



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

# External evaluation 2003–2007

Executive summary

**UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP). External evaluation 2003–2007; Executive summary**

**© World Health Organization 2008**

All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: [bookorders@who.int](mailto:bookorders@who.int)). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press, at the above address (fax: +41 22 791 4806; e-mail: [permissions@who.int](mailto:permissions@who.int)).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Views expressed in this document are those of the 2003–2007 HRP External Evaluation Team.

Printed in Switzerland

# Contents

Introduction and methods	1
Executive summary	4
I. Long-term safety and effectiveness of copper intrauterine devices	4
II. Maternal and perinatal care: translating evidence-based methods into policy and practice	7
III. Medical (non-surgical) induced abortion	10
IV. Improving the safety and effectiveness of contraception in China	12
V. Knowledge synthesis and transfer	15
VI. HRP follow-up on governance, management, administration and efficiency	18
Overview of conclusions and recommendations of the 2003–2007 external evaluation	21
Annex 1: Background note and terms of reference	23



# Introduction and methods

## Introduction

This external evaluation of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) was designed to complement the comprehensive external evaluation covering 1990–2002, conducted by Management Sciences for Health and the Swiss Centre for International Health of the Swiss Tropical Institute. It was recognized that the findings of the previous external evaluation remained relevant to most of HRP's work. Therefore, for the current evaluation, a case-study approach was chosen to highlight specific areas in which HRP's work produces global public goods. (For terms of reference and information about the five case-studies conducted during this evaluation, see Annex 1.) A sixth case-study was included to update information on the governance, management, administration and efficiency of HRP's work.

The conclusions and recommendations of the 1990–2002 external evaluation were based on document review, analysis of key publications, seven country visits and input from more than 300 informants, of whom 249 provided detailed information through interviews and e-mail questionnaires. The evaluation addressed four key issues:

- the relevance and effectiveness of HRP-supported research in reproductive health;
- dissemination, global use and impact of the results of HRP's reproductive health research;
- capacity-strengthening for reproductive health research by HRP and use and impact of HRP's work at country level; and
- HRP's governance, management, administration and efficiency.

The external evaluators gave HRP a strong, favourable endorsement for its performance, management and strategic direction. The overall conclusion was that, during the period 1990–2002, HRP had clearly met expectations in terms of its core mission to coordinate, promote, conduct and evaluate international research in reproductive health, and had achieved its major objectives. The Programme established its position as the global leader in generating research results and establishing scientific consensus to advance reproductive health policies and practices, especially in developing countries.

## Selected conclusions from the 1990–2002 external evaluation

- HRP's contribution to global public goods include its cumulative impact on fertility regulation and reproductive health, leading to significant public health benefits for women, couples and children throughout the world.
- HRP is uniquely important in supporting national health administrations' efforts to improve reproductive health through research, research training, setting of standards and guidelines, and promoting the use of research results in policy-making and planning. While other organizations carry out some of these functions, none comes close to the breadth, capacity, prestige and credibility of HRP, with its base in WHO, international composition and links to governments.
- Because of the good credibility of the Programme and WHO in general, HRP's research results have a greater influence on reproductive health policies and standards than the research of any other organization.
- Research capacity-building is one of HRP's major strengths.





- HRP has created an impressive global research network, particularly in developing countries (123 supported centres in 59 countries in 2000–2001).
- The research results of HRP and the centres it supports have contributed substantially to shaping national policies and practice.
- Cosponsorship of HRP is vital both for financial reasons and for enhancing global and inter-organizational acceptability. Cosponsorship strengthens the credibility of HRP as the premier international institution in reproductive health research.
- The overall management of HRP is considered effective and is appreciated by cosponsors and donors.
- Total HRP income from all sources has been decreasing for the past 8 years, despite expanding priorities and activities to be addressed.

The conclusions were the basis for a number of recommendations for further improvement on each of the key issues. One of the main recommendations, which forms the basis of the current evaluation, was "HRP should continue to focus on global public goods, and should try to document the contribution of its work to global public health. As a measure of efficiency, the cost to HRP of its contribution to health outcomes should be calculated. Estimates and projections of abortions averted, unwanted pregnancies prevented, and improved reproductive health through more effective contraceptive methods, emergency contraception, and service guidelines will help to demonstrate HRP's important contributions and cost-efficiency."

The report was approved by the External Evaluation Monitoring Team and presented to the Policy and Coordination Committee in June 2003.

The HRP secretariat then prepared a detailed action plan to respond to the recommendations. This was presented to the Policy and Coordination Committee at its meeting on 30 June–1 July 2004.

## Methods used in the 2003–2007 external evaluation

Financial support to the Programme from the World Bank, one of its four cosponsors, is provided by the Development Grant Facility and awarded annually by the Development Grant Facility Council. One of the conditions for grants is a periodic external evaluation. Thus, at a meeting to decide on grants in fiscal year 2006, the Development Grant Facility Council, in approving a budget allocation to the Programme, requested that an "independent evaluation" be undertaken in 2007. This request was discussed by HRP's Standing Committee of cosponsors at their 54th meeting on 1 February 2006. The Committee agreed that the new independent evaluation should be more limited in scope and focus than the previous evaluation. Specifically, the Committee "agreed that the focus of the forthcoming external evaluation should be on the impact of the Programme on global public goods", in accordance with the proposal of the Policy and Coordination Committee "... to strengthen and monitor follow-up actions to the recommendations of the 1990–2002 external evaluation..."

In the five technical case-studies, the definition<sup>1</sup> of 'global public goods' used, in accordance with the terms of reference, was:

*Public goods are generally defined as those goods that produce benefits that are non-rival (many*

1. The two definitions that follow are taken from the Independent Evaluation Group of the World Bank Guidelines for Global Program Reviews, 24 January 2006. The Group was known until November 2005 as the Operations Evaluation Department of the World Bank.

*people can consume, use, or enjoy the good at the same time) and non-excludable (it is difficult to prevent people who do not pay for the good from consuming it). If the benefits of a particular good accrue across all or many countries, then this is deemed a global or international public good.*

The International Task Force on Global Public Goods made the above definition operational, as follows:

*International public goods, global and regional, address issues that: (i) are deemed to be important to the international community, to both developed and developing countries; (ii) typically cannot, or will not, be adequately addressed by individual countries or entities acting alone, and, in such cases (iii) are best addressed collectively on a multilateral basis.*

The team mandated to conduct the external evaluation for 2003–2007 was composed, for overall coordination, supervision of the technical case-studies and the case-study on HRP governance, of Douglas Huber, Management Sciences for Health, and Claudia Kessler, Swiss Centre for International Health of the Swiss Tropical Institute, and, for the analyses of cost-effectiveness and economic analysis of the five technical case-studies, William Winfrey, Futures Institute.

In line with the terms of reference (Annex 1), the following global public goods were examined in-depth (with the names of independent reviewers who wrote the technical case-studies):

- promoting family planning: long-term safety and effectiveness of copper-releasing intrauterine devices (Roberto Rivera);
- promoting family planning: improving the quality of care in family planning in China (Barbara Pillsbury);

- medical (non-surgical) induced abortion (Jane Norman);
- improving maternal and newborn health (Affette McCaw-Binns); and
- knowledge synthesis and transfer (Cynthia Farquhar).

The five case-studies follow a standard case review template designed by the two external evaluation coordinators, with input from the HRP secretariat, which was approved by the Policy and Coordination Committee's External Evaluation Committee.

The consultants were guided by the question, "By investing in HRP, how has the world, region or country changed?" A person in HRP was identified to provide documents, programme costs and factual input requested by the consultants for each of the five technical case-studies.

In addition to document review, the consultants conducted in-depth interviews with key stakeholders and collaborated with the economist (William Winfrey) who helped quantify cost-effectiveness and potential health impacts. The governance case-study assessed HRP's actions related to governance, management, administration and sustainability in response to its own action plan for responding to the recommendations of the 1990–2002 external evaluation.

Feedback and comments on the technical case-studies were provided by the Scientific and Technical Advisory Group at its meeting on 19–21 February 2008, and the feedback was used by the consultants to finalize their reports. The complete report of the external evaluation was approved by the Policy and Coordination Committee's External Evaluation Committee for presentation to the Policy and Coordination Committee in June 2008 and for further dissemination.



# Executive summary



## Executive summaries of case-studies, 2003–2007

The following are executive summaries of the full case-studies as presented in the full report. In addition to the summaries, the evaluation coordinators made a number of overall conclusions and recommendations on the various global public goods, in collaboration with the team of external reviewers and the economist.

### I. Long-term safety and effectiveness of copper intrauterine devices

HRP's research programme on intrauterine devices (IUDs) was initiated in 1972. At that time, multiple models existed, but their safety and efficacy had not been established in appropriate clinical trials. HRP's research was designed to provide information on the safety of existing IUDs, the duration of effectiveness of copper IUDs, their mechanism of action and their relation to pelvic inflammatory disease. Another goal was to prepare internationally acceptable evidence-based guidelines for service delivery. These goals provided the foundation for HRP's extended IUD research initiative.

#### Methods

Four main methods were used to obtain the information included in the case-study: personal interviews and continuous communication with HRP staff in Geneva; interviews with 21 experts on IUD research and use, covering various geographical regions and institutions; review of a large number of HRP documents and publications; and analysis of national data on IUD use to estimate impact.

#### Findings

The major milestones in HRP's work on IUDs have been:

- establishment in 1972 of the Task Force on IUDs, which provided the necessary research

infrastructure to the Programme and improved research capability in developing countries to allow them to conduct research on other aspects of sexual and reproductive health of national or international interest,

- provision of data for approval in 1994 of the TCU 380A device by the United States Food and Drug Administration for 10 years of use; and
- publication of *Medical eligibility criteria for contraceptive use - third edition*, *Selected practice recommendations for contraceptive use*, *Decision-making tool for family planning clients and providers*, and the *Family planning: a global handbook for providers*, which have become the standard references guiding delivery of IUD services worldwide.

HRP's IUD research between 1972 and 2007 resulted in 21 randomized and seven non-randomized clinical trials, 11 studies on menstrual blood loss, 10 on the mechanism of action of IUDs, seven on new IUDs, three on agents to treat excessive bleeding, three on special safety issues and one on the demographic and economic impacts of IUD use. These studies produced 156 publications, which form a major portion of the global body of scientific evidence on the safety and efficacy of IUDs.

The main outcomes of the programme have been: establishing the duration of contraceptive effectiveness and safety of copper IUDs; consensus-based, internationally accepted guidelines for the use of IUDs; evidence of the low



risk for pelvic inflammatory disease associated with IUD use; and the mechanism of action of IUDs. The main global public good has been establishment of the TCu 380A as a safe, highly effective long-term contraceptive, expanding the limited choices women have for such methods. It is estimated that, between initiation of the HRP programme and 2007, the number of IUD users increased from 70 million to 160 million, and it is reasonable to attribute an important part of this increment to the Programme. HRP research also established that the primary mechanism of action of the TCu 380A is prevention of fertilization and that the risk for pelvic inflammatory disease is low. Updated IUD guidelines have been incorporated into numerous country norms. Our analysis of the most recent data indicates that increasing the duration of use and the number of IUD users can have a major impact on global health and economic outcomes.

HRP's research programme has been cost-effective. In 1990, 45 scientists in 15 countries conducted clinical trials on the TCu 380A, TCu 220C, Multiload 375, a new frameless IUD and an implantable post-placental IUD. The total research expenditure for that year was US\$ 78 000, a fraction of the cost of similar trials by other organizations. The cost of conducting high-quality clinical trials has increased substantially within the past few years, mainly due to the exigencies of good clinical practice, research ethics and national regulations. The favourable cost differential between HRP and other public sector research organizations will continue, but probably at a reduced level. We consider, however, that conducting research with HRP is more than a cost-saving alternative: HRP provides important advantages for making changes in policies and practice, including its national and international recognition and its influential relationships.

HRP's research on IUDs has built effectively on the work of other organizations. In addition, it has collaborated with numerous national and international training and service delivery organizations to increase the health impact of IUDs.

A finding that will require special attention is the persistent discrepancy between the scientific evidence generated by HRP and other organizations and the perspectives of providers and the public. Our interviews with IUD experts indicate that, in many countries, there is still a belief that the efficacy of the TCu 380A lasts for less than 10 years, that it prevents implantation (or functions as an abortifacient) and that it causes a high rate of pelvic inflammatory disease. Programme and translational research must be strengthened to overcome these barriers and misconceptions.

We identified differing perceptions of the role of HRP in translating research results into practice. Some thought HRP's responsible only for research, publication and dissemination, while others considered that HRP should also be responsible for evaluating the health and economic impacts of its research. This requires further clarification.

### *Conclusions*

1. The goals of the HRP research agenda, established in 1972, to provide relevant information to country programmes on the long-term safety and effectiveness of IUDs have been fully and successfully achieved.
2. There is a general perception that the essential clinical research on copper IUDs is almost complete, with the possible exception of additional clinical research on the relation between IUD use and HIV/AIDS.





3. A disturbing gap persists between the available scientific evidence and the perceptions of providers and the public. This area requires continued effort.
4. The development of and introduction to programmes of the TCU 380A is the result of the collective work of numerous national and international organizations.



### *Recommendations*

1. Strengthen the 'research to practice' strategy of HRP/RHR<sup>2</sup>. Service and medical barriers persist that continue to limit the use of IUDs.
2. Define the level of impact of IUDs for which HRP/RHR is responsible. Identify appropriate indicators for that impact.
3. Strengthen the collaboration between HRP/RHR and WHO regional and country offices, other international organizations and national stakeholders to enhance the translation of research into practice.

---

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

## II. Maternal and perinatal care: translating evidence-based methods into policy and practice

The work of HRP on maternal and perinatal health between 2003 and 2007 included trials on the prevention and management of pre-eclampsia, an assessment of the maternal and neonatal consequences of female genital mutilation and scaling-up of a new approach to antenatal care. The last activity, the WHO antenatal care model for translating evidence-based interventions into policy and practice, combined work on best practices, safe motherhood and control of sexually transmitted infections and is relevant for low-income countries in which maternal health must be improved (Millennium Development Goal 5—MDG5).

### Methods

Publications, technical reports, 'grey' literature and a site visit to Thailand provided the basis for evaluating the new approach in operation. Meetings with policy-makers, health providers and mothers and an e-mail questionnaire to elicit expert opinion provided information on experiences, potential barriers and facilitators of use of the model.

### Findings

#### Process

Between 1991 and 1998, HRP designed an evidence-based antenatal care model for low-risk women, which was integrated into a four-visit programme of screening, intervention and health promotion for delivery at the first visit and at 26, 32 and 38 weeks. A cluster-randomized trial was conducted to compare the clinical and cost-effectiveness of the model with that of the standard Western model in Argentina, Cuba, Saudi Arabia and Thailand. On the basis of the results, published in 2001, HRP's maternal and perinatal

health team of four persons supported a scaled-up approach in Khon Kaen Province, Thailand, between 2003 and 2006 by helping to prepare training material (*WHO antenatal care randomized trial: manual for the implementation of the new model*, translated into Thai) and e-learning tools and by sponsoring training workshops.

#### Outputs

The new model was equivalent to the standard model in terms of perinatal outcome. Intervention clinics achieved more effective treatment of syphilis and a significant reduction in the number of visits (median, five versus nine). In a low-risk population, participating women had a higher rate of pre-eclampsia (prevalence, < 2%; odds ratio, 1.26; 95% confidence interval, 1.02;–1.56) out of three maternal outcomes (pre-eclampsia/eclampsia, postpartum anaemia and urinary-tract infection); however, there was no difference in complication rates.

#### Policy and programme outcomes and collaborative arrangements

The Thai Government's strong support for research on public policy results in collaboration between academia and the State and creates an atmosphere receptive to evidence-based interventions. The Khon Kaen provincial team modified the model to address psychosocial and logistical concerns and inefficiencies in the health promotion component. During the transformation, stakeholders (the public and health providers) were informed by various media about the new approach. Deficiencies in skills were addressed, and facilities were equipped to deliver new services. The programme will be extended to five additional provinces in 2008, to reach 12% of the Thai population.

The study team from a WHO collaborating centre in Rosario, Argentina, introduced the new





model elsewhere in Argentina and in Yap State, Federated States of Micronesia. The United States Agency for International Development promoted the model as ‘focused antenatal care’ in Ghana, Kenya and South Africa. It is also in use in the United Republic of Tanzania and Zimbabwe. In 2007, HRP initiated modification of the model for the African setting, adding new components on, among others, HIV counselling, testing and treatment.

### Cost-effectiveness and expected annual global benefits

The four-visit model is less expensive than the commonly used standard model, even with an additional visit. Women attending clinics under the new model spent less time and money for antenatal care, and the health sector costs per pregnancy were lower. Globally, US\$ 16.4 billion dollars could be saved annually by switching to the four-visit antenatal care model, and US\$ 5.4 billion in countries considered to have medium (50–500/100 000) and high (> 500/100 000) maternal mortality rates.

### Impact

Stanton C et al.<sup>3</sup> reported that, in Africa and Asia, antenatal care increased the rate of births with a skilled attendant, from 13%–45% for women who made two or three visits to 73% for those who made four or more visits. The availability of high-quality antenatal care may encourage women to attend the recommended four visits and help increase skilled attendance, with the long-term potential of significantly reducing both maternal and perinatal mortality.

3. Stanton C et al. Skilled care at birth in the developing world: progress to date and strategies for expanding coverage. *Journal of Biosocial Science*, 2006; 39:109–120.

## Conclusions

### Strengths

HRP research has set the global standard for antenatal care. The framework for monitoring attainment of MDG5 now includes the HRP recommendation of using the proportion of pregnant women worldwide who attend for four antenatal visits as an indicator of antenatal care use.

The model should be seen as a blueprint, to be adapted to the local context and updated as new evidence becomes available. Its robustness is demonstrated by its capacity to yield equivalent results in four different developing countries, whether delivered by midwives, general practitioners or obstetricians. It has also performed well in Africa, where antenatal care attendance has usually been lower than in other regions of the world.



Cost-effective interventions can be designed systematically and implemented on a wide scale, resulting in savings for both individuals and the health sector without compromising outcomes while, at the same time, improving care, as health providers have more time to spend with women. A political environment receptive to evidence-based approaches eases the transition from research to practice. Leadership is critical, as an agent of active change will be more effective in bringing new evidence into policy and practice.

### **Weaknesses**

This new approach will require modification of basic obstetric and midwifery training programmes. Concern that too few visits during the third trimester could result in under-diagnosis of pre-eclampsia must be addressed, as this condition is a significant risk factor for maternal and perinatal morbidity and mortality, especially in countries with few resources.

### ***Recommendations***

As the HRP maternal and perinatal health team consists of only four persons, HRP should use collaborating centres, institutions and networks of health professionals to share its experience more widely, e.g. by sponsoring regional meetings and attending professional meetings. By working with local champions, HRP could reach policy-makers and health authorities to increase use of the model.

In the future HRP could evaluate the impact of the new approach on health systems, especially in countries with few resources, where demand may increase. It could also design and test strategies for health promotion and behaviour change and draw up guidelines for women at high risk attending clinics as outpatients.





### III. Medical (non-surgical) induced abortion

Unsafe abortion, defined as “a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal standards, or both”, remains a major public health problem. Medical abortion, that is, abortion effected by drugs rather than through a surgical procedure, is a safe and effective alternative to surgical abortion and can potentially play a major role in reducing unsafe abortion.

#### Methods

This case-study was conducted on the basis of face-to-face meetings with HRP personnel and other stakeholders and by a review of the published literature on medical abortion from WHO and other sources. The focus of the review was activities between 1997 and 2007.

#### Findings

HRP’s work on preventing unsafe abortion included: highlighting the issue; conducting, analysing and publishing clinical trials on medical abortion; preparing guidelines; and collaborating on the development of Medabon®. HRP’s direct expenditure on research on medical abortion was US\$ 1.7 million over the 8-year period 1999–2007.

The outputs fall into three categories: an extensive, widely cited list of original publications; registration of Medabon®; and addition of mifepristone and misoprostol to the *WHO Model list of essential medicines*. Other outputs include contributions to meta-analyses and systematic reviews, organizing sessions at conferences, local and regional workshops, generation of new research questions and individual and institutional capacity-building.

HRP worked with 15 medical centres and three academic institutions in conducting its clinical trials and in public-private partnership with the (not-for-profit) Concept Foundation and the pharmaceutical firm Sun Pharma in the registration and production of Medabon®.

#### Cost-effectiveness (including finances)

The price of Medabon® is significantly lower than the public sector prices of mifepristone and misoprostol, its components. Estimation of the numbers of women worldwide who could access Medabon® at its anticipated cost but who could not afford mifepristone marketed by current manufacturers and who would otherwise choose unsafe abortion indicates that 1 million unsafe abortions and 3600 maternal deaths could be potentially averted annually by registration of Medabon® where abortion is legal. HRP expenditure on medical abortion over the past eight years could be translated into a projected cost of US\$ 0.95 per unsafe abortion averted and US\$ 264 per maternal death averted.

#### Outcomes and global public goods

Most of HRP’s work in medical abortion during the decade involved conducting clinical trials. Five of the seven large randomized clinical trials conducted in developing countries in the past 10 years were undertaken by HRP. These trials are of the highest quality, have clear relevance for clinical service provision and were conducted with sufficient rigour and detail that they can be used to support licensing applications for mifepristone and misoprostol. This is unusual for academic clinical trials, and HRP deserves congratulations for achieving this degree of quality. Twice as many citations (which are quality indicators) of HRP-run clinical trials have been made than of the two large trials conducted by other organizations in developing countries during this period.

Additionally, HRP has disseminated the results of these trials in evidence-based clinical guidelines and reports. They have also, in strategic reviews of abortion provision generally, helped governments develop strategies for introducing medical abortion.

HRP also collaborated with the Concept Foundation to enable the manufacture, registration and distribution of a low-cost, good clinical practice standard medical abortion product (Medabon<sup>®</sup>) to the public sector in developing countries. This ambitious and novel approach has enabled translation of HRP clinical research into a formulation which can benefit developing countries. The potential impact of this agent is described below.

### *Impact*

HRP's work has helped change the global health status, with a demonstrated 5.4% reduction in maternal mortality between 1990 and 2005, and work on preventing unsafe abortion is likely to effect further reductions. The rate of unsafe abortions per 1000 women of reproductive age has also declined.

HRP's work has laid the foundation for a potential increase in access to medical abortion. Medabon<sup>®</sup> is now registered in one country, and registration is pending in a further 10. The work of HRP on misoprostol allows health-care providers to recommend a safe regimen (albeit less effective than the mifepristone-misoprostol combination) in countries where mifepristone is unavailable. Where medical abortion with mifepristone is freely available, about 50% of women chose this option for inducing abortion.

### *Conclusions*

#### **Successes and failures**

The major success of HRP's work in this area is the good clinical practice standard clinical trials, which

have provided an important knowledge base for medical abortion practice and enabled registration of a low-cost formulation. HRP's strengths include collaboration with centres and individuals that allowed these trials to be completed as planned within a small budget.

There are no apparent failures or major weaknesses of HRP's work in this area. Funding shortfalls have necessarily limited the scope of activity.

#### **Lessons learnt**

Timely publication is crucial in translating HRP's work into practice. The excellent data from the clinical trials must now be matched by research on how to introduce Medabon<sup>®</sup> into countries for use in abortion to the full extent of the law.

### *Recommendations*

- The work done by HRP during the period 1997–2007 has been highly cost-effective and is likely to have a major impact in reducing unsafe abortion.
- HRP should sustain its influential, evidence-based, highly respected leadership in facilitating safe medical abortion, replacing unsafe practices.
- WHO, other cosponsors and members of the Policy and Coordination Committee should help the new Director of RHR and HRP to maintain the work in preventing unsafe abortion.
- Now that much of the research has been done to define an appropriate regimen, future work should focus on barriers to service delivery and on synthesis of evidence.
- The WHO management hierarchy should review its internal procedures for approving publication of work on abortion, including medical abortion, and set targets to minimize the delays of the review and approval process.





#### IV. Improving the safety and effectiveness of contraception in China

HRP has a long history of successful collaboration in China. WHO is widely respected in that country, and HRP benefits from its prestige. Since 1979, HRP has helped establish and strengthen a network of research institutes and provided support to build the capacity of Chinese sexual and reproductive health researchers. Today, HRP facilitates a wide array of research and capacity-building activities that are contributing in strategic ways to improve the quality of care and outcomes in family planning and sexual and reproductive health in China.



This case-study addresses one example of this long, multi-faceted collaboration: HRP's assistance in improving the safety and effectiveness of China's locally produced contraceptives. The terms of reference for this case-study called for examination of HRP's role in the withdrawal of less effective IUDs (stainless-steel and copper rings) and the once-a-month oral contraceptive, in particular.

All contraceptives used in China are produced domestically. IUDs are the most widely used, by about 110 million women, constituting about

50% of contraceptive methods. A pivotal study was conducted in 1991–1992 to quantify the numbers of unplanned pregnancies, abortions and cases of reproductive morbidity due to use of the steel-ring IUD. It projected the health, cost savings and other benefits that would accrue from shifting IUD use from steel rings to copper-T IUDs (220C and 380A) and recommended this shift. In 1993, the Government banned production of the steel-ring device. Factories, however, turned to producing a copper-treated variant, which was also considerably less effective than the recommended copper-Ts.

Once-a-month oral contraceptives have been the most popular and most widely used oral contraceptives in China. Concern about their efficacy and long-term safety were raised during a strategic assessment conducted in Chongqing, which led to systematic reviews, the results of which guided recent decisions about procurement.

#### *Methods*

The case-study was based on extensive document review, a study visit to HRP counterparts in China (interviewed in Chinese and English, 5–13 December 2007), in-depth telephone interviews and hundreds of e-mail exchanges with key informants, a follow-up questionnaire, and feedback from multiple reviewers.

#### *Findings*

##### **Effective collaborations**

Achievements were made possible by collaborative relationships. HRP's principal partner was China's National Population and Family Planning Commission, which oversees the national family planning programme. HRP's principal research partner in this work was the Shanghai Institute



of Planned Parenthood Research, which HRP has assisted since 1979.

### Process

The HRP formula that brought about the changes described is a combination of evidence-based research methods and processes that involve policy-makers from the start. HRP's strategic approach was a significant innovation, involving high-level policy-makers in rural field assessments (carried out in the year 2000), which gave them perspectives and feedback from providers and clients. HRP then worked with Chinese counterparts to complete seven systematic reviews that involved policy-makers in a series of experts' meetings (years 2002–2004) and generated evidence on the safety and effectiveness of commonly used contraceptives, providing the evidence base for policy-making.

### Outputs

The most significant outputs were:

- the research findings;
- recommendations that four widely used contraceptives should be removed from the national family planning programme on the basis of considerations of safety and effectiveness: these were the copper ring, the once-a-month pill, a 'visiting' pill and a daily pill;
- a new conceptual guiding framework for overall quality-of-care in sexual and reproductive health in China; and
- better understanding by colleagues in family planning and sexual and reproductive health about systematic, evidence-based research and evidence-based contraceptive improvement.

Other outputs included generation of new research questions, individual and institutional capacity-building, training and dissemination workshops,

and more than a dozen publications in authoritative English and Chinese journals.

### Cost-effectiveness

This work was highly cost-effective in comparison with research for policy change in other large programmes for family planning and sexual and reproductive health. The financial input of HRP for this work has been modest: the total expenditure for the strategic assessment and the systematic reviews was approximately US\$ 300 000 over five years (2000–2004). There is no evidence that HRP resources could have been used much more effectively.

### Outcomes and public goods

The outcome of this collaboration was the policy decision, in 2004, by the National Population and Family Planning Commission to withdraw the four problematic contraceptives from the national family planning programme. They were removed from the list of centrally procured contraceptives, and, as of 2005, these were no longer purchased or provided by the National Commission. The research findings and recommendations also led to decisions in India (and perhaps Thailand) not to import the Chinese once-a-month pill. Publication in the prestigious journal *Contraception* of findings on the high estrogen content and potential safety concerns about this pill reduces the likelihood of formal importation by other countries.

### Impact

The phasing-out of less-effective IUDs and higher-dose hormonal contraceptives might be averting millions of unplanned pregnancies, abortions and adverse reactions. We consider that the decrease in reported abortion rates since 1991 may be attributable to three main factors: phasing-out of steel and copper rings in favour of more effective copper-bearing IUDs; changed Government





policies; and improved quality of care in family planning services. We estimate that about one-third of the decrease in abortion rates might be due to phasing-out of ring IUDs (about 1.4 million abortions averted in 2007).

### *Conclusions*

- Removal of the four contraceptives from the procurement list for the national family planning programme was a major policy achievement by China, attributable in significant part to collaboration with HRP and leading to a significant reduction in the numbers of unintended pregnancies and abortions and associated pain and suffering.
- While UNFPA and other partners provided important support for China's family planning and sexual and reproductive health quality-of-care movement, it is unlikely that the translation of research to policy and the decision taken in 2004 would have occurred when it did without the input by HRP. The National Population and Family Planning Commission and Chinese researchers have stated that, without HRP, the decision would have taken much longer and the process would have been less rigorous.

The phasing-out of the contraceptives is still under way, as they continue to be manufactured, are available for purchase and are provided through some public channels in China. Family planning manuals contain cautions about using the once-a-month pill, although it is still available, and it is reportedly available in the private sector in neighbouring countries.

### *Recommendations*

- Future engagements of HRP should be strategic to ensure that its investment has the greatest impact on health. The National Population and Family Planning Commission and researchers have stated that their greatest need from HRP is technical support to ensure that their research and programmes are up-to-date. HRP should support the unfinished research that emerged from the Chongqing strategic assessment and the systematic reviews (e.g. rationalizing the mix of available contraceptive methods and reconsidering the efficiency and the need for a quarterly IUD check-up). HRP should help conceptualize the research agenda and provide modest technical assistance. It should consider supporting use of the strategic approach by Chinese colleagues in assessing the actions required to improve the quality of care in abortion services.
- WHO in general should use its prestige in China to ensure that contraceptives of established safety and efficacy are used in China or exported, including supporting the full phasing-out of the four contraceptives from health facilities throughout the country and discontinuing production. Given UNFPA's commitment to the Programme of Action of the International Conference on Population and Development and its position to provide "contraceptives of assured quality", HRP and WHO should use the WHO-UNFPA Strategic Partnership Programme and other links with UNFPA to support China's progress towards these goals.

## V. Knowledge synthesis and transfer

This case-study on knowledge synthesis and transfer at HRP focuses primarily on *The WHO Reproductive Health Library* (RHL)<sup>4</sup> and systematic reviews. HRP does not have a working definition of the term 'knowledge synthesis and transfer'. For this case study, 'knowledge synthesis' was defined as the sifting and combining of evidence from research to guide clinical decision-making and health policies, and 'knowledge transfer' was defined as the dissemination and implementation of that evidence. The terms of reference of the case-study were to evaluate systematic reviews, RHL, dossiers for medications on the essential medicines list, summaries of evidence for consensus statements and evidence-based guidance.

### Methods

Interviews were held with relevant staff at HRP and contributors and users of the products of HRP. The feedback from stakeholders was used for the sections on inputs and outcomes and the recommendations. Additional information on HRP's activities was collected by document review and use of the web site of RHR and HRP.

### Findings

#### Inputs

The human resources available are one full-time staff member and a full-time administrator for all the knowledge synthesis activities including RHL and systematic reviews. Since knowledge synthesis and transfer is a transversal activity of the RHR Department, most other HRP and

other RHR staff are involved in these activities. Quantifying human resource inputs is therefore difficult.

Between 2002 and 2007, a total of US\$ 756 931 was spent on knowledge synthesis.

Parallel funding has been provided from partnerships and networks with collaborative groups and nongovernmental agencies.

### Outputs

The main outputs are:

- systematic reviews on practice and interventions in sexual and reproductive health service delivery, which are the building blocks of RHL and other evidence-based guidance from HRP/RHR;
- annual production of RHL in five languages;
- summaries of evidence and guidelines based on systematic reviews, e.g. applications for inclusion in the *WHO Model list of essential medicines*;
- consensus statements on matters of concern to WHO Member States;
- capacity-building through workshops and local support;
- other outputs, including *Medical eligibility criteria for contraceptive use*, the Knowledge Gateway of the Implementing Best Practices Consortium, policy briefs, provider briefs, fact sheets, the HRP newsletter *Progress in sexual and reproductive health research* and presentations at scientific meetings.

### Collaborative arrangements

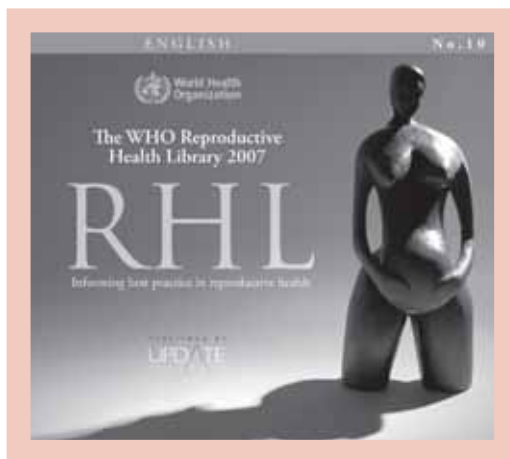
Partnerships have been established with regional collaborating centres (RHL focal points), predominantly in low- and middle-income



4. RHL is an electronic compilation of best practices in sexual and reproductive health and other materials relevant to the management of such services. It is updated annually.



countries, to assist with systematic reviews and preparation and dissemination of RHL. The preparation of systematic reviews is supported by a special collaborative arrangement with the Cochrane Collaboration, an international organization committed to producing high-quality systematic reviews. This arrangement allows publication of full Cochrane reviews in RHL.



### Cost-effectiveness

The cost of preparing systematic reviews at HRP is low and comparable to that of others producing Cochrane reviews. The cost was less than US\$ 20 000 per review, as much of the work conducted involved volunteer work by experts.

### Outcomes and public global goods

This work is used as the basis for guidelines and policy changes, within RHR, by professional medical societies and at global, regional and country levels. As a result of the work, technologies were developed or improved, new research questions were generated and new clinical trials initiated. The global dissemination of the evidence generated contributed to evidence-based advocacy and synthesis documents. Other outcomes include greater uptake of evidence-based practices and

commitment of donors and countries to use evidence.

### Impact

The impact of this work on health status and outcomes, coverage of services and progress towards MDGs can only be established indirectly. HRP's work on knowledge synthesis and transfer directly affects access to evidence-based information, knowledge for policy-making and improved service delivery.

### Conclusions

#### Successes and strengths

- The outputs are growing progressively, with a varied range of products and demonstrated effects on evidence-based clinical and policy decisions.
- HRP has the ability to convene large numbers of individuals and organizations, which is an important factor in the cost-effectiveness of the work on knowledge synthesis and transfer.
- The work addresses globally important issues in sexual and reproductive health and is of high relevance to low- and middle-income countries.
- The staff at WHO includes experienced, competent researchers who can manage and lead systematic reviews.
- In response to the recommendations of the previous external evaluation, HRP works increasingly by electronic means for improved dissemination. Implementation of the planned dissemination strategies results in efficient use of knowledge products, such as RHL and the Sexual and Reproductive Health Series published in 2006 by *The Lancet*.

## Weaknesses

Limited funding has inevitably meant that the number and timeliness of reviews are not always optimal. The small case group working on knowledge synthesis and transfer is involved in an increasing range of activities in addition to systematic reviews and RHL, such as guideline development and implementation research, and capacity-strengthening. It was difficult to assess the impact of the activities in this area of HRP's work in the absence of indicators against which the work could be evaluated. The true costs of the work are unknown.

## Lessons learnt

The provision of evidence-based tools through knowledge synthesis and transfer is a necessary but not sufficient step to bring about change. The barriers to uptake and implementation are many and should be addressed through strong collaborative links with stakeholder groups at country level. The absence of a commonly agreed working definition of "knowledge synthesis and transfer" in HRP/RHR made it difficult to establish a comprehensive list of all the products published during the period evaluated, 1997–2007.

## Recommendations

- Develop and adopt a working definition of knowledge synthesis and transfer to guide further activities in this field. The inclusion of knowledge exchange (as a more collaborative and interactive approach between stakeholders and HRP) into the definition should be considered.
- In view of the widening scope and demands, establish an independent advisory committee for setting priorities.
- Consider establishing a unit for translational research or knowledge synthesis and transfer

within RHR in order to broaden the activities and strengthen transfer.

- Continue to invest in training at national and regional levels by establishing RHL fellowships, a toolkit for training in use of RHL and evaluation of all educational activities
- Strengthen involvement of HRP in the formulation of evidence-based guidelines for use in low- and middle-income countries.
- Adopt tools such as performance indicators to assist monitoring and evaluation of the impact of HRP's work on knowledge synthesis and transfer.





## VI. HRP follow-up on governance, management, administration and efficiency

### *Objectives and methods*

The aim of this case-study is to assess progress on implementing the recommendations of the previous external evaluation of HRP with regard to governance, management, administration and efficiency. Both document reviews and interviews with various stakeholders were used to collect information.

### *Findings*

Regarding implementation of recommendations of the previous external evaluation, HRP responded well, creating a task force for that purpose. Adequate, rapid action was taken, and the transparent reporting to HRP's Policy and Coordination Committee was remarkable. Much progress has been made since 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.

The most notable positive change is the much improved financial situation 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 HRP to cover all three levels of priorities.

HRP has strengthened collaboration with its partners in advocating for implementation of the Programme of Action 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.

When WHO urged bilateral donors to shift from earmarking funds for projects and programmes, such as HRP, to core funding, HRP experienced a significant loss of income. As a result, the United Kingdom, one of the most important bilateral donors to HRP, 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 with 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 crucial 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 has remained similar to that in 2002–2003. UNDP did not make donations to HRP 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.

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 its work and functioning to external evaluations.

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, whilst maintaining the Programme's links with the programme development activities in sexual and reproductive health (PDRH) in WHO within the RHR context.

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 (PCC) on matters relevant to HRP's operation and progress on technical issues. The case-study presents suggestions additional to those already envisaged by HRP.

## Conclusions

- HRP responded actively to the recommendations of the 1990–2002 external evaluation.
- HRP'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 exchange 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.





### *Recommendations*

- 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, sexually transmitted infections, and gender 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 HRP 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 HRP's performance to partners, cosponsors and donors.
- Give HRP a new name for clear recognition and public relations.



# Overview of conclusions and recommendations of the 2003–2007 external evaluation

HRP remains a global leader in sexual and reproductive health research and capacity-building with particular relevance to the needs of populations in resource-poor settings. The evidence base resulting from this research has been translated effectively into health policy changes and improved practice standards and has ultimately improved health outcomes. The case-studies in this external evaluation indicate that HRP is in a good position to continue advancing global public goods in a cost-effective way.



## Overall conclusions

- The importance of increased contraceptive use and reduced population growth for achieving the MDGs, combined with the desire of the four HRP cosponsors to act as 'one United Nations', provide important strategic opportunities for HRP to maximize the health impact of its work.
- The technical case reviews demonstrate that investments in the work of HRP resulted in a significant contribution to a range of global public goods in the field of sexual and reproductive health, both at the global level and at the level of many countries. HRP's work addresses global priorities in sexual and reproductive health with greatest benefit to low- and middle-income countries. The research agenda and activities of HRP are inherently designed to produce global public goods.
- In relation to the main conclusions and recommendations of the previous evaluation, much has changed: many problems have been addressed and solved. Notable improvements can be seen in the financial situation, the diversity of income, collaboration between HRP and like-minded partners in advocating for the Cairo agenda, and the role of sexual and reproductive health in achieving the MDGs.
- HRP's has achieved leadership for several reasons, including the prestige and credibility of WHO as a neutral multilateral agency, the ability of HRP to set standards, the intergovernmental organization of HRP's work and relations, the expertise of its staff and its long history of strong collaborative partnerships.
- As recognized in the previous evaluation, there is currently no other organization that could have been as effective as HRP in the research it has conducted.
- Although HRP's primary mandate does not include converting research into practice, the case-studies demonstrate that it has effectively used partnerships and collaboration for knowledge dissemination. The case-studies also show that effective dissemination does not automatically lead to uptake of evidence. Knowledge transfer and exchange remain key activities linking research to the ultimate impact on health.
- At the country level (e.g., China, Thailand and Turkey), research capacity-building, mature professional relationships and sustained effort were crucial in effecting change.
- HRP's ability to facilitate drug registration in both resource-poor and rich countries by sharing its research results, including with product manufacturers, is an effective example of translation of research into access and practice. Likewise, HRP's success in adding new drugs to the *WHO Model list of essential medicines* is an important contribution to sexual and reproductive health, especially for low-income countries.
- The cost of clinical trials has increased enormously over the past few years (due to the requirements of good clinical practice, research ethics and regulatory measures). More resources will be needed to produce the same outputs. While some of the comparative



financial advantages of HRP could decrease in the future, its research will remain competitive thanks to its quality and the potential that its research will lead to product development and changes in policy and practice.

- Long-term involvement in strategic research agendas (e.g., IUDs, medical abortion and maternal and perinatal care) continues to be important, as a necessary means for providing global public goods.
- HRP's work has been cost-effective, partly due to its capacity-strengthening paying off and its effective collaboration with national research partners.
- HRP has gone through a very difficult financial phase, resulting temporarily in greatly reduced activities at the operational level. However, funding constraints were shared equally across priorities, and HRP did not have to sacrifice important areas of work, such as preventing unsafe abortion, in order to address its income situation.
- Continued financial support to HRP is justified and essential for advancing global sexual and reproductive health, given HRP's recognized and effective leadership in the United Nations family.
- The outgoing HRP Director has successfully led a large team through often difficult periods, with financial constraints, attacks on the agenda of the International Conference on Population and Development (Cairo, 1994), and changing WHO leadership and commitment. He has played a crucial role in the continuity of the success and stability of HRP.
- Contribute to integrating sexual and reproductive health into country and regional programmes, to act effectively as 'one United Nations' at these levels.
- Accelerate the removal of the remaining barriers for translating evidence from research into practice. Review and strengthen strategies at the interface with the rest of RHR for better knowledge transfer and exchange.
- Develop strategies to feed the evidence obtained more systematically into the work of cosponsors, donors and partner countries, to maximize efforts to bridge the gap between research and practice.
- Identify operational barriers or facilitators to uptake of evidence. Strengthen translational research and capacity-building for country partners in this field.
- Write concise one- to two-page research updates for donors on a regular basis, instead of longer reports that are seldom read.
- Hold discussions with the cosponsors to ensure that their expectations about what HRP can and cannot do in responding to requests to support country programmes are realistic. Often, country collaborators in sexual and reproductive health research are leaders and can effect changes in local policy and practices better than could HRP by acting directly.
- Design a general framework for quality improvement to better demonstrate the impact of HRP's work, including indicators, especially of impacts, against which HRP's work can be evaluated. The indicators should reflect the specificities of the various fields of activity of HRP, such as knowledge synthesis and transfer. Include process and outcome indicators in guidelines to monitor uptake of research products.

### Overall recommendations

- Collaborate with the cosponsors in achieving the MDGs, emphasizing the relevance of sexual and reproductive health to each of the Goals.

# Annex 1

## 2003–2007 In-depth external evaluation of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction Background note and terms of reference

### 1. Background: the 1990–2002 external evaluation

The UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction ("the Programme") has been the subject of periodic independent external evaluations commissioned by the Programme's Policy and Coordination Committee (PCC). The most recent of these external evaluations covered the Programme's activities during the period 1990–2002 and was considered by PCC at its 16th meeting on 30 June–1 July 2003. The executive summary of the comprehensive external evaluation report is available from the Programme's Secretariat or can be downloaded from [www.who.int/reproductive-health/management/index\\_hrp.html](http://www.who.int/reproductive-health/management/index_hrp.html).

The 1990–2002 external evaluation was conducted by Management Sciences for Health (MSH) and the Swiss Centre for International Health (SCIH) of the Swiss Tropical Institute. These organizations, working as a consortium, were selected following an international tender process by the External Evaluation Monitoring Team (EEMT), set up by PCC to select the external evaluators, to provide overall guidance to the external evaluation and, in particular, to ensure that the external evaluation report fully addressed the terms of reference given to the external evaluation team.

The 1990–2002 external evaluation focused on four key issues: (1) the relevance and effectiveness of Programme-supported research in reproductive health; (2) the dissemination, global use and impact of the results of the Programme's reproductive health research; (3) reproductive health research capacity strengthening by the Programme and the use and impact of the Programme's work at country level; and (4) the

Programme's governance process, management, administration and efficiency. Conclusions and recommendations made by the external evaluation team were based on document review, citation analysis of selected publications, seven country visits, and input from more than 300 informants, of whom 249 provided detailed information through interviews and email questionnaires. Two thematic case-studies (one on emergency contraception and one on mainstreaming gender and women's perspectives) were also performed, which provided further in-depth information on specific aspects of the Programme's work.

The external evaluation report provided a strong and favourable endorsement of the direction and management of the Programme. The overall conclusion of the external evaluation, as reported in the evaluation report, was that, during the period 1990–2002, the Programme clearly met expectations in terms of its core mission to coordinate, promote, conduct and evaluate international research in reproductive health and that it achieved its major objectives. The Programme maintained its position as the global leader in generating research results and establishing the scientific consensus needed to advance sexual and reproductive health policies and practices, especially for developing countries. The external evaluation also made numerous recommendations, described in the report, to further enhance the performance of the Programme. The Programme reported on implementation of these recommendations to PCC at its 17th meeting on 30 June–1 July 2004.





## 2. The proposed 2003–2007 external evaluation

### 2.1 Rationale

Financial support to the Programme by the World Bank – one of the Programme's four cosponsors – is provided from the World Bank's Development Grant Facility (DGF) and awarded on an annual basis by the DGF Council following favourable review of the report on progress of the Programme's activities. One of the conditions governing DGF grant-making is the requirement of a periodic external evaluation of grantees (every 3–5 years). Thus, at its recent meeting to decide on Fiscal Year 2006 (FY06) grants the DGF Council, in approving a US\$2 million allocation to the Programme, requested that an "independent evaluation" be undertaken in 2007 with completion date no later than 30 November 2007.

At its 17th meeting on 30 June–1 July 2004 following review of the actions taken by the Programme in response to the recommendations of the 1990–2002 external evaluation, PCC "SUGGESTED that, in place of another external evaluation in the next five years, efforts should be made to strengthen and monitor follow-up actions to the recommendations of the 1990–2002 External Evaluation including the implementation of actions from the recently adopted WHO Strategy on Reproductive Health".

The request for an independent evaluation made by the DGF Council was discussed by the Programme's Standing Committee of cosponsors at their 54th meeting on 1 February 2006. The Standing Committee concurred that the new independent evaluation should be more limited in scope and focus. Specifically, the Standing Committee "AGREED that the focus of the

forthcoming external evaluation should be on the impact of the Programme on global public goods". Such a focus would be in accordance with PCC's proposal "... to strengthen and monitor follow-up actions to the recommendations of the 1990–2002 External Evaluation...". Indeed, one of the recommendations of this external evaluation reads as follows: "HRP should continue to focus on global public goods, and should try to document the contribution of its work to global public health. As a measure of efficiency, the cost to HRP of its contribution to health outcomes should be calculated. Estimates and projections of abortions averted, unwanted pregnancies prevented, and improved reproductive health through more effective contraceptive methods, emergency contraception, and service guidelines will help to demonstrate HRP's important contributions and cost-efficiency."

The World Bank's representative in the Standing Committee welcomed the proposed focus of the new external evaluation, "stressing that the evaluation should not only serve the immediate needs of the World Bank but also provide an opportunity for advocacy for the Programme. It would demonstrate [the Programme's] impact through the application of its research findings, and its contribution to poverty reduction and to meeting the MDGs." The Scientific and Technical Advisory Group at its meeting on 14–16 February 2006 endorsed the evaluation's focus as proposed by the Standing Committee and made suggestions of possible candidate "global public goods" for evaluation.



The Special Programme of Research, Development and Research Training in Human Reproduction (HRP) was established by the World Health Organization in 1972 to coordinate, promote, conduct and evaluate international research in human reproduction. The United Nations Development Programme, the United Nations Population Fund and the World Bank joined WHO as cosponsors of HRP in "coordination of the global research effort in the field of reproductive health". As the main instrument within the United Nations system for research in human reproduction, HRP brings together health care providers, policy-makers, scientists, clinicians and consumer and community representatives to identify and address priorities for research aimed at improving sexual and reproductive health. Since 1998, HRP has functioned within the WHO Department of Reproductive Health and Research (RHR).

HRP investigates the extent and nature of sexual and reproductive health problems, their determinants and the interventions needed for their alleviation or resolution. Its research agenda addresses all of the main challenges in sexual and reproductive health identified in international fora, particularly the International Conference on Population and Development in 1994 and the Fourth World Conference on Women in 1995, and their respective five-year follow-ups. HRP also carries out activities to strengthen the capabilities of developing countries to meet their own research needs and to enable them to participate in global sexual and reproductive health research.

HRP promotes the use of research results in policy-making and planning at national and international levels and contributes to the setting of norms, standards and guidelines – including ethical guidelines – in the field of sexual and reproductive health research. In order to foster the achievement of greater equity and reproductive rights, HRP works to ensure that gender issues, especially the perspectives of women, are reflected in both its research and research capability strengthening activities.

## 2.2 Scope

Public goods are generally defined<sup>5</sup> as those goods that “produce benefits that are non-rival (many people can consume, use, or enjoy the good at the same time) and non-excludable (it is difficult to prevent people who do not pay for the good from consuming it). If the benefits of a particular good accrue across all or many countries, then this is deemed a global or international public good.” The International Task Force on Global Public Goods has made the above definition operational as follows: “International public goods, global and

regional, address issues that: (i) are deemed to be important to the international community, to both developed and developing countries; (ii) typically cannot, or will not, be adequately addressed by individual countries or entities acting alone; and, in such cases (iii) are best addressed collectively on a multilateral basis.” Both in terms of its mandate and the nature of its outputs, as well as with respect to its modus operandi (see Box), the Programme is without doubt a major contributor to global public goods.

For the present evaluation it is proposed to focus on five Programme achievements that fulfil the criteria of global public goods and lend themselves to an in-depth analysis of inputs, outputs, outcomes and, where possible, impact

5. The two definitions that follow are taken from IEGWB Guidelines for Global Program Reviews -January 24, 2006. IEGWB is the Independent Evaluation Group of the World Bank, formerly (until November 2005) known as the Operations Evaluation Department (OED) of the World Bank.



on sexual and reproductive health status and contribution to achievement of MDGs, including poverty alleviation. In general, preference has been given to Programme achievements in the recent past (approximately the last decade). In addition, the external evaluation will review actions taken by HRP as follow-up to recommendations of the previous external evaluation in the areas of governance process, management, administration and efficiency. The five global public goods selected are:

- Promoting family planning - improving quality of care in family planning in China
- Medical (non-surgical) induced abortion
- Improving maternal and newborn health
- Knowledge synthesis and transfer
- Promoting family planning - long-term safety and effectiveness of copper-releasing IUDs.

### *2.3 Conduct*

The external evaluation will be overseen by Claudia Kessler (Swiss Tropical Institute, International Centre for Health) and Douglas Huber (Management Sciences for Health). They will also carry out the review of follow-up actions taken by HRP on the recommendations made in the previous External Evaluation in the areas of governance process, management, administration and efficiency. For each of the five selected global public goods, an acknowledged expert in the relevant field will be commissioned to undertake the in-depth review. In addition, a health economist with experience in the assessment of economic analyses in sexual and reproductive health will be contracted to support the five technical reviews.