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EXTERNAL EVALUATION OF THE UNDP-UNFPA-UNICEF-WHO-WORLD BANK SPECIAL PROGRAMME OF RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION (HRP) 2013-2017

Evaluation Report
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Cover picture: hera

ABBREVIATIONS

AGH	Adolescents and at-Risk Populations (HRP Team)
AHPSR	Alliance for Health Policy and Systems Research
ANC	Ante-natal Care
CEDAW	UN Convention on the Elimination of all Forms of Discrimination Against Women
CHNRI	Child Health and Nutrition Research Initiative
CRC	UN Convention on the Rights of the Child
CRPWD	UN Convention on the Rights of Persons with Disabilities
DAC	Development Assistance Committee (of OECD)
EES	External Evaluation Subcommittee (of PCC)
FWC	WHO Cluster for Family, Women, Children and Adolescents
GAP	Gender and Rights Advisory Panel
GFF	Global Financing Facility (for RMNCAH)
HRX	Human Reproduction (HRP Team)
IBP	Implementing Best Practice Initiative
ICD-10 (-11)	International Classification of Diseases (10^{th} and 11^{th} edition)
ICPD	International Conference on Population and Development
IDRC	International Development Research Centre
IPPF	International Planned Parenthood Federation
KII	Key Informant Interview
LID	Long-term Institutional Development
MCA	WHO Department of Maternal, Newborn, Child and Adolescent Health
MDGs	Millennium Development Goals
MPA	Maternal and Perinatal Health and Preventing Unsafe Abortion (HRP Team)
MPS	Making Pregnancy Safer (former department of WHO)
NSA	Non-State Actor
PCC	Policy and Coordination Committee
PDRH	Programme Development for Reproductive Health (WHO)
RAP	Regional Advisory Panel (former HRP structure)
RCS	Research Capacity Strengthening
RHR	WHO Department of Reproductive Health and Research
RHT	Technical Support for Reproductive Health (former department of WHO)
RP2	Research Project Review Panel
RQ+	Research Quality Plus
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
STAG	Scientific and Technical Advisory Group
STI	Sexually Transmitted Infection
TDR	Special Programme for Research and Training in Tropical Diseases
VAW	Violence Against Women
VC	Voluntary Contributions Fund (WHO budget)
WHA	World Health Assembly

EXECUTIVE SUMMARY

INTRODUCTION

HRP is hosted by WHO and managed under the leadership of the Department of Reproductive Health and Research (RHR) that includes two programmes, the cosponsored HRP funded from the HRP Trust Fund, and the Programme Development for Reproductive Health (PDRH) programme funded from the WHO Voluntary Contributions Fund (VC) and from WHO assessed contributions. In 2013, HRP was internally reorganised into three teams: (i) Maternal and Perinatal Health and Preventing Unsafe Abortion (MPA), (ii) Human Reproduction (HRX), and (iii) Adolescents and at-Risk Populations (AGH).

Until 2015, HRP worked under the Strategic Plan 2010-2015. A new five-year Strategic Plan was not developed after 2015. HRP instead explicitly aligned the targets of its biennial programmes of work with global strategies, primarily the relevant goals of the 2030 Agenda for Sustainable Development (SDGs) and of the UN Global Strategy for Women's Children's and Adolescents' Health.

The five-year external evaluation of HRP covers the period of 2013 to 2017 comprising the second half of the 2012/13 programme of work and those of the following two biennia, 2014/15 and 2016/17. Four previous external evaluations of HRP were commissioned by the Policy and Coordination Committee (PCC), the governing body of HRP, starting in 1990. The external evaluation, conducted in 2013 for the period from 2008-2012, issued 26 recommendations including that HRP give higher priority to implementation research, a recommendation that has since been strongly endorsed by the PCC and by technical committees of HRP.

METHODOLOGY

The evaluation of the 2013-2017 period was conducted between June and December 2018 by hera led by an *ad hoc* External Evaluation Subcommittee (EES) of PCC. It included four case studies: (i) HRP's work in defining and monitoring global indicators, (ii) HRP's work in maternal and perinatal health, (iii) HRP's work in gender, equity and rights, and (iv) HRP's work in adolescent sexual and reproductive health and rights, including in humanitarian settings.

The evaluation used a mixed-methods approach based on a matrix of nine evaluation questions and 26 sub-questions. Data collected from five data sources were triangulated in the analysis to generate the evidence for the evaluation findings. They included (i) an extensive document review; (ii) an on-line survey of 594 HRP stakeholders that had 165 valid responses; (iii) semi-structured key informant interviews with 71 HRP stakeholders including 29 RHR staff members; (iv) quality assessments applying the Research Quality Plus (RQ+) tool to a sample of 13 research projects implemented or funded by HRP; and (v) a social media scan. Information collected in the four case studies was also incorporated in the main evaluation findings.

The evaluation findings are presented under the nine headings that correspond to the evaluation questions.

CREATING NEW KNOWLEDGE

HRP has supported research of good to excellent quality. There is, however, room for improvement in the gender responsiveness of research projects and research priority setting. Improvements were noted since the portfolio review and priority-setting process initiated in 2016 which, however, only affected the work at the end of the evaluation period. HRP's systems and practice of reporting on research products to the PCC and of maintaining records to document research need considerable improvements.

The research portfolio covers SRHR priorities in low- and middle-income countries and raised few comments or questions among interviewed stakeholders. The main issue raised was a concern that the

wide scope of the expanding portfolio was not matched by the human resources of the Programme. Concerns were raised that HRP was spreading itself too thin with suggestions that this risk could be mitigated by refocusing the effort on working more extensively in partnership with research centres in programme countries and less on conducting research projects by in-house scientists.

Intentions to focus more strongly on implementation research have been expressed since the start of the evaluation period and are strongly supported by a majority of interviewed stakeholders. The challenges of realising these intentions are known to the Programme. The research quality assessment found that in general, the Programme produced higher quality research in innovation studies and in studies to generate evidence for the development of norms and standards than in implementation research studies. An analysis of the expenditure database of research products for the past three biennia found that expenditures on implementation studies had decreased rather than increased over this time-period.

SYNTHESISING RESEARCH EVIDENCE

Synthesising and building consensus on evidence for SRHR, including for global data and indicators, was considered by interviewed informants as a key function of HRP that could hardly be performed with the same degree of credibility by others. Some considered it as a more important function for HRP than generating new evidence.

The performance of HRP in this results area was considered by a majority of stakeholders as strong. The focus of HRP's work has been on SRHR priorities in low- and middle-income countries. The example of HRP's work in synthesising and building consensus on the evidence on violence against women for the development of a WHO Global Plan of Action was cited by several respondents as an outstanding achievement.

STRENGTHENING RESEARCH AND TECHNICAL CAPACITY

Following the external evaluation in 2013, HRP started to revise and rebuild its approach to research capacity strengthening under the HRP Alliance. Progress has so far been slow, and the envisaged regional capacity-building networks are not yet fulfilling their role. Although the concept and goal of the HRP Alliance are clear, there is little information about the strategy of how to reach this goal. During the evaluation period, the promotion of gender equality, equity and human rights received insufficient attention in the efforts to develop the HRP Alliance.

Key informants agreed that the human resources mobilised by HRP to develop and support the HRP Alliance as a capacity-building network for SRHR research are greatly insufficient. External informants commented mostly on the invisibility of the HRP Alliance. This included respondents from WHO Collaborating Centres who are, according to the concept, themselves network members.

Collaboration with the Tropical Disease Research (TDR) Programme for short-course training in research methods and approaches has started and is being further developed. This is a promising initiative, in part also because TDR has a much greater training budget, more human resources and a well-established global network of training partners. This does, however, not replace the goal to build the regional networks of strong SRHR research, training and mentoring centres for SRHR research as envisaged under the HRP Alliance. Such a network is also essential for supporting HRP's intended shift of focus towards implementation research.

STRENGTHENING THE RESEARCH/POLICY DIALOGUE

HRP's work in knowledge translation and the engagement of decision-makers in dialogues on the implementation of evidence-based solutions and policies has been effective but not very visible, especially at country level. This is in part related to the fact that large partnerships for maternal and neonatal health

were formed during the MDG era and multiple platforms for policy dialogue in this programme area exist. Furthermore, the work in this results area is central to WHO's mandate to provide technical and policy support to countries. Even when a policy dialogue on SRHR is supported by HRP, it is often delivered with the branding of WHO. HRP, nevertheless, continues to occupy an important niche for driving the policy dialogue on sexual health and rights and other sensitive issues globally and in countries.

The indicator and data used by HRP to monitor and report results under this output do not adequately reflect the performance and achievements of the Programme in the translation of evidence into policy.

DEVELOPING EVIDENCE-BASED GUIDELINES, IMPLEMENTATION TOOLS AND POLICY STATEMENTS

An extensive portfolio of guidelines and other normative documents was developed and published with HRP support during the evaluation period. The documents are well known and highly appreciated although some stakeholders complained about the length of the development process and others about the inaccessibility of the content to front-line health workers who are looking for more practice-oriented guidance. Procedures to develop more contextualised guidelines with less delay are already being considered according to information provided to the evaluation team. The issue of uptake and implementation of the guidance was raised by interviewed PCC members. It is at the margins of the HRP remit, but nevertheless pursued quite vigorously in programme areas in which there are few other technical or normative agencies, for instance in the area of abortion safety or in sexual rights. HRP has achieved some notable policy results in these areas, although they are not monitored and reported in the results framework.

The mainstreaming of gender, equity and human rights aspects in normative WHO documents that were developed with HRP support has been consistent and follows the WHO guideline development standards. Internal and external key informants stressed that in terms of gender and human rights mainstreaming the RHR Department was a leader within WHO.

ADVOCACY, COMMUNICATION AND PARTNERSHIP

The leadership of HRP in SRHR research is recognised widely and the programme has an extensive network of partners some of whom are also competitors for donor funds, including some of HRP's cosponsoring agencies.

The position of HRP as a programme hosted by WHO is a major reason for its recognition as a global leader, but it can also constrain its visibility because its branding may be hidden behind the WHO brand. In its approach to interact with partners at country level, HRP has to follow WHO procedures and work through the Regional Offices. This can greatly facilitate communications, but it can also be a constraining factor.

Despite human resource limitations, HRP succeeded in implementing an effective communication strategy that uses its own and the corporate WHO social media channels.

GOVERNANCE

The Scientific and Technical Advisory Group (STAG) and the Gender and Rights Advisory Panel (GAP) are effective and highly appreciated advisory committees that function well together and complement each other. While the STAG has a clear mandate as an advisory structure to HRP, the terms of reference of the GAP define it as an advisory structure to the WHO RHR Department.

The Standing Committee is barely exercising its governance role as defined in the memorandum signed by the cosponsoring agencies. It has, however, recently experienced a revival in its role as a forum for information exchange and the promotion of cosponsor cooperation and engagement.

The PCC is highly appreciated for its openness and the participatory nature of its annual meetings. It formally fulfils its role as a governance committee providing strategic guidance to HRP. The weak participation of PCC delegates from countries elected by the WHO regional committees in the PCC deliberations has been commented on in previous evaluations and has not improved substantially. In the view of some delegates from donor countries, the processes of the PCC meetings constrain the ability of the PCC to act as an effective organ of governance and to engage delegates in meaningful strategic discussions.

MANAGEMENT

HRP is managed on the basis of a results framework that monitors results at the output level. Although it has largely achieved or surpassed its performance targets throughout the evaluation period, the indicators and targets are established at a very low level of the results chain. Information about results at the outcome level is available and could be monitored. In addition, the reported output results are overloaded with double counting and the inclusion of data that are only marginally meaningful.

Average costs per output can be calculated with available expenditure information and vary between US$ 110,000 for the development of a guideline to US$ 590,000 for a research project in maternal and perinatal health. The evaluation team was not aware of any benchmarks against which these costs could be evaluated.

The co-management of HRP with the WHO PDRH programme in the RHR Department is complex. However financial management is well separated. The boundaries of roles and mandates between the two programmes vary by programme area which is in part due to the limited and project-specific funding of PDRH. RHR staff have established a functional way to deal with this complexity that maintains the independence of HRP while maximising the advantages of linking the work of HRP to the normative and technical advisory role of WHO.

There is extensive collaboration of HRP through its position in RHR with other departments of WHO through the regular inter-departmental cooperation processes in WHO. In the area of maternal and perinatal health, HRP collaborates closely with the MCA department. Despite some overlapping mandates, the two departments work in a largely complementary fashion based on collegiality and mutual respect. Staff of both departments, however, acknowledge that the division of their work in two separate departments creates unnecessary administrative and bureaucratic hurdles.

FINANCE

HRP had sufficient funding to implement its programme during the evaluation period. By the end of 2015, it had built up a large closing balance in the Trust Fund account which it started to decrease in the last biennium. However, there was a trend towards an increase in the proportion of designated funding during the period which, if it continues, would be an issue of concern.

The number and profile of donors to the Trust Fund have been steady but funding from cosponsors almost fully collapsed except for regular contributions by WHO. There appears to be little appetite by cosponsors to resume undesignated contributions to the HRP Trust Fund, but there are indications that the cosponsoring agencies may consider other means of financial contributions, for instance through designated funding for HRP research support of their implementation programmes.

The Global Financing Facility (GFF) was mentioned by many informants as a natural financing partner of HRP. Applicant countries have major needs for research evidence in SRHR for the development of their investment cases and for the implementation of their programmes. The adolescent health team of HRP reported some activities in supporting countries in the development of their investment cases.

Consultations between HRP and the GFF Secretariat aiming at establishing more structured and substantive cooperation have so far not been productive.

CONCLUSIONS

Relevance

As a programme cosponsored by four UN agencies and the World Bank, HRP fills a unique and critical niche as a global authority for evidence on issues of human reproduction, sexual health and sexual rights. It is embedded in WHO which provides it with a close link to the authority that defines global norms and standards in the health sector and supports countries in their application, while the co-sponsorship and distinct funding model provides a greater degree of freedom from political influence in the pursuit of evidence. The work of HRP focuses on priority issues of sexual and reproductive health and rights in low- and middle-income countries. Among its scope of activities, HRP was particularly well placed to synthesise and build consensus around existing evidence, including on global data and indicators. This is an area of work in which HRP has an undisputed leadership role.

As a research agency, HRP maintains an essential role in niche areas such as the prevention of unsafe abortion and the promotion of sexual rights where there are few global players. In other areas, for instance in maternal and perinatal health, there are many research organisations seeking solutions, and the stakeholders of HRP have asked for a shift to implementation research, i.e. to focus on overcoming barriers to the implementation of policies, programmes and technologies of known effectiveness. The Programme has endorsed this shift but did not make much progress in during the 2013 to 2017 evaluation period.

HRP has a key role in translating knowledge and evidence through the development of norms, standards and guidelines, and through the engagement in policy dialogue at global and country level. While it has a unique position in these tasks in some niche areas, its role in most areas of sexual and reproductive health and rights overlaps with the roles and mandates of normative UN agencies, primarily WHO.

Strengthening the capacity in low- and middle-income countries to conduct research in sexual and reproductive health and rights is part of the core mandate of HRP. It is also essential to support the Programme's intended shift to increased implementation research because it would strengthen its network of in-country partners who are essential for this type of work. It was, however, not implemented with sufficient energy and human resources during the evaluation period.

Effectiveness

Throughout the evaluation period, HRP has supported research of good to excellent quality and the performance of HRP in synthesising and building consensus on evidence has been strong. Progress in the work on research capacity strengthening through the HRP Alliance has been slow, and the envisaged regional capacity-building networks are not yet fulfilling their role. There is insufficient information about the strategy of how to reach this goal.

HRP's engagement with decision-makers contributed directly to a substantial number of policy, legal or programme changes in the areas of rights-based family planning, abortion, violence against women and sexual health and rights. These outcomes were, however, not monitored nor systematically reported.

HRP succeeded in implementing an effective communications strategy despite human resource constraints. However, its results monitoring framework developed on the basis of a Theory of Change is weak. It only monitors results at the output level, including outputs that are sometimes only marginally meaningful. This has constrained the ability of the Programme to document its effectiveness.

Efficiency

Governance of HRP through the PCC is appreciated by stakeholders for its openness and inclusiveness, but for the same reasons there are concerns that it is not a fully effective organ of governance. The Standing Committee of cosponsoring partners is barely exercising its governance functions but is experiencing a revival as a coordination platform. The two technical advisory committees, the STAG and the GAP, are uniformly considered as highly effective.

The co-management of HRP with the WHO PDRH within the WHO Department of RHR is complex with overlapping roles that vary by programme area. A similar situation exists in terms of inter-departmental work, especially in maternal and perinatal health with the WHO Department of MCA. RHR staff have established a functional way to deal with this complexity that maintains the independence of HRP while maximising the advantages of linking the work of HRP to the normative and technical advisory role of WHO. Many stakeholders, including WHO staff, however expressed a need to come to arrive at a more stable situation of formal role divisions without creating programme silos.

HRP had sufficient funding to implement its programme during the evaluation period. Average costs per HRP output ranged from US$ 110,000 for the development of guidelines to US$ 590,000 for research projects in maternal and perinatal health.

Impact

HRP's contribution to its stated impact, namely 'improved sexual and reproductive health and rights, in particular among young women and young people', is mitigated by many contextual factors and would require a more complex evaluation design than was possible with available means. The way HRP contributes most directly to this impact is through its performance in influencing policy and programme decisions at global, regional and country level through the evidence it brings to the dialogue with decision-makers. The evaluation found ample evidence for changes in programmes and policies that were achieved with a contribution of HRP, indicating that the work of the Programme had an impact. These changes were however not systematically monitored and reported.

Sustainability

Progress in generating sustainable outcomes through building research capacity was slow and outcomes were weak. The process of creating a regional capacity-building network through the HRP Alliance was started without an explicit strategy and with insufficient allocation of human resources.

Gender, equity and human rights

HRP generated influential evidence that focused on gender and human rights in sexual and reproductive health. Although the Programme was a leader in the WHO structure in mainstreaming of gender, equity and human rights, consistent mainstreaming in HRP's research portfolio was not achieved.

RECOMMENDATIONS

The evaluation formulated 22 recommendations based on the analysis of findings in response to the nine evaluation questions enriched by findings of the four case studies. The recommendations are directed at the Programme and its governing bodies. Some are taking up recommendations that were already made in the report of the 2013 evaluation but that continue to be valid. The priority and actionability of the recommendations vary. Some should be acted on as soon as possible, others take a somewhat more long-term view, while some require no direct action but rather continued vigilance to maintain the successful operation of the Programme. This is indicated by symbols of a rabbit for immediate action, a turtle for a longer-term perspective and an owl for continued vigilance. The recommendations are organised according to the nine evaluation areas and the action leader for each evaluation is identified.

Creating new knowledge		
1	HRP should urgently upgrade and organise its documentation system, assuring that approved research protocols (RP2 decisions) as well as all published and unpublished research outputs can be readily retrieved from a central server.	 HRP
2	HRP should strengthen its research proposal screening and approval processes and mechanisms to ensure that issues of gender, equity and human rights are effectively mainstreamed in the portfolio of HRP-supported research. • Middle management of all three research teams should be accountable for the effective integration of gender, equity and human rights in research. • Guidelines for gender, equity and human rights mainstreaming should be disseminated and HRP staff should be coached to ensure stronger integration of gender, human rights and equity issues during the research design process. • Relevant research projects to be selected with participation of the GAP should be reviewed by the GAP during the design and approval stage.	 HRP
3	HRP should implement its stated intentions of giving implementation research increasing priority in its research portfolio. Since implementation research requires a presence at the sites of programme implementation and close collaboration with programme implementers, the effort needs to be linked to expanding the network of SRHR research partners in programme countries and to supporting their capacity to conduct research.	 HRP
4	In its emerging research agenda of SRHR in the context of migration and in humanitarian settings HRP should include the documentation of data gaps and the development of tools for estimating and monitoring the incidence and prevalence of key SRHR issues in such populations or situations.	 HRP
5	In developing its portfolio of research activities in SRHR in humanitarian settings, HRP should assure that it balances its plans to fill existing research gaps with an appropriate allocation of human and financial resources.	 HRP
Synthesising research evidence		
6	HRP should continue to give priority to evidence synthesis and consensus building in SRHR as a work area in which it occupies a unique leadership role and has established a record of excellent performance.	 HRP/PCC
Strengthening research and technical capacity		
7	HRP should with some urgency develop and widely communicate a comprehensive strategy for the development of the HRP Alliance in close collaboration with the established HRP hubs and key partners among the WHO Collaborating Centres. This should include a timed implementation plan and the mobilisation of sufficient human resources to implement it.	 HRP
8	To build sustained capacity for research and technical expertise in adolescent SRHR, in SRHR among migrants and in humanitarian settings, HRP should expand the HRP Alliance network through strategic engagement with regional research partners that have proven strengths and track records in research on adolescent health as well as in working with migrants and populations affected by humanitarian crises.	 HRP
9	HRP should continue and expand its collaboration with the Tropical Disease Research Programme (TDR) and eventually also the Alliance for Health Policy and Systems Research (AHPSR) in developing and delivering a curriculum of short research training courses in parallel and within the strategy for the HRP Alliance network.	 HRP

Strengthening the research/policy dialogue		
10	HRP should continue to exercise its role and consolidate its niche for driving the policy dialogue at global, regional and national level for the adoption of policies and programmes in sensitive areas of SRHR that promote gender equality, social equity and human rights.	 HRP/PCC
11	To achieve sustainable changes in national policies and programmes for adolescent sexual and reproductive health and rights, HRP should intensify its engagement with implementing organisations, including the UN cosponsors and INGOs, with the aim of strengthening the financial and technical support they provide to governments with the evidence generated by the research of HRP and its research partners.	 HRP/PCC
Developing evidence-based guidelines, implementation tools and policy statements		
12	The RHR Department, in collaboration with the WHO Guideline Development Group, should explore means and procedures for more rapid development of practical guidelines for programme implementers.	 WHO/RHR
13	HRP should continue to maintain its strong profile in supporting the development and the implementation of policy guidance at global, regional and national levels in areas where it has built its strength and where few other international agencies are active such as in abortion safety, gender-based violence and sexual rights.	 HRP/PCC
Advocacy, communication and partnership		
14	HRP should continue to exercise its recognised role as a global leader in SRHR research based on its close association with WHO. At the same time, it should work on gaining more visibility at country level by increasing its engagement with the WHO Regional Offices and with the appropriate structures (Regional or Country) of the cosponsoring agencies.	 HRP/WHO
15	When negotiating designated contributions, HRP should consider adding a communications budget. This would provide resources to increase the number of influential followers of HRP's social media messages, to ensure consistent strategic social media communication during conferences and meetings and to effectively track and respond to results of social media engagement indicators.	 HRP
HRP Governance		
16	HRP should continue to seek greater engagement of cosponsors through the Standing Committee and this should be supported vigorously by the PCC, especially by the donor representatives who, in the majority, represent governments that are donors and key members of governing committees of cosponsoring agencies and who should use this leveraging power.	 HRP/PCC
17	The PCC should review and revise its procedures to increase its effectiveness as an organ of governance assuring that HRP in its activities is fully accountable to programme and donor countries. Steps should be taken to increase the space for meaningful strategy discussions between the Programme and its PCC.	 PCC/ Cosposnors

HRP Management		
18	HRP should revise its results framework in a participatory process aimed at adopting a more structured approach based on a Theory of Change and an associated performance management and reporting framework. Output targets and reports should not be based on just counting as many outputs as possible but rather on presenting meaningful outputs organised by theme and importance. Indicators and targets should be defined at the outcome level and reported systematically. • For HRP's work on global monitoring and indicators, the Programme should report performance separately for, (i) outputs related to the global indicators for which it is the custodian, (ii) outputs related to global indicators for which it provides input and support to other agencies, (iii) outputs of research into new global indicators, and (iv) outcomes of its work in global monitoring and indicators in terms of improved global accountability for SRHR. • To ensure effective gender, human rights and equity integration, outputs and outcomes should be disaggregated by sex wherever relevant and targets should be included for results with a primary focus on gender, equity and human rights.	 HRP
19	The PCC should urge WHO to increase its fund-raising efforts for undesignated and designated financing of PDRH so this programme can become more effective in fulfilling its role of facilitating the translation of HRP-generated evidence into programmes and policies at country level.	 PCC/WHO
20	The PCC should engage with the ADG FWC of WHO to find a better structural solution for joint work in maternal and neonatal health between HRP and the MCA Department that avoids working across departmental boundaries. This should include a review of the portfolio of activities in maternal, perinatal and adolescent health of the RHR and MCA Departments of WHO as well as a clear division of responsibilities of the two departments for global monitoring and indicator development. These deliberations should consider the lessons learnt from the efficiency of RHR in the area of contraception, where the entire value chain from evidence generation to the development of norms and research to support their implementation is located within one department.	 PCC/WHO
HRP Finance		
21	The PCC should continue to monitor the levels of designated contributions to the HRP Trust Fund to be able to react in time before the proportion of designated funds reaches a level where it could seriously distort the portfolio of HRP activities.	 PCC
22	PCC delegates from cosponsoring agencies and from donor countries should work together on lobbying for a greater financial engagement in HRP of the cosponsors as well as of the GFF through programmatic cooperation rather than undesignated funding.	 PCC

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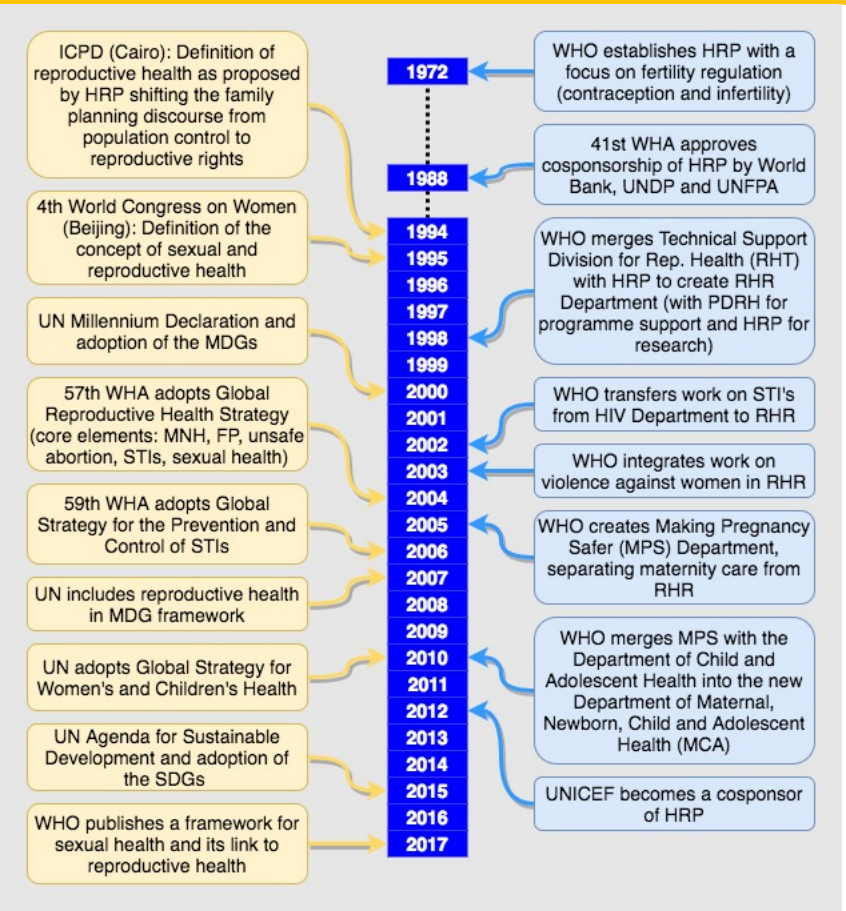
1 INTRODUCTION

The 4th five-year evaluation of HRP covers the period of 2013 to 2017 comprising the second half of the 2012/13 programme of work and those of the following two biennia, 2014/15 and 2015/16. Until 2015, HRP worked under the Strategic Plan 2010-2015. After HRP came under new leadership in October 2012 organisational changes followed without fundamental changes in the strategy. Programme leadership changed again in January 2016, introducing some new accents but without organisational changes. A new five-year Strategic Plan was not developed after 2015. HRP instead explicitly aligned the targets of its biennial programmes of work with global strategies, primarily the relevant goals of the 2030 Agenda for Sustainable Development (SDGs) [1] and of the UN Global Strategy for Women's Children's and Adolescents' Health.[2]

HRP was created as a department of WHO in 1972 focusing on basic science research in areas of infertility and fertility regulation, but also studying the sequelae of induced abortion. [3] Since then, the focus of the Programme's work evolved significantly together with its institutional structure. Figure 1 tracks the institutional changes of HRP against the historical context of key events in the development of concepts and strategies for sexual and reproductive health and rights (SRHR) to which the Programme contributed at each step. [4][3]

Figure 1. HRP historical markers



As apparent in the history of the unfolding SRHR concept in the discourse of the UN System, the context and demand on HRP for evidence generation, consensus building, development of norms and of monitoring their implementation evolved significantly, especially following the international consensus on reproductive and women's rights achieved at the Cairo and Beijing conferences in the 1990s. The Programme's scope of activities expanded, and at the same time it was affected by organisational changes in WHO, the host agency. The most significant among them was the merger of HRP with the WHO

Technical Support Division for Reproductive Health (RHT) in 1998, creating the WHO Department of Reproductive Health and Research (RHR) with two programme arms, the UN cosponsored HRP with its own governance structure and funding mechanism through the HRP Trust Fund, and the Programme Development for Reproductive Health (PDRH) arm as a regular line programme of WHO. Both arms are under unified management of RHR and thereby in line with the management structure of WHO.

External evaluations of HRP were commissioned by the governance body of HRP, the Policy and Coordination Committee (PCC) starting in 1989 covering the initial years of the cosponsored programme. This was followed by external evaluations in 2003 for the period 1990-2002, in 2008 for the period 2003-2007 and in 2013 for the period 2008-2012. Since 2003, each evaluations included case studies, some with narrowly defined technical themes such as the safety of copper intra-uterine devices in 2008. The evaluation conducted in 2013, however, defined the case study themes more strategically, including case studies on research capacity strengthening and on strengthening implementation research.

Implementation research, defined most succinctly as *research to bridge the evidence-to-programme gap* [5], was a relatively new area for HRP during the 2008-2012 period. Out of 160 research studies identified in the 2013 evaluation, 25 were labelled as operational or implementation research. In response to a recommendation of the evaluation and with strong support by the PCC, HRP aimed to increase its support of implementation research in the subsequent period. This is not explicitly reflected in the evaluation questions of the 2018 evaluation, but it was nevertheless implicit and was therefore addressed.

The evaluation of the 2013-2017 period was conducted between June and December 2018 by hera and governed by the ad hoc External Evaluation Subcommittee (EES) of PCC. The terms of reference are presented in Volume 2. A final inception report was approved by the EES in September 2018. The evaluation includes four case studies which are presented in Volume 2. They cover the following themes as agreed with the EES at inception:

- HRP's work in co-designing, monitoring and reporting on SRHR indicators, including in the context of the implementation of the 2030 Agenda for Sustainable Development and of the Global Strategy for Women's, Children's and Adolescents' Health
- HRP's work in comprehensive maternal and perinatal health, including postpartum contraceptive use
- HRP's work in gender, equity and rights, including broader work from a 'leave no one behind' perspective
- HRP's work in adolescent SRHR and SRHR in emergency and humanitarian settings with a focus on adolescents

1.1 Methodology

The detailed methodology of the evaluation is presented in Volume 2. The evaluation used a mixed-methods approach that is based on the matrix of nine evaluation questions and 26 sub-questions that also serve as sub-headings in the section on performance evaluation findings in this report. Additional evaluation questions were formulated for each of the four case studies. Data collected from five data sources were triangulated in the analysis to generate the evidence for the evaluation findings. They included (i) document reviews, (ii) an on-line survey, (iii) key informant interviews with HRP stakeholders, (iv) research quality assessments and (v) a social media scan. Information collected in the four case studies was also incorporated in the main evaluation findings.

A document library for the evaluation was assembled during the inception phase. Documents were obtained from the HRP Secretariat, from stakeholders including other research funding organisations, and through internet searches. They included documents related to governance and administration of HRP

such as minutes of PCC, STAG and GAP meetings as well as research reports, normative guidelines, implementation tools, policy papers and advocacy material generated by HRP or with HRP support.

An on-line survey was launched in English, French and Spanish on September 13. Invitations to participate were mailed to 706 stakeholders of the HRP programme and received by 594. The survey was opened by 213 respondents for an overall response rate of 36 percent. After removing incomplete responses and those by current RHR staff, 165 valid responses remained for an effective response rate of 28 percent. The questionnaire had 29 questions asking primarily for scoring responses on five-point Likert scales.

Semi-structured key-informant interviews (KIIs) were conducted in person or via telephone with 71 stakeholders sampled by purposeful sampling from a list of 732 stakeholders in seven stakeholder groups. KIIs with an additional 23 sampled stakeholders could not be conducted because they did not respond, were not available or declined to be interviewed.

Previous evaluations had used bibliometric analysis of research publications to assess research quality. Because of limitations in this methodology, especially for research conducted in a development context, [6] an adaptation of the Research Quality Plus (RQ+) tool [7] was used on a purposive sample of 13 research projects approved by the HRP Research Project Review (RP2) panel between 2012 and 2016.

A scan of the social media platforms used by HRP for microblogging (Twitter) was conducted to assess the extent and the reach of HRP's use of social media to communicate its work, to network with partners and a wider audience, and to advocate for evidence-based SRHR policies and programmes.

Reviewed documents and transcripts of key informant interviews were coded according to the evaluation questions and sub-questions for content analysis using the MAXDQA content analysis software.[1]

LIMITATIONS

The limitations of the evaluation methodology are detailed in Volume 2. The main limitations were:

- The evaluation work plan included the attendance by the evaluators of meetings of the HRP Alliance and of the Standing Committee. Both meetings were cancelled on short notice which greatly reduced the number of planned key informant interviews and the collection of additional information through direct observation of the processes.
- The HRP performance reports do not track outcomes but only outputs, some at a very low level. The evaluation methodology did not include the systematic collection of outcomes and some evaluation questions could therefore only be answered on the basis of partial information. In addition, HRP performance at the outcome level cannot be distinguished from PDRH results.
- Only limited data for the planned social media scan were not made available to the evaluation team.

1.2 OPERATIONAL CONTEXT OF HRP

A memorandum of cosponsoring agencies was first developed in 1988 and revised in 2012 when UNICEF joined as a cosponsor. In some of its detailed statements it is slightly out of date, however it still serves to define the overall operational context. The memorandum defines the **executing agency** of HRP as WHO; the **cosponsors** as UNDP, UNFPA, UNICEF, WHO and the World Bank; and the **cooperating partners** as the governments and international institutions or organisations contributing financial or technical resources or using HRP outputs in their plans for health, social and economic development or programmes. [8]

[1] www.maxqda.com

The 34-member PCC is the governing body of HRP. (see Section 2.7) The PCC has a broad governance mandate that is executed with inputs from …

- the Standing Committee (of cosponsoring agencies),
- the Executing Agency (WHO), and
- the Scientific and Technical Advisory Group (STAG)
- the Gender and Rights Advisory Panel (GAP)[2]

While the STAG and the GAP have the function to provide 'a continuous and independent evaluation of the scientific and technical aspects of HRP's work' to the PCC, their main ways of operation has been to review the work of RHR (including both HRP and PDRH), and to make their recommendations directly to the Department, specifying for each recommendation whether it applies to HRP or to the RHR Department as a whole.

The Director and all staff members of HRP are appointed by WHO and work under the overall management authority of the Assistant Director General of the WHO Cluster for Family, Women, Children and Adolescents (FWC). HRP is thereby established as a programme that is fully under WHO management, however not under the governance of the World Health Assembly (WHA) since it has its own governing body, the PCC. Several interviewed key respondents were not aware of this separation of governance and some did not perceive a difference between the WHO RHR Department and the cosponsored HRP. Those who were aware, almost uniformly considered the separation of governance a major source of strength of HRP, allowing it to conduct research and provide evidence-based guidance on sensitive issues that could create divisions among the representatives of member states in the WHA.

In 1988, when the WHO RHT Department merged with HRP to create the RHR Department, the situation became more complex. RHR now had, in addition to HRP, a programme arm, the PDRH, that was fully under the regular governance structure of WHO. The mandate of PDRH is to translate the evidence generated by HRP into changes in practice at the programme level. According to WHO's mandate, this translation and dissemination of knowledge is provided in the form of technical guidance to global partners on one hand, and on the other to member states via the WHO Regional and Country Offices. The merging of the knowledge generation and knowledge translation tasks in a single department was considered positive or even essential by all informants interviewed. However, a clear separation of these two tasks within the RHR Department in terms of products, staff roles and expenditures has been challenging. This is further explored under heading 8.3.

In January 2018, 46 RHR professionals were working under HRP and 19 under PDRH. All were employed by WHO,[3] but their personnel costs were covered either from the HRP Trust Fund (for those with the HRP label) or from the Voluntary Contributions Fund (VC) of the WHO budget (for those with the PDRH label), almost all of it provided as specified funds on a project basis. In practice, however, 'HRP professionals' were also executing work that was accounted for under the PDRH budget (up to 20% according to one senior staff), and knowledge translation and dissemination activities were also prominent in the HRP programme of work.

The RHR Department has three programme teams:

- The human reproduction team (HRX) working in the areas of contraception, reproductive tract and sexually transmitted infections, infertility, cervical and other reproductive system cancers, and linkages between sexual and reproductive health and rights and HIV;

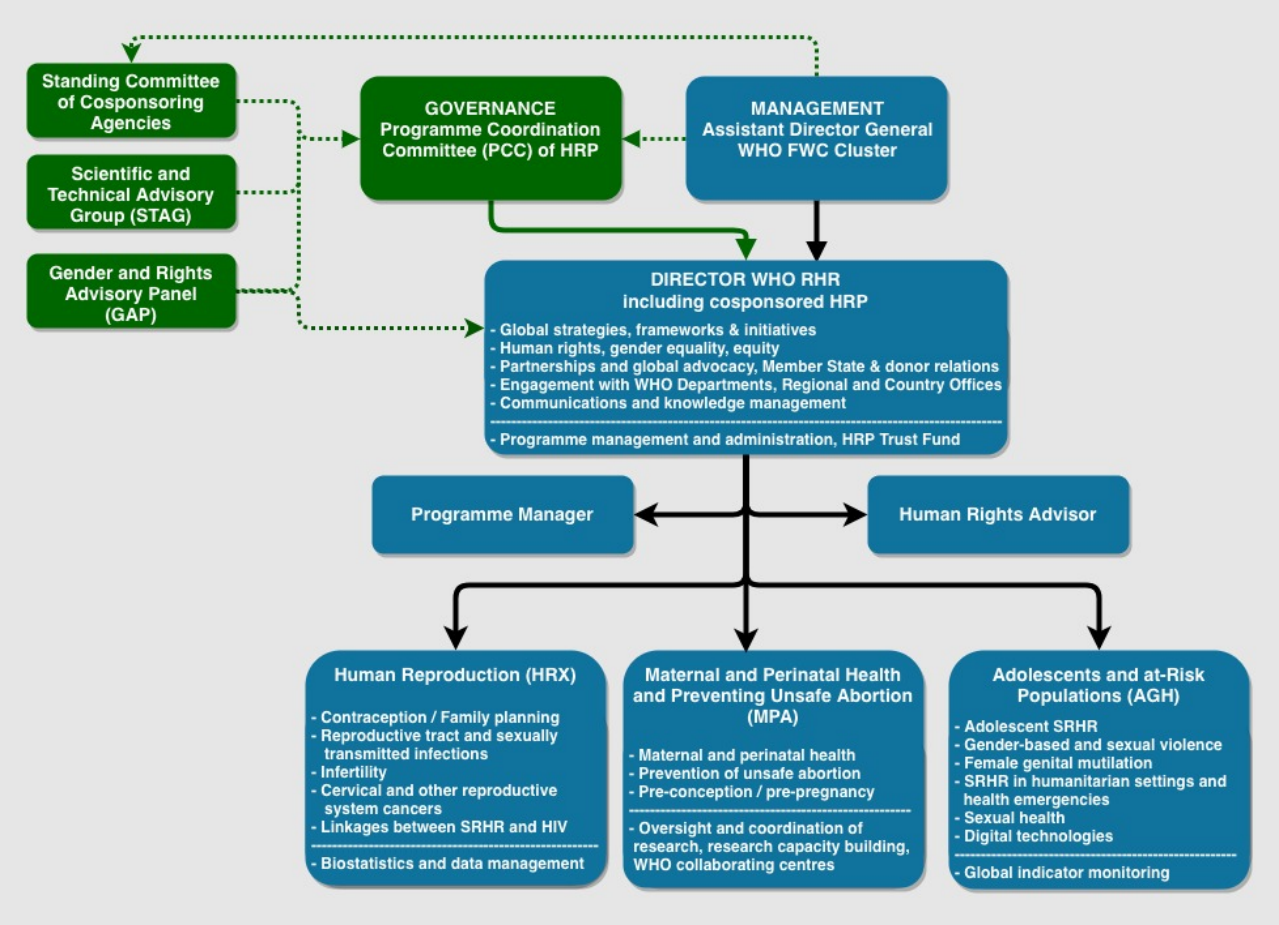
[2] A Gender Advisory Panel was established by the PCC in 1996 and later renamed 'Gender and Rights Advisory Panel' without changing the acronym GAP. The GAP is not mentioned in the text of the memorandum which was originally drafted in 1988

[3] Except for one seconded staff from CDC Atlanta

- the team for maternal and perinatal health and the prevention of unsafe abortion (MPA) working in these areas; and
- the team for adolescents and at-risk populations (AGH) working on issues of adolescent sexual and reproductive health and rights, gender-based and sexual violence, female genital mutilation, SRHR in humanitarian settings and health emergencies, sexual health, and digital technologies. The workstream of global indicator monitoring which spans the competence of all three programme teams is also located in AGH.

A human rights advisor is attached to the office of the Director of RHR. PDRH professional staff is integrated with HRP staff in the relevant programme teams.

Figure 2. HRP organisational chart



2 HRP PERFORMANCE 2013-2017

The performance of the programme is analysed in terms of its relevance, effectiveness, efficiency, impact and sustainability under the headings of seven evaluation areas. These were made up of the five output areas of the HRP Results Framework, [15] plus two additional areas related to communication and management:

1) Creating new knowledge
2) Synthesising research evidence
3) Strengthening research and technical capacity
4) Strengthening the research/policy dialogue
5) Developing evidence-based guidelines, implementation tools and policy statements
6) Advocacy, communication and partnership
7) Governance, management and financing

Under the seven evaluation areas, nine evaluation questions and 26 sub-questions were explored by the evaluation team. Each sub-question is linked to one of the DAC evaluation criteria as presented in the evaluation matrix of the inception report. The evaluation matrix also includes indicators of performance for each sub-question. Not all of the indicators were found to be relevant or measurable, nor did they always capture all relevant findings under the evaluation question. This is further discussed under each sub-heading

2.1 CREATING NEW KNOWLEDGE

Evaluation Question 1: Has HRP supported high quality research (including implementation research) that created new knowledge on SRHR?

Main Findings:
HRP has supported research of good to excellent quality. There is, however, room for improvement in the gender responsiveness of research projects and research priority setting. Improvements were noted since the portfolio review and priority-setting process initiated in 2016 which, however, only affected the work at the end of the evaluation period. Reporting on research products to the PCC and maintaining records to document work done, however, still needs considerable improvement.

The research portfolio covers the SRHR priorities in low- and middle-income countries and raised few additional comments or questions among interviewed stakeholders. The main issue raised was a concern that the wide scope of the expanding portfolio was not matched by the human resources of the Programme. Concerns were raised that HRP was spreading itself too thin with suggestions that this risk could be mitigating by refocusing the effort on working more extensively in partnership with research centres in programme countries and less on conducting research projects by in-house scientists.

Intentions to focus more strongly on implementation research have been expressed since the start of the evaluation period and are strongly supported by a majority of interviewed stakeholders. The challenges of realising these intentions are known to the programme and the research quality assessment found that in general, the Programme produced higher quality research in innovation studies and in studies to generate evidence for the development of norms and standards than in implementation research studies. An analysis of the expenditure database of research products for the past three biennia found that expenditures on implementation studies had decreased rather than increased over this time-period.

Recommendations

- HRP should urgently upgrade and organise its documentation system, assuring that approved research protocols (RP2 decisions) as well as all published and unpublished research outputs can be readily retrieved from a central server.

- HRP should strengthen its research proposal screening and approval processes and mechanisms to ensure that issues of gender, equity and human rights are effectively mainstreamed in the portfolio of HRP-supported research.

- HRP should implement its stated intentions of giving implementation research increasing priority in its research portfolio. Since implementation research requires a presence at the sites of programme implementation and close collaboration with programme implementers, the effort needs to be linked to expanding the network of SRHR research partners in programme countries and to supporting their capacity to conduct research.

Systematic reporting under the HRP Results Framework started in 2014. Over the four years from 2014 to 2017 the Programme reported 1,030 scientific publications and 20 global estimates as 'creating new knowledge' outputs. The scientific publications included commentaries, editorials and letters to the editor of scientific journals. They also included systematic reviews that were again reported as products under the next output area, and publications of global estimates that were reported twice, under the subheading of scientific publications and the sub-heading of global estimates.

2.1.1 Has HRP-supported research (including implementation research) addressed priority issues of SRHR for people in low- and middle-income countries? (Relevance)

Indicators:	**Results:**
Stakeholder views of the extent to which the HRP research portfolio is aligned with SRHR priorities in low- and middle-income countries	Interviewed and surveyed stakeholders generally considered that the HRP research portfolio was well aligned with SRHR priorities in programme countries.
Extent to which the HRP approach to research priority-setting contributed to a research portfolio that answers priority questions on SRHR in low- and middle-income countries	The research portfolio throughout the evaluation period broadly covered the priority SRHR issues in programme countries and raised few additional comments by key informants. A formal portfolio analysis and priority-setting process was only initiated towards the end of the evaluation period.

In 2016, HRP implemented an extensive portfolio review process that covered more than the review and priority setting for the research agenda by also including discussions of HRP's role and priorities in research capacity building, dissemination of evidence, partnerships and communications. HRP staff prepared a total of 17 background papers on their area of work based on their assessment of recent achievements and current engagement in specific thematic areas, important knowledge and implementation gaps, and the mandate and comparative advantage of HRP in filling these gaps. In the process of developing these background papers, HRP staff consulted non-state, state and inter-state stakeholders through interviews and surveys ranging from four consultations on the theme of STIs to 237 on the theme of SRHR-HIV linkages. Several units initiated or completed the process using the prioritisation process developed by the Child Health and Nutrition Research Initiative (CHNRI), [17] but according to interviews with senior staff it was found to be too resource intensive and formalistic without generating additional value.

The staff papers were discussed in a three-day multi-stakeholder workshop in October 2016 involving, in addition to RHR leadership and technical staff, representatives of the PCC, STAG, GAP, Standing Committee, the HRP Alliance, and relevant departments of WHO. In the follow-up, the STAG issued recommendations for a 'proposed programme of work by thematic areas' in 2017 which was adopted by the PCC in June 2017 and published almost verbatim in a report of the portfolio review process. [13]

A challenge for the evaluation was the fact that the majority of stakeholders surveyed or interviewed, especially those who had comprehensive information about the HRP research portfolio, based their responses on the results of the portfolio review and priority-setting process in 2016/17 which arguably is most relevant for the post-2017 programme and thereby outside the evaluation period.

Respondents to the on-line survey rated the leadership provided by HRP in SRHR research highly with 87 percent considering that HRP provided strong or very strong leadership. The research priorities of HRP in terms of their relevance to SRHR issues in low- and middle-income countries received similarly high

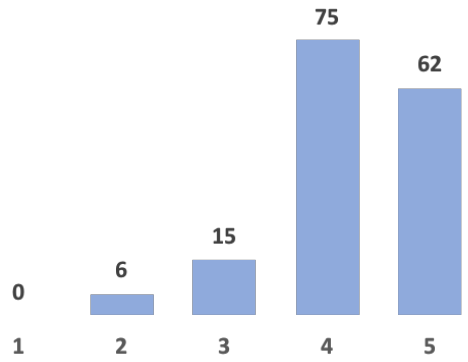
ratings, with 85 percent of respondents choosing the response options of either all or most of HRP research focused on priority areas. The mechanisms and processes of research priority setting were rated somewhat lower, with only 67 percent of respondents considering them to be strong or very strong, and only 43 percent of respondents thought that programme countries had a strong or decisive influence on HRP's research priorities.

The survey responses did not differ to a major extent from those of the survey conducted in 2013. The perception of a strong alignment of research priorities with SRHR priorities in programme countries increased from 71 to 84 percent, however the questions were not fully comparable as the 2013 survey focused specifically on the MDG agenda. The priority setting process was also perceived to be stronger in 2018, an increase from 61 to 67 percent, possibly reflecting reactions to the portfolio review process. The respondents' rating of the influence of programme countries in priority-setting, however, weakened from 51 percent in 2013 to 43 percent in 2018. Detailed results of the survey and the comparison with the previous survey are presented in Volume 2.

Figure 3. Survey results: Research

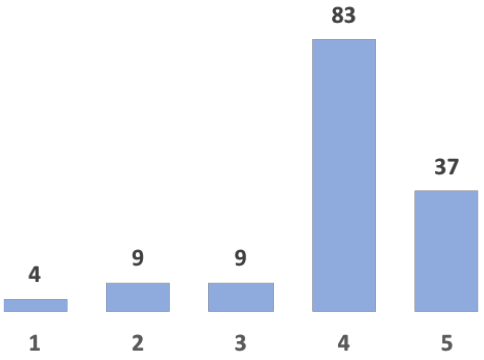
Respondents' ratings of HRP performance as a global leader in SRHR research *(N=160)*

LEADERSHIP	
1. No leadership	0
2. Weak leadership	6
3. Some leadership	15
4. Strong leadership	75
5. Very strong leadership	62
Median Score	**4**
I don't know	*2*



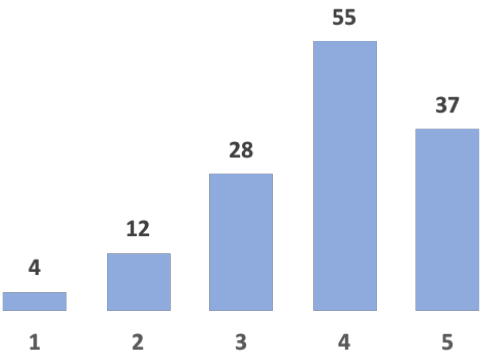
Did HRP-supported research focus on SRHR priorities in low- and middle-income countries? *(N=165)*

RESEARCH PRIORITIES	
1. Only non-priorities	4
2. Mostly non-priorities	9
3. ½ priorities and ½ non-priorities	9
4. Mostly priorities	83
5. All work focused on priorities	37
Median Score	**4**
I don't know	*23*



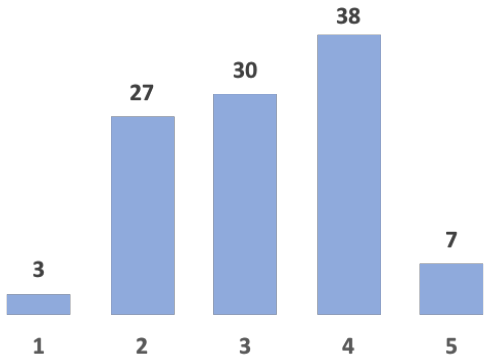
Respondents' ratings of the mechanisms and processes of HRP research priority-setting *(N=165)*

PRIORITY SETTING	
1. Very weak	4
2. Weak	12
3. Neither weak nor strong	28
4. Strong	55
5. Very strong	37
Median Score	**4**
I don't know	*29*



Respondents' ratings of the influence of programme countries in research priority-setting *(N=165)*

PROGRAMME COUNTRY INFLUENCE	
1. No influence	3
2. Weak influence	27
3. Neither weak nor strong	30
4. Strong influence	38
5. Decisive influence	7
Median Score	**3**
I don't know	*60*



More differentiated views about the HRP research priorities were collected in key informant interviews. Not all of the informants had a complete overview over the HRP portfolio, and some could only answer questions about priorities as related to their own institution's interaction with the programme. The most commonly expressed view, however, was that HRP focused on the 'right' priorities.

- **Abortion** research: Two informants stated that more work could be done because the issue is otherwise neglected in global SRHR research and has become a strategic niche for HRP
- Research in **adolescent SRHR**: Two informants stated that it should receive more attention because of increased demand from programme countries
- **Economic research**: Two informants felt that there was a need to generate more evidence about the cost effectiveness of SRHR interventions
- **Infertility** research: Five informants mentioned infertility research. Opinions were mixed with two informants considering it an issue of lesser importance, especially for low-income countries. The other three thought that this was an issue that should receive more attention either because it moved the area of fertility research of HRP further into a human rights focus, or because of concerns about an uncontrolled and unregulated expansion of private clinics providing infertility services in programme countries, many of them not adhering to ethical standards.
- Research on **masculinity**: This area required more attention according to one respondent citing the need for more evidence on engaging men and boys in gender equity issues.
- Research in **maternal and perinatal health**: Four informants commented on this area. None of them questioned the priority of continued work in this area, but they raised questions about how research in maternal health could be more efficiently shared across existing partnerships and networks, and especially across programmes and departments in WHO.
- Research on SRHR in the context of **migration and humanitarian crises**: Four informants raised this issue, three of them considering that it should receive more attention while the fourth saw a need to define an appropriate niche for HRP's to work in this area.
- Research on **STIs**: Two informants pointed out that research in this area is greatly under-funded and that HRP has not been able to engage in this research area optimally because of financial constraints.

A concern that HRP research resources were spread over too many areas was expressed by four informants. They pointed to a trade-off between the breadth and the depth of the portfolio and noted that some of the more technical areas, such as research on new medications or treatment protocols could be implemented and coordinated by scientific or academic institutions. The same respondents favoured a more strategic approach to priority setting that started with a reflection on the mandate and

comparative advantage of HRP rather than on the enumeration of current efforts to fill perceived evidence gaps.

Interviews and document reviews conducted in the context of the case study on gender, equity and human rights (see Volume 2) indicate that during the first part of the evaluation period (2012 - 2015) these three areas were not consistently mainstreamed in HRP's processes of setting research priorities. Mainstreaming of gender, equity and human rights was deepened across the Programme during the portfolio review in 2016. Key informants identified three causes for inconsistent gender, equity and human rights mainstreaming, in particular in the area of gender:

- Among HRP professionals, the perceptions of the meaning of mainstreaming of gender, equity and human rights vary and the relevant WHO frameworks on both gender and human rights are not well known and applied to their work.
- The mainstreaming quality depended on the expertise of involved staff. Key informants perceived that there were substantial differences in individual and team capacities for mainstreaming gender, equity and human rights. Expertise for human rights mainstreaming was felt to be applied more consistently with the support of a full time human rights advisor in the Director's office. In the area of gender, on the other hand, key informants expressed that the gender focal point had limited time to support gender mainstreaming across all teams due to her high workload.
- Consultations initiated by HRP when developing the evidence base for normative work were in most cases limited to working with expert professionals and did not systematically include the voices of beneficiary groups.

One theme that generated many comments by informants was the question of what type of research HRP should be conducting. Several informants noted and endorsed the perceived pressure on the Programme by the PCC to investment more in implementation research. At the same time, HRP management pointed out that the messaging from donor representatives in the PCC created a tension: *"They tell us that we should focus on the implementation of guidelines while at the same time they say that supporting guideline adoption is the work of WHO and should be funded through the core contributions of WHO and not to HRP".* Shifting the portfolio of HRP research from basic science and the generation of evidence for norms and standards towards research on the implementation of these standards was pointed out to be a difficult task because HRP had no presence at the country level where implementation takes place. It could only be achieved by working more extensively with local research partners who could more directly collaborate with governments or other implementing organisations. According to HRP management, some progress has been achieved in this area although more effort was required.

In order to generate evidence about the development of the HRP research portfolio throughout the evaluation period, the evaluation team analysed programme expenditures against work plan outputs in the three biennia from 2012 to 2017. The 409 outputs listed in the expenditure report do not always give a clear indication of the actual activity financed. Decisions on whether to allocate the expenditure to research, generating consensus, knowledge translation or strengthening research capacity were therefore made using best guess estimates, especially because a single output expenditure line may comprise several of these activity areas.

Expenditures on HRP outputs in the three biennia totalled US$ 95.7 million. Staff costs of US$ 68.2 million are not included, neither are US$ 3.8 million of programme support costs charged by WHO as well as US$ 2.3 million of commitments reported in the annual financial reports but charged to the work plan in a different biennium. Based on outputs coded by the evaluation team, 60 percent of output expenditures (US$ 57.1 million) were identified as research expenditures, the largest proportion for maternal and perinatal health (43%), followed by human reproduction (28%), adolescents and at-risk populations (15%)

and abortion (11%).[4] The budget by output area reported by HRP for the 2014/15 and 2016/17 confirmed that 62% of HRP budgets were allocated to 'research and development'. [16,18]

The output expenditures coded as research were stratified into four types of research studies, using again a best guess approach based on the title of the budget line. Large expenditure lines were checked against narratives in annual reports. Five research outputs in 2012/13 with total expenditures of about US$ 600K could not be classified and were removed from the analysis leaving the total of coded research expenditures at US$ 56.5 million over six years. A list of coded research expenditures is presented in Volume 2.

A. **Formative research** comprised preparatory studies to better define evidence and knowledge gaps, as well as to generate the engagement of ultimate beneficiaries such as adolescents or communities in the planned research.
B. **Implementation research** aims at developing strategies and solutions to increase the access and the use of evidence-based health interventions by populations in need. [9] Implementation research is not always clearly distinguishable from operational research which aims at developing solutions to operational issues of programme delivery in specific contexts. Both operational and implementation research studies are captured under this heading.
C. **Normative research** serves to strengthen the evidence-base for global standards, norms and guidelines on SRHR. Research on the development of global indicators is also included in this category. There is an overlap with implementation research to the extent that research on guidelines may also address their implementability, although the main focus of normative research is to generate evidence about the efficacy or effectiveness of the researched practice or product in order to issue recommendations for adoption or avoidance.
D. **Innovation research** includes randomised controlled trials of new medicines or procedures. Innovation studies are generally large and expensive and therefore have a significant weight in terms of programme expenditures although the number of studies may be quite small.

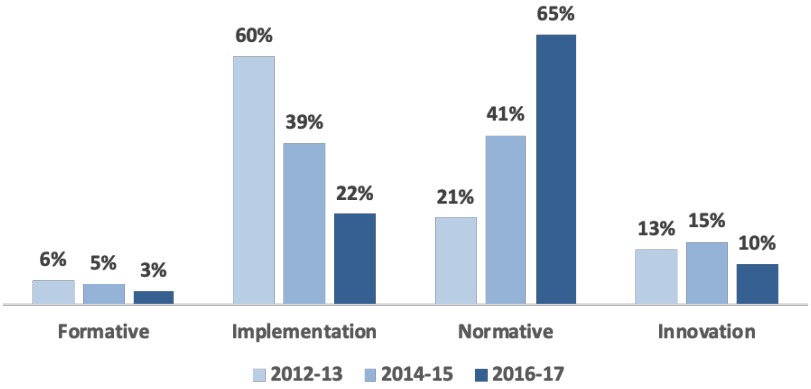
Table 1. Expenditures by type of research (,000 US$)

Biennium	Formative	Implementation	Normative	Innovation	Total
2012/13	653	6,722	2,352	1,493	**11,219**
2014/15	721	5,604	5,865	7,757	**19,947**
2016/17	543	3,663	15,771	5,361	**25,338**
Total	**1,916**	**15,989**	**23,988**	**14,661**	**56,504**

Table 1 shows the outcome of the analysis. Data are approximate because the allocation of outputs to research types was based primarily on the description in the budget lines which were not always very informative. The results are also to some extent distorted by expenditures on a few very large projects funded with designated contributions, for instance the grant for the Oxytocin/Carbetocin non-inferiority trial which accounted for 28 percent of expenditures on innovation research over the two biennia from 2014 to 2017, and the grant for the antenatal corticosteroid efficacy trial which accounted for 31 percent of expenditures on normative research in the 2016/17 biennium. But even if these two large grants are removed from the expenditure data as in Figure 2, the analysis shows that there has been a decrease in the expenditure on implementation research in relation to normative research over the past six years.

[4] The remaining expenditures were for 'policy and programme strengthening', an expenditure line that was discontinued after 2013 and that could not be allocated to any specific type of research

Figure 4. Relative expenditure by research type (adjusted)[5]



2.1.2 Was research conducted or supported by HRP (including implementation research) of high scientific merit and ethical standard; did it involve stakeholders in a meaningful way, and did it consider the local context, including gender and social inequalities? (Effectiveness)

Indicator:	**Result:**
Average RQ+ scores for research in specific areas	A sample of 13 reviewed research projects had an acceptable standard of quality, with 6/13 in the range of excellent that could serve as examples of high-quality research.

Research Quality Plus (RQ+) is a methodology for evaluating the quality of research in the context of development that was published by the Canadian International Development Research Centre (IDRC). [7] Like the methodology of bibliometric analysis used in previous evaluations, RQ+ is not suited to evaluate the quality of individual projects which requires a much more differentiated review, but rather for the evaluation of a programme based on a representative sample of projects. The RQ+ methodology was adapted with some minor modifications for the HRP evaluation. The basis of the methodology is the scoring of the outputs of research projects by independent peer reviewers according to four parameters of context and nine parameters of quality grouped in four categories: validity, legitimacy, importance and positioning for use. The application and results are described in more detail in Volume 2.

For the sampling of projects to be scored, the HRP Secretariat provided a database of 78 eligible research projects approved by the HRP RP2 review panel between 2012 and 2016. This timeframe was chosen because the projects approved in 2012 were most likely to start in 2013 and therefore fall into the evaluation period, while projects approved in 2017 were unlikely to have produced outcomes that could already be assessed. Among these 78 projects, 14 (18%) were sampled by purposive sampling. The sampling process was challenging and took about three months to complete. HRP did not have a functional central system for filing and maintaining research approval and output documents. Six initially sampled projects had to be replaced because they were incorrectly identified as research projects, had been cancelled, had not yet started, or had not yet generated any outputs. Full documentation could only be obtained from each responsible officer, some of whom had left HRP and others who had to search for documents on hard drives of decommissioned computers. In the end, sufficient documentation for evaluation were obtained for only 13 of the 14 projects in a sample that did not perfectly fit but came close to the intended purposive sample profile.

[5] Two large grants funded with designated contributions were removed (Carbetocin trial and ACS trial)

Table 2. Final sample profile for research quality assessment

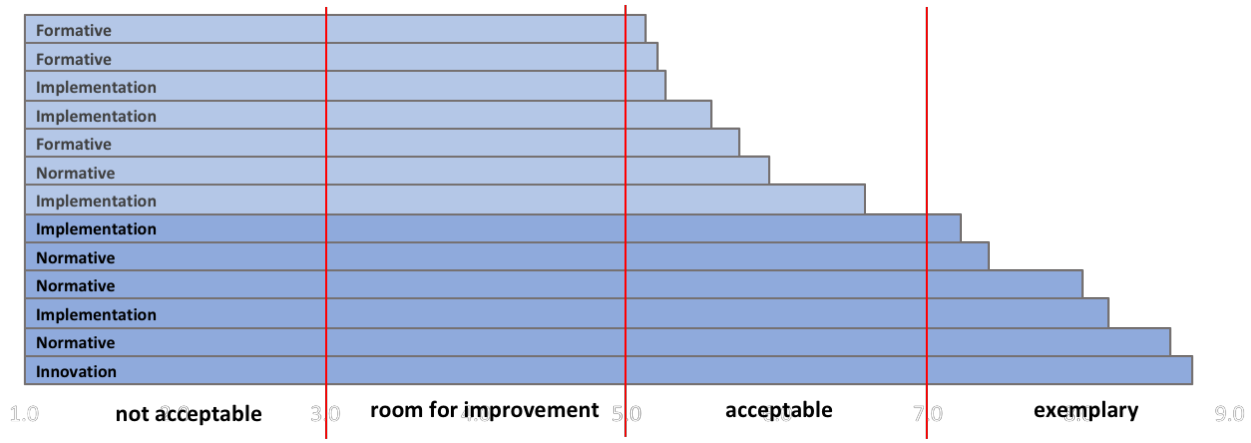
TYPE	FORMATIVE	IMPLEMENTATION	NORMATIVE	INNOVATION	--	--
	3	5	4	1	--	--
THEME	ABORTION	CONTRACEPTION	ADOLESCENTS	MATERNITY	STI	VAW
	1	3	3	4	1	1
YEAR	2012	2013	2014	2015	2016	--
	3	2	4	2	2	--
REGION	AFRO	AMRO	EMRO	EURO	SEARO	Multiple
	4	0	2	1	2	4

The four research types described under the previous heading were represented in the sample.

- Investigating the research field and generating buy-in by stakeholders in distinct **formative research** studies is evidence of good practice. These types of studies are, however, more difficult to publish in high impact journals. For one of the reviewed studies only an unpublished report was available for assessment. Furthermore, two of the three formative studies did not result in follow-up research. In such situations, there is a risk that expectations are raised that cannot be met. This was evident in one of the reviewed projects.
- **Implementation research** projects were prominently represented in the sample. This type of research was considered a priority for HRP by many interviewed stakeholders.
- **Normative research** has long been a major component of the HRP research portfolio, they were also prominently represented.
- One **innovation research** project was included. Innovation studies have a significant weight in the HRP budget, but the number of these types of projects is quite small.

EVALUATION FINDINGS

Figure 5. RQ+ scores of sampled research projects



Out of a total possible score of 9.0, studies that scored in the range of 5.0 to 6.9 are considered to have acceptable quality and those in the range of 7.0 to 9.0 exemplary quality. The 13 sampled projects were rated by the reviewers with a mean score of 6.7 based on individual scores ranging from 5.1 to 8.8.

The scores for the four contextual parameters did not feed into the quality assessment. Among the sampled projects normative and innovation research tended to be conducted in mature research fields with well-established theoretical and conceptual frameworks and research outlets, while formative and implementation research tended to be more often in emerging fields. Research risks in terms of risks in

the data, research and political environment were generally avoided with a few notable exceptions that required rapid action such as the response to an outbreak of Ebola virus infection.

There was some differentiation in the scoring results of the four categories that were used to assess research quality:

- **Research validity** scored the research design and methodological rigor of the studies. It received overall the highest mean score (7.2) albeit with a wide range from 3.8 to 9.0.
- **Research importance** rated the originality and the relevance of the sampled studies. It was rated with the second highest mean score (7.0) with a range of 4.0 to 8.9.
- **Research legitimacy** examined parameters of attention to potentially negative consequences, gender responsiveness, inclusion of vulnerable populations and engagement with local knowledge. The mean score was in the high acceptable range (6.7) with individual project scores ranging from 4.9 to 8.7.
- **Positioning for use** was scored on two parameters: Accessibility and sharing of knowledge, and timeliness and actionability of the research. The sampled programmes had the lowest mean score for this parameter. It was also the only parameter where one project scored in the 'not acceptable' range of 1.0 to 2.9. Mean score: 6.4, range 2.9 to 8.9.

Among all sampled projects, the formative research projects had the lowest average scores overall and in all categories except research importance. This may in part be related to the fact that they were poorly documented, or documentation may not have been provided completely. As already mentioned, two of the three sampled studies did not lead to a follow-up study using the generated findings and building on the mobilisation of research subjects and users. Although the reasons differed, it raises questions about the prior assessment of actionability.

Surprisingly, the five implementation research studies scored lower on average than the four normative research studies on the parameter of 'positioning for use'. (6.0 compared to 7.6) One would have expected that implementation research was particularly strongly focused on knowledge sharing and actionability. Although this issue could only be examined in a larger and more detailed review of the HRP research portfolio, it suggests the hypothesis that normative research, due to its long history of practice by HRP, has developed a number of automatisms that ensure that research results are translated and extensively disseminated by WHO. This has not yet happened to the same extent with implementation research. Several interviewed stakeholders, primarily financial donors of HRP, pointed out that the degree to which HRP research is effectively translated into policy and programme changes is an issue that requires closer examination and better documentation. That HRP is able to support high quality implementation research studies is documented in the case of the study on ante-natal care summarised in the textbox.

Implementation research in Mozambique

In 2011, a formative study using focus groups and interviews with women and health workers in three health facilities in Mozambique identified bottlenecks in the provision and use of quality ante-natal care. Among them, the malfunctioning of the supply chain for ANC commodities was identified as a critical factor. [10]

Based on these findings, an intervention study of supplying pre-packaged ANC kits was launched in 2014 to determine its effect on the detection, treatment and prevention of major health conditions in prenatal care. The study was conducted in close cooperation with the Ministry of Health. It used a stepped wedge design, providing the kits progressively to 10 ANC clinics in a stepped fashion with two months delay for each step, and collecting data from routine ANC records over a 22-month period from all clinics, before and after introducing the intervention. [11]

The research showed that the provision of pre-packed supply kits at the point of care can generate major long-lasting improvements in the delivery and quality of antenatal care. [12] Because the implementer (the Ministry of Health) was closely involved in the research from the start, and because the intervention was both financially and logistically feasible, the research results are highly actionable.

Among all nine parameters scored for research quality, gender-responsiveness had the lowest mean score at 5.7 suggesting that there is room for improvement. This finding was confirmed by an assessment of

gender mainstreaming in four research projects conducted in the context of the case study on gender, equity and human rights. (Volume 2) The integration and mainstreaming of gender issues was patchy and limited to a focus on girls' and women's health issues. Social determinants, the causes and impact of gender roles and the perceptions of boys and men were not or only superficially analysed. In three of the research proposals, gender was treated as an add-on and considered purely from a women's health perspective.

The RP2 approval forms in the beginning of the evaluation period included a section entitled 'gender considerations' with four questions ranging from how the proposed research addresses needs expressed by men and women to a question about the gender composition of the research team. In some of the reviewed research proposals, these questions were only answered in a perfunctory manner. The current RP2 submission forms no longer include this section, however a checklist is used by the HRP Research Manager to pre-screen proposals for gender, equity and human rights integration prior to RP2 submission. The sample of evaluated projects does not allow an analysis whether there has been a change in gender responsiveness over time. The findings of research quality analysis and of the case study on gender, equity and human rights indicate that there is room for strengthening the current research planning and approval processes and mechanisms to ensure consistent and effective integration of gender in the research portfolio of HRP.

2.2 SYNTHESISING RESEARCH EVIDENCE

Evaluation Question 2: Has HRP supported synthesis or consensus publications or processes that have contributed to evidence-based global, regional or national policies and programmes on SRHR?

Main Findings:
Synthesising and building consensus on evidence for SRHR, including for global data and indicators, was considered by interviewed informants as a key function of HRP that could hardly be performed with the same degree of credibility by others. Some considered it as more important than generating evidence.

The performance of HRP in this output area was considered by a majority of stakeholders as strong and the focus of the work has been on the SRHR priorities in low- and middle-income countries. The example of HRP's work in synthesising and building consensus on the evidence on violence against women for the development of a WHO Global Plan of Action was cited by several respondents as an outstanding achievement.

Recommendations

- HRP should continue to give priority to evidence synthesis and consensus building in SRHR as a work area in which it occupies a unique leadership role and has established a record of excellent performance.

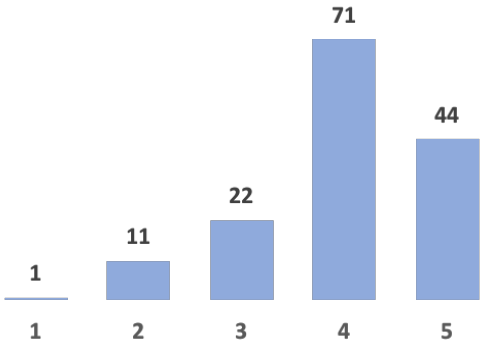
Synthesising and building consensus on scientific evidence in all areas of SRHR is a key mandate of HRP. It includes conducting or commissioning systematic evidence reviews through meta-analytical studies as well as convening panels of experts, and sometimes representatives of affected population groups. The purpose is to generate authoritative and evidence-based documentation of the acceptability, feasibility, effectiveness and impact of interventions; the effects of policies and programmes on human rights and the achievement of gender equality; and the validity and accuracy of methodologies, systems and data to inform and monitor global SRHR strategies.

In the on-line survey, 77 percent of respondents rated the activities of HRP in synthesising evidence and in convening experts to generate consensus on SRHR issues as usually or always effective.

Figure 6. Survey results: Effectiveness of evidence synthesis and consensus building

Respondents' ratings of processes for synthesising evidence *(N=165)*

EVIDENCE SYNTHESIS	
1. Not effective	1
2. Not very effective	11
3. Sometimes effective	22
4. Usually effective	71
5. Always very effective	44
Median Score	**4**
I don't know	*16*



Several interviewed key informants considered that the task of synthesising evidence was of higher priority for HRP than the task of generating evidence. This was summarised in an interview comment by a senior UN staff: *'There used to be a need for HRP to do basic research in order to generate new knowledge but today there are many institutions in the South that have this capacity. But there is a need for an impartial institution that can synthesise the research findings and generate a consensus on them, and HRP is well positioned to fill this role.'* Interviewed informants in research institutions agree. They are able to generate evidence through research, but HRP has an undisputed lead in bringing it together and resolving scientific controversies. One researcher commented: '*HRP should have the authority in this area. They should be some kind of a Cochrane for SRHR. This is where HRP can really make a difference. Not only in doing synthesis and meta-analysis but also in having Delphi panels with many other partners.'*

Given the many examples that were cited by key informants, it is evident that HRP has been very active in this workstream. The actual extent of activity is difficult to capture. The results reports issued by HRP since 2014 indicate that the Programme has consistently performed above target on the output indicator of *'systematic reviews of key questions in sexual and reproductive health published'*. Against the target of producing 180 publications over the four years, 281 are listed in the reports. The number of published papers, however, is at best a proxy indicator for the execution of a programme of work that has many dimensions and that also includes many inputs of HRP in consensus processes that are led by others, for instance for the update on the UNESCO guide on sexuality education. [14]

An analysis of the output expenditure database is also not helpful. Some large meta-analysis studies are listed, but most of the consensus panels and systematic reviews are financed under budget lines of research projects or labelled as general technical support. Only 11 items could be clearly identified as pertaining to the synthesis of evidence with a total expenditure of US$ 2.6 million over three biennia. As past and current RHR staff members pointed out, the work of consensus building is not a high budget activity and it is not always very visible. One current RHR staff stated: *'We are not only building the evidence base on the effectiveness of an intervention, but also on acceptability, feasibility, equity and cost effectiveness. For these, we commission groups that have expertise in reviewing qualitative evidence depending on the question we are looking at. An average review will cost between US$5,000 to US$10,000. If it results in a publication, we are sometimes co-authors.'*

2.2.1 Have the HRP-supported publications and processes for synthesising and building consensus on research evidence addressed priority issues of SRHR for people in low- and middle-income countries? (Relevance)

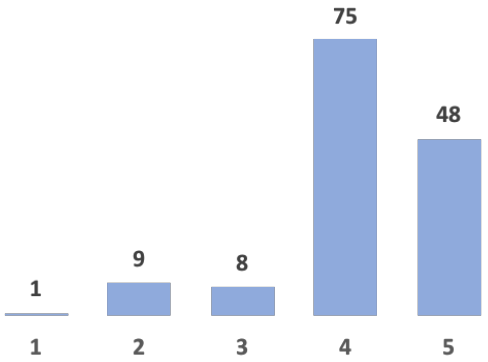
Indicator:	**Result:**
Stakeholder views of the extent to which synthesis and consensus publications and consultations supported by HRP address SRHR priorities in low- and middle-income countries	A large majority of interviewed and surveyed stakeholders (87% of survey respondents) stated that synthesis and consensus publications and consultations supported by HRP mostly or always focus on SRHR priorities in low- and middle-income countries.

The majority of respondents to the on-line survey, 87 percent of those who felt competent to answer the question, stated that HRP's work in synthesising research evidence and building consensus focused mostly or exclusively on SRHR priorities in low- and middle-income countries.

Figure 7. Survey results: Relevance of evidence synthesis and consensus building

Did HRP's work of synthesising research evidence and building consensus focus on SRHR priorities in low- and middle-income countries? *(N=165)*

RESEARCH SYNTHESIS	
1. Only non-priorities	1
2. Mostly non-priorities	9
3. ½ priorities and ½ non-priorities	8
4. Mostly priorities	75
5. All work focused on priorities	48
Median Score	**4**
I don't know	*24*



Interviewed stakeholders agreed with the findings of the survey, but it also became clear that many informants had a holistic view of the process of synthesising evidence and translating it into a normative statement. They did not see this as two distinct links in a value chain. While this reflects the reality of the majority of work processes in HRP, it also is a source of an organisational challenge. At the start of this process is a clear mandate for a research programme, i.e. HRP, while the tail end reaches into the remit of a normative agency, i.e. WHO and therefore the PDRH. This is further discussed under Heading 2.8.3.

2.2.2 Has HRP-led synthesis of research evidence contributed to evidence-based consensus on SRHR issues and priorities at national, regional or global level? (Effectiveness)

Indicators:	**Results:**
Stakeholder knowledge about, and use of HRP-supported research synthesis reports and publications	A sample of HRP-supported research synthesis reports was known by 79% of surveyed stakeholders and considered very or extremely important by 87% of those who knew the publication.
Satisfaction with the process and the outcome of HRP-supported processes for synthesis and consensus building among implementers of SRHR programmes in low- and middle-income countries	Among 30 implementers responding to the on-line survey (government or national NGO in low- and middle-income countries) 66% considered that the processes for evidence synthesis and consensus building supported by HRP was strong or very strong, and 93% considered that the focus was mostly or exclusively on priority issues of SRHR in their countries

To explore the level of knowledge about HRP outputs in the area of evidence synthesis, survey respondents were asked to rate the importance of seven HRP publications of consensus or synthesis reports published between 2014 and 2017. The publications were sampled by purposive selection to cover a range of programme areas and included journal papers and WHO statements. Knowledge of the publications overall was 79 percent, ranging from a high of 88 percent of respondents stating that they knew about a paper on abortion incidence published in a high impact general medical journal, to 62 percent stating their knowledge about a paper on HIV and syphilis testing published in a more specialised journal. Among those who knew the publications, an average of 87 percent considered them very or extremely important, ranging from 75 percent to 94 percent.

Among the 30 respondents to the on-line survey who identified themselves as staff of government agencies or NGOs in low- and middle-income countries and who answered questions about the effectiveness of the consensus-building initiatives of HRP and the focus of these initiatives on SRHR priorities in their countries, two-thirds considered the processes as strong and 93 percent stated that they focused mostly or exclusively on priority issues. Key informants interviewed for the evaluation cited several examples of effective initiatives by HRP to synthesise, build consensus and communicate evidence to inform global or national decision-making. The most often cited example was HRPs collaboration with UNWomen and other network partners to synthesise evidence and prevalence data to feed into WHO and UN strategy discussions on violence against women. As one former senior UN official noted: '*One example on how well HRP performed in building consensus based on evidence was in the development of the global plan of action on violence against women and girls. HRP synthesised the evidence, had a stream of regional consultations and managed the process very well to obtain the endorsement of all countries which on such a difficult topic was a very difficult task. Decisions were challenged, for instance the concept of marital rape or child marriage, but HRP had all the data and drove the process by the presentation of evidence and not by ideology.'* (see textbox)

Synthesising evidence on violence against women

In 2016, the World Health Assembly endorsed the 'Global Plan of Action to strengthen the role of the health system within a national multi-sectoral response to address interpersonal violence, in particular against women and girls, and against children'. In preparing this document, HRP led the internal working group steering its development. In a first step, a draft zero was written in consultation with WHO departments and regional advisors. This was followed by extensive consultations seeking inputs from Member States, civil society groups, professional associations and UN partners. Based on feedback collected from these consultations, a new draft was issued. Another round of consultations followed, and the draft plan was presented to a formal meeting of all WHO Member States. The outcome was a final draft that was submitted to the WHO Executive Board for approval before presentation to the World Health Assembly.

The final Global Plan of Action is evidence based and draws extensively on HRP's work in the area of violence against women and sexual health and rights.

2.3 STRENGTHENING RESEARCH AND TECHNICAL CAPACITY

Evaluation Question 3: Has HRP support contributed to increased SRHR research, knowledge transfer and implementation capacity of institutions and individuals in low- and middle-income countries?

Main Findings:
Following the external evaluation in 2013, HRP started to revise and rebuild its approach to research capacity strengthening under the HRP Alliance. Progress has so far been slow, and the envisaged regional capacity-building networks are not yet fulfilling their role. Although the concept and goal of the HRP Alliance are clear, there is insufficient information about the strategy of how to reach this goal. During the evaluation period, the promotion of gender equality, equity and human rights has received insufficient attention in the efforts to develop the HRP Alliance.

Key informants agreed that the human resources mobilised by HRP to implement the approach are greatly insufficient. External informants commented mostly on the invisibility of the HRP Alliance network. This included respondents from WHO Collaborating Centres who are, according to the concept, themselves network members.

Collaboration with the Tropical Disease Research (TDR) Programme for short-course training in research methods and approaches has started and is being further developed. This is a promising initiative, in part also because TDR has a much greater training budget, more human resources and a well-established global network of training partners. This does, however, not replace the goal to build the regional networks of strong SRHR research, training and mentoring centres for SRHR research as envisaged under the HRP Alliance which is also imperative for supporting HRP's intended shift of focus towards implementation research.

Recommendations

- HRP should with some urgency develop and widely communicate a comprehensive strategy for the development of the HRP Alliance in close collaboration with the established HRP hubs and key partners among the WHO Collaborating Centres. This should include a timed implementation plan and the mobilisation of sufficient human resources to implement it.
- HRP should continue and expand its collaboration with the Tropical Disease Research Programme (TDR) and eventually also the Alliance for Health Policy and Systems Research (AHPSR) in developing and delivering a curriculum of short research training courses in parallel and within the strategy for the HRP Alliance network.

'Strengthening the training and research capability of developing countries in the field of human reproduction' is one of the four core objectives of HRP. [8] According to the financial reports of the Programme, research capacity strengthening (RCS) accounted for about five percent of total expenditures, including human resource expenditures, over the three biennia from 2012 to 2017. The evaluation team analysed reported programme expenditures on the 409 workplan outputs reported over the three biennia on the basis of the budget line labels. This method can only provide an approximation because the labels do not always exactly reflect the activity that was funded. (see Section 2.1.1) Expenditures that could be allocated to RCS accounted for seven percent of programme expenditures, ranging between five percent in 2014/15 and ten percent in 2012/13.

Budget and expenditure data suggest that RCS was not a major area of HRP's work during the evaluation period. In 2016/17, eleven percent of the operations budget was allocated to RCS, and executed to 74 percent. In the same period the Special Programme for Research and Training in Tropical Diseases (TDR) allocated 49 percent of its budget to RCS and executed it to 90 percent. In absolute terms, the reported 2016/17 expenditures on RCS by HRP of US$ 3.3 million compare to expenditures of US$ 10.2 million reported by TDR for the same period. [19]

There are major differences in the approach to RCS pursued by TDR and HRP which can be roughly described as a difference in focus on individual versus institutional capacity strengthening. Individual training is, however, also a necessary component of institutional strengthening. There are therefore opportunities for collaboration between the two programmes, and potentially also with the third research programme hosted by WHO, the Alliance for Health Policy and Systems Research (AHPSR). Opportunities were seized in 2016 with the joint HRP/TDR/PAHO small grants programme on Zika research, but there is room for expanded collaboration.

Key informant interviews confirmed that HRP's efforts to strengthen research capacity lacked visibility, with many informants not able to cite any examples. RCS was likely a component of some research grants, but the extent to which it was built into these grants and implemented in the research projects cannot be assessed. RCS is not subject to review by the RP2 panel that approves research projects, nor is it integrated in the checklist that is used by the Research Manager to pre-screen research proposals. In the assessment of research quality by the evaluation team (see Section 2.1.2), the parameter of RCS was therefore removed from the RQ+ tool.

During the 2013-2017 evaluation period, HRP initiated the restructuring of its activities in RCS based on recommendations of the 2008-2012 external evaluation. [9] Prior to 2013, HRP had operated a dual approach of a small cadre of staff delivering training workshops on research methodology, as well as a network of research institutions supported with time-bound long-term institutional development (LID) grants and guidance from four regional advisory panels (RAPs) that were part of the governance structure of HRP.

In 2013, this approach was revised. Although HRP continued to provide or commission some training workshops on selected topics or methodologies, the training team was gradually disbanded. Instead, HRP launched the HRP Alliance in 2014, a global institutional network for RCS in SRHR involving WHO Collaborating Centres as well as selected research centres supported with long-term institutional development (LID) grants. In 2016, HRP initiated a process of restructuring the HRP Alliance. A new strategy for the HRP Alliance was laid out in a background paper developed for the 2016 HRP Portfolio Review. [20] HRP began to gradually phase out support to the LID grantees and launched a new process to select and support institutions to form regional research hubs for SRHR research and training. The former RAPs were disbanded, and an Advisory Board was created to oversees the activities of the HRP Alliance. Efforts were made to establish closer links between the networking activities of the HRP Alliance at global and regional level with WHO Collaborating Centres working in SRHR. By the end of 2017, five institutions in Brazil, Burkina Faso, Ghana, Kenya and Khon Kaen had been contracted to act as regional hubs, had submitted their first annual work plans and had started to train PhD and Master students linked to SRHR research in their regions. As further analysed in the case study on HRP's work on gender, equity and rights (see Volume 2), the focus on these areas in the work plans was weak, but key informants reported that plans to strengthen the institutional capacity of the HRP alliance hubs in gender and human rights perspectives of SRHR research were under development by the end of 2017.

The HRP Alliance aims at strengthening the sustainability of HRP's work by re-focusing RCS from individual to institutional capacity strengthening. In addition, the building of the HRP Alliance is conceptually aligned with the intention to shift the focus of HRP research towards implementation research which requires a decentralisation of research capacity from headquarters towards the sites where SRHR programmes are implemented. At the time of the external evaluation it was still in an early development phase, affecting the findings on HRP performance in RCS during the evaluation period. In the view of several key informants, this slow development was to a large extent due to an insufficient allocation of human and financial resources to the implementation of the new RCS strategy.

2.3.1 Has HRP supported capacity-building of individuals and institutions in SRHR research and knowledge translation in areas that are a priority for achieving SRHR in low and middle-income countries? (Relevance)

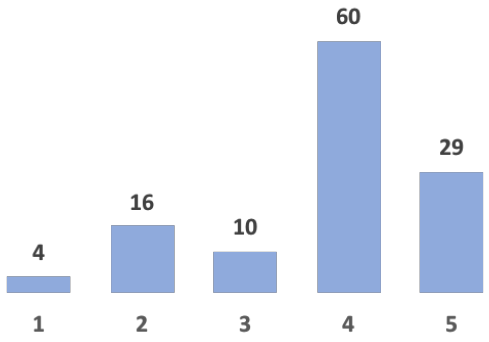
Indicators:	**Results:**
Stakeholder views about the extent to which HRP addressed priorities for achieving SRHR in low- and middle-income countries in its programme of capacity-building in research and knowledge translation	75% of respondents to the on-line survey stated that HRP RCS activities focused mostly or exclusively on priority areas. However only 72 percent of survey respondents were able to answer this question. Interviewed key informants focused more on the form of delivery than the content of the HRP RCS programme.
Degree of satisfaction of individuals (disaggregated by sex) and institutions with the capacity-building support they received from HRP	RCS support of HRP has not had an extensive reach, and the number of individuals and institutions who were able to respond to questions about satisfaction was therefore small. Of 32 grantees (19 female and 12 male) who answered the question in the on-line survey, 78 percent stated that they were very or extremely satisfied.

Among the participants in the on-line survey, 75 percent of respondents stated that HRP's work on strengthening research capacity focused mostly or exclusively on SRHR priorities in low- and middle-income countries. Among the questions on relevance of the four output areas of HRP, the lowest proportion of respondents chose the highest score of 'all work', 24 percent compared to 41 percent for normative work. The fact that only 72 percent of survey participants were able to answer this question supported the statements of interviewed informants that this aspect of HRP's work lacks high visibility.

Figure 8. Survey results: Relevance of research capacity strengthening

Did HRP's work in RCS focus on SRHR priorities in low- and middle-income countries? *(N=165)*

CAPACITY-BUILDING	
1. Only non-priorities	4
2. Mostly non-priorities	16
3. ½ priorities and ½ non-priorities	10
4. Mostly priorities	60
5. All work focused on priorities	29
Median Score	**4**
I don't know	*46*



Among the 165 survey respondents, 33 stated that their institution or they personally had received RCS support from HRP, the majority through institutional development grants. Only seven among them, five female and two male respondents, had received an individual training grant. Of the 32 respondents (19 female and 13 male) who answered the question on satisfaction with the support received, 25 (78%) stated that they were very satisfied or extremely satisfied, among them 15 female and ten male respondents. This is, of course, a very small sample on which to draw any conclusion. But it has to be understood in the context of only 47 research institutions supported with LID grants between 2014 and 2017, [6] and only 48 individual training grants provided in the five years from 2013 to 2017.

[6] Reporting against the HRP results framework only started in 2014. The names of LID grant recipients in 2013 were not available.

Table 3. Individual training grants awarded by HRP

YEAR	2013	2014	2015	2016	2017
NUMBER OF GRANTS	0	21	13	6	8

Comments of key informants on the relevance of the HRP RCS activities were very limited. None raised any issues about the content of the RCS programme, but more of them focused on the way it was being delivered, and the HRP Alliance in particular. Among staff of financial donor agencies, several made comparisons to the TDR programme and some also to the Alliance for Health Policy and Systems Research (AHPSR), another health research partnership programme hosted by WHO. Several made the point that the capacity to do research depends, to some extent, on generic skills of mastering methodologies of data collection, analysis and presentation. This has led to calls for greater cooperation or even a merging of the RCS component of the three research programmes. That such cooperation has potential was illustrated by a respondent from one of the HRP LID grantee institutions. He recounted that a training course in implementation research delivered with TDR support at his institution, capacitated staff working in SRHR research to offer the same training to graduates and fellows working in their research area.

Interviewed HRP staff readily agreed that much could be gained by increased cooperation in RCS between the three WHO-hosted research programmes. They pointed out that TDR has the structure, staff and financial resources to support highly visible individual training programmes through methodology workshops and research fellowships provided by their global network of research partners. One partnership with TDR, joint funding of community-based research projects on SRHR issues related to the Zika epidemic has already been initiated and joint training in implementation research methodology is being discussed. [16] SRHR research may continue to require some specialised methodological skills in sensitive fields that are not covered by TDR training courses, such as for research in gender-based violence. But the main difference between the two programmes is in their RCS approach and goals. While TDR aims to raise the overall level of research skills in a well-established field of investigation, HRP is still aiming to establish and strengthen the field of SRHR research in low- and middle-income countries. There is, as yet, no critical mass of high capacity SRHR research institutions in these countries. The focus of HRP is therefore on institutional strengthening. Support for individual training through workshops, diploma courses or fellowships is highly selective to serve the purpose of building the capacity of these institutions.

2.3.2 Did HRP apply objectives of achieving global equity, human rights standards and gender equality in targeting support for SRHR research capacity-building? (Relevance)

Indicators:	**Results:**
Evidence for the inclusion of equity, human rights and gender equality objectives in grant-making for capacity grants	The objectives of the HRP Alliance include a focus on gender, equity and human rights, but they were only developed in 2016. The first-year work plans of five established LID hubs do not effectively mainstream gender, equity and human rights and only two hubs have planned for one training or awareness raising on gender and human rights.
Profile of individual capacity grant recipients (sex, age, academic field, country context)	Data on the profile of grant recipients have not been systematically collected and reported by the Programme.
Profile of institutional capacity grant recipients (academic field, country context)	LID grants in 2014-17 were primarily (74%) awarded to institutions in countries of the AFRO and AMRO Regions and more than half (57%) to institutions in countries with low-income or lower-middle-income economies.

The HRP Alliance has four stated objectives:

1) To strengthen the research capacity of institutions in low resourced settings
2) To promote RCS within prioritised SRHR research areas globally and regionally
3) To support equitable research capacity strengthening within SRHR by implementing HRP Alliance core values (promoting gender equality, human rights and equitable outcomes by prioritising investments in the least resourced settings)
4) To monitor and evaluate the impact of RCS activities by applying a theory of change, including qualitative and quantitative indicators.

The third objective focusses explicitly on gender, equity and human rights. Finding evidence to what extent this objective was realised was challenging:

- The objectives of the Alliance were only defined in 2016, hence, towards the end of the evaluation period.
- There was little documentation on the work of the HRP Alliance, and some documents were not dated so it was not clear if they had been developed during or after the evaluation period.
- Sex-disaggregated numbers of training participants, doctoral and master level students were only available from 2018 forward, but not for the evaluation period.
- Information provided in the annual and result reports on RSC was unspecific and did not allow to extract information on gender, equity and human rights mainstreaming at institutional or process level.
- Most of the interviewed RHR staff had little information about the development of RCS work by the Department since the start of the reform process in 2013. Plans to collect more information at the HRP Alliance meeting in October 2018 could not be realised because the meeting was cancelled on short notice.

Sex-disaggregated data of the 48 master or doctoral level students sponsored by HRP during the evaluation period are not available, including for the 14 since inception of the HRP Alliance. Three short-term training courses that included gender and human rights components were organised since inception under the HRP Alliance but sex-disaggregated data on trainees were also not available:

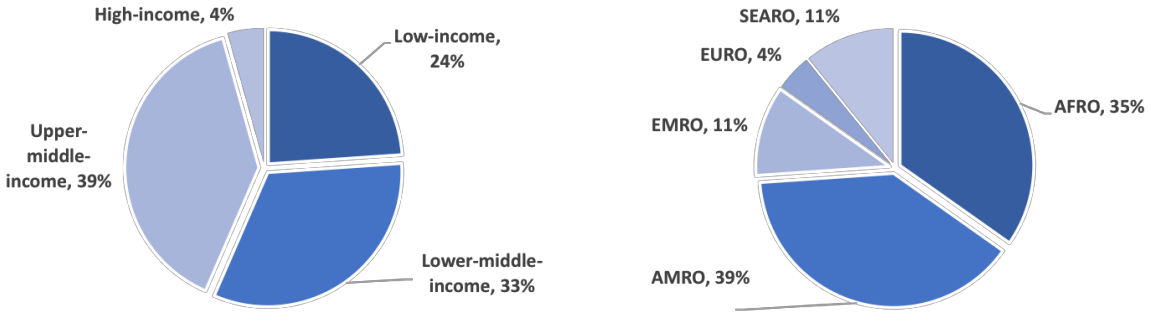
- Two short courses on implementation research with a total of 50 participants conducted in collaboration with the University of Lausanne that included a gender and HR components. Three criteria were applied for the selection of participants: (i) at least 50 percent women; (ii) wide representation from least resourced countries; and (iii) fulfilment of academic criteria for the course.
- A training course on methodologies in research on gender-based violence and violence against women for Spanish-speaking regional participants in the Americas delivered by the Centro Paraguayo de Estudios de Poblacion (CEPEP) in Paraguay.

The portfolio review conducted in 2016 identified two issues related to gender, equity and human rights that needed to be addressed by the work of the HRP Alliance: (1) inequity in research capacity (imbalance of high-income countries compared to middle and low-income countries and disparities in age and sex in research teams) and (2) the need to strengthen capacity of individuals, institutions and systems to conduct research that address inequities and inequalities and that promote the protection and fulfilment of human rights. From the evidence available to the evaluation team, it is not clear whether or not this is currently reflected in the work plans of the HRP Alliance. The first-year work plans (2017 - 2018) of the five LID hubs do not include any meaningful commitments to mainstreaming these issues in the processes and content of their work. Only two of the hubs have planned trainings or awareness raising on gender and human rights. Process outputs for capacity building of individuals (trainings, PhDs etc.) do not have

disaggregated targets to monitor gender and socio-economic characteristics of recipients and none of the plans have gender, equity or human rights-specific results (e.g. in terms of addressing the dominance of older, male researchers, or for mainstreaming gender, equity and human rights in research proposals or lead authorship).

Between 2014 and 2017, HRP awarded LID grants to 47 institutions, including one multi-country grant to an association of researchers in human reproduction in Latin America. Among the 46 country institutions, the majority (74%) were in countries in the African and American regions, and the majority (57%) in countries with low-income and lower-middle income economies according to World Bank classification.

Figure 9. Profile of countries with LID grant recipient institutions



2.3.3 To what extent have HRP capacity-building grants and network support of the HRP Alliance strengthened the capacity of individuals and institutions to conduct SRHR research and translate knowledge into policies and programmes? (Effectiveness)

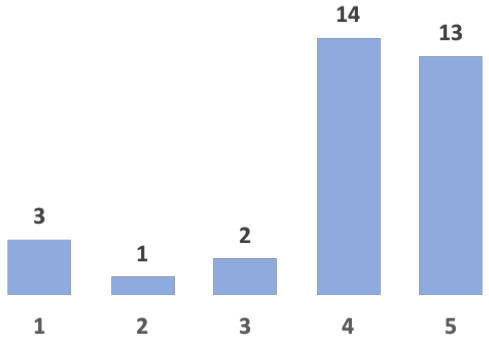
Indicator:	**Result:**
Perception and documented evidence of institutional representatives and individual capacity grant recipients (disaggregated by sex) about changes in their ability to raise research funds, conduct research and influence decision-makers in policies and programmes	Considerable or major Institutional capacity strengthening for research was reported by 82%, for capacity to influence decision-makers by 75%, and for capacity to raise research funds by 48% of survey respondents. Considerable or greatly strengthened personal capacity to do research was reported by 75% (74% by female and 77% by male respondents) and for personal or institutional networking by 79% (75% by female and 85% by male respondent).

The effectiveness of the RCS support provided by HRP was surveyed among the 33 on-line survey respondents (61% female) who stated that they or their institution had received training or institutional development grants. Among those who were able to answer the questions, 82 percent reported that their institution's capacity to do research was strengthened considerably or to a major extent, 75 percent for their capacity to influence decision-makers, and only 48 percent for their capacity to raise research funds. Considerable or greatly strengthened personal capacity to do research was reported by 75 percent (74% by female and 77% by male respondents) and for personal or institutional networking by 79 percent (75% by female and 85% by male respondent). The total number of respondents who had received RCS support from HRP was small, but the RCS programme pursued by HRP was also constrained during the past five years of restructuring its approach. The survey results are presented in Table 8.

Figure 10. Survey results: Effectiveness of research capacity strengthening

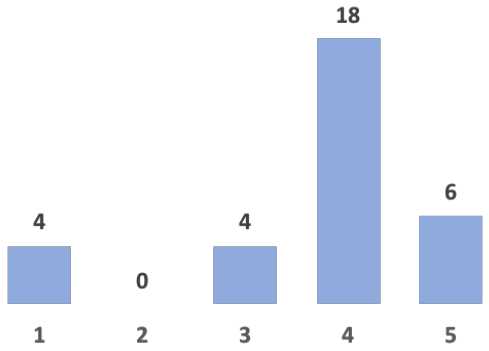
Did HRP contribute to strengthening the institutional research capacity? *(N=33)*

INSTITUTIONAL RESEARCH CAPACITY	
1. Not at all	3
2. A little	1
3. More than just a little	2
4. Considerably	14
5. To a major extent	13
Median Score	**4**
I don't know	*0*



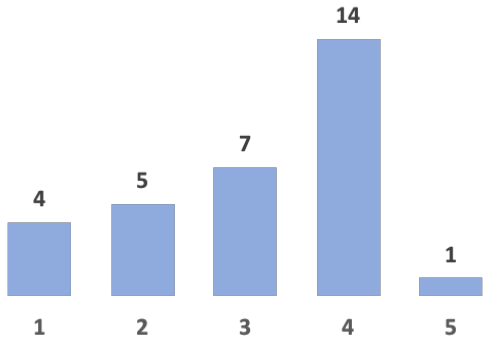
Did HRP contribute to strengthening the institutional capacity to influence decision-makers? *(N=33)*

CAPACITY TO INFLUENCE DECISIONS	
1. Not at all	4
2. A little	0
3. More than just a little	4
4. Considerably	18
5. To a major extent	6
Median Score	**4**
I don't know	*1*



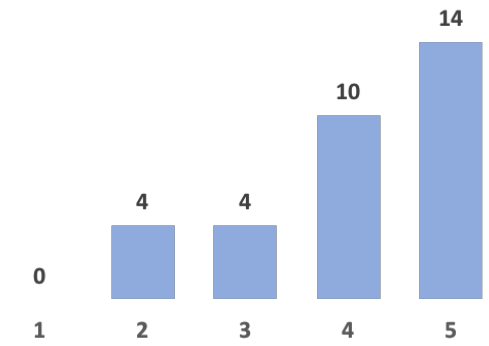
Did HRP contribute to strengthening the institutional fund-raising capacity *(N=33)*

FUND-RAISING CAPACITY	
1. Not at all	4
2. A little	5
3. More than just a little	7
4. Considerably	14
5. To a major extent	1
Median Score	**3**
I don't know	*2*



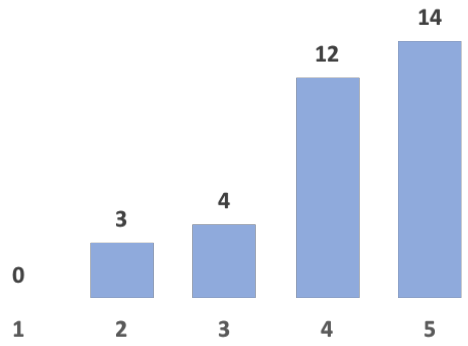
Did HRP contribute to strengthen your personal capacity to conduct research *(N=33)*

PERSONAL RESEARCH CAPACITY	
1. Not at all	0
2. A little	4
3. More than just a little	4
4. Considerably	10
5. A great deal	14
Median Score	**4**
I don't know	*1*



Did HRP contribute to strengthening the institutional and your personal networking capacity? *(N=33)*

NETWORKING CAPACITY	
1. Not at all	0
2. A little	3
3. More than just a little	4
4. Considerably	12
5. A great deal	14
Median Score	**4**
I don't know	*0*



On the basis of recommendations of the 2013 evaluation, HRP developed the 'HRP Academic Alliance' in 2013 that was later renamed 'HRP Alliance' on recommendation by the STAG. It comprises selected regional research institutions supported by HRP with long-term institutional development and research mentoring grants to act as regional hubs for training, mentoring and networking in SRHR research, as well as WHO Collaborating Centres working with the RHR department. By the end of 2017, five research centres in Brazil, Burkina Faso, Ghana, Kenya and Thailand had been contracted and had submitted plans for their work as regional hubs starting in 2017. In addition, 21 WHO Collaborating Centres were identified as potential participants in the HRP Alliance.

The evaluation team conducted interviews with senior staff of three HRP Alliance hubs and one Collaborating Centre. The hubs were at the beginning of implementing their work plans and had each accepted a small number (2 to 3) graduate students from potential institutional development partner institutions in their region. Some had also organised some short course methodology seminars in their institution. The graduate student sponsorship programme was largely aligned with the HRP Alliance objective to build regional networks by selecting candidates from promising SRHR research centres in the region and linking their post-graduate work to the research agenda of HRP. But none of the five HRP Alliance partners had yet progressed to the next step of mentoring and strengthening research facilities within the planned regional network. This was not yet foreseen in their 2017/18 work plan.

WHO Collaborating Centres are established research partners in the HRP Alliance that do not receive any grant support. A number of them have participated in the meetings for the formation and structuring of the HRP Alliance and there is great willingness by some of the centres to engage in an HRP-led RCS network for SRHR research. Some of the centres already facilitate active SRHR research networks with important capacity-building components. They could thereby contribute important technical resources to the HRP Alliance. Furthermore, since these networks are often funded by the same donor agencies that contribute to the HRP Trust Fund, greater network coordination could increase efficiencies and reduce duplications and competition for resources. While there have been active discussions between HRP management and some networks for greater collaboration in 2018, until the end of the evaluation period in 2017 there was little evidence of active participation of the WHO Collaborating Centres in the HRP Alliance.

The key informant interviews with PCC and technical committee members confirmed that the promises raised by the launching of the HRP Alliance in 2013 had not been realised by the end of 2017. Progress was made, but it has been very slow. A majority of informants expressed disappointment about the lack of transparency and the lack of results of the initiative, calling the development of the HRP Alliance erratic and lacking strategy. HRP staff stressed that the process of building the HRP Alliance was managed

throughout the evaluation period with minimal human resources, essentially by the Research Manager (who also had many other tasks) supported by one or two consultants. Recently (in August 2018), a consultant was engaged to develop action plans for expanding and strengthening the linkages between the HRP Alliance hubs and other HRP research partners, including the WHO Collaborating Centres.

Against this background of slow and incomplete organisational change of the HRP RCS programme that lasted throughout the evaluation period, an assessment of outcome effectiveness is hardly pertinent. The effectiveness of process management, however, was less than optimal.

2.3.4 What capacity-building outcomes have been achieved by individuals and institutions that are sustained independently from HRP financial and technical support? (Sustainability)

Indicators:	**Results:**
# of scientific publications produced by individuals (disaggregated by sex) who received capacity building support from HRP	The RCS support of HRP during the evaluation period focused on developing a revised RCS strategy by building the HRP Alliance which was not yet fully operational by the end of 2017. While these indicators may be useful for future monitoring of the HRP Alliance, they do not yet provide any information about the sustainability of the HRP RCS effort. Data for reporting against these indicators are not yet available.
# of publications produced by institutions that received capacity building support from HRP (that can be directly or indirectly linked to this support)	
# of research grants obtained by capacity grant recipients from sources other than HRP	

Findings on sustainability of RCS initiatives by the external evaluation in 2013 were one of the factors driving the reform of the HRP RCS strategy and the launching of the HRP Alliance. Throughout the 2013 to 2017 evaluation period, HRP worked on operationalising the new approach which was still incomplete by the end of 2017 and lacked a clearly formulated strategic plan against which appropriate indicators could be developed to monitor its sustainability. At this point in its development, the sustainability of the HRP RCS approach cannot be evaluated.

2.4 Strengthening the research/policy dialogue

Evaluation Question 4: Has HRP convened regional and national consultations on SRHR issues that have strengthened the translation of research evidence into laws, policies and programmes?

Main Findings:
HRP's work in knowledge translation and the engagement of decision-makers in dialogues on the implementation of evidence-based solutions and policies has been effective but not very visible, especially at country level. This is in part related to the fact that large partnerships for maternal and neonatal health were formed during the MDG era and multiple platforms for policy dialogue in this programme area exist. Furthermore, the work in this output area is central to WHO's mandate to provide technical and policy support to countries. Even when implemented by HRP staff it is often delivered with the branding of WHO. HRP, nevertheless, continues to occupy an important niche for driving the policy dialogue on sexual health and rights and other sensitive issues globally and in countries.

The indicator and data used by HRP to monitor and report results under this output do not adequately reflect the performance and achievements of the Programme in the translation of evidence into policy. This is addressed in a recommendation under heading 2.8 (Management).

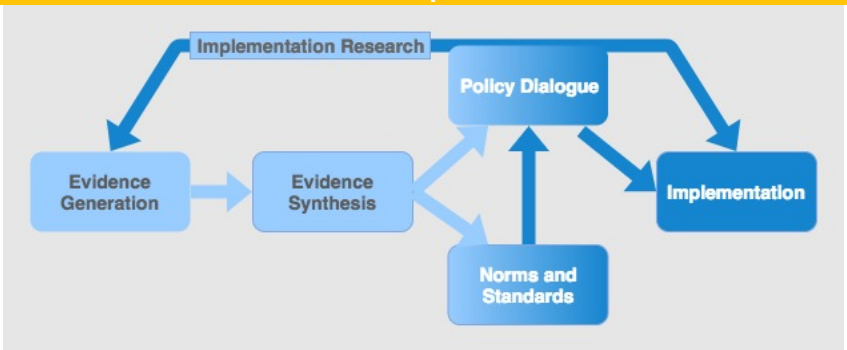
Recommendations:

- HRP should continue to exercise its role and consolidate its niche for driving the policy dialogue at global, regional and national level for the adoption of policies and programmes in sensitive areas of SRHR that promote gender equality, social equity and human rights.

Research-policy dialogue or the knowledge translation from research to implementation has a pivotal position in the value chain from generating evidence to implementing evidence-based practices, norms and standards. By engaging in this work area, the role of HRP merges with the normative mandate of its host agency, and, through implementation and operational research interacts directly with implementing

partners such as ministries of health, UN implementing agencies and NGOs. The activity of research policy dialogue at national, regional and country level is critical in the definition of the HRP mandate. As one senior HRP staff stated in the interview: '*Everyone in my team who develops something would like to see it used. You cannot just say "here it is, use it". You have to engage.'*

Figure 11. Value chain from evidence to implementation



The position of HRP in WHO, as well as the endorsement by its UN cosponsors provides it with the necessary credibility and the open doors to directly engage in policy dialogue on SRHR evidence at all levels. But it also softens the margins of its remit and creates overlaps and even potential conflicts with the mandates of others. Within the RHR department itself, the lines of responsibility between HRP and PDRH for driving the policy dialogue are not sharply divided, and there also overlap with the mandates of other departments of WHO. This is further discussed in Section 2.8.

2.4.1 Has HRP initiated and supported consultations among researchers and decision-makers on priority issues for the improvement of SRHR among people in low- and middle-income countries? (Relevance)

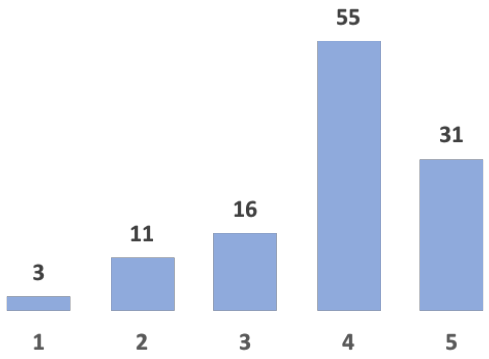
Indicator:	**Result:**
Stakeholder views about the extent to which the research/policy consultations initiated or conducted with HRP support addressed national or regional SRHR priorities	The majority of surveyed stakeholders (74%) considered that HRP's engagement in or support of policy dialogues focused mostly or exclusively on national or regional priorities

Only 70 percent of respondents to the on-line survey had information to answer the question about the relevance of HRP's work in knowledge translation. Among them 74 percent stated that the work focused mostly or exclusively on SRHR priorities in programme countries. These survey results are very similar to those on the question of research capacity strengthening, indicating that HRP's outputs in these two areas are not known as well as those of the other work streams. The majority of respondents considered the work relevant but not as relevant as for instance research or normative outputs.

Figure 12. Survey results: Relevance of knowledge translation

Did HRP's work in knowledge translation focus on SRHR priorities in low- and middle-income countries? *(N=165)*

KNOWLEDGE TRANSLATION	
1. Only non-priorities	3
2. Mostly non-priorities	11
3. ½ priorities and ½ non-priorities	16
4. Mostly priorities	55
5. All work focused on priorities	31
Median Score	**4**
I don't know	*49*



Key informants external to the RHR department primarily mentioned the role of HRP in the global policy dialogue, for instance by influencing the global discourse on family planning. RHR staff, on the other hand, cited many engagements in policy dialogue at country level. One senior UN agency staff pointed out that several strong global networks and alliances for improved maternity care had formed during the MDG area, and governments as well as international organisations working in this field had therefore many additional options to engage in policy dialogues at global and national level. However, on sensitive and potentially controversial themes such as sexual rights, abortion safety or violence against women, HRP is often the only or the most credible global partner that is accepted by governments as a partner in dialogue. This narrowing of the focus on areas of comparative advantage may have contributed to lowering the mean relevance scores of the survey respondents.

2.4.2 Have HRP-initiated or supported consultations between researchers and decision-makers contributed to legislative, policy or programme changes at regional or national level improving the SRHR of people in low- and middle-income countries? (Impact)

Indicators:	**Results:**
# of legislative, policy or programme changes at national or regional level that respond to evidence provided by HRP-supported research, knowledge translation, policy dialogue or consensus-building activities	The number of policy or programme changes for which there is documented evidence of influence through knowledge transferred from HRP-supported research is not monitored although many examples were cited in interviews with HRP staff and external stakeholders. Survey respondents cited 75 examples in 41 countries.
# of countries that adopted WHO-endorsed strategies for universal access to SRH services and respect of sexual and reproductive rights in their national health policy and/or strategy during the evaluation period	Several examples were cited by HRP staff, but the number of countries was not monitored and data for this indicator are therefore not available

According to the HRP results framework [15] the impact of the Programme is defined as *'improved sexual and reproductive health and rights, in particular among young women and young people'*. While a contribution to this goal is the ultimate rationale for investing resources and energy in HRP, it is very far removed from its sphere of influence. There are no credible means to generate the necessary evidence for a contribution of the Programme to the achievement of this impact. For the purpose of the evaluation, the HRP outcome statement *'sustainable change in national and international policy and public health programmes'* has been taken as an evaluable impact goal.

Policy dialogue on family planning in the Philippines

Since the enactment of the Responsible Parenthood and Reproductive Health Act in 2012, opponents had blocked the allocation of budgets to family planning through legal action blocking the registration of 51 contraceptive products by the Philippines Food and Drug Administration (FDA) because of concerns about their mechanisms of action. They had achieved a temporary restraining order issued by the Supreme Court of the Philippines.

In 2017, the WHO West Pacific Regional Office reached out to HRP for support to respond to questions of the FDA. In collaboration with the WHO Regional and Country Offices, HRP prepared a detailed evidence brief that was submitted by the WHO Representative. It paved the way for an advisory issued by the FDA declaring that the 51 contraceptive methods were non-abortifacient, resulting in the removal of the restraining order by the Supreme Court.

A strengthened research/policy dialogue, i.e. effective translation of knowledge into policies and programmes is a critical step towards achieving this impact. In the HRP results framework it is defined as an output. The Programme has been monitoring this output by counting the number of policy papers generated and conferences convened or attended. These are easily countable; in 2016/17 for instance, 98 such 'outputs' were delivered. But policy briefs and conferences do not constitute a 'strengthened dialogue', they are the necessary inputs for such a dialogue to happen. The monitoring approach also reflects a linear concept of knowledge translation: Evidence is created by researchers and then transferred to decision-makers. This has long been questioned. Interactive models of knowledge transfer, closely involving decision-makers in evidence generation, are considered indispensable for implementation research. [21] (See example in textbox in Section 2.1.2)

Data on the extent to which evidence generated by HRP has resulted in policy or programme changes, the measurement of the Programme's impact selected by the evaluation, are not routinely monitored although HRP staff were readily able to cite many examples such as the one presented in the textbox.

In the on-line survey, respondents were asked to cite one example of a policy on SRHR in one country that was developed or revised on the basis of information provided by HRP. Among them, 75 (45%) responded to this question citing policy changes in 41 countries. The most common policy area mentioned was contraception followed by maternal health and abortion. A list of countries and policy areas is presented in Volume 2.

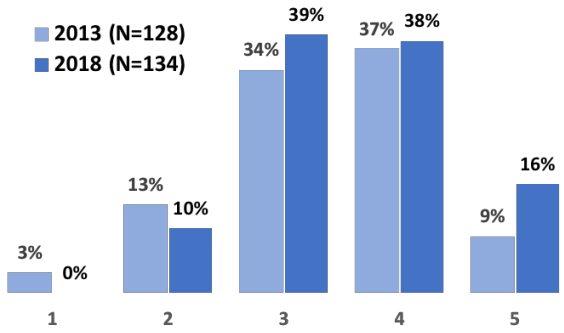
Stakeholder views of the effectiveness of HRP's policy dialogue at country level were surveyed in the 2013 and the 2018 evaluation, albeit with slightly different questions. In 2013, respondents were asked to rate the **impact** of HRP on shaping SRH dialogue and policy-making at national level. In 2018 they were asked to rate the **level of influence** on shaping national policies. In both surveys, five-point Likert scales were used to register the responses. Although the different formulation of the question compromises comparability, the responses suggest that perceptions about HRP's influence on national policies had increased from 46 percent rating it in the highest two categories in 2013 to 54 percent in 2018.

Figure 13. Perceived impact of HRP policy dialogue – comparison 2013 and 2018

2013: What is the impact of HRP on shaping SRH dialogue and policy-making at national level?

2018: How much influence does HRP have on shaping national policies on SRHR in low- and middle-income countries?

(from 'no influence / no impact' to 'extremely influential / large impact)



2.5 Developing evidence-based guidelines, implementation tools and policy statements

Evaluation Question 5: Has HRP supported the production or updating of WHO-endorsed normative documents that have shaped global, regional or national policies and programmes contributing to improved SRHR for people in low- and middle-income countries?

Main Findings:
An extensive portfolio of guidelines and other normative documents was developed and published with HRP support during the evaluation period. The documents are well known and highly appreciated although some stakeholders complained about the length of the development process and others about the inaccessibility of the content to front-line health workers who are looking for more practice-oriented guidance. Procedures to develop more contextualised guidelines with less delay are already being considered according to information provided to the evaluation team. The issue of uptake and implementation of the guidance was raised by interviewed PCC members. It is at the margins of the HRP remit, but nevertheless pursued quite vigorously in programme areas in which there are few other technical or normative agencies, for instance in the area of abortion safety or in sexual rights. HRP has achieved some notable policy results in these areas, although they are not monitored and reported in the results framework.

The mainstreaming of gender, equity and human rights aspects in WHO guidelines developed with HRP support has been consistent and follows the guidance that WHO has issued for the guideline development process. Internal and external key informants stressed that in terms of gender and human rights mainstreaming the RHR Department was a leader among the WHO departments.

Recommendations

- The RHR Department, in collaboration with the WHO Guideline Development Group, should explore means and procedures for more rapid development of practical guidelines for programme implementers.
- HRP should continue to maintain its strong profile in supporting the development and the implementation of policy guidance at global, regional and national levels in areas where it has built its strength and where few other international agencies are active such as in abortion safety, gender-based violence and sexual rights.

The work-stream for normative work of HRP, i.e. the production of guidelines, implementation tools and policy-statements is, like the work in knowledge translation, at the margins of a research programme and it is in fact shared with the PDRH programme in the RHR Department and with other departments of WHO. Outputs in this area of work grew steadily throughout the evaluation period from six WHO endorsed guidelines in 2014 when they were first counted to 28 in 2017. HRP's work on norms and guidelines was not restricted to publications by WHO, although only these are reported in the results reports. HRP provided, for instance, also significant input into updating technical guidelines on sexuality education led by UNESCO and published in 2018. [22]

The issue of translating normative guidelines into national policies and practices has been a point of discussion of the PCC and was also mentioned in interviews by several key informants. Involvement in this activity stretches the remit of HRP well beyond its research mandate. The instructions of PCC are therefore

worded carefully, for instance by recommending that HRP use *'mechanisms and partners for facilitating the implementation of its guidelines'* in 2016. [23] Structurally, the translation of SRHR guidelines into practice is a central remit of PDRH, of other technical departments of WHO at HQ, Regional Office and Country Office level and, for some issues, of UN cosponsoring agencies. In practice, there is considerable collaboration in the execution of this task across WHO departments and programmes as well as with UNFPA. The importance of the role of HRP in this collaboration is subject-dependent. On issues in which there are few or no external partners, for instance in the translation of guidance on abortion safety into policies and practice, HRP has a much more prominent role than, for instance, on issues of maternity care.

2.5.1 Were WHO-endorsed normative documents produced with HRP support that address priority issues of SRHR of people in low- and middle-income countries? (Relevance)

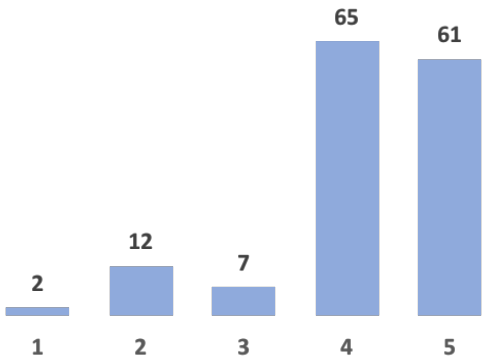
Indicator:	**Result:**
Stakeholder views of the extent to which HRP supported WHO-endorsed policy and programme guides cover priority SRHR issues in low- and middle-income countries	WHO-endorsed guidelines that were developed with HRP support were considered highly relevant by a large proportion of stakeholders. Critical comments addressed mostly the length of the guideline development process and the accessibility and practical relevance of the guideline information to clinicians and other front-line health staff.

HRP's work on guidelines and other normative documents was rated as highly relevant by respondents to the on-line survey with 86 percent of respondents stating that it focused mostly or exclusively on priorities in programme countries. This was in the same range as the respondent's assessment of research and research synthesis, and clearly higher than capacity-building and knowledge translation.

Figure 14. Survey results: Relevance of HRP's normative work

Did HRP's normative work focus on SRHR priorities in low- and middle-income countries? *(N=165)*

NORMATIVE WORK	
1. Only non-priorities	2
2. Mostly non-priorities	12
3. ½ priorities and ½ non-priorities	7
4. Mostly priorities	65
5. All work focused on priorities	61
Median Score	**4**
I don't know	*18*



Survey respondents were asked to rate the importance of a sample of nine WHO guidelines published between 2013 and 2017. The guidelines were selected by purposive sampling to cover all years of the evaluation period and the main areas of HRP's work. They included guidelines on sexuality education, violence against women, contraception, abortion, maternity care and the sexual transmission of Zika virus. Between 75 percent and 89 percent of respondents knew the publications. Among these, between 75 and 95 percent rated them as very or extremely important. The importance of five of the nine guidelines was rated at 90 percent or higher. They included guidelines on contraception, maternity care, abortion and on responding to violence against women.

Interviewed key informants, including RHR staff, confirmed the importance of HRP's input in developing WHO guidelines. Many examples were mentioned. One of the constraints mentioned by internal and external informants was the time it takes for the highly structured process outlined in the WHO Handbook

for Guideline Development. [24] Development of a 'full guideline' is cited to take two to three years. But informants also mentioned examples of guidelines for STI care that took almost four years to develop and for infertility that were, according to the informant, under deliberation for five years and already outdated by the time they were ready for release. The handbook, however, also lists processes for the development of rapid advice guidelines on emergency issues that can be released within one to three months, and for guidance on a change of practice in single clinical or policy areas that requires a preparation of about nine to twelve months. According to interviewed RHR staff, this process is increasingly used by HRP to fast-track the release of evidence-informed guidelines.

Several country-based informants involved in service implementation commented on the fact that WHO guidelines are not sufficiently practical and accessible to programme implementers and therefore remain unread on bookshelves. Senior RHR management acknowledged that by attempting to be generally valid, the context-specific practical needs of implementers are sometimes short-changed. According to this informant, a new process of guideline development is currently being developed by HRP and will soon be published.

2.5.2 Are gender, rights and equity issues mainstreamed in the WHO-endorsed normative documents that were produced or updated with HRP support? (Effectiveness)

Indicator:	**Result:**
Extent to which gender, human rights and equity dimensions are mainstreamed in normative documents on SRHR produced with HRP support	Gender, equity and human rights are mainstreamed in HRP support for the development of normative documents at process and at content level. The level of integration was consistent for human rights followed by equity and to a lesser extent for gender.

For the case study on gender, equity and human rights, four WHO guidelines or recommendations were assessed for gender, equity and human rights mainstreaming in process and content. Where relevant, these issues had been mainstreamed, although integration of equity and human rights was more systematic than for gender. The strong effort for mainstreaming at guideline level was also confirmed by key informants who highlighted that guideline development at WHO was a rigorous multi-staged process involving consultations with experts from different fields and extensive document reviews. Internal and external key informants stressed that in terms of gender and human rights mainstreaming RHR was a leader among the WHO departments.

One contributing factor to the high quality of the guidelines was the issuing of the second edition of the WHO handbook for guideline development in 2014. [24] In this new edition, the mainstreaming of gender, equity and human rights is a requirement. The handbook provides detailed guidance on how to integrate the three areas during each stage of the guideline development process.

In the area of human rights integration, it is also noteworthy that two out of the four reviewed guidelines had incorporated beneficiary participation in the process of guideline development. The process for the guideline development on sexual and reproductive health and rights of women living with HIV enabled extensive, meaningful right holder participation, including from marginalised groups, which was also highlighted in key informant interviews as a good practice example. The two remaining guidelines drew on the expertise of academics, scientists, WHO staff and users, but did not involve beneficiaries in the process. According to key informants, this approach is the most common practice in HRP guideline development processes.

Developing guidelines on SRHR for women living with HIV

The development process of the guidelines started with a community survey which assessed perceptions about the sexual and reproductive health and rights of women living with HIV. The survey was led by a group of women living with or affected by HIV and became the largest survey on this topic. It revealed the extent of violence and discrimination against women living with HIV in health care settings and the adverse consequences on their mental health.

HRP supported the women's group in publishing their findings in a peer reviewed journal and used the survey data as evidence in the development of the guidelines. The guideline development process was supported by a balanced group of health care providers, researchers, women living with HIV and other experts. At the end of the process, the women who were involved wrote a letter to the DG of WHO to inform him about how valuable the process had been to them and how much it had affected them in a positive way.

Only one of the guidelines had integrated gender transformative pictorial material in the content which could also serve as a good practice example. The other reviewed guidelines did not use any pictorial materials and thereby missed an opportunity to challenge harmful gender stereotypes in health care settings through visuals.

2.5.3 Were SRHR laws, policies or programmes at global, regional or national level revised to ensure the mainstreaming of gender, equity and rights issues with reference to WHO-endorsed norms or guidelines that were produced with HRP support? (Impact)

Indicator:	**Result:**
Extent to which national policies and laws as well as national, regional and global programmes on SRHR (that were revised or adopted with reference to WHO norms during the evaluation period) mainstream gender, equity and rights issues	Evidence collected in interviews and the on-line survey indicates that HRP contributed directly to a substantial number of policy, legal or programme changes in the areas of rights-based family planning, abortion, violence against women and sexual health and rights.

HRP does not monitor performance at the outcome level and the documentation of evidence for the impact of the Programme's work on policies and programmes therefore relied primarily on information provided by key informants and the on-line survey. These sources, however, provided rich information.

HRP's research and normative work on rights-based family planning influenced the global discussion on human rights and family planning, in particular through engagements at the FP2020 family planning summits and through work on the FP2020 countries' commitments. Key informants stated that HRP's evidence and normative work was instrumental in increasing political will at country level to revise policies that restrict girls' and women's access to contraceptive services and in scaling up accessibility to contraceptive services. On-line survey respondents cited five countries in which the evidence generated and communicated by HRP contributed to reviews or revisions of family planning policies.

The safe abortion guidelines developed in 2012 [25] include an explicit, evidence-based chapter on legal and policy considerations for abortions. These were presented by HRP to treaty body members of different human rights conventions (CRC, CEDAW, CRPWD), influencing the human rights standards on abortion and contributing to a progressive decriminalisation of abortion and to changes in the definition of grounds for legal termination of pregnancy in at least eight countries. The contribution of HRP to policy changes in Ireland is particularly well documented. In the context of the Irish referendum on abortion, the

WHO Regional Director for Europe was invited by the Oireachtais Committee on the Eight Amendment of the Irish Constitution to present evidence and guidance on safe abortion to the Irish Parliament. HRP drafted a testimony that was presented by the Director of RHR to the Irish Parliament that was widely broadcasted and influential for the outcome of the referendum and the legalisation of abortion. To this date, HRP is supporting the Irish government on the implementation of the legislation.

During the period under evaluation, HRP also successfully influenced policy and legal frameworks related to violence against women. In 2013, the Programme released guidelines on intimate partner violence and sexual violence against women. [26] These were disseminated in 2014 at country level jointly with the UNFPA, initiating important policy changes in several countries. Drawing on the prevalence estimates and wider research on violence against women, HRP contributed significantly to the endorsement by the World Health Assembly of the 'Global Plan of Action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children' in 2016. [27] The Programme provided the evidence-base and led the development process of the Global Plan including the endorsement from member countries. The Global Plan, in turn, has had a positive impact on policy and legal frameworks at country level. India, for example, newly introduced and mandated a health care response to violence against women.

Another area were HRP's contributions have been effective in influencing SRHR policies from a gender, equity and human rights perspective, was sexual health. The Programme published a report on the relationship between sexual health and human rights in 2015. The report was based on a review of public health data and human rights law at national, regional and international levels. HRP staff also took up an active role in the revision of the international disease classification system (ICD-10) and successfully influenced discussions on gender incongruence.[7] In the updated classification system (ICD-11), gender incongruence was re-categorised from a mental health illness to a sexual health condition with a recognition of an increased need for health services. As one key informant stated, *'the de-pathologisation of transgender people is one of the big things that this department holds to its credits'*. The 2015 HRP report on the relationship between sexual health and human rights also had an impact at country level. In 2018, the Supreme Court in India revised Section 377 of the Indian Penal code to decriminalise consensual gay sex. A participant of the on-line survey reported that HRP's report was cited as a reference in the revised code.

2.6 Advocacy, communication and partnership

Evaluation Question 6: Has HRP mobilised a broad partnership network in its efforts to communicate and advocate for SRHR research and for evidence-based SRHR policies and programmes?

Main Findings:
During the evaluation period, HRP has succeeded in implementing an effective communication strategy despite its very small human resource base. It strategically uses its own and the corporate WHO social media channels.

The leadership of HRP in SRHR research is recognised widely and the programme has an extensive network of partners some of whom are also competitors for donor funds, including some of HRP's cosponsoring agencies.

The position of HRP as a programme hosted by WHO is a major reason for its recognition as a global leader, but it can also constrain its visibility because its branding may be hidden behind the WHO brand. In its approach to interact with partners at country level, HRP has to follow WHO procedures and work through the Regional Offices. This can greatly facilitate communications, but it can also be a constraining factor.

[7] Gender incongruence is defined as 'a marked and persistent incongruence between an individual's experienced gender and the assigned sex'

Recommendations

- HRP should continue to exercise its recognised role as a global leader in SRHR research based on its close association with WHO. At the same time, it should work on gaining more visibility at country level by increasing its engagement with the WHO Regional Offices and with the appropriate structures (Regional or Country) of the cosponsoring agencies.
- When negotiating designated contributions, HRP should consider adding a communications budget. This would provide resources to increase the number of influential followers on Twitter, to ensure consistent strategic social media communication during conferences and meetings and to effectively track and respond to results of social media engagement indicators.

2.6.1 Has HRP engaged a global partner network in promoting SRHR research and evidence-based policies and programmes? (Relevance)

Indicators:	**Results:**
# of agencies, foundations or states that are co-funding HRP-supported research, knowledge transfer, capacity strengthening or advocacy activities	The information is not available. It is not a useful indicator because practically all partners contribute time, resources, or infrastructure when collaborating with HRP
Amount of leveraged funds mobilised for HRP-supported projects	Duplicate indicator – see Section 2.9.2

The key informant interviews provided different examples of how HRP engaged with global partner networks in promoting SRHR research:

- HRP staff are invited to sit on advisory boards for research implemented by other research organisations which allows them to establish linkages to HRP's work and to contribute to strengthening the quality in SRHR research.
- HRP has built partnerships with other key UN and non-state actors influential in specific fields of SRHR (e.g. OHCHR, CRR or UNWomen for data on violence against women).
- HRP convenes SRHR institutions from their network for consultations during priority setting exercises and the development of normative guidelines.
- HRP engages its network during the preparation and implementation of large conferences.
- At country and regional level, the HRP Alliance has started to build regional SRHR research networks although this work is still in an early phase and according to informants has been too slow in unfolding.

Information on co-funding of research by other agencies is not systematically collected, but a list of 'leveraged funding' is prepared annually with the financial reports. The list includes many minor items such as per diems and travel costs paid by NGOs for the attendance of conferences. For instance, 15 of the 31 'leveraged activities' reported for the 2016/17 biennium were for conference and travel costs for meetings of the Implementing Best Practice (IPB) family planning network. Obtaining data on levels of co-funding of research projects is likely to be quite difficult and the cost/utility ratio of pursuing this systematically is doubtful. (see also Section 2.9.2)

2.6.2 Has HRP adopted and used effective communication and advocacy tools for mobilising and engaging with global SRHR partners, including through social media? (Efficiency / Effectiveness)

Indicators:	**Results:**
Extent to which the HRP communication and advocacy strategy has been implemented	The HRP communications group have established a fairly light and effective communications approach despite the fact that it is working with a much lower human resource base than proposed by the draft strategy.
# and reach of sampled communication campaigns or press releases during the evaluation period	The assessment of HRP's social media work for three key conferences (AIDS 2016, Women Deliver and FIGO World Congress) showed that there was significant social media engagement at two and insufficient engagement at one of the assessed conferences.
Profile, audience size, reach and engagement, content, traffic back to the programme website, and community responsiveness of social media and IT-based communication activities	The number of HRP followers on Twitter has steadily grown and reached over 4000 to date. There is also a number of highly influential accounts following the HRP twitter account.

A key recommendation of the HRP external evaluation 2008-2013 was to invest in a new *'communication strategy, which explores innovative ways of packaging and disseminating HRP's research findings and other products for use in strengthening national SRH policies and programmes.'* [9] In August 2014 the firm Grayling and HRP staff presented a 2014-2016 Communications strategy for the Programme. The strategy put forward an ambitious vision for internal and external communications supported by six to nine staff, stating that *'it will not be possible to undertake the strategy and the accompanying actions without the necessary staff.'* [32]

In the reports of the programme from 2013 onwards it is clear that the human resources required to enact the plan were not put in place. For the period of this evaluation (2013-2017) two communications officers (one full time and one three-quarter time) have been and continue to be responsible for the communications portfolio. They are supported by a departmental Communications Group that meets regularly to set yearly communications priorities and calendars for campaigns. The establishment of *'a cross-cutting communications coordinating and implementation group'*, was a recommendation of the draft Grayling communications strategy.

Documents reviewed by the evaluation team confirm that the work done on communications since the 2014 Grayling strategy was first tabled has moved the Programme forward and a sensible communication workflow and fairly light and nimble strategy is in place based on the available resources. There is also evidence that all the tools, including the newsletter, internal briefings, the public website, project related communication plans and campaigns are being used in appropriate and influential ways ensuring the visibility of HRP communications efforts. Over 80 percent of the participants in the online survey, for instance, agreed somewhat or fully with the statement that 'HRP adopted and used effective communication and advocacy tools for mobilising and engaging with global SRHR partners, including through social media." Participants were also asked to rate HRP's communication channels on 5-point Likert scales ranging from 'not at all important' to 'extremely important'. All of HRP's communication channels were rated higher than three, and six communication channels had mean scores between four and five (between very important and extremely important).

The interviewed key informants shared diverging opinions about the effectiveness of HRP's communication and advocacy work. Six key informants - a mix of internal and external stakeholders - voiced that the Programme had insufficient visibility, in particular at country level and in influencing fora such as global health meetings. *'It [HRP's communication work] is not sufficient. The people in HRP are*

fantastic, they are very competent, high profile, but overworked and never sufficiently engaged in communication and advocacy work. As a result, some of what they do is a bit of a best kept secret.' Five key informants commented that HRP's communication and advocacy work had seen strong improvement in both scale and quality during the period under evaluation despite the limited resources allocated for this purpose. One key informant appreciated HRP's presence in relevant global conferences and meetings, but also stressed the need to find a better mechanism for disseminating publications at the country level.

Despite limited staff resources, HRP has progressed towards the establishment of an independent media identity and voice equipped with the necessary communication channels and an established audience for HRP communications. This is essential for the programme to distribute and share the available knowledge to improve sexual and reproductive health on a global scale. To this end during the evaluation period a number of key communications products were renewed, refined, or established including the co-branded WHO HRP Alliance website, a renewed newsletter and partner/donor communications plan, a YouTube account and a Twitter account. As noted in key informant interviews, having direct communication channels such as Twitter also allows the HRP to listen to global conversations and to be prepared to address emerging topics and issues. The established communications channels including social media also allows the HRP to take part in conversations and campaigns that are not covered by the WHO main channels.

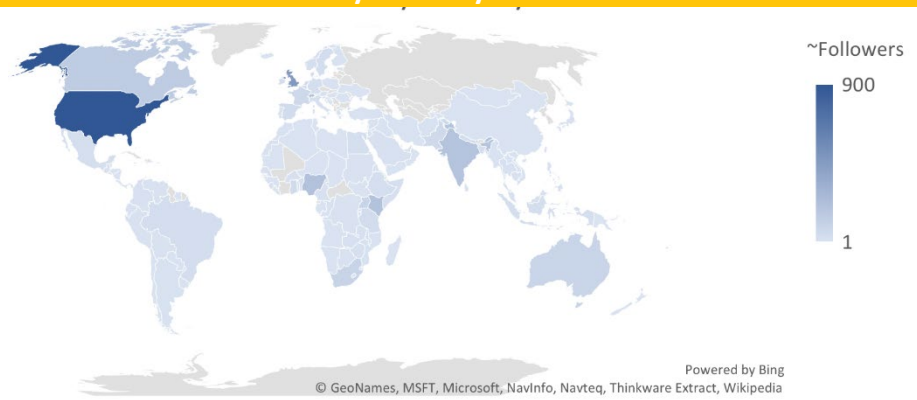
HRP also uses the main WHO communications channels in collaboration with the WHO corporate communications office. An internal twitter report submitted for review for this evaluation illustrates the extent to which WHO corporate communications can amplify the reach of HRP messages. For World Contraception Day in 2017 the HRP team prepared infographics and messages for the WHO main Twitter account and received 986K impressions that was amplified by Member States, UN partners and influencers such as the Ministry of Health of India, Development Canada, the Canadian Mission to the UN in New York, the Swedish Mission in Geneva, the Danish Ministry of Foreign Affairs, the UN, the UN Youth Envoy, UN SDGs account, US Congresswoman Barbara Lee, UNFPA, UNFPA Sri Lanka, and WHO Regional and Country Offices. Working together with WHO corporate communications clearly brings added value and is a key for the continued success of the HRP communications portfolio. The co-branded WHO HRP website also supports this relationship. This co-branding site was another component of the draft Grayling HRP strategy that was implemented. However, as noted by key informants and the Grayling document, there are some drawbacks to solely using the WHO communications channels because this approach provides limited visibility for HRP. Informants also noted that working with the WHO corporate communications office was not always reliable as HRP cannot directly access the WHO channels. Sometimes ideas or proposed campaigns are not accepted because of scheduling conflicts, priority conflicts with other global campaigns or just due to a limitation of resources.

Assessing all HRP communication channels was out of scope. The evaluation focused on social media as one of the newer elements in the HRP communications toolbox. Initially, the Programme's use of YouTube was included in the social media scan, but after further review of internal documents and the analytics provided and a review of the two YouTube libraries curated by the HRP, only the Programme's work on Twitter was included as the most actively used social media tool. The social media scan was limited by the fact that the evaluation team did not have access to the HRP account and only received a small number of statistics but no raw data. To mitigate this limitation, the application Tweepsmap[8] was used to analyse accessible data for HRP's engagement on Twitter. The full social media scan report is available in Volume 2. Its results can be summarised as follows:

[8] https://tweepsmap.com/

- The number of HRP's Twitter followers has grown at a steady pace over the evaluation period but increasing influential followers as catalysts for reaching more people could receive greater attention;
- The strategy of preparing materials and campaigns to share with larger WHO corporate account and partners have shown strong results in terms of reach and engagement;
- HRP's work on Twitter has enabled global reach, with particularly good coverage of the African continent and with lower adherence in Latin America and the Middle East;
- HRP has reasonably well explored the potential of global conferences as a catalyst for social media activities in some but not all conferences;
- The monitoring of impressions has its limitations if not cross-analysed with other engagement indicators.

Figure 15. HRP Twitter followers by country



Generally, the analysis of HRP's communication and advocacy work showed that with limited resources the HRP communications team has been effective and efficient and contributed significantly to HRP's overall visibility and presence in the social media. Without increasing the workforce, there is limited room for scale up or strategic improvements. Some key informants, however, mentioned that there is still a need to increase HRP's visibility. Adding a communications budget to designated grants could secure additional resources for communications work. The evaluation team identified some 'low hanging fruits' to further enhance HRP's communications work:

- Engage with big SRHR influencers who may be able to re-tweet HRP messages by providing them with communication material and by inviting them to re-tweet HRP. An important asset, for example, would be re-tweets from the Twitter account of Dr Tedros.
- Ask all researchers presenting at conferences or publishing articles to also credit and tag HRP for any support they may have received.
- Improve analytics reporting by going beyond the monitoring of impressions to monitoring clicks. In addition, engagement can be assessed by analysing likes, re-tweets and cross references with other analytics such as website hits and newsletter opens and content downloads. This would enable the Programme to identify and further engage influential people accessing HRP's messages.

2.6.3 Is HRP recognised as a global leader in a broad network of partners for SRHR, including researchers, implementers, policy-makers and advocates? (Effectiveness)

Indicators:	Results:
Knowledge of HRP's role, mandate and products among SRHR researchers, advocates and programme implementers	HRP's mandate, role and products are well known although many interviewed stakeholders know them as WHO products rather than HRP products.
Perception among SRHR research and programme stakeholders of the extent to which HRP has a global lead in SRHR research, research synthesis and the development of norms and standards	HRP is recognised as a global leader in SRHR research, consensus building and development of normative guideline. There was disagreement, however, whether or not HRP makes sufficient and the right use of its leadership, in particular at the country level.

Responses to the online survey showed that HRP's mandate and role in research, consensus building and the development of norms and standards for SRHR were well understood. Information collected in interviews was more nuanced and brought to light the difficulty of distinguishing the work of HRP and PDRH which is a WHO programme. Many external stakeholders do not distinguish between HRP and WHO. Internally, in the RHR department, the work of HRP and PDRH is separated by funding sources but often executed by the same people which makes it challenging to draw a line where HRP's work ends and where PDRH work starts. (see Section 2.8.3) This lack of clarity became particularly visible when it came to communication and influencing work.

Results of the online survey and the key informant interviews showed that HRP's products are generally well known in the field of SRHR though there were some differences. Articles published in specialised journals were less well known than those published in papers with broader scope. Participants in the online survey had also solid knowledge of guidelines released during the evaluation period: 75 to 87 percent knew the guidelines. Several interviewed informants mentioned that HRP's products were better known at global than at country level because they are not always systematically disseminated.

All but one key informant perceived that HRP is a global leader (or one of the global leaders) in SRHR research, consensus building and development of normative guidelines. This was in line with the findings of the online survey in which the great majority of participants (84%) rated HRP leadership either as strong or very strong. (see Figure 3)

There was less agreement to what extent HRP uses the leadership role in the right way and to its full potential. One key informant said, for instance, that *'HRP should profile itself much stronger by defining and publishing the global SRHR research priorities.'* Another stated that *'HRP is the global leader but could do better in communicating this leadership. Others have to fight for leadership but the fact that HRP is close to WHO gives it an enormous advantage.'* Others also stressed that HRP's leadership was undermined by limited visibility, insufficient dissemination or untimely and unclear positioning. One respondent stated: *'One of our disappointments was how HRP failed to support pregnancy management during the Zika outbreak. It was even noted at the PCC that HRP was very hesitant to come out with a clear position and the Pan American Health Organization (PAHO) did a much better job by taking a clear position on pregnancy management in Zika affected communities.'* This statement is, however, contrasted by the record of the 2017 PCC meeting in which the PCC *'congratulated the Programme on improvements made in implementing abortion and Zika research'*.

The issue of HRP's visibility and influence at country level was discussed extensively by some informants. As a structure within WHO, HRP has to adhere to WHO procedures. WHO Country Offices which are usually very lightly staffed in technical expertise on SRHR, cannot directly communicate with a WHO HQ department without going through their Regional Office. The same is true for communications from WHO HQ to Country Offices. Informants recounted several successful HRP initiatives at country level that were

brokered by Regional Offices, but others mentioned that this link is sometimes blocked or even broken. Little was known or mentioned by informants about the extent to which HRP has been able to reach the country-based staff of the implementing cosponsors, primarily UNFPA and UNICEF.

There was also disagreement on whether or not the Programme had competitors and if yes, who they were. A few informants stated that the Programme had no relevant competitors because there was no comparable programme connected to a UN institution. The majority of informants, however, responded that HRP was competing with different organisations for funding. The most often cited institutions were:

- Academic institutions such as the London School of Hygiene and Tropical Medicine, the Liverpool School of Tropical Medicine, the Karolinska Institute, and Harvard, Yale and Johns Hopkins Universities;
- Government institutions or agencies, for example CDC and DFID,
- International NGOs such as the Population Council, Guttmacher Institute and IPPF;
- Foundations such as the Bill and Melinda Gates, Buffet, and Kaiser Foundations as well as the Clinton Health Access Initiative;
- Medical federations including FIGO and the International Federation of Midwives
- Multilateral agencies or initiatives including the HRP cosponsors as well as the GFF and the H6-and UHC 2030 partnerships

While these institutions, agencies or initiatives may compete for funding, key informants also highlighted that they were at the same time collaborators and partners. The contradiction that the cosponsors were also competing with HRP for donor funds was raised by several informants.

Key informants listed five attributes that gave HRP a strong competitive advantage: (1) the legitimacy, credibility and convening power due to the close link to WHO; (2) the independence of the programme; (3) the possibility to connect to governments and ministries of health through the WHO Country Offices; (4) the access to undesignated funding; (5) its well-known cadre of researchers that have high levels of expertise and large networks.

2.7 GOVERNANCE

Evaluation Question 7: Does HRP have an effective governance structure to support its mandate and goals?

Main Findings

The STAG and the GAP are effective and highly appreciated advisory committees that function well together and complement each other. While the STAG has a clear mandate as an advisory structure to HRP, the terms of reference of the GAP define it as an advisory structure to the WHO RHR Department.

The Standing Committee is barely exercising its governance role as defined in the memorandum signed by the cosponsoring agencies. It has, however, recently experienced a revival in its role as a forum for information exchange and the promotion of cosponsor cooperation and engagement.

The PCC is highly appreciated for its openness and the participatory nature of its annual meetings. It formally fulfils its role as a governance committee providing strategic guidance to HRP. The weak participation of PCC delegates from regional countries in the PCC deliberations has been commented on in previous evaluations and has not improved substantially. In the view of some delegates from donor countries, the processes of the PCC meetings constrain the ability of the PCC to act as an effective organ of governance and the engagement of delegates in meaningful strategic discussions.

Recommendations

- HRP should continue to strengthen its initiatives to seek greater engagement of cosponsors through the Standing Committee and this should be supported vigorously by the PCC, especially by the donor representatives who, in the majority, represent governments that are key donors to the programmes of the cosponsors and who should use this leveraging power.

- The PCC should review and revise its procedures to increase its effectiveness as an organ of governance assuring that HRP in its activities is fully accountable to programme and donor countries. Steps should be taken to increase the space for meaningful strategy discussions between the Programme and its PCC.

The governance structure of HRP is illustrated in the Programme's organisational chart in Figure 2. The Programme is governed by the PCC as defined in the memorandum on the administrative structure of HRP signed by the Heads of the cosponsoring agencies. [8] The PCC has 34 members in 4 categories:

- Government representatives from the countries that were the largest financial contributors to the HRP Trust Fund in the previous biennium
- Government representatives from WHO member states elected by the WHO regional committees for three-year terms
- Permanent PCC members which include the representatives of the five cosponsoring agencies plus UNAIDS and the International Planned Parenthood Federation (IPPF)
- Two representatives of other cooperating partners elected by the PCC for three-year terms

The PCC meets annually for two-day meetings. The meetings are open to observers who participate in the open discussions and deliberations. It's decisions and deliberations are informed by reports and recommendations provided by (i) WHO, (ii) the Standing Committee of cosponsoring agencies, (iii) the STAG, and since 1996 (iv) the GAP. On recommendation of the 2013 evaluation the feasibility of merging the GAP and STAG was discussed and led to a greater alignment of STAG and GAP processes with the decision by the PCC in 2015 to maintain the them as two separate advisory panels.

The Standing Committee meets biannually to review the Programme's action plans and budgets and make proposals to PCC on the financing of HRP as well as recommendations on other matters of interest. The STAG and GAP meet annually in back-to-back meetings. Both have a dual function of providing scientific and technical advice to the PCC on governance issues and to the HRP on programming issues. While the scope of technical advice by the STAG is very broad, the GAP focuses specifically on issues of gender, equity and human rights. A review of reports issued by the two committees during the evaluation period reveals that most of their recommendations are issued in the form of strategic or project-specific advice to the RHR Department, including both the HRP and the PDRH programme. Higher-level strategic advice, as for instance recommendations issued in the context of the STAG-initiated programme portfolio review in 2016, is also presented to the PCC for endorsement.

In addition, a Steering Committee of the HRP Alliance was established in 2014 incorporating the previous HRP Regional Advisory Panels (RAPs). It started reporting to the PCC in 2015. The operationalisation of four Regional Research Committees was announced to the PCC in 2015, but this was not yet achieved by the end of 2017.

2.7.1 Do the HRP governance, oversight and technical committees set the priorities and strategies of the Programme, monitor its performance and provide financial oversight? (Effectiveness)

Indicators:	**Results:**
Extent to which the PCC, Standing Committee, STAG and GAP provide relevant, clear and implementable guidance to the Programme on priority-setting, strategy and management (including financial management)	The PCC, STAG and GAP provide extensive and actionable technical, strategic and financial guidance to HRP. The Standing Committee reviews and acknowledges reports and provides a forum for information exchange with cosponsoring agencies, but it exercises minimal governance functions.
Extent to which the Programme responds to guidance provided by the governance committees	HRP provides detailed tabulated responses of actions taken against each decision, observation or recommendation of the PCC, STAG and GAP.
Extent to which the governance committees monitor the Programme's response	Programme responses are reviewed and discussed systematically by the committees in their next meeting.

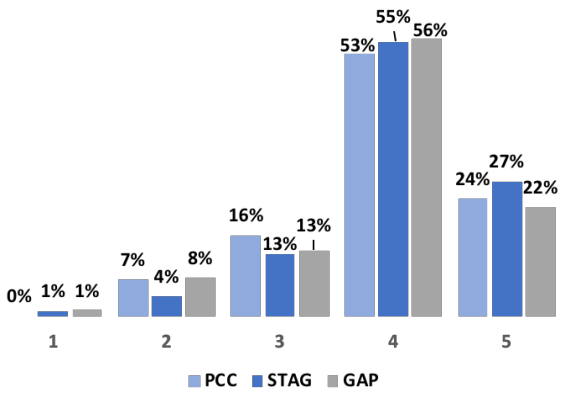
Among the 165 respondents to the on-line survey, 106 stated that they had experience with HRP's governance structures, almost two thirds as PCC delegates or observers. Almost all of them responded to questions asking for their perception of the effectiveness of the PCC, STAG and GAP. The majority stated that the committees were usually or always very effective, 77 percent for the PCC, 82 percent for the STAG and 78 percent for the GAP. Questions about the Standing Committee were not included. Key informant interviews revealed that the role of the Standing Committee was not well known among many members of HRP governance committees. It is further discussed in Section 2.7.2.

The perceptions about the committees' effectiveness increased between the 2013 and 2018 surveys, from 57 to 77 percent for the PCC, 73 to 82 percent for the STAG, and 73 to 78 percent for the GAP.

Figure 16. Survey response: Effectiveness of governance committees

Proportion of respondent scores of the effectiveness of HRP governance committees *(N=160)*

GOVERNANCE	PCC	STAG	GAP
1. Totally ineffective	0%	1%	1%
2. Somewhat ineffective	7%	4%	8%
3. Moderately effective	16%	13%	13%
4. Usually effective	53%	55%	56%
5. Always very effective	24%	27%	22%
Median Score	**4**	**4**	**4**
I don't know	*31%*	*36%*	*43%*



In interviews, stakeholders expressed more differentiated views about the effectiveness of the governance committees. There was an almost uniform endorsement of the effectiveness of the STAG and GAP as technical committees providing advice on scientific and strategic issues, including the mainstreaming of gender and human rights in HRP's activities. Some members of the committees, however suggested that their effectiveness could be increased if they were provided with documents of plans, protocols and initiatives throughout the year rather than having to work their way through large documentation folders just prior to their annual meeting.

Many PCC delegates and observers expressed their appreciation of the presentations and discussions during the annual PCC meetings, commenting on the openness of the forum and the ability to raise and

discuss critical issues of SRHR in an objective and informed manner, relatively free of political and institutional constraints. While they appreciated the participatory discussions of technical issues, they expressed disappointment that when issues of governance, accountability or strategy were discussed, only the voices of HRP donors were heard. Even the representatives of the cosponsoring agencies remained silent.

Views expressed by representatives of donor governments were generally less positive about the effectiveness of the PCC. They acknowledged the relative passivity of regional programme country delegates as a problem. The most commonly cited critique, however was that a two-day meeting in a large open forum provided insufficient time for fully executing the PCC's mandate for accountability and governance. Not enough time was spent on discussing issues of strategy and accountability, and decision processes were sometimes not sufficiently transparent, for instance when a technical presentation and discussion merged into a decision item, and when comments of PCC observers suddenly appeared in the list of PCC decision items. Most of the comments on the effectiveness of the PCC raised structural or procedural issues that are presented under 2.7.3.

In its biannual meetings, the **Standing Committee** reviews HRP plans and budgets, as well as the reports of the PCC, STAG and GAP and provides updated information of relevant activities of cosponsoring partners. Governance decisions are rare and mostly expressed in the form of an acknowledgement or appreciation. The reports are presented to the PCC. There are few, if any, specific recommendations to HRP and the Programme therefore does not prepare a response.

The annual back-to-back meetings of the **STAG** and the **GAP** issue a large list of decisions and recommendations that are directed at the RHR Department or specifically at HRP. A proportion of these decisions are project specific and may address methodological, ethical or procedural issues of approved research projects. Project-specific recommendations on gender, equity and human rights make up a large proportion of the GAP recommendations. The STAG reports are broader and better documented. Since 2016, the Programme presents detailed technical reports to the STAG covering all its work streams. The deliberations, observations and recommendations of the STAG therefore have a stronger focus on higher level strategy issues, for instance on the organisation of the HRP Alliance or the follow-up to the portfolio review. For both committees, the RHR Department provides detailed responses at their subsequent meeting listing the actions taken against each observation or recommendation.

The PCC receives and reviews the annual programme and results reports of HRP, the reports of the Standing Committee, STAG and GAP, and the annual financial reports. The Programme then presents a select number of thematic issues for discussion before presenting the programme of work and budget for the next biennium (every second meeting) and inviting financial donors to pledge funds for the next year. With this highly charged agenda, the PCC arrives at up to 50 recommendations or decisions at each meeting. For the subsequent meeting, the Programme provides a tabulated list of actions taken on each decision which is then reviewed and commented by the PCC. While the documentation available to the evaluation team suggests that this process was implemented smoothly throughout the five years of the evaluation period, it gives credence to the comments of some interviewed PCC members that such a highly charged agenda in a very large committee did not allow the PCC to exercise its governance remit of assuring accountability and strategic leadership with sufficient diligence.

2.7.2 Do the co-sponsors of HRP coordinate their support for SRHR research in a transparent way without overlaps?

Indicators:	Results:
Extent to which the co-sponsoring agencies use HRP as a platform to coordinate their SRHR research and programme implementation	Collaboration and coordination of SRHR programme and research activities between HRP and its cosponsoring agencies was weak throughout the evaluation period but there are signs that the increased focus of HRP on implementation research has started a slow recovery of cosponsor engagement.
Extent to which the co-sponsoring agencies participate in HRP-led consensus processes and use the outcome of these processes as guides for their own programmes	There are multiple consensus processes at UN level in which HRP staff and staff of other UN agencies participate. Guidelines developed with HRP support are primarily WHO guidelines that are accepted as the global normative standard in health by all UN agencies.

The interviews with stakeholders, primarily WHO RHR staff, former staff, and focal points in the other four cosponsoring agencies, revealed widely diverging perceptions about the level of coordination and cooperation in SRHR programmes. One common view was that after many years of strong cooperation in the early years of co-sponsorship, the engagement of cosponsors with HRP, with the exception of WHO, gradually deteriorated and was at a low point at the start of the evaluation period. Different reasons were cited by representatives of the cosponsoring partners. They included financial pressures on the agencies leading to discontinuation of HRP co-funding and in some cases also to competition with HRP for donor funds; retirement or mobility of key contact points in the agencies without timely replacement; and the emergence of other large cooperation platforms in maternal and neonatal health that competed with budget allocations to HRP. While there were different perceptions about the level to which the cooperation among HRP cosponsors has recovered from this low point, there was a general acknowledgement that recovery is taking place.

Currently, the main driver towards improved cooperation with cosponsoring agencies is HRP's intention to strengthen its portfolio of implementation research. This can only be done in collaboration with implementing agencies. All cosponsoring agencies, except WHO, have strong implementing arms. These include, among others, UNICEF in maternity and neonatal care and increasingly also in adolescent health; UNFPA in family planning, reproductive and adolescent health; UNDP through its role as principal recipient of Global Fund grants in 30 countries; and the World Bank through its hosting of the Global Financing Facility in support of Every Woman Every Child (GFF).

It is difficult to point to any concrete results prior to 2018 beyond some cited examples that still have the appearance of singular events; for instance, the collaboration with the GFF on the investment case for adolescent contraception in Liberia. However, in November 2017, HRP developed a cosponsor engagement plan listing all projects and areas of current or potential collaboration with cosponsoring agencies, also including other UN partners and IPPF. According to informants from the agencies, an agreement over US$ 800,000 has already been negotiated for implementation research support to UNFPA, and UNICEF reported that the agency was developing a list of implementation programmes for which HRP research support would be feasible. This points to a more structured revival of cosponsor collaboration, but it did not affect programming during the evaluation period.

Regarding the use of guidelines and the cooperation in joint processes to build consensus on evidence, the situation is somewhat different. The guidelines developed with HRP support are WHO guidelines and are the normative global standard used as a reference by all UN partners, including those who develop their own set of guidelines. The continued interaction with UN partner agencies in consensus processes

is assured by the departmental or individual HRP expert mandate of participation in global policy processes such as the monitoring framework of the SDGs or in global commissions such as the Lancet commission on sexual and reproductive health and rights.

2.7.3 Does the PCC and its sub-committees have the optimal structure, mandate and processes for providing governance and oversight to HRP without duplication of responsibilities and tasks? (Efficiency)

Indicators:	**Results:**
Existence of clear definitions of tasks and responsibilities for each of the HRP governance committees	The governance and advisory committees have clearly defined remits. However, the Standing Committee has, over time, progressively withdrawn from executing its governance mandate and has become primarily a committee for information exchange and the coordination of cosponsor programmes.
Perception among current and former governance committee members of the mandate and effectiveness of their committees in guiding the HRP strategy and providing oversight over its implementation	Stakeholders are satisfied with the execution of the advisory functions of the GAP and the STAG. However, many PCC delegates commented on the tension between the participatory character of the PCC and its ability to execute its governance functions effectively.
Perception among RHR management staff of the mandate and effectiveness of the governance committees in guiding the HRP strategy and providing oversight over its implementation	RHR management and staff are generally satisfied with the guidance received by the governance and advisory committees.

The mandates and tasks of the governance and advisory committees are defined in the memorandum on the administrative structure of HRP agreed by the cosponsoring agencies. [8] The GAP is not included in this document. Terms of Reference for the GAP were established in 2014 and clearly set out its tasks as an advisory body to the RHR Department (rather than to the HRP) on issues of gender and rights. [28] The committees exercise their functions as outlined in the documents.

The Standing Committee continues to perform the governance tasks of reviewing action plans, budgets and the allocation of resources, as well as the preparation of annual reports to the PCC. Over time, however, it has minimised its role in the governance of the programme. Its decisions are generally formulated in the form of acknowledgements or expressions of appreciation without issuing substantive recommendations. It currently functions primarily as a committee for the exchange of information about the programmes of the cosponsoring agencies. This is the reason why since 2016 the former Assistant Director General of WHO delegated the WHO participation in the Standing Committee to the Director of RHR and thereby acknowledging its reduced governance role. According to informants, this decision was taken because the capacity of the committee to make governance decisions was already compromised by the fact that the other cosponsoring agencies delegated primarily technical staff to represent them in the committee. As a coordination and information committee, it has, however recovered some strength towards the end of the evaluation period as is evidenced by current discussions of the cosponsor engagement plan. [29] One element in this revival may have been the practice to rotate the responsibility to host the committee meetings among all cosponsoring agencies.

Expressed views among all interviewed stakeholders about the role and function of the STAG and GAP were positive with only some minor concern about the volume of work voiced by some members of these panels.

Interviewed PCC delegates of financial donor agencies, but also some senior UN staff, expressed considerable concern about the ability of the PCC to perform its governance functions. While all supported the inclusiveness and participatory nature of the annual PCC meetings, they expressed dissatisfaction that

these characteristics precluded high-level strategy discussions and the execution of the accountability tasks of the committee. Delegates of donor governments are generally well prepared for the meetings, have a long history of attendance, and meet in small groups prior to the PCC meeting to coordinate their positions and interventions. Regional country delegates, on the other hand, are often unprepared, have little knowledge of the Programme and are confronted with a large amount of documentation when they arrive in Geneva. Some have technical knowledge in one specific area of SRHR, others have only a limited mandate by their government to speak on specific issues. Although a pre-meeting briefing is organised, their weak participation in substantive governance discussions, and therefore the dominance of donor voices in the PCC was noted with concern by many interviewed delegates and observers.

While RHR management staff generally expressed their satisfaction with the structure and processes of the PCC, interviewed delegates felt that the process should be reviewed and tightened. Suggested reforms included a minimalist step to conduct the second day of the PCC in the form of a closed meeting which would reduce the attendance and allow a stronger focus on strategic discussions. One informant suggested to hold biannual meetings to decompress the agenda. The most frequent suggestion was to establish a permanent sub-committee that would meet biannually back-to-back with the Standing Committee to review action plans, budget execution and programmatic performance as well as discuss portfolio and medium-term priority issues. Governance decisions drafted by this sub-committee could then be presented to the PCC for discussion and validation. Some informants raised concerns that it may be difficult to assure the representation of all stakeholder groups (programme countries, donor countries, UN cosponsoring agencies, NGOs, Foundations and the private sector) in such a committee. The tension between broad participation and governance effectiveness was, nevertheless, acknowledged by almost all informants although opinions on the need for reform of the PCC differed widely.

The issues raised by informants regarding the low involvement of regional government delegates in PCC discussions as well as dissatisfaction with the level of discussions of policy, strategic, and financial issues in the PCC were already raised in the 2013 evaluation. They resulted in two specific recommendations for the PCC agenda (see Annex 2). The Programme responded with some changes of the agenda that were implemented in 2014. Although there was a marked increase in the perception of the PCC's effectiveness among participants in the online surveys in 2013 and 2015 from 57 to 77 percent (see Section 2.7.1), there was no change in the substantial issues raised by key informants.

2.8 MANAGEMENT

Evaluation Question 8: Does the WHO RHR Department manage HRP efficiently and effectively?

Main Findings

HRP is managed on the basis of a results framework that monitors results at the output level. Although it has largely achieved or surpassed its performance targets throughout the evaluation period, the indicators and targets are established at a very low level of the results chain although information on results at the outcome level is available and could be monitored. In addition, the reported output results are overloaded with double counting and the inclusion of results that are only marginally meaningful.

Average costs per output can be calculated with available expenditure information and vary between US$ 110,000 for the development of a guideline to US$ 590,000 for a research project in maternal and perinatal health. The costs do not include HRP staff costs for organising and implementing the activities. The evaluation team was not aware of any benchmarks against which these costs could be evaluated.

The co-management of HRP with the WHO PDRH programme in the RHR Department is complex. However financial management is well separated and the boundaries of roles and mandates between the two programmes vary by programme area which is in part due to the limited and project-specific funding of PDRH. RHR staff have established a functional way to deal with this complexity that maintains the independence of HRP while maximising the advantages of linking the work of HRP to the normative and technical advisory role of WHO.

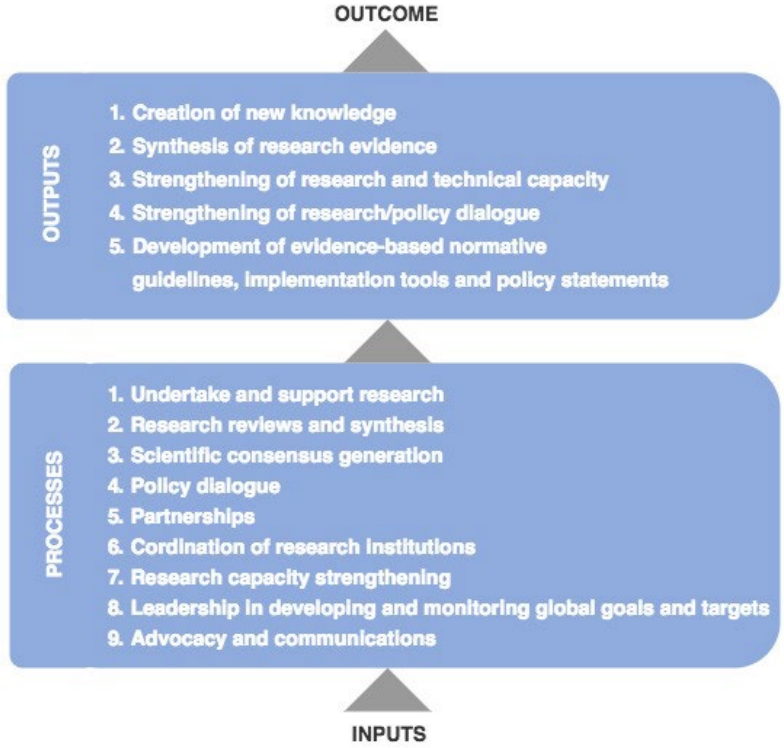
There is extensive collaboration of HRP through its position in RHR with other departments of WHO through the regular inter-departmental cooperation processes in WHO. In the area of maternal and perinatal health, HRP collaborates closely with the MCA department. Despite some overlapping mandates, the two departments work in a largely complementary fashion based on collegiality and mutual respect. Staff of both departments, however, acknowledge that the division of their work in two separate departments creates unnecessary administrative and bureaucratic hurdles.

Recommendations

- HRP should revise its results framework by developing a Theory of Change and an associated performance management and reporting framework that defines indicators and targets at the outcome as well as the output level and include indicators on gender, equity and human rights.
- PCC should urge WHO to increase its fund-raising efforts for undesignated and designated financing of PDRH so this programme can more fully take up its role in facilitating the translation of HRP-generated evidence into programmes and policies at country level.
- PCC should engage with the ADG FWC of WHO to find a better structural solution for joint work in maternal and neonatal health between HRP and the MCA Department that avoids working across departmental boundaries. These deliberations should consider the lessons learnt from the efficiency of RHR in the area of contraception, where the entire value chain from evidence generation to the development of norms and research to support their implementation is located within one department.

Since 2014 HRP is managed according to a results framework based on a Theory of Change that defines the Programme's impact, outcome, outputs, processes and inputs. Performance management and reporting of the Programme to PCC centres on setting targets, monitoring and reporting at the output level.

Figure 17. HRP Theory of Change (excerpt)



Source: Excerpted from HRP Programme Budget 2018/19

There is considerable repetition between the process and output statements and some are just reformulations of the same text with slightly altered syntax. Gender, human rights and equity are not mainstreamed at either level.

2.8.1 Did the Programme achieve its objectives of the three latest biennial work plans? (Efficiency / Effectiveness)

Indicators:	**Results:**
% achievement of programme performance targets in each of the three biennia of the evaluation period	The targets set in the HRP results frameworks from 2014 to 2017 were largely achieved or over-achieved. However, there are questions about the low level of outputs that are reported as evidence of performance and about double-counting of outputs against targets.
Number of products (by type) completed against Programme targets in each of the five output areas. (research studies and global/regional estimates published; interventions developed, tested and disseminated)	The number of reported products largely exceeded the targets in all output areas except in research capacity strengthening
Extent to which any underachievement was analysed and extent to which lessons were drawn for the next programme period	The only underachievement (in research capacity strengthening) was due to the fact that the target did not match the strategy that HRP pursued in building the HRP Alliance. Although this initiative could have been pursued more vigorously, the short-term response should have been a reduction of the target for 2016/17

In 2013, prior to the adoption of the new results framework, HRP published an annual technical report that presented detailed narratives on the achievements in seven activity areas that were in part thematic (e.g. 'human reproduction') and in part process focused (e.g. 'advocacy and communications'). Output targets were not yet defined, but in annex, the report listed some outputs that resembled the output lists of the results report that have been presented since 2014:

- 20 technical publications issued
- 10 evidence briefs, information sheets, statements or infographics
- 14 'language versions'
- 98 articles published in scientific journals
- 37 conferences, symposia and international meetings supported

In 2014, this form of output reporting became more structured as it was now presented in a framework of output indicators and targets. These were summarised at the end of each biennium.

Table 4. Targets and output results 2014 – 2017

Outputs	Indicators	Target definition	2014/15		2016/17	
			Target	Result	Target	Result
1	1.1 Implementation research and clinical trials on SRH published	# Scientific articles published	180	326	240	376
	1.2 Global and regional estimates of reproductive, maternal and perinatal conditions published	# Global/regional estimates published	4	2	4	13
	1.3 Interventions developed, tested and implemented to address unmet needs in SRH	# New interventions developed, tested and disseminated	3	3	3	6
	1.4 New or ongoing research projects funded	# Research projects approved by the RP2 panel	30	24	24	42

Outputs	Indicators	Target definition	2014/15		2016/17	
			Target	Result	Target	Result
2	2.1 Systematic reviews in SRH published	# Systematic reviews published	30	89	60	107
3	3.1 National research capacity strengthened	# Research centres strengthened through HRP grants	50	50	50	16
4	4.1 Technical, clinical and policy guidelines and other issued on SRH	# New or updated guidelines issued	6	15	6	28
5	5.1 Policy options analysed and synthesised, derived from technical and clinical guides	# Policy briefs/guideline derivatives issued	20	39	20	26
	5.2 National capacity to support and develop evidence-based policies strengthened	# Regional or international consultations convened or supported	8	74	8	72

As can be seen in the table, practically all targets were met or surpassed, some of them like the target for indicator 5.2 by an incredible 925 percent in the 2014/15 biennium. Rather than reviewing and drawing lessons from these results, most of the targets were maintained for the next reporting period. But there were also other issues with the results reports. Many results were doubly reported. For instance, almost all outputs reported against indicator 2.1 were also reported and counted under indicator 1.1. Against output 4.1, clinical guidelines, the publication of the guideline for medical eligibility of contraceptive use, the executive summary of the guideline, and the tool for its application by clinicians were each counted as a separate output. The 702 listed scientific articles counted against indicator 1.1 include editorials, commentaries and letter to the editor of scientific journals. It is difficult to conceive that PCC delegates, many among them without a technical background, who received these extensive lists of outputs a day or two before starting deliberations were able to use them effectively to reach conclusions about the Programme's performance.

While the interviewed PCC delegates readily stated that HRP achieved its objectives, several were critical about the way the Programme monitored and reported its results. They noted that many of the reported results reflected on processes or counted low-level outputs and missed information about the outcomes of HRP's work. As one PCC delegate from a donor country remarked: '*HRP achieved its objective. The staff are its main assets. They are dedicated and skilled researchers. But HRP needs a more professional approach and stronger systems for setting agendas and for monitoring and reporting results.'*

2.8.2 What were the costs of inputs in relation to the outputs for each type of product? (Efficiency)

Indicator:	**Result:**
Costs per output	Costs per product in three output areas and one activity area were estimated at: • Creating new evidence: US$ 396,808 • Strengthening capacity: US$ 235,627 • Developing norms and guidelines: US$ 110,465 • Global monitoring and indicators: US$ 158,060

In the database of expenditures per product maintained by HRP, the products are coded per budget section which is not aligned with the five outputs of the results framework. Furthermore, because of a restructuring of the budget in 2014, both the old and the new budget codes are used for the 409 expenditure lines. The evaluation team recoded each expenditure based on the budget line narrative which can only generate an approximate result as one expenditure line may cover multiple types of outputs (e.g. creation of knowledge, knowledge synthesis and guideline development). Furthermore, the nature of the output cannot always be clearly determined by the narrative of the budget line. Clearly identifying products for Output 2 (synthesis of research evidence) and Output 4 (strengthening of research/policy dialogue) was not possible on the basis of the budget line narrative. Most of these outputs ended up being classified under 'general technical activities' and were not further analysed.

Although the activities in global monitoring and indicator development is not a separate output category, it was nevertheless coded separately because most of the outputs in this area of work could clearly be identified but it was not always clear whether they were primarily research, research synthesis or normative outputs. Lastly, using the Programme's budget section codes and consolidating the pre-2014 with the new codes, the cost of research products was sub-analysed by four research areas.

Table 5. Cost per product in different output categories

Output	# products	Expenditure ($)	Cost per product ($)
Creation of new knowledge	144	57,140,312	396,808
• Adolescents, Gender, Human Rights	31	8,324,648	268,537
• Human Reproduction	50	16,266,947	325,339
• Maternal and Perinatal Health	42	24,812,099	590,764
• Safe Abortion	13	6,050,809	465,447
• Not Categorised	8	1,685,809	210,726
Strengthening research and technical capacity	23	6,495,445	235,627
Developing evidence-based norms and guidelines	61	6,738,373	110,465
Global monitoring and indicators	40	6,322,402	158,060

The calculated costs per product are 'activity costs' and do not include the HRP staff costs for organising implementing the activities. Differences in the cost of research in different areas are plausible because of the high costs of clinical research which is most commonly conducted in the areas of maternal health and safe abortion and least commonly in the areas of adolescent health, gender and human rights. The evaluation team is not aware of any standards or similar analysis against which these costs could be benchmarked.

2.8.3 Are there clearly defined remits and financial controls for the work of HRP and PDRH within the RHR Department of WHO, and are the two units cooperating effectively? (Efficiency)

Indicators:	**Results:**
Documented evidence of a clear division of responsibilities, budgets and accountability between HRP and PDRH	Budgeting and financial reporting of HRP and PDRH are clearly separated. The division of responsibilities between the two programmes is fluid and differs according to programme area. Most stakeholders consider this to be a strength rather than a problem.
Documented evidence (case examples) of effective cooperation between HRP and PDRH in translating HRP research results into the development of programmes by PDRH	There are many examples, especially in the areas of family planning and STI control. One cited example is the cooperation of HRP contraception research with the PDRH-supported IBP initiative for the promotion of family planning in the same programme team.

Historically, the split between the HRP and the PDRH units in the RHR department arose with the merger of the former WHO Department of Reproductive Health Technical Support (RHT) with HRP in 1998. (Figure 1) Administratively or organisationally, PDRH and HRP are fully integrated in RHR with staff working under the same Director as part of the same programmatic units. The main effect of this integration has been that the mandate of HRP was expanded towards the mandate of WHO to set norms, communicate them and provide technical support for their implementation. This expansion was to be managed by the split of RHR into HRP and PDRH. The expansion of the HRP role along the continuum from evidence generation to setting and supporting the implementation of standards was seen by all interviewed stakeholders as a positive if not essential development. It was pushed even further in recent years with the demand on HRP by its governance organs for greater involvement in implementation research.

While the RHR Department has quite successfully managed the expansion of the HRP scope into a normative mandate and is working hard towards pushing this further into research to support implementation, the split of the roles into HRP and PDRH has been less successful. The main reason for this is that PDRH is funded almost exclusively from designated contributions to the WHO CVC fund for a limited range of SRHR priorities, primarily in family planning and STI control, and to a lesser extent in maternal and adolescent health. In addition, PDRH funding levels, compared to HRP funding levels have been quite low. In the 2014/15 biennium, when RHR still published a combined financial report for both programmes in RHR, PDRH expenditures accounted for 22 percent of the total. For the HRX team which includes family planning and STIs, it was 43 percent, for the MNH team including maternal and perinatal health as well as safe abortion it was 15 percent and for the ADH team working in research on SRH for adolescents and gender, equity and human rights issues it was 12 percent.

There are many examples of very productive cooperation across HRP and PDRH programme lines. For instance, the Implementing Best Practice (IBP) initiative is a networking organisation with a large global reach that supports the translation of family planning evidence into practice. The secretariat is housed in the RHR Department funded with a designated grant channelled through the WHO CVC fund to PDRH. The secretariat staff is part of the HRX team. In this position IBP has direct and immediate access to technical and research support. Conversely, IBP is also consulted in the development of implementation research protocols because it can directly access the implementers among its members. According to respondents, this was instrumental in changing some approaches in a planned research on the distribution of contraceptive commodities by informal providers.

Assuming that the resources needed for developing and supporting the implementation of norms and standards are more or less correctly reflected in the 43 percent of PDRH expenditures by the HRX unit,

the shortfall of PDRH funds for the other priority research areas of HRP becomes evident. A compensation mechanism exists for maternal and perinatal health because the task can to be taken up by another unit in WHO, the MCA Department. But there is none for issues such as sexual rights, safe abortion and similarly sensitive areas for which designated donor funding is limited, and when it is done channelled through the HRP Trust Fund rather than the WHO CVC Fund. In these programme areas, HRP has fully occupied the 'PDRH space' by necessity.

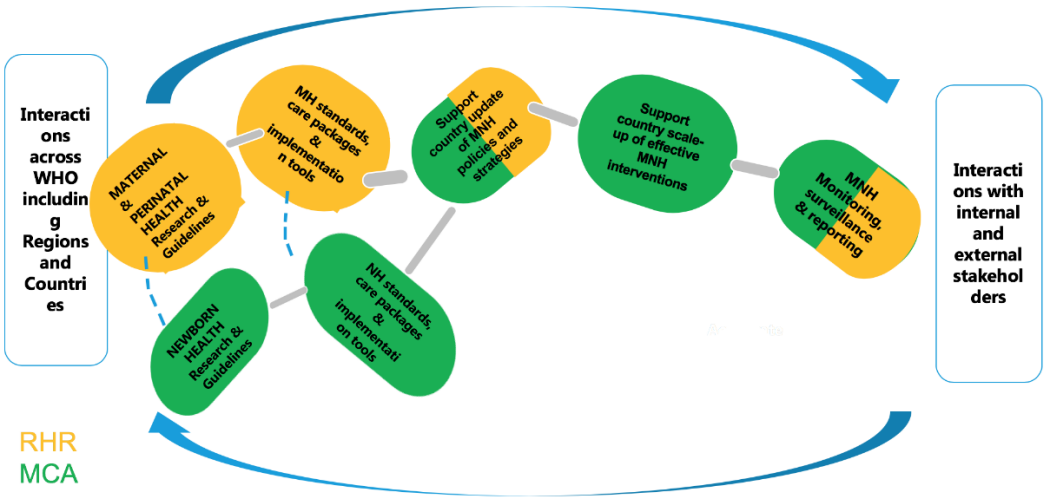
The overall result of this situation is a complex administrative situation that is difficult to disentangle, while a clear separation of financial reporting for the two programmes has been achieved. The majority of interviewed external informants, and even some members of advisory committees were largely unaware of this situation and equated HRP with RHR. Several of those who were aware commented on the low level of funding of PDRH, but the majority agreed that the situation may look confusing, but it is stable, and it is functioning well. Attempts or recommendations for structural reforms could destabilise a functional organisational arrangement. While some PCC members stressed the importance of the maintenance of HRP as a separate cosponsored programme in RHR in order to maintain its independence in research, most RHR staff agreed that clear separations of the lines of responsibility between within the RHR Department would not be desirable. To quote one staff member: *'We rarely discuss ourselves as either HRP or RHR. We know there is a distinction but the work we do is fluid between the two parts. We should not create unnecessary silos.'*

2.8.4 Does WHO ensure that SRHR research is coordinated without overlap with other relevant departments of WHO and co-sponsored programmes implemented by WHO? (Efficiency)

Indicators:	**Results:**
# of HRP research and knowledge translation activities that were jointly developed and supported with relevant WHO HQ departments or programmes	Interdepartmental cooperation in the development of normative documents in WHO is the rule rather than the exception. The list is therefore very long. As an example of excellent cooperation, the WHO standards for quality of maternal and newborn care in health facilities were cited by informants
Perceptions among senior WHO HQ staff in relevant departments about the division of labour with HRP and the added value of HRP	Only the cooperation and relationship between HRP and the MCA Department were explored. It is excellent in the areas of antenatal and maternity care. Staff in both departments voiced no support for the departmental split that runs through their work area

Interdepartmental cooperation in WHO is the rule rather than the exception and is particularly active in the development of norms and standards. In this area, RHR and particularly HRP collaborates closely with many WHO Departments. A very close collaboration has been established with the Department of Maternal, Newborn, Child and Adolescent Health and the HRP MNH team in their work on maternal and perinatal health. There are clearly overlapping mandates in these areas that arose in part from organisational reforms by WHO in 2005 and 2010. (see Figure 1) The cooperation between the two departments has not always been smooth in the past. In 2016, a 'value chain' diagram was developed by the office of the ADG for the FWC cluster to clarify the lines of responsibility and accountability of RHR and MCA.

Figure 18. HRP-MCA Value Chain



Source: WHO 2016 – personal correspondence Anshu Banerjee

According to interviewed staff in both departments, there is currently a very productive and collegial cooperation over a broad area of technical issues in antenatal and maternity care. The cooperation in neonatal care and adolescent health is less firmly established. Both sides, however, point out that the collaboration is based primarily on excellent personal relationships rather than on structural agreements. MCA fills, to a large extent, the gap that is left by the low level of funding of PDRH projects in maternal and neonatal health. The two departments cooperate in a number of large project grants that are split between MCA and HRP. A Maternal and Newborn Quality of Care Core Working Group, for instance incudes staff from both departments who worked together in developing and publishing the WHO standards for improving quality of maternal and newborn care in health facilities. [31]

Despite the excellent collaboration, interviewed stakeholders expressed little understanding for the reasons of the departmental split dividing their areas of work. While this did not interfere in the quality of cooperation, it created additional administrative and bureaucratic hurdles according to two respondents. Senior WHO management indicated in interviews that the organisational split between and division of responsibilities between RHR and MCA will be subject to review in the near future. In this context, others point out that the proximity of HRP and PDRH in the area of contraception and family planning creates a synergy and mutual feedback between evidence generation, development of norms and standards, and the translation of knowledge into policy and practice is a model for success that should serve as a lesson for other areas of sexual and reproductive health.

2.9 FINANCE

Evaluation Question 9: Does HRP have the necessary financing to realise its strategy?

Main Findings

HRP had sufficient funding to implement its programme during the evaluation period and had actually built up some large closing balances in the Trust Fund account which it started to decrease in the last biennium. However, there was a trend towards an increase in the proportion of designated funding during the period which, if it continues, would be an issue of concern.

The number and profile of donors to the Trust Fund has been steady except that funding from the cosponsors has almost fully collapsed except for WHO. There appears to be little appetite by cosponsors to resume undesignated contributions to the HRP Trust Fund, but there are indications that the cosponsoring agencies may consider other means of financial contributions, for instance through designated funding for HRP research support of their implementation programmes.

The GFF was mentioned by many informants as a natural financing partner of HRP as applicant countries have major needs for research evidence in SRHR for the development of their investment cases and for the implementation of their programmes. Consultations between HRP and the GFF Secretariat have so far not been very productive.

Recommendations

- PCC should continue to monitor the levels of designated contributions to the HRP Trust Fund to be able to react in time before the proportion of designated funds reaches a level where it could seriously distort the portfolio of HRP activities.
- PCC delegates from cosponsoring agencies and from donor countries should work together on lobbying for a greater financial engagement of the cosponsors as well as of the GFF in HRP through programmatic cooperation rather than undesignated funding.

2.9.1 Is the activity planning and budgeting of the Programme realistic?

Indicator:	**Result:**
% of biennial budgets that were funded (by budget category)	The budgets in all programme areas were fully funded in the three biennia of the evaluation period. Low budget execution has been an issue in some areas, particularly in the programme area of research capacity strengthening.

When HRP faced a protracted situation of falling income around the turn of the century, it instituted the practice in 2000/01 of establishing a full budget to completely finance the biennial programme of work, and a contingency budget to assure the implementation of priority tasks. This practice was maintained throughout the 2012/13 and 2014/15 biennia and was abandoned in 2016/17 because the funding situation had stabilised, and full budget funding had been secured over several budget periods. In fact, over the two biennia between 2012 and 2015 low rates of budget execution resulted in growing biennial closing balances in the accounts of the HRP Trust Fund, a situation that only started to reverse in 2016/17.

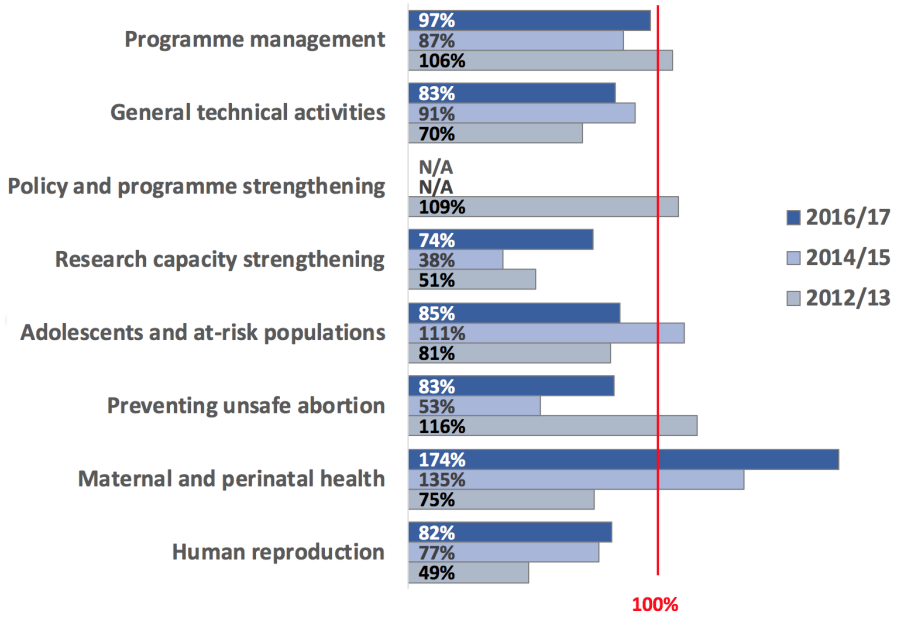
Table 6. Income, budgets and expenditures 2012-2017 (US$ million)

BIENNIUM	OPENING BALANCE	INCOME	BUDGET	EXPENDITURE (BUDGET EXECUTION)	CLOSING BALANCE
2012/13	18.6	61.5	57.1	45.3 (79%)	34.7
2014/15	34.7	63.0	62.9	56.8 (90%)	41.0
2016/17	41.0	62.1	68.4	67.8 (99%)	35.2

The ability of HRP to fully finance its planned activities has thus not been an issue of concern during the evaluation period. On the contrary, budget execution was an issue in the first years, but has since resolved, at least at the total budget level. There is, however, some differentiation when looking at individual budget categories.

In 2014, the budget structure was revised in alignment with HRP's. The 13 budget categories of the 2012/13 budget were collapsed into seven categories in alignment with the newly adopted output structure in 2014. Twelve of the previous budget categories could be easily collapsed into the new system of seven categories. The thirteenth, 'policy and programme strengthening', cut across several of the new categories and could therefore not be considered in the budget execution analysis of 2014 to 2017.

Figure 19. HRP Budget execution by budget section



The graphic illustrates that there were programme areas with persistent implementation gaps. The largest was in the area of research capacity strengthening which underlines the findings in the programmatic evaluation of this output area. (see Section 2.3). The other notable gap was in the area of human reproduction, including HRP's work in contraception, fertility, STIs and cervical cancer. At the RHR level, human reproduction is the unit with the largest funding as it receives more than half of the designated PDRH project funds. Its execution rate of the combined (HRP and PDRH) budget has been considerably higher than of the HRP budget (e.g. 90% versus 77% in 2014/15). Possible reasons for the different budget execution rates are that activities in the HRP programme of work were covered by designated grants to PDRH and therefore reported as PDRH expenditures, or that the efforts to absorb large designated PDRH grants may have interfered with the HRX team's capacity to fully implement the HRP programme of work.

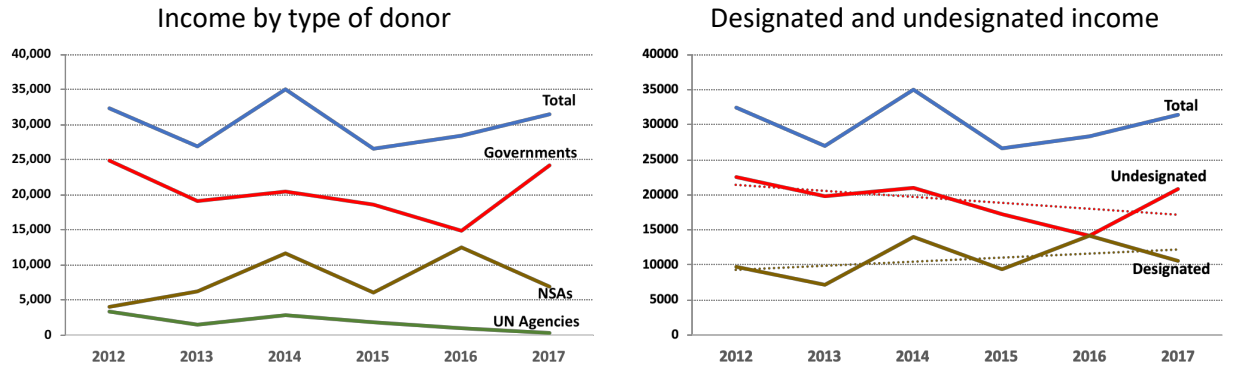
2.9.2 Is the WHO RHR Department effective in raising funds for the planned activities of HRP? (Effectiveness)

Indicators:	**Results:**
Trends in the number of programme donors and designated / undesignated donor contributions during the evaluation period	The number of donors and the level of funding of HRP was relatively stable throughout the evaluation period. There has, however, been a slight trend towards an increase in designated versus undesignated funding.
Trends in amount of leveraged funding in support of projects initiated by HRP	Data on leveraged funding to assess the catalytic effect of HRP's work are collected by staff on a project by project basis. Information is only available for a limited number of projects. The calculated catalytic effect is so highly dependent on the selection of included projects that it does not provide useful information.

HRP income from contributions to the HRP Trust Fund has been relatively stable between 2012 and 2017. Excluding interest and royalty income, it has totalled US$ 180.8 million, averaging about US$ 30 million per year. HRP receives contributions from about 20 donors each year, about half of them government agencies. Non-state actors (NSAs) such as foundations, private sector companies and international NGOs made up about half of the donors and provided about 26 percent of income. The proportion, however, varied considerably in each year. UN Agencies have become a marginal contributor to HRP resources with only WHO and UNFPA contributing in the last biennium.

The main source of income of the HRP throughout the three biennia have undesignated donor contribution to the HRP Trust Fund. However, donors may also contribute designated funds to support specific activities that are within the Programme's mandate and approved budget. The principles and procedures for designated funding were updated and reaffirmed by the PCC in 2014. [30] Of the total grant income of US$ 180.8 million, 36 percent was designated to specific projects. Despite fluctuation in the proportion of designated contributions during the evaluation period the linear trend points towards a slow increase. To a major extent, this was caused by two large grants received between 2014 and 2016 for clinical trials of antenatal corticosteroids and of a temperature-stable uterotonic. An average of 20 organisations provided designated funds each year, about two-thirds of them NSAs who accounted for about 74 percent of the funds. More than half of the designated funding (56%) was for maternal and neonatal health projects. Family planning and contraception projects received 13 percent of the funds. Adolescents SRHR, work in global monitoring and indicators, and projects responding to Zika and Ebola epidemics received each between five and six percent. The rest was distributed over eight other areas.

Figure 20. HRP income trends 2012 to 2017



To assess the catalytic effect of HRP in SRHR research, the Programme estimates the level of leveraged funding each year. These are funds that are not channelled through or reported to HRP, but spent by

other partners on research projects, guideline development or knowledge transfer activities initiated by HRP. The information is collected by staff working in these projects and there is no system to verify its completeness or validity. The catalytic effect which is estimated as the amount spent by other partners for each dollar spent by HRP on a joint project, applies only to the projects for which it is calculated and not to the entire HRP portfolio. The reported number of projects in 2016/17 is inflated by the inclusion of 15 line items pertaining to travel and conference costs paid by NGOs for the attendance of meetings of the IBP network which is, strictly speaking, not an HRP but rather a PDRH project.

Table 7. Leveraged funding

BIENNIUM	NUMBER OF PROJECTS	DIRECT FUNDING (MILLION $)	LEVERAGED FUNDING (MILLION $)	CATALYTIC EFFECT ($ LEVERAGED FOR EACH $ SPENT)
2012/13	11	0.7	3.8	5.3
2014/15	17	1.5	7.9	5.2
2016/17	30	3.4	13.5	3.9

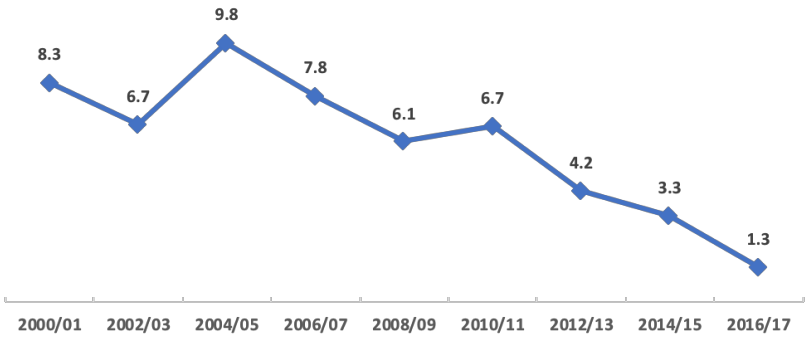
The calculation of the catalytic effect is based on a small fraction of HRP projects, and the results of the calculation in the three biennia are likely highly sensitive to the types of projects that were captured for inclusion in the calculation. While it is an interesting calculation that does confirm the existence of a catalytic effect of HRP, the values generated are not meaningful. It would not be feasible nor particularly informative to systematically collect data for the calculation of this indicator across all of HRP's programmes.

2.9.3 Do the cosponsors of HRP support the financing and fund-raising of HRP to ensure the realisation of its strategy? (Effectiveness)

Indicators:	**Results:**
Trends in financial support to HRP by the 5 cosponsoring agencies	The trend of decreasing undesignated contributions by cosponsoring agencies to the HRP Trust Fund continued during the evaluation period
Documented evidence of cosponsor support for HRP fundraising	There is no evidence that cosponsors supported the fund-raising efforts of HRP during the evaluation period.

The cosponsoring agencies that signed the original memorandum on the administrative structure of HRP are UNDP, UNFPA, WHO and the World Bank, with UNICEF joining the group in 2012. The World Bank provided annual contributions to the HRP Trust Fund at gradually decreasing levels until 2015 and then stopped contributing. Between 2012 and 2015 it contributed US$ 5.5 million. WHO provided biennial contributions between 2012 and 2017 totalling US$ 2.8 million. Smaller contributions from UNDP in 2012 and from UNFPA in 2017 were also recorded, but in general, cosponsors did not provide a significant financial contribution to HRP during the evaluation period. This was a continuation of a trend that has been observed since the turn of the century.

Figure 21. Cosponsor funding since 2000/01 (US$ million)



Interviews with key informants of the cosponsoring agencies indicated that there is currently no appetite for resuming undesignated funding of the HRP Trust Fund with the exception of WHO which is continuing its biannual contributions of about one million US$. However, with advancing discussions of the cosponsor engagement plan in 2018, there is growing interest in developing modalities for designated funding of implementation research linked to the cosponsors' implementation programmes. According to the respondent from UNFPA, such a grant was already negotiated in 2018.

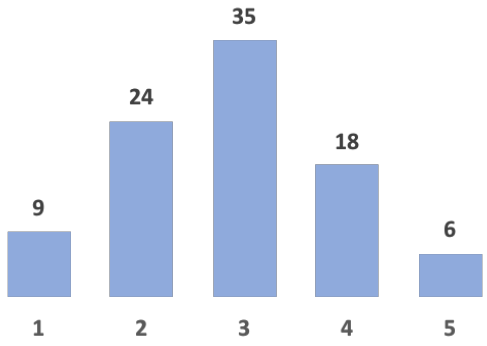
The Global Financing Facility (GFF) hosted by the World Bank was mentioned by many interviewed respondents as an opportunity for HRP engagement that has not yet been realised. There have been discussions with the Programme since the launch of the GFF, and there was uniform agreement among key informants that the GFF had a great need for technical and research support in the development of the country investment cases and in the implementation of the programmes at country level. But beyond some discussions at headquarter levels and a small number of country-initiated requests for the involvement of HRP technical staff in supporting the development of GFF investment cases, for instance in Liberia, nothing has happened. As stated by one senior UN informant: *'HRP can be not only catalytic but also instrumental in doing the work that leads to an investment case, including the involvement of the private sector. The collective work that HRP has been doing over the years can be very helpful. The average time for the development of an investment case takes about two years and that could be substantially reduced if we would involve HRP. I am not sure why it has not happened. GFF does not need 18 months to conclude that the supply chain in [country] needs to be improved. That work has been done.'*

That there is room for improvement in the financial and political engagement of cosponsoring agencies in the programmes of HRP was also expressed by stakeholders who responded to the online survey. Among the 92 respondents who expressed their views about this engagement, 74 percent thought that it was insufficient or at best sometimes sufficient.

Figure 22. Survey response: Political and financial support by cosponsors

Respondent views of the political and financial support of HRP by its co-sponsors (N=160)

CO-SPONSOR SUPPORT	
1. Grossly insufficient	9
2. Mostly insufficient	24
3. Sufficient in some areas	35
4. Nearly sufficient	18
5. Sufficient	6
Median Score	**3**
I don't know	*68*



2.10 Follow-up of recommendations from the 2013 external evaluation

The report of the external evaluation for the period 2008 to 2012 included 27 major recommendations as well as more than 40 recommendations in the four case-study reports. The Programme provided a report of the follow-up to the major recommendations to the PCC at its meeting in 2014. The evaluation team reviewed the major recommendations and assessed their level of implementation and their current validity. A brief assessment of all 27 recommendations is provided in Volume 2. In this section, 14 recommendations are listed that require further or continued attention. They are linked to the respective recommendation of the 2018 evaluation.

Recommendation (2013)	Unresolved or continuing issues (2018)
1. For future biennia, starting in 2014–2015, HRP should develop a new results framework which, in addition to a simplified approach to quantifying outputs, should identify and monitor utilisation of its products in programme countries, and, wherever possible, identify their potential and/or actual impact.	HRP developed a new results framework that was adopted by the PCC and used from 2014 onwards. However, the evaluation found that the results framework only monitored outputs rather than outcomes and needs further improvements. This is captured in Recommendation 18
2. The Programme should commission a periodic review of the utilisation of its products in programme countries and estimates of their potential or actual impact. Such a review will demonstrate the value of investing in HRP and thus further strengthen its fundraising ability.	This recommendation was not implemented. However, the evaluation team recommends that instead of periodic reviews, HRP should revise its results monitoring framework to routinely collect and report information about its work at the outcome level. (see Recommendation 18)
5. For its major areas of work, the Programme needs to develop mechanisms for identifying research needs and priorities, as well as planning and monitoring research studies, utilising external expertise. 6. HRP needs to strengthen and take a more uniform approach to its priority-setting process, in order to identify those key research questions and knowledge gaps in SRH that are most likely to have an impact in programme countries. Criteria should include: a priority issue for countries furthest from the MDGs and other global targets; likely impact; implementability; sustainability; practicality; cost; risk; comparative advantage of HRP; and lead time.	In 2013, HRP conducted a research prioritisation process for some of its portfolio using the CHNRI methodology. It was found to be a very resource intensive exercise. The process was continued in 2016 in the context of the portfolio review using internal and external expertise. Priority-setting is a dynamic task that needs continuous attention. The Programme is continuing its attention to this issue and is receiving extensive guidance by the STAG. Issues raised by key informants were: • Demands by some PCC members for a stronger involvement of the PCC in this task. • Concern that the identified priorities may over-extend the Programme's human resource capacity. Both of these issues are being addressed. The evaluation team sees currently no need to make further recommendations on priority setting.
8. In its overall programme of work, HRP should consider giving higher priority to implementation research, research on adolescents and research on the social determinants of SRH.	Implementation research was identified as a key area for HRP. The intentions to shift the portfolio into this direction are documented. An analysis of research outputs between 2013-2017 indicates that this has not yet happened. Adolescent SRHR research grew in importance during 2013-2017. Some social determinants were also included in the research portfolio, for instance on the subject of gender-based violence. The shift to increased implementation research, especially in support of the programmes of cosponsoring agencies, is a potential driver towards more research on social determinants of SRHR. This is addressed in Recommendation 3.

RECOMMENDATION (2013)	UNRESOLVED OR CONTINUING ISSUES (2018)
10. In order to gain further efficiencies, the Programme may need to re-examine the balance between the proportion of research being done by programme staff and the proportion being managed by programme staff but implemented by outside institutions. 11. The Programme needs to continue to increase the level of involvement of researchers from programme countries.	The slow development of the HRP Alliance has affected the slow Programme response to these two recommendations. Further effort is needed to make the HRP Alliance more functional. This is addressed in Recommendations 7-9.
15. There is a need for a more formal mechanism for coordination of research between HRP and MCA, particularly in the areas of maternal and perinatal research, and research on adolescent SRH; and between HRP and TDR on implementation research.	The coordination and collaboration of research between HRP and MCA continues to be an area of discussion. The collaboration between HRP and TDR on training in research methodology has increased, but this also requires further attention. The issues are addressed in Recommendation 9 and Recommendation 20.
16. All donors to HRP should reflect on the importance of providing the Programme with undesignated funding, and, wherever possible, provide such funding on a multiyear basis. Where this is not possible, the current practice of providing designated funds for specific items of HRP's already approved workplan and budget should continue. The Programme should explore the possibility of additional funding from new foundations located outside the USA.	HRP received sufficient funding during the 2013-2017 evaluation period. A slight trend towards more designated funding was observed. Although this did not affect the portfolio or priorities of HRP to a major degree, further growth of designated funding has a potential to generate future risks. This is addressed in Recommendation 21.
17. HRP needs to continue to build on the success of its resource-mobilisation work and strengthen it further by demonstrating and communicating the utilisation of its products in programme countries, their potential impact, and how this helps the achievement of global targets in SRH.	Monitoring and documenting the utilisation of HRP products and in programme countries continues to be an issue that HRP should pay more attention. This is addressed in Recommendation 18.
19 HRP needs to develop, invest in, and implement a strategy for the utilisation of its key products in a limited number of countries, to demonstrate their potential or actual impact, and to thereby leverage and guide use of the funds of national governments, cosponsors, bilateral agencies, CSOs, foundations and others, in their support to national SRH programmes.	The evaluation found evidence that HRP outputs are utilised in countries and have influenced national policies and programmes. Recommendation 18 is about a revised results framework to systematically monitor these changes. This is, however, an area where the mandate of HRP overlaps with PDRH (especially in family planning and STIs) and with MCA (in maternal and perinatal health). This is addressed in Recommendations 19 and 20.
21. HRP donors and cosponsors need to review and strengthen their systems and processes for utilising HRP's products in their own programmes of development assistance.	There is some indication of progress among cosponsors through the cosponsor engagement plan, but the issue requires further attention. This is addressed in Recommendation 16.

RECOMMENDATION (2013)	UNRESOLVED OR CONTINUING ISSUES (2018)
22. HRP and the cosponsors need to strengthen their engagement, developing clear plans and mechanisms to use the programmatic experience and networks of the cosponsors to help identify key research questions and needs for policy, programmatic and technical guidance, and to use their programmes and networks to promote and expand the use of HRP's products in countries. A progress report should be presented to PCC after 2 years. The Programme should, somewhat cautiously, explore additional cosponsors.	Engagement by cosponsors reached a low point between 2013 and 2017, but with the development of a cosponsor engagement plan and the associated discussions, there is indication of a revival, associated with HRP's intention of a stronger focus on implementation research. The revival was still fragile at the end of 2017. Discussions with cosponsors about engagement are ongoing, addressed in Recommendation 16.
23. PCC needs to ensure that its agenda gives sufficient space for the discussion of policy, strategic and financial issues central to the well-being, growth and development of the Programme, as well as receiving reports on progress, outcomes and impact.	Although the Programme reports that progress has been made, stakeholders continued to voice concerns about the governance effectiveness of the PCC. This is addressed in Recommendation 17.

3 CONCLUSIONS

RELEVANCE

The HRP **research portfolio** covers SRHR priorities in low- and middle-income countries. There are risks that the expansion of the portfolio overstretches the capacity of the Programme's human resources. The risk can be mitigated by working more extensively in partnership with research centres in programme countries and less on conducting projects by in-house scientists. Intentions to focus more strongly on implementation research have been expressed since the start of the evaluation period and are strongly supported by internal and external stakeholders. An analysis of expenditures by type of research, however, indicates that relative expenditures on implementation research have decreased rather than increased during the evaluation period.

Synthesising and building consensus on evidence for SRHR, including for global data and indicators, is a key function of HRP that could hardly be performed with the same degree of credibility by others.

Strengthening SRHR research capacity in low- and middle-income countries is an area of work that stakeholders considered highly relevant, but that was not implemented with sufficient energy and human resources. Collaboration with TDR on short-course training in research methods and approaches has started and is a promising initiative. It should, however, not replace the Programme's goal to build regional networks of strong SRHR research, training and mentoring centres for SRHR research as envisaged under the HRP Alliance. This is also imperative for supporting HRP's intended shift of focus towards implementation research.

HRP's work in **knowledge translation** and the engagement of decision-makers in dialogues on the implementation of evidence-based solutions and policies is considered relevant by stakeholders. It overlaps with the core mandate of WHO to provide technical support on health issues to member states. In sensitive policy areas such as sexual rights, abortion safety or violence against women, HRP is, however, often the only or the most credible global organisation as a partner in dialogue with governments.

HRP's support for the development of **norms and guidelines** endorsed by WHO and also by other UN partners such as UNESCO is considered highly relevant by stakeholders. HRP's work in this area is closely integrated in the WHO guideline development process which assures that issues of gender, equity and human rights are effectively mainstreamed in processes and products. The length of the guideline development process and the inaccessibility of their content to front-line health workers is an issue that was raised. Procedures to develop more practical and contextualised guidelines with less delay are already being considered according to information provided to the evaluation team.

EFFECTIVENESS

HRP has supported **research** of good to excellent quality. There is, however, room for improvement in the gender responsiveness of research projects and in the process of research priority setting. Improvements were noted since the portfolio review in 2016 which, however, only affected the work at the end of the evaluation period.

The performance of HRP in **synthesising and building consensus** on evidence has been strong. The example of HRP's work in synthesising and building consensus on evidence about violence against women for the development of a WHO Global Plan of Action was cited by several respondents as an outstanding achievement.

Progress in the work on **research capacity strengthening** through the HRP Alliance has been slow, and the envisaged regional capacity-building networks are not yet fulfilling their role. There is insufficient information about the strategy of how to reach this goal. The promotion of gender equality, equity and human rights has so far received insufficient attention in the efforts to develop the HRP Alliance.

HRP's work in **knowledge translation** and the engagement of decision-makers in dialogues on the implementation of evidence-based solutions and policies has been effective but not very visible, especially at country level. Work in this output area is central to WHO's mandate and delivered primarily under the general WHO brand. Nevertheless, HRP's engagement with decision-makers contributed directly to a substantial number of policy, legal or programme changes in the areas of rights-based family planning, abortion, violence against women and sexual health and rights.

HRP's efforts to generate, synthesise and build consensus on evidence provided valuable input into the **development of standards and guidelines** by WHO. The mainstreaming of gender, equity and human rights aspects in WHO guidelines developed with HRP support has been consistent. The RHR Department was seen by many as a leader for gender and human rights mainstreaming in WHO.

HRP succeeded in implementing an effective **communications** strategy despite its small human resource base. It strategically uses its own and corporate WHO social media channels. The **leadership** of HRP in SRHR research is recognised widely and the programme has an extensive network of partners. The position of HRP as a programme hosted by WHO is a major reason for its recognition as a global leader.

The **STAG** and the **GAP** are effective and highly appreciated **advisory committees** that function well together and complement each other. The **Standing Committee** is barely exercising its **governance** role as defined in the memorandum signed by the cosponsoring agencies. It has, however, recently experienced a revival in its role as a forum for information exchange and the promotion of cosponsor cooperation and engagement. The **PCC** is highly appreciated for its openness and the participatory nature of its annual meetings. It formally fulfils its role as a governance committee providing strategic guidance to HRP. However, the weak participation of PCC delegates from regional countries in the PCC deliberations has not improved substantially since the last external evaluation period. In the view of delegates from donor countries, the processes of the PCC meetings constrain the ability of the PCC to act as an effective organ of governance and to engage delegates in meaningful strategic discussions.

HRP is **managed** on the basis of a **results framework** that monitors results at the output level. Although the Programme largely achieved or surpassed its performance targets throughout the evaluation period, the indicators and targets are established at a very low level of the results chain, the reported output results are overloaded with double counting and by the inclusion of results that are only marginally meaningful.

EFFICIENCY

Average costs per HRP output estimated by the evaluation team range from US$ 110,000 for the development of guidelines to US$ 590,000 for research projects in maternal and perinatal health. The evaluation team, however, is not aware of any comparable information against which these expenditures could be benchmarked.

HRP had sufficient funding to implement its programme during the evaluation period. It had built up large closing balances in the Trust Fund account because of low budget execution rates at the beginning of the period. These started to decrease in the last biennium. The proportion of designated funding fluctuated throughout the evaluation period, primarily because of a small number of large research grants. There appears to be a slowly increasing linear trend towards more designated funding which could be a long-term risk to the Programme's independence and should therefore be watched.

The number and profile of donors to the HRP Trust Fund has been steady except that funding from cosponsors other than WHO collapsed. There appears to be little appetite by cosponsors to resume undesignated contributions to the HRP Trust Fund, but there are indications that the cosponsoring agencies may consider other means of financial contributions, for instance through designated funding for HRP research support of their implementation programmes. The GFF was mentioned by many

informants as a natural financing partner of HRP because applicant countries have major needs for research evidence in SRHR for the development of their investment cases and for the implementation of their programmes. Consultations between HRP and the GFF Secretariat have so far not been productive.

The co-management arrangement of HRP with the WHO PDRH programme in the RHR Department is complex. However financial management is well separated. The boundaries of roles and mandates between the two programmes vary by programme area. RHR staff have established a functional way to deal with this complexity that maintains the independence of HRP while maximising the advantages of linking the work of HRP to the normative and technical advisory role of WHO.

There is extensive collaboration of HRP with other departments of WHO through regular inter-departmental cooperation processes. In the area of maternal and perinatal health, HRP collaborates closely with the MCA Department. Despite overlapping mandates, the two departments work in a complementary fashion based on collegiality and mutual respect. The division of their work in two separate departments may, however, create inefficiencies.

IMPACT

The stated impact of the HRP Theory of Change, namely '*improved sexual and reproductive health and rights, in particular among young women and young people'* is within the Programme's sphere of interest. HRP's influence at this level, however, is mitigated by many contextual factors and by decisions that are made by others. Although the HRP contribution to this impact could potentially be determined through specific research projects, it is beyond the range of monitoring. The way HRP most directly affects this impact is through its performance in influencing policy and programme decisions at global, regional and country level through the evidence it brings to the dialogue with decision-makers. The evaluation team collected a lot of evidence for changes in programmes and policies that were achieved with a contribution of HRP, indicating that the work of the Programme has an impact. These changes are however not systematically monitored and reported in the HRP results framework.

SUSTAINABILITY

The key areas of work where HRP is expected to generate sustainability outcomes are in the areas of network building and research capacity strengthening. They are closely linked in the portfolio of building the HRP Alliance. Progress in this area of work was slow during the evaluation period and the outcomes were weak. This affects the assessment of the sustainability of HRP's work. Insufficient allocation of human resources by the Programme to this area of work were cited as the main reason for low performance in this area.

GENDER, EQUITY AND HUMAN RIGHTS (CROSS-CUTTING PARAMETER)

A case-study of HRP's work on gender, equity and human rights conducted within the context of the evaluation (see Volume 2) concluded that HRP's high-quality products that focused on gender or human rights have been very influential. The uptake of these outputs at global level was high, and somewhat lower at national level. While output delivery on gender and HR has been impressive, consistent mainstreaming of gender, equity and human rights in the Programme's research portfolio was not achieved in the period under evaluation. Due to girls' and women's lower social status in most countries, their urgent sexual and reproductive health needs and the many violations of their sexual and reproductive rights, it is understandable that HRP focused mostly on this demographic group. To achieve gender equality, however, it will be important to consistently analyse and drive change from all perspectives (boys, girls, men and women).

4 RECOMMENDATIONS

Based on the analysis of findings in response to the nine evaluation questions, the evaluation team formulated **18** recommendations addressed to the Programme or to its governing bodies. A further **12** recommendations were formulated on the basis of the four case studies. Findings of the case studies, deepened insights gained in the Programme evaluation. Most recommendations were therefore more nuanced but not different in substance from those that responded to the analysis of the main evaluation questions. To avoid duplication, they were therefore consolidated under the nine evaluation areas resulting in a total of **22** recommendations.

Some recommendations require immediate action, others are formulated with a more long-term view on Programme development, and others require no direct action but continued vigilance to maintain the successful operation of a Programme that is highly valued and that fills an important gap in global health. This is indicated by symbols of a rabbit for immediate action, a turtle for a longer-term perspective and an owl for continued vigilance. While the responsibility for implementation of most recommendations is shared by all stakeholders of HRP, the action leader is identified.

Creating new knowledge		
1	HRP should urgently upgrade and organise its documentation system, assuring that approved research protocols (RP2 decisions) as well as all published and unpublished research outputs can be readily retrieved from a central server.	 HRP
2	HRP should strengthen its research proposal screening and approval processes and mechanisms to ensure that issues of gender, equity and human rights are effectively mainstreamed in the portfolio of HRP-supported research. • Middle management of all three research teams should be accountable for the effective integration of gender, equity and human rights in research. • Guidelines for gender, equity and human rights mainstreaming should be disseminated and HRP staff should be coached to ensure stronger integration of gender, human rights and equity issues during the research design process. • Relevant research projects to be selected with participation of the GAP should be reviewed by the GAP during the design and approval stage.	 HRP
3	HRP should implement its stated intentions of giving implementation research increasing priority in its research portfolio. Since implementation research requires a presence at the sites of programme implementation and close collaboration with programme implementers, the effort needs to be linked to expanding the network of SRHR research partners in programme countries and to supporting their capacity to conduct research.	 HRP
4	In its emerging research agenda of SRHR in the context of migration and in humanitarian settings HRP should include the documentation of data gaps and the development of tools for estimating and monitoring the incidence and prevalence of key SRHR issues in such populations or situations.	 HRP
5	In developing its portfolio of research activities in SRHR in humanitarian settings, HRP should assure that it balances its plans to fill existing research gaps with an appropriate allocation of human and financial resources.	 HRP
Synthesising research evidence		
6	HRP should continue to give priority to evidence synthesis and consensus building in SRHR as a work area in which it occupies a unique leadership role and has established a record of excellent performance.	 HRP/PCC

Strengthening research and technical capacity		
7	HRP should with some urgency develop and widely communicate a comprehensive strategy for the development of the HRP Alliance in close collaboration with the established HRP hubs and key partners among the WHO Collaborating Centres. This should include a timed implementation plan and the mobilisation of sufficient human resources to implement it.	 HRP
8	To build sustained capacity for research and technical expertise in adolescent SRHR, in SRHR among migrants and in humanitarian settings, HRP should expand the HRP Alliance network through strategic engagement with regional research partners that have proven strengths and track records in research on adolescent health as well as in working with migrants and populations affected by humanitarian crises.	 HRP
9	HRP should continue and expand its collaboration with the Tropical Disease Research Programme (TDR) and eventually also the Alliance for Health Policy and Systems Research (AHPSR) in developing and delivering a curriculum of short research training courses in parallel and within the strategy for the HRP Alliance network.	 HRP
Strengthening the research/policy dialogue		
10	HRP should continue to exercise its role and consolidate its niche for driving the policy dialogue at global, regional and national level for the adoption of policies and programmes in sensitive areas of SRHR that promote gender equality, social equity and human rights.	 HRP/PCC
11	To achieve sustainable changes in national policies and programmes for adolescent sexual and reproductive health and rights, HRP should intensify its engagement with implementing organisations, including the UN cosponsors and INGOs, with the aim of strengthening the financial and technical support they provide to governments with the evidence generated by the research of HRP and its research partners.	 HRP/PCC
Developing evidence-based guidelines, implementation tools and policy statements		
12	The RHR Department, in collaboration with the WHO Guideline Development Group, should explore means and procedures for more rapid development of practical guidelines for programme implementers.	 WHO/RHR
13	HRP should continue to maintain its strong profile in supporting the development and the implementation of policy guidance at global, regional and national levels in areas where it has built its strength and where few other international agencies are active such as in abortion safety, gender-based violence and sexual rights.	 HRP/PCC
Advocacy, communication and partnership		
14	HRP should continue to exercise its recognised role as a global leader in SRHR research based on its close association with WHO. At the same time, it should work on gaining more visibility at country level by increasing its engagement with the WHO Regional Offices and with the appropriate structures (Regional or Country) of the cosponsoring agencies.	 HRP/WHO
15	When negotiating designated contributions, HRP should consider adding a communications budget. This would provide resources to increase the number of influential followers of HRP's social media messages, to ensure consistent strategic social media communication during conferences and meetings and to effectively track and respond to results of social media engagement indicators.	 HRP

HRP Governance		
16	HRP should continue to seek greater engagement of cosponsors through the Standing Committee and this should be supported vigorously by the PCC, especially by the donor representatives who, in the majority, represent governments that are donors and key members of governing committees of cosponsoring agencies and who should use this leveraging power.	 HRP/PCC
17	The PCC should review and revise its procedures to increase its effectiveness as an organ of governance assuring that HRP in its activities is fully accountable to programme and donor countries. Steps should be taken to increase the space for meaningful strategy discussions between the Programme and its PCC.	 PCC/ Cosposnors
HRP Management		
18	HRP should revise its results framework in a participatory process aimed at adopting a more structured approach based on a Theory of Change and an associated performance management and reporting framework. Output targets and reports should not be based on just counting as many outputs as possible but rather on presenting meaningful outputs organised by theme and importance. Indicators and targets should be defined at the outcome level and reported systematically. • For HRP's work on global monitoring and indicators, the Programme should report performance separately for, (i) outputs related to the global indicators for which it is the custodian, (ii) outputs related to global indicators for which it provides input and support to other agencies, (iii) outputs of research into new global indicators, and (iv) outcomes of its work in global monitoring and indicators in terms of improved global accountability for SRHR. • To ensure effective gender, human rights and equity integration, outputs and outcomes should be disaggregated by sex wherever relevant and targets should be included for results with a primary focus on gender, equity and human rights.	 HRP
19	The PCC should urge WHO to increase its fund-raising efforts for undesignated and designated financing of PDRH so this programme can become more effective in fulfilling its role of facilitating the translation of HRP-generated evidence into programmes and policies at country level.	 PCC/WHO
20	The PCC should engage with the ADG FWC of WHO to find a better structural solution for joint work in maternal and neonatal health between HRP and the MCA Department that avoids working across departmental boundaries. This should include a review of the portfolio of activities in maternal, perinatal and adolescent health of the RHR and MCA Departments of WHO as well as a clear division of responsibilities of the two departments for global monitoring and indicator development. These deliberations should consider the lessons learnt from the efficiency of RHR in the area of contraception, where the entire value chain from evidence generation to the development of norms and research to support their implementation is located within one department.	 PCC/WHO
HRP Finance		
21	The PCC should continue to monitor the levels of designated contributions to the HRP Trust Fund to be able to react in time before the proportion of designated funds reaches a level where it could seriously distort the portfolio of HRP activities.	 PCC
22	PCC delegates from cosponsoring agencies and from donor countries should work together on lobbying for a greater financial engagement in HRP of the cosponsors as well as of the GFF through programmatic cooperation rather than undesignated funding.	 PCC

5 REFERENCES

1. UN General Assembly (2015). Transforming our world: the 2030 Agenda for Sustainable Development. UN A/RES/70/1
2. Office of the UN Secretary-General (2015). The Global Strategy for Women's, Children's and Adolescents' Health 2016-2030.
3. Benagiano G, et al. (2012). The Special Programme of Research in Human Reproduction: Forty Years of Activities to Achieve Reproductive Health for All. Gynecol Obstet Invest 2012;74:190–217. DOI: 10.1159/000343067
4. WHO (1993). Handbook of Resolutions and Decisions of the World Health Assembly and the Executive Board. Volume 3 Third Edition 1985-1992
5. Padian NS, et al. (2011). Implementation science for the US president's emergency plan for AIDS relief (PEPFAR). Journal of Acquired Immune Deficiency Syndromes 56(3): 199-203
6. Lebel J, McLean R (2018). A better measure of research from the global south. Nature, 599, 23-26
7. Ofir Z, Schwandt T, Duggan C, McLean R (2016). Research Quality Plus: A holistic approach to evaluating research. International Development Research Centre, Canada
8. WHO (2012). Memorandum on the Administrative Structure of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP). HRP/1988/1(rev.2012)
9. WHO (2013). HRP External Evaluation 2008-2012 Report. WHO/RHR/HRP/13.07
10. Biza A, et al. (2015) Challenges and opportunities for implementing evidence-based antenatal care in Mozambique: a qualitative study. BMC Pregnancy and Childbirth; 15:200; DOI 10.1186/s12884-015-0625-x
11. Chavane L, et al. (2014) Implementation of evidence-based antenatal care in Mozambique: a cluster randomized controlled trial: study protocol. BMC Health Services Research; 14:228
12. Bertán AP, et al. (2018) Provision of medical supply kits to improve quality of antenatal care in Mozambique: a stepped-wedge cluster randomised trial. Lancet Global Health; 6:e57–65
13. HRP (2017). Portfolio Review Process Report. RHR/PCC (30)/2017/11 **RESTRICTED DOCUMENT**
14. UNESCO (2018). International technical guidance on sexuality education (revised edition). UNESCO, France
15. WHO (2017). HRP programme budget 2018–2019. WHO/RHR/HRP/17.19
16. HRP (2017). Reports to the 34th Meeting of the Scientific and Technical Advisory Group, 22-24 February 2017
17. Rudan I, et al. (2008). Setting Priorities in Global Child Health Research Investments: Guidelines for Implementation of CHNRI Method. Croat Med J. 49:720-33; doi:10.3325/cmj.2008.49.720
18. WHO (2016). HRP Annual Technical Report 2015. WHO/RHR/HRP/16.08
19. WHO (2016). TDR Financial report 2016-2017 and outlook 2018-2021
20. HRP (2016). HRP Portfolio Review Background Paper 12: Research capacity strengthening.
21. Weiss C (1979). The many meanings of research utilization. Public Administration Review; September/October 1979; 426-431
22. UNESCO (2018). International technical guidance on sexuality education; revised edition.
23. WHO (2016). Twenty-ninth meeting of the Policy and Coordination Committee: 23–24 June 2016; HRP/PCC(29)/2016; **RESTRICTED DOCUMENT**
24. WHO (2014). Handbook for guideline development, Second edition
25. WHO (2012). Safe abortion: technical and policy guidance for health systems. Second edition
26. WHO (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.

27. WHO (2016). Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children.
28. WHO (2014). Gender and Rights Advisory Panel: Terms of reference
29. HRP (2017). Strengthening engagement in HRP: A plan for HRP and its Cosponsors. 21 November 2017
30. HRP (2014). Policy and Coordination Committee 27th Meeting: Agenda item 6.2
31. WHO (2016). Standards for improving quality of maternal and newborn care in health facilities.
32. Grayling (2014). Draft Communications Strategy for HRP. **CONFIDENTIAL**