just WHO'. (see Annex 3)

Despite continuous effort and repeated high-level contacts, the Programme has not succeeded in obtaining funds from UNDP. UNDP has, however, been represented at the two previous meetings of the Policy and Coordination Committee and the meetings of the Standing Committee, one of which they hosted. This is perceived as a positive sign, and the recent setting-up of a formal HRP focal point within the MDG team at UNDP in New York is also promising. There has been good collaboration between UNDP and HRP in integrating the targets of the International Conference on Population and Development (Cairo, 1994) into MDG5. Other cosponsors understand that health is not a priority for UNDP, but, in view of the importance of sexual and reproductive health in achieving the MDGs and HRP's work in the field of HIV and AIDS, the other cosponsors would like to engage UNDP fully, including financial contributions. HRP's work is seen to contribute to MDGs 3–6 and also to MDGs 1, 2 and 8. The MDGs are an opportunity for engaging the cosponsors further.

UNDP is also a cosponsor of TDR and, similarly, does not contribute financially to that Programme. The views of respondents were divided about whether UNDP should remain a cosponsor of HRP when it does not contribute financially. While some clearly saw funding as a prerequisite for being a cosponsor, others, including the HRP secretariat, saw the value of maintaining UNDP as part of the group, even in the absence of funding. UNDP helps in advocating for HRP and sexual and reproductive health, promoting a stronger link between sexual and reproductive health and HIV/AIDS. Furthermore, UNDP has a lead role in coordinating programme implementation of United Nations organizations at country level. UNDP recently commissioned an evaluation of its partnerships. Owing to a change in the division director, the results are not yet published. The HRP secretariat hopes, however, that a favourable decision might be taken with regard to funding.

To make HRP more relevant to cosponsors, some respondents considered that it should provide more field support, including linkage with country programmes.

HRP has not succeeded in attracting new cosponsors. The secretariat has, however, attempted to identify potential partners:

- *UNICEF*: There are natural, strong links between HRP's work and UNICEF's 'Healthy timing and spacing of pregnancy' initiative and improved child survival. The other cosponsors have urged direct collaboration between HRP and UNICEF (even in the absence of cosponsorship) in emphasizing birth intervals of 3 years or more for improved child health outcomes as well as reduced maternal morbidity and mortality. Although UNICEF is a cosponsor of TDR, the strong influence of the USA on the agency and political sensitivities around issues related to sexual and reproductive health and abortion will make UNICEF an unlikely funding partner for HRP.
- *UNAIDS* is itself a cosponsored programme, WHO being one of the cosponsors. It is not clear yet how UNAIDS could become a cosponsor of HRP.
- *Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM):* HRP has approached the Fund formally and organized technical presentations. According to the regulations, United Nations agencies cannot benefit from GFATM funding, and WHO staff cannot participate in its Technical Review Panel. HRP has, however, repeatedly provided support to Member States in preparing proposals to the Global Fund, despite not receiving financial support from the Fund for such capacity-building efforts. HRP and RHR staff have been involved in encouraging the Fund to accept and encourage proposals that include links between sexual and reproductive health and HIV/AIDS in Round 7.

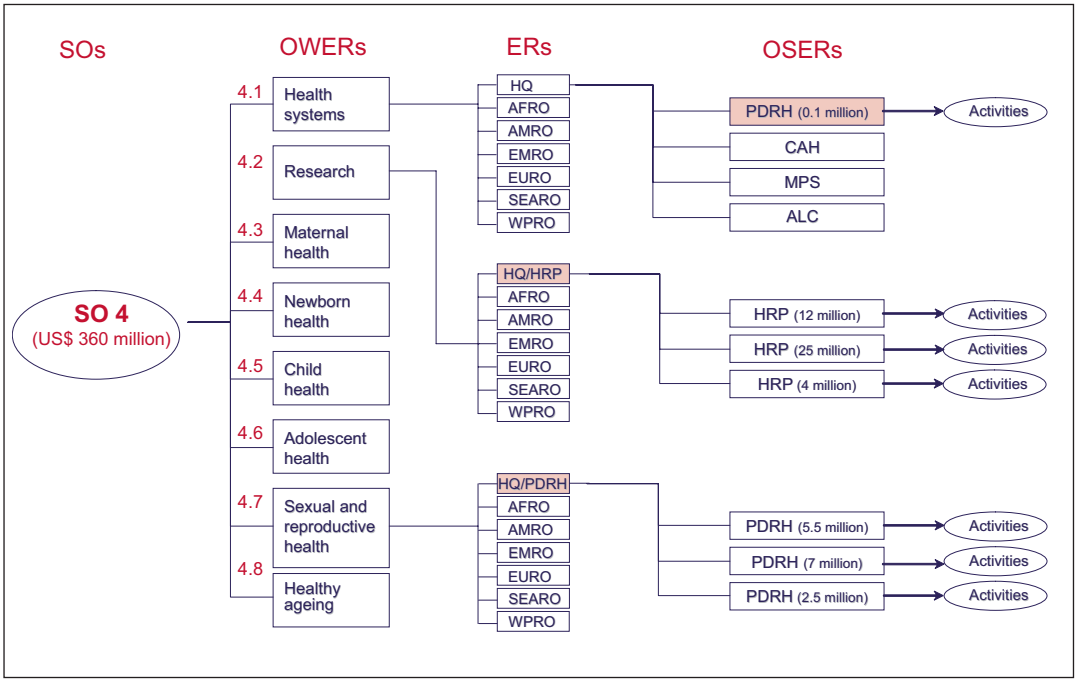
There is concern among some of the major country donors and cosponsors that WHO's own contribution to the Programme is stagnating. One cosponsor stated that HRP has been a "step child of WHO far too long". Respondents considered that WHO should provide sustained, predictable financial support to the Programme, irrespective of what other cosponsors and donors do. Another cosponsor welcomed the stronger institutional commitment of WHO to the Programme under its new leadership, as confirmed by the HRP secretariat. The HRP Trust Fund is a clearly identified budget entity in the WHO Programme Budget 2008–2009, which, according to the HRP secretariat, gives it a better status as compared to other WHO partnerships. Having the Trust Fund as an identified budget entity facilitates earmarking by donors. In WHO's Medium-term Strategic Plan 2008–2013, which contains 13 strategic objectives, about 90% of HRP's work is reflected in strategic objective 4, while the work of TDR, for example, is split between two strategic objectives (Figure 1).

3.1.1 Conclusions and recommendations

Conclusions

- HRP responded to the recommendations of the 2003 evaluation to maintain and revitalize its cosponsorship status and to obtain additional funding. Cosponsorship was maintained, although limited success was achieved in revitalization. Contacts with possible additional cosponsors were initiated, and the collaborative potential explored.
- HRP worked to engage its cosponsors, especially UNDP. It interacted technically and collaborated with UNDP in introducing the new reproductive health target into the MDGs, a major achievement. The partnership with UNDP provides important collaborative value to HRP even in the absence of a financial contribution.
- WHO commitment to the Programme was ambivalent before the present Director-

Figure 1. WHO's Programme Budget 2008–2009



General came into office. While the financial commitment of WHO remains relatively stable, the reallocation of important donor country contributions away from HRP during the phase of core funding left the impression that WHO's commitment to the Programme was weak at that time. Under the new Director-General, WHO's commitment to the Programme is more visible to cosponsors and donors, a development that is appreciated by the latter.

- The move to act as 'one United Nations' represents a window of opportunity for revitalizing cosponsorship of HRP.

Recommendations

- Intensify efforts to ensure broad institutional commitment, beyond the individual level, both within WHO and from the other cosponsors. High-level meetings are a good step in this direction.
- Obtain a commitment from WHO for predictable funding for HRP, to avoid the sudden declines experienced in the past and the impression of ambivalent support for the Programme.
- The Programme should not be pushed much further to identify new multilateral cosponsors. Unless cosponsorship is considered likely, efforts should be focused on maintaining the commitment of existing cosponsors and winning a financial contribution from UNDP.
- Explore whether membership on the Policy and Coordination Committee could be expanded to include partners from multilateral organizations and selected foundations. This might require a modification of the Memorandum of Understanding.
- HRP activities at global and country levels should be linked more strongly to the country programmes of cosponsors and bilateral donors, through advisers on sexual and reproductive health at WHO regional and country offices and local research institutions.

3.2 Funding base

3.2.1 Income

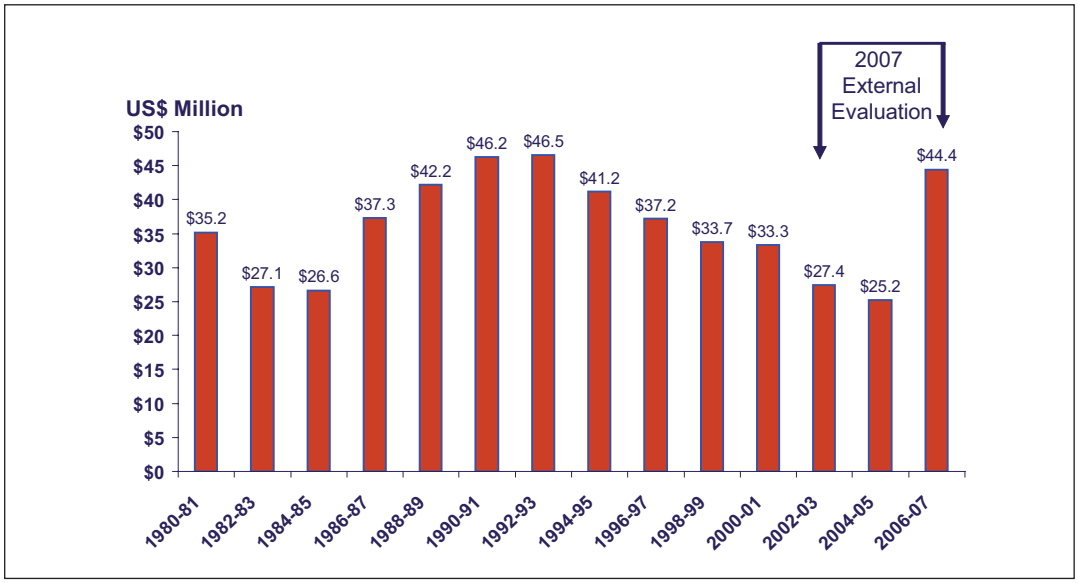
HRP went through an extremely difficult financial situation in 2002–2005, the effects of which were felt well into 2006. Reinstatement of the "global gag rule" also affected United States funding to HRP from 2002, although the United States Government remains a donor to RHR. The loss of United States funding coincided with the decision of WHO to move towards core funding or 'flexifunds'. These are unspecified, un-earmarked, voluntary contributions made by Member States to WHO, which are allocated among WHO programmes at the discretion of the Director-General. WHO worked hard to convince more governments to give flexifunds in place of the traditional earmarked voluntary contributions. The effect on HRP's income is illustrated in Annex 3, with the example of the contributions of the United Kingdom. As requested by WHO, the United Kingdom shifted from earmarked funding to flexifunds in the late 1990s, resulting in a major diversion of its funding from HRP. Peak funding of £ 3 000 000 annually in 1992 diminished to £ 3000 in 2006. Similarly, funds were diverted from HRP when the Finnish Government shifted to flexifunding in 2007. In 2006, the United Kingdom returned to earmarking its contribution to HRP, and the resulting increase in funding was dramatic.

The Programme reacted to the difficult financial situation by intensifying resource mobilization. A full-time external relations officer was recruited in March 2005 for fundraising and for maintaining and establishing new contacts with donors and sponsors, a move welcomed by the stakeholders who were interviewed. That post is now a fixed-term position. Materials targeting donors were prepared, reporting on grants was made more efficient, and responsiveness to donors was improved. At the 2007 meeting of the Policy and Coordination Committee, it was reported that 21 foundations (9 in the USA and 12 in Europe) had been made aware of HRP, and three round tables were organized, resulting in overall donations from foundations of US$ 1 908 549 in 2006. A round-table discussion was held for 17 Geneva-based diplomatic missions in early 2007, in addition to nine briefings for Member States in 2006 (*Follow-up to Policy and Coordination Committee (19) recommendations, report to Policy and Coordination Committee 2007*). Additional round-table discussions were held with United States foundations in 2005, 2006 and 2007, at which HRP received invaluable support from some of its current bilateral and foundation donors.

In January 2007, HRP launched a resource mobilization strategy. Several respondents at foundations and cosponsors credit HRP with being exceptionally strategic and effective in terms of its administrative, technical and scientific approaches. One cosponsor stated that, "on a scale of 1–10, HRP rates a 7 or 8" in improving its financial situation. The sum of these efforts paid off remarkably well, as reflected in Figure 2. Annex 3 gives a detailed comparison of the levels and distribution of income by source for the biennium 2006–2007 as compared with 2000–2001.

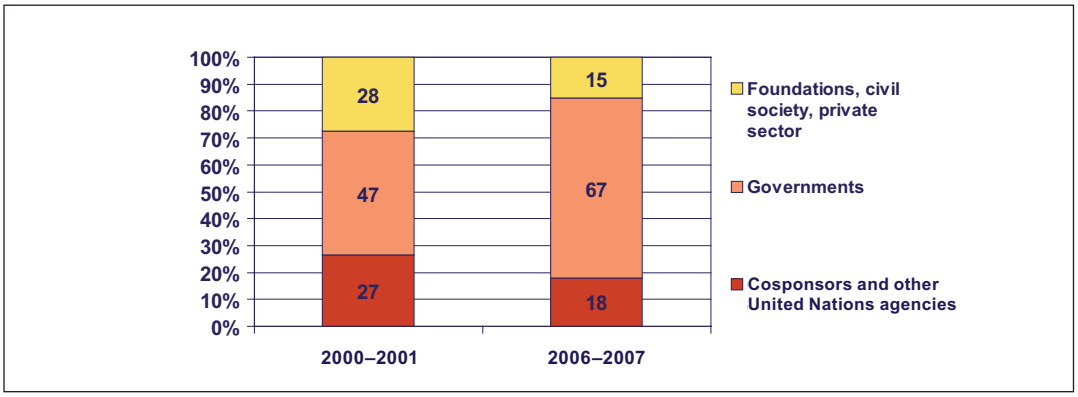
HRP was successful in attracting new donors, and several existing donors expanded their contributions to the Programme (Annex 3). In particular, the Programme succeeded in attracting three new country donors, namely France, Finland and the Flemish Government of Belgium, as well as new foundations. From 12 contributing countries in the baseline biennium, the group of country donors has expanded to 15. It is regrettable that HRP has so far not succeeded in bringing Germany back as a donor. The bulk of the additional funding, however, comes from increased support from existing bilateral and foundation donors.

Figure 2. Trends in HRP income between 1980 and 2007



The distribution of income from the major groups of donors has changed considerably over time: income from country donors increased from 47% in 2000–2001 to 67% in 2006–2007, and the share contributed by the cosponsors and other United Nations agencies decreased slightly, as shown in Figure 3. Income provided by foundations, civil society and the private sector dropped significantly, from 28% to 15%, due mainly to reduced funding from the Bill & Melinda Gates Foundation. In 1999, HRP received a 5-year grant of US$ 10 million. Currently the Foundation is devising a new strategy and it has been a less prominent supporter of the field of sexual and reproductive health in the past few years. As can be seen in Annex 3, other foundations significantly increased their financial contributions to the Programme. The respondents proposed that HRP review the new strategy of the Bill & Melinda Gates Foundation carefully and devise a plan to demonstrate the contribution and advantages of HRP's work to the strategy. Interviews with staff of other foundations revealed a willingness to work with HRP in identifying appropriate strategies for engaging

Figure 3. Distribution of HRP income by major donor group, 2000–2001 to 2006–2007



other foundations, including the Bill & Melinda Gates Foundation. This could be useful for HRP, in that networks of foundations providing support for sexual and reproductive health have close relationships and know each other's priorities.

One foundation supported HRP by funding the placement of two medical officers specialized in family planning from the University of North Carolina (USA) in RHR for a 2-year overlapping period. According to the HRP secretariat, this secondment has worked well and should be considered a valuable mechanism for supporting the Programme.

While the USA was the largest bilateral donor to HRP in 2000–2001, the Netherlands, Norway, Sweden and the United Kingdom led country donor support in 2006–2007 (for details, see Annex 3). The substantial increase in earmarked or direct funding to the Programme by these countries, and a doubling by Switzerland of its more modest contribution in 2007, reflect a commitment to global sexual and reproductive health of the donor community that supports HRP.

The current biennium also saw, for the first time, a contribution from an individual donor in the amount of US$ 100 000. In the near future, HRP plans to pay further attention to attracting funds from medium-sized foundations in Europe and the USA, individual donors and from Internet fund-raising.

The private commercial sector is still a minor contributor to HRP. HRP is the only WHO entity that earns income from royalties (see Annex 4.). This source of income has remained at less than 1% of the total since 2003, amounting to US$ 104 213 in 2006, with more funds from Gedeon Richter to come. In both absolute and relative terms, the income from this source has dropped as compared with 2002 and earlier. There are still two sources for royalty earnings: the collaboration with Gedeon Richter and income from statistical software used for analysis of cluster-randomized trials. The software was developed by HRP and is now marketed. The income from Gedeon Richter derives from trials conducted by HRP on the use and dosage of Escapelle® single-dose levonorgestrel for emergency contraception, whereby HRP receives royalties on sales in the private sector (only). HRP succeeded in negotiating a preferential price for resource-poor countries (around US$ 0.25 per packet for the public sector, as compared with US$ 40–50 in the private sector in the USA). While income from these sources remains insignificant, it shows that HRP can do work that meets private industry standards in terms of research and development, quality and efficiency. The Programme plans to explore the potential for future relations further, while respecting WHO guidelines and avoiding conflicts of interest. Some donor representatives welcomed small additional revenue from such sources, as long as the influence of corporate partners on HRP's strategic or technical work did not become too great, the administrative burden on the secretariat remained limited and conflicts of interest were avoided. HRP must remain neutral and should maintain an appropriate distance from the commercial sector in developing new products. Some respondents discouraged such revenue.

The bulk of HRP funding (93% in 2006) remains unspecified core funding. Only 7% (amounting to US$ 1.85 million from 16 sources in 2006) is designated funding, following the "conditions for acceptance of designated contributions". Most of these contributions come from foundations and civil society organizations.

3.2.2 Cash flow

In view of the greatly reduced income levels, managing the cash flow to avoid interruptions or delays in project implementation posed serious challenges to HRP during the period 2002–2006, and the programme of work suffered considerably as a result. Research contracts and grants had to be delayed; country visits for technical support and other Programme activities had to be cancelled. The cuts included activities at the 'priority 1' budget level, and 'priority 2' and 'priority 3' activities could not be implemented. The Programme was obliged to lay off staff and relied heavily on short-term personnel. The situation remained critical until well into 2007, when the financial position improved. HRP could report for the first time to the 2007 Policy and Coordination Committee an estimated biennium income that was higher than the budget, allowing it to cover projects at all three priority levels.

Figures 4 and 5 show the budget allocations for expenditure lines for the biennium 2006–2007, based on a total budget of US$ 38 798 000 for that period, and the trend in HRP's income versus approved budget over time.

As a result of the improved income situation and of a review of strategic development and competency by WHO in 2005, the staff composition of the department has changed considerably. While the overall number of staff at departmental level has decreased by 27 persons, there are more fixed-term positions (currently 92% of all staff), comprising a higher proportion of professional staff (currently 62%) as compared with general service staff (38%). Annex 5 gives details of the trends in departmental staffing. The changes at the level of the Programme were comparable to those at departmental level.

The move to more fixed-term contracts and a higher proportion of professional staff, as well as the weakening of the US dollar against the Swiss franc, led to cost increases. As the absolute number of staff was reduced, HRP managed to keep staff costs close to the ceiling set by the Policy and Coordination Committee in the 2006–2007 biennium.

3.2.3 Leveraged funding

HRP managed not only to attract funding directly for its own operations but also played a catalytic role by providing support to initiatives in sexual and reproductive health that are funded or implemented by HRP's partners. So-called 'leveraged funding' comprises projects in which HRP develops a partnership involving cost sharing or contributions in kind and those brokered in their entirety by another agency. A report presented to the Policy and Coordination Committee in 2007 (agenda item 8.3) contains the full list of collaborations involving leveraged funding, reflecting also the diversity of funding sources for these activities. Annex 6 shows the positive trend over the period evaluated. It should be stressed that any such assessment is based on estimates, and the total amount of HRP funds used for leveraging is quite small. In 2006–2007, about US$ 1 million generated US$ 4.7 million in leveraged funds, reflecting a ratio of HRP funding to leveraged funding of 1:4.7 in a total of 22 projects.

3.2.4 Conclusions and recommendations

Conclusions

- HRP's ability to function was compromised during the years of substantial funding cuts.
- HRP was creative and effective in reversing the downward trend in funding, and the Programme should be commended for these efforts.

- The investment in recruiting a full-time external relations officer for fund-raising and contacts has paid off and is highly appreciated by respondents and members of the Policy and Coordination Committee.
- For the first time in many years, HRP has reported an income for 2006–2007 that is higher than the budget, allowing HRP to cover priorities at all three levels.
- Country donors are providing an increasingly large proportion of HRP's budget. This should not encourage cosponsors to reduce their funding.
- HRP has leveraged funds for some of its projects, reflecting the interest of other

Figure 4. HRP financial implementation (expenditure) in 2006–2007, by budget sector

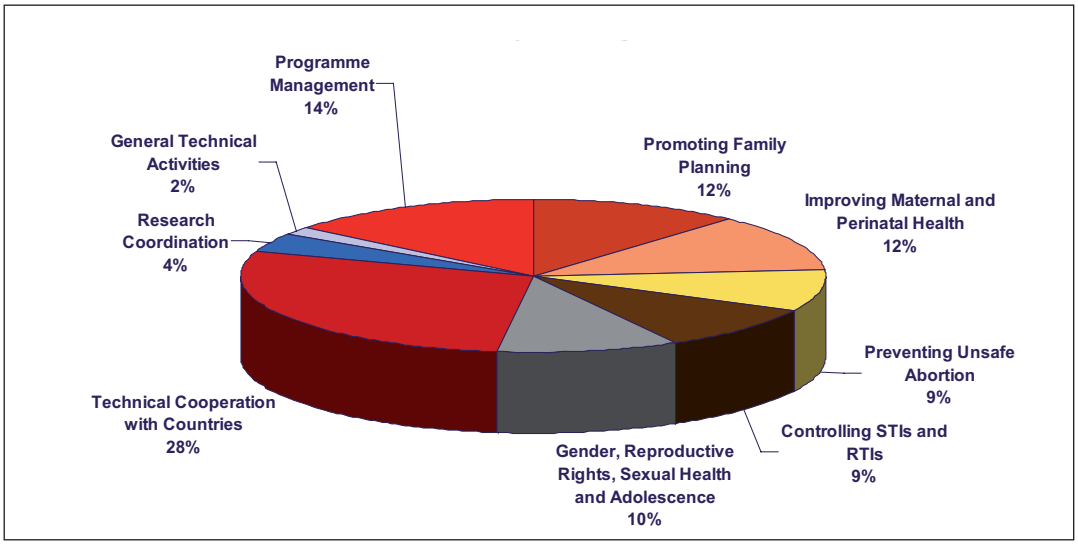
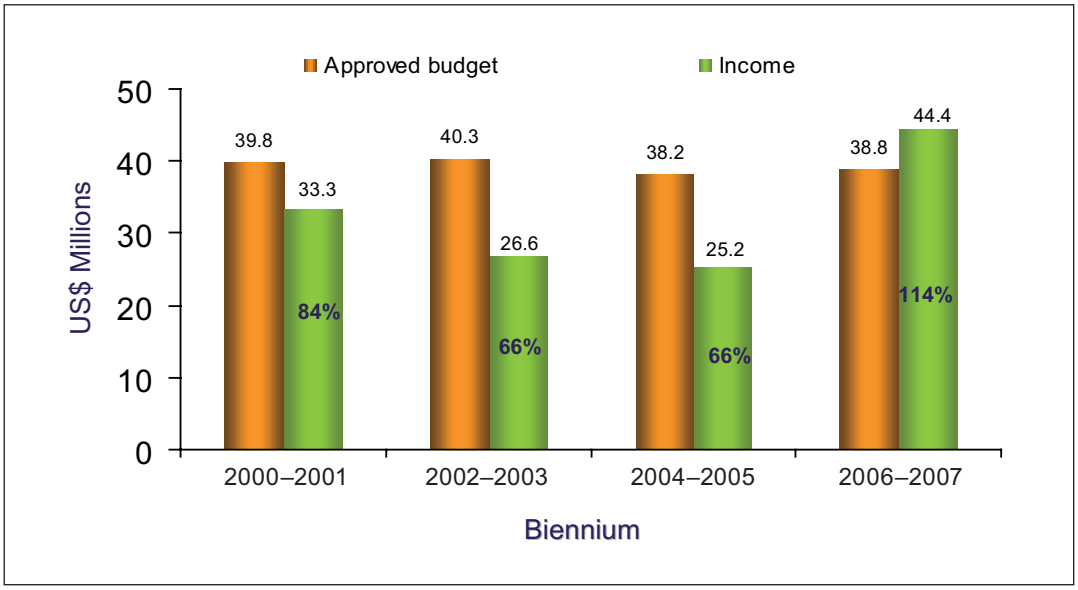


Figure 5. HRP income and approved budgets, 2000–2001, 2002–2003, 2004–2005 and 2006–2007



organizations, governments and institutions in working with HRP.

- HRP today works with a more appropriate, adequate staff composition, with a higher proportion of professional and fixed-term staff. Despite the increase in staff costs due to the weakening of the US dollar, HRP has stayed close to the cost ceiling fixed by the Policy and Coordination Committee.

Recommendations

- In the short term, continue to maintain and increase earmarked funding from donor countries. In the long term, WHO must credibly demonstrate to donors that shifting to core funding will not result in loss of income to HRP.
- Maintain caution in generating royalty funds, ensuring HRP's neutrality, objectivity and freedom from commercial pressures.
- Increase leveraged funds, given the strong interest of other institutions and governments in working with HRP.
- Continue external relations with foundations and other donors to secure funding.
- Collaborate with staff at donor foundations for developing approaches to other foundations.
- Position HRP well in view of the forthcoming new strategy of the Bill & Melinda Gates Foundation on sexual and reproductive health.

3.3 Advocacy by members of HRP's advisory bodies

The previous external evaluation recommended that members of the Policy and Coordination Committee, the Scientific and Technical Advisory Group and other advisory bodies of the Programme should take a stronger lead in advocating for the sexual and reproductive health agenda. This reflected the difficult context at the turn of the century, when the Cairo agenda came under attack by several stakeholder groups and HRP suffered severe funding cuts from the United States Government.

Respondents acknowledged that HRP has significantly contributed to placing sexual and reproductive health higher on the global agenda. The evidence generated by HRP helps inform donor countries' advocacy work. Members of the Policy and Coordination Committee are said to have easier access to scientific knowledge as well as to the global discourse on sexual and reproductive health. According to several respondents, when WHO makes an announcement or summarizes the evidence, it has more impact than any other institution in global health.

The research and advocacy of HRP in preventing unsafe abortion was highly valued by the respondents. For some of the United States foundations, the work of HRP in this field is one of the main reasons for donating to the Programme. One cosponsor mentioned the importance of recruiting a new director who is ready to defend the Programme's work in preventing unsafe abortion. HRP was admired for and encouraged by many of the respondents to "stay true and continue taking stands" in sensitive areas of public health importance.

The inclusion of new targets and indicators for sexual and reproductive health into the MDG monitoring framework is seen as a milestone, to which HRP contributed significantly. Publication of a series of articles in *The Lancet*, further described in the case-study on knowledge synthesis and transfer, was another achievement in terms of advocacy. HRP received support from its partners in these efforts, and cosponsors and bilateral donors worked closely with HRP in integrating the goals of the International Conference on

Population and Development (Cairo, 1994) into MDG5. They also helped HRP to organize round-table discussions for current and potential new donors and were active during WHO Executive Board meetings as well as during the International Federation of Gynecology and Obstetrics (FIGO) World Congress. Several bilateral donors to HRP have been instrumental in filling the 'decency gap' and supporting creation of a 'safe abortion action fund' by the International Planned Parenthood Federation. *The Lancet* articles are based on contributions from several members of the Scientific and Technical Advisory Group and the Policy and Coordination Committee, co-financed with extrabudgetary funds from bilateral and foundation donors and launched with partners' support, e.g. at the Global Forum for Health Research 2006.

One cosponsor urged that HRP take a stronger role in promoting the health components of the agenda of the 'one United Nations' family. This platform provides opportunities for raising awareness and building alliances for sexual and reproductive health. The United Nations family should be more responsive to the mandate reflected in the new reproductive health target in the MDGs, as well as the importance of sexual and reproductive health in achieving each of the MDGs. The cosponsored Programme itself is seen as a good example of attainment of MDG8, on forming critical partnerships for health and development.

3.3.1 Conclusions and recommendations

Conclusions

- Members of the Policy and Coordination Committee and the Scientific and Technical Advisory Group have contributed to advocacy, as recommended in the 2003 evaluation. In their own name, they have been active in defending the agenda of the International Conference on Population and Development (Cairo, 1994) and contributing to positive outcomes in the global policy debate. They have also collaborated with HRP by authoring and co-authoring important articles on sexual and reproductive health and family planning in leading journals.
- HRP research can increasingly be translated into policy and practice through the cosponsors as the 'one United Nations' concept becomes practice. To some extent, this is already happening, by the use of HRP and WHO statements as rationales for the positions of other cosponsors.
- Some donors support HRP because it takes a stand and provides sound scientific evidence on important sexual and reproductive health issues that others consider too sensitive for their agencies.
- Collaboration between HRP and its cosponsors, including UNFPA, UNDP (within the context of the Millennium Project) and WHO, contributed greatly to incorporation of sexual and reproductive health into MDG5.

Recommendations

- Collaborate with UNDP to expand efforts to include sexual and reproductive health in other MDGs and advocate for financial support for these elements.
- Explore how best to use the 'one United Nations' concept for advocating sexual and reproductive health, interacting with cosponsors, regional and country representatives and country-level research institutions.
- Support the new director of HRP in defending the agenda of the International Conference on Population and Development (Cairo, 1994), including a strong position on unsafe abortion.

- HRP and its cosponsors should take advantage of the growing acknowledgment that population growth and sexual and reproductive health, including family planning, are important in achieving all the MDGs. This provides an excellent opportunity for advocating for sexual and reproductive health and for expanding HRP's (and the cosponsors') contributions to achieving the MDGs.

3.4 Efficiency of governance committees

To respond to the criticism in the previous external evaluation and to take into account the difficult funding situation, the secretariat established an internal ad-hoc working group to review the functioning of the governance committees. As a result, some changes were introduced to increase their efficiency. The most notable are:

- Specialist panels no longer hold separate meetings but meet with the Scientific and Ethical Review Group.
- Strategic committees, which were set up to provide medium-term strategic guidance in setting priorities, no longer meet physically but conduct exchanges by electronic means. The new Medium-term Strategic Plan 2010–2015 will be elaborated by exploiting synergies with other events and planned stakeholder meetings.
- The Gender Advisory Panel (now the Gender and Rights Advisory Panel) did not meet in 2006 owing to the financial constraints.
- The meetings of the Scientific and Technical Advisory Group are more focused on areas in which guidance is needed. In alternation, one year the Scientific and Technical Advisory Group meeting focuses on strategic forward-looking questions and one year more on the review of achievements, ongoing activities and budgets. In 2006, for budgetary reasons, the meeting took place with reduced participation and a shorter duration.
- SEARO and WPRO began 3 years ago to combine meetings of their regional advisory panels with meetings for programme and policy managers. These meetings engage regional and country stakeholders in sexual and reproductive health, and were co-funded largely by the host governments. Such meetings helped to translate research into practice.
- Attendance of the chairperson of the Policy and Coordination Committee as an observer in meetings of the Standing Committee has been found to be helpful.

One concern is that, according to the regulations for the functioning of the Scientific and Technical Advisory Group, several members, including the current chairperson and vice-chairperson, will be replaced in autumn 2008, coinciding unfortunately with the change in the HRP Director.

Annex 7 shows that the streamlining of governance committee meetings resulted in reduced costs (US$ 1.2 million in the most recent biennium as compared to US$ 1.4 million at baseline). The absolute number of meetings was reduced, although the nature of the meetings did not change. The main explanation for cost increases for several meetings between 2001 and 2007 is the exchange rate between the Swiss franc and the US dollar. As HRP's budget and accounts are maintained in US dollars, with only a modest inflation rate for the Swiss franc, the cost, expressed in US dollars, of organizing a typical meeting increased by about 40% over the period.

The interviews with some representatives of country donors and cosponsors indicated that, while the Programme's governance is perceived

overall as well organized and managed, the processes are still considered to be heavy. Several respondents saw potential for improving efficiency. At the same time, they gave credit to the Programme for its accountability and transparency. While one respondent questioned the necessity of maintaining a separate Gender and Rights Advisory Panel and proposed including gender throughout the Programme's work, others stressed the importance of that body. The general view was that the remaining problems would not be solved by eliminating any of the existing bodies.

To revitalise the governance bodies, respondents stress the need for regular rotation of members and a balanced mix between experienced members and new and younger members who can bring in "fresh blood".

Other suggestions for improvement included cutting down on cross-reporting among the various bodies and giving each committee a clearer profile. It was proposed that meeting documents be sent earlier to members of the Policy and Coordination Committee. It was also suggested that HRP could cut down on staff time and printing costs if all delegates brought print-outs of the documents. Reports in general should be more concise.

The current composition of the Policy and Coordination Committee was questioned with respect to whether it is adequate in quality and size for fulfilling its intended role of providing focused governing and strategic advice. The governance of UNITAID (http://www.unitaid.eu/en/governance.html) was mentioned by one respondent as an example of leaner governance. UNITAID only has three governing, advisory and administrative bodies, composed of an 11-member executive board in charge of decision-making (a smaller equivalent to the Policy and Coordination Committee), a consultative forum that is a platform for debate, advocacy and fund-raising and includes some functions similar to those of the Scientific and Technical Advisory Group, and a small secretariat that accounts for only 0.81% of the total budget. The secretariat is hosted by WHO. The mandates of UNITAID and HRP are distinct, with different needs in terms of governance. The hosting of both programmes by WHO could, however, make it possible for the HRP secretariat and the Policy and Coordination Committee to study UNITAID's governance more closely with a view to identifying mechanisms and structures that could be of interest to HRP.

The issue of greater involvement of country representatives is discussed below in section 3.8.

3.4.1 Conclusions and recommendations

Conclusions

- The secretariat has taken the recommendations of the previous external evaluation seriously and introduced a series of changes with the aim of reducing and rendering governance committee meetings more efficient.
- None of the governance bodies had been eliminated.
- The main changes are combining meetings and holding a reduced Scientific and Technical Advisory Group meeting in 2006.
- These changes resulted in some minor economies, which have, however, been offset by fluctuations in the US dollar–Swiss franc exchange rate.

Recommendations

- Replicate the successful model of joint meetings between regional advisory panels and policy-

makers and programmers in other regions, where feasible.

- Anticipate and plan for a difficult transition when several members of the Scientific and Technical Advisory Group, including the Chairperson and the Vice-Chairperson, and the Programme's Director will be replaced.
- Review the terms of office of governance committee members and establish a good mix between longstanding members with experience and younger colleagues who can bring in innovations.
- Send preparatory information earlier to members of the Policy and Coordination Committee, and distribute most of the information and documentation in electronic form only.
- Further explore the governance of UNITAID and possible adaptation to HRP.

3.5 Grant processing and ethical review

The processing of grants differs slightly for those for national research strengthening and those for research of global relevance. For the first type (capacity-building), the area manager at HRP headquarters receives the proposal and forwards a summary to two reviewers on Regional Advisory Panels. All proposals involving research on human subjects or animals that are funded by HRP undergo ethical review. The research grants, including those at national level, are dealt with by HRP headquarters. The previous evaluation highlighted delays in grant processing.

Three measures were introduced to overcome this problem. The process was streamlined to some extent by combining the meetings of specialist panels with those of the Scientific and Ethical Review Group, for joint technical and ethical review. Electronic contract processing, introduced in 2007, has led to improved efficiency and has eliminated the risk for physically losing contracts during in-house clearance. Ethical review of proposals is now done at full and 'mini' meetings of the Scientific and Ethical Review Group and, if needed, in the interim by mail exchange.

Overall, this new approach was judged to be successful, even though coordination between the secretariats of the two groups and the workload for reviewers who must submit their reports in advance of meetings are reported to have increased as a result. Processing of some grants, not including those for research projects, was decentralized, and this is reported to have slowed the process. This impression could not be verified objectively, however, as the current system does not allow tracking of the time for grant processing: the first entry is sometimes made only months after submission. Unlike TDR, where a single person is in charge of data entry, in HRP different project managers enter data inconsistently. In view of the pending implementation of Oracle in WHO, HRP is likely to explore new options for research contract management in the future.

The main concern with respect to grant processing remains the two steps of ethical review required. HRP introduced an ethical review process long before the rest of WHO. As WHO subsequently set up the institution-wide Research Ethics Review Committee (ERC), proposals sent to HRP must also be sent to this Committee. HRP considers that the ethical issues linked to sexual and reproductive health are specific, requiring specific competencies. At the same time, the workload of ERC is increasing. It does not seem an appropriate moment to disband the Scientific and Ethical Review Group. As there have been no

major discrepancies between the findings of SERG, the specialist panels and ERC in 2006–2007, the Policy and Coordination Committee recommended that the duplication should be eliminated by delegating ethical review for HRP proposals to the Scientific and Ethical Review Group, designating it as a subcommittee of the Research Ethics Review Committee.

At present, local ethical approval is also required. As an option, ethical review could be fully decentralized to the regions. This would, however, require capacity-building and might have negative repercussions. Influence of religious or moral values could negatively impact on ethical standards. Decentralization might be a long-term aim but is not a practical solution at present.

An internal audit of ethical review processes is under way in WHO to assess duplication. Results and recommendations will be discussed at a meeting in early March.

3.5.1 Conclusions and recommendations

Conclusions

- HRP has introduced measures to speed up grant processing. While some, like the electronic contract processing, have led to definite improvements, overall, the effect of the measures on speeding up the process remains inconclusive.
- The current TRIMS[3] system has not been efficient for data management, and data input is inconsistent, being done by several people. Data entry by one person in TRD seems to work better than the HRP approach.

Recommendations

- Explore alternative, better systems for monitoring grant processing and management of projects.
- Institutionalize a more formal process for submission of research, such as a password-protected Internet-based system that allows tracking of work electronically.
- Continue to follow up on the recommendation of the Policy and Coordination Committee that the WHO Research Ethics Review Committee delegate the responsibility for ethical review of sexual and reproductive health projects to the Scientific and Ethical Review Group of HRP.

3.6 Administration, decentralization and collaboration with regions and other entities and levels of WHO

3.6.1 Administration and decentralization

Administration has been decentralized mainly with regard to data management, the management of certain funds (the use of which is planned jointly by advisers in sexual and reproductive health at the regional offices and the area managers of HRP) and greater involvement of decentralized levels in monitoring.

On the basis of a decision taken during the meeting of Regional Advisory Panel chairs in February 2004, it was agreed that service guidance centre grants should be administered through WHO regional offices and that country offices should be involved in monitoring long-term institutional development grants. Annual reports from centres and of symposia are now shared with country and regional offices (Follow-up actions to the external evaluation of HRP, report for the 2004 Policy and

3. The TDR-RHR Internal Management System

Coordination Committee). In 2007, the secretariat reported that decentralized grant management has resulted in greater ownership, sometimes at the expense of slowing the process.

Currently, data from 36% of multicentre trials supported by HRP are managed in countries. The target is to increase that share to 55% by the end of 2009. This is an important part of capacity-strengthening for research. HRP stresses the importance of maintaining central control and management of large research grants of global relevance in order to safeguard their scientific quality and ethical standards. This is particularly true for studies of new drugs or devices, the data from which may become part of registration dossiers.

HRP is exempt from the decision of WHO to progressively transfer budget allocations from headquarters to the regions and countries. This exception protects HRP's global leadership in research and its normative functions. Even so, the amounts transferred to all regions increased sharply. These funds supported activities, meetings or conferences organized in the regions or countries and were only exceptionally used to cover HRP research. These transfers more than doubled during 2006–2007 (US$ 703 419) as compared with 2002–2003 (US$ 259 692). In comparison with the full biennium budget of US$ 38.8 million, however, this represents less than 2% of the Programme's budget. At the peripheral level, many respondents still perceive HRP as a highly centralized programme with most decisions and funds managed at headquarters. As in the 2003 external evaluation, some respondents considered this was reasonable and necessary, given the global nature of the Programme and its research.

In June 2008, profound changes in the WHO management system are foreseen. The Oracle-based general management system will be introduced, and all administrative management functions will be fully electronic. The secretariat of HRP is concerned to ensure a smooth transition to the new system. The fact that it will be introduced only in June and not at the beginning of the calendar year will not make things easier. In addition, a number of management tasks will be delegated to the new WHO centre in Kuala Lumpur. This change coincides with the start of a new biennium, when cash-flow management is particularly challenging, as donor contributions usually start to arrive only towards the middle of the year.

3.6.2 Regional Advisory Panels

No major change in the functioning of the Regional Advisory Panels is reported. At the decentralized level, they fill a role similar to that of the Scientific and Technical Advisory Group.

Regional office staff continue to be encouraged to participate fully in Regional Advisory Panels as ex-officio members, with the costs covered by the Programme. The chairs of Regional Advisory Panels take part in the meetings of the Scientific and Technical Advisory Group to ensure that regional perspectives and needs are taken into account. The chairs of the Regional Advisory Panels consider that the work is overwhelming and the responsibility huge, with very limited funds available. Some well-established research centres have been peer-mentoring and guiding less mature institutions in the same or other countries. Such informal, unpaid training and mentoring is a success of HRP's long-term capacity-building efforts in countries.

3.6.3 Interaction of HRP with other entities and decentralized levels of WHO

HRP was regularly invited to present its work at the regional offices' annual meetings of WHO country representatives, at meetings of WHO regional advisory committees for health research and to the Task Force on Maternal, Neonatal and Child Health of the Regional Director of the African region. According to the secretariat, collaboration between the Programme and reproductive health advisers in regional offices has much improved. Joint site visits; monitoring involving HRP area managers, Regional Advisory Panel members, regional and country reproductive health advisers and national programme officers; and the organization of workshops have contributed to better cooperation. Frequent staff changes have at times slowed down progress. Another recurring challenge is that colleagues in regional and country offices usually have huge portfolios with many programme responsibilities, leaving little capacity for research. In addition, many regional and country staff are not conversant with issues in sexual and reproductive health research. Occasionally, regions have asked HRP for help in capacity-building for sexual and reproductive health research. EMRO is recruiting a specialist in this field with financial support from RHR. Lack of interaction with country offices has been due to several factors, including the reduced funding, staff cuts and reduced resources for research grants.

HRP is convinced that the new structure of WHO in the Medium-term Strategic Plan of Work 2008–2013 will further help its full integration into the Organization. Since objectives are shared between the various entities, stronger dialogue and collaboration is an immediate consequence. Interdepartmental thematic working groups have been created (e.g. on male circumcision, human papillomavirus (HPV) vaccine and prevention of mother-to-child transmission of HIV) in which HRP takes an active part. RHR convenes weekly meetings to strengthen links between HIV and sexual and reproductive health and organizes joint missions with other departments. A good example of broad-based collaboration is the Réseau d'Afrique Francophone pour la Télémedicine. These web-based training sessions on sexual and reproductive health started in 2006 via WHO video conference facilities, involving HRP and RHR staff, staff of other WHO departments at headquarters, regional office and country office staff, collaborating centres and Regional Advisory Panel experts in teaching. The training has been well received by regional and country offices.

3.6.4 Conclusions and recommendations

Conclusions

- The secretariat found that decentralized grant management resulted in greater local ownership, sometimes, however, slowing the process considerably. In the absence of a tracking system that would allow quantification of the duration of the process, this impression cannot be verified objectively.
- Centralized decisions about research agendas are accepted at regional level as being necessary for some multicentre trials and might also be desirable when country priorities are influenced by extraneous factors that may not be conducive to sound research.
- Data from 36% of multicentre trials are currently managed at country level, and the proportion is projected to be 55% by 2009.
- Despite initial success in improving collaboration between headquarters and decentralized levels, there remains room for strengthening of the link

between HRP and country offices in particular, although it is recognized that qualified staff might not be available in some regional and country offices.

- The functions of Regional Advisory Panels have not changed markedly, and they fill an important role, similar to that of the Scientific and Technical Advisory Group at central level.

Recommendations

- Continue efforts to improve collaboration and communication with, and involvement of, country and regional office advisers in sexual and reproductive health. Ensure that priorities, such as preventing unsafe abortion, are better embedded at country and regional levels.
- Strengthen capacity to prepare proposals, write reports and conduct research on sexual and reproductive health at decentralized level. Where relevant, systematically involve Regional Advisory Panels and area managers from the beginning. Continue involving country and regional staff in identifying collaborating institutions.

3.7 Comparison of HRP and TDR governance

In a small case-study, the governance of HRP was compared to that of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, TDR. For the findings and more detailed recommendations, the reader is referred to Annex 8.

3.7.1 Conclusions and recommendations

Conclusions

- Neither the main governance body of HRP nor that of TDR has a full member who represents a foundation, another nongovernmental entity or a private for-profit organization.
- The issues related to participation and turnover of beneficiary country government representatives in meetings of the Joint Coordinating Board and the Policy and Coordination Committee are addressed under section 3.8.1.
- TDR's experience with decentralizing Joint Coordinating Board meetings to the regions has been positive. Meetings outside Geneva were well attended, although only a small, selected group of TDR staff could attend as travel costs had to be kept within reasonable limits. Meetings in the regions also allow direct observation of research initiatives in the host country, giving a better sense of realities in the field. The 2008 Policy and Coordination Committee meeting will be held in Buenos Aires, the first time it is being held outside Geneva.
- As both are cosponsored special research programmes, hosted and executed by WHO, they share unique characteristics and similarities in governance. While differences between the two programmes justify certain differences in governance and related processes, synergies can be improved.
- The TDR web site (http://www.who.int/tdr/about/governance/default.htm) gives an excellent insight into its governance, with easy-to-understand graphical illustrations and information on details, if needed. While the HRP website includes a section on governance (http://www.who.int/reproductive-health/management/index.html), it consists mainly of full reports and there is no simple access to basic Programme governance. Many HRP partners (such as decentralized WHO staff in regions and countries, beneficiary country

governments and scientists) have difficulty in grasping the identity of HRP in relation to RHR and WHO.

Recommendations

- The Directors of TDR and HRP should meet formally and regularly to exchange information on questions, challenges or lessons learnt about the governance of their programmes. Key areas for collaboration might include administrative and strategic interaction of the two programmes within WHO and how to reinforce the regional nature and representation of their governance.
- Consider inviting one or several foundations to become full members of the Policy and Coordination Committee as category 3 or as permanent members.
- The Chair of the Policy and Coordination Committee is invited to follow the discussion of TDR's Joint Coordinating Board on constituency positions among members and to judge the relevance for the Policy and Coordination Committee.
- In line with TDR's governance, the HRP Standing Committee could become more inclusive, allowing representation of the Scientific and Technical Advisory Group and the Policy and Coordination Committee during meetings. It should discuss whether the Memorandum of Understanding allows the chairs of those committees to have adviser or ex-officio status.
- It is strongly recommended that HRP include easy-to-access, understandable illustrations and information on its structure and governance on its web site, following the example of TDR.

3.8 Other issues related to governance

3.8.1 Greater involvement of country representatives in categories 2 and 3

As further described in Annex 8, HRP's Policy and Coordination Committee faces problems similar to those of TDR's Joint Coordinating Board regarding limited contributions to discussions and the rapid turnover of beneficiary country government representatives. Many respondents stressed the minimal role played by recipient countries in the Policy and Coordination Committee as one of the major weaknesses of HRP's governance.

HRP is formulating the following strategies to address these shortcomings (details given in Annex 8):

- stronger involvement of WHO regional directors and country representatives in selecting delegates;
- longer briefings for members before meetings;
- strengthened translation services for non-English- or French-speaking representatives; and
- decentralizing alternate meetings to the regions.

The few respondents from the survey of category 2 members said that benefits for delegates do not automatically translate into benefits to their countries, depending on the position and role the delegates play in their country and their commitment to share the information and lessons learned with other key actors in the country.

According to respondents, the benefits for delegates could be an enhanced understanding of HRP's objectives, strategies and dynamics, a broadened approach for analysing problems and challenges in sexual and reproductive health and

rights, and better understanding of the interests and political commitment of the donors. For the countries, the benefits could include an opportunity to sensitize both HRP and donors to national problems that require international cooperation, sharing of experiences, an opportunity to push strategies for better use of evidence in policy, presentations of the sexual and reproductive health context and priorities and involvement in decision-making about projects and funding allocation.

3.8.2 Conclusions and recommendations

Conclusions

- Limited participation in meetings and frequent rotation of representatives of category 2 beneficiary countries remains a serious barrier to balanced input for governance of the Programme. The secretariat has developed strategies to address this weakness.
- The planned rotation of Policy and Coordination Committee meetings between Geneva and one of the regions is welcomed and should contribute to better involvement of beneficiary country stakeholders, making their concerns and realities more visible.

Recommendations

- Inspired by TDR's instruments, adapted to the needs of HRP, formulate a draft strategy and guidelines for greater involvement and participation of categories 2 and 3 in the Policy and Coordination Committee, to be discussed and validated at the 2008 meeting of the Policy and Coordination Committee. The instruments should include clear guidance on the selection criteria and process to ensure that the right persons, with a technical and scientific background and the necessary link to the policy level, will represent their countries and that they will be given a proper briefing in-country.

In addition, the Committee could consider some of the following strategies which are envisaged or in place for TDR's Joint Coordinating Board:

- Strengthen the role of and promote close contacts with regional offices and regional committees in the selection, briefing and follow-up of representatives of Member States and selecting appropriate country representatives.
- Organize a preliminary meeting of beneficiary countries, chaired by a member from these countries.
- Invite members and regional offices to present sexual and reproductive health issues during meetings of the Policy and Coordination Committee or visit projects in host countries when meetings are held outside Geneva.
- Establish an electronic network of beneficiary country and other regional representatives, complemented by a peer-coaching system for new members to ensure continued discussions between them and better preparation for meetings.
- Make country representatives aware of their responsibility to represent both their country and the region and keep both their governments and regional groupings informed about HRP-related activities.
- TDR covers the expenses of a representative from each regional office to attend the Joint Coordinating Board, and these representatives brief government representatives from their respective regions in line with the new strategy to increase their participation. There is also a de-briefing at the end of the session.

3.9 Monitoring, evaluation and reporting on benchmarks

HRP uses Organization-wide expected results (OWERs) and indicators to report to WHO and the World Health Assembly. Currently, this report is not shared with the Policy and Coordination Committee or the cosponsors. The World Bank accepts the annual technical report and the annual 'highlights' document to help avoid parallel reporting. In the view of one of the cosponsors, HRP's monitoring framework "has not been great".

During the biennium 2006–2007, HRP worked on six objectives (WHO's objectives in sexual and reproductive health as defined in RHR's Medium-term Programme of Work 2004–2009) and six expected results, linked to nine indicators at output and outcome levels, as shown in Annex 9. In addition, the thematic areas of work were organized around 215 products, almost all of which were linked to milestones for monitoring at the end of 2006 and the end of 2007. A systematic assessment of achievement of the milestones is used internally. Progress on the products is reported in the annual 'highlights' document.

Annex 10 shows progress towards achieving the main indicators (extract from *World Health Organization-wide expected results*) that HRP uses as benchmarks for its work. In terms of research studies completed between 2004 and 2007, the financial constraints with which HRP was confronted resulted in a relatively low achievement rate of 59% (47 completed studies as compared with the target of 80). The Programme has, however, far exceeded the target for systematic reviews (30), having completed 55 during the past 4 years. HRP also exceeded the target for new research centres that received comprehensive institutional development support. The number of countries that reviewed national laws, regulations or policies on sexual and reproductive health was six times higher than the target set. While all activities suffered from the funding shortage, research studies are usually long-term and costly, and the field takes longer to recover. The activities relating to systematic reviews benefited from the stronger emphasis of WHO on evidence-based guidance, which created an increased demand for such reviews.

Beginning in 2008, the old products are being replaced by a more streamlined set of products and activities to bring HRP's operational planning into line with WHO's new approach to planning and programming. Products and activities will be monitored more systematically from 2008 with WHO's Oracle-based information system. Thus, although the milestones have disappeared, the Programme activities will be tracked much more systematically.

In the 2008–2009 programme of work, the six objectives in sexual and reproductive health continue to be used. At the same time, however, the new strategic objectives and Organization-wide expected results (OWERs) will be applied to HRP's work. In the transition phase 2008–2009, HRP will use both the old and the new framework of expected results for monitoring and reporting. Thus, each product in the Programme's budget is linked to the relevant strategic objective and Organization-wide expected result in order to facilitate reporting during the current biennium. There is concern both inside WHO and externally, however, that WHO's new approach to programming by strategic objectives and Organization-wide expected results is so different from the former approach of areas of work that trend assessment (for instance, the overall level of spending on sexual and reproductive health) will become almost impossible.

HRP has had a regular cycle of external evaluations and reviews for many years. There have been five overall Programme evaluations (in 1978, 1982, 1989, 2003 and 2007), and in-depth reviews of specific areas in between.

The thematic case-studies all highlight the fact that HRP does not currently have a set of indicators and related baseline information that would allow easily monitoring and evaluating the outcomes and impacts of HRP's areas of work.

3.9.1 Conclusions and recommendations

Conclusions

- HRP has a longstanding culture of regularly submitting the Programme to external evaluations.
- Until recently, HRP used a complex monitoring system. The information generated was used mainly for internal steering purposes. Little of it flowed into official reporting to cosponsors and the Policy and Coordination Committee.
- Financial monitoring and reporting in HRP continue to be very good.
- HRP performed well in terms of making progress towards the benchmarks set. The period of funding shortage, however, had a lasting negative impact on the rate of completed research.
- The new strategic framework of WHO, with the related monitoring framework, to which HRP also subscribes, will involve much uncertainty in the transition phase. HRP is confronting the challenge to produce meaningful information that ensures comparability of data before and after the transition. This shift can be seen as an opportunity to revise a rather complicated system of monitoring and evaluation to something more operational.
- HRP currently lacks a monitoring and evaluation system which would allow effective monitoring of the outcomes and impacts of its various areas of work. Using MDGs as impact indicators will make it difficult to attribute any effects to HRP's work, as these indicators will change only in the long term.

Recommendations

- HRP should consult with its cosponsors on the best way to design a strong, concise monitoring and information system that fits into the new WHO guidance but at the same time produces better information on the outcomes and impacts of the Programme's work.
- Consider creating a full or part-time position for a monitoring and evaluation specialist or obtain external short-term support in this field. This specialist could strengthen the monitoring and evaluation framework and support the collection of data on indicators. A stronger monitoring system will help to demonstrate effectiveness and will be useful for future reporting and evaluation requirements.

3.10 HRP and web-based communications

Following up on a recommendation from the previous evaluation, HRP developed and continues to update web-based communications. It has an extensive website, with norms and guidelines, which was accessed by an estimated 2.7 million visitors in the first 11 months of 2007. A remarkable 1.4 million documents were downloaded during this period.

Working with the consortium for Implementing Best Practices (IBP), HRP has developed the IBP Knowledge Gateway, which is an interactive electronic tool that provides access to evidence-based practices, guidelines and other publications, currently reaching 190 countries and supporting over 18 000 members in various "communities of practice". Members can share experiences and lessons learnt and participate in online discussions of technical and programme issues in sexual and reproductive health.

HRP has also established routine use of the web for password-protected links to share documents in advance of meetings. This has now been extended from the Policy and Coordination Committee and the Scientific and Technical Advisory Group to all advisory body meetings and all large technical meetings, with the 'Sharepoint' technology. This provides a secure means for sharing confidential background papers and agendas and for updating meeting participants.

3.10.1 Conclusions and recommendations

Conclusions

- HRP effectively implemented its proposal after the 1990–2002 external evaluation to use the web for facilitating document-sharing in governance and technical meetings.
- HRP web-based communications have expanded greatly to support millions of Internet visitors and the downloading of more than 1.4 million documents on sexual and reproductive health per year. The interactive Knowledge Gateway site reaches 190 countries and supports 18 000 members in communities of practice. These are major achievements.

Recommendations

- Continue to support and strengthen the successful and popular web-based document-sharing sites and the IBP Knowledge Gateway for sexual and reproductive health communities of practice.

3.11 Other comments and views of respondents on governance of HRP

- "HRP has one of the best governance structures I have seen." (comment by a cosponsor)
- Short reports, annual highlights and newsletters with condensed information were welcomed by donors. Large reports are not read.
- Transparency and accountability were rated to be very good to exemplary by respondents.
- The HRP secretariat staff are very responsive to partners and colleagues not represented on the Policy and Coordination Committee, which is exemplary and highly valued.
- Donors consider that they have their say in the Programme. Some stress that the agenda should be driven by the Programme, the beneficiary countries and technical priorities rather than by donors.

General conclusions and recommendations

For better readability, most of the conclusions and recommendations are presented in the relevant sections. They are not repeated here, where we give some general final conclusions and recommendations.

- HRP was very responsive to the recommendations of the previous evaluation. The secretariat acted promptly by creating a task force for the follow-up. Appropriate actions were taken rapidly, and the transparency and reporting of the process to the Policy and Coordination Committee are to be commended.
- When considering the main conclusions and recommendations of the previous evaluation, much has changed, and many problems have been addressed and solved, as highlighted in this case-study. The most notable differences are in the financial situation, increased diversity of income, strong bonds between HRP and its partners in advocating for the agenda of the International Conference on Population and Development (Cairo, 1994), and a greater role of sexual and reproductive health in the MDGs.
- Effective, strong collaboration between HRP at headquarters and at the country level remains a goal, as found in 2003.
- Decentralization is progressing, albeit slowly; ultimately, it might not be crucial for a global programme such as HRP.
- The speed of grant processing and the efficiency of governance remain areas for potential improvement.
- The Programme should be given a new name to better support effective public relations and to improve its visibility. Following the TDR example, a simple descriptive name, such as 'Reproductive Health Research' or 'Human Reproduction Research Programme' could be considered. The new director could take on this task.
- The different roles of HRP and the broader RHR should be clarified for partners. The concise conceptual framework developed by HRP for the previous external evaluation (Annex 10) could be updated and used for this purpose.

List of abbreviations

EMRO	Regional Office for the Eastern Mediterranean
ERC	WHO's Research Ethics Review Committee
GAP	Gender and Rights Advisory Panel
GMS	General Management System
HPV	Human papillomavirus
HRP	UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
MDG	Millennium Development Goal
OWERs	Organization-wide expected results
PCC	Policy and Coordination Committee
PDRH	Programme Development in Reproductive Health
PMTCT	Prevention of mother-to-child-transmission
RAP	Regional Advisory Panel
RHR	Department of Reproductive Health and Research
SEARO	Regional Office for South-East Asia
SERG	Scientific and Ethical Review Group
STAG	Scientific and Technical Advisory Group
TDR	UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WPRO	Regional Office for the Western Pacific

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Annex 1. Leading questions used in the governance case-study

Cosponsorship

Has cosponsored status been maintained and revitalized? Were benefits made clearer and more tangible?

Has HRP succeeded in attracting new donors or cosponsors, such as new foundations, new government institutions?

Is there any new revenue from product development? What are the pros and cons of that type of income generation?

HRP governance

Has the number of committee meetings and of participants been reduced? If yes, what was the effect in terms of savings or improved efficiency?

Have functions been combined and deliberations made more efficient?

What is the current status and role of regional advisory panels?

Has involvement of regional office staff in sexual and reproductive health in regional advisory panels become more direct?

How have the members of the Policy and Coordination Committee and the Scientific and Technical Advisory Group contributed to sexual and reproductive health advocacy at international events?

HRP management: programme effectiveness and efficiency

What steps have been taken to further decentralize administration and monitoring functions?

What changes in scientific grant processing affected the efficiency and speed of the procedure? What is the effect of these changes in terms of improved efficiency and speed?

How far has HRP managed to attract additional funding to allow it to fulfil its mandate (programme of work, priority levels)?

WHO internal and external cooperation and collaboration

Have HRP staff made efforts to become more familiar and get involved in operations of WHO at other levels (regional and country), with what outcome?

What efforts have been made to inform regional offices about HRP's work?

Has exchange and collaboration within WHO increased?

How has the support of regional directors to HRP evolved?

Any other suggestions on how HRP could improve its performance in terms of governance?

To what extent is the governance and management of the Programme: transparent in providing information about the Programme; clear with respect to roles and responsibilities; accountable to donors, beneficiary countries, scientists, professionals and other stakeholders?

Annex 2. List of respondents to in-depth interviews by group

Cosponsors

UNDP

Maha El-Adawy, Policy Adviser Health, MDG Support Team, Bureau for Developmental Policy

UNFPA

Purmina Mane, Deputy Executive Director (Programme)

Hedia Belhadji, Deputy Director, Technical Support Division

Lindsay Edouard, Senior Technical Adviser, Reproductive Health Branch

WHO

Daisy Mafubelu, Assistant Director-General, Family and Community Health Cluster

World Bank

Khama Rogo, Lead Health-Sector Specialist/ Adviser, Population/Reproductive Health

HRP secretariat

Paul Van Look, Director, Department of Reproductive Health and Research

Catherine d'Arcangues, Coordinator, Office of the Director

Mike Mbizvo, Coordinator, Office of the Director

Craig Lissner, Coordinator, Programme Management

Alexis Ntabona, Coordinator, Technical Cooperation with Countries for Sexual and Reproductive Health

Heli Bathija, Area Manager, African and Eastern Mediterranean Regions

Katherine Ba-Thike, Area Manager, Asia and Pacific Regions

HRP committees

Anna Glasier, Chair of Scientific and Technical Advisory Group

Timothy Hargreave, Chair of Scientific and Ethical Review Group (communication by mail)

Sharad Iyengar, Co-Chair of Gender and Rights Advisory Panel

Bilateral donor representatives

Netherlands: Elly Leemhuis, Chair of Policy and Coordination Committee, Senior Advisor Reproductive Health, Social Policy Division, Ministry of Foreign Affairs

Norway: Berit Austveg, Former Chair of Policy and Coordination Committee, Senior Advisor, Norad (communication by mail)

Sweden: Viveka Persson and Pär Svensson, Division of Human Sciences for Social Development, SAREC, SIDA

United Kingdom: John Worley, Team Leader, RCH, DFID

Representatives of Category II members of PCC [1]

Foundations

Ford Foundation: Barbara Klugman, Program Officer

William and Flora Hewlett Foundation: Nicole Gray, Program Officer, Reproductive Health

Regional Advisory Panel chairs

Wagida Anwar, African and Eastern Mediterranean

Sylvia Guendelman, Americas

Mainmunah A. Hamid, Asia and Pacific

Reproductive health advisers in regional offices

Ardi Kaptiningsih, Regional Reproductive Health Adviser, SEARO

[1] Due to the low response rate in the survey for respondents representing Category II PCC member countries and to ensure confidentiality, the names of the three respondents are not given in this list.

Annex 3. Revenue from foundations, civil society and country donors

Table 1. Contributions to HRP by foundations and countries in 2000–2001 and 2006–2007

Foundations, civil society	Total contribution (US$) for	
	2000–2001	2006–2007
Anonymous donor	0	1 350 000
Bill & Melinda Gates Foundation	4 000 000	184 000
David and Lucile Packard Foundation	2 020 000	538 000
Ford Foundation	230 000	800 000[a]
Geneva International Academic Network	0	102 000
HLSP Ltd.	0	88 000
Ipas	0	22 000
John D. and Catherine T. MacArthur Foundation	50 000	50 000
March of Dimes	0	53 000
Peninsula Community Foundation	0	100 000
Program for Appropriate Technology	5 000	0[b]
Reproductive Health Alliance Europe	41 000	0
Rockefeller Foundation	220 000	0
University of Michigan	0	81 000
Wallace Global Fund	0	75 000
Wellcome Trust	25 000	0
William and Flora Hewlett Foundation	150 000	886 000
Subtotal for foundations and civil society	**6 741 000**	**4 329 000**
Countries		
Canada	523 000	345 000
China	110 000	110 000
Commission of European Communities	0	480 000
Finland	0	118 000
Flemish Government (Belgium)	0	444 000
France	0	129 000
Germany	457 000	0
India	70 000	70 000
Mexico	7 000	7 000
Netherlands	3 450 000	11 763 000
Norway	2 465 000	3 677 000
Spain	20 000	56 000
Sweden	2 085 000	4 038 000
Switzerland	301 000	725 000
Thailand	0	40 000
United Kingdom	1 089 000	8 390 000
USA	5 000 000	0
Subtotal for countries	**15 577 000**	**30 427 000**

[a] Confirmed that a grant in the amount of US$ 800 000 for 2 years has been approved.

[b] Contributed US$ 104 846 for the Department of Reproductive Health and Research.

Table 2. Comparison of top five country and top five foundation donors in 2000–2001 and 2006–2007

	Country	Contribution (US$)		Foundation, civil society	Contribution (US$)
2000–2001					
1	USA	5 000 000	1	Bill & Melinda Gates Foundation	4 000 000
2	Netherlands	3 450 000	2	David and Lucile Packard Foundation	2 020 000
3	Norway	2 465 000	3	Ford Foundation	230 000
4	Sweden	2 089 000	4	Rockefeller Foundation	220 000
5	United Kingdom	1 089 000	5	William and Flora Hewlett Foundation	150 000
2006–2007					
1	Netherlands	11 763 000	1	Anonymous donor	1 350 000
2	United Kingdom	8 390 000	2	William and Flora Hewlett Foundation	886 000
3	Sweden	4 038 000	3	Ford Foundation	800 000
4	Norway	3 677 000	4	David and Lucille Packard Foundation	538 000
5	Switzerland	725 000	5	Bill & Melinda Gates Foundation	184 000

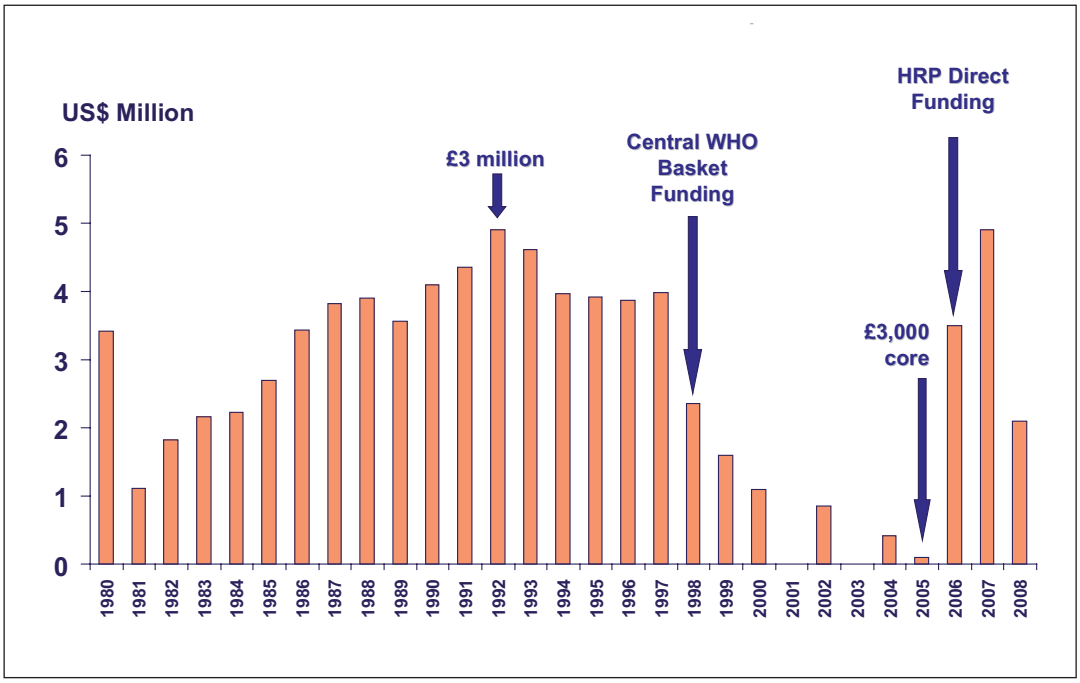
Table 3. New or expanded HRP income sources over the biennium 2006–2007

New:
CG Therapeutics
Finland
France
Geneva International Academic Network
HLSP Ltd.
India
MacArthur Foundation
March of Dimes
Peninsula Community Foundation
Wallace Global Fund

Expanded[1]**:**	
Anonymous	↑↑
Flanders	↑
Ford Foundation	↑
Hewlett Foundation	↑
Netherlands	↑↑
Norway	↑
Packard Foundation	↑
Sweden	↑
Switzerland	↑↑
United Kingdom	↑↑
University of Michigan	↑

[1] ↑ = Funding increased
↑↑ = Funding increased strongly

Figure 1. Evolution of United Kingdom's contribution to HRP and effect of core-funding mechanism



Annex 4. HRP income trends from royalties

	2000	2001	2002	2003	2004	2005	2006	2007
Total income	17 968 000	15 297 000	14 377 000	13 031 000	13 324 000	11 830 000	23 371 000	13 715 000
Royalties								
Update Software Ltd.			3070	1070	364	1274	1081	
Gedeon Richter[a]						49 312	103 132	68 403
Schering	304 300	410 915	318 661	96 293	42 294			
John Wiley & Sons Ltd.					276			
Women's Capital Corporation	50 000	100 000	100 000					
Total	354 300	510 915	421 731	97 363	42 934	50 586	104 213	68 403
Royaltiesas percent-age of total income	1.97%	3.34%	2.93%	0.75%	0.32%	0.43%	0.45%	0.50%

[a] Funds from Gedeon Richter for 2005, 2006 and 2007 were only partially received (US$ 14 321 were received). The remaining funds will probably be received in early 2008.

Annex 5. Staffing levels before (2004) and after (2006) the 2005 WHO Strategic Development and Competency Review

Numbers are for RHR; however, HRP developments are in line with overall departmental developments

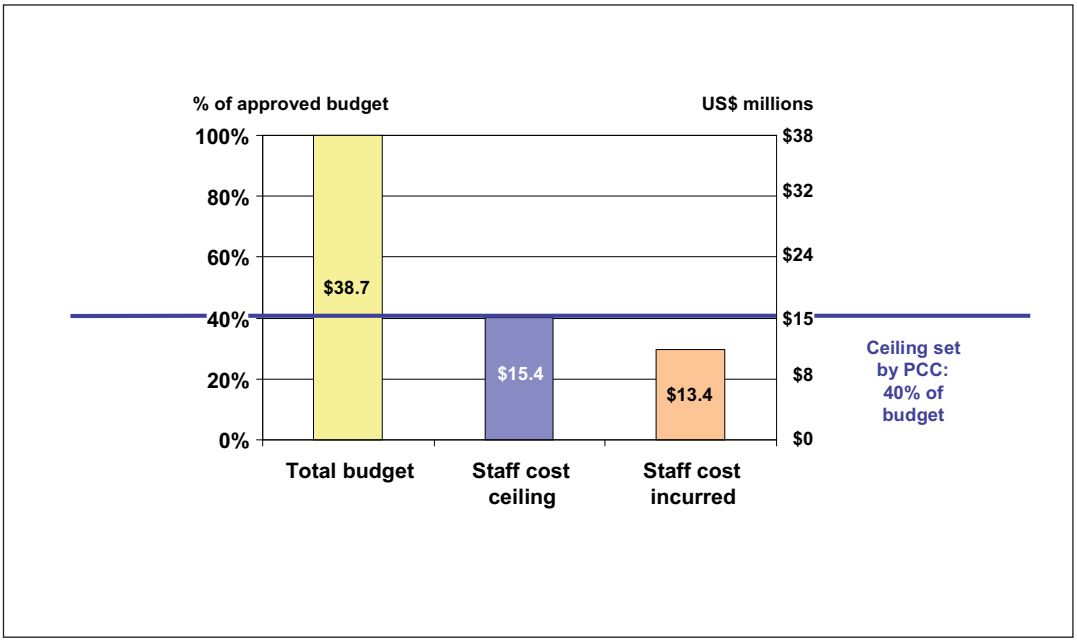
Total staffing	Fixed-term staff	Short-term staff	Total staff
Total staff in 2004	62 (56%)	48 (44%)	110
Total net posts in 2006	76 (92%)	7 (8%)	83
Change	+14	-41	-27

Fixed-term posts	P[1]	GS[2]	Total
Occupied posts in 2004	29 (47%)	33 (53%)	62
Posts abolished	0	9	9
Vacant posts to be filled	9	4	13
New posts to be established	9	1	10
Total net posts in 2006	47 (62%)	29 (38%)	76

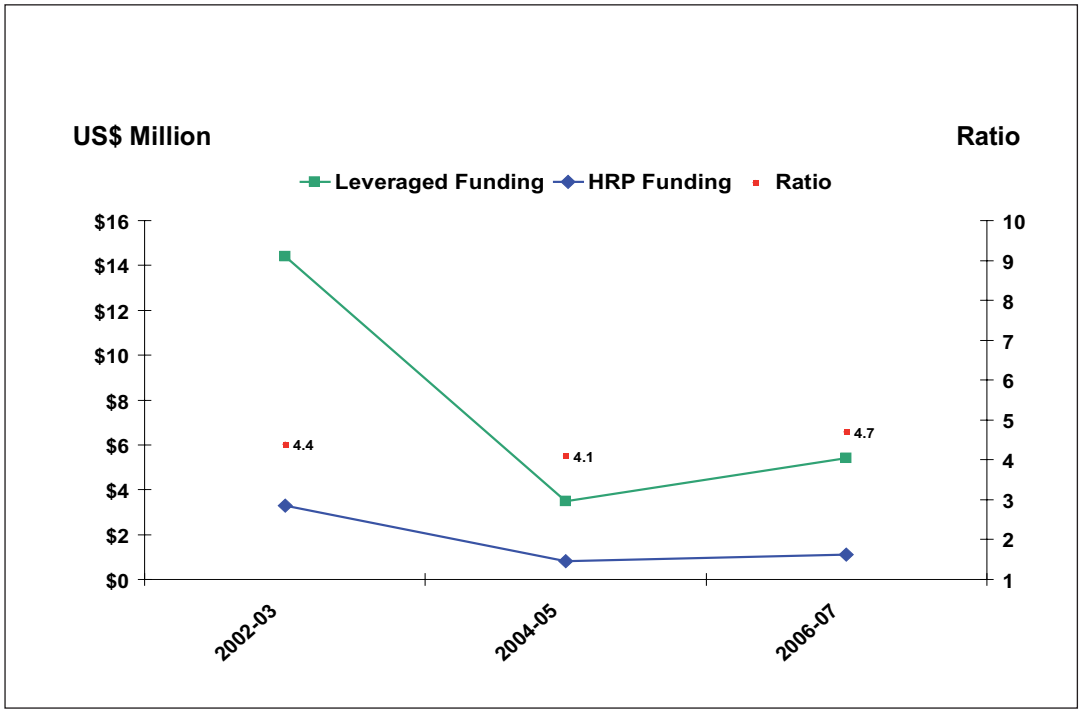
[1] Professional staff posts

[2] General service staff posts

HRP staff cost, 2006–2007



Annex 6: Leveraged funding 2002–2007



Note: 2006–2007 projections updated June 2007

Annex 7: Cost of HRP governance committee meetings (US$)

	2002–2003	2006–2007
Policy and Coordination Committee	176 359	222 159
Scientific and Technical Advisory Group	187 139	140 352
Scientific and Ethical Review Group	222 930	262 560
Gender Advisory Panel[1]	81 509	54 842
Standing Committee	7 385	3 569
Regional advisory panel Americas Region	37 795	137 717
Regional advisory panel African and Eastern Mediterranean Regions	70 416	95 467
Regional advisory panel Asia and Western Pacific Regions	86 943	104 934
Regional advisory panel European Region	53 759	
Strategic Committee on Promoting Family Planning	48 807	
Strategic Committee on Making Pregnancy Safer	46 476	
Strategic Committee on Addressing Sexually Transmitted Infections	50 351	
Strategic Committee on Preventing Unsafe Abortion	53 364	
Specialist Panel on Social Science Research	106 754	122 617
Specialist Panel on Basic and Biomedical Research	86 826	14 978
Specialist Panel on Epidemiological Research	115 651	7 943
Specialist Panel on Country Programme Development	0	59 783
Total	1 432 464	1 226 921

[1] Now the Gender and Rights Advisory Panel

Annex 8: Comparison of the governance of TDR and HRP: main issues

1. History and similarities

HRP was created in 1972, while TDR followed in 1975, inspired by the HRP model. TDR first introduced the concept of cosponsorship, followed by a similar move for HRP in 1988 under José Barzelatto, who was then Director of HRP and former responsible officer for research capability strengthening at TDR. The HRP Memorandum of Understanding between the cosponsors was modelled on that for TDR.

The governance of the two programmes has many similarities, both having a governing board (the Policy and Coordination Committee in HRP, the Joint Coordinating Board in TDR), a standing committee to oversee the management and financing of the programmes, comprising the four cosponsors, and a Scientific and Technical Advisory Group (STAG) for HRP, which is the Scientific and Technical Advisory Committee (STAC) in TDR. Both programmes, while cosponsored, are hosted and executed by WHO, and their staff, including the directors, are WHO staff members.

In addition, TDR has an Assistant Director-General as Special Programme Coordinator. This function was requested mainly by the World Bank at the time it accepted to become a cosponsor of TDR.

2. Main differences in governance and issues to highlight for the external review

2.1 Joint Coordinating Board and Policy and Coordination Committee

The membership composition of the two governing boards differs slightly.

The TDR Standing Committee and Joint Coordinating Board have been discussing

	Joint Coordinating Board of TDR	Policy and Coordination Committee of HRP
Donor country representatives (governments)[a]	12	11
Beneficiary country representatives (governments) (selected by WHO regional committees)	12[b]	14[c]
Other interested cooperating parties (presently countries)	6	2
Cosponsors	4	4
Additional permanent member (International Planned Parenthood Federation)		1
Total	34	32

[a] For the Policy and Coordination Committee, category 1 includes the countries that have been the most important financial contributors over the past biennium. In the Joint Coordinating Board, government representatives are selected by the governments and agencies that contribute; there is no stipulation of the level of funding and, in fact, in recent years the resource contributors have selected more disease-endemic country donors as Joint Coordinating Board members.

[b] Composed of two representatives per WHO region.

[c] Composed of four representatives from the African region, two from the Region of the Americas, three from the South-East Asia Region, one from the European Region and three from the Western Pacific Region.

governance, partly as a result of the report of the fourth external review of TDR. Various options for TDR's governance were presented to the Board at its session in 2007 and it agreed (i) to maintain the current definition of 'cooperating parties'; (ii) to the voluntary establishment of constituencies among the governmental resource contributor members of the Board; (iii) to increase the involvement of disease-endemic country and other regional representatives in the Board; (iv) to increase the length of the term of office of all Board members from 3 to 4 years; (v) to make no change in the role of the Standing Committee; (vi) to continue to strengthen relations among the Joint Coordinating Board, the Scientific and Technical Advisory Committee, the TDR secretariat and WHO; and (vii) to ensure that the Standing Committee maintained awareness of activities in WHO to determine the need for an administrative services agreement with WHO as executing agency. The agreement to amend the TDR Memorandum of Understanding to meet recommendations (ii) and (iv) is being sought with the cosponsoring agencies. As requested by the Joint Coordinating Board, the Standing Committee is reviewing issues relating to seeking candidates from the private for-profit sector and from nongovernmental organizations and the feasibility and merit of constituency positions among other interested cooperating parties, the feasibility and merit of voluntary versus defined constituency groupings and a 2-year term of office for the Vice-Chair of the Joint Coordinating Board. The Standing Committee will present its recommendations to the Board at its next session, in June 2008.

Neither of the governance bodies currently has a foundation, another nongovernmental entity or a private for-profit organization as a full member, except that the International Planned Parenthood Federation is a permanent member of HRP's Policy and Coordination Committee. TDR once had a foundation member on the Joint Coordinating Board. Discussions on membership are under way in TDR, as described above. Under paragraph 2.2.3 of the TDR Memorandum of Understanding, any cooperating party, including entities other than governments, can apply for membership. Similarly, the HRP Memorandum of Understanding would allow inclusion of a foundation or other nongovernmental entity among the other interested parties. The process for selecting such entities would have to be decided. The selection criteria might include whether only parties that make a financial contribution could be included. This is not a prerequisite for TDR membership under paragraph 2.2.3 of the Memorandum of Understanding. Of relevance for the Policy and Coordination Committee is the discussion by the Joint Coordinating Board about constituency positions among members.

As described above for TDR and in this evaluation report, the two programmes have a similar problem of a lack of active participation and rapid turnover of beneficiary country government representatives.

For the 2007 Joint Coordinating Board meeting, as part of a discussion of options for TDR's governance, "points for the strategy to increase the role of disease-endemic countries and other regional representation in the Joint Coordinating Board" were prepared (Annex 3, Joint Coordinating Board document for Agenda Item No. 6 on options for TDR's governance). They are intended to (i) increase regional office and regional committee involvement, (ii) increase national involvement, (iii) increase individual involvement and (iv) other points. An extract of selected issues that may be of greatest interest to HRP and the Policy and Coordination Committee is given below.

- The regional offices and regional committees will have a much stronger role in the selection, briefing and follow-up of representatives of Member States. Prior to the Joint Coordinating Board session, each regional office will brief representatives from its region on relevant regional issues. Close contacts between the regional office and the country delegates include briefing and debriefing visits and feedback reports.
- In addition to a briefing meeting for all new members the day before the Joint Coordinating Board, similar to that of the Policy and Coordination Committee, there is a pre-meeting of disease-endemic countries (non-OECD), chaired by a Board member from a disease-endemic country with support from the TDR secretariat, to allow specific issues to be discussed in advance of the meeting.
- Members and regional offices are invited to share information on the status of target diseases and research capacities in their countries and regions and to participate proactively in the deliberations of the Board.
- A network of disease-endemic country representatives and other regional representatives will be established by electronic exchange, complemented by a peer-coaching system for new representatives to ensure continued discussions between and better preparation of the Board meetings.
- Country representative members are made aware of their responsibility to represent both their country and their region on the Board and to keep both their governments and regional groupings informed of their TDR-related activities.
- The Board agreed to prolong the term of office of its members from 3 to 4 years.
- TDR covers the expenses of a representative from each regional office to attend Board meetings, and these representatives brief the government representatives from their respective regions in line with the strategy to increase their participation; there is also a de-briefing at the end of the session.
- The Board has approved guidelines for representatives selected by WHO regional committees, which should help to ensure that the right delegates are chosen for the purpose and help the delegates to prepare accordingly.

Based on the strategies discussed in TDR, HRP could consider the following strategies in view of strengthening the Policy and Coordination Committee:

- Greater involvement of WHO regional directors and country representatives in the selection of delegates, changing the selection process during regional committee meetings from one based on alphabetical order to one based on stringent criteria. This would probably mean that the HRP Director and other senior secretariat would have to visit regional and country offices and attend regional committee meetings systematically.
- Preliminary briefings for members of the Policy and Coordination Committee: currently a 2-h briefing is offered on the afternoon before the meeting starts. While extending this briefing could allow new members to better understand the nature of the Programme and the functioning of the Committee, it would be difficult to arrange a full-day briefing on the day before the meeting, as there is a Standing Committee meeting in which the senior HRP secretariat must be present.
- Send out documentation for preparation of meetings to members and observers earlier.

- Strengthen translation services for non-English- and French-speaking government representatives.
- Decentralize meetings to the regions on an alternating basis (one year in Geneva, one year in a region), including field trips (prolonging the meeting to 3 days), choosing the region in consultation with TDR. In 2008, the Policy and Coordination Committee meeting will be held in Argentina and the Joint Coordinating Board meeting in Brazil.
- Both the HRP secretariat and the Policy and Coordination Committee Chair and Vice-Chair should inform themselves in detail about the TDR strategy and guidelines. Inspired by these instruments, adapted to the needs of HRP and also based on the category 2 stakeholder survey of this external evaluation, it is proposed that the HRP secretariat design a draft strategy and guidelines for greater involvement and participation of categories 2 and 3 members in the deliberations of the Policy and Coordination Committee to be discussed and validated by the Committee at its meeting in 2008.

Decentralizing meetings to the region will mean additional costs to HRP (flying in secretariat staff) and will limit the number of HRP secretariat staff who can attend. It could also limit the representation of some bilateral donor governments. It should not have a negative impact on the access of beneficiary government representatives, as their travel costs are covered by the Programme. TDR's experience (the TDR Joint Coordinating Board meeting in Brazil will be the fifth session outside Geneva) shows that sessions outside Geneva are well attended. TDR secretariat participation has generally been limited to the coordinator level, in addition to the Director, the Special Programme Coordinator, the Manager for External Relations and Governing Bodies, staff servicing the Board, and the WHO Legal Counsel.

2.2 Standing Committee

The Standing Committee of HRP is composed of four cosponsors; the Director of HRP and HRP secretariat also attend Standing Committee meetings. It meets three times a year.

The Standing Committee of TDR is composed of four cosponsors; the Director of TDR ex officio (and the Manager of TDR External Relations and Governing Bodies ex officio plus limited attendance from other staff if justified), the Joint Coordinating Board Chair and Vice-Chair ex officio, the Scientific and Technical Advisory Committee Chair and three co-opted Board members (one representing OECD members and two representing disease-endemic country members, including one from sub-Saharan Africa) also attend Standing Committee meetings. Inclusion of the ex officio participants did not require amendment of the TDR Memorandum of Understanding. It meets three times a year.

The HRP Standing Committee could benefit by becoming more inclusive, allowing Scientific and Technical Advisory Group and Policy and Coordination Committee representation (chairs, vice-chairs) during the meetings. The PEEC (PCC external evaluation committee) of the current and previous evaluations actually followed this more inclusive composition. The move was discussed recently by the Standing Committee, but there is reluctance to amend the Memorandum of Understanding, which currently would not allow full membership. It should be determined whether the Memorandum of Understanding allows for an adviser or ex officio status of the chairs of the Scientific and Technical Advisory Group and the Policy and Coordination Committee.

2.3 Scientific and Technical Advisory Committee or Group

The HRP Scientific and Technical Advisory Group (STAG) meets once a year and has 15–18 members representing a broad range of biomedical and other disciplines. The chairs of the Gender and Rights Advisory Panel and the Policy and Coordination Committee, the chairs of the Regional Advisory Panels and the Scientific and Ethical Review Group also attend Advisory Group meetings. The HRP secretariat is represented with a large delegation. Invited participants include individuals from other organizational units at WHO (e.g. departments of Research Policy and Cooperation and HIV/AIDS, TDR) and from other research organizations (e.g. the Global Forum for Health Research).

The Scientific and Technical Advisory Group recently changed its focus to become more forward looking in its strategic advice to the Policy and Coordination Committee, rather than being retrospective (alternating full with more focused, strategic meetings). It holds its meetings in February, before the Policy and Coordination Committee, so that its report, which is technical, is available for the Committee members to help them prepare their contributions.

The TDR Scientific and Technical Advisory Committee holds annual meetings, consisting of 15–21 scientists, selected on the basis of scientific or technical competence. Members serve for a period of 3 years and may be reappointed. During preparation of TDR's new strategy, sub-groups of the Committee have met as necessary. After some criticism in the draft interim report of the Joint Coordinating Board subcommittee on the review of TDR governance, efforts are under way to strengthen relations and communication between the Scientific and Technical Advisory Committee, the TDR secretariat and the Joint Coordinating Board. The Board Chair and Vice-Chair attend the Committee meetings and the Scientific and Technical Advisory Committee Chair attends the Board meetings. As indicated earlier, all three officers attend the Standing Committee meetings ex officio. The chairs of the scientific and technical advisory committees of the relevant WHO disease control departments are invited to the next meeting of the Committee in February 2008, and this policy will continue. In addition, since 2007, a representative from each WHO regional office is invited to attend, at TDR's expense. Directors of relevant WHO departments, including HRP and the Department of Research Policy and Cooperation, are also invited to attend. Since 2007, there has been an item on the agenda to allow regional office and disease control department directors to update their perceptions of key research needs.

In HRP, the relation between the Scientific and Technical Advisory Group and the Policy and Coordination Committee is very close and constructive, and communication with the Programme is frequent. Several participants in Advisory Group meetings also attend Committee meeting (chairpersons of the Advisory Group, the Gender and Rights Advisory Panel and the Scientific and Ethical Review Group) and present the highlights of their meetings to the Policy and Coordination Committee. The Chair of that Committee also attends the Advisory Group meetings. HRP might discuss whether inviting representatives from regional offices would further improve mutual understanding and collaboration.

2.4 Other issues

2.4.1 Exchanges between HRP and TDR on governance

Currently, there is no formal arrangement for the two directors to meet regularly and exchange questions, challenges or lessons learnt about

governance. The use of and exchange on milestone documents and processes between the two programmes could be improved. While the two directors meet on other WHO task forces, periodic bilateral meetings on governance and programme steering and management questions could be suggested. Sharing of evaluation reports and other key documents that could be of relevance to each other is suggested. These steps could be effective for strengthening mutual learning and knowledge-sharing for more effective and efficient governance of the two programmes. According to TDR, interaction has been stronger in recent years, as WHO seeks to discuss its strategy. A key area of common interest is how the programmes interact administratively and strategically within WHO. They could also work together to reinforce the regional nature and representation of their governance.

2.4.2 Transparency of governance and organization

The TDR website gives an excellent insight into its governance set-up (http://www.who.int/tdr/about/governance/default.htm), with easy-to-understand graphical illustrations and additional information if needed. While the HRP website has a section on governance (http://www.who.int/reproductive-health/management/index.html), the visitor finds many governance-related reports but no simple access to the Programme's governance. As many HRP partners (such as decentralized WHO staff in regions and countries, beneficiary country governments and scientists) have difficulty in understanding the identity of HRP in relation to RHR and WHO, it is recommended that HRP include a similar set of easy-to-access, understandable illustrations and information on its structure and governance on its website.

Annex 9: WHO Programme Budget 2006–2007

Organization-wide expected results in reproductive health

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Adequate guidance and support provided to improve sexual and reproductive health care in countries through dissemination of evidence-based standards and related policy, and technical and managerial guidelines.	• Number of new or updated guidance documents to support national efforts to improve reproductive and sexual health validated and disseminated in countries	Existing portfolio of tools and standards	8 new or updated
2. New evidence, products and technologies of global and/or national relevance available to improve reproductive and sexual health, and research capacity strengthened as necessary.	• Number of completed studies of priority issues in reproductive and sexual health	Existing evidence base	40 new studies
	• Number of new or updated systematic reviews on best practices, policies and standards of care	Existing portfolio of systematic reviews	15 new or updated systematic reviews
	• Number of new research centres strengthened through comprehensive institutional development support	More than 100 centres supported by Special Programme of Research, Development and Research Training in Human Reproduction since 1972	6 new centres
3. Policy and technical support effectively provided to countries for the design and implementation of comprehensive plans for increasing access to, and availability of, high-quality sexual and reproductive health care, strengthening human resources, and building capacity for monitoring and evaluation.	• Number of targeted countries with new or updated strategies and plans for strengthening access to, and availability of, high-quality sexual and reproductive health care	20	20 additional
	• Number of countries completing operational research studies to evaluate approaches to provision of high-quality sexual and reproductive health care	25 in previous two bienniums	15 additional
4. Adequate technical support provided to countries for better reproductive and sexual health through individual, family and community actions.	• Number of targeted countries developing new or improved interventions to foster action at individual, family and community levels for better reproductive and sexual health	0 (new area)	5
5. Ability of countries to identify regulatory obstacles to provision of high-quality sexual and reproductive health care strengthened.	• Number of targeted countries having reviewed their existing national laws, regulations and policies relating to reproductive and sexual health and rights	2	3
6. International efforts for achieving international development goals in reproductive health, including global monitoring, mobilized and coordinated.	• Global report on progress towards achievement of international development goals in reproductive health submitted to the Health Assembly	1	2

Reproductive health is also supported by results expected to be achieved in other areas of work (http://www.who.int/gb/ebwha/pdf_files/PB2006/P2-en.pdf).

Annex 10. Reporting on benchmarks

Indicator	Baseline	Target 2004–2007	Achievements by end 2005	Achievements by end 2007
Number of completed studies on priority issues in reproductive health (ER 2)	Existing evidence base	80 studies	19 completed	47 completed
Number of new or updated systematic reviews on best practices, policies and standards of care (ER 2)	Existing portfolio of systematic reviews	30 new or updated systematic reviews	19 reviews	55 new or updated reviews carried out in headquarters and regional offices
Number of countries completing operational research to evaluate approaches to provision of high-quality reproductive health care (ER 2 – 2004–2005; ER 3 – 2006–2007)	Existing national evidence bases	15 countries (target 2004–2005)	11 countries	Use of indicator discontinued
Number of new research centres strengthened by comprehensive institutional development support (ER 2)	More than 100 centres supported by HRP since 1972	6 new centres (target 2006–2007)	Indicator added in 2006–2007 biennium	15 new research centres strengthened in 2006–2007
Number of targeted countries that have reviewed their existing laws, regulations and policies relating to sexual and reproductive health (ER 5)	2 countries	3 countries (target 2006–2007)	Indicator added in 2006–2007 biennium	18 countries

Source: Programme Budget 2004–2005, Performance Assessment Report and Programme Budget 2006–2007, Performance Assessment Report (in preparation)

ER = Expected result

Annex 11. HRP/RHR conceptual framework (from last external evaluation)