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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

Volume 2: Annexes

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ABBREVIATIONS

AFHS	Adolescents Friendly Health Services
AFRO	African Regional Office (WHO)
AGH	Adolescents and at-Risk Populations (HRP Team)
AH-HA	Accelerated Action for the health of adolescents
AHEAD	Adolescent Health Experience After Delivery or Abortion
AHPSR	Alliance for Health Policy and Systems Research
ANC	Antenatal Care
ARMADILLO	Adolescent Reproductive Mobile Access and Delivery Initiative for Love and Life Outcomes
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AU	African Union
BMGF	Bill & Melinda Gates Foundation
CAQDAS	Computer Assisted Qualitative Data Analysis Software
CEFM	Child, Early and Forced Marriage
CHNRI	Child Health and Nutrition Research Initiative
CIRE	Continuous Identification of Research Evidence
COIA	Commission on Information and Accountability
CSE	Comprehensive Sexuality Education
DAC	Development Assistance Committee (OECD)
DFID	Department for International Development (UK)
DHS	Demographic Health Survey
ECHO	Evidence for Contraceptive Options and HIV Outcomes
EES	External Evaluation Subcommittee (of PCC)
EPMM	Ending Preventable Maternal Mortality
ERC	Ethics Review Committee (WHO)
EWEC	Every Woman Every Child
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
FWCW	Fourth World Conference for Women
GAM	Global AIDS Monitoring
GAP	Gender and Rights Advisory Panel
GASP	Gonococcal Antimicrobial Surveillance Programme
GBV	Gender-based Violence
GE	Gender Equality
GEAS	Global Early Adolescent Study
GFF	Global Financing Facility
GSWCAH	Global Strategy for Women´s, Children´s and Adolescents´ Health
HR	Human Rights
HRX	Human Reproduction (HRP Team)
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
ICD	International Classification of Diseases
ICFP	International Conference on Family Planning
ICPD	International Conference on Population and Development

IDRC	International Development Research Centre
IER	Department of Information, Evidence and Research (WHO)
IHME	Institute for Health Metrics and Evaluation
IPU	Inter-Parliamentary Union
IWHC	International Women's Health Coalition
KII	Key Informant Interview
LID	Long-term Institutional Development (Hubs)
MAXQDA	(a qualitative and quantitative data analysis software)
MCA	WHO Department of Maternal, Newborn, Child and Adolescent Health
MDG	Millennium Development Goal
MISP	Minimum Initial Service Package
MMEIG	Maternal Mortality Estimation Interagency Group
MMR	Maternal Mortality Ratio
MNCA	Maternal, Newborn, Child and Adolescent Health
MPA	Maternal and Perinatal Health and Preventing Unsafe Abortion (HRP Team)
PAHO	Pan-American Health Organization
PCC	Policy and Coordination Committee
PDRH	Programme Development for Reproductive Health (WHO)
PMNCH	Partnership for Maternal, Neonatal and Child Health
QA	Quality Assurance
RCS	Research Capacity Strengthening
RHR	Department of Reproductive Health and Research (WHO)
RMC	Respectful Maternity Care
RP2	Research Project Review Panel
RQ+	Research Quality Plus
RTI	Reproductive Tract Infection
SDG	Sustainable Development Goal
SEARO	South East Asia Regional Office (WHO)
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STAG	Scientific and Technical Advisory Group
STI	Sexually Transmitted Infection
TAG	Technical Advisory Group
TDR	Special Programme for Research and Training in Tropical Diseases
ToR	Terms of Reference
UNODC	UN Office on Drugs and Crime
VAW	Violence Against Women
WHA	World Health Assembly
YFHS	Youth Friendly Health Services

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1. DETAILED METHODOLOGY

The evaluation used a mixed-methods approach to answer nine evaluation questions broken down into 26 sub-questions that were defined during the inception phase. The evaluation questions covered the DAC evaluation criteria of relevance, effectiveness, efficiency, and sustainability. The impact of HRP according to its Theory of Change framework, is the achievement of improved sexual and reproductive health and rights. This was not evaluable within the framework of this evaluation and would require a different approach to an impact evaluation. The evaluation examined the impact at the level of HRP's influence on national, regional and global policies and programmes.

For each sub-question, indicators were formulated to guide data collection, however the data availability varied by indicator.

Evaluation questions, sub-questions and indicators

EVALUATION QUESTIONS	SUB-QUESTIONS	INDICATORS
1. Has HRP supported high quality research (including implementation research) that created new knowledge on SRHR?	1.1 Has HRP-supported research (including implementation research) addressed priority issues of SRHR for people in low- and middle-income countries? (Relevance)	1.1.1 Stakeholder views of the extent to which the HRP research portfolio is aligned with SRHR priorities in low- and middle-income countries 1.1.2 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
	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)	1.2.1 Average RQ+ scores for research in specific areas
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?	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)	2.1.1 Stakeholder views on the extent to which synthesis and consensus publications and consultations supported by HRP address SRHR priorities in low- and middle-income countries
	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)	2.2.1 Stakeholder knowledge about, and use of HRP-supported research synthesis reports and publications 2.2.2 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
3. Has HRP support contributed to increased SRHR research, knowledge transfer and implementation capacity of institutions and individuals in low- and middle-income countries?	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)	3.1.1 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 3.1.2 Degree of satisfaction of individuals (disaggregated by sex) and institutions with the capacity-building support they received from HRP
	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)	3.2.1 Evidence for the inclusion of equity, human rights and gender equality objectives in grant-making for capacity grants 3.2.2 Profile of individual capacity grant recipients (sex, age, academic field, country context) 3.2.3 Profile of institutional capacity grant recipients (academic field, country context)

Evaluation Questions	Sub-questions	Indicators
	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)	3.3.1 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
	3.4 What capacity-building outcomes have been achieved by individuals and institutions that are sustained independently from HRP financial and technical support? (Sustainability)	3.4.1 # of scientific publications produced by individuals (disaggregated by sex) who received capacity building support from HRP 3.4.2 # of publications produced by institutions that received capacity building support from HRP (that can be directly or indirectly linked to this support) 3.4.3 # of research grants obtained by capacity grant recipients from sources other than HRP
4. Has HRP convened regional and national consultations on SRHR issues that have strengthened the translation of research evidence into laws, policies and programmes?	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)	4.1.1 Stakeholder views about the extent to which the research/policy consultations initiated or conducted with HRP support addressed national or regional SRHR priorities
	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)	4.2.1 # 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 4.2.2 # 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
5. Has HPR 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?	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)	5.1.1 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
	5.2 Are gender, rights and equity issues mainstreamed in the WHO-endorsed normative documents that were produced or updated with HRP support? (Effectiveness)	5.2.1 Extent to which gender, human rights and equity dimensions are mainstreamed in normative documents on SRHR produced with HRP support
	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)	5.3.1 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
	6.1 Has HRP engaged a global partner network in promoting SRHR research and evidence-based policies and programmes? (Relevance)	6.1.1 # of agencies, foundations or states that are co-funding HRP-supported research, knowledge transfer, capacity strengthening or advocacy activities 6.1.2 Amount of leveraged funds mobilised for HRP-supported projects

Evaluation Questions	Sub-questions	Indicators
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?	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)	6.2.1 Extent to which the HRP communication and advocacy strategy has been implemented 6.2.2 # and reach of sampled communication campaigns or press releases during the evaluation period 6.2.3 Profile, audience size, reach and engagement, content, traffic back to the programme website, and community responsiveness of social media and IT-based communication activities
	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)	6.3.1 Knowledge of HRP's role, mandate and products among SRHR researchers, advocates and programme implementers 6.3.2 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
7. Does the HRP have an effective governance structure to support its mandate and goals?	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)	7.1.1 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) 7.1.2 Extent to which the Programme responds to guidance provided by the governance committees 7.1.3 Extent to which the governance committees monitor the Programme's response
	7.2 Do the co-sponsors of HRP coordinate their support for SRHR research in a transparent way without overlaps? (Relevance)	7.2.1Extent to which the co-sponsoring agencies use HRP as a platform to coordinate their SRHR research and programme implementation 7.2.2 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
	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)	7.3.1 Existence of clear definitions of tasks and responsibilities for each of the HRP governance committees 7.3.2 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 7.3.3 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
8. Does the WHO RHR Department manage HRP efficiently and effectively?	8.1 Did the Programme achieve its objectives of the three latest biennial work plans? (Efficiency/ Effectiveness)	8.1.1 % achievement of programme performance targets in each of the three biennia of the evaluation period 8.1.2 Number of products (by type) completed against Programme targets in each of the five objective areas. (research studies and global/regional estimates published; interventions developed, tested and disseminated) 8.1.2 Extent to which any underachievement was analysed and extent to which lessons were drawn for the next programme period
	8.2 What were the costs of inputs in relation to the outputs each type of product? (Efficiency)	8.2.1 Cost per output
	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)	8.3.1 Documented evidence of a clear division of responsibilities, budgets and accountability between HRP and PDRH 8.3.2 Documented evidence (case examples) of effective cooperation between HRP and PDRH in translating HRP research results into the development of programmes by PDRH

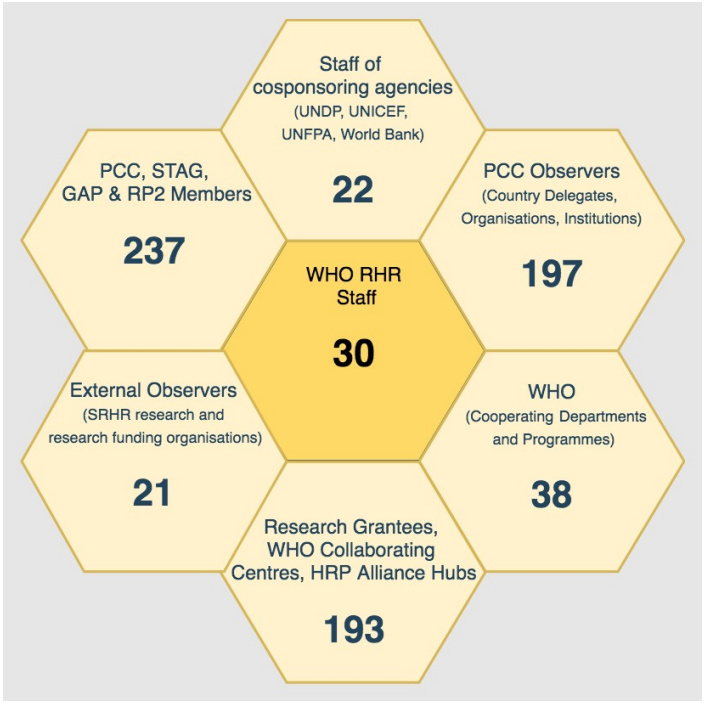
Evaluation Questions	Sub-questions	Indicators
	8.4 Does WHO ensure that SRHR research is coordinated without overlap with other relevant departments of WHO and co-sponsored programmes implemented by WHO? (Efficiency)	8.4.1 # of HRP research and knowledge translation activities that were jointly developed and supported with relevant WHO HQ departments or programmes 8.4.2 Perceptions among senior WHO HQ staff in relevant departments about the division of labour with HRP and the added value of HRP
9. Does HRP have the necessary financing to realise its strategy?	9.1 Is the activity planning and budgeting of the Programme realistic? (Efficiency)	9.1.1 % of biennial budgets that were funded (by budget category)
	9.2 Is the WHO RHR Department effective in raising funds for the planned activities of HRP? (Effectiveness)	9.2.1 Trends in the number of programme donors and specified / unspecified donor contributions during the evaluation period 9.2.2 Trends in amount of leveraged funding in support of projects initiated by HRP
	9.3 Do the co-sponsors of HRP support the financing and fund-raising of HRP to ensure the realisation of its strategy? (Effectiveness)	9.3.1 Trends in financial support to HRP by the 5 co-sponsoring agencies 9.3.2 Documented evidence of co-sponsor support for HRP fundraising

Four case studies were conducted in accordance with separate terms of reference. A limited number of additional evaluation questions were defined for each case study.

Data collection

Data for the evaluation were collected from six sources: (i) Document reviews, (ii) an on-line survey, (iii) key informant interviews with HRP stakeholder, (iv) research quality assessments, (v) case studies and (vi) a social media scan.

Stakeholder database



A database of stakeholders of individuals in institutions, organisations and structures that influence the Programme, work in partnership with the Programme or are affected by the Programme's activities was prepared with assistance from the HRP Secretariat. The database included 738 names and contact addresses grouped in seven categories after removing duplications (many stakeholders are members of several groups). The database was used as a listserv for invitations to participate in the on-line survey and as a sampling frame for key informants to be interviewed by the evaluation team. WHO RHR staff and persons who were RHR staff during the evaluation period were removed from the listserv for the on-line survey but included in the key informant interviews.

Document reviews: A document library for the evaluation was assembled during the inception phase and expanded throughout the evaluation. Documents were obtained from the HRP Secretariat, from stakeholders, including other research funding organisations, and through internet searches. They

include 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.

On-line survey: To collect perceptions from as many stakeholders involved in the programme as possible, an on-line survey was conducted in English, French and Spanish. The survey was pretested among members of the PCC External Evaluation Sub-committee. It consisted of 29 multiple choice or ranking questions using 5-point Likert scales. The survey was launched on September 13th, 2018 on the SurveyMonkey platform by an email invitation sent by the HRP Secretariat on behalf of the PCC Chair to a list of 708 programme stakeholders (all except WHO RHR staff). Two reminders were subsequently sent by the Director of RHR and by the evaluation team before the survey was closed on October 22nd.

Stakeholder interviews: Interviews were conducted in person in Geneva or by telephone. Plans to attend meetings of the HRP Alliance and of the Standing Committee could not be realised because both meetings were cancelled on short notice. This limited the number of planned interviews. Semi-structured interview guides were used for all interviews. All interviews were recorded and transcribed except one because of refusal of the interviewee.

Research quality assessment: The HRP Secretariat provided a database of 78 research projects that were approved by the RP2 panel between 2012 and 2016. Projects that were approved in 2017 were excluded as they were unlikely to have generated evaluable outputs by August 2018. Projects approved in 2012 were included because it was assumed that most of the work under these projects was conducted during the evaluation period from 2013 to 2017. A sample of 14 projects were selected for quality assessment by purposive sampling balancing thematic areas, year of approval and region of implementation. Several projects had to be replaced during two replacement rounds because they had either been cancelled, had not yet generated any outputs, or were of a type that could not be assessed. In the end, only 13 projects remained for analysis.

Case studies: Additional data through interviews and document reviews were collected by members of the evaluation team for the preparation of four case studies with the following themes:

- HRP'S work on co-designing, monitoring and reporting on SRHR indicators.
- HRP's work on comprehensive maternal and perinatal health, including postpartum contraceptive use.
- HRP's work on gender, equity and rights.
- HRP'S work on adolescent SRHR and SRHR in emergency and humanitarian settings with a focus on adolescents

Additional data for the evaluation were extracted from the case study reports.

Social media scan: The HRP Communications department provided analytic reports for Twitter and YouTube accounts as well as internal communications reports and strategic plans that covered the evaluation period. The evaluation team did, however, not have direct access to HRP social media accounts and the analytic reports and communications planning documents provided by HRP were rather limited. Key informant interviews with communications staff provided context for the social media scan. Additional data were collected through public searches of HRP's Twitter and YouTube accounts, primarily detailing audience composition, reach and engagement where possible. In addition, the evaluation team purchased social media records for a sample of 20,000 historical tweets using the hashtag #SRHR between June and December 2016 from Twitter and analysed the dataset using the third-party software Tweepsmap.

DATA ANALYSIS

Documents retrieved for the document review as well as transcripts of key informant interviews were analysed using qualitative content analysis. To organise and explore the large number of documents the Computer Assisted Qualitative Data Analysis Software MAXQDA was used. It is designed to analyse qualitative and mixed data and allows to import, organise and visualise data in various file formats. Once data were imported to MAXQDA, a system of codes and sub-codes was developed for data analysis using both deductive and inductive coding. Main codes were established on the basis of the evaluation questions and sub-questions (deductive coding). Additional sub-codes were developed while data were being read (inductive coding). During the coding process, the coding matrix was regularly updated to improve its relevance. Once all data were coded, the coding patterns, coding frequencies and established mappings and relationships were explored. This approach allowed quantification of the frequency and similarity of reports, responses, experiences and reactions to generate evidence for the evaluation indicators.

The HRP expenditure database from 2012 to 2017 was used as the basis of financial analysis. Expenditure lines were coded on the basis of the budget line narrative, labelling each of the 409 lines as either administrative, capacity strengthening, general technical, monitoring and indicator development, normative or research expenditures. Research expenditures were then further labelled as formative, innovation, normative or implementation research. Labelling was in all cases approximative as the budget line narrative did not always allow a clear allocation. For large expenditure lines, additional information was sought in the annual reports. Expenditures by activity were analysed with the aid of Excel pivot tables.

The on-line survey responses were analysed by frequency of choices in the Likert scales after exporting the data to an Excel platform. The responses were treated as ordinal data and the median was used as the main measure of central tendency.

For the assessment of research quality, the 13 sampled projects were stratified into formative studies (3), implementation research (5), normative research (4) and innovation research (1). The study protocols and research outputs of each project were assessed by two independent reviewers using the IDRC RQ+ assessment tool. The tool consists of 13 qualitative rating scales that assess constraining and enabling contextual factors as well as the technical quality, legitimacy, importance and positioning for use of the research outputs. The scores in each of the 13 scales were then compared between the two reviewers and difference of more than two points on a nine-point scale were discussed among them before the mean scores were recorded.

LIMITATIONS

Despite excellent cooperation by the Secretariat of the RHR Department, the evaluation team experienced considerable difficulties in gaining timely access to relevant documents, especially for the research quality assessment. Outputs of sampled research projects, including published scientific papers, papers submitted for publication, research reports, policy briefs and similar material could only be obtained from the responsible research officer. Some had left WHO, others were on extended duty travel, and some had to search for the material on the hard drives of decommissioned computers. One promised product was never provided despite repeated reminders. This caused considerable delays in conducting the research quality assessments, required repeated resampling, and in the end resulted in an incomplete sample.

Key informants to be interviewed for the evaluation were difficult to contact and some never responded to invitations. The evaluation work plan included attendance of the team in two meetings in October 2018, the Standing Committee and the HRP Alliance, to conduct interviews with key informants from

these important stakeholder groups. Both meetings were cancelled, one on very short notice and the other without notification of the evaluation team. This required last-minute scheduling of telephone interviews which was not always successful.

In 2014, one year after the start of the evaluation period, HRP adopted a new results monitoring framework, reporting outputs against nine indicators. Outputs generated in 2013 were more difficult to track and reconcile, especially as the structure of budget categories had also changed. But even post-2014 output reporting had many challenges with undifferentiated reporting of relevant and irrelevant publications and meetings including many duplications. Although interviewed RHR research staff as well as external respondents to the on-line survey readily cited outcomes that were achieved by HRP during the evaluation period, these were not systematically tracked and reported, and it was impossible for the evaluation team to gain a comprehensive overview of HRP outcomes.

The database of HRP stakeholders that was the basis for invitations to participate in the on-line survey and for sampling interviewed informants was assembled from databases of PCC meeting attendees, committee members, technical service agreements and similar sources. In addition, the RHR Secretariat provided contact names for WHO staff in other departments. Attempts by the evaluation team to obtain a contact list of country-level staff of WHO and UNFPA were not successful. Although the evaluation team was able to increase the list of stakeholders through a snowball approach, the fact that contact names for staff in WHO and other cosponsoring agencies were supplied by the RHR Secretariat was a potential source of bias.

The planned social media scan could only be conducted in a limited format because the evaluation team received only limited information on HRP's social media accounts. Instead of Twitter and YouTube raw data in spreadsheet format by year as requested, the team received only a small set of statistics. To mitigate this limitation, the application Tweepsmap[1] was used to analyse accessible data for HRP's engagement on Twitter.

The position of HRP in the structure of WHO which, according to the evaluation findings, contributes to the strength of the Programme, also created challenges for the evaluation. Many external informants could not make a distinction between WHO and HRP. Although there was a clear separation of budgets and expenditure reports between HRP and PDRH, work of these two arms of the RHR Department, as well as with other departments of WHO during the evaluation period was integrated and cooperative. The extent to which observed or reported outcomes, especially at country level, could be attributed to HRP and therefore accounted against donor investments in the HRP Trust Fund could not be clearly delineated, especially in thematic areas where HRP did not have a unique niche such as in research on the prevention of unsafe abortion.

[1] https://tweepsmap.com/

2. ON-LINE SURVEY

The on-line survey was launched in English, French and Spanish on September 13 with an invitation to 708 stakeholders of the HRP programme. The list was assembled as follows:

- Delegates to PCC meetings between 2014 and 2018
- Registered observers of PCC meetings between 2014 and 2018
- Members of GAP and STAG committees between 2013 and 2017
- Members of the RP2 Panel
- Main contacts in WHO Collaborating Centres for sexual and reproductive health
- Researchers and scientists who had signed Technical Service Agreements with HRP between 2013 and 2017
- Staff in WHO HQ departments who had collaborated with HRP between 2013 and 2017 (list supplied by HRP)
- Names of SRHR specialists, researchers and research funding organisations collected by the evaluation team using a snowballing approach

Current WHO RHR staff and those who worked in RHR between 2013 and 2017 were excluded from the survey.

A reminder e-mail to all stakeholders was sent by the Director of RHR on September 27th and a second reminder by the evaluation team on October 15th with a final closure of the survey on October 22.

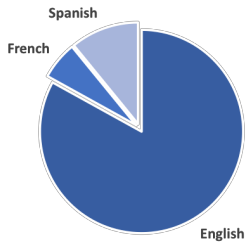
Of the 708 e-mail invitations, 112 were returned because the e-mail address was no longer valid or there was an automated message that the person had retired or left the organisation.

- The invitation was received by 594 potential respondents
- The survey was opened by 213 respondents (**overall response rate: 36%**)
- 48 respondents were either RHR staff during the evaluation period or submitted only profile data. They were removed from the analysis which left 165 valid responses (**valid response rate: 28%)**

PROFILE OF SURVEY RESPONDENTS

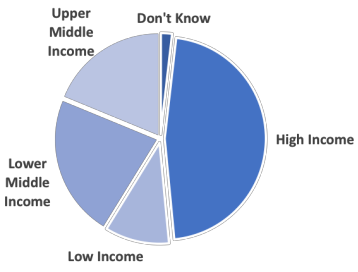
Language of completed questionnaire
Most respondents chose to complete the questionnaire in English

Questionnaire	
English	137
French	10
Spanish	18
Total	**165**



Economic context of respondents
Almost half the respondents lived in high income economic environments

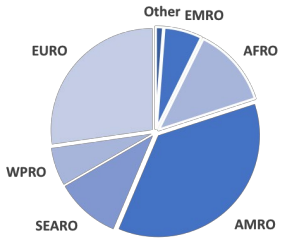
Economic context	
Don’t know	3
High income	77
Low income	17
Lower middle income	37
Upper middle income	31
Total	**165**



WHO region of respondents

Responses were received from all regions with the highest numbers from the Americas and from the European region.

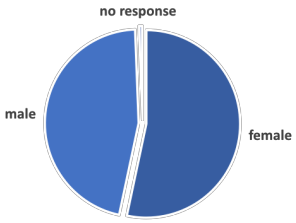
Region	
Other	2
Eastern Mediterranean	10
African	21
American	60
South-East Asian	17
Western Pacific	10
European	45
Total	**165**



Respondents' sex

Slightly more than half of the respondents were female

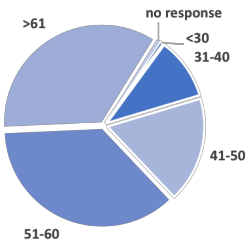
Sex	
Female	88
Male	76
No response	1
Total	**165**



Respondents' age

The great majority of respondents (71%) were older than 50 years. The very low participation of the age group below 30 is remarkable but likely related to the sampling frame used for the survey.

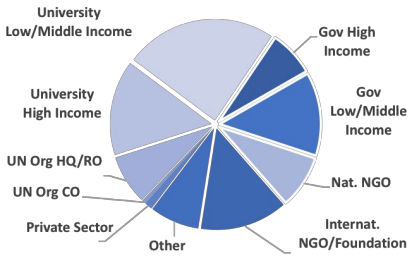
Age	
30 years and younger	1
31-40 years	17
41-50 years	29
51-60 years	60
61 years and older	57
No response	1
Total	**165**



Institutional affiliation of respondents

The high participation of respondents from universities and governments in low and middle-income countries (46%) was encouraging. Only one respondent based at a country office of WHO, UNFPA or any other UN Organisation participated. The country offices were not specifically included in the sampling frame because the evaluation team was not able to obtain a list of email contacts.

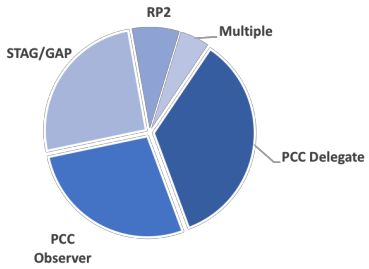
Institution	
Government (high income)	12
Government (low/middle income)	22
National NGO (low/middle income)	14
International NGO/Foundation	23
Private Sector	2
UN Organisation (Country Office)	1
UN Organisation (HQ/RO)	13
University (high income)	25
University (low/middle income)	40
Other	13
Total	**165**



Respondent's participation in HRP governance and scientific committees

106 respondents (64%) had participated in one of the governance or scientific committees of HRP between 2013 and 2017. This corresponded to the proportion in the sampling frame. The largest proportion had been delegates to the PCC, and five of them had multiple roles, primarily as delegates to the PCC and members of one of the scientific committees.

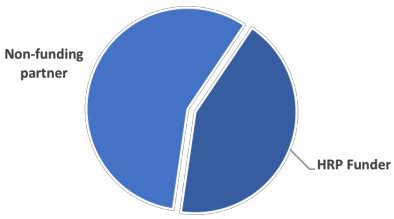
HRP committee participation	
PCC Delegate	37
PCC Observer	29
STAG or GAP Member	27
RP2 Panel Member	8
Multiple roles	5
Total	**106**



Funding relationship to HRP

49 respondents answered the question about their institution's financial partnership with HRP. Almost half of them (43%) stated that their institution had at one time provided funds to the Programme.

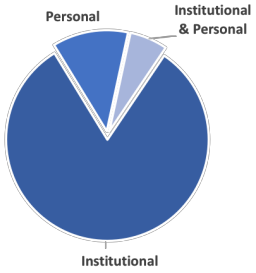
Funding relationship	
HRP funding partner	21
HRP non-funding partner	28
Total	**49**



Capacity-building partnerships

A total of 34 respondents stated that they or their institution received capacity-building grants but only 33 answered the corresponding section of the questionnaire. Almost all of them cited institutional capacity support and only a minority cited grants for personal training.

Capacity-building support	
Institutional	27
Personal	4
Institutional & personal	2
Total	**33**



ANALYSIS OF SURVEY RESPONSES

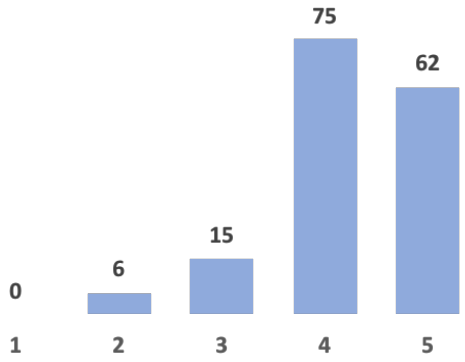
The majority of survey questions asked for scoring responses using Likert scales from 1 to 5. This option was chosen because of feed-back from the on-line survey conducted in 2013 which was felt to be too long and time-consuming by many stakeholders, and which consequently had low response rates and many incompletely filled questionnaires. More detailed and qualitative information was therefore sought in key informant interviews. Responses to the English, French and Spanish questionnaires were consolidated in a single database. For all Likert scales, the individual responses were treated as **ordinal data** and the **median** was therefore calculated as summary statistic.

GLOBAL LEADERSHIP

The survey respondents were asked to score the overall performance of HRP as a global leader in research, consensus building and the development of norms and standards for SRHR. 160 respondents answered this question, the great majority (84%) rating HRP leadership either as strong or very strong.

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*

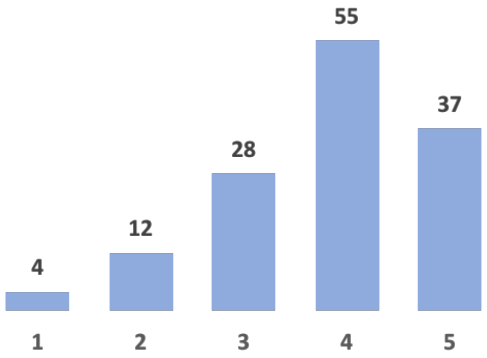


PRIORITY SETTING

The survey respondents were asked seven questions about the priorities of HRP's work and about the process of priority setting. This, and most subsequent questions, were answered by 165 respondents.

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

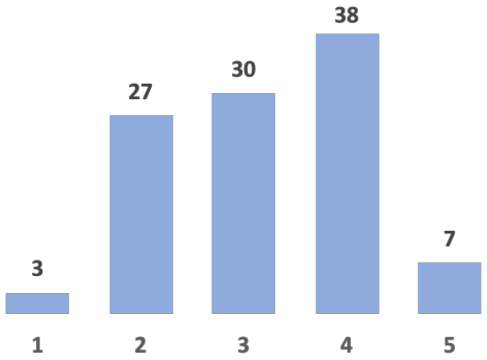
Priority setting	
1. Very weak	4
2. Weak	12
3. Neither weak nor strong	28
4. Strong	55
5. Very strong	37
Median Score	**4**
I don't know	*29*



While the mechanisms and processes of priority-setting were mostly considered to be strong or very strong (68%), country involvement and influence in priority-setting was judged to be weaker (43%).

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

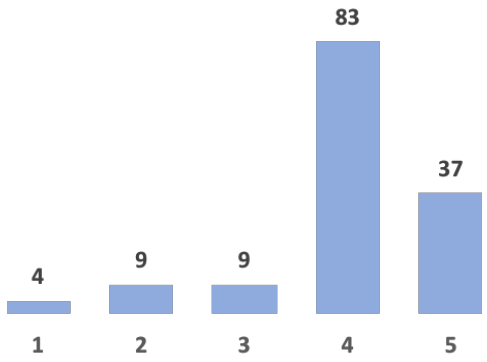
Programme country influence	
1. No influence	3
2. Weak influence	27
3. Neither weak nor strong	30
4. Strong influence	38
5. Decisive influence	7
Median Score	**3**
I don't know	*60*



As a follow-up, respondents were asked to rate HRP's priorities in the five work streams of research, evidence synthesis & consensus-building, research capacity-building, knowledge translation, and normative work.

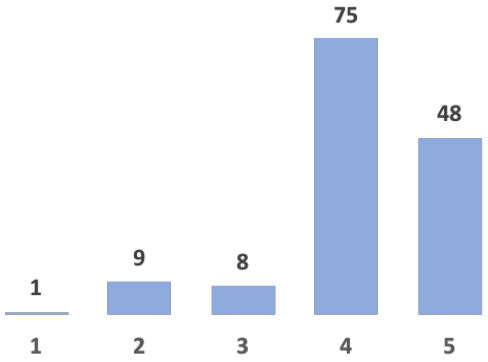
Did HRP-supported research focus on SRHR priorities in low- and middle-income countries? *(N=165)*

Research	
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*



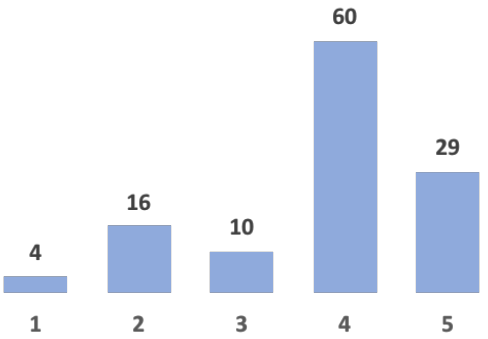
Did HRP's work of synthesising research evidence and building consensus focus on SRHR priorities in low- and middle-income countries? *(N=165)*

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*



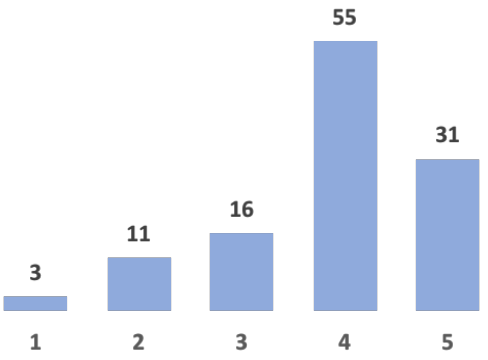
Did HRP's work in research capacity-building focus on SRHR priorities in low- and middle-income countries? *(N=165)*

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*



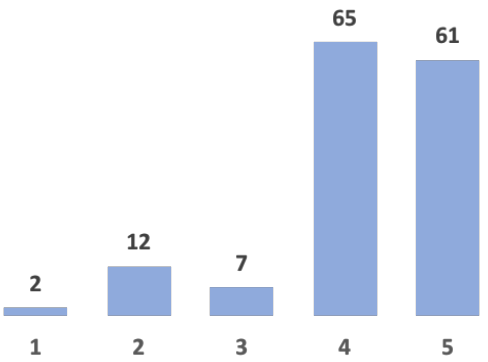
Did HRP's work in knowledge translation focus on SRHR priorities in low- and middle-income countries? *(N=165)*

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*



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

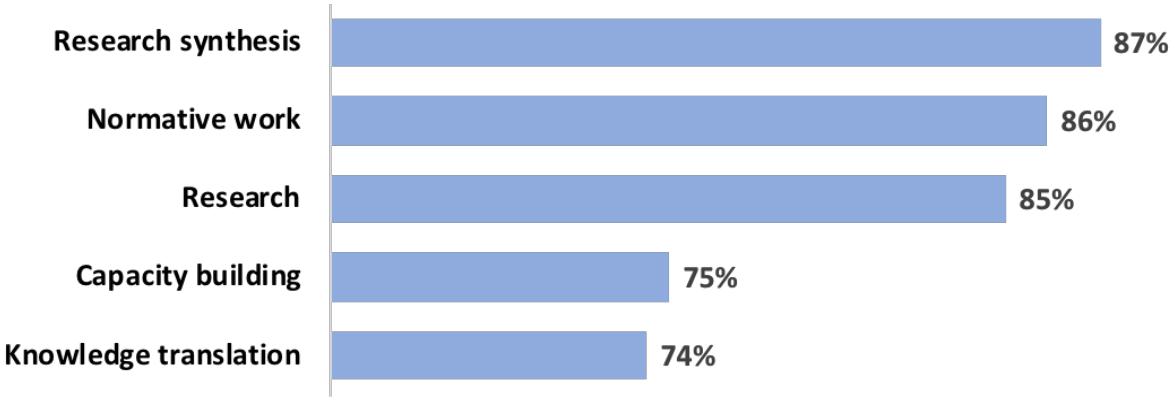
Normative work	
1. Only non-priorities	2
2. Mostly non-priorities	12
3. ½ priorities and ½ non-priorities	7
4. Mostly priorities	65
5. All work focused on priorities	61
Median Score	**4**
I don't know	*18*



Although the process of priority-setting and the priorities in all areas of HRP's work were strongly endorsed by the great majority of respondents, the opinions of where HRP has made the most

relevant contribution to SRHR were nuanced. This is illustrated by the proportions of respondents who selected 'all work focused on priorities' in response to questions in each of the five work areas.

Proportion of respondents who responded that HRP's work focused mostly or exclusively on SRHR priorities in low- and middle-income countries



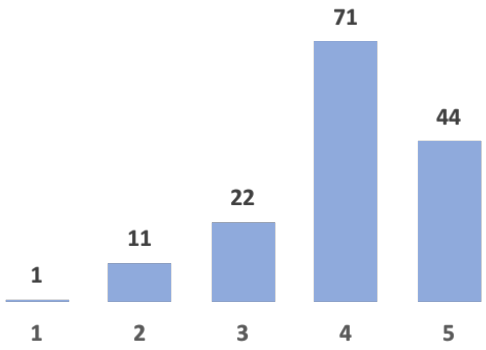
These responses indicate that the development of guidelines and other normative documents, as well as the synthesis of research evidence were seen as the most relevant products of HRP by the survey respondents.

Synthesis of Evidence and Consensus-building

The survey respondents were asked to answer a general question about the effectiveness of HRP in synthesising evidence and in convening experts to generate consensus on SRHR issues. Among them, 77% considered that the processes were usually or always effective. They were then asked to rate the importance of seven publications that resulted from systematic reviews or consensus-building processes. The publications were selected by purposive sampling to include documents that were published in different years of the evaluation period covering a range of thematic areas.

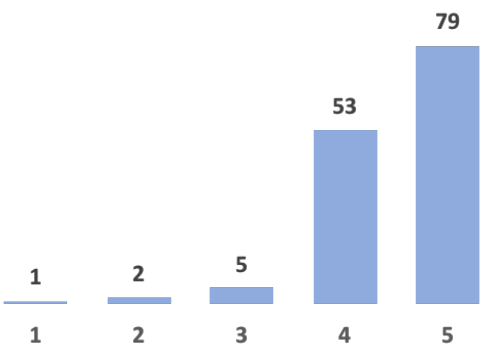
Respondents' ratings of processes for synthesising evidence *(N=165)*

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*



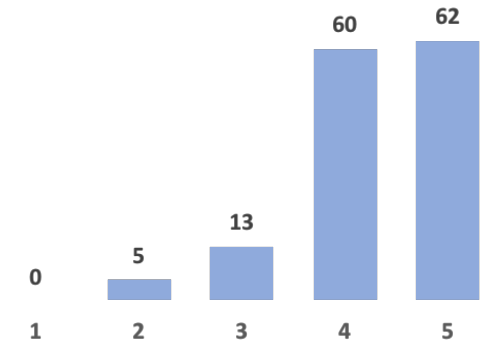
2014: Targets and strategies for ending preventable maternal mortality (WHO Statement) *(N=165)*

Maternal mortality strategies	
1. Not at all important	1
2. Slightly important	2
3. Moderately important	5
4. Very important	53
5. Extremely important	79
Median Score	**5**
I don't know this publication	*25*



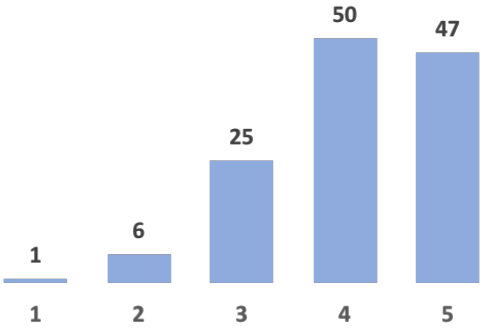
2014: The prevention and elimination of disrespect and abuse during facility-based childbirth (WHO Statement) *(N=165)*

Disrespect & abuse in childbirth	
1. Not at all important	0
2. Slightly important	5
3. Moderately important	13
4. Very important	60
5. Extremely important	62
Median Score	**4**
I don't know this publication	*25*



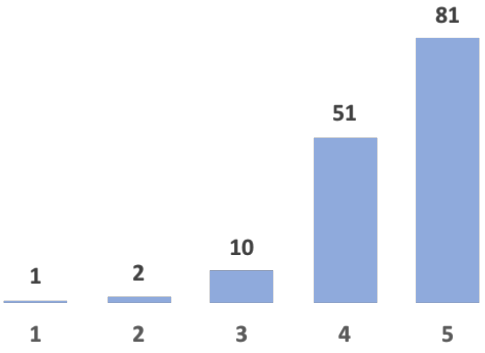
2015: The International Conference on Population and Development – special supplement (Journal of Adolescent Health Volume 56, Issue 1, Supplement, S1-S60, 2015) *(N=165)*

ICPD journal supplement	
1. Not at all important	1
2. Slightly important	6
3. Moderately important	25
4. Very important	50
5. Extremely important	47
Median Score	**4**
I don't know this publication	*36*



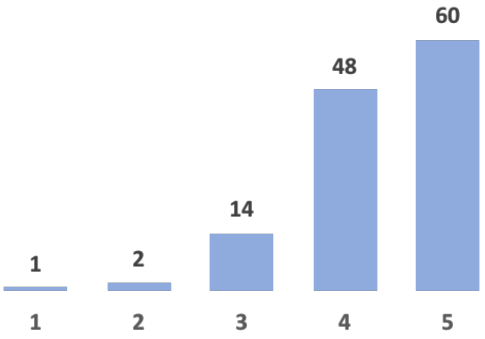
2016: Abortion incidence between 1990 and 2014: global, regional, and sub regional levels and trends (The Lancet 2016; 388: 258–67) *(N=165)*

ICPD journal supplement	
1. Not at all important	1
2. Slightly important	2
3. Moderately important	10
4. Very important	51
5. Extremely important	81
Median Score	**5**
I don't know this publication	*20*



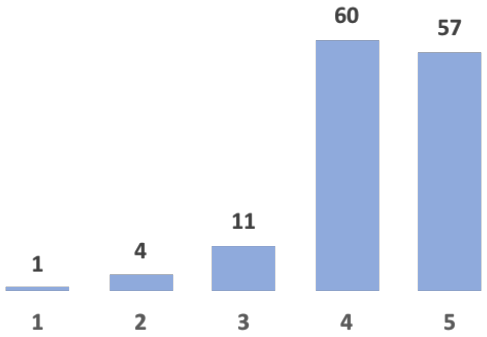
2017: Statement on maternal sepsis (WHO Statement) *(N=165)*

Maternal sepsis	
1. Not at all important	1
2. Slightly important	2
3. Moderately important	14
4. Very important	48
5. Extremely important	60
Median Score	**4**
I don't know this publication	*40*



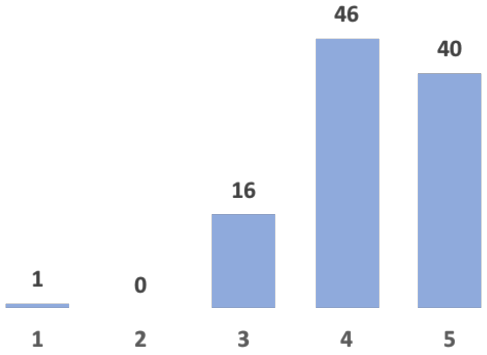
2017: Evidence Briefs on Family Planning (Set of 7 briefs) *(N=165)*

Family planning briefs	
1. Not at all important	1
2. Slightly important	4
3. Moderately important	11
4. Very important	60
5. Extremely important	57
Median Score	**4**
I don't know this publication	*32*



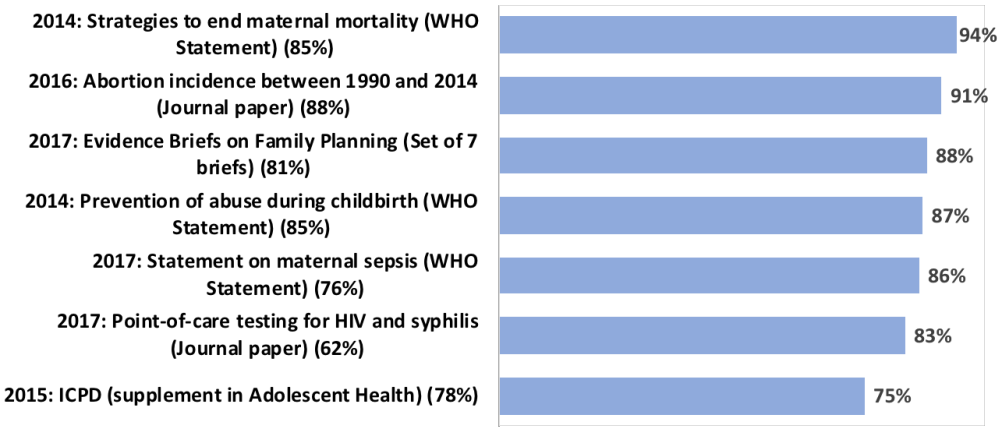
2017: A systematic review and meta-analysis of studies evaluating the performance and operational characteristics of dual point-of-care tests for HIV and syphilis (Sex Transm Infect, Online First: 26 July 2017) *(N=165)*

HIV/syphilis point-of-care tests	
1. Not at all important	1
2. Slightly important	0
3. Moderately important	16
4. Very important	46
5. Extremely important	40
Median Score	**4**
I don't know this publication	*62*



The publications were generally well known by the survey participants although there were differences. Two papers published in more specialised journals were generally less well known, such as the paper in *Sexually Transmitted Infections* (62% knowledge) and in the *Journal of Adolescent Health* (78% knowledge). In the following figure, the level of knowledge of the publication is indicated in brackets after the abbreviated title. The bars indicate the proportion of respondents who rated the publication as 'extremely important' among those who provided any rating. Overall, the values are high as are the median scores for each publication. The differences in scores among them should not lead to conclusions because each publication focuses on a distinct SRHR area.

Proportion of respondents who rated the publication as very or extremely important



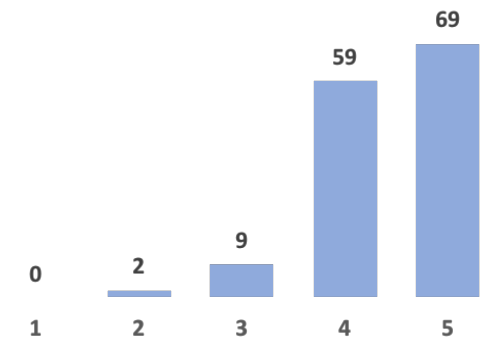
Norms and Guidelines

In order to assess the respondents' views about the work of HRP in generating or supporting the generation of WHO-endorsed normative documents, they were asked to rate the importance of eight

guidelines that were published between 2013 and 2017. The guidelines were selected by purposive sampling to include documents published in different years of the evaluation period covering a range of thematic areas.

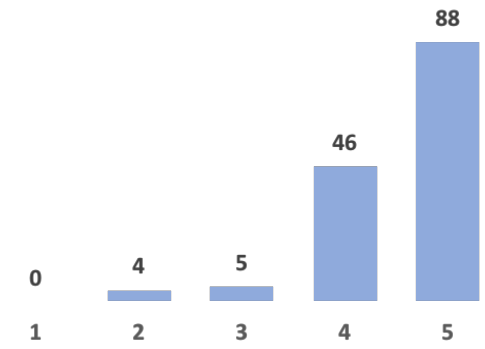
2013: Responding to intimate partner violence and sexual violence against women; clinical and policy guidelines *(N=165)*

Intimate partner violence	
1. Not at all important	0
2. Slightly important	2
3. Moderately important	9
4. Very important	59
5. Extremely important	69
Median Score	**4**
I don't know this publication	*26*



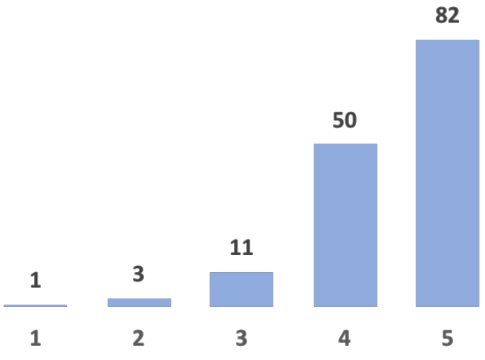
2014: Clinical practice handbook for safe abortion *(N=165)*

Safe abortion	
1. Not at all important	0
2. Slightly important	4
3. Moderately important	5
4. Very important	46
5. Extremely important	88
Median Score	**5**
I don't know this publication	*22*



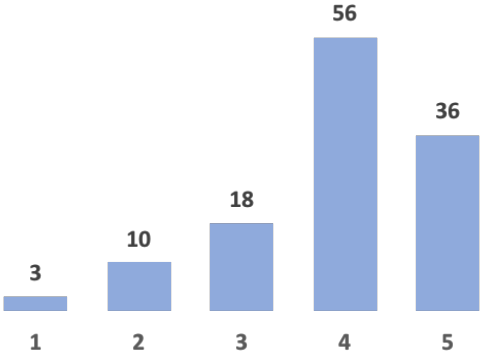
2015: Medical eligibility criteria for contraceptive use; Fifth Edition *(N=165)*

MEC for contraception	
1. Not at all important	1
2. Slightly important	3
3. Moderately important	11
4. Very important	50
5. Extremely important	82
Median Score	**5**
I don't know this publication	*18*



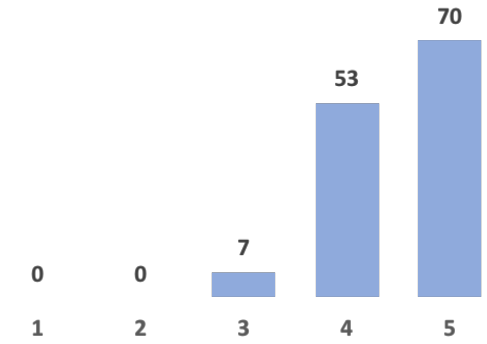
2015: Brief sexuality related communication. Recommendations for a public health approach *(N=165)*

Sexuality-related communication	
1. Not at all important	3
2. Slightly important	10
3. Moderately important	18
4. Very important	56
5. Extremely important	36
Median Score	**4**
I don't know this publication	*42*



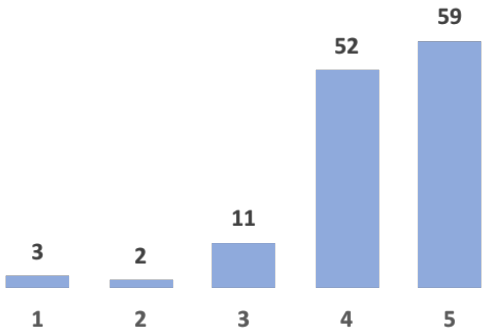
2016: WHO recommendations for prevention and treatment of maternal peripartum infections *(N=165)*

Peripartum infections	
1. Not at all important	0
2. Slightly important	0
3. Moderately important	7
4. Very important	53
5. Extremely important	70
Median Score	**5**
I don't know this publication	*35*



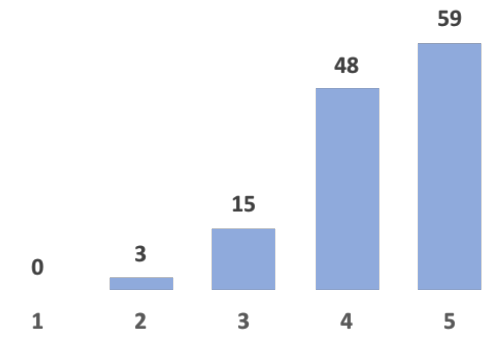
2016: WHO guidelines on the management of health complications from female genital mutilation *(N=165)*

Female genital mutilation	
1. Not at all important	3
2. Slightly important	2
3. Moderately important	11
4. Very important	52
5. Extremely important	59
Median Score	**4**
I don't know this publication	*38*



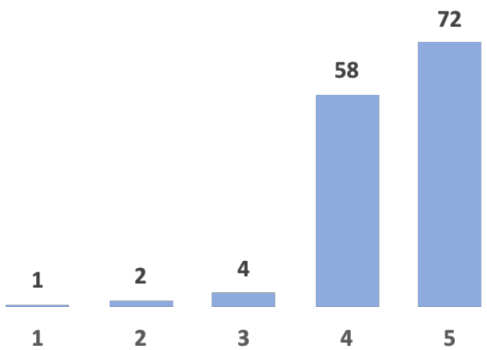
2016: Prevention of sexual transmission of Zika virus. Interim guidance *(N=165)*

Zika transmission	
1. Not at all important	0
2. Slightly important	3
3. Moderately important	15
4. Very important	48
5. Extremely important	59
Median Score	**4**
I don't know this publication	*40*



2017: Hormonal contraceptive eligibility for women at high risk of HIV *(N=165)*

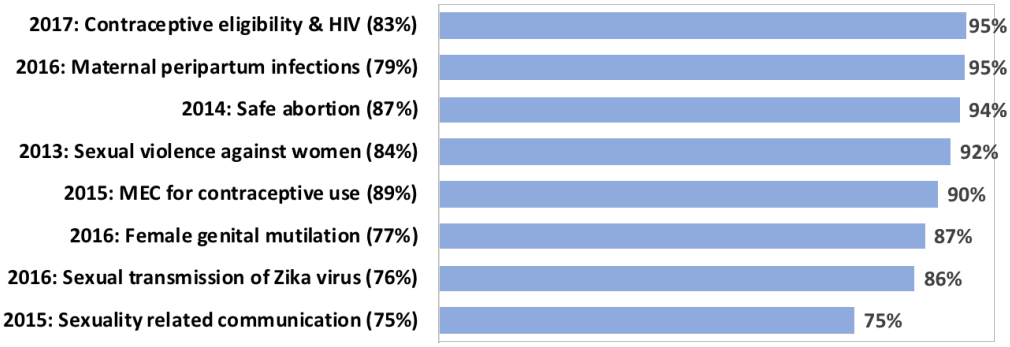
HIV contraceptive eligibility	
1. Not at all important	1
2. Slightly important	2
3. Moderately important	4
4. Very important	58
5. Extremely important	72
Median Score	**5**
I don't know this publication	*28*



Among the survey participants, 75 to 87 percent knew the guidelines and predominately rated them as 'very important' or 'extremely important', with median scores of 'extremely important' for four of the eight guidelines. In the following figure, the level of knowledge of each guideline is indicated in brackets after the abbreviated title. The bars indicate the proportion of respondents who rated it as

very or extremely important among those who provided any rating. The differences in scores among them should not lead to conclusions because each guideline focuses on a distinct SRHR area.

Proportion of respondents who rated the guidelines as very or extremely important

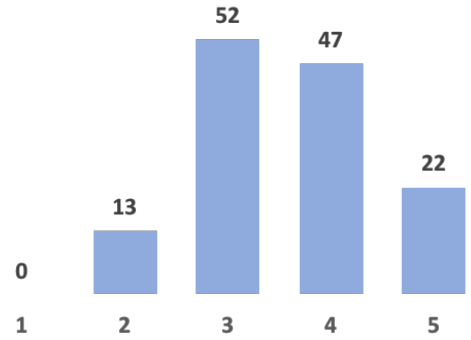


KNOWLEDGE TRANSLATION

To collect the respondents' views on HRP's performance in knowledge translation, they were asked to rate the level of influence that HRP has on shaping national SRHR policies. Slightly more than half (51%) rated the programme very influential or extremely influential.

Respondents' ratings of HRP influence in shaping national policies *(N=165)*

Priority setting	
1. Not at all influential	0
2. Slightly influential	13
3. Somewhat influential	52
4. Very influential	47
5. Extremely influential	22
Median Score	**4**
I don't know	*31*



Respondents were then asked to cite one example of a policy in one country that was developed or revised on the basis of information provided by HRP. 75 respondents cited examples of policy changes in 11 SRHR areas in 41 countries. Although the question specified 'low or middle-income countries', some countries with high income economies were included in the responses. Brazil was the most frequently mentioned country (5 times) and contraception policy was the most frequently cited policy area (20 times)

Policy changes by SRHR area cited by survey respondents *(N=75)*

Policy area	n
Contraception	20
Maternal Health	17
Abortion	16
Sexual Health	9
Cervical Cancer	4
Zika	3

Policy area	n
STI / HIV	2
Adolescent Health	1
Female Genital Mutilation	1
Infertility	1
Violence Against Women	1

Countries in which HRP influenced SRHR policies cited by survey respondents *(N=75)*

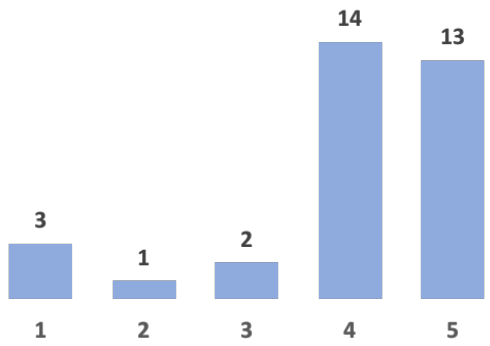
Country	n	Country	n	Country	n
Brazil	5	Mozambique	2	Guinea	1
El Salvador	4	Philippines	2	Iran	1
India	4	Thailand	2	Ireland	1
Kenya	4	Tunisia	2	Jamaica	1
Nigeria	4	Zimbabwe	2	Mongolia	1
Chile	3	Argentina	1	Moldova	1
South Africa	3	Bangladesh	1	Nepal	1
Uganda	3	Cambodia	1	Pakistan	1
UK	3	Chad	1	Peru	1
Colombia	2	China	1	PNG	1
France	2	Egypt	1	Tanzania	1
Honduras	2	Eritrea	1	Uruguay	1
Malawi	2	Ethiopia	1	Zambia	1
Mexico	2	Guatemala	1		

Support for Strengthening Research Capacity

The 33 respondents who completed this section rated the outcome of the HRP support they received and their satisfaction with the training provided.

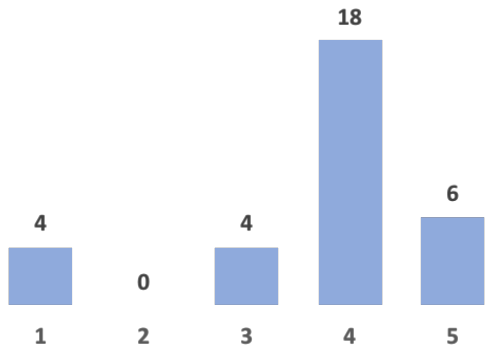
Did HRP contribute to strengthening the institutional research capacity? *(N=33)*

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*



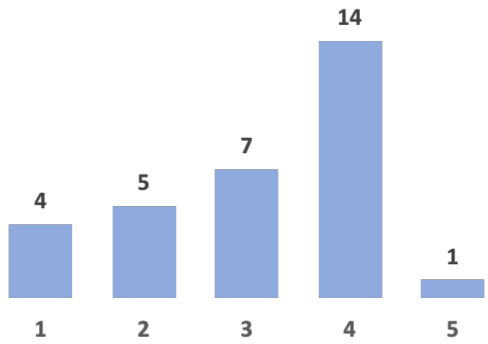
Did HRP contribute to strengthening the institutional capacity to influence decision-makers? *(N=33)*

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*



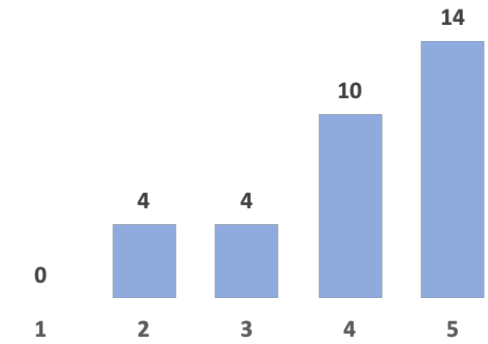
Did HRP contribute to strengthening the institutional fund-raising capacity *(N=33)*

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*



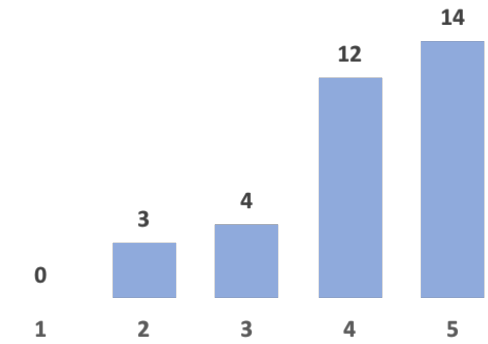
Did HRP contribute to strengthen your personal capacity to conduct research *(N=33)*

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*



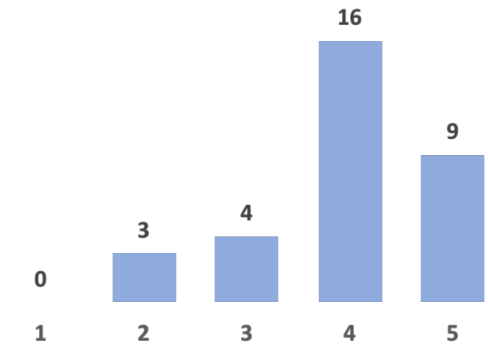
Did HRP contribute to strengthening the institutional and your personal networking capacity? *(N=33)*

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*



Satisfaction with institutional or personal capacity support *(N=33)*

Satisfaction	
1. Not at all satisfied	0
2. Slightly satisfied	3
3. Moderately satisfied	4
4. Very satisfied	16
5. Extremely satisfied	9
Median Score	**4**
I don't know	*1*



Communication and Advocacy

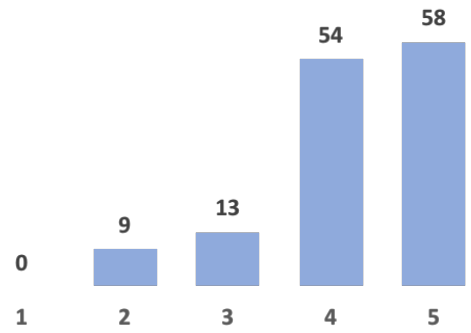
To collect the survey respondents' views about the effectiveness of HRP's performance in communicating its research findings and engaging with global partners, they were asked to signal their level of agreement with a statement about communications and advocacy tools, and then rate the importance of 11 channels

by which HRP communicates its activities and outputs. A total of 160 respondents answered this section of the questionnaire.

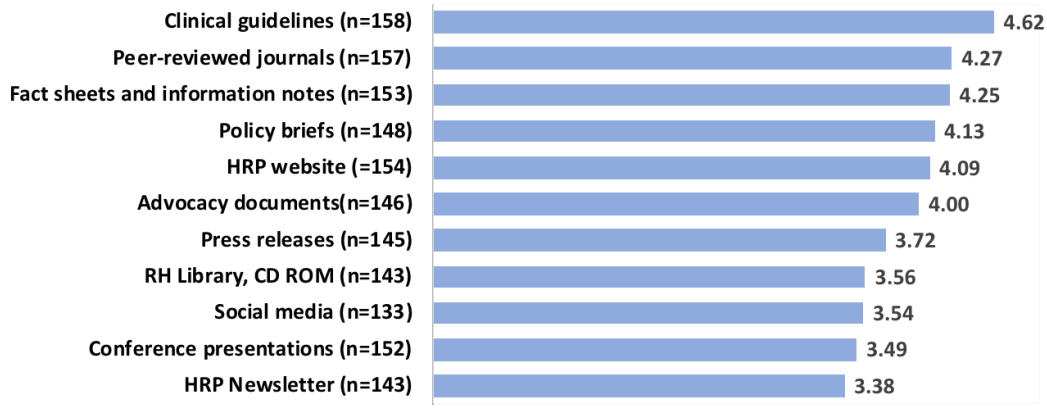
Like most of the questionnaire, the questions for rating the 11 communication channels asked for responses on 5-point Likert scales ranging from 'not at all important' to 'extremely important'. Although this methodology provides **ordinal data** for each channel, they were treated as **interval data** by calculating **mean** rather than **median** scores in order to a allow a ranking of the channels by perceived level of importance.

Respondent's agreement with the statement: "HRP adopted and used effective communication and advocacy tools for mobilising and engaging with global SRHR partners, including through social media." *(N=160)*

Agreement	
1. Disagree	0
2. Somewhat disagree	9
3. Neither agree nor disagree	13
4. Somewhat agree	54
5. Agree	58
Median Score	**4**
I don't know	*26*



Rating of the relative importance of different HRP communication channels ranging from 1 (not at all important) to 5 (extremely important)



GOVERNANCE AND FINANCING

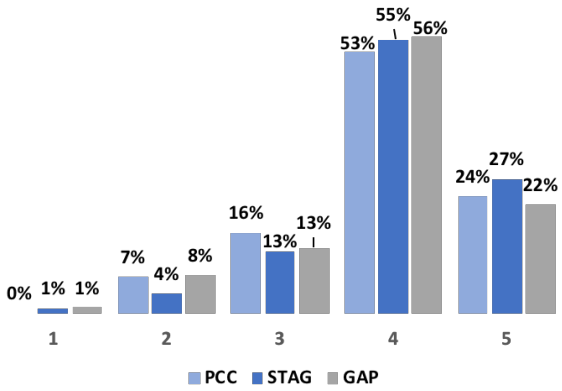
Respondents were asked about their perception of the effectiveness of the HRP governance committees (PCC, STAG and GAP), about their views on the political and financial commitment to HRP by the five co-sponsoring agencies (UNDP, UNFPA, UNICEF, WHO and World Bank) and about the effectiveness of fund-raising by HRP.

Although 160 respondents completed this section of the questionnaire, knowledge about the governance committees was considerably lower, with only 110 providing scores for the PCC, 97 for the STAG and 91 for the GAP. This is in line with the profile of the respondents. Among them, 106 had indicated experience as PCC delegates, observers or members of technical committee members (see above). Among those who provided a score, the assessment of effectiveness of the three committees was approximately equal with median scores of 'usually effective' for all three committees.

Knowledge about co-sponsor engagement and financing of HRP was also low with only 92 and 94 respondents providing scores to answer each question respectively.

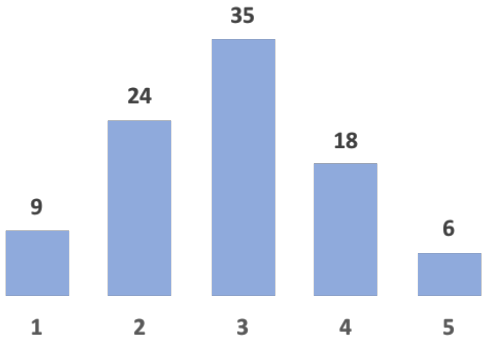
Proportion of respondent scores of the effectiveness of HRP governance committees *(N=160)*

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%*



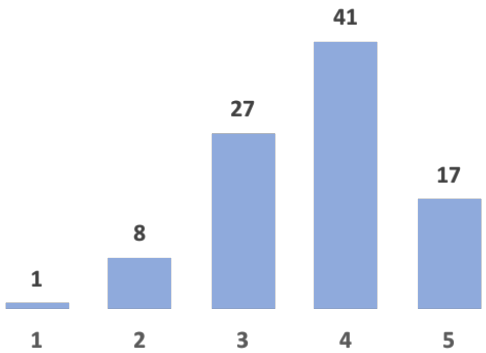
Respondent views of the political and financial support of HRP by its co-sponsors (N=160)

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*



Fund-raising effectiveness of HRP since 2013 *(N=160)*

Fund-raising effectiveness	
1. Totally ineffective	1
2. Somewhat ineffective	8
3. Moderately effective	27
4. Usually effective	41
5. Very effective	17
Median Score	**4**
I don't know	*66*



COMPARISON WITH THE RESULTS OF THE 2013 ON-LINE SURVEY

An on-line survey was conducted in 2013 for the 2008-2012 evaluation of HRP. It was more extensive than the 2018 survey with a total of 65 questions including Likert scales and many questions asking for narrative responses. The 2018 survey had only 29 questions without any questions asking for text responses. According to the team leader of the 2013 evaluation, the survey received many comments that the questionnaire was too long and time-consuming. This was the main reason why it was greatly reduced in 2018. Against expectation, however, the response rate did not improve. It was, in fact, lower than in 2013. However, in 2018 a greater proportion of respondents completed the questionnaire until the last question.

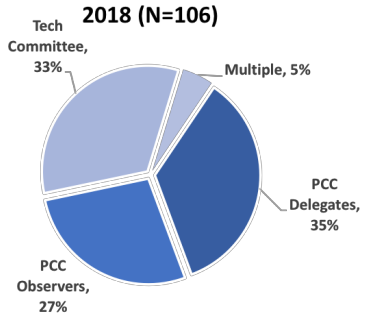
The response database for the 2013 questionnaire was unfortunately no longer available and a comparison of responses therefore had to rely only on the PDF printouts generated by the SurveyMonkey

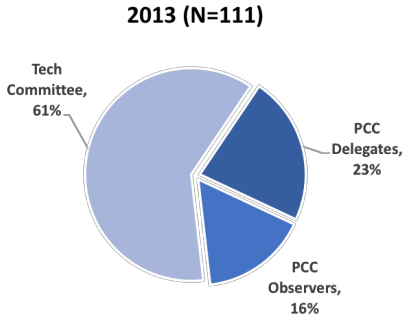
programme that did not include the narrative responses, nor was it possible to analyse survey responses by types of respondents.

In 2013, a total of 416 stakeholders were invited to participate in the survey and 166 full or partial responses were received for a response rate of 40 percent. The number of responses was therefore equal to the 2018 survey (165 completed surveys) although the effective response rate in 2018 was only 28 percent.

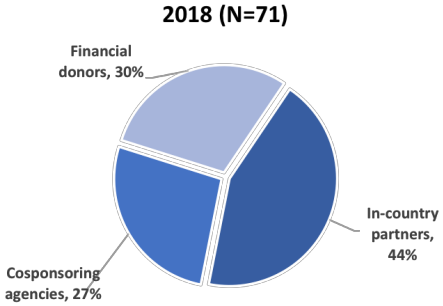
Comparing the profile of respondents between the two surveys was difficult because the database for 2013 was not available for analysis. To the extent that it could be reconstructed, the profiles were quite similar. About one third of respondents in both surveys had participated in one of the governance or technical committees of HRP, although the technical committee members (STAG, GAP, RP2) were much more prominently represented in the 2013 survey. For those whose institutional affiliation could be aligned between the surveys, almost half were in-country partners (governments and research partners in low- and middle-income countries) in both surveys. There was a stronger representation of financial donors to HRP in the 2018 survey. This comparison should, however, be interpreted with caution because the questions were asked in different form in each of the two surveys.

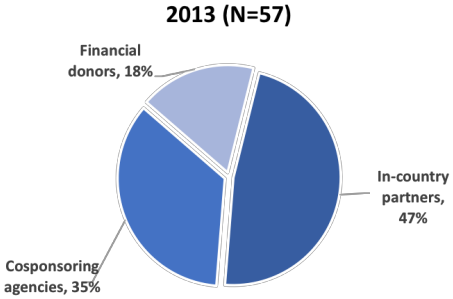
Profile of respondents who had participated in a technical or governance committee of HRP:





Institutional affiliation of respondents that could be compared between the two surveys:





Likert scales from 1 to 5 were used for almost all questions in the 2018 survey and for a large number of questions in 2013. But a direct comparison of results should be interpreted with great caution because neither the wording of the questions nor the labels for the scale values were identical.

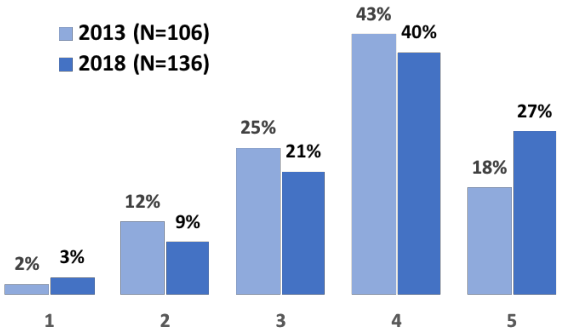
Juxtaposed statistics for responses to questions that are comparable in content are nevertheless presented. Each is scored on a scale from one (very low, very weak, very ineffective, etc.) to five (very high, very strong, very effective, etc.).

PRIORITY SETTING

2013: Does HRP have sufficiently strong mechanisms to determine its own research priorities?

2018: How do you rate the mechanisms and processes used by HRP to determine research priorities?

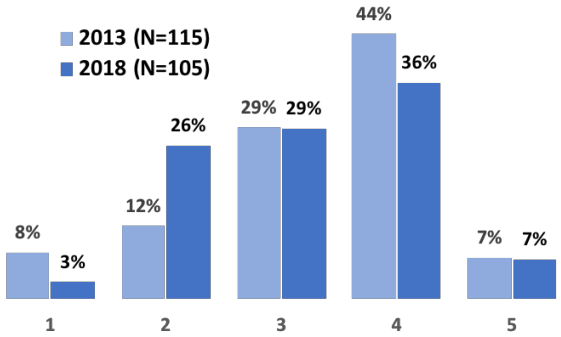
(from were weak to very strong)



2013: Do programme countries have a sufficient voice in HRP's priority setting?

2018: To what extent are programme countries involved in the HRP priority setting process?

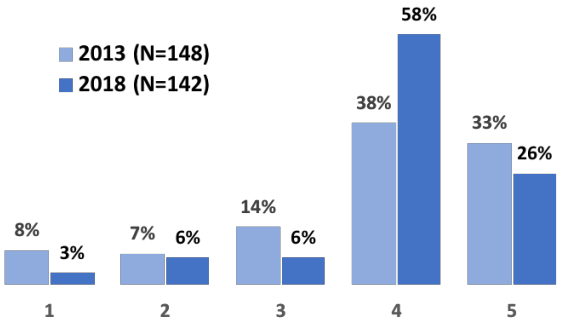
(from 'not at all' to 'very much')



2013: Do the research priorities and programmes supported by HRP address SRH issues most likely to assist programme countries to achieve MDG targets?

2018: To what extent has HRP research focused on the main priority issues that affect the sexual and reproductive health and rights of people in low- and middle-income countries?

(from 'not at all' to 'very much')



The comparison of the two survey results suggest:

- The HRP mechanisms for research priority setting are perceived to have strengthened. The perceptions of 'strong' or 'very strong' increased from 61 percent in 2013 to 67 percent in 2018.
- The voice of programme countries in priority-setting has weakened according to respondents' perceptions. The ratings for programme country having much or very much influence decreased from 51 percent in 2013 to 43 percent in 2018.
- The research priorities are perceived to be better aligned with country needs and priorities, although the questions in the two surveys differ significantly. Nevertheless, there is a suggestion that the perception of a high or very high level of alignment increased from 71 percent in 2013 to 84 percent in 2018.

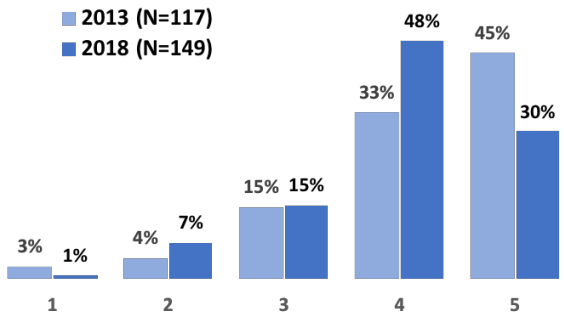
SYNTHESIS OF EVIDENCE AND CONSENSUS-BUILDING

The questions about the effectiveness of HRP's work in synthesising evidence and building consensus were almost identical in the two surveys. Differences in the responses were only nuanced with 78 percent of respondents in both surveys rating the HRP's work as effective or very effective.

2013: How effective is HRP in convening groups of technical experts to develop consensus guidance on various SRH issues?

2018: How effective is HRP in convening groups of technical experts to synthesise and promote consensus on SRHR issues?

(from not effective to very effective)



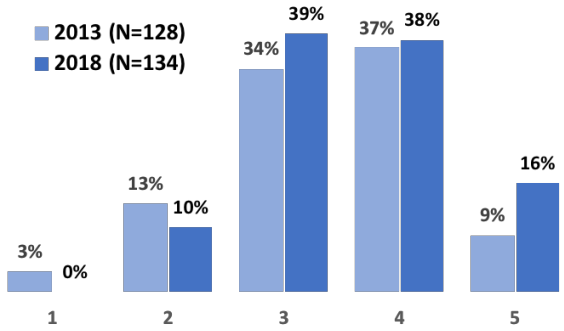
KNOWLEDGE TRANSLATION

The questions about the influence of HRP on the national SRHR dialogue and on national policies differed as in 2013 the respondents were asked about the impact (ranging from 'no impact' to 'large impact') and in 2018 about influence (ranging from 'not influential' to 'extremely influential'). Nevertheless, the responses are comparable and suggest that perceptions about HRP's influence on national policies had increased with 46 percent rating the impact in the two highest categories in 2013 and 54 percent rating HRP is being very influential or extremely influential in 2018.

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

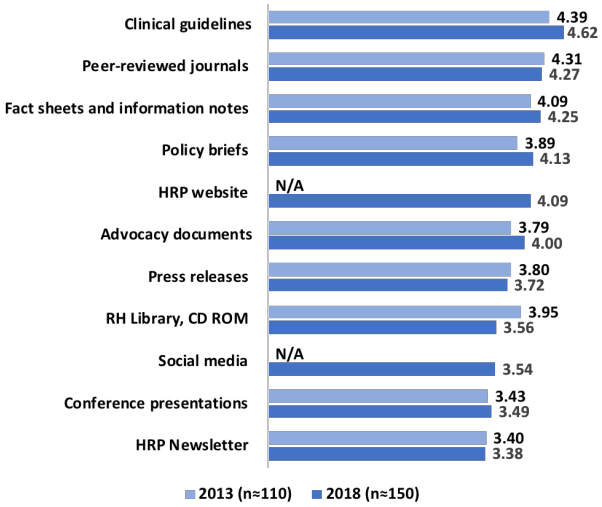
2018: How much influence does HRP have on shaping national policies on SRHR in low- and middle-income countries?

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



COMMUNICATION

The perceived importance of the HRP communications tools and products were surveyed in both evaluations. Respondents were asked to grade them on scales of one (not important) to five (extremely important). Social media and the HRP website were not included in the 2013 survey. On average, approximately 110 respondents scored the different products in 2013 and 150 in 2018. There were only minor changes in the perceived importance of individual products and none in the relative ratings except for a significant decrease in the rating of the RH Library/CD ROM.



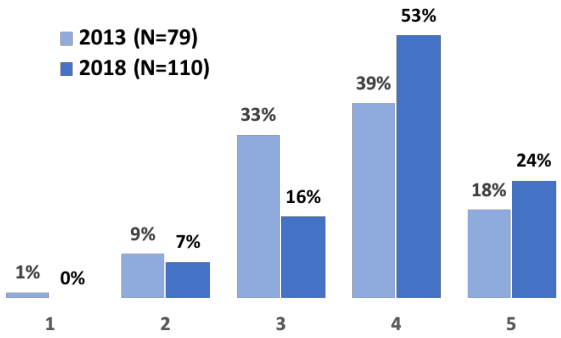
GOVERNANCE

Questions about the effectiveness of the governance and technical committees of the HRP were not answered by all respondents which is understandable as only 106/166 respondents in 2013 had experience as members, delegates or observers in one of these committees, and only 111/165 in 2018. The perceptions about the effectiveness of all three committees increased between surveys. In 2013 the PCC was rated in the top two categories of the effectiveness scale by 57 percent of respondents, the STAG by 73 percent and the GAP also by 73 percent. In 2018, ratings for 'usually effective' and 'always very effective' combined for the PCC were 77 percent, for the STAG 82 percent and for the GAP 78 percent.

2013: How effective is the PCC in performing its functions?

2018: How effective is the PCC in steering the Programme?

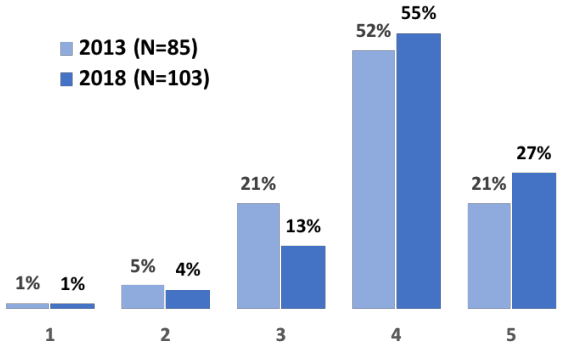
(from ineffective / totally ineffective to highly effective / always very effective)



2013: How effective is the STAG in performing its functions?

2018: How effective is the STAG in steering the Programme?

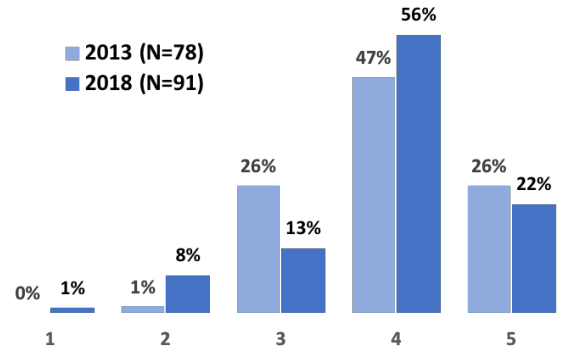
(from ineffective / totally ineffective to highly effective / always very effective)



2013: How effective is the GAP in performing its functions?

2018: How effective is the GAP in steering the Programme?

(from ineffective / totally ineffective to highly effective / always very effective)



LIMITATIONS OF THE COMPARISON OF TWO SURVEYS

The main limitations were already mentioned in the introduction. The profile of the survey respondents is not identical and sub-sample analyses among similar respondents could not be done as the databased for the 2013 survey was not available. The formulation of the questions also differed as well as the rating scales. While the 2013 survey only defined the endpoints of the Likert scales and asked respondents to score in relation to these two endpoints, the 2018 survey provided definitions for each of the five scale points based on the content of the question.

3. CLASSIFICATION OF RESEARCH EXPENDITURES

Based on the budget line label, research expenditures in the three biennia between 2012 and 2017 were categorised into four research categories:

A. **Formative research** comprising 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** to develop strategies and solutions to increase the access and the use of evidence-based health interventions by populations in need. 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** 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** including 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.

A number of research expenditures could not be categorised, and categorisation is in any case approximative as the budget labels are not informative enough to allow an exact categorisation. In few cases, additional information was readily available and used.

FORMATIVE STUDIES:

Biennium	Budget label (classified as formative research)	Expenditure
2012-13	086HI Generating evidence on the impact of laws and policies on different aspects of sexual and reproductive health	3,677
2012-13	087HV Develop and disseminate evidence contributing to the elimination of FGM	219,474
2012-13	093HV Generation and use of evidence on women's health and violence	40,260
2012-13	097HE Generating evidence and policy positions on VAW in conflict settings	162,226
2012-13	100HE Generating evidence on priority policy and programmatic issues for adolescents through supporting implementation of relevant research	8,551
2012-13	047aHE Neonatal Morbidity Research	119,465
2012-13	119HV Increased understanding of health system strengthening/health sector reforms' effects on sexual and reproductive health and HIV/AIDS policy and programmes	86,369
2012-13	120HE Increased understanding of the impact of improved reproductive health on poverty reduction	12,698
2014-15	314H2-B29 Implementation and social science research around recommendations in the WHO safe abortion guidelines	73,979
2014-15	314H2-C5R1 Contribution to improved understanding of sexual development and gender socialisation in early adolescence, and its influence on relationship formation and sexual behaviours in later adolescence	202,715
2014-15	314H2 Building evidence on effective interventions to address violence against women	13,033

Biennium	Budget label (classified as formative research)	Expenditure
2014-15	314H2 Building evidence for contributing to the elimination of harmful practices including FGM and management of consequences	162,517
2014-15	314H2 Modelling research to provide evidence for promising STI control strategies	49,191
2014-15	314H2 Identifying emerging public health issues in MPH: review literature, identify knowledge gaps, conduct systematic reviews as needed particularly in the areas of noncommunicable diseases	219,441
2016-17	316H1 Identify and prioritize key research in second trimester medical/surgical abortion and develop a clinical protocol for research	21,901
2016-17	316H1 Qualitative study: Qualitative research on women's reproductive and psychosocial health in the context of Zika virus	298,277
2016-17	316H1 Adolescent Health Experience after Abortion or Delivery Study (AHEAD)	67,111
2016-17	316H1 Violence against women	49,574
2016-17	316H1 Access to SRHR for adolescents in humanitarian settings	54,342
2016-17	316H1 Maternal and Perinatal Health related ZIKV outbreak	51,503
	Total	**1,916,304**

IMPLEMENTATION RESEARCH

Biennium	Budget label (classified as implementation research)	Expenditures
2012-13	072HV Implementation research to expand access to medical abortion	2,287,220
2012-13	078HE Implementation research on mid-level provision of safe abortion care	7,000
2012-13	091HI Operations research on the implementation of a comprehensive sexuality curriculum	1,715
2012-13	092HV Implementation research to address violence against women (VAW) in antenatal care	576,797
2012-13	012HE Research on impact of assessment tools for national scale-up of integrated services in SRH/HIV linkages	7,615
2012-13	013HV Operational research on postpartum care and SRH/HIV linkages	103,958
2012-13	046HV Country research focus: policies to improve maternal and newborn health	100,855
2012-13	048HV Implementation research on maternal and perinatal health	35,531
2012-13	049HV Implementation research: integrated antenatal care	937,331
2012-13	027HE Development of methods for the integration of FP and infertility services into various settings	82,752
2012-13	028HI Implementation research on evaluating and improving the delivery and impact of family planning guidance and tools into national policies and programmes	285,704
2012-13	017HV Overcoming barriers to family planning use through social science and operations research on users' perspectives	43,062
2012-13	143HV Implementation Research	780,452
2012-13	144bHE Guideline adaptation and implementation studies	38,148
2012-13	082aHV Evaluation of the Mother Baby 7 day mCheck tool	105,399
2012-13	059HV Impact evaluation of interventions aiming at eliminating congenital syphilis	751,488
2012-13	060HI Operations research to identify best strategies and practices to strengthen sexual and reproductive health programmes	24,500
2012-13	061HV Research to support and improve programmes and interventions for prevention and control of cervical cancer	552,249

Biennium	Budget label (classified as implementation research)	Expenditures
2014-15	314H2 Combining - Intervention study to evaluate the effectiveness of combining interventions to prevent pregnancy and STIs in adolescents	342,559
2014-15	314H2 Evaluations of initiatives/programmes to expand sexual and reproductive health education and services for adolescents	377,646
2014-15	314H2 Research study to develop and test mHealth intervention for one African and one Asian population, targeted at increasing young people's access to, and use of, adolescent sexual and reproductive health services	1,170,648
2014-15	314H2 Study on addressing violence against women in pregnancy in South Africa and Mozambique	672,333
2014-15	314H3 Improving the implementation and monitoring of effective sexual and reproductive health interventions and human rights especially for adolescents and other vulnerable/at risk populations	505,028
2014-15	314H2 Implementation research on post abortion and postpartum family planning (UPTAKE)	1,160,032
2014-15	314H2 Linking the Blue Star social franchise with demand-side financing to improve poor women's access to reproductive health services. Project in Eastern Visayas in the Philippines	116,740
2014-15	314H2 Comparative impact evaluation: demand-side financing (Voucher scheme) for increasing demand and utilisation of birth spacing in Punjab Province, Pakistan	190,160
2014-15	314H2 Advancing STI prevention through new evidence-based behaviour-change interventions. Implementation research on new evidence-based short (30 minutes) and intensive (up to nine hours) behaviour-change interventions	27,715
2014-15	314H2 Development and evaluation of innovative approaches to increase utilisation of magnesium sulphate for pre-eclampsia and eclampsia	48,661
2014-15	314H2 Evaluate an implementation strategy for an integrated quality antenatal care package	847,211
2014-15	314H2 Implementation research in maternal and newborn health	145,262
2016-17	316H1 Develop and evaluate innovative approaches to decentralising access to safe abortion via task shifting	49,027
2016-17	316H1 Intervention study to evaluate the effectiveness of combination interventions to prevent pregnancy and STIs in adolescents	1,121
2016-17	316H1 Adolescent/Youth Reproductive Mobile Access and Delivery Initiative for Love and Life Outcomes (ARMADILLO)	439,844
2016-17	316H1 Operations and implementation research to address violence against women	299,578
2016-17	316H1 Multicountry study to address intimate partner violence against women in health-care settings	964
2016-17	316H1 Study on addressing violence against women in pregnancy in South Africa	60,324
2016-17	316H1 Building evidence on interventions to address gender-unequal norms and their impact on sexual and reproductive health and HIV outcomes (Gender norms research)	5,316
2016-17	316H1 Electronic tools to assess and report on the quality of sexual and reproductive health services for adolescents	56,377
2016-17	316H1 Research on how demand-side financial incentive model functions in different settings in improving contraceptive outcomes	23,012
2016-17	316H1 Implementation research in family planning (UPTAKE)	1,041,295
2016-17	316H1 Research on new evidence-based behaviour-change interventions to advance STI prevention	454,778
2016-17	316H1 Zika Health System Strengthening	486,271

Biennium	Budget label (classified as implementation research)	Expenditures
2016-17	316H1 Exploring modern contraceptive method use, continuation, switching and change in fertility behaviour among the underserved women - an 18-month post-voucher intervention follow-up assessment in Punjab, Pakistan	110,618
2016-17	316H1 Quality of care research: Implementation research conducted to scale up companion of choice during childbirth	93,683
2016-17	316H1 Quality of care research: Evaluation of an implementation strategy for an integrated quality antenatal care package in Mozambique	412,995
2016-17	316H1 (STEPMAG) Development and evaluation of innovative approaches to increase the utilisation of magnesium sulphate for pre-eclampsia and eclampsia	127,571
	Total	**15,988,545**

NORMATIVE RESEARCH

Biennium	Budget label (classified as normative research incl. monitoring & indicators)	Expenditures
2012-13	074HV Clinical research to expand the knowledge base on medical abortion regimens	64,548
2012-13	077HE Research to improve adjuvant clinical procedures in relation to safe abortion care	69,268
2012-13	038HV Hypertension in pregnancy (prediction research)	138,338
2012-13	039HE Hypertension in pregnancy (treatment research)	92,476
2012-13	040HV Hypertension in pregnancy (prevention research)	283,582
2012-13	041aHV Research to improve perinatal health, including research to develop foetal growth standards and preterm birth genetics	992,655
2012-13	041bHV Research to improve perinatal health, including research to develop foetal growth standards and preterm birth genetics	173,649
2012-13	020HV Research on the safety and efficacy of existing methods of contraception. Longitudinal studies of the safety and efficacy of hormonal contraceptive methods for women	219,556
2012-13	082HV Determining the impact of an mHeath system on reproductive health outcomes	318,144
2014-15	314H2 Clinical research on priority questions such as pain relief during medical abortion and techniques for high-risk groups	288,613
2014-15	314 H2 ECHO 2 trial - A randomised controlled trial comparing efficacy, safety, adverse effects, and acceptance of the intrauterine device and progesterone contraception	963,700
2014-15	314H2 Research to increase safe access to infertility interventions in low-resource settings: 1) Affordable IVF laboratory components and clinical protocols 2) Infertility interventions to achieve zero sexual and perinatal	8,660
2014-15	314H2 Development of assessment tool for the integration of infertility into sexual and reproductive health services	187,075
2014-15	314H2 Strengthening cervical cancer control programme - introduction of new screening/testing algorithms (planned)	1,279,799
2014-15	314H2 Ebola Survivals Study	390,246
2014-15	314H2 Placental angiogenic factors to predict pre-eclampsia: additional analysis	45,561
2014-15	314H2 Multicentre foetal growth study for development of foetal growth standards for international application	278,166
2014-15	314H2 Assessment of antenatal and intrapartum events and their role in early child development. Follow-up study of infants born to mothers with severe morbidity up to two years to assess their neurocognitive development in	24,721

Biennium	Budget label (classified as normative research incl. monitoring & indicators)	Expenditures
2014-15	314H2 Prevention and management of obstetric fistula: complete the multicentre RCT to evaluate the effectiveness of short-term urinary bladder catheterization following simple fistula repair	38,542
2014-15	314H2 Strategies for Better Outcomes in Labour Difficulty (BOLD/ Intrapartum Care): Research for developing an intrapartum care monitoring-to-action tool (SELMA), community antenatal/intrapartum-care tool	1,875,551
2014-15	314H2 Research for improving management of second stage of labour (GAP trial): Evaluation of the safety and effectiveness of gentle assisted pushing during second stage of labour	484,570
2016-17	316H1 Clinical research to determine optimal management of second trimester miscarriage and pregnancy termination	253,680
2016-17	316H1 Assess the burden, severity, safety and pathways to care seeking for women presenting with abortion complications at secondary and tertiary care facilities (WHOMCS-A)	2,523,838
2016-17	316H1 Development of mixed methods approaches and tools to determine population-based incidence and safety of abortion	109,590
2016-17	316H1 Expanding the evidence base on abortion safety through secondary data analysis and systematic reviews, including on abortion incidence and associated morbidity and mortality	3,869
2016-17	316H1 Global Early Adolescent Study (GEAS)	589,764
2016-17	316H1 Technologies for Health Registries, Information, and Vital Events (THRIVE)	714,477
2016-17	316H1 Building evidence contributing to the elimination of harmful practices including female genital mutilation (FGM) and management of consequences	476,511
2016-17	316H1 Research on the impact of laws and policies on the realisation of sexual and reproductive health and rights	143,671
2016-17	316H1 Clinical trial on breastfeeding and use of combined oral contraceptives	127,151
2016-17	316H1 ECHO trial - A randomised controlled trial comparing efficacy, safety, adverse effects, and acceptance of the intrauterine device and progesterone contraception (DMPA and LNG Implant)	2,558,114
2016-17	316H1 Strengthen the knowledge and evidence base of AMR through surveillance and research. Research to improve diagnostic testing for N. gonorrhoea resistance contributing to strengthening antimicrobial resistance	56,662
2016-17	316H1 Risk of STI with the use of non-barrier contraception	23,204
2016-17	316H1 Research to improve methods for STIs estimates	76,827
2016-17	316H1 Research to validate STI case management algorithms	30,710
2016-17	316H3 Validation of elimination of mother to child transmission of syphilis & HIV	274,851
2016-17	316H1 Ebola survivals study	641,945
2016-17	316H1 Zika Sexual Transmission	568,861
2016-17	316H1 Quality of care research: Development and validation study of a tool to measure the mistreatment of women around childbirth in 4 countries	58,716
2016-17	316H1 Quality of care research: Better Outcomes in Labour Difficulty to develop new labour algorithm and barriers to quality childbirth care identified (BOLD)	434,978
2016-17	316H1 Quality of care research: Research for improving management of second stage of labour: Gentle Assisted Pushing trial (GAP)	20,971
2016-17	316H1 Multicentre trial of pre-conception calcium supplementation to reduce preeclampsia and other adverse pregnancy outcomes	123,465
2016-17	316H1 Research conducted to develop and validate simplified criteria for maternal near miss	504
2016-17	316H1 Indirect causes of maternal mortality research	17,243

Biennium	Budget label (classified as normative research incl. monitoring & indicators)	Expenditures
2016-17	316H1 ACS trial	4,828,703
2016-17	316H1 Maternal Sepsis	1,112,677
	Total	**23,988,402**

INNOVATION RESEARCH

Biennium	Budget label (classified as innovation research)	Expenditures
2012-13	043aHV Labour, delivery and postpartum care - Obstructed labour - New technologies	470,931
2012-13	023HV Development of new and improved user-controlled methods of fertility regulation for women	420,078
2012-13	024HV Development of fertility regulation methods for men, in order to widen the range of family planning products and technologies through the development of new methods of contraception	276,229
2012-13	026HV Research and development of methods to assist diagnosis, early (pre-conception) and late management and treatment of infertility	325,812
2014-15	314H3 MHealth innovations to monitor and improve coverage and effectiveness of sexual and reproductive health especially for vulnerable populations	971,040
2014-15	314H2 Basic science research for new contraceptive methods	60,863
2014-15	314H2 Phase II trial of combined progestin and androgen male contraceptive	54,892
2014-15	314H2 Trial of oral 1.5 mg levonorgestrel as pericoital contraception	32,943
2014-15	314H2 Trial of implantable hormonal contraceptives Jadelle and Implanon	24,879
2014-15	314H2 Multipurpose prevention technologies: long-acting reversible contraception with Nano-particle-based anti-HIV activity	417,347
2014-15	314H2 Multipurpose prevention technologies: development of a Levonorgestrel/Tenofovir intravaginal ring for the prevention of HIV acquisition and unintended pregnancies	184,404
2014-15	314H2 Research to accelerate development of STI diagnostics	309,029
2014-15	314H2 Multicentre RCT of pre-conceptional calcium supplementation to prevent pre-eclampsia and other adverse pregnancy outcomes	103,487
2014-15	314H2 Assessment of clinical effectiveness of heat-stable carbetocin and heat exposure of oxytocin in drug supply chain	5,590,104
2014-15	314H2 Phase I and phase II trials of Odon device evaluation implemented in multiple research sites in collaborating institutions	7,649
2016-17	316H1 Research on pericoital or on-demand contraception	71,230
2016-17	316H1 Research to accelerate development of STI diagnostics	452,974
2016-17	316H1 Research on STI vaccines efficacy and development	37,010
2016-17	316H1 Research on cervical cancer and human papilloma virus vaccines	493,608
2016-17	316H3 Microbicide research, development, and introduction	91,859
2016-17	316H1 Research on emerging issues in diagnosis and management of infertility	81,529
2016-17	316H1 Temperature-monitoring vaginal ring for measuring adherence	13,761
2016-17	316H1 Carbetocin oxytocin comparison trial for postpartum haemorrhage prevention	3,718,028
2016-17	316H1 Phase I and II trials of Odon Device evaluation for safety, feasibility and efficacy conducted	326,096
2016-17	316H1 Oxytocin	75,115
	Total	**14,610,897**

4. RESEARCH QUALITY ASSESSMENT

METHODOLOGY

Under the output 'generation of new knowledge', HRP conducts and commissions research on a wide range of SRHR issues. In the 2013 evaluation, a bibliometric analysis of published research results was used to assess research quality. The assessment of research quality on the basis of the volume of published papers and the number of citations, however, has known limitations in research conducted in the international development context.[1] The 2018 evaluation therefore applied an alternative method, an adaptation of the Research Quality Plus (RQ+) tool developed by the Canadian International Development Research Centre (IDRC).[2]

The requirement for the RQ+ assessment is a detailed study protocol and at least one report of the research outcome. This may be an academic paper published in a peer-reviewed journal, a policy paper, a published monograph or a draft research results paper that may or may not be prepared for submission to publication. Based on this documentation, each research project was scored for the following parameters:[3]

Four key influencers or risk factors of the research context, each scored on an interval scale of whole numbers from one (low risk) to three (high risk). The purpose of this assessment was to capture contextual factors that may have influenced the quality of the research.

Score 1	Score 2	Score 3	Score N/A
Maturity of the research field			
Well-established and recognised theoretical and conceptual frameworks, a substantial body of conceptual and empirical research, discernible outlets (journals, conferences, curriculum) and the presence of a vibrant corps of experienced researchers all characterise the field	Research field with a discernible body of work, theory and practice, and discernible outlets, and a modest body of active researchers who easily associate with the field, and recognise each other	The field of research has a very limited theoretical or empirical knowledge-base that is still debated or rapidly changing, is not widely recognised, has no dedicated journals or academic programmes, and only few active researchers, seeking to be recognised	Not applicable to this project or cannot be assessed with the evidence that is available to the reviewers
Risk in the data environment			
Low risk Instrumentation and measures for data collection and analysis were widely agreed upon and available; the data environment was well developed, stable and data rich	Medium risk	High risk Instrumentation and measures for data collection and analysis were not available; the research activities were conducted in severely underdeveloped, unstable and/or data-poor environments	Not applicable to this project or cannot be assessed with the evidence that is available to the reviewers

[1] Lebel, J. McLean, R (2018). A better measure of research from the global south. Nature, 599, 23-26.

[2] Ofir, Z. Schwandt, T. Duggan, C. McLean, R (2016). Research Quality Plus: A holistic approach to evaluating research. International Development Research Centre, Canada.

[3] All scoring systems and parameters were adapted from Ofir Z et al. (2016)

Score 1	Score 2	Score 3	Score N/A
Risk in the research environment			
Low risk The research environment (institutional priorities, incentives, facilities, etc.) was established and supportive	Medium risk	High risk The research environment was weak or largely under-developed and not supportive	Not applicable to this project or cannot be assessed with the evidence that is available to the reviewers
Risk in the political environment			
Low risk Stable political environment with established governance practices, no conflict, etc	Medium risk	High risk Very unstable or volatile political environment with weak governance practices, conflict, etc.	Not applicable to this project or cannot be assessed with the evidence that is available to the reviewers

In the next step, four categories of research quality were scored, divided into nine sub-categories. Each subcategory was scored individually on an interval scale of one to nine with the possibility to assign both whole and fractional scores. The sub-category scores were then combined by averaging.

Category 1: Research validity (research design and methodological rigor, no sub-categories)

Score 1.0 – 2.9	Score 3.0 – 4.9	Score 5.0 – 6.9	Score 7.0 – 9.0	Score N/A
There are severe lapses in methodological rigor of literature review, data collection and data analysis	There is evidence of efforts to meet methodological standards, but the efforts do not fully succeed. There are major shortcomings in the justification for the choice of research design and methods	Accepted methodological standards in the design and execution of the research are met	There is evidence of exceptional thoroughness in the research design and all phases of research execution. The project could serve as an example of what it means to achieve high quality methodological standards	Not applicable to this project or cannot be assessed with the evidence that is available to the reviewers

Category 2: Research legitimacy (scored in four sub-categories)

Score 1.0 – 2.9	Score 3.0 – 4.9	Score 5.0 – 6.9	Score 7.0 – 9.0	Score N/A
Are potentially negative consequences addressed?				
There was no apparent effort to address what could be serious negative consequences or outcomes from the research process or results. The researchers appear to have been insensitive to this aspect of the research	There are signs that the researchers were sensitive to this issue. Some efforts were made to address what could turn into negative consequences or outcomes. The extent to which this was successful is not quite clear; there may be a need for more attention to this issue	The researchers were sensitive to this issue. Appropriate and timely measures were taken in almost all instances to avoid or mitigate foreseeable negative consequences or outcomes of the research	Appropriate and timely measures were taken to eliminate or mitigate foreseeable negative consequences or outcomes of research. There are indications that this was the result of a systematic effort by the research team to mitigate negative consequences and outcomes, to the extent possible for the research team	The nature of the research is such that negative consequences or outcomes are extremely unlikely. Or, no apparent risk in this regard has as yet emerged. Or, the extent to which potential negative consequences were addressed cannot be assessed with the evidence that is available to the reviewers

SCORE 1.0 – 2.9	Score 3.0 – 4.9	SCORE 5.0 – 6.9	SCORE 7.0 – 9.0	SCORE N/A
Was the research gender responsive?				
There is no indication that gender was a consideration in the project. There was insufficient attention to gender in the research design, data collection, analysis and interpretation of findings. The research might therefore reinforce previous or existing gender-based discriminations, without any new insights into the gender aspects of social or technological change	Gender was a consideration in the research design, data collection, analysis and interpretation of findings. However, not enough was done to address previous or existing gender-based discriminations, or to understand the gender aspects of social or technological change	Gender was considered across all aspects of the research design, data collection, analysis and interpretation of findings. Some issues related to the gender aspects of social or technological change might, however, need further examination	Gender was considered with great sensitivity across all aspects of the research design, data collection, analysis and interpretation of findings. It has brought significant new, highly credible insights that can be used to address gender discrimination, and facilitate social or technological change	The nature of the research is such that a gender analysis would not generate a useful contribution. Or, no gender issues have as yet emerged in this research area. Or, the extent to which gender was addressed or mainstreamed in this project cannot be assessed with the evidence that is available to the reviewers
Was the research inclusive of marginalised or vulnerable populations?				
Inclusiveness was not a focus in the research design, execution or findings. Relevant selection processes and the prioritisation and safeguarding of vulnerable or marginalised communities did not receive sufficient attention. It is not clear if undue coercion or influencing of a vulnerable person, community or population was prevented	Inclusiveness was addressed in the research design, execution and findings. Weaknesses remain that demand more attention, e.g., in selection processes, and/or the prioritisation and safeguarding of vulnerable or marginalised communities. It is not clear if undue coercion or influencing of a vulnerable person, community or population was completely prevented	Inclusiveness was intentionally and appropriately addressed in research design, execution and findings. Few if any weaknesses remain in selection processes, and/or the prioritisation and safeguarding of vulnerable or marginalised communities. There is no sign of undue coercion or influencing of a vulnerable person, community or population	Inclusiveness was intentionally and systematically addressed in the research design, execution and findings. There are no apparent weaknesses in relevant selection processes, and/or the prioritisation and safeguarding of vulnerable or marginalised communities, or signs of undue coercion or influencing of a vulnerable person, community or population	The nature of the research is such that inclusiveness or any risks to exclusion of vulnerable or marginalised populations does not apply Or, no apparent risk in this regard has as yet emerged. Or, inclusiveness cannot be assessed with the evidence that is available to the reviewers

Score 1.0 – 2.9	Score 3.0 – 4.9	Score 5.0 – 6.9	Score 7.0 – 9.0	Score N/A
Did the research engage with local knowledge?				
Engagement with local contexts was neglected during the research process. Several major weaknesses can be found, related to how research needs and questions were identified, local communities or populations engaged, local contexts and knowledge systems considered, and local benefits from the research process assured	Local contexts and engagement were considered during the research process, but some weaknesses remain related to how research needs and questions were identified, local communities or populations engaged, local contexts and knowledge systems considered, and/or local benefits from the research process assured	Local context and engagement were a focus in the research process. Few, if any, minor weaknesses remain related to how research needs and questions were identified, local communities or populations engaged, local contexts and knowledge systems considered, or local benefits from the research process assured	Local context and engagement were a clear and systematic focus in the research process. Research needs and questions were appropriately identified, local communities or populations engaged, local contexts and knowledge systems considered and respected, and local benefits from the research process assured	The nature of the research is such that engagement with local knowledge did not apply. Or, engagement cannot be assessed with the evidence that is available to the reviewers

Category 3: Research importance (scored in two sub-categories)

Score 1.0 – 2.9	Score 3.0 – 4.9	Score 5.0 – 6.9	Score 7.0 – 9.0	Score N/A
Was the research original?				
There is little or no evidence that the research reflects originality in terms of building on and extending existing knowledge, breaking new ground, or making improvements in existing technologies and/or methods	The project was pertinent and significant but not particularly novel, original or ambitious. It was primarily concerned with adding to what is already known in the field (via extension, new applications, critique, etc.). While the research was not innovative, it was useful because it added to what was already known	The project was reasonably ambitious. It presented a fresh, ground-breaking idea, brought an innovative approach to solving existing challenges, and/or dealt with a new, emerging issue worth pursuing. It challenged taken-for-granted assumptions	There is strong evidence of (a) novelty of substantive ideas, information, problems, and interpretation; (b) originality in relation to existing related research (approach/paradigm, techniques, theoretical or conceptual framework, use of evidence); (c) promise (ideas that are likely to stimulate further research and development); as well as (d) potential for a substantial contribution to theory and/or practice	The nature of the research is such that it is not intended to advance existing knowledge or generate new insights (e.g. systematic reviews) Or, the originality of the research cannot be assessed with the evidence available to the reviewers

Score 1.0 – 2.9	Score 3.0 – 4.9	Score 5.0 – 6.9	Score 7.0 – 9.0	Score N/A
Was the research relevant?				
There is little or no evidence that the research might contribute to a local priority, a key development policy or strategy, or an emerging area that might demand solutions in the foreseeable future. Needs assessments and justification for the work are absent or unconvincing	There is some evidence that the research might contribute to a local priority, a key development policy or strategy, or an emerging area that might demand solutions in the foreseeable future. A focus on this area of work at this time appears sufficiently justified	There is good evidence that the research might contribute to an important local priority, a key development policy or strategy, or an emerging area of some significance that might demand solutions in the near future. A focus on this area of work at this time has been well justified	There is good evidence that the research is already recognised as having the potential to address a critical local priority, a key development policy or strategy, or an important emerging area that is highly likely to demand solutions in the near future. A focus on this area of work at this time puts the researchers at the cutting edge of an active and/or important field of work	The relevance of this research cannot be assessed with the evidence available to the reviewers

Category 4: Positioning for use (scored in two sub-categories)

Score 1.0 – 2.9	Score 3.0 – 4.9	Score 5.0 – 6.9	Score 7.0 – 9.0	Score N/A
Was the accessibility and sharing of knowledge considered in the research design?				
There is little or no evidence that the research was initiated and conducted with use in mind, i.e., no evidence of understanding of the context(s) within which the results are likely to be used; no evidence of stakeholder or user mapping. There is little or no evidence that there has been attention to making research findings available in formats and through mechanisms suited to well-targeted audiences. Potential users will struggle to know about, and access these knowledge products	There was a documented effort to map and understand stakeholders or key potential user groups, and some engagement with understanding the larger context within which they operate. There is evidence that some attention was paid to making research findings available in appropriate formats and through appropriate mechanisms to well-targeted potential user groups. There is evidence that some analysis of potential users was undertaken, however, it was incomplete and, furthermore, the analysis is not accompanied by discussion of actual strategies or plans to move the knowledge to policy or practice	There were significant efforts to map stakeholders and potential user groups. Researchers appear to have a credible understanding of the context within which key potential users/user groups operate. There is evidence of a significant focus on making research findings appropriately available to different potential user groups. Different types of user-friendly formats were prepared. Although different modes of dissemination were used, it is not clear that the formats were well-tailored to make them user-friendly and attractive to different user groups	There is evidence that the research was not only initiated and conducted with use in mind, but with an emphasis on engaging with the contexts of potential users. There is evidence of a significant focus on making research findings appropriately available to well-targeted and influential potential user groups in different sectors. Different types of user-friendly formats were prepared for the different groups. Significant efforts were made to identify and use mechanisms that make the findings highly accessible in user-friendly formats, including to those identified as particularly influential	With the evidence available to the reviewers, the aspect of knowledge translation and knowledge sharing of this research cannot be assessed

Score 1.0 – 2.9	Score 3.0 – 4.9	Score 5.0 – 6.9	Score 7.0 – 9.0	Score N/A
Was the research timely and actionable?				
There is little or no evidence that any analysis of the relevant user environment was undertaken and that institutional, political, social or economic contingences were considered	There is evidence that some analysis of the user setting was under undertaken; however, consideration of is incomplete and, furthermore, the analysis is not accompanied by discussion of actual strategies or plans to move the knowledge to policy or practice	There is evidence that the user environment and major contingencies were examined and reflected upon and connected to strategies and plans for moving the research into policy or practice in a timely manner	The analysis of the user environment and contingencies is exceptionally thorough and well-documented or articulated. There is evidence of careful prospective appraisal of the likelihood of success of strategies designed to address contingencies	With the evidence available to the reviewers, the timeliness and actionability of this research cannot be assessed

Each research project was scored independently by a team of two reviewers that included members of the evaluation team and additional research experts. The score sheet included a sheet where reviewers could make notes to justify their scoring decision. The two scores were then compared and if there was a difference in score of more than two points for any parameter, the two reviewers entered into discussion. The purpose was not to reach a consensus on the score, but to assure that they did not overlook an important piece of information in the available document. Diverging scores within review teams were relatively rare and applied only to one or two parameters in about half of the scored projects. The scores of the two reviewers were then averaged for a final score of the project. Increasing the review teams for each project to three members could have stabilised the scores even further but was not possible with available budget.

Sampling

The sampling frame for the RQ+ assessment were all research projects approved by the HRP RP2 committee 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. Many projects approved in 2017, on the other hand were unlikely to have produced outcomes that could be assessed at the time of the evaluation.

The Secretariat provided a database of 78 eligible research projects. On the basis of the project titles, they were allocated to the four case study themes or in an 'other' category. Several could be allocated to more than one theme and the allocation was therefore made on the basis of a best fit. In a first round, 14 projects were selected by purposive sampling, favouring the thematic areas of the evaluation case studies and balancing thematic areas, year of approval and region of implementation.

The first-round sample was well balanced, reflecting the overall profile of approved research. However, two replacement rounds were required for projects that were not real research projects, that had been cancelled, that had not yet started, or that had not yet generated any outputs. In total, six of the initially selected 14 projects had to be replaced. Each time, attempts were made to maintain the balanced profile, but it proved to be increasingly more difficult. In addition, the process of sampling from the first request of a project database to the receipt of the final set of documentation took three months (July 23rd to October 24th). The document management system of the HRP Secretariat was apparently being revised, and documentation of individual research projects could only be obtained from the research staff directly. Some had left the organisations, in another instance, one respondent had to search for documents in the hard drive of a decommissioned computer. Many documents we received, even among those that dated

back to 2013, were in draft form with multiple track changes. And, when we finally closed sampling on November 23rd, documentation of one project still had not been received. The final sample was therefore reduced to 13 and the initial balanced profile of the sample was not fully maintained.

The sample included implementation research projects, normative research that had the objective to develop or test standards and guidelines, one innovation project, i.e. a trial of a new medicine and three formative research projects that were conducted to analyse the research field and context in preparation of a definitive study of an SRHR intervention or policy.

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

Results

Research context

Among the sampled HRP research 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. None of the research projects were conducted in new research fields with theoretical bases that were still debated. Although this is a plausible finding, the sample was too small for a definitive analysis or for an analysis of the maturity of research fields by study theme.

	Established	Emerging
Formative & Implementation	**3**	**5**
Normative & innovation	**3**	**2**

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.

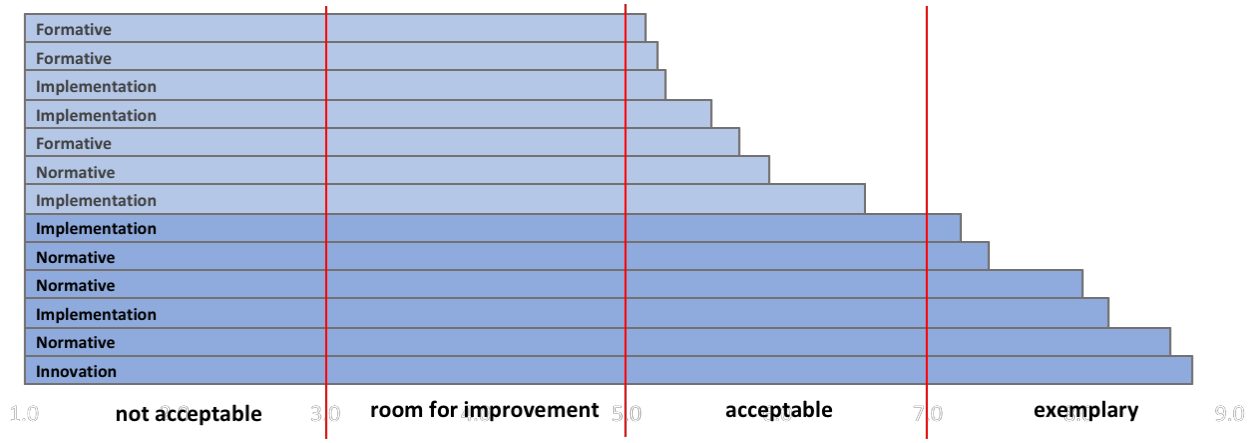
Research quality

The overall research quality, as well as the quality of the sampled studies in the four sub-categories (validity, legitimacy, importance and positioning for use) was assessed by average scoring intervals.

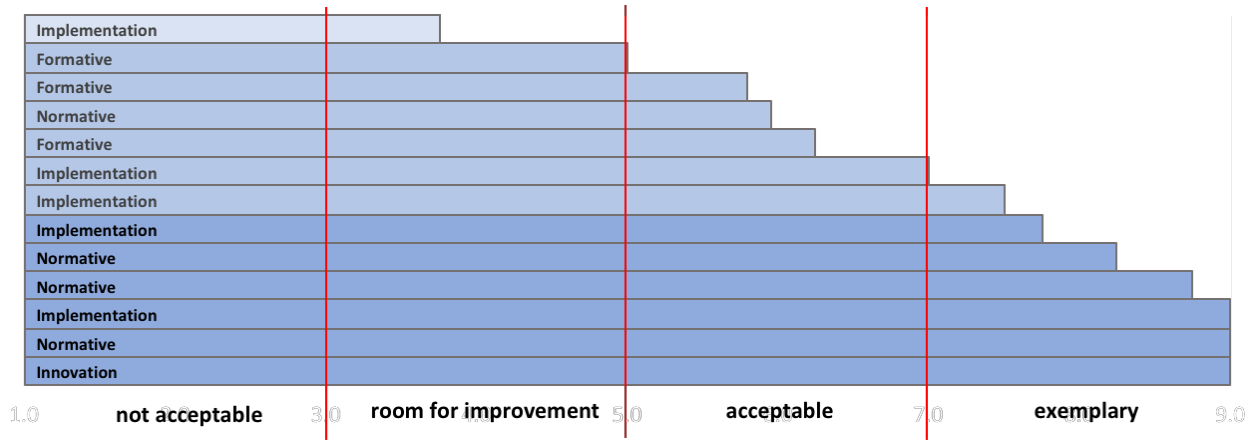
Not acceptable	**Score 1 – 2.9**
Room for improvement	**Score 3 – 4.9**
Acceptable	**Score 5 – 6.9**
Exemplary	**Score 7 - 9**

The results are presented in the following graphics.

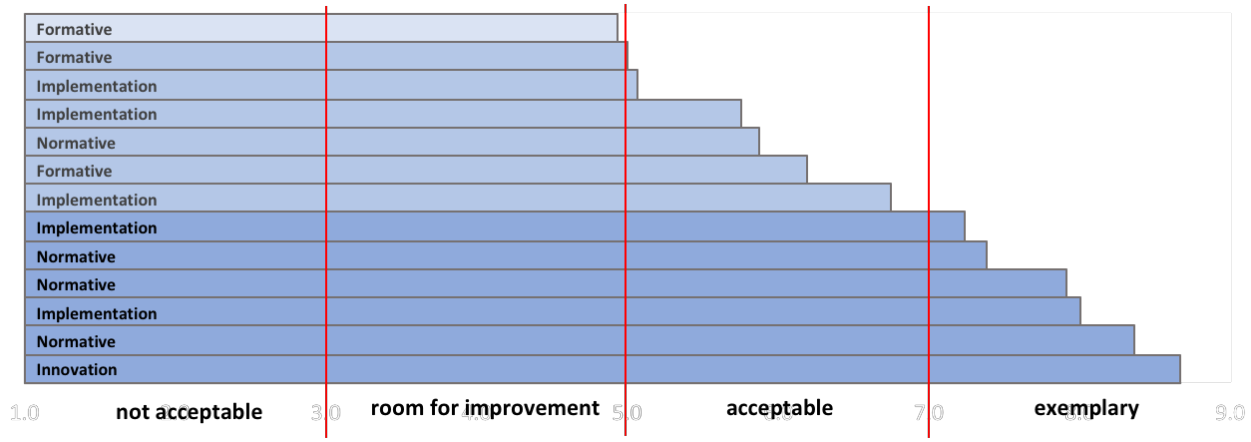
Overall research quality: Mean Score: 6.7 (5.1 – 8.8)



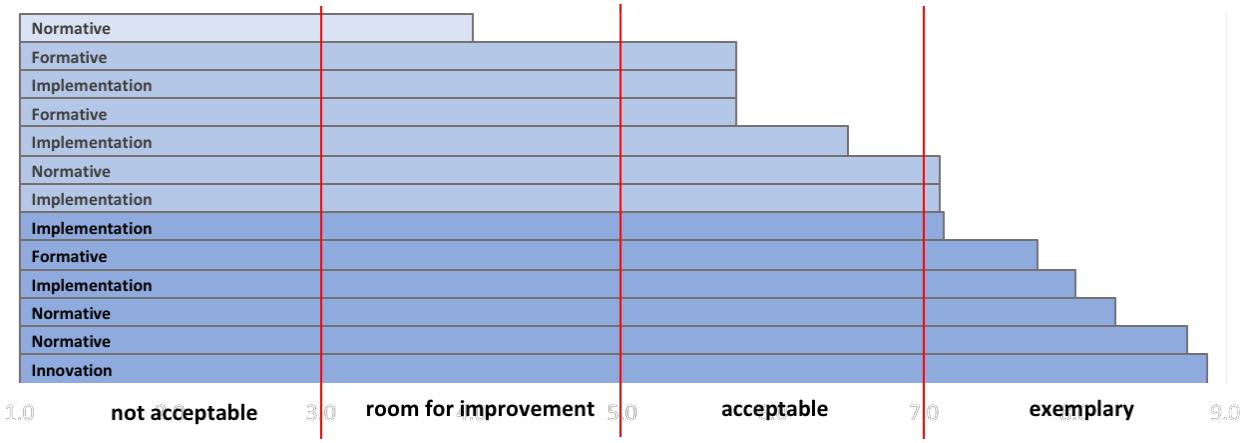
Research validity: Mean Score 7.2 (3.8 – 9.0)



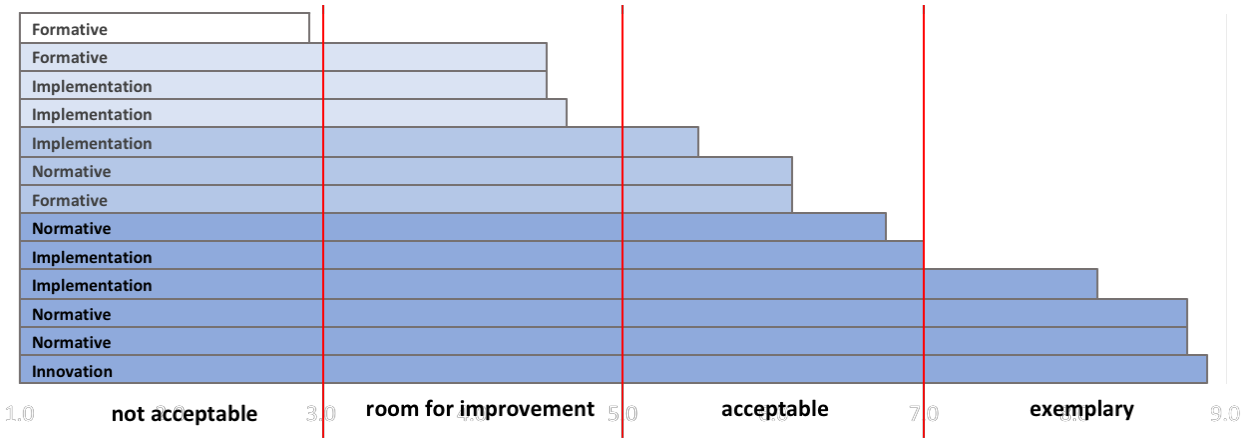
Research legitimacy: Mean Score 6.7 (4.9 – 8.7)



Research importance: Mean 7.0 (4.0 – 8.9)



Research positioning for use: Mean 6.4 (2.9 – 8.9)



The emerging patterns which are further analysed in the main report show that in general, about half of the HRP research projects scored in the exemplary range, meaning that they could serve as standards for this type of research. The remaining half scored in the acceptable range, meaning that this was good research conducted according to agreed standards of quality.

Formative research studies and implementation research scored generally lower in all parameters, but there are exceptions of two implementation studies in the exemplary range overall and in each parameter.

Overall, the average scores for research validity (research design and methodological rigor) and for research importance (originality and relevance) were in the exemplary range. The lowest mean score was achieved under the parameter 'positioning for use', with 4/13 projects scoring below the acceptable level, all of them formative or implementation research.

The objective of the RQ+ exercise was to assess the quality of research conducted by or under leadership of HRP, it was not to evaluate individual research projects. The following table therefore presents the scores for each sampled project without identifying the project.

Research Type Approval year	Impl. 2012	Form. 2012	Impl. 2012	Norm. 2013	Innovat. 2013	Impl. 2014	Form. 2014	Norm. 2014	Impl. 2014	Norm. 2015	Form. 2015	Norm. 2016	Impl. 2016
Maturity of the research field	1.0	1.0	2.0	1.5	1.0	2.0	2.0	1.0	2.0	2.0	2.0	2.0	1.5
Risk in data environment	1.0	1.0	2.0	1.0	1.0	1.0	1.0	1.0	1.0	2.5	2.0	1.5	1.0
Risk in research environment	1.0	1.0	2.0	1.0	1.0	1.0	1.0	1.5	1.0	2.0	1.0	1.5	1.0
Risk in political environment	1.0	1.0	1.0	1.0	1.0	2.5	n/a	2.0	1.0	2.5	1.5	1.0	2.0
MEAN - Research Risk	**1.0**	**1.0**	**1.8**	**1.0**	**1.0**	**1.6**	**1.3**	**1.3**	**1.3**	**2.3**	**1.6**	**1.5**	**1.4**
Research design and methodological rigor	7.8	5.0	3.8	8.8	9.0	7.5	5.8	6.0	9.0	9.0	6.3	8.3	7.0
Addressing potentially negative consequences	8.5	5.0	5.5	8.8	8.8	5.0	n/a	8.0	n/a	8.5	4.0	7.5	6.5
Gender responsiveness	7.0	7.0	5.5	N/A	n/a	3.0	4.8	5.5	n/a	7.5	4.5	7.3	4.5
Inclusiveness of vulnerable populations	7.5	4.5	4.5	8.8	8.8	7.0	6.0	4.0	7.5	8.5	4.5	6.8	8.5
Engagement with local knowledge	6.0	8.3	7.5	6.3	8.5	5.3	4.0	6.0	8.5	9.0	7.0	8.0	7.5
Originality	6.8	4.5	6.0	6.7	8.8	6.5	7.5	4.0	7.0	8.5	5.8	7.8	6.5
Relevance	7.5	7.0	5.5	7.5	9.0	6.5	8.0	4.0	9.0	9.0	n/a	8.8	7.8
Knowledge accessibility and sharing	8.0	6.5	4.5	9.0	8.8	5.0	3.0	7.5	7.8	8.5	5.0	6.3	6.0
Timeliness and actionability	6.0	5.8	4.5	8.5	9.0	4.3	2.9	6.0	8.5	9.0	4.0	6.0	5.0
MEAN - Research Quality	**7.2**	**5.8**	**5.3**	**8.0**	**8.8**	**5.6**	**5.2**	**6.0**	**8.2**	**8.6**	**5.1**	**7.4**	**6.6**

5. KEY INFORMANT INTERVIEWS

METHODOLOGY

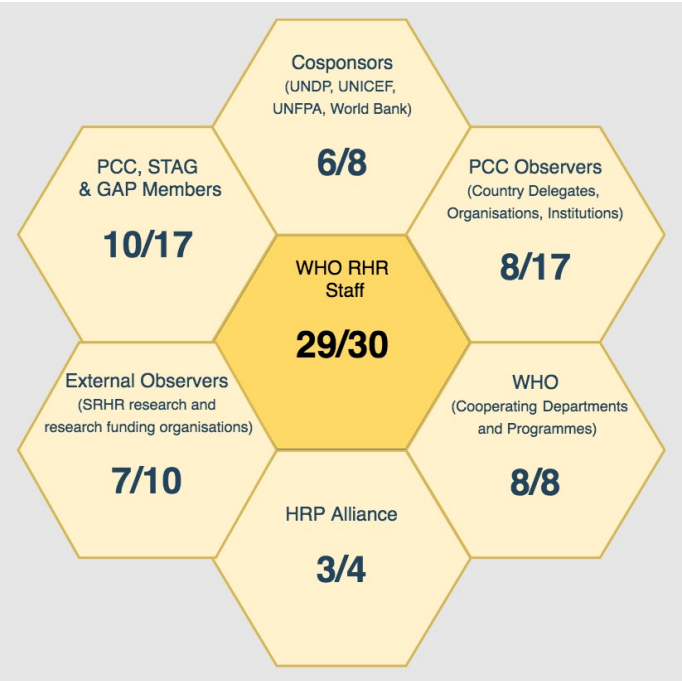
Key informant interviews were conducted by the evaluation team in person or per telephone as semi-structured interviews using interview scripts that were developed in accordance with the evaluation questions and sub-questions and adapted to the profiles of the interviewees. For the four case study interviews, additional questions and themes were added by the lead consultants for the case studies, however to the extent possible, general evaluation questions were covered.

Interviewees were assured of the confidentiality and anonymity of their responses. The majority of interviews were audio-recorded after permission was granted. Only one interviewee refused permission. The recordings, or in a minority of instances, the interviewer notes were transcribed, and the transcriptions analysed using the MAXDQA content analysis software. Coding for the content analysis followed the sub-questions of the evaluation matrix. Only one of the four case study lead consultants used this methodology for content analysis. The other three did the analysis by manually extracting and organising the information provided by the interviewees.

SAMPLING

The sample frame for key informant interviews were the lists of 732 stakeholders in the seven stakeholder groups (see graphic) provided by the HRP Secretariat. Sampling was purposeful, combining criterion and critical case sampling, assuring all four case studies were covered, as well as a sample of stakeholders in all stakeholder groups, in high-income and in low-and middle-income countries, and in all WHO Regions. A larger sample was drawn among staff of the WHO RHR Department including senior management as well as specialists in the case study areas.

Interviews were requested with 94 stakeholders, not including those who were already interviewed during the inception phase. A total of 71 interviews were conducted, the remaining 23 either did not respond to repeated requests or refused to be interviewed. The number of requested and realised interviews in the seven stakeholder groups are presented in the figure.



Large proportions of non-responders or refusals were only registered among PCC observers 9/17 and among PCC, STAG and GAP members (5 PCC delegates and 2 STAG or GAP members). However, saturation

had been reached in the interviews in these groups, and they were also prominently represented among participants in the on-line survey.

Most interviewees (42/71) resided in Switzerland and, because of the head office locations of the cosponsoring agencies, nine were residents in the USA. The regions of residence among the remaining 20 interviewees were EURO (8), AFRO (4), AMRO (3), SEARO (3) and EMRO (2). 42 interviewees were female and 29 were male.

LIST OF STAKEHOLDERS INTERVIEWED

NAME	First Name	POSITION	INSTITUTION
ADANU	Richard	Professor	University of Ghana
ADUKWEI ALLOTEY	Pascale	Director	IIGH/UN University
AL TUWAIJRI	Sameera	Lead, Population and Development	World Bank
AMSLER	Susanne	Senior Advisor SRHR	Swiss FDFA
ASKEW	Ian	Director	WHO RHR
BAHAMONDES	Luis	Professor	University of Campinas
BANERJEE	Anshu	Director	WHO MCA
BIQUE OSMAN	Nafissa	Associate Professor	Eduardo Mondlane University
BIRGA	Veronica	Chief, Women's Rights	OHCHR
BOERMA	Ties	Professor (ex Director WHO IER)	University of Manitoba
BUCAGU	Maurice	Medical Officer	WHO MCA
BUSTREO	Flavia	ex ADG WHO FWC	
CARVALHO	Catarina	Representative	IPPF, Geneva
CASTANO	Juncal Plazaola	Policy Specialist VAW	UNW
CHANDRA-MOULI	Venkatraman	Scientist	WHO RHR
CHOU	Doris	Medical Officer	WHO RHR
DAHER	Paola	Global Advocacy Advisor	Center for Reproductive Rights
DEGOMME	Olivier	Director	ICRH/ University Gent
DIAZ	Theresa	Coordinator EME	WHO MCA
DONNAY	France	Technical Advisor SRH	BMGF
ERDMAN	Joanna	Professor	Dalhousie University
ESOM	Kenechukwu	Policy Specialist HR/Gender/Law	UNDP, HIV Health and Dev.
FOGSTAD	Helga	Director	PMNCH
GAFFIELD	Mary Lyn	Technical Officer	WHO RHR
GANATRA	Bela	Scientist	WHO RHR
GARCIA MORENO	Claudia	Medical Officer	WHO RHR
GIRARD	Francoise	Coordinator/ President	IWHC
GÜLMEZOGLU	Metin	Coordinator Mat & Perinatal Health	WHO RHR
HAMILTON	Catherine	Technical Officer	WHO RHR
HUIJTS	Ini	Thematic Expert Health / SRHR	MFA Netherlands
JOHNSON	Ronnie	Scientist	WHO RHR
KALASA	Benoit	Director	UNFPA, Technical Division

NAME	First Name	POSITION	INSTITUTION
KHOSLAN	Rajat	HR Advisor	OHCHR
KIARIE	James	Coordinator Human Reproduction	WHO RHR
KINN	Sue	Team Leader	DFID, Research Division
KOBEISSI	Loulou	Medical Officer	WHO RHR
KOLLER	Theodora	Equity Officer	WHO GER
LAVELANET	Antonella	Medical Officer	WHO RHR
LISSNER	Craig	Programme Manager	WHO RHR
LUMBIGANON	Pisake	Professor	Khon Kaen University
MAGAR	Veronica	Director	WHO GER
MBIZVO	Mike	Director (ex Director WHO RHR)	Population Council, Zambia
MCCULLOUGH	Michael	Manager	WHO FWC Cluster
MOAZZAM	Ali	Medical Officer	WHO RHR
MUELLER	Dirk	Health Adviser	DFID
NARASIHMHAN	Manjulaa	Scientist	WHO RHR
NOBLE	Elisabeth	Information Officer	WHO RHR
NORMAN	Jane	Professor	University of Edinburgh
O'HANLON	Lucinda	Human Rights Advisor	WHO RHR
OLADAPO	Olufemi	Medical Officer	WHO RHR
PALLITTO	Christina	Scientist	WHO RHR
PLESONS	Marina	Consultant	WHO RHR
PUL	Tom	Director of Research	ICF, Demog. & Health Survey
RASHIDIAN	Arash	Regional Director IER	WHO EMRO
REGE	Sangeeta	Coordinator	CEHAT
REQUEJO	Jennifer	Medical Officer	UNICEF
ROOS	Nathalie	Technical Officer	WHO MCA
ROSS	David	Medical Officer	WHO MCA
SAY	Lale	Coordinator Adol & At-Risk Pop	WHO RHR
SEROUR	Gamal	Professor	IICPSR
SIMELELA	Princess Nothemba	ADG	WHO FWC Cluster
SPANOGHE	Sander	Policy Officer	DFA Flanders
TAYLOR	Melanie	Medical Officer	WHO RHR (CDC secondment)
TEMMERMAN	Marleen	Professor (ex Director WHO RHR)	Aga Khan University
TEN HOOPE BENDER	Petra	Technical Advisor SRH	UNFPA
THORSON	Anna	Scientist	WHO RHR
TOSKIN	Igor	Medical Officer	WHO RHR
TUNCALP	Özge	Scientist	WHO RHR
UNIKKADATH	Vinod	Programme Officer	WHO RHR
YORDI	Isabel	Technical Officer, Gender & Health	WHO EURO
ZECK	Willibald	Head, Global MNA Health	UNICEF

6. SOCIAL MEDIA SCAN

During the evaluation period a number of key HRP communications products were renewed, refined, or established including a co-branded WHO HRP Alliance website, a renewed newsletter and partner/donor communications plan, as well as a YouTube account and a Twitter account. The evaluation focus on social media was selected as social media represents one of the newer elements implemented in the HRP communications toolbox.

A key limitation of the scan was a lack of data provided for HRP social media activities. As access to the HRP Twitter and YouTube accounts could not be granted, the evaluation team requested the raw data for YouTube and Twitter activities by year. These data were not made available. Information provided for YouTube was limited to a short snapshot user analytics report for HRP's two YouTube accounts. The Reproductive Health Library (RHL) Channel for the WHO RHL website (www.who.int/rhl) is a YouTube channel geared towards providing technical guidance and knowledge transfer and translation resources. With close to 53 million views of videos and over 6,800 subscribers the channel clearly plays a role in supporting the RHL website, however content seems to be added infrequently, the channel lacks any HRP branding and the analytics provided only covered the top 10 videos. For these reasons it was decided this channel would not fall within the scope of the social media scan.

The second HRP YouTube channel (https://www.youtube.com/user/MediaHRP/) is branded as an HRP channel and has content that falls more within the scope of the scan. This account has a much smaller subscriber base with only 193 current subscribers and a significantly lower viewership with several key exceptions. Animations and videos created as part of larger advocacy campaigns appear to perform well and receive high viewership (over ten thousand views) and extend the reach of specific messages. Limited or no audience profile information was available for this account and similarly user engagement statistics (likes, shares, embedded in external sites) were not provided, so further analysis was not possible. While YouTube may not be a primary focus or channel for the HRP social media strategy it is clear that the account can add value and extend the reach of well-produced messages connected to larger communication campaigns on the platform.

To assess the extent and the reach of the Programme's use of Twitter to communicate its work, to network with partners and a wider audience and to advocate for evidence-based SRHR policies and programmes, we conducted a review and scan of the HRP's Twitter account and the #SRHR hashtag. As the evaluation team did not have access to the HRP Twitter account and only received a very limited set of statistics but no raw data, the application Tweepsmap[1] was used to analyse accessible data for HRP's engagement on Twitter. We also looked at HRP participation and visibility during three large global academic conferences. Key informants noted that the @HRPresearch Twitter account is primarily used to send out technical information, neutral in tone, geared primarily towards the scientific community. There was an interest in expanding this mandate, to adopt a more engaged and conversational approach to reach out to a broader audience, and to expand the scope to include knowledge translation and advocacy, however RHR did not have sufficient human resources to manage such an expansion. Interviewed informants also noted that an internal assessment of the impact of communications activities and products has not been made because of resource constraints.

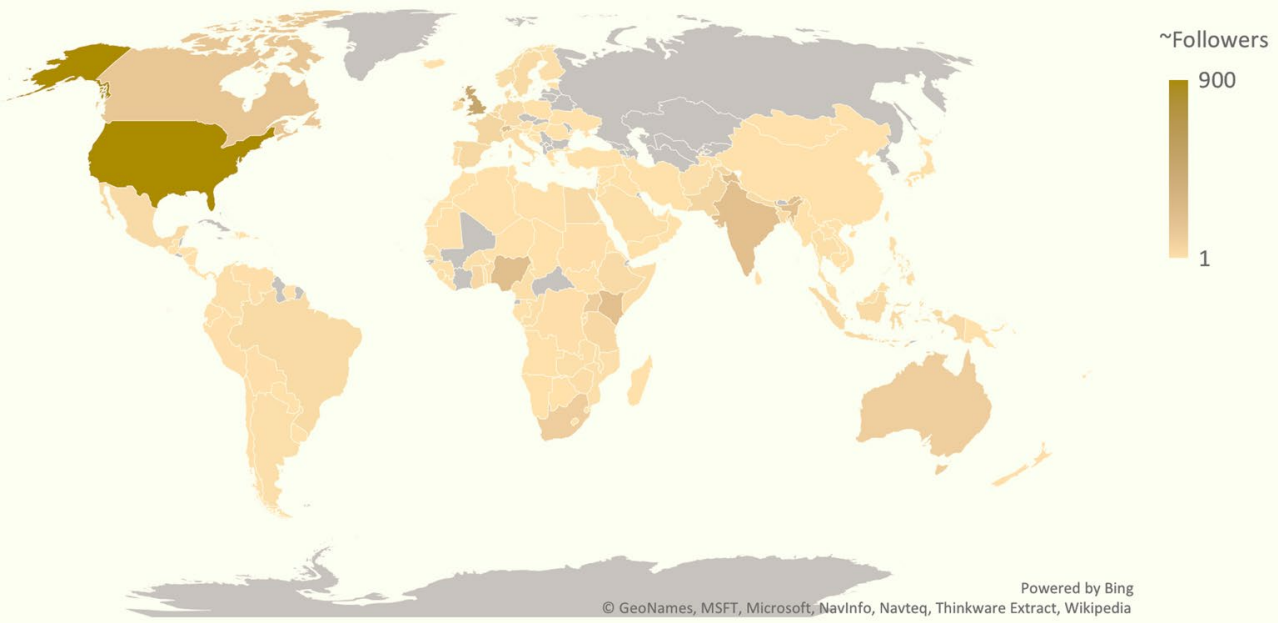
The @HRPresearch Twitter account was launched in 2014. By November 2018 over 7,000 tweets had been posted. A review of the implementation of HRP'S communications strategy in 2016 reported that the account had 1,700 followers. By November 2018 this had increased to just over 4,000 followers indicating slow but steady growth. Exponential growth that would occur when high influencing followers engaged

[1] https://tweepsmap.com/

with HRP content was not evident. The @WHO account had over 4.5 million followers in November 2018, suggesting that the HRP Twitter account has further room for growth.

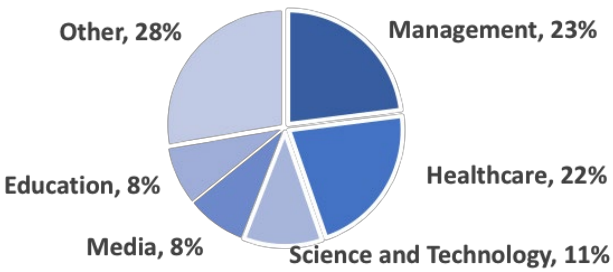
The followers of the HRP Twitter account are geographically spread with 28 percent residing in Europe, 26 percent in North America, 26 percent in Africa, 14 percent in Asia Pacific, four percent in Latin America, and two percent in the Middle East. The largest number of followers is in the USA followed by the UK and Nigeria. In the list of global cities, London is followed by New York, Geneva, Washington and Nairobi.

HRP Twitter followers by country, November 2018



Almost 50 percent of the account followers identify as female which is in line with the target audience that HRP communications set out to reach. 35 percent identify as male and the remaining 15 percent are categorised as businesses or groups. 78 percent of the account followers are between 24 and 64 and 22 percent are younger than 24 years old. Very few followers are older than 64.

Profile of HRP Twitter followers 2018



The HRP account has between ten and twenty influential followers with their own audience of, in many cases, well over 100,000 followers. The @WHO account being the highest with 4.5 million followers. However, the HRP communications officers indicated that @WHO has a policy to not retweet tweets from other accounts and therefore does not magnify the tweets from HRP.

THE MOST RETWEETED TWEETS

The International AIDS Conference @AIDS_conference
What a girl wants: Sexual and reproductive health and rights, treatment access and gender equality #AIDS2016 #srhr; 77 retweets 76 likes

FEMNET @FemnetProg
Strengthening #SRHR for Kenyan Women & Girls through Policy Advocacy & Capacity Building #SRHRDialogues #YoungWomenSay; 65 retweets, 63 likes

UNFPA @UNFPA
In 2015, #contraceptives provided by us had the potential to avert 34,000 maternal and 220,000 child deaths. #SRHR; 52 retweets. 37 likes

As a part of the social media scan we analysed a sample of 20,000 tweets using the hashtag #SRHR, issued between June and December 2016. Of the 20,000 tweets, 6,096 were original tweets, 13,324 were retweets and 580 tweets were replies. There were 6,100 contributors from 139 countries and 592 cities of which 36 percent come from Africa, 25 percent from Europe, 24 percent from North America, 13 percent from Asia and the Pacific, two percent from Latin America and less than one percent from the Middle East. The maximum total exposure or reach of the sample was 30.3 million accounts.

@HRPresearch was the fifth highest contributor of content to the #SRHR hashtag stream during the period, issuing 157 tweets. The highest contributor, with 179 tweets, was @FP2020, a global partnership for family planning information, services and supplies based in Washington, DC. Among the tweeters submitting the 6,096 original tweets, HRP ranked in position 37 in terms of number of followers. The nine most influential tweeters in terms of number of followers that used the #SRHR hashtag during the period are listed in the table below. Five of them are based in Africa.

Most influential tweeters using the #SRHR hashtag between June and December 2016

Name	Account	Number of Followers
UNWomen	@UN_women	1.5 million
Wazobia FM 95.1 (Nigeria)	@Wazobia_FM	1.1 million
Mail & Guardian (South Africa)	@mailandguardian	971 thousand
UN Foundation	@unfoundation	563 thousand
Maria Sarungi Tsehai (Tanzania)	@MariaSTsehai	410 thousand
Ebuka Akara (Nigeria)	@ebuka_akara	406 thousand
Stella Damasus (Nigeria)	@stelladamasus	387 thousand
L'Humanité (France)	@humanite_fr	365 thousand
Tedros Adhanom Ghebreyesus (WHO)	@DrTedros	359 thousand

Scientific conferences have become Twitter events and major opportunities to expand networks and share ideas. We conducted a scan of three conferences that took place during the evaluation period, looking primarily at conference tweets tagged with the main conference hashtag.

- The AIDS 2016 Conference took place in July 2016 in Durban. The top number of tweets using the #SRHR hashtag were posted by the conference Twitter account. We reviewed 2,000 tweets with the hashtag #AIDS2016 and found three tweets that tag, reference, or were tweeted by @HRPresearch.
- The Women Deliver Conference in May 2016 used the hashtag #WD2016. 43 tweets tagged, referenced or were tweeted by @HRPresearch. The communication campaign to release and showcase new guidelines on female genital mutilation at the #WD2016 conference received over ten thousand impressions.
- The XXI FIGO World Congress of Gynaecology and Obstetrics took place in Vancouver in October 2015. 45 tweets tagged, referenced, or were tweeted by @HRPresearch.

A deeper analysis of a wider range of engagement indicators that look beyond impressions, as well as the key influencers tweeting and retweeting HRP messages would be useful for increasing the HRP social media footprint.

7. FOLLOW-UP OF RECOMMENDATIONS OF THE 2013 EVALUATION

In 2013, the HRP evaluation 2008-2012 made 27 recommendations. The evaluation report was adopted by the 26th meeting of the PCC in June 2013. A management response to the recommendations was not prepared, however, on request by the PCC recommended that a report on the implementation of the recommendations was prepared by the HRP management and presented to the 27th meeting of the PCC. The terms of reference of the 2018 evaluation include an assessment of the extent to which HRP management has responded to recommendations of past evaluations.

	Recommendation (2013)	Assessment (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
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.	Although the HRP results framework adopted since 2014 includes an output indicator of 'interventions developed, tested and implemented', implementation was not monitored or reviewed
3	HRP needs to clearly identify in its reporting mechanisms the results it achieves, as distinct from the results achieved by PDRH.	Since 2014, reported results appear to reflect the outputs of HRP activities, although drawing a sharp line between HRP and PDRH results is difficult, especially in view of the above recommendation.
4	In future reporting, HRP should distinguish between peer-reviewed articles generated through its global agenda, and those generated from research-capacity strengthening activities. This would provide more transparency and permit a greater understanding of the impact of the Programme's work at both global and regional levels.	This recommendation was not implemented. In view of HRP's efforts to refocus its portfolio on implementation research and to build research partnerships in programme countries through the HRP Alliance, the recommendation has lost its relevance.
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.	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. A new effort was made in 2016 in the context of the portfolio review using internal and external expertise. The results are promising although there is a concern that the identified priorities may over-extend the Programme's human resource capacity.

	Recommendation (2013)	Assessment (2018)
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.	This is a further elaboration of the previous recommendation. It was addressed in the 2016 portfolio review. Priority-setting, however is a dynamic task that needs continuous attention. The Programme, with strategic guidance by the STAG is currently making sufficient efforts. There are demands by PCC members for a stronger involvement of the PCC in this task.
7	For HRP to maximise its potential impact, it needs to strengthen its focus on research questions that will benefit the least developed countries and those furthest from the MDG targets, and, wherever possible, on undertaking this research in these countries. All proposed work should include a clear statement of how it contributes directly or indirectly to the achievement of MDG targets 4, 5 and 6 or any post-2015 global targets. This statement should be used by STAG as a major indicator of the relevance of the proposed research.	Throughout the 2013-2017 evaluation period, HRP has focused its research on SRHR priorities in low- and middle-income countries and are aligned with the SDG agenda.
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 and there are firm intentions to shift the portfolio into this direction. 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, but it is not certain that HRP has a strong comparative advantage for research in social determinants of SRHR in general.
9	The Programme should renegotiate its relationship with regard to the overlapping functions that exist between RP2 and ERC. Ideally, a way needs to be found for WHO senior management to entrust the ethical review of HRP's research to RP2. This will most likely require a number of actions, including investment in a more robust RP2 database with support for data management, and application by RP2 for FWA-OHRP accreditation (Federal Wide Assurance for the Protection of Human Subjects – Office for Human Research Protections Database), which would include a system of periodic external reviews of RP2.	This issue was discussed at the level of the WHO ADG. The review of research proposals by the RP2 and ERC was maintained. The evaluation team did not receive any information of inefficiencies or overlapping functions between the two panels during the 2013 to 2017 period.

	Recommendation (2013)	Assessment (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.	The slow development of the HRP Alliance has affected the slow Programme response to this recommendation. Further effort is needed which is in line with the recommendation of the 2018 evaluation to increase the effort for making the HRP Alliance more functional.
11	The Programme needs to continue to increase the level of involvement of researchers from programme countries.	This relates to the above recommendation and depends on future efforts for strengthening the HRP Alliance
12	When submitting research proposals to RP2 for final assessment and approval, programme staff should ensure that the proposals are complete and conform to the required technical and scientific standards.	Proposals submitted to RP2 are being pre-screened for completeness and technical conformity by the Research Manager using a checklist tool.
13	In addition to the regular annual review of ongoing research proposals, programme staff should consult RP2 at any point after a research proposal has been approved, if any scientific, technical, ethical or management issues arise during the lifetime of the project until its completion.	The evaluation team has no information on whether consultations of the RP2 after approval are taking place. However, technical issues of on-going research projects are being discussed by the STAG and GAP.
14	HRP should consider developing an e-platform to enable organisations engaged in research on SRH to share information on their current work and future plans.	There have been considerable developments in the implementation of HRP's communications strategy. HRP has, however, not developed an open e-platform for SRHR research organisations to share information on their current work.
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 and recommendations are made in the 2018 evaluation report. The collaboration between HRP and TDR on training in research methodology has increased, but this also requires further attention.
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 .

	Recommendation (2013)	Assessment (2018)
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. In this sense, the 2018 evaluation recommends a review of the HRP results framework.
18	There is a need for HRP to develop and invest in a new communication strategy, which explores innovative ways of packaging and disseminating HRP's research findings and other products for use in strengthening national SRH policies and programmes. The strategy should consider the role of knowledge intermediaries and gatekeepers of change, and that different products will require very different approaches. Subsequent communication workplans should identify clear deliverables and associated indicators.	A communications strategy was developed. It was only partially implemented because of human resource constraints. Key informants generally considered that HRP was effective in its communications, that there have been considerable improvements during the evaluation period, but that there is room for further improvement.
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. 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).
20	The PCC will need to provide guidance on the source of funding for HRP's communication and utilisation work.	HRP did not have any major financial constraints during the evaluation period that would have prevented the roll-out of the communications strategy
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.	This is an on-going recommendation. There is some indication of progress among cosponsors through the cosponsor engagement plan.
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. No efforts were made to explore additional cosponsors. Discussions with cosponsors about engagement are ongoing.

	Recommendation (2013)	Assessment (2018)
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 HRP reports that progress has been made, there is a continuing issue of creating space for the PCC to effectively exercise its governance mandate.
24	PCC may wish to consider adding an agenda item every other year that would provide an opportunity for donors, cosponsors and programme countries to report on their use of the Programme's products.	HRP reports that changes in the agenda of the PCC meetings were made to allow more input from delegates. This does, however, not address the more fundamental issue of the PCC's effectiveness as a governing body.
25	PCC may wish to consider a number of different options for STAG, including the following: STAG could revert to its original function as the scientific and technical review body for HRP, and could receive and review a report only on the overall work of PDRH on a biennial basis; STAG could undertake in-depth reviews, perhaps in alternate years, of two to three of the main areas of the Programme's work; in other years, it could focus on more strategic, policy and forward-looking issues, as well as reviewing and advising on overall workplans and budgets.	Changes were made in the agenda and organisation of the STAG meetings. Throughout the evaluation period, the STAG has been involved in a number of strategy issues, for instance in the context of the 2016 portfolio review. Interviewed key informants and on-line survey respondents considered the STAG to be an effective technical and strategic advisory body to the Programme and the PCC.
26	HRP should examine the feasibility of merging GAP into STAG. This would require ensuring that STAG maintains adequate gender and sexual and reproductive health rights expertise; carries out biennial reviews of HRP's full programme of work from a gender and rights perspective; and commissions an independent review of its approach to gender and human rights after 5 years.	This recommendation was discussed and not implemented. However, the scheduling of back-to-back meetings and the attendance of the chairs in the respective meeting of the other committee has greatly improved the complementarity of the two advisory committees.
27	The Programme should consider periodically holding a PCC meeting outside Geneva, but only after pre-negotiating a cost-sharing agreement with the host government.	The recommendation was not implemented

8. HRP'S WORK ON CO-DESIGNING, MONITORING AND REPORTING ON SRHR INDICATORS

SUMMARY

This case study covers HRP's work on (i) designing, revising and validating global sexual and reproductive health and rights (SRHR) indicators, (ii) collecting, compiling and analysing global SRHR data, and (iii) advocacy for inclusion of SRHR indicators in global monitoring systems.

HRP's overall mandate is to lead research in SRHR and to conduct research capacity strengthening. It is embedded in the WHO Department for Reproductive Health and Research (RHR) to ensure linkages between evidence-based outputs of HRP and the normative guidance and programme development role of WHO. As identified in previous evaluations, it became apparent that it is not always easy to distinguish between the outputs of HRP and the outputs of RHR.

HRP's involvement in setting targets, defining indicators and monitoring global progress in SRHR is generally considered appropriate and in line with HRP's mandate and comparative strengths. Some informants considered HRPs work on global monitoring and indicators more relevant compared with the actual research that is carried out under the Programme. As highlighted in previous evaluations, the HRP work on global monitoring and indicators continues to be highly valued by numerous stakeholders. The outputs and products of HRP in the area of global monitoring and indicators are considered by stakeholders as authoritative. Through its monitoring work HRP continues to provide global leadership on sensitive SRHR issues, and to generate global public health goods of high quality and utility. Despite the difficulty in distinguishing between WHO and HRP, the majority of the informants believes that because of its location in WHO, HRP is ideally placed for setting the agenda and advocating for global SRHR.

HRP's work in defining indicators, setting of targets and global monitoring has been influential in the development of global strategies and conventions. The MDGs, SDGs and the GSWCAH stand out as the most important global strategies to which HRP has contributed. HRP's work on monitoring maternal mortality and morbidity was used by the Human Rights Council to adopt a resolution on preventable maternal mortality and morbidity, and HRP received the mandate to develop a global indicator framework on human rights in family planning.

As highlighted in previous evaluations, informants identified adolescent reproductive health as an important area for HRP to engage in more actively. There was a general view that HRP could take on a role in monitoring adolescent SRHR. The need for global SRHR monitoring in more recent work streams like humanitarian settings was also expressed by informants. During the evaluation period, HRP was not yet actively engaged in these areas. Since data are still scarce and many countries do not yet prioritise some of these streams, global estimates do not yet take issues like migration into consideration. HRP already engaged for some time in defining indicators and monitoring global data on themes like human rights and gender equality in SRHR, and on gender-based violence. Informants anticipated that the current focus on primarily monitoring health outcomes will shift towards a greater focus on social determinants.

Within the broader set of HRP programme indicators there is only one indicator related to the publication of global and regional estimates of reproductive, maternal and perinatal conditions. No other programme targets exist for HRP's work on global monitoring and indicators. The achievements reported during the period under evaluation largely exceed the target of four publications per biennium.

INTRODUCTION

This case study covers HRP's work on (i) designing, revising and validating global sexual and reproductive health and rights (SRHR) indicators, (ii) collecting, compiling and analysing global SRHR data, and (iii) advocacy for inclusion of SRHR indicators in global monitoring systems.

The HRP Programme is embedded in the WHO Department of Reproductive Health and Research (RHR). Typical outputs for HRP's work on global monitoring and indicators include the definition of indicators, development of guidance documents and monitoring tools, surveillance data, trends and global estimates. HRP collaborates with a number of partner organisations and academic institutions to generate internationally comparable estimates for a number of global indicators with independent advice from technical advisory groups (TAG) that include scientists and academics with relevant experience. HRP is custodian and hence responsible for reporting on four global indicators in the context of the Sustainable Development Goals (SDGs):

- 3.1.1 Maternal mortality ratio
- 3.1.2 Proportion of births attended by skilled health personnel
- 5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age
- 5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence

METHODOLOGY

For the case study, data were collected through document review and key informant interviews. To ensure comprehensive conclusions, information collected was analysed and triangulated with information available in key documents, websites, and the results of the on-line survey that was part of the overall HRP evaluation.

A number of HRP outputs (products) related to global monitoring and indicators were assessed in more detail, concerning in particular HRP's work on:

- Maternal Mortality Ratio (MMR)
- Reproductive morbidities
- Sexually Transmitted Infections (STIs)
- Unsafe abortions
- Human rights and gender equality
- Violence against women, including gender-based violence (GBV)
- Sexual health

A list of these products can be found in Annex. Instead of an in-depth analysis of the sampled individual products or outputs, a more general assessment of the work done on global monitoring and indicators for those thematic areas was done, since many of the sampled products and outputs were part of a broader set of publications and were delivered over a time period that extended beyond the sampled biennium.

The evaluation questions that guided the case study are listed in the table below.

Evaluation Question	DAC Criteria
1. What is the scope of HRP involvement in global monitoring and does it match the Programme's mandate and comparative strengths?	Relevance

Evaluation Question	DAC Criteria
2. To what extent are more recent HRP programme streams (adolescent SRHR, SRHR in humanitarian settings and emergencies, etc.) reflected in the Programme's work on global data and indicators?	Relevance
3. Does HRP's work on SRHR indicators generate or support the timely outputs that are recognised by stakeholders as authoritative data, methodologies or indicator definitions?	Effectiveness
4. Has HRP technical and advocacy work in global SRHR monitoring, including monitoring of human rights and gender equality indicators, contributed to the achievements of global strategies and conventions? How?	Effectiveness Sustainability
5. How many global indicator data updates and agreements on global monitoring frameworks were generated against Programme targets?	Efficiency

RATIONALE

HRP was established in 1972 and focused in the early days mainly on fertility regulation. A comprehensive definition of infertility was developed in 1975. The first epidemiological studies in 1979 found that a prevalence study was required to understand the burden of infertility [22]. This is considered an important landmark for HRP's work on indicator definition and global monitoring.

Throughout the years, HRP's general focus as well as its work on monitoring and indicators shifted from fertility regulation to a broader reproductive health agenda [12]. HRP's work on global monitoring and indicators became more prominent with the adoption of the Millennium Development Goals (MDGs) in 2000 and the SDGs in 2015 setting a number of global targets for SRHR. Many of these targets were adopted by countries as part of their national health-related policies, programmes and services. To be able to appreciate the degree to which countries achieve these targets, uniform indicator definitions and systems for monitoring and evaluation had to be established. In 2000, UN Member States pledged to work towards a 75% reduction in the MMR from 1990 levels by 2015. HRP leads the work of the Maternal Mortality Estimation Interagency Group (MMEIG) which periodically published trends and levels of maternal mortality to assess progress towards the MDG. Building upon the increased expectations during the MDG period, the SDGs established a transformative new agenda for SRHR. In the final years of the MDG reporting period, a number of initiatives – including the Global Strategy for Women's, Children's and Adolescents' Health (GSWCAH) [21] as well as the high-level Commission on Information and Accountability (COIA) – were developed to accelerate progress and enable improved measurement of MMR. In the UN SDG monitoring system, HRP is currently responsible for monitoring four indicators as listed above.

Generally, the definition of uniform and aligned indicators, and the shortage of reliable data represent long-standing barriers for effective monitoring. The deficiency of existing systems, particularly in low- and middle-income countries, challenges international comparability by variations in the representativeness, reliability and heterogeneity of the data. This is even more the case for more sensitive work streams like unsafe abortions, GBV and sexual health.

Estimates published by HRP to date are generally considered reliable, coherent and internationally comparable. Because of its reputation, and in particular its work conducted on the MMR indicator, HRP was requested to develop the monitoring framework for the UN Secretary General's GSWCAH [14].

HRP'S WORK ON CO-DESIGNING, MONITORING AND REPORTING ON SRHR INDICATORS

Since the development of a comprehensive definition of infertility in 1975, HRP produced a large number of publications on global SRHR indicators. The publications range from guidance for selection of indicators

and surveillance, to global estimates (MMR, reproductive morbidities, STIs, etc.). In addition to its role as the custodian for four SDG indicators, HRP works with partner agencies on nearly 30 indicators.

1. Maternal mortality ratio **(SDG 3.1.1)**
2. Maternal cause of death
3. Proportion of births attended by skilled health personnel (SDG 3.1.2)
4. Proportion of women aged 15-49 who received four or more antenatal care visits
5. Proportion of women who have postpartum contact with a health provider within two days of delivery
6. Stillbirth rate
7. Adolescent birth rate (10-14, 15-19) per 1000 women in that age group **(SDG 3.7.2)**
8. Proportion of ever-partnered women and girls aged 15 and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age **(SDG 5.2.1)**
9. Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
10. Proportion of young women and men aged 18-29 who experienced sexual violence by age 18 **(SDG 16.2.3)**
11. Proportion of women and girls aged 15-49 who have undergone female genital mutilation/cutting (FGM/C), by age **(SDG 5.3.2)**
12. Preterm birth estimates
13. Abortion incidence
14. Abortion (safety)
15. Caesarean section prevalence
16. Early antenatal care (ANC)
17. ANC one- visit
18. Percentage of women of reproductive age (15-49) who have their need for family planning satisfied with modern methods **(SDG 3.7.1)**
19. Contraceptive prevalence rate
20. T. pallidum (syphilis) incidence
21. N. gonorrhoeae incidence
22. Congenital syphilis incidence
23. Proportion of women in ANC screened for syphilis during pregnancy
24. Proportion of women aged 20-49 who report they were screened for cervical cancer
25. Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action and the outcome documents of their review conferences
26. Proportion of men and women aged 15-24 with basic knowledge about sexual and reproductive health services and rights
27. Number of countries with laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information and education **(SDG 5.6.2)**
28. Percentage of women aged 20-24 who were married or in a union before age 15 and before age 18 **(SDG 5.3.1)**
29. Proportion of rape survivors who received HIV post-exposure prophylaxis (PEP) within 72 hours of an incident occurring

Providing leadership in developing and monitoring global goals and targets in SRHR is one of the key processes included in HRP's overall results framework [10].

Most of the indicators listed above are closely linked or feed into the four SDG indicators for which HRP is the custodian. For some thematic areas, the definition of indicators and data collection is still in an early phase, and the work done around MMR serves often as an example. HRP, in collaboration with the WHO Department of Information, Evidence and Research (IER), UNICEF, UNFPA, the World Bank Group and the UN Population Division analyses maternal mortality levels on a routine and continuing basis [31]. The updated estimates allow for trend analysis to determine the progress towards attaining the SDGs. In

addition to the MMR indicator, the work done on the indicator related to skilled birth attendance also serves as an example for more recent work streams. This indicator does not require modelling and statistical analysis like the MMR indicator, but it needed substantial efforts to reach consensus on the definition among diverse stakeholders since the definitions differed among countries.

During the evaluation period, HRP produced a number of outputs related to global monitoring and indicator setting that represent more recent work streams. As such, work was done on violence against women [25], abortion [6, 7, 8, 15, 16, 20], sexual health [5, 18, 27] and human rights [9, 16, 28, 29, 34]. HRP is also the recognised authority working on global surveillance of STIs [32, 33].

INPUTS

FINANCIAL RESOURCES

The financial reports and budgets of HRP for the period under evaluation do not allow distinguishing between HRP's work on global monitoring and indicators, and other programmatic areas. The HRP budget lines are categorised according to thematic area (e.g. human reproduction, maternal and perinatal health, unsafe abortions, etc.). While HRP reports on expenditures for each product or output for global monitoring and indicators, the available data do not allow comparing the budget versus expenditures. Based on the budgets for HRP products in the area of global monitoring and indicators that were identified for this case study for each biennium under the evaluation period, the resources allocated to this area represented between 1.8 and 3.8 percent of the total HRP budget [10, 11].

BIENNIUM	HRP BUDGET	BUDGET FOR MONITORING AND INDICATORS PRODUCTS/OUTPUTS	%
2012-13	$57,148,000	$2,012,986	3.5%
2014-15	$62,863,000	$1,149,894	1.8%
2016-17	$68,400,000	$2,632,638	3.8%

Some informants considered the investments in monitoring and indicators as too small, particularly taking into consideration the potential impact that WHO data and statistics generally have in countries. The limited availability of budgets for global monitoring is in line with findings of previous HRP evaluations [12], and with a general observation that the UN allocates relatively few resources to global monitoring, certainly compared with organisations like the Institute for Health Metrics and Evaluation (IHME) which carries out similar work but can rely on substantial budgets and more staff. Although HRP operates in a SRHR niche and continues to be highly valued by numerous stakeholders, its limited investment in global monitoring challenges its comparative advantage in this area. Interviewed stakeholders particularly pointed out that STI monitoring is under-developed and that there is scope for expansion and increased investment in this area.

HUMAN RESOURCES AND TECHNICAL SUPPORT

Most informants were appreciative of the quality and efforts of the HRP staff. While the health science background of the staff is important for research, for much of the work on global estimates HRP depends on contracted consultants with a background in statistics and demography and on the experts gathered in the TAGs. The MMIEG is the inter-agency estimation group on maternal mortality. The TAG supports the MMIEG and usually consists of six external experts and representatives of the co-sponsors. It often serves as an example for other TAGs.

For the work on global monitoring and indicators, HRP collaborates with a range of partner organisations, and institutions, including statistics offices and academic institutions. Some informants stated that academic institutions from the South should be more actively involved.

The co-sponsors of the Programme (WHO, UNFPA, UNICEF, UNDP, World Bank) work closely on many thematic areas in global monitoring and indicators. While UNICEF and UNFPA are often mentioned in terms of co-sponsor collaboration for data-collection and joint work on global estimates, the other co-sponsors (UNDP and World Bank) are regarded as less prominent actors. The collaboration between the co-sponsors is generally characterised by collegiality although there is also some level of competition. Rather than questioning the quality of work, the competition is more related to prioritising certain topics on the HRP agenda according to the workstreams and priorities of each agency. Co-sponsors recognise the expertise of HRP in performing the work on global monitoring and indicators. Among informants (co-sponsors and external stakeholders) there is however a common perception that HRP is a WHO programme, mainly because it is located in WHO.

HRP develops the majority of indicator estimates based on data from several external sources. UNAIDS, UNWomen and the UN Population Division are important sources of data from within the UN system (no co-sponsors) while the USAID supported Demographic Health Survey (DHS) programme is an important source from outside the UN system. Indeed, the lack of reliable country data for some thematic areas forces HRP to fully rely on data collected by other partners. As such, the work on STIs is based on four different external tools (Global Aids Monitoring (GAM)/UNAIDS, Spectrum modelling tool for HIV, Gonococcal Antimicrobial Surveillance Programme (GASP), and the congenital syphilis estimation tool). For violence against women there is a collaboration with the UN Office on Drugs and Crime (UNODC), responsible for collecting data on homicides and sexual crime. The statistical modelling work that is done for the development of MMR global estimates [26] is to a large extent outsourced to external consultants. In the case of abortions, the Guttmacher Institute produces reports on the global incidence [20]. HRP works on the consensus of defining unsafe, less safe and safe abortions, as well as on global estimates of unsafe abortions [6, 7, 8, 15, 16].

There is a strong collaboration with WHO's IER department for all publications concerning data and global estimates. IER is involved by validating the methodology as well as the results before publishing. IER does not conduct any research for global estimates, its role is primarily to coordinate research for global statistics. IER also accompanies the external consultant(s) working on MMR estimates. While there is no perceived overlap with IER's work, some informants pointed at possible overlap, including efficiency losses, with the WHO Department of Maternal, Newborn, Child and Adolescent Health (MCA) which has a unit for monitoring and evaluation that includes monitoring progress in countries towards the achievement of global targets in its mandate.

For many of the more recent HRP work streams, reliable data are still scarce, and several countries do not provide any data yet (e.g. unsafe abortions and violence against women). In a context characterised by a general shortage of health information, the dissemination of SRHR indicators and monitoring data is needed, but it might represent an additional reporting burden on often under-resourced (health) facilities. Regional offices of the HRP co-sponsors, particularly WHO, are not yet fully engaged in the coordination of HRP work on global monitoring and indicators but may play an important role in supporting countries in data collection and consolidation.

OUTPUTS

Typical outputs for HRP's work on global monitoring and indicators include the definition of indicators, development of guidance documents and monitoring tools, collecting and analysing surveillance data, trends, and the development of global estimates.

The HRP performance framework includes only one output indicator for the Programme's work on global monitoring: The number of publications of global and regional estimates of reproductive, maternal and perinatal conditions (output 1.2). Achievement against programme targets only started to be explicitly documented in HRP annual reports from 2014 onwards [10], with the following results:

YEAR/BIENNIUM	TARGET	ACHIEVED
2013	N/A	16
2014-15	4	2
2016-17	4	13

These achievements are encouraging but the target of four publications may be queried, also considering the fact that the preliminary list of sample products for this case study included considerably more than four outputs per biennium and considering the fact that the publications listed under the header "Monitoring and Evaluation" on the WHO/HRP website also contain more than the four targeted outputs per biennium. The list extracted from the website does not only include global estimates but also guidance documents, tools and other reports linked to HRP's role in global monitoring and indicator development:[1]

2013	1. WHO guidance for measuring maternal mortality from a census 2. Baseline report on global sexually transmitted Infection surveillance 2012 3. Global and regional estimates of violence against women *Prevalence and health effects of intimate partner violence and non-partner sexual violence* 4. Monitoring national cervical cancer prevention and control programmes *Quality control and quality assurance for visual inspection with acetic acid (VIA) based programmes*
2014	1. Report on global sexually transmitted infection surveillance2013 2. Trends in Maternal Mortality: 1990 to 2013 *Estimates by WHO, UNICEF, UNFPA, the World Bank and the United Nations Population Division*
2015	1. Significant decline in maternal mortality - but much remains to be done 2. Trends in maternal mortality: 1990 to2015 *Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division* 3. A tool for strengthening STI surveillance at the country level
2016	1. A tool for strengthening gender-sensitive national HIV and Sexual and Reproductive Health (SRH) monitoring and evaluation systems 2. Report on global sexually transmitted infection surveillance 2015 3. The WHO application of ICD·10 to deaths during the perinatal period: ICD·PM 4. Time to respond: a report on the global implementation of maternal death surveillance and response (MDSR) 5. Making every baby count: audit and review of stillbirths and neonatal deaths
2017/ 18	1. Standard protocol to assess prevalence of gonorrhoea and chlamydia among pregnant women in antenatal clinics 2. Monitoring human rights in contraceptive services and programmes 3. Reaching the every newborn national 2020 milestones *Country progress, plans and moving forward*

[1] www.who.int/reproductivehealth/publications/monitoring/en/

The achievements reported in the annual reports, publications listed on the WHO/HRP website and the product list provided by HRP for this case study do however not seem to be fully aligned. As such, not all global or regional estimates appear to be listed on the website and the product list for this work area extracted from the HRP expenditure reports included a larger number of products and products that were not mentioned in the annual reports nor listed on the website.

Some publications are only marked with the WHO logo, while the majority is marked with both the WHO and the HRP logo. This may depend on the particular budget line used for the publication. As already observed in previous evaluations of HRP [12], it was challenging to distinguish between the outputs of HRP and the outputs of RHR. According to some informants, the HRP Programme provides a comfortable umbrella under which activities can be carried out that may not be typical WHO activities. For the work done on unsafe abortions, for example, HRP provides a neutral environment considering the sensitivities that exist around this topic. An endorsement by WHO is however also needed, as the work around sexual health demonstrates. Although discussions on indicators and targets for sexual health already started in the early 1970s, it is still considered as an upcoming area. Sexual health only became a priority since around 2010, with STIs as a point of departure. No sexual health indicators existed yet, and a group of global experts on sexual health requested WHO/HRP to develop indicators. This resulted in a core set of process and impact indicators on sexual health [27]. Once the indicators were ready, there were still considerable sensitivities around the topic, which led to WHO putting the publication on hold in 2014. Up to today, the document is not yet officially released, although it is already widely used. Even though the indicators were developed under the neutral HRP umbrella, it will still be an official WHO document, hence the caution.

Staff members of RHR working on HRP products expressed different views on the neutral environment in which HRP operates compared with regular WHO work. Some of them emphasised that the neutral ground on which HRP works was essential, while others stressed that without the official endorsement of publications by WHO publications their work would not have any impact.

OUTCOMES

HRP's work on global monitoring and indicators contributes to public goods in the sense that it is non-excludable and that it has global reach. The question whether the public goods can be (in)directly attributed to HRP's work on global monitoring and indicators cannot be answered in a straightforward manner since the work is multi-facetted, multi-sectoral and involves a large number of stakeholders.

HRP has been actively engaged in the promotion of the use of SRHR-related indicators, acting as a prominent focal point for SRHR within the global community. Within the context of the SDGs, the Global Strategy for Women's, Children's and Adolescents' Health (GSWCAH) 2016-2030 launched by Every Woman Every Child movement in 2015. When it was launched, HRP and RHR were requested to develop the monitoring framework. With indicators across health and other sectors, a broad engagement of stakeholders was required. Based on a systematic review of existing frameworks and extensive consultations, consensus on the framework was reached in less than a year [14]. It includes 60 indicators: 34 from the SDGs and 26 from related global monitoring initiatives. Of these, a subset of 16 key indicators was selected to provide a snapshot of progress. While HRP and RHR played a key role in developing the monitoring framework and contribute to the reporting, they do not lead the global reporting on those indicators.

HRP and RHR were also requested to take responsibility in coordinating the revision of chapters 14 (diseases of the genitourinary system), 15 (pregnancy, child birth and puerperium) and 16 (conditions originating in the perinatal period) of the 11th revision of the International Classification of Diseases (ICD) [24].

The SDGs and the GSWCAH stand out as the most important global strategies to which HRP has contributed. The global landscape on SRHR is developing progressively, and HRP is considered to be a key resource to these developments. As such, research done, and estimates produced on MMR led to work on global monitoring and indicators for maternal morbidity, with a maternal morbidity indicator framework published [2, 3, 4, 13]. Consequently, some studies now use as outcome not only mortality but also a composite outcome that includes mortality and morbidity. Informants state that it can easily take 10 to 15 years until this kind of work is taken up systematically and for the case of morbidity it is still considered in its early stages.

Social determinants are increasingly present in the work streams of HRP. The work around MMR and morbidity was used in the Human Rights Council, for example, to adopt a resolution on preventable maternal mortality and morbidity. HRP also received the mandate at the Family Planning (FP) Summit in London in 2012 to develop programmatic, clinical and technical guidelines, as well as to develop a global indicator framework on human rights in FP [28]. HRP is actively engaged in human rights within the context of SRHR. In 2008, a Lancet article was published related to the assessment of health systems and the right to health in 194 countries [1]. In 2014 work was published around indicators for human rights analysis within contraceptive programmes, and a toolbox for examining laws, regulations and policies in the context of human rights and RMNCH were developed [29]. In 2017 a tool was published for monitoring human rights in contraceptive services and programmes [34], and in 2018 a peer-reviewed article on human rights-based monitoring specifically with FP indicators was published [9].

HRP and RHR, in collaboration with partners, led the process of developing the Ending Preventable Maternal Mortality (EPMM) strategy [30], including goals, targets, and indicators for measurement of maternal health [17, 19]. The EPMM strategy was published in February 2015 and served as a reference document to support the inclusion of the maternal mortality goals in the SDG framework.

The potential HRP contribution to the public good is sometimes challenged, especially in more sensitive work streams. When the SDGs were developed, a suggestion for six indicators for measuring violence against women was provided by HRP but the committee opted for only one. Furthermore, the definition of the indicator was broadened (extension of age group, for which there was actually no consensus on what counts and what not) with the result that there are concerns that this indicator cannot be measured appropriately. Moreover, the core set of indicators for sexual health are only used to a limited extent since they are not yet officially published. It is therefore challenging to determine whether any achievements can be attributed to HRP's work in this area.

IMPACT AND ADDED VALUE OF HRP CONTRIBUTION

Reaching consensus on global indicators is a demanding and time-consuming process and measuring the impact of the work done by HRP on global monitoring and indicators is challenging. The work on monitoring MMR is largely recognised by informants as having produced a significant impact. MMR declined globally by an average of 3% per year between 2000 and 2015, although this can obviously not be attributed directly to HRP's work on global monitoring and indicators. Most informants referred to the essential tole of HRP in monitoring trends across countries and regions and in tailoring programmes and developing guidelines. Indeed, respondents to the online survey conducted for this evaluation rated HRP as very influential in shaping national policies on SRHR in low- and middle-income countries. HRP is regarded as a unique global resource for developing, monitoring and updating evidence-based norms and standards to support policy formulation, which includes global monitoring, development of definitions, indicators and monitoring frameworks [23]. HRP's outputs such as global estimates and guidance documents are widely used for monitoring progress towards national and global SRH targets. There are no similar institutions that provide global leadership on sensitive technical and policy issues in the area of

SRHR, such as unsafe abortion, violence against women, human rights, sexual health and STIs. Some informants consider the work stream of global monitoring and indicators as more important than other HRP work streams, such as conducting or coordinating research.

Most informants stated that because of its location within WHO, the credibility of HRP is assured, and its publications related to global monitoring and indicators are considered more valid and to have a larger global health impact than similar products from other institutions.

CONCLUSIONS AND FUTURE PERSPECTIVES

SCOPE OF HRP'S INVOLVEMENT IN GLOBAL MONITORING, AND THE MATCH WITH HRP'S MANDATE AND COMPARATIVE STRENGTHS

HRP's overall mandate is to lead research in SRHR and to conduct research capacity strengthening. Within that context, it brings together a range of stakeholders to identify and address priorities for research to improve SRHR. It is embedded in the WHO RHR to ensure linkages between evidence-based outputs of HRP and the normative role of WHO. As identified in previous evaluations, it is not always easy to distinguish between the outputs of HRP and the outputs of RHR. From a practical point of view, the distinction between RHR and HRP is not clear. RHR staff work on both WHO and HRP outputs or products with the source of budget as the only distinction between the two.

HRP's involvement in setting targets, defining indicators and monitoring global progress in SRHR is generally considered appropriate and in line with HRP's mandate and comparative strengths.

REFLECTION ON MORE RECENT WORK STREAMS IN HRP'S WORK ON GLOBAL DATA AND INDICATORS

in the 2013 evaluation of HRP [12], informants were asked to rank thematic areas that should be given more attention in the future. Informants identified adolescent reproductive health as an important area in which HRP should engage more actively. In the current evaluation, informants continued to stress this importance and confirmed that more could be done in this area. There was a general view that HRP could take on a role in monitoring adolescent SRHR in joint collaboration with the MCA Department in WHO.

The need for global monitoring of SRHR in humanitarian settings was also expressed by informants. During the evaluation period of 2013-2017, HRP did not actively engage in this area. Many of the countries concerned do not yet prioritise SRHR in the context of humanitarian crisis and migration and data that could feed into global monitoring are therefore scarce.

HRP has already engaged for some time in defining indicators and monitoring global data on human rights and gender equality in SRHR and on GBV [25]. Informants anticipated that the current focus on primarily monitoring health outcomes will shift towards a greater focus on social determinants.

RECOGNISED OUTPUTS AS AUTHORITATIVE DATA

As highlighted in previous evaluations, the HRP work on global monitoring and indicators continues to be highly valued by stakeholders. HRP's outputs and products in the area of global monitoring and indicators are considered by stakeholders as authoritative. Through its monitoring work HRP continues to provide global leadership on sensitive SRHR issues and generates global public health goods of high quality and utility.

Despite the difficulty in distinguishing between WHO and HRP, the majority of the informants believes that because of its location in WHO, HRP is ideally placed for setting the agenda and advocating for global SRHR.

CONTRIBUTION TO GLOBAL STRATEGIES AND CONVENTIONS

HRP's work in defining and monitoring indicators and targets for SRHR has been influential for the development of global strategies and conventions. The MDGs, SDGs and the GSWCAH stand out as the most important global strategies to which HRP has contributed. HRP's work on monitoring maternal mortality and morbidity was used by the Human Rights Council to adopt a resolution on preventable maternal mortality and morbidity, and HRP received the mandate to develop a global indicator framework around human rights in family planning.

OUTPUTS AGAINST PROGRAMME TARGETS

The HRP performance monitoring framework includes only one output indicator related to the publication of global and regional estimates of reproductive, maternal and perinatal conditions. No other programme targets exist for HRP's work on global monitoring and indicators. The achievements reported during the period under evaluation largely exceeded the targets of four publications per biennium.

RECOMMENDATIONS

1. In the area of defining and monitoring indicators for maternal, neonatal adolescent health, WHO, in consultation with the HRP Standing Committee and the PCC, should review the division of tasks and mandates of HRP and the WHO MCA Department to arrive at a solution that clearly avoids a potential duplication of efforts and structures.
2. 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.
3. In its results framework, HRP should define its outputs and outcomes more precisely, (i) reporting the outputs related to the global indicators for which it is the custodian, (ii) the outputs related to global indicators for which it provides input and support to other agencies, (iii) the outputs of research into new global indicators, and (iv) the outcomes of its work in global monitoring and indicators in terms of improved global accountability for SRHR.

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ANNEXES

HRP PRODUCTS SAMPLED FOR THE CASE STUDY

- HRP ID 90: Development and testing of indicators for measuring sexual health (2012/13)
- HRP ID 112: Estimates of reproductive morbidities (2012/13)
- HRP ID B30: Estimating the magnitude and impact of unsafe abortion and monitor safe abortion policies (2014/15)
- HRP ID C8: Development and testing of survey tools to measure sexual and other forms of gender-based violence including in conflict-affected settings (2014/15)
- HRP ID C34: Integrating human rights, gender equality and sexuality related issues into sexual and reproductive health externally and internally (2014/15)
- HRP ID C27: Maternal mortality global estimates (2016/17)
- General HRP work on global monitoring and indicators for STIs

KEY INFORMANTS INTERVIEWED*

BOERMA, Ties	University of Manitoba, Lead Countdown 2030
CHOU, Doris	Medical Officer WHO RHR
DONNAY, France	Bill & Melinda Gates Foundation (formerly)
GANATRA, Bela	Medical Officer WHO RHR
GARCIA MORENO, Claudia	Medical Officer WHO RHR
KHOSLAN, Rajat	Human Rights Advisor OHCHR
LAVELANET, Antonella	Medical Officer WHO DRHR
NORMAN, Jane	Professor Maternal and Foetal Health University of Edinburgh
PULLUM, Tom	Research Director DHS
RASHIDIAN, Arash	Director Information, Evidence and Research WHO EMRO
REQUEJO, Jennifer	Medical Officer UNICEF
SAY, Lale	Coordinator AGH Team WHO RHR
TAYLOR, Melanie	Medical Officer WHO RHR
TEN HOOPE BENDER, Petra	Technical Advisor SRH UNFPA
TOSKIN, Igor	Medical Officer WHO RHR

** This list includes stakeholders interviewed specifically for case study 1.*

9. HRP'S WORK ON COMPREHENSIVE MATERNAL AND PERINATAL HEALTH, INCLUDING POSTPARTUM CONTRACEPTIVE USE

SUMMARY

The review of HRP performance in the area of maternal and perinatal health and postpartum contraceptive use in the period from 2013 to 2017 was carried out through document reviews and key informant interviews. The interviews and document reviews were conducted within the context of the overall HRP evaluation. Interview scripts for relevant stakeholders were expanded accordingly.

The UN Millennium Declaration in 2000 and the associated health sector goals and targets drew the world's attention to the service gaps and global inequities in maternal and child health and gave rise to global strategies, partnerships and financing initiatives. Major improvements in maternal and neonatal health were achieved although the global targets set for 2015 were not reached.

In this context HRP built a strong reputation as a global leader in maternal and perinatal health research and attracted large designated contributions for research projects in this work stream. HRP's work in maternal and perinatal health was conducted in close collaboration with the WHO Department of Maternal, Newborn, Child and Adolescent Health (MCA).

Postpartum contraception was addressed in all relevant research projects and guidelines on contraception produced by HRP, however no specific projects on postpartum contraception were identified during the evaluation period. An assessment of HRP's work in postpartum contraception would require a review of the entire contraceptive research portfolio which was beyond scope for the evaluation.

Despite the fact that HRP's budget and expenditures in maternal and perinatal health between 2014 and 2017 were dominated by just two multi-centre trials on Carbetocin and antenatal corticosteroid use, the Programme managed to implement a broad women-centred research portfolio with a focus on improving the quality of antenatal and intrapartum care.

In the very active global programming environment for maternal and perinatal health, the contribution of any single actor is difficult to identify. Furthermore, HRP monitored its outputs by counting publications and events in a very undifferentiated manner and did not monitor its outcomes at all. Nevertheless, there is evidence that outputs in terms of changes in national policies and programmes were achieved on the basis of HRP's work.

More than in any other workstream, HRP's work in maternal and perinatal health is conducted across departmental boundaries within WHO. The mandate for normative work and technical assistance to countries in this area is placed with the MCA Department of WHO. The interdepartmental work was described to be cooperative and collegial by all interviewed staff, but the departmental boundaries were at times felt to be cumbersome and the organisational arrangement is being questioned by senior WHO officials.

Based on the findings of this review, the evaluation team recommends that HRP should adopt a more structured approach to monitoring outputs and start to systematically monitor outcomes. Furthermore, PCC should ask senior WHO management to clarify the division of tasks and mandates between the RHR and MCA departments in the area of maternal and perinatal health research.

INTRODUCTION

In the WHO Department of Reproductive Health and Research (RHR), HRP's work in maternal and perinatal health is managed by the Maternal and Perinatal Health and Preventing Unsafe Abortion (MPA) team, while research and guideline development on postpartum contraception is managed by the Human Reproduction (HRX) team. Over the three biennia from 2012 to 2017, the budget for the work stream of maternal and perinatal health increased from 13 to 16 percent of the HRP budget, and expenditures from 12 to 28 percent of total expenditures. In the past two biennia, budgets for maternal and neonatal health were significantly overspent (by 175% in 2016/17) which was largely due to a small number of designated grants, especially for the CHAMPION project funded by Merck for Mothers and conducted in partnership with Ferring Pharmaceuticals. Under this project, HRP conducted a non-inferiority trial of Carbetocin [1] as a heat stable alternative to Oxytocin for the prevention of post-partum haemorrhage. It accounted for 44 percent of all of HRP's designated grant income in 2014/15 and for 20 percent in 2016/17.

In 2013, WHO published the programming strategy for postpartum family planning based on work by HRP and PDRH in the previous evaluation period. [13] HRP's work in this area during the 2013-2017 evaluation period was largely integrated in the overall portfolio of contraceptive research and guideline development and cannot be separated. Contraception in the postpartum period, for instance, is covered in detail in the WHO global handbook for family planning providers that was released as a 3rd revised edition in 2018. [2] Research to improve postpartum family planning uptake was also included in the UPTAKE project, a three-country study funded with designated grants from USAID and the Bill and Melinda Gates Foundation (BMGF) and one of the flagship projects of the HRX team during the evaluation period. The study explores how social accountability activities can improve contraceptive uptake. Formative research was completed during the evaluation period and one of the formative studies was included in the research quality assessment. The implementation phase started in 2017. No outputs from this phase were available to the evaluation team.

Only two projects were identified that focused specifically on postpartum contraception.

- Operational research in Burkina Faso and the DR Congo explored the feasibility and effectiveness of family planning counselling and service provision in conjunction with antenatal, post-delivery and postpartum care. [3] The research was funded with a grant from the Government of France to WHO under the French Muskoka Initiative. The funds were channelled through the WHO account for specified voluntary contributions to the RHR Department's PDRH account and the research is therefore not an output of HRP.
- In 2017, HRP started the initiation phase of a trial of the safety of contraceptive pills in conjunction with breastfeeding in the postpartum period. The study sites are in Zambia and Malawi. The research was still in the early initiation phase at the end of the evaluation period.

HRP's work in maternal and perinatal health was conducted in close collaboration with the WHO Department of Maternal, Newborn, Child and Adolescent Health (MCA). Several donors split their designated grants deliberately between the HRP Trust Fund and voluntary contributions to WHO for implementation by MCA. Mandate overlaps and conflicts between HRP and MCA that, according to interviewees existed in early years, were not noted during the evaluation period. According to interviewed staff in both departments, collaboration in working groups was collegial and productive, with an efficient division of responsibilities. The 2018 WHO recommendations on intrapartum care [4] that were developed jointly under leadership of HRP were cited as an example for this cooperation.

METHODOLOGY

The review of HRP performance in the area of maternal and perinatal health and postpartum contraceptive use in the period from 2013 to 2017 was carried out through document reviews and key informant interviews. The interviews and document reviews were conducted within the context of the overall HRP evaluation. Evaluation questions 1-5 of the programme evaluation (see detailed methodology) were modified to specifically refer to maternal and perinatal health. Interview scripts for relevant stakeholders were expanded accordingly. Ten key informant interviews were conducted with the expanded interview scripts. They included interviews with staff of the MPA and HRX teams of HRP, WHO MCA staff, and staff of the Partnership for Maternal Neonatal and Child Health (PMNCH). (see Annex) Additional data for the case study were collected through the general evaluation interviews, the on-line survey and the research quality assessment of four out of 13 research projects that focused on issues of maternal and perinatal health.

LIMITATIONS

With the exception of the PDRH-funded operational research in Burkina Faso and DR Congo and the initiation of a trial of oral contraceptives among breastfeeding mothers in Malawi and Zambia, no specific work stream for postpartum contraception was pursued by HRP during the evaluation period. Questions about postpartum contraception were fully embedded in all relevant research and guideline development work on contraception and family planning. An evaluation of HRP's work in this area would require an overall evaluation of HRP's contraceptive research and guideline portfolio which was beyond scope for this case study.

RATIONALE

HRP's work in maternal and perinatal health started in the mid 1990s as part of the shift of the Programme's focus from research on fertility regulation to a broader reproductive health agenda. Over more than 20 years, HRP built a strong reputation as a global leader in generating and synthesising evidence for the improvement on maternity services. At the same time, the UN Millennium Declaration in 2000 and the associated health sector goals and targets drew the world's attention to the service gaps and global inequities in maternal and child health and gave rise to global strategies, partnerships and financing initiatives, including new fora for cooperation among the UN organisations that are cosponsoring HRP. Nevertheless, the direct link to WHO as the lead normative UN agency in health, as well as the established reputation of high-quality work, continued to be the source of HRP's strong comparative advantage as a global reference for evidence in MNH.

The intense focus of global health initiatives on maternal and perinatal health during the era of the millennium development goals (MDGs) resulted in major improvements in the availability, access, utilisation and quality of reproductive health services, without, however, reaching the global targets that were set for 2015. Between 1990 and 2015, the global maternal mortality ratio fell from 380 to 210 per 100,000 and the neonatal mortality rate from 33 to 19 per 1,000 live births. [5] In 2015, the UN General Assembly adopted a broader framework of goals and targets in health under the 2030 agenda for sustainable development. [6] The sustainable development goals (SDGs) were translated into the 'survive, thrive, transform' framework of the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030 with considerable technical input from HRP. [7] While the framework of action to reach the SDG targets in sexual and reproductive health has broadened under the umbrella of universal health coverage (UHC), the targets for the reduction of maternal and neonatal mortality by 2030 remain a challenge with aims to achieve a global reduction of the maternal mortality ratio to 70/100,000 and of the neonatal mortality rate to 12/1,000.

In this global context, the MPA team initiated a formal process of setting priorities and defining its portfolio of activities. In the priority-setting process, 140 stakeholders scored 190 priority research questions for the period of 2015 to 2025. Among the priorities to close evidence gaps through research in maternal and perinatal health, the highest scores were obtained for implementation research of existing interventions. [8] On the basis of these findings and a review of the current portfolio by the MPH team, the STAG proposed a programme of work for the period 2017-2021 with six focus areas for MPH: [9]

- Develop guidance on implementing WHO guidelines for antenatal care at scale;
- Develop guidance on implementing WHO guidelines for intrapartum care at scale;
- Develop and evaluate digital and technological innovations to improve pregnancy and childbirth experience and health outcomes;
- Develop recommendations on interventions to reduce unnecessary caesarean sections;
- Provide global leadership in preventing and managing maternal and newborn sepsis;
- Continuous review and revision of WHO maternal and newborn health guidelines.

Although this programmatic guidance applies to the post-evaluation period, it reflects a consensus opinion among experts and implementers of where the research agenda of HRP should be positioned by 2017, and it is therefore a benchmark against which the work between 2013 and 2017 can be assessed.

PROCESS

WHAT HRP DID AND HOW

To analyse the work of HRP in maternal and perinatal health, we extracted the HRP products labelled with the MPH budget category from the expenditure database for the three biennia (2012-2017) provided by the HRP Secretariat. After removing administrative expenditure lines and budget lines without expenditure, 80 products remained with total expenditures of US$ 29 million, excluding all staff and overhead expenditures. A small number of products were reported twice because expenditures were made over more than one biennium. We then recoded each expenditure on the basis of the task name using the following labels:

- Antenatal care
- C-Section
- Fistula
- Intrapartum care
- Perinatal or neonatal health
- Policy research /methodology research
- Post-partum haemorrhage
- Sepsis
- Other

The ‘other’ category included single studies on Zika virus, surveys, a human rights assessment, and a number of products that could not be coded such as a product labelled ‘implementation research platform’.

Over the three biennia, the number of products and the expenditures increased sharply after the first biennium. Further analysis, however, showed that the increase in spending was driven by only two projects funded with designated contributions. The non-inferiority trial of Carbetocin for the prevention of post-partum haemorrhage funded by Merck for Mothers and the trial of antenatal corticosteroids for improving outcomes in preterm new-borns funded by the Bill and Melinda Gates Foundation accounted for almost half of all HRP expenditures on maternal and perinatal health over the three biennia of the evaluation period.

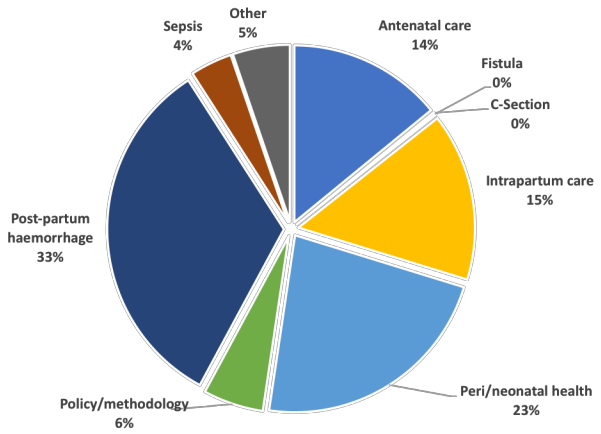
MPH products and direct expenditures (without staff and overhead costs)

Biennium	Number of products	Expenditures (US$)			
		Carbetocin Non-inferiority Trial	Antenatal Corticosteroid Trial	All other products	Total
2012/13	21	0	0	4,325,026	4,325,026
2014/15	30	5,590,104	0	5,884,925	11,475,029
2016/17	29	3,718,028	4,828,703	4,528,098	13,074,829
Total	80	9,308,132	4,828,703	14,738,049	28,874,884

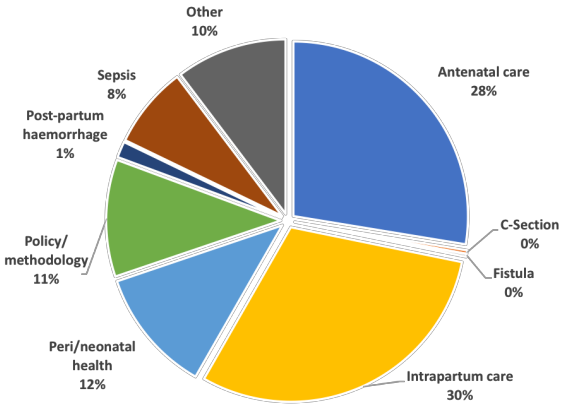
The profile of expenditures by research area was also strongly influenced by the two projects as seen in the graphics.

MPH expenditures by research area

Expenditure profile 2012-2017 (US$ 28,874,884)



Profile without 2 trials (US$ 14,736,049)



Expenditures are only an indirect measure of the level of effort and the scope of activities. Expenditures on implementation research studies, for instance, were generally much lower than for the two large multi-centre trials. Synthesising evidence and convening panels of experts to build consensus for the development of guidelines are also activities that do not require heavy investments. The second figure, the HRP MPH profile without the two projects funded with designated contributions is therefore a more valid reflection of activities during the evaluation period. Nevertheless, large high-budget projects with designated funding, even if all costs are covered by the donor, have an opportunity cost that is born by the Department. The first figure shows the extent to which just two projects with designated funding affected the profile of HRP's work. The issue of designated funding was the subject of extensive discussions during the 30th meeting of the PCC in 2017. On request of the PCC, the conditions for acceptance of designated contributions were amended. [20] While the balance of designated versus undesignated funding continues to be an issue that raises programmatic risks and continues to require close observation by the PCC, it was addressed by the Programme and the PCC at the end of the evaluation period.

The second figure shows that the two areas of quality antenatal and intrapartum care that are on the top of the list of STAG-proposed priorities for 2017-2021 were already well covered during the evaluation period of 2013-2017. The 'development and evaluation of digital and technological innovations' was pursued throughout the evaluation period under the 'Better Outcome in Labour Difficulty' study. [11] It was coded under intrapartum care and accounted for about half of all expenditures in this category.

According to the list of scientific publications reported by HRP for 2016/17, considerable work was done with HRP support on studying the practice and trends of caesarean section in several countries. During the evaluation period, this work involved primarily the synthesis of evidence and the publication of trends in countries and regions. As these are not costly studies, they only show up very weakly in the expenditure reports. This work, however, generated the necessary evidence for HRP to start addressing the issue of unnecessary caesarean sections systematically since 2017. The issue of maternal and neonatal sepsis was picked up in 2017 as a global initiative for the prevention, early identification and management of maternal and early neonatal sepsis in more than 50 low- and middle-income countries. [10] Finally, the continuous revision of guidelines cuts across several thematic areas and therefore did not show as separate items in the expenditure analysis.

INPUTS

HRP's work in maternal and perinatal health was financed with undesignated and designated contributions to the HRP Trust Fund. Undesignated contributions by the cosponsoring agencies practically ceased during the evaluation period and only made up two percent of contributions to the Trust Fund in 2016/17. (see Volume 1) The main contributors of undesignated funds were governments.

The financial reports for 2014/15 and 2016/17 include the list of designated grants received. Maternal and perinatal health was the programme area that received most of the designated funds with a total of about US$ 28 million over two biennia or 58 percent of all designated grants. Almost all of these funds (93%) were provided by Merck for Mothers and by the Bill and Melinda Gates Foundation. [12]

All research projects in maternal and perinatal health were conducted in collaboration with research institutions or ministries of health in programme countries. For knowledge translation, including the convening of expert panels for evidence assessment, the development of guidelines and norms, and the follow up of guideline implementation with technical support, the MPH team of HRP worked closely with the WHO MCA Department. The Partnership for Maternal, Neonatal and Child Health (PMNCH) as the main partnership and advocacy platform for the Global Strategy for Women's, Children's and Adolescents' Health has a key role in communicating evidence and normative work generated by HRP and MCA to its more than one thousand member organisations. According to key informants, PMNCH works closely with HRP but sees room to further strengthen the collaboration.

OUTPUTS

In 2013, HRP had not yet adopted its results reporting framework. MPH-relevant outputs reported in 2013 included two technical publications: WHO programming strategies for postpartum family planning and WHO guidelines for measuring maternal mortality from a census. In addition, the Programme listed 47 papers published in scientific journals in 2013 that dealt with maternal or perinatal health issues, the great majority based on work done prior to the evaluation period.

For the following two biennia, HRP reported against the nine output indicators of its results framework. We reviewed the reported outputs and filtered those that were relevant to HRP's work in maternal and perinatal health.

MPH-relevant outputs reported by HRP in 2014/15 and 2016/17

OUTPUT INDICATORS *(DEFINITION)*	TOTAL	MPH
1.1 Implementation research and clinical trials on SRH published. *(# scientific articles published)*	702	288 (41%)
1.2 Global and regional estimates of reproductive, maternal and perinatal conditions published. *(# global/regional estimates published)*	15	10 (67%)

OUTPUT INDICATORS *(DEFINITION)*	TOTAL	MPH
1.3 Interventions developed, tested and implemented to address unmet needs in sexual and reproductive health (e.g. adolescent interventions). *(# new interventions developed, tested and disseminated)*	9	4 (44%)
1.4 New or ongoing research projects funded. *(# research projects approved by the HRP Research Project Review Panel)*	66	23 (35%)
2.1 Systematic reviews of key questions in sexual and reproductive health published. *(# systematic reviews published)*	196	88 (45%)
3.1 National research capacity strengthened. *(# research centres strengthened through HRP grants)*	66	N/A
4.1 Technical, clinical and policy guidelines and other issued on sexual and reproductive health (e.g. family planning, maternal and perinatal health). *(# new or updated guidelines issued)*	43	11 (26%)
5.1 Policy options analysed and synthesised, derived from technical and clinical guides. *(# policy briefs/guideline derivatives issued)*	65	18 (28%)
5.2 National capacity to support and develop evidence-based policies strengthened. (# *regional or international consultations convened or supported for systematic introduction of policy options)*	146	N/A

Sources: HRP Results Reports 2014 to 2017

- The 702 scientific articles counted and listed in the HRP results reports from 2014 to 2017 under **output 1.1** were produced by HRP staff and by research partners of HRP-supported projects. They include published corrections of errors of previously published papers, responses to letters to the editor, double entries of the same paper published electronically and in print, and editorial comments. The real number of scientific publications is therefore considerably lower, probably in the range of 600 to 650. The filtered list of MPH-relevant publications (288) was cleaned of duplications and inappropriate entries. The proportion of scientific publications on maternal and perinatal health among all HRP scientific publications during the four-year period was therefore larger than 41 percent calculated.
- For **output 1.2**, considerable over-reporting was also noted. All of the 15 reported outputs were already reported under output 1.1, and about half of them only marginally qualified as work for the generation of global or regional estimates but were rather academic studies of secondary analyses of available data. More relevant outputs were two updates of global maternal mortality estimates and projections by the UN Maternal Mortality Estimation Inter-Agency Group in which HRP participates. HRP also published global, regional and national estimates of Caesarean section rates and of stillbirth rates.
- For **output 1.3**, interventions developed, some duplications were noted as interventions developed in 2014/15 were again reported in 2016/17, albeit at a more mature stage, for instance after being published as a WHO guideline. The actual programme output in this category should be seven rather than nine, of which four were in the MPH area. These included a new model for antenatal care, new intrapartum care guidelines, a system for monitoring progress and adapting national programmes for the elimination of perinatal HIV and syphilis transmission, and a procedure for shorter urinary catheterisation after fistula repair.
- Among the 65 new studies approved under **output 1.4** (one study was withdrawn and should not have been reported), 23, roughly one third, were in the area of maternal and perinatal health. This may be surprising considering that almost half of all research expenditures were in this area. (Volume 1, Table 5) It is explained by the small number of high-budget studies in MPH that were conducted by

HRP during the evaluation period. Of note is that eleven of the 65 approved studies were concerned with Zika virus, most of them funded under the HRP/TDR/PAHO Joint Small Grants Programme for research on the Zika virus outbreak in the Americas.[1] MPH research projects approved included, among others, the two large trials of Carbetocin and antenatal corticosteroids (see above), two further global studies on better outcome of labour and on maternal sepsis and two studies on mistreatment of women during childbirth.

- The 196 systematic reviews reported under **output 2.1** are in fact not additional outputs and were already reported under output 1.1, 1.2 or both. After cleaning the data by removing double entries (e-publications and print publications of the same paper) and a few inappropriate entries (e.g. a case study), 182 publications remained of which 88 were relevant to maternal and perinatal health. Reviews were performed by HRP staff and by research partners with HRP support. The themes varied widely from highly specialised technical issues such as a review of evidence of skin preparation for preventing infection following caesarean section to broad health systems questions such as a systematic review of facilitators and barriers to facility-based obstetric delivery.
- **Output 3.1**, research capacity strengthening, cuts across all areas of HRP's work and the results cannot be allocated to a specific work stream. Research capacity strengthening should happen in the context of all funded research that is implemented by or in collaboration with research partners in low- and middle-income countries, but it is not reported separately by HRP. Specific training courses on MPH research were not reported by interviewed internal informants.
- After cleaning the results reports for **output 4.1** (guidelines issued) by removing, for instance executive summaries of guideline documents that were reported as a separate output, 39 publications remained of which 11 were relevant to the area of maternal and perinatal health. Although the number of guidelines was not large compared to the overall output of the Programme in this area, it included some high-impact publications that received much attention. The WHO recommendations for prevention and treatment of maternal peripartum infections, [14] for instance was known by 79 percent of respondents to the on-line survey conducted for the evaluation among whom 95 percent rated it as a publication that was very or extremely important. (see Section 2) Other important outputs were updated recommendations for antenatal care [15] and standards for improving the quality of maternal and newborn care in health facilities. [16] Work on WHO guidelines for intrapartum care [4] was also conducted during the evaluation period, but the guidelines were published in 2018 and are therefore not included in the output reports. While the MPH team of HRP provided critical input in the generation of these guidelines, they are products of the inter-departmental cooperation in WHO including, for instance, considerable input by the MCA Department.
- Under **output 5.1** (policy briefs/guideline derivatives) 65 products were reported, among them two in duplicate. Of these, 18 were in the thematic area of maternal and perinatal health followed closely by family planning (15) and STIs including HIV (12). Among the MPH-relevant outputs were a guide for safe delivery and newborn care in the context of an outbreak of Ebola in 2014 [18] and an interim guide to pregnancy management in the context of Zika virus infection in 2016. [19] Another important output was the WHO Statement on caesarean section rates (2015) with the message that 'every effort should be made to provide caesarean sections to women in need, rather than striving to achieve a

[1] www.paho.org/hq/dmdocuments/2016/call-applic-hrp-trd-paho-grant-2016-en.pdf

specific rate', [17] thereby preparing the field for the work of HRP in 2017/18 deliver the evidence for ending the harmful practice of unnecessary caesarean section.

- Finally, under **output 5.2** all conferences and consultations were reported that were organised by HRP or to which HRP contributed in some form. Among them were some key events that provided a venue for HRP to influence policies, programmes, and the practice of maternal and perinatal health service delivery such as the Congress of the International Federation of Midwives in 2014, the World Congress of the International Federation of Gynaecology and Obstetrics (FIGO) in 2015, and the 4th Women Deliver Global Conference in 2016. But it also included a long list of conferences and meetings which may have provided opportunities for catalytic input by HRP, but in which HRP had at best a marginal role such as UN General Assembly and G7 meetings or International AIDS Conferences. Counting all meetings and combining them in a single statistic is not very useful for performance monitoring.

In summary, the HRP work stream of maternal and perinatal health generated many outputs during the evaluation period and was particularly prominently represented among the overall Programme results in the production of scientific publications, global estimates and systematic reviews. It also generated the majority of new interventions that were tested and disseminated, most notably among them new antenatal and intrapartum care guidelines.

OUTCOMES AND IMPACT

The evaluation period from 2013 to 2017 spanned the last years of the MDG era from 2013 to 2015 when governments, international agencies, global health initiatives and NGOs focused intensively on reaching the targets for the reduction of maternal and neonatal mortality. The global targets were not reached, and maternal health remained as an unfinished agenda at the end of 2015. But many national, regional and global coalitions worked intensively to increase the access, utilisation and quality of antenatal and maternity care, and considerable progress was charted during those years. Policies to decrease the barriers to service access, to mobilise communities for stimulating the demand for services, to increase the motivation and the skills of health workers to increase the quality of services and to improve the infrastructure and coverage of maternity services were adopted in many countries. The coverage rates for at least four antenatal visits and for skilled attendance at birth in developing countries increased from 42 to 52 percent between 2010 and 2014, the proportion of skilled attendance at birth increased globally from 61 to 71 percent, the maternal mortality ratio from 330 to 210 per 100,000 and the neonatal mortality rate from 22 to 19 per 1,000. [5]

In the context of the intensive global activity in maternal and neonatal health it is impossible to assess the HRP contribution, especially since Programme outcomes in terms of the adoption of evidence-based policies and programmes are not monitored and reported by HRP. Respondents to the on-line survey 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, 17 cited an example for maternal health policy in 13 countries, surpassed only by contraception for which 20 examples were cited. Brazil, South Africa and Thailand were cited more than once. Among the specific areas of policy influence, the antenatal care guidelines were cited four times, guidelines on quality of care during childbirth twice, and the guidelines on prevention and treatment of postpartum haemorrhage as well as the reduction of unnecessary caesarean section once each.

The recommendations to improve the quality of antenatal care [15] were among the most recent outputs to be published (November 2016) which may be one of the reasons why they were mentioned most frequently. In a rare instance of outcome reporting, HRP stated in its 2017 annual report that '*in 2017,*

nine African countries adopted the new WHO recommendations in their policies, and national scale-up in South Africa began in April 2017'. The outcome information is apparently available, it just not systematically monitored.

Outcomes in maternal and perinatal health, to the extent that they can be captured, are, however, not exclusively attributable to the research supported by HRP. The WHO MCA department is closely involved in developing relevant guidelines, and technical support for their implementation is provided by many partners, including the WHO Regional and Country Offices. In key informant interviews, questions about the attributability of MPH outcomes led invariably to discussions about the division of tasks and responsibilities within WHO and raised a number of questions, including among senior WHO officials. There was a general acknowledgment among all key informants that the HRP MPH team has the global recognition for the high quality of its work and is seen as a global leader in MPH research. This presumably also contributes to the capacity of the team to attract resources for the implementation of large multi-country research projects. The main mandate for translating the research evidence into policies and in providing technical support via the WHO regional and country offices for their implementation rests with the MCA Department. Unlike for the areas of STI control or contraception, where these tasks are located in the RHR Department (although split between the HRH and PDRH budgets), for MPH they require the organisation of work across departmental boundaries. Although the cooperation was smooth and collegial throughout the evaluation period, the departmental separation was felt to be at times cumbersome by staff of both departments.

CONCLUSIONS AND FUTURE PERSPECTIVES

CONCLUSIONS

The reputation for research excellence in maternal and perinatal health, and the global race to reach the MDG targets by 2015 contributed to the acquisition of large designated research grants by HRP that dominated the financial performance of the Programme in this work area during the evaluation period. HRP, however, continued to generate a broad spectrum of research outputs in identified priority areas. The Programme implemented its own priority agenda of generating evidence and guidance for quality improvement in antenatal and intrapartum care.

In this context, HRP started to build the evidence for addressing issues that were less prominently in the international focus because their potential contribution to reaching mortality reduction targets were less evident. HRP started to document the mistreatment and disrespect of women delivering in health facilities. While international attention was rightfully focused on increasing access to caesarean sections in order to decrease maternal and perinatal mortality, HRP recognised the adverse impact of excessive use of operative delivery and started to build the evidence needed to address this issue. These two examples suggest that HRP was able to implement a women-centred research programme based on priorities chosen with foresight and independently of available sources for designated funds. Nevertheless, the risks of depending on designated funds from a small number of donors over a protracted period should not be underestimated.

Throughout the evaluation period, HRP was very productive in generating a large number of outputs in maternal and perinatal health, especially scientific publications. More differentiated reporting of outputs, for instance by grouping them according to themes, type of research and level of HRP input in the research would help in presenting a clearer picture of the achievements of HRP's work in maternal and perinatal health. Equally important is the establishment of a monitoring system for outcomes which, during this evaluation period, could only be appreciated on the basis of quasi-anecdotal reports. There is good evidence the HRP has contributed to global, regional and national improvements in the delivery of maternal and perinatal health care and thereby to an increased realisation among women of their right

to a positive pregnancy experience. Documenting this with attractive photographs in annual reports is one thing, but donors to the HRP Trust Fund are asking for more substantive documentation.

For historical reasons, the research, normative work and technical support to countries in the area of maternal and perinatal health of WHO is split between two departments. This is, to some extent, unique for this particular work stream. The evaluation found no evidence that it has in any way hindered the quality or effectiveness of work during the evaluation period. It did, however, raise questions among senior WHO management and it was felt to be somewhat cumbersome by the involved staff.

LESSONS LEARNT

During the evaluation period, HRP demonstrated that it can absorb large designated research funds without losing track in pursuing its woman-centred agenda based on an objective assessment of research gaps and needs.

HRP research in maternal and perinatal health is in a position of great strength based on its excellent reputation for research quality, its closeness to WHO as the lead normative agency for health, its close interdepartmental links within WHO, and the ready availability of international funds for work in this area as the MDG era is slowly retreating into history. However, HRP should not forget that its core strength as one of the oldest cosponsored UN health programmes is the trust placed in the programme by the contributors of non-designated funds to the HRP Trust Fund. The needs of these donors to account for their contributions should not be neglected.

Throughout the history of HRP, there have been departmental reorganisations in WHO that have affected the scope and modality of its work. The current situation of a split mandate for research, normative work and technical support in maternal and perinatal health across two departments of WHO was felt to be somewhat cumbersome by the involved staff. But it is working and has worked over the past five years and the evaluation did not find any evidence for inefficiencies.

RECOMMENDATIONS

1. HRP should review and revise its results monitoring and reporting framework, adopt a more structured approach to monitoring outputs that does not focus on counting as many outputs as possible but rather concentrate on presenting meaningful outputs organised by theme and importance. Furthermore, it should define indicators at the outcome level and monitor and report them systematically.
2. WHO should clarify the division of tasks and mandates between the RHR and MCA departments in the area of maternal and perinatal health research within the WHO structure. On this basis, the Programme, with support of the STAG, should review its portfolio of activities in this area and define it in a way that minimises duplications and overlapping mandates.

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ANNEXES

KEY INFORMANTS INTERVIEWED*

BANERJEE, Anshu	Director, WHO MCA
BUCAGU, Maurice	Medical Officer, WHO MCA
DIAZ, Theresa	EME Coordinator, WHO MCA
FOGSTAD, Helga	Executive Director, PMNCH
GAFFIELD, Mary Lyn	Scientist, HRX Team, WHO RHR (PDRH)
GÜLMEZOGLU, Metin	Coordinator MPA Team, WHO RHR
KIARIE, James	Coordinator HRX Team, WHO RHR
OLADAPO, Olufemi	Medical Officer, MPA Team, WHO RHR
ROOS, Natalie	Technical Officer, WHO MCA
TUNCALP, Özge	Scientist, MPA Team, WHO RHR

** This list includes all stakeholders interviewed specifically for case study 2.*

10.HRP'S WORK ON GENDER, EQUITY AND RIGHTS

SUMMARY

Introduction: As a result of persistent inequalities, countless women, adolescent girls and other vulnerable groups face barriers to access their right to sexual and reproductive health services. One of the most frequent forms of human rights abuses worldwide – and a major public health concern - is violence against women and girls. It is part of the mandate of the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) to contribute to improving this situation. The Programme undergoes external evaluations on a five-year basis to ensure accountability to its donors, beneficiaries and its partners. The current evaluation aimed at assessing the efficiency, effectiveness, impact and sustainability of its work, as well as its governance and management in the period from 2013 to 2017. Issues of particular interest were assessed through case studies. The objective of the current case study report was to analyse HRP's work on gender, equity and rights, including broader work from a 'leave no one behind' perspective.

Methods: The external evaluation exercise took place from September to December 2018. The data collection for the case study included interviews with 26 key informants who had been selected based on a stakeholder mapping and with recommendations from the HRP team in Geneva. The key informant interviews were complemented by an extensive document review and data from the online survey. Due to the limited time available, products for review were selected based on the titles. Additional documents were collected directly from key informants. We also conducted an assessment of the quality and depth of gender, human rights and equity mainstreaming in a randomly selected sample of 10 HRP products.

Results: The Programme's priority setting and rigorous guideline development processes have resulted in numerous outputs with primary focus on gender, human rights or worst-off groups that are of critical relevance for sexual and reproductive health and rights in low- and middle-income countries. The uptake of HRP's outputs is high, in particular at the global level and to a lesser extent at country level. Significant outcomes were achieved in the areas of safe abortions, the mainstreaming of human rights norms and standards in family planning, violence against women and sexual rights.

The assessment of gender, human rights and equity mainstreaming in a sample of HRP's products showed inconsistencies, in particular in the area of gender. Mainstreaming was of lower quality and depth in research than in technical guidelines. There are two main reasons for that: (1) the capacity of the Programme's staff to mainstream gender, HR and equity varies within HRP's team and (2) The accountability mechanisms in place are not strong enough to ensure effective integration of the three areas in HRP's research.

The Programme has achieved geographical and gender diversity in its governance and the technical committees. The Gender and Rights Advisory Panel adds significant value for ensuring that important gender and human rights are kept on the agenda and are effectively addressed by the Programme. Meaningful participation of country delegates in the Policy and Coordination Committee meetings, however, merits improvement.

Conclusion and recommendations: HRP's outputs have delivered evidence as well as technical and clinical guidance that is instrumental to achieving equitable access to SRH and for decreasing adverse health outcomes of gender-based violence and harmful traditional practices. While output delivery on gender and HR has been impressive, consistent mainstreaming of gender, equity and human rights in the Programme's research has not been achieved. To further enhance the integration of gender, human rights and equity into the Programme, we recommend to (1) initiate a participatory revision exercise of the programmes results framework to ensure effective gender, HR and equity integration; (2) strengthen the

accountability mechanism for gender, HR and equity mainstreaming and (3) ensure stronger support for gender, HR and equity integration during the research design process through coaching and stronger implication of the GAP.

INTRODUCTION

The 2013-2017 evaluation of HRP (henceforth referred to as the 'Programme') aimed to provide information on the relevance of the Programme's objectives in the context of global strategies and goals for sustainable development in general and for the promotion of sexual and reproductive health and rights (SRHR) in particular. It assessed the Programme's performance in terms of the efficiency, effectiveness, impact and sustainability of its work, as well as its governance and management. In doing so, it aimed at enabling the continued incorporation of lessons learnt into its decision-making processes and into those of its partners including its co-sponsors, the member states in its Policy and Coordination Committee (PCC), and other cooperating parties. As in previous evaluations, four case studies were conducted to provide in-depth assessments of issues that are of particular interest to the PCC. The current case study report analyses HRP's work on gender, equity and rights, including broader work from a 'leave no one behind' perspective.

The objective of the case study was to assess the effectiveness, efficiency, impact, relevance and sustainability of HRP's work on gender, equity and human rights. More specifically, it looked at

- The Programme's strategic ambition on gender[1], equity and human rights and at how this ambition was translated into practice
- The diversity in HRP's governance committees
- The quality and scope of gender, equity and human rights mainstreaming in HRP products
- The extent to which HRP's results contributed to advancing gender equality, reducing inequity and protecting and fulfilling human rights commitments.

The specific questions analysed for the case study are listed in the table below.

Evaluation questions for Case Study 3

EVALUATION QUESTION	DAC CRITERIA
1. How have gender, equity and human rights dimensions been integrated in HRP's strategy? Have the strategic ambitions regarding these three cross-cutting areas been effectively translated into the operational performance frameworks and biennial work plans?	Relevance Effectiveness
2. To what extent are gender, human rights and equity parameters integrated in the priority setting process and in the review and approval process of research projects?	Relevance
3. What mechanisms exist to ensure diversity in HRP governance bodies? Are women, different age groups and minorities represented appropriately in governance committees?	Effectiveness
4. How many and what type of outputs have been produced to decrease inequity, gender inequality and human rights violations (against programme targets)?	Efficiency
5. To what extent have HRP research capacity strengthening projects mainstreamed gender and equity dimensions in (a) the selection of institutions and individuals and (b) the content of training/ capacity building?	Relevance Sustainability

[1] This included products with focus on gender-based violence (e.g. prenatal sex selection, female infanticide, FGM, CEFM, sexual violence, intimate partner violence, coerced pregnancy, forced sterilisation) as well as gender identity and orientation.

Evaluation Question	DAC Criteria
6. To what extent are gender, rights and equity mainstreamed in the HRP products (research and normative documents) that were produced or updated with HRP support?	Effectiveness
7. How is evidence generated by HRP used to advocate for human rights, equity and gender equality and what changes has the Programme contributed to?	Effectiveness Impact

Methodology

The methodological approach was based on a stakeholder analysis to ensure contributions from relevant groups and to control bias. We conducted 26 Key Informant Interviews (KII) (Annex 1), an extensive document review, and consulted the results from the online survey (Section 2 of Volume 2) and the Research Quality (RQ)+ assessments (Section 3 of Volume 2) to ensure data triangulation of both data sources and collection methods. For the document review, we organised products into three categories and concentrated our analysis on the first two:

- Products/ documents where either equity, human rights and/or gender were the primary focus.
- Products/ documents where equity, HR & GE were not the primary focus of the product, but where it should have been mainstreamed.
- Products/ documents where equity, HR and GE parameter were less relevant due to the focus on biomedical subjects.

The principal method of data analysis was qualitative content analysis facilitated by the use MAXQDA software. Main codes were established based on the case study evaluation questions (deductive coding). Additional sub-codes were developed while data were being read (inductive coding).

Overall, our aim was to go beyond a technical exercise in data collection and analysis and to encourage a dialogue enabling to learn from each other, to strengthen accountability and to discuss power relations between stakeholders. Due the high number of potential interviewees for the KIIs of this case study, the initial list of participants was suggested by the HRP Adolescents and at-Risk Populations (AGH) team. Some of the proposed interviewees had little knowledge of the Programme and were not able to make significant contributions to the evaluation. After starting the interviews, we added further participants based on the recommendations of other interviewees. It is, however, possible that the initial selection of participants by the HRP team introduced a bias to the results of the case study. Another limitation was that products and outputs for the document review were categorised based on their product titles. This was the only feasible approach considering the timelines for the evaluation, but it is possible that it led to the exclusion of relevant documents. Generally, it was difficult to obtain internal research and documents that are not accessible on the HRP webpage.

Rationale

CONTEXT

Nearly 20 years after ICPD Programme of Action (1994) and the Beijing Platform for Action (1995), the importance of addressing gender equality and human rights in in SRHR have remained a critical global priority. This is reflected in the content of the 2030 Agenda for Sustainable Development[1] adopted by world leaders in 2015. It includes targets on SRHR and a goal on gender equality (including a target on SRHR). In the context of this case study, it is worth mentioning target 3.7: '*By 2030, ensure universal access*

[1] Relevant documentation available at: https://www.un.org/sustainabledevelopment/development-agenda

to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes'. Other highly relevant targets are under goal 5, in particular:

- 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
- 5.3. Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation
- 5.6. Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

The 2030 Agenda states that goals and targets apply for all and aim at reaching first those who are worst off. It recognises that development has not resulted in equitable outcomes and that vulnerable groups such as persons with disability, refugees, people living with HIV or indigenous people are more often denied access to their rights. By taking this commitment, tackling inequities have become a central part of the SDGs. Albeit its ambition, the 2030 agenda has been criticised by SRHR activists for the omission of provisions related to sexual rights, comprehensive sexuality education (CSE), discrimination on the basis of sexual orientation or gender identity; the right to access quality, safe abortion services; and the importance of high quality, confidential and timely sexual and reproductive health services, including for children and adolescents. [1] To support countries to implement the 2030 agenda, the Global Strategy for Women's, Children's and Adolescent Health (2016–2030) and its accountability framework was released in 2015. It explicitly includes certain SRHR issues which were omitted in the SDGs, namely, CSE, safe abortion, post-abortion care and sexual orientation.

RATIONALE FOR HRP'S ENGAGEMENT ON GENDER, EQUITY AND HUMAN RIGHTS

The Programme, as stipulated in its mission statement 'strives for a world where all women's and men's rights to enjoy sexual and reproductive health are promoted and protected, and all women and men, including adolescents and those who are underserved and marginalised, have access to sexual and reproductive health information and services'[1]. This statement is a direct commitment to contribute to achieving gender equality and equity and to promoting and protecting Human Rights (HR) related to sexual and reproductive health.

HRP's commitment to gender, equity and human rights has also been reflected in the Programme's priorities which include work on gender-based violence and harmful traditional practices, on SRHR for particularly vulnerable groups (e.g. women living with HIV, populations in humanitarian crises) as well as the application of human rights in SRHR services. HRP has also engaged on particularly sensitive topics related to the discrimination of vulnerable minority groups (e.g. sexual health and rights or abortion). Another indicator for the Programme's commitment to gender and right is the existence of the gender and right advisory panel which holds the mandate of ensuring that women's perspectives are taking into account and that gender and rights are integrated in HRP's work.

[1] Retrieved on November 30th from HRP's website at https://www.who.int/reproductivehealth/hrp/en/

PROCESS

HOW ARE GENDER EQUALITY, HUMAN RIGHTS AND EQUITY INTEGRATED IN STRATEGIC AND OPERATIONAL PLANNING?

The high-level strategic foundation for HRP's work is the WHO's first global strategy on reproductive health which was adopted by the 57th World Health Assembly (WHA) in May 2004. The strategy draws on human rights as a guiding principle and emphasises issues related to inequity, poverty and the impact of gender roles and gender equality on SRHR. For the period under evaluation, HRP's work was also directed by a medium strategic plan. [2] By and large, the situational analysis of this plan as well as the vision and strategic directives and actions for the seven priority areas[1] mainstream GE, HR and equity considerations, but HR are only mentioned as a guiding principle for one of the areas (gender, reproductive rights, sexual health and adolescents [GRR]). The monitoring framework of the strategic plan contains 15 indicators. It does not include any indicator to track performance on gender, HR and equity specific results or on GE, HR and equity mainstreaming into the different result areas. Targets are only set in the biennial work plans, but not for the duration of the strategic plan. The targets for the area of GRR (gender, reproductive rights, sexual health and adolescents) are specified for each indicator, although gender and HR specific targets are diluted in this wider category and cannot be singled out. Specific targets for equity are not defined.

The Programme's following **biennial work plan (2014 – 2015)** [3] introduced a new high-level results framework including five new output areas (generation of new knowledge, synthesis of research evidence, strengthening of research and technical capacity, development of guidelines, tools and policy statements and strengthening of research policy dialogue). Interestingly, the results framework, its indicators and its accompanying narrative are neutral in regard to gender, HR and equity. There is no mentioning of gender, vulnerable or marginalised populations or HR standards and principles. Furthermore, it is noteworthy that the GRR unit that had been attached to the office of the Director of RHR was removed during the 2013 restructuring of the Programme. HR and gender-specific work was categorised as a work area of the team for adolescents and at-risk populations (AGH). The position of the Human Rights Adviser, however, remained in the Director's office which translates a strong commitment for HR mainstreaming across the portfolio.

The product list of the AGH team includes gender and HR-specific results. There is no information, however, how HR, gender and equity mainstreaming is implemented in the remaining products. In the 2014/15 operational work plan, the thematic area (SRHR in humanitarian settings) is added, hence, increasing focus on a particularly vulnerable and underserved group. The work plan also includes for the first time the aims and deliverables of the HRP Alliance. As for the results framework, the approach of the HRP Alliance is – at this period of time – gender and HR neutral and neither includes specific results for gender equality, HR or equity nor outlines any ambition on how to ensure mainstreaming of the three dimensions it is work. It is noteworthy, however, that the objectives of the HRP Alliance were only developed during the portfolio review exercise in 2016. These objectives effectively integrate gender equality, HR and equity. [4]

The **2016 – 2017 operational work plan** [5] follows the same content structure, provides again a list of gender-based violence and HR products in the section for adolescents and at-risk populations. There are no changes regarding the mainstreaming of gender, HR or equity dimensions.

[1] (1) overarching themes, (2) promoting family planning, (3) Improving maternal and newborn health, (4) Controlling sexually transmitted and reproductive tract infections, (5) preventing unsafe abortions, (6) Gender, reproductive rights, sexual health and adolescents and (7) research capacity strengthening and programme development.

In the two work plans covering the period 2014 – 2017, the indicator targets are no longer presented by thematic unit. There are only global figures incorporating target figures from all thematic areas which makes it impossible to analyse trends in the production of specific products in the areas of gender and HR.

The analysis of the strategic and operational work plans for the period under evaluation showed that there was a fair level of integration of gender, HR and equity at strategic level, but that there were gaps in the translation into operational mechanisms, results and targets. Since the restructuring of the Programme into three teams in 2014, the institutional accountability mechanism to ensure gender mainstreaming across HRP's work has been weakened. According to key informants, it has negatively affected the quality of gender mainstreaming in the Programme. Output targets for gender, HR and equity specific results or gender mainstreaming were not disaggregated. These issues were partially addressed, however, in the 2018-2019 work plan in which three new indicators to the performance framework were introduced that specifically captured performance in gender equality, HR and equity integration.[1]

TO WHAT EXTENT ARE GENDER, HUMAN RIGHTS AND EQUITY PARAMETERS INTEGRATED IN THE PRIORITY SETTING PROCESS AND IN THE REVIEW AND APPROVAL PROCESS OF RESEARCH PROJECTS?

The **priority setting process** for identifying HRP products is done on a biannual basis. The teams of each specific thematic area conduct the exercise with varying methodological approaches, but all of them involve some form of expert stakeholder consultation. Key informants unanimously stated that there were substantial efforts to mainstream gender, HR and equity during the research priority setting processes. Four drawbacks, however, that are currently undermining the quality of mainstreaming, in particular of gender, were identified by key informants:

- Due to the lack of knowledge of relevant WHO frameworks on gender and HR, perceptions vary on what GE, HR and equity integration means among HRP staff. Some key informants had observed that certain key words such accountability, marginalised groups or inequity had a high 'hit list' in HRP's documents but were not necessarily used in a meaningful way;
- the outcomes depended on the expertise of involved staff members. Key informants perceived that HRP staff have inconsistent capacity for mainstreaming HR, gender and equity. Expertise was reported to be stronger in the ADH team than in the two other teams;
- there was little knowledge on how sub-teams of other thematic areas actually proceeded;
- consultations were mostly limited to expert professionals and did not systematically include voices from beneficiary groups.

In 2016, an extensive portfolio review [6] was initiated based on a recommendation of the Scientific and Technical Advisory Group (STAG) and endorsed by the Policy and Coordination Committee (PCC) with the aim of defining the Programme's research priority-setting criteria and of reviewing the current research portfolio in view of these criteria. The portfolio review and its 17 thematic reports thoroughly integrated gender, HR and equity mainstreaming in the analysis. The identified Programme priorities for each thematic area fully incorporate gender, HR and equity dimensions. The portfolio review reiterates HRPs continued commitment to *'make sure that all of HRP's research respects, protects and enables the*

[1] These are: (1) Gender balance among PIs of new and ongoing HRP research projects with target of 50% of PIs should be women; (2) Gender balance in individual capacity strengthened and female investigators strengthened; (3) Gender, rights and equity considerations mainstreamed into guidance development with target of 100% of technical, clinical, and policy guidelines issued on sexual and reproductive health in which gender and rights are explicitly elaborated.

fulfilment of all people's human rights and promotes gender equality, and that social accountability mechanisms are developed and tested for monitoring adherence to these principles.' (p.7).

In sum, the findings indicate that gender, HR and equity mainstreaming in research priority setting took place with varying consistency and depth during the first part of the evaluation period (2012 – 2015). It was consolidated and deepened across the Programme during the portfolio review in 2016. But concerns remain justified that - due to varying staff capacity for gender, HR and equity integration - the translation into practice during research design and implementation may continue to be of inconsistent in depth and quality, unless addressed.

The appreciation of gender, HR and equity integration in the **approval process of research projects** takes place through the RP2 approval mechanism. The RP2 proposal template includes a sub-header on the human rights context as well as five mandatory items under a header entitled 'gender considerations'. The items, however, lack focus on social determinants, conditions and environments of SRH that affect human rights in SRH and inequalities in service access and use.

After proposal submission, all proposals are screened by the HRP research manager with a checklist [7] that includes three questions to capture gender, HR and equity dimensions[1]. A sample of approved RP2 forms reviewed by the evaluation team indicated that

- the RP2 questions are insufficient to engage research teams in a thorough analysis of gender, HR and equity determinants related to the study subjects. The provided information in these sections was often superficial and lacked a deeper HR and gender analysis;
- reviewers on the RP2 panel do not request meaningful gender, HR and equity integration in research proposals.

A small number of products (approximately nine per year) are also reviewed by the Gender and Rights Advisory Panel (GAP). For the evaluation period, these reviews usually took place after the approval process by RP2 or even during the stage of the implementation. Key informants confirmed unanimously that the input from GAP was of high quality and useful for effective GE and HR integration. But it was also voiced that

- GAP's recommendations were not always implemented and sometimes too vague to be operationalised;
- GAP would only be able to suggest minor modifications as the projects had already been approved or were more advanced in implementation;
- the research products reviewed by GAP were selected by the HRP team coordinators who were asked to select three products a year. Some key informants felt this was a biased approach and that the number of products reviewed were too small.

WHAT MECHANISMS EXIST TO ENSURE DIVERSITY IN HRP GOVERNANCE BODIES? ARE THEY SUFFICIENTLY DIVERSE AND HOW DO THEY MAKE USE OF THIS DIVERSITY?

We analysed the Terms of References (ToR) and member profiles of HRP's principal governance body, the PCC and of its two technical committees, the STAG and the GAP. The PCC has permanent members (representatives of the Co-sponsors, UNAIDS and IPPF) and non-permanent members that include representatives of the 11 largest financial contributors as well as country representatives with quota for each of the WHO regions. Delegates are nominated by selected country governments.

[1] Gender equality, human rights and equity: (i) How does this product/activity support broader efforts towards gender equality? (ii) How does it promote and protect human rights? (iii) How does it ensure no-one is left behind and prioritise the most vulnerable?

The members of the STAG are selected by the RHR Director, in consultation with the Standing Committee and with the endorsement of PCC. They are selected based on their technical competencies related to the HRP portfolio. Criteria regarding sex and geographical diversity are not included in the ToR.

The GAP is composed of a maximum of 10 members who are also selected by the RHR director with advice from WHO regional offices. They need to have one of the three profiles: (a) sexual and reproductive health scientists with proven expertise and experience in gender equality and/or human rights (b) international women's health groups, (c) sexual and reproductive health programme implementers and policy makers with gender equality and/or HR experience. It is desired to have all three categories and an equal geographical presentation in the committee. The GAP also has the mandate to monitor and advise on the diversity of the other technical advisory groups. During the period under evaluation, there were several attempts to remove the GAP and to merge it with the STAG (2015 – 2016). Several external key informants were concerned about these attempts which were interpreted as a decreasing commitment to GE and HR integration in SRHR. The PCC did not approve the proposed merger of GAP into STAG and the mandate of the GAP continued. In interviews with key informants for this evaluation, the support of the GAP to the Programme was in unison described as a good practice and as an asset to the Programme.

None of the three groups (PCC, STAG and GAP) has a quota for the representation of women or men. An analysis of the current member profiles of GAP, STAG and the PCC showed that the representation of men and women was about equal with slightly higher number of women in the PCC and GAP. There is also a balanced geographical representation in all committees. Key informants generally confirmed this finding and highlighted that the achievement of an equitable balance of men and women and geographical regions in leadership positions and in the technical committees was the result of consistent attention and leadership support, in particular from the PCC chair.

Despite the balanced diversity of people in the PCC, STAG and GAP, some key informants were concerned about the lack of meaningful participation of country delegates in the PCC. Discussions, although being vibrant and well moderated, would mainly take place among donors, WHO and the co-sponsors while country delegates did not bring in their knowledge and expertise. This was experienced as 'a bit embarrassing' by other participants. It was observed that the PCC is not fully exploring the multiple benefits that the diversity of member profiles offers. They recommended to discuss the roles that delegates are there to serve and to find a way to engage country delegates more meaningfully.

INPUTS

Human resources: The Programme is currently supported by a full time HR adviser in the RHR Director's office. There is no such function for gender or equity. Gender mainstreaming is supported by a focal point in the AGH team, although this task is not included in the ToRs of the position. Key informants stated that she had limited time for supporting colleagues on gender mainstreaming. The Programme also finances the external guidance and support from the GAP. Key informants also reported sporadic collaboration and technical support from the WHO Gender, Equity and Rights (GER) team, in particular in the area of equity, but at a rather small scale. The reasons provided for this low level of engagement of the GER were disagreements on conceptual frameworks.

Financial resources: HRP's work on gender, human rights and equity was financed with undesignated and designated contributions to the HRP Trust Fund. Undesignated contributions by the cosponsoring agencies practically ceased during the evaluation period and only made up two percent of contributions to the Trust Fund in 2016/17 (see Volume 1). The main contributors of undesignated funds were governments.

Budget and expenditures on programming in gender, human rights and equity in the 2012/13 biennium were reported under the category of sexual health, gender, reproductive rights and adolescence. In the

following two biennia, the budget category label changed to adolescents and at-risk populations. Expenditures under these categories ranged from 13 percent of total expenditure in 2012/13 to 25 percent in 2014/15. It would, however, be difficult to estimate the expenditures on programming in gender, human rights and equity within these categories or on mainstreaming these issues in the HRP portfolio.

OUTPUTS

HOW MANY AND WHAT TYPE OF OUTPUTS HAVE BEEN PRODUCED IN THE AREAS OF EQUITY, GENDER INEQUALITY AND HUMAN RIGHTS? HOW HAVE THEY BEEN USED?

Due to the lack of specific targets (and reporting on targets) for gender, HR and equity specific results in the biennial work plans, there is no reliable way of assessing the exact number of outputs produced, in particular because gender, human rights and equity are cross-cutting dimensions. Mainstreaming has also not been tracked for the period under evaluation. We attempted to do an analysis based on the titles of outputs in the result reports but concluded that an analysis of this type would be both error prone and of limited added value. A table summarising key output achievements with primary focus on gender and human rights is presented in Annex 3. It was established based on KII data, the Programme's website and annual reports and highlights. We did not establish a list for equity related outputs because vulnerable, marginalised and worst-off groups are highly context specific. There are, however, numerous publications that aim to benefit groups that are known to be vulnerable or marginalised (e.g. women living with HIV, adolescent girls experiencing rapid repeat pregnancies or women and children surviving sexual abuse). External key informants emphasised the scientific merit of HRP's academic publications as well as the high quality and usefulness of its technical publications. Key informants described four key areas of using them:

- Evidence-based influencing work at national, regional and global level for improved SRHR policy and legal frameworks;
- technical support and capacity building to national governments and civil society actors;
- resource mobilisation;
- as information source for regional and global working groups on gender equity, human rights and SRHR and for regional and global SRHR partnerships and alliances.

TO WHAT EXTENT ARE GENDER, RIGHTS AND EQUITY MAINSTREAMED IN THE HRP PRODUCTS (RESEARCH AND NORMATIVE DOCUMENTS) THAT WERE PRODUCED OR UPDATED WITH HRP SUPPORT?

To assess the mainstreaming of gender, equity and HR in the Programme's work, 10 products were selected through a purposeful sampling approach. In a first step, we conducted a random selection of 20 products out of the list of products that had been identified as not having a primary focus on gender or human rights. After the random selection, we classified products into three categories: (1) research, (2) guidelines and (3) evidence briefs. Out of these categories, we did a random selection of four research projects, four guidelines or WHO recommendations and two evidence briefs. Three of the randomly selected products had the same thematic focus and we replaced two of them with products from other thematic areas. The selected documents are listed in Annex 2. They were assessed for the integration of gender, HR and equity drawing on relevant conceptual WHO frameworks and guidelines on gender and human rights and guidelines on equity focussed evaluations from UNICEF. [8, 9] The results of the RQ+ analysis on gender responsiveness (see Section 3 of Volume 2) were also included in the analysis.

The assessment of the four guidelines indicated that – where relevant – gender, human rights and equity had been mainstreamed both at process and content level although the integration of equity and HR was more systematic than gender mainstreaming. The relatively consistent mainstreaming at guideline level was also confirmed by key informants who highlighted that guideline development was a rigorous, multi-

staged process involving consultations with experts from different fields and extensive document reviews. Furthermore, WHO issued the second edition for the WHO handbook for guideline development in 2014. In this new edition, the mainstreaming of gender, HR and equity is a requirement and the handbook provides detailed guidance on how to integrate the three areas during each stage of the guideline development process. [10] For HR mainstreaming, it is noteworthy that for two out of the four reviewed guidelines beneficiary participation had been incorporated in the process of guideline development. The process for the guideline development for SRHR services for women with HIV is particularly impressive. It 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 is the most common practice in HRP guideline development processes.

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 do not use any pictorial materials and lose, hence, the opportunity to challenge harmful gender stereotypes in SR health care settings through visuals.

In the four reviewed **research projects**, equity, HR and gender were not as consistently mainstreamed as in the guidelines. Gender integration, in particular, was patchy and often limited to a focus on girls' and women's health issues whereas social determinants, the causes and impact of genders roles and 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 same result was found in the RQ+ assessment on gender responsiveness. As for equity, the analyses of worst off and vulnerable groups related to the study topic were mostly superficial and two of the research projects had not succeeded in integrating stakeholders from vulnerable or marginalised groups in the data collection. HR integration was more consistent, but not as strong as in the guidelines. The analysis of the two evidence briefs showed a solid integration of HR and equity dimensions, but weaknesses in mainstreaming gender equality.

In sum, the document analysis showed that mainstreaming of gender, HR and equity was strongest at the level of guidelines which is probably a result of the rigorous development process supported by the handbook on guideline development. The quality of mainstreaming varied across the other documents confirming the observation of key informants that the quality and depth of mainstreaming depends on the capacity and commitment of individuals. The current accountability mechanisms (RP2 review process and support from GAP) are not sufficient to achieve consistent gender, HR and equity mainstreaming in the Programme's research. Interestingly, despite the intrinsic link of gender, HR and equity, HRP's products often excel in one area, but show weaknesses in the other two areas. This was confirmed by discussions with key informants which indicated a tendency to 'tag' products specifically for human rights or gender integration, but few of the reviewed products actually effectively address more than one of the three dimensions. That notwithstanding, both internal and external key informants stressed that RHR was among the most advanced departments in WHO in terms of gender and HR mainstreaming in its work.

TO WHAT EXTENT HAS HRP RESEARCH CAPACITY STRENGTHENING MAINSTREAMED GENDER, HUMAN RIGHTS AND EQUITY DIMENSIONS?

During the evaluation period, the implementation model for research capacity strengthening (RCS) was reorganised under the umbrella of the HRP Alliance. The Alliance has four objectives. The third has an explicit focus on gender, equity and human rights: '*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)'[1]. It was challenging to find evidence to what extent this objective was realised for the following reasons:

- The objectives of the HRP Alliance were only defined in 2016, hence, towards the end of the period under evaluation.
- We received only a few documents for the work of the HRP Alliance and some of them were not dated so it was not clear if they had been developed during the period under evaluation or after.
- Disaggregated numbers for training participants, doctoral students and master level student were only available from 2018 forward, but not for the period under evaluation.
- Information provided in the annual and result reports on RCS was unspecific and did not allow to extract information on gender, HR and equity mainstreaming at institutional or process level.
- Most key informants from the RHR team reported to have limited knowledge on what had happened in terms of RCS.

We received, however, information from the HRP Alliance manager that three training sessions which included gender or human rights components had been organised as part of the HRP Alliance work:

- HRP in collaboration with the University of Lausanne provided two training courses to a total of 50 students on SRHR implementation research including gender and HR components. For this training three criteria were applied for the selection of participants: (1) gender: at least 50% women; (2) wide representation from least resourced countries; (3) fulfilment of academic criteria for the course.
- A regional training course about research on violence against women was designed and delivered in Paraguay for Spanish speaking participants in the Americas region.

The portfolio review conducted in 2016 identified two issues related to gender, HR and equity 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 team) 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. [10] From the evidence available to the evaluation team, it is not clear whether or not this is currently reflected in the set up and work plans of the HRP Alliance. The work plans (2017 – 2018) for the Long-term Institutional Development (LID) hubs do not include meaningful commitments for gender, equity and rights mainstreaming in work processes and content. 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 distribution of recipients and none of the plans have gender, HR or equity specific results (e.g. in terms of addressing the dominance of older, male researchers, mainstreaming gender, HR and equity in research proposals or lead authorship).

[1] The three other objectives are: (1) To strengthen the research capacity of institutions in low resourced settings; (2) To promote RCS within prioritized SRHR research areas globally and regionally; (3) To monitor and evaluate the impact of RCS activities by applying a theory of change, including qualitative and quantitative indicators.

OUTCOMES AND IMPACT

HOW IS EVIDENCE GENERATED BY HRP USED TO ADVOCATE FOR HUMAN RIGHTS, EQUITY AND GENDER EQUALITY AND WHAT CHANGES HAS THE PROGRAMME CONTRIBUTED TO?

HRP's Theory of Change has only one outcome: *'Sustainable change in national and international policy and public health programmes'*. It was challenging to assess and analyse change at outcome and impact level because the results framework does not include indicators beyond output level and changes in policies and SRHR programmes were not systematically monitored and documented. The annual reports and highlights as well as the technical reports to STAG focus primarily on the output level. Our main data sources for exploring HRP's outcomes in gender, equity and HR were therefore key informants and the online-survey. The examples reported by key informants demonstrated that the Programme has achieved substantial and important contributions at global and country level. It was generally confirmed that evidence generated through HRP's research was effectively translated into policy and normative guidance which was then widely used by UN, scientists and non-state actors for policy and programme work. One indicator for the high use of HRP's outputs by scientists is a high number of cross citations on research gate. Representatives from the OHCHR highlighted that HRP's guidelines, recommendations and research evidence are very influential at the global level, in particular on human rights norms and standards.

The Programme uses its work in global SRHR policy and programme platforms to support evidence-based discussions and decision-making. Strategic partnerships (e.g. with the OHCHR) have enabled the Programme to be present in relevant fora. All key informants emphasised that HRP's key role and added value was to bring facts to discussions and to decrease ideological and emotional influences in global dialogues and decision-making processes. Both internal and external key informants as well as the online-survey results provided evidence for the following outcomes in the areas of violence against women, family planning and rights, abortion and sexual health and rights:

- **VAW**: in 2013, HRP released guidelines on intimate partner violence and sexual violence against women. [12] These were disseminated in 2014 jointly with UNFPA at country level which led to important policy changes in several countries (e.g. Uganda, Malawi, Pakistan and Afghanistan according to key informants and the online survey). Also in 2014, HRP's evidence based influencing work contributed to the adoption of the Pan-African resolution on gender-based violence. The global and regional estimates of violence against women [13] were also reported to be used by governments around the world. Drawing on the estimates and wider VAW research, HRP also 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. [14] The Programme provided evidence to the content and led the development process including the endorsement from member countries. The Global Plan, in turn, has positively affected policy and legal frameworks at country level. India, for example, introduced and mandated a health care response to VAW which was not covered under previous policies.

- **Rights based family planning**: HRP's research and normative work influenced the global discussion on human rights and family, in particular through engagements at the FP2020 family planning summits and through work with FP2020 on 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 access to contraceptive services. According to the results in the online-survey, this contributed to policy development or reviews in at least five countries (Pakistan, Iran, Tanzania, Honduras and Kenya).

- The **safe abortion** guidelines from 2012 [15] have an explicit, evidence-based chapter on legal and policy considerations for abortions. These were presented to treaty body members of different HR conventions (CRC, CEDAW, CRPWD) which influenced the human rights standards on abortion and contributed to a progressive decriminalisation of abortion and to a reduced use of minimum grounds for abortion in at least eight countries (Mozambique, Moldova, Ireland, Nepal, Chile, Uganda, Ethiopia and Zambia). The direct contribution of HRP in the case of Ireland is particularly tangible. The Director of RHR was invited by Amnesty International to give a presentation on evidence and guidance for abortion to the Irish Parliament. The presentation was widely broadcasted and influential in the national referendum on abortion laws. To this date, HRP is supporting the Irish government on the implementation of their new legislation related to abortion.
- Another area were HRP's contributions influenced 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. [16] 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 process of the ICD-10 and successfully influenced discussions on gender incongruence resulting in the re-categorisation of gender incongruence from mental disorders to sexual health issues with an increased need for health services of this minority group. 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 above cited report also had an impact at country level. In 2018, the Supreme Court in India revised the section 377 of the Indian Penal code to decriminalise consensual gay sex. A participant of the online survey reported that the HRP report was cited as a reference in the revised penal code.
- Most key informants – internal and external to the Programme – stated that the outcomes and impact of HRP's work could be strengthened by ensuring a more systematic dissemination and implementation of guidelines and tools at country level. They pointed to the limited capacity of WHO regional and country offices to advance sensitive issues related to gender equality, human rights and equity.

Conclusions and future perspectives

Conclusions

The Programme has produced multiple high-quality products with a primary focus on gender or HR. For gender, the work on VAW, harmful traditional practices (FGM, child marriage) and on sexual rights have been highly influential. The work on abortion and family planning with an integrated rights perspective has led to important progress in policy and legal frameworks and national SRH programmes.

The Programme's priority setting and guideline development processes have produced outputs of critical relevance to SRHR in low- and middle-income countries. They deliver evidence for policy and legal frameworks that are instrumental to achieving universal access to SRH and for ensuring that vulnerable groups are reached. The uptake of HRP's outputs is high, in particular at the global level. At country level, there is need to develop more systematic approaches to ensure that the Programme's publications feed into national policy and legal frameworks and SRH programmes.

The Programme has achieved geographical and gender diversity in the PCC and the technical committees (STAG and GAP). The GAP adds substantial value as a critical voice to the Programme for ensuring that important gender and human rights are kept on the agenda and are effectively addressed. The evaluation also indicated, however, that participation of country delegates in the PCC meetings requires a different facilitation approach to enable more meaningful contributions and dialogue in meetings.

While output delivery on gender and HR has been impressive, consistent mainstreaming of gender, equity and human rights in the Programme's research has not been achieved in the period under evaluation. We identified five causes for inconsistent mainstreaming, in particular in the area of gender, which are closely inter-related:

- Gaps in operational planning and in the Programme's performance monitoring framework which did not require disaggregated data, and which did not set targets for mainstreaming;
- the absence of a gender advisor in the RH Directors team to ensure that gender will be advocated for at the decision-making table as it is currently done for HR by the Human Rights advisor;
- different perceptions on what gender, HR and equity mainstreaming entails and confusion on conceptual frameworks to be used (despite the availability of a range of tools at WHO level);
- the capacity of the Programme's staff to mainstream gender, HR and equity varies; and
- the accountability mechanisms (through the GAP, RP2 approval process) have been insufficient to ensure effective integration.

Due to girls' and women's lower social status in most countries and their urgent needs in SHR, it is understandable that the Programme's outputs focus mostly on SRH outcomes for this group. To achieve gender equality, however, it will be important to consistently analyse and drive change from all perspectives (boys, girls, men and women).

LESSONS LEARNT

Three lessons learnt can be drawn from this case study:

1. The Programme's choice to limit the measuring of its results framework to non-disaggregated outputs is problematic in several ways: (1) it demonstrates low accountability towards beneficiaries and donors; (2) many important outcome contributions of the programme are not at all or not systematically monitored and documented. This impedes learning and effective scale up of interventions; (3) the lack of disaggregation makes it difficult to analyse trends and to track progress in specific areas.
2. Effective gender, human rights and equity mainstreaming requires strong accountability mechanisms that need to be clearly defined in strategic and operational plans. Relevant expertise needs to be placed at the decision-making table and preferably linked to the office of the Director of RHR.
3. The added value of the GAP to HRP and RHR merits scaling up as a good practice approach for other departments in WHO.

RECOMMENDATIONS

1. Initiate a participatory revision exercise of the programmes results framework to ensure effective gender, HR and equity integration, including disaggregated outputs and outcomes, targets for results with a primary focus on gender and HR and targets for mainstreaming.
2. Strengthen the accountability mechanism for gender, HR and equity mainstreaming and ensure that advisors for the three areas are present during decision processes. It is also recommended to mandate middle management to be accountable for effective integration of gender, equity and human rights in research.
3. Disseminate relevant guidelines for gender, equity and HR mainstreaming among HRP staff and ensure stronger support for gender, HR and equity integration during the research design process

through coaching. To avoid that gender, equity and HR are treated as add-ons with a tick-box-mentality, we also recommend that a higher number of research projects is reviewed by GAP prior to the approval process. For better transparency and accountability, the projects to be reviewed should be selected with participation from GAP.

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ANNEXES

KEY INFORMANTS INTERVIEWED*

ADUKWEI ALLOTEY, Pascale	IIGH, UNI
AMIN, Avni	Medical Officer (AGH), HRP/ WHO
ASKEW, Ian	RHR Director, WHO
BIRGA, Veronica	Chief of women's right section, OHCHR, Geneva
CASTANO, Juncal, Plazaola	VaW data, UNWomen, New York
CHANDRA-MOULI, Venkatraman	Scientist (AGH), HRP/ WHO
DAHER, Paola	Center for Reproductive Health and Rights, Geneva
ERDMAN, Joanna	Prof., Dalhousie University
GARCIA MORENO, Claudia	Medical Officer (AGH), HRP/ WHO
GIRARD, Francoise	President, International Women's Health Coalition, New York
HAMILL, Catherine	Technical Officer, HRP/ WHO
JOHNSON, Ronald	Scientist (safe abortions), HRP/WHO
KHOSLAN, Rajat	Former Human Rights Advisor HRP currently seconded to OHCHR
KOBEISSI, Loulou	Medical Officer (AGH), HRP/ WHO
MAGAR, Veronica	Team Leader Gender Equity and Human Rights, WHO Headquarters
MOAZZAM, Ali	Medical Officer (HRX), HRP/ WHO
NARASIHMHAN, Manjulaa	Scientist (HRX), HRP/ WHO
NOBLE, Elisabeth	Information officer, HRP/WHO
O'HANLON, Lucinda	Human Rights Advisor, HRP/WHO
PALLITTO, Christina	FGM Scientist, HRP/WHO
PLESONS, Marina	ASRHR consultant (AGH), HRP/WHO
REGE, Sangeeta	Coordinator, CEHAT, Delhi
SAY, LALE	AGH Team Coordinator, HRP/WHO
TEEN-HOOPE BENDER, Petra	Technical Advisor SRH UNFPA
TUNCALP, Özge	Scientist (MPA), HRP/ WHO
YORDI, Isabel	Regional Office, WHO EURO

** This list includes all stakeholders interviewed specifically for case study 3. For the data analysis of this case study, all interviews conducted during the evaluation were coded and analysed.*

OUTPUT SAMPLE ASSESSED FOR GENDER, HUMAN RIGHTS AND EQUITY MAINSTREAMING

NR	PRODUCT NAME	CATEGORY
1	Consolidated guideline on sexual and reproductive health and rights of women living with HIV	Guidelines/ recommendations
2	WHO recommendations on antenatal care for a positive pregnancy experience	Guidelines/ recommendations
3	Brief sexuality-related communication: recommendations for a public health approach	Guidelines/ recommendations
4	WHO recommendations on adolescent sexual and reproductive health and rights	Guidelines/ recommendations
5	The "UPTAKE" Project – A health sector and community-based participatory approach in a human rights framework, to increase met needs for contraception. Previous Title: UPTAKE: A context-specific health sector and community-based participatory approach in a human rights framework, to increase met needs for contraception	Research
6	Mistreatment of women - How women are treated during facility-based childbirth: Development and validation of measurement tools a 4-country study in Nigeria, Ghana, Myanmar and Guinea	Research
7	Vouchers study - Exploring modern contraceptive method use, continuation, switching and change in fertility behaviour among the underserved women – an 18-month post-voucher intervention follow-up assessment in Punjab, Pakistan	Research
8	AHEAD trial: Adolescent Health Experience After Delivery - preventing rapid, repeat pregnancy	Research
9	Evidence brief: improving family planning service delivery in humanitarian crisis	Evidence brief
10	Companion of choice during labour and childbirth for improved quality of care. An evidence to action brief	Evidence brief

HRP OUTPUTS (2013 – 2017) WITH GENDER OR HUMAN RIGHTS FOCUS

YEAR	GENDER	HUMAN RIGHTS
TECHNICAL PUBLICATIONS		
2013	1. 16 Ideas for addressing violence against women in the context of the HIV epidemic A programming tool 2. Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines 3. Global and regional estimates of violence against women :Prevalence and health effects of intimate partner violence and non-partner sexual violence 4. Violence against women : The health sector responds	
2014/ 2015	5. Strengthening the medico-legal response to sexual violence 6. Brief sexuality-related communication Recommendations for a public health approach 7. WHO multi-country study on women's health and domestic violence against women - Initial results on prevalence, health outcomes and women's responses 8. Health care for women subjected to intimate partner violence or sexual violence : A clinical handbook - Field testing version 9. WHO multi-country study on women's health and domestic violence against women - Initial results on prevalence, health outcomes and women's responses 10. Ending violence and discrimination against lesbian, gay, bisexual, transgender and intersex people : UN statement	11. Framework for ensuring human rights in the provision of contraceptive information and services 12. Prevention and elimination of disrespect and abuse during childbirth 13. Sexual and reproductive health and rights: a global development, health, and human rights priority :Comment 14. Ensuring human rights within contraceptive programmes :A human rights analysis of existing quantitative indicators 15. Reproductive, maternal, newborn and child health and human rights : A toolbox for examining laws, regulations and policies 16. Eliminating forced, coercive and otherwise involuntary sterilization :An interagency statement 17. Ensuring human rights in the provision of contraceptive information and services Guidance and recommendations 18. Sexual health, human rights and the law 19. Safe abortion: Technical & policy guidance for health systems Legal and policy considerations - Key messages 20. Ensuring human rights within contraceptive service delivery : Implementation guide
2016/ 2017	21. A tool for strengthening gender-sensitive national HIV and Sexual and Reproductive Health (SRH) monitoring and evaluation systems 22. WHO guidelines on the management of health complications from female genital mutilation 23. 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 24. Global Plan of Action: Health systems address violence against women and girls	28. Child, early and forced marriage legislation in 37 Asia-Pacific countries 29. Monitoring human rights in contraceptive services and programmes 30. Accelerating uptake of voluntary, rights-based family planning in developing countries : Evidence brief 31. Consolidated guideline on sexual and reproductive health and rights of women living with HIV 32. Quality of care in contraceptive information and services, based on human rights standards : A checklist for health care providers

YEAR	GENDER	HUMAN RIGHTS
	25. Ethical and safety recommendations for intervention research on violence against women 26. Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: : A manual for health managers 27. Responding to children and adolescents who have been sexually abused : WHO clinical guidelines	33. The importance of sexual and reproductive health and rights to prevent HIV in adolescent girls and young women in eastern and southern Africa : Evidence Brief
JOURNAL ARTICLES		
2013/ 2104	34. Empowering adolescent girls: developing egalitarian gender norms and relations to end violence. 35. Women's perspectives on marriage and rights in Morocco: risk factors for forced and early marriage in the Marrakech region. 36. Research gaps in the care of women with female genital mutilation: an analysis. 37. Gynaecological consequences of female genital mutilation/cutting (FGM/C): Systematic review 38. Immediate health consequences of female genital mutilation/cutting (FGM/C): Systematic review 39. Estimates of female genital mutilation/ cutting in 27 African countries and Yemen. 40. What works and what does not: a discussion of popular approaches for the abandonment of female genital mutilation. 41. Intimate Partner Violence after Disclosure of HIV Test Results among Pregnant Women in Harare, Zimbabwe 42. A Systematic Review of the Correlates of Violence Against Sex Workers. 43. Worldwide prevalence of non-partner sexual violence: a systematic review. 44. Intimate partner violence, abortion, and unintended pregnancy: results from the WHO Multi-country Study on Women's Health and Domestic Violence. 45. The global prevalence of intimate partner homicide: a systematic review. 46. The global prevalence of intimate partner violence against women. 47. What is the scale of intimate partner homicide?	48. WHO guidance grounded in a comprehensive approach to sexual and reproductive health and human rights: topical pre-exposure prophylaxis. 49. Sexual and reproductive health and rights: a global development, health, and human rights priority.

YEAR	GENDER	HUMAN RIGHTS
2015/ 2106	50. Research priorities on ending child marriage and supporting married girls. 51. Early adolescent childbearing in low- and middle-income countries: associations with income inequity, human development and gender equality. 52. Addressing Gender Socialization and Masculinity Norms Among Adolescent Boys: Policy and Programmatic Implications. 53. Female Genital Mutilation: A Visual Reference and Learning Tool for Health Care Professionals. 54. Episiotomy and obstetric outcomes among women living with type 3 female genital mutilation: a secondary analysis . 55. A repeat call for complete abandonment of FGM. 56. Violence motivated by perception of sexual orientation and gender identity: a systematic review. 57. Interventions to address unequal gender and power relations and improve self-efficacy and empowerment for sexual and reproductive health decision-making for women living with HIV: A systematic review. 58. Gender equality and human rights approaches to female genital mutilation: a review of international human rights norms and standards. 59. Special supplement on sexual and reproductive health and rights of women living with HIV . 60. Child marriage legislation in the Asia-Pacific Region. 61. Testing a counselling intervention in antenatal care for women experiencing partner violence: a study protocol for a randomized controlled trial in Johannesburg, South Africa .	62. An analysis of adolescent content in South Africa's contraception policy using a human rights framework. 63. Advancing sexual and reproductive health and rights of young women at risk of HIV. 64. Advancing sexual and reproductive health and rights of young women at risk of HIV. 65. Advancing the sexual and reproductive health and human rights of women living with HIV. 66. Sexual and reproductive health and human rights of women living with HIV. 67. Addressing gender inequalities to improve the sexual and reproductive health and wellbeing of women living with HIV. 68. Sexual and reproductive health and human rights of women living with HIV: a global community survey. 69. International Human Rights and the Mistreatment of Women during Childbirth. 70. Advancing sexual and reproductive health and rights in low- and middle-income countries: Implications for the post-2015 global development agenda. 71. Sexual health, human rights, and law. 72. Women's health trials in developing countries: under-registration is the keyword?
2017-2018	73. Female Genital Mutilation/Cutting: sharing data and experiences to accelerate eradication and improve care: part 1 74. Gender equality and human rights approaches to female genital mutilation: a review of international human rights norms and standards. 75. Understanding the motivations of health-care providers in performing female genital mutilation: an integrative review of the literature. 76. Virginity testing: a systematic review 77. Calling for action on violence against women: is anyone listening?	78. Harmonizing national abortion and pregnancy prevention laws and policies for sexual violence survivors with the Maputo Protocol: proceedings of a 2016 regional technical meeting in sub-Saharan Africa. 79. A global database of abortion laws, policies, health standards and guidelines. 80. Health systems and the SDGs: lessons from a joint HIV and sexual and reproductive health and rights response. 81. Interventions to address unequal gender and power relations and improve self-efficacy and empowerment for sexual and reproductive health decision-making for women living with HIV: A systematic review

YEAR	GENDER	HUMAN RIGHTS
		82. Using GRADE as a framework to guide research on the sexual and reproductive health and rights (SRHR) of women living with HIV – methodological opportunities and challenges. 83. Investing in sexual and reproductive health and rights of women and girls to reach HIV and UHC goals. 84. Broadening understanding of accountability ecosystems in sexual and reproductive health and rights: A systematic review. 85. Health systems and the SDGs: lessons from a joint HIV and sexual and reproductive health and rights response. 86. Ensuring an inclusive global health agenda for transgender people.

11. ADOLESCENT SRHR AND SRHR IN EMERGENCY AND HUMANITARIAN SETTINGS WITH A FOCUS ON ADOLESCENTS

SUMMARY

Introduction: Reports on global and national health outcomes indicate the urgent need for an increased focus on the sexual and reproductive health and rights of adolescents. They face among the highest rates of unmet need for family planning. Complications associated with pregnancy, childbirth and unsafe abortions are a leading cause of death among adolescent girls. Exposure to gender-based violence, especially in humanitarian settings, affects adolescents disproportionally. The objective of the current case study in the context of the external evaluation of HRP 2013-2017 was to assess HRP's work on adolescent sexual reproductive health and rights (ASRHR) including in humanitarian settings.

Methods: The external evaluation was implemented from September to December 2018. For the case study, all data collected for the evaluation were analysed with a specific focus on ASRHR, including in humanitarian settings. Additional data were collected through a limited number of targeted interviews and document reviews. Qualitative content analysis was the main method for data analysis.

Results: HRP's priority setting and rigorous guideline development processes have resulted in numerous outputs in the thematic area of ASRHR that are aligned to priority needs of this group in low- and middle-income countries. The ASRHR research products were of good to exemplary quality. A particular strength of the Programme has been to feed evidence into discussions on ASRHR at high level global and regional meetings. HRP has engaged successfully a broad network of partners and collaborators on ASRHR. HRP supported policy revisions or the drafting of new policies and programmes in several countries by using global accountability mechanisms such as the FP2020 commitments. At global level, the programme has made instrumental contributions to shaping high level resolutions, strategies and guidelines. Systematic and comprehensive mapping of HRP outcomes, however, was constrained by the lack of outcome monitoring and reporting. Research capacity strengthening initiatives implemented under the umbrella of the HRP Alliance did not integrate ASRHR and only one of the five Long-term Institutional Development hubs has built this thematic area in its work plan.

The portfolio on SRHR in humanitarian setting was only built in 2017 and incorporates a strong focus on adolescents and on gender and human rights dimensions. There were no outputs and outcomes that could be evaluated, and, at the time of the evaluation, there was not yet an approved research project in this area.

Conclusion and recommendations: HRP's ASRHR outputs have increased available evidence and technical guidance on ASRHR. Due to efficient influencing work, HRP has been able to position itself as a key player in ASRHR and to contribute to policy and programme changes at global, regional and national level. The emerging portfolio on SRHR in humanitarian settings has not yet produced a substantial number of outputs, but its strong focus on vulnerable groups, especially adolescents, is promising. Based on the learning from this case study, we recommend that HRP should (1) revise its monitoring system to enhance learning and accountability; (2) intensify its engagement with programme implementing organisations in order to increase the translation of evidence on ASRHR into policies and programmes; (3) expand the HRP Alliance network through strategic engagement with regional research partners that have proven strengths and track records in research on adolescent health and on SRHR in humanitarian settings; (4) assure that its efforts to build a research portfolio in SRHR in humanitarian settings are matched by an appropriate allocation of human and financial resources.

INTRODUCTION

The 2013-2017 evaluation of HRP (henceforth referred to as the 'Programme') aimed to provide information on the relevance of the Programme's objectives in the context of global strategies and goals for sustainable development in general and for the promotion of sexual and reproductive health and rights (SRHR) in particular. It assessed the Programme's performance in terms of the efficiency, effectiveness, impact and sustainability of its work, as well as its governance and management. In doing so, it aimed at enabling the continued incorporation of lessons learnt into its decision-making processes and into those of its partners including its co-sponsors, the member states in its Policy and Coordination Committee (PCC), and other cooperating parties. As in previous evaluations, four case studies were conducted to provide in-depth assessments of issues that are of particular interest to the PCC. The current case study report analyses HRP's work on Adolescent Sexual and Reproductive Health and Rights (ASRHR) and on Sexual and Reproductive Health (SRH) in humanitarian settings with a focus on adolescents.

SRHR in humanitarian settings is a relatively new area within the Programme which emerged during the most recent biennium. Many activities currently conducted under this thematic area fall outside the scope of this evaluation. To approach this area, we conducted a review of all work conducted in SRH in humanitarian settings with particular focus on any activities designed for adolescents or which integrate adolescents as a target group.

The assessment of the case study has been guided by the evaluation questions in the table below. A summary response to each of the evaluation questions is provided in the conclusion section with the exception of evaluation question 5 for which the figures are presented in chapter 5.

Evaluation questions for Case Study 4

EVALUATION QUESTION	DAC CRITERIA
1. To what extent has HRP (in all work streams including in SRHR in humanitarian contexts) addressed SRHR issues and priorities of adolescents in low- and middle-income countries?	Relevance
2. Has HRP contributed to new evidence, consensus-building, guidelines, and evidence-based global, regional or national policies on adolescent SRHR?	Effectiveness
3. Is HRP recognised as a global leader in a broad network of partners for adolescent SRHR, including researchers, implementers, policy-makers and advocates?	Effectiveness
4. Did the efforts of HRP in any of its work streams contribute to national, regional or global policy or programme changes that improved the availability and access of adolescents to SRH services (including adolescents in difficult circumstances)?	Impact
5. How many research studies, consensus and synthesis outputs, knowledge transfer activities and normative documents on adolescent SRHR were generated against Programme targets?	Efficiency
6. Has HRP adopted and used effective communication and advocacy tools for mobilising and engaging adolescent and young people in an agenda for SRHR?	Efficiency
7. What are the capacity-building outcomes in adolescent SHRH research that were achieved with HRP support?	Effectiveness

METHODOLOGY

We used different data sources and methods to analyse HRP's work on ASRHR and adolescents in humanitarian settings. We conducted key informant interviews (KIIs) (see Annex 1 for Key Informants' list) and undertook an extensive document review including scientific articles, guidelines and tools. In addition, we consulted emails related to HRP's engagement with external stakeholders provided by HRP

staff, HRP's posts on Twitter and YouTube. We also analysed findings from the online survey in which 180 stakeholders from various backgrounds participated.

Data were analysed with support of Atlas.ti, a content analysis software.[1] The coding of the data followed a deductive-inductive procedure. The initial code set up followed the structure of the evaluation questions (deductive coding). In the process of data analysis, further codes were added based on recurring patterns in the data (inductive coding). Qualitative content analysis was the main tool used for data analysis.

The initial list of key informants to be interviewed was provided by HRP staff. Although all potential interviewees were contacted, several declined to participate in interviews by stating lack of knowledge about HRP as a reason. Others did not reply to the invitation. The relatively short list of key informants interviewed is a limitation of this case study which we mitigated by cross-analysing information from KIIs with other data sources.

RATIONALE

UNDERLYING ISSUES

Adolescents constitute one sixth of the world´s population and are a diverse and, in many circumstances, particularly vulnerable group. In 2016, an estimated 1.1 million adolescents died of preventable or treatable causes. The leading causes of death among 15-19 year-old girls globally were complications of pregnancy and childbirth. Each year, an estimated 21 million girls aged 15 to 19 years and 2 million girls aged under 15 years become pregnant, the vast majority in low- and middle-income countries, and an estimated 3.9 million girls aged 15 to 19 undergo unsafe abortions. Globally, nearly one in three adolescent girls aged 15 – 19 years (84 million) has been a victim of emotional, physical and/or sexual violence perpetrated by their husband or partner. [1] While progress has been achieved in certain areas, disparities remain enormous. The situation of populations affected by humanitarian crises is particular dire. Adolescent and young people under 25 years make up close to 60 percent of the 1.4 billion people living in situations of humanitarian crisis. Among them, adolescent girls and young women represent a particularly vulnerable group, exposed to high risks of gender-based violence and discrimination. [2]

A growing concern for health during different stages of an individual's development has already been noted in various discussion forums and has also gained significance within the 2030 Agenda for Sustainable Development. [3] Goal 3, for instance, aims to: 'Ensure healthy lives and promote well-being for all at all ages', with target 3.7 specifically addressing sexual and reproductive health: 'Ensure universal access to sexual and reproductive health care services, including for family planning, information and education'. Moreover, Goal 5 aspires to 'achieve gender equality and empower all women and girls', with several specific targets related to sexual and reproductive health: 5.1. to 'end all forms of discrimination against all women and girls everywhere'; 5.2. to 'eliminate all forms of violence against all women and girls in the public and private spheres ...'; and 5.6. to 'ensure universal access to sexual and reproductive health and reproductive rights…'. While the SDGs incorporate a strong commitment on improving the situation of girls, adolescent as a group are not explicitly mentioned. Their specific needs, however, are reflected and addressed in the Global Strategy on Women's, Children's and Adolescents' Health which also includes a chapter humanitarian and fragile settings. [2]

Despite high level commitments to improve the situation of adolescent girls and boys, scientific evidence for this age-group, its characteristics and needs is still limited, in particular in the area of SRHR. Efforts to generate knowledge are often hampered by limitations related to ethics that impose ethical and legal restrictions on the implementation of research studies investigating this age-group.

[1] https://atlasti.com/

RATIONALE FOR HRP ENGAGEMENT

The HRP mission statement stipulates to 'strive for a world where all women's and men's rights to enjoy sexual and reproductive health are promoted and protected, and all women and men, including adolescents and those who are underserved and marginalised, have access to sexual and reproductive health information and services'. As reflected in this statement, the Programme explicitly mentions adolescents as a target group and indirectly refers to populations affected by humanitarian crises as part of those who are underserved and marginalised. Improving ASRHR and populations affected by humanitarian crises is, thus, enshrined in HRP's mission.

The commitment to adolescents and worst-off groups is also reflected in HRP's structure with one of the three programme teams, Adolescents and at-Risk Populations (AGH), overseeing work related to ASRHR and to SRHR in humanitarian crises.

PROCESS

WHAT HRP DID – AND HOW

The AGH team conducted several research priority setting exercises in the year before and during the evaluation period. An adapted Child Health and Nutrition Research Initiative (CHNRI) exercise on ASRHR with participation of more than 300 researchers, health programme manager and donors from all WHO regions was conducted in 2012/2013 and resulted in the definition of seven priority areas for ASRHR: (a) maternal health, (b) contraception, (c) gender-based violence, (d) treatment and care of patients with human immunodeficiency virus (HIV) infection; (e) abortion; (f) integration of family planning and HIV-related services and (g) sexually transmitted infections. In each of these areas, priority research questions were also identified [4] Another exercise was organised in 2013 to map research priorities on ending child marriage and supporting married girls. [5] In 2016, an extensive portfolio review was initiated based on a recommendation of the Scientific and Technical Advisory Group (STAG) and endorsed by the Policy and Coordination Committee (PCC) with the aim of defining the Programme's research priority-setting criteria and of reviewing the current research portfolio in view of these criteria. The portfolio review included extensive consultations of external stakeholders with representation from low- and middle-income countries. It resulted in the production of 17 thematic reports. A specific thematic report on ASRHR was prepared according to key informants but was not made available to the evaluation team. SRHR subjects related to this group were treated in a cross-cutting manner in most reports and specific research gaps concerning ASRHR were highlighted. There was also a thematic report on child marriage that focused exclusively on adolescents. Although maternal health of adolescents had been identified as a research priority in the CHRNI exercise, the thematic report for maternal health of the portfolio review did not mention any knowledge gaps in this area. [6]

The main report for the portfolio review highlights five products for ASRHR for the period from 2017 to 2021:

- Guidance on implementing multidimensional interventions for improving adolescents' SRHR service;
- strengthen evidence base around the use of digital health innovations to reach adolescents;
- strengthen the understanding of gender norm development in early adolescence and reaching very young adolescents;
- development of WHO guidelines for addressing the full range of SRHR needs of adolescents; and
- ensure that adolescents' SRHR needs are fully addressed in all guidelines and innovations of RHR.

In addition, products that either explicitly mention adolescents as a group or specifically target adolescents were identified in the areas of contraception, sexual transmitted and reproductive tract infections, human rights and gender equality, violence against women, health emergencies and humanitarian settings, global monitoring and measurement of SRHR indicators, and digital and digitalised innovations.

In the approach to working with adolescents and populations affected by crises, the AGH team takes a holistic view on ASRHR by analysing and developing solutions related to factors at individual, peer, family, school, health service and community level. In addition, adolescents and at-risk groups are treated as cross-cutting subjects by all teams, for example in human rights, equity and gender integration processes. This includes a focus on particular vulnerabilities of adolescent girls, for instance through subjects such as violence against women and girls.

To reach out to target audiences including youth groups, the Programme makes use of diverse communication channels including webinars and blogs. To amplify the reach of their publications, videos are recorded and disseminated. Short and at times non-technical articles are placed in specialist journals or mass media. Social media networks (YouTube, Twitter) are also used extensively. The ASRHR lead researcher in the AGH Team maintains an influential presence on both Twitter and YouTube. His account on Twitter has over 1200 followers and his YouTube Ted Talk on comprehensive sexuality education was viewed by over 45,000 people.

SRHR in humanitarian settings was not a priority focus of the Programme for most of the period under evaluation. There was one product funded by the MacArthur Foundation on obstetric and maternal health. The Programme's attention to the topic increased after the adoption of the UN Global Strategy for Women's, Children's and Adolescents' Health. The Programme created a new position to specifically covering this area which was filled in March 2017. According to key informants and reports to STAG, an expert meeting was convened in February 2017 with a wide range of stakeholders to discuss knowledge gaps. Three priorities were agreed: (i) adolescent's SRHR and their access to services, (ii) the implementation of safe abortion care in humanitarian settings and (iii) increasing access to contraception in humanitarian crises. A follow up meeting was organized in June 2018. A priority setting exercise for SRHR in humanitarian setting was under way during the data collection for this evaluation. Most of the currently available products on SRHR in humanitarian settings were developed during and after 2017.

In sum, HRP priorities for work in ASRHR were identified in a structured priority setting process including meaningful participation of relevant stakeholders from low- and middle-income countries. This resulted in the implementation of an ambitious and relevant portfolio of products. (see Outputs) HRP's work in the area of SRHR in humanitarian settings gained traction and was scaled up in the last year of the evaluation period, and few outputs were generated prior to 2018. Responding to the particular needs and vulnerabilities of adolescents is part of the identified priorities of this work.

INPUTS

Human resources: The areas of ASRHR and SRHR in humanitarian settings are covered by the work of the AGH team. For most of the period under evaluation, the ASRHR team consisted of two scientists and a team assistant. Additional technical support was provided by interns and consultants, including a longer-term consultant. One medical officer covers the work on SRHR in humanitarian settings. This position was newly created in early 2017. Both ASRHR and SRHR in humanitarian settings are cross-cutting themes, and professionals of all three HRP teams have made significant contributions to the production of outputs, especially for the area of ASRHR.

Financial resources: HRP's work on ASRHR and SRHR in humanitarian settings was financed with undesignated and designated contributions to the HRP Trust Fund. Undesignated contributions by the

cosponsoring agencies practically ceased during the evaluation period and only made up two percent of contributions to the Trust Fund in 2016/17 (see Volume 1). The main contributors of undesignated funds were governments. The following designated funds for the two work areas were reported in HRP financial reports 2014/15 and 2016/17.

DONOR	BIENNIUM	GRANT	AMOUNT ($US)
United States of America	2014/15	Family planning research, and adolescent sexual and reproductive health research	497,000
Packard Foundation	2014/15	Global early adolescent survey	250,000
Packard Foundation	2014/15	Lessons learnt from ASRH Initiatives in India	150,000
Packard Foundation	2014/15 & 2016/17	Global early adolescent study	850,000
MacArthur Foundation	2014/15 & 2016/17	Toolkit to evaluate young people's sexual and reproductive health programming	225,000
International Planned Parenthood Federation	2016/17	Strengthening the evidence base for SRHR in humanitarian settings	353,000

Source: HRP Financial Reports 2014/15 and 2016/17

Budgets and expenditures in the two programmes areas were not reported separately in previous biennia. For the 2018/19 biennium 4.8 percent (US$ 1,950,000) of the HRP budget for products (US$ 41,040,000) is planned to be spent on ASRHR and 3.4 percent (US$ 1,400,000) on SRHR in humanitarian settings.

CONTRIBUTIONS FROM OTHER STAKEHOLDERS

In its work on ASRH and of SRHR in humanitarian settings, HRP collaborated extensively with a broad range of state and non-state partners, UN Agencies, and global initiatives. Within WHO, there is extensive collaboration with the MCA department and with the WHO Regional Offices, for instance with the Pan-American Health Organization (PAHO) on adolescent pregnancy within the context of social and economic inequities, with SEARO on increasing the met need for contraception among married and unmarried adolescents and with AFRO on developing a regional ASHRH position paper.

For SRHR in humanitarian settings, the HRP focal point serves on the committee of the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) as well as on IAWG's research committee.

OUTPUTS

HRP adopted a new results framework in 2015. It includes five outputs and nine indicators. We cross-analysed information from key informant interviews, annual reports, result reports and products on HRP's website to generate an overview of HRP's outputs in the areas of ASRHR and SRHR in humanitarian settings. A detailed list of all outputs generated for ASRHR during the evaluation period is listed in Annex 2. Due to lack of disaggregation of output data in HRP's reports, it was not possible to track output delivery towards targets per thematic area.

From 2013 – 2017, five research projects with specific focus on ASRHR were funded and approved by RP2. The most important multi-country studies were:

- The Global Early Adolescent Study (GEAS) was conducted in partnership with the John Hopkins Bloomberg School of Public Health in 15 countries. It explored social processes that shape gender norms in early adolescence in diverse social and cultural contexts, and how these influence adolescents' health behaviours and health, with a particular focus on sexual and reproductive health. GEAS comprised two phases. The first phase was undertaken during the evaluation period and a journal article was published announcing the formative research findings. [7] In addition, a

toolkit was prepared. The GEAS integrates effectively gender, human rights and equity dimensions and seeks to move the perspective of adolescents as vulnerable, illness-prone individuals towards resilient individuals with multiple strengths and vulnerabilities.

- The Adolescent/Youth Reproductive Mobile Access and Delivery Initiative for Love and Life Outcomes (ARMADILLO) study is a three-stage study assessing the effect and coverage of providing youths with SRHR content via their mobile phones. The study is conducted in Kenya and Peru. The study protocol for the formative stage was published in 2015, [8] the formative stage was completed in 2016, and the protocol for Stage II was approved by RP2 in 2017.
- The Adolescent Health Experience After Delivery or Abortion (AHEAD) Study is implemented in Malawi and Ghana in partnership with the University of Ghana School of Public Health and the University of Malawi. It aims at investigating contraceptive use and prevention of rapid repeat pregnancy, to assess health sector and community responses to adolescent pregnancy and teenage motherhood and to analyse the acceptability of potential intervention strategies.

Between 2013 and 2018 HRP produced or supported the production of 42 scientific publications on ASRHR. Over half of the papers were produced in the 2015/16 biennium whereas only six articles were published in the 2013/14 biennium. Additional papers published in 2018 were based on research done during the evaluation period.

To strengthen the evidence on ASRHR, HRP supported meta-analyses and secondary analyses of published data, for example disaggregated data on SRHR outcomes and selected aspects of SRHR service use, [9, 10] linkages between levels of early adolescent child-bearing in low–and middle-income countries and social determinants and wellbeing, [11] levels of and trends in adolescent births in Latin America and the Caribbean, [10] and in Sub-Saharan Africa disaggregated by age and social characteristics. [12]

A secondary analysis of qualitative data with focus on a particularly vulnerable group discusses research priorities on ending child marriage and supporting married girls. [5] Furthermore, a significant number of publications aimed at strengthening the evidence for effective ASRHR interventions, including analyses of policy and legal frameworks for contraception and the service needs of adolescents in South Africa, [13] Paraguay, [14] and the Philippines [in preparation]. The programme has also documented selected initiatives of adolescent-friendly health services and comprehensive sexuality education [for example 15, 16] and evaluated projects at country level [for example 17,18].

For ASRHR, HRP delivered a strong track record under the output on research evidence synthesis: 21 systematic reviews were carried out and published between 2013 and 2017 with a strong performance peak again in the biennium 2015/16 during which 16 out of the 21 reviews were published. Several key informants mentioned the publication 'What does not work in adolescent sexual and reproductive health: A review of evidence interventions commonly accepted as best practices'. [19] The paper was based on a literature review and identified ineffective and effective practices in ASRHR. It has already been cited in over 20 peer-reviewed publications and in a book on child and adolescent health issued by the World Bank. HRP's work in synthesising evidence also includes systematic reviews carried out under the AHEAD [4,20,21] and GEAS studies. [22]

Key informants consistently reported HRP's ASRHR research work to be of high quality and relevance. As evidence, they cited the rigorous approval processes guaranteeing highest ethical standards, the high number of peer-reviewed publications, the stable support from donors as well as the requests for HRP's presence in high-level meetings and conferences. The research quality assessment conducted in the context of this evaluation also included ASRHR projects and confirmed HRP's research to be of good to exemplary quality.

The Programme's indicator on Research Capacity Strengthening (RSC) does not provide information on specific thematic areas. According to internal key informants, none of the HRP Alliance initiatives focused on ASRHR or SRHR in humanitarian settings during the period under evaluation. A review of the Long-term Institutional Development (LID) Hub work plans (which started in 2017) showed that four out of five hubs do not mention adolescents. Only one of the Hubs (Ghana) offers courses on ASRHR and has also plans to strengthen its relationship with the adolescent reproductive health centre of Obafemi Awolowo University in Nigeria. While ASRHR was not a focus of the HRP Alliance during the period under evaluation, RCS was nonetheless an integrated part of the AGH team's work. According to key informants, capacity building took place through dissemination of tools, trainings embedded in the process of research implementation and through dissemination of knowledge via communities of practice.

HRP issued seven normative guidelines for ASRHR between 2013 and 2018. It is noteworthy that most of the documents were issued in 2018 which indicates HRP's progress on ASRHR. After using two biennia of conducting research and synthesising evidence, the Programme has started to draw on its outputs for developing technical documents. A key output referenced by several key informants was the WHO recommendations on adolescent sexual and reproductive health and rights. [23] (see textbox)

THE WHO RECOMMENDATIONS ON ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

The recommendations cover a wide range of subjects related to ASRH: Comprehensive sexuality education; contraceptive counselling and services; antenatal, intrapartum and postpartum care; safe abortion services and post-abortion care; STI´s; HIV; gender-based violence; and harmful traditional practices, including child marriage and female genital mutilation (FGM). The document makes use of gender-transformative pictorial materials and deals with sensitive topics such as abortion by using carefully crafted and evidence-informed statements. By covering a broad range of topics, it represents a critical tool for individuals, countries or organisations working on ASRHR.

Under the objective to strengthen the research- policy dialogue, HRP delivered five evidence briefs and convened or contributed to over 30 global and regional consultations with specific focus on ASRHR. Conferences and meetings with a broader SRHR focus are not counted in this number. Key informants reported, however, that HRP's ASRHR team also contributed to numerous conferences of this kind, such as the Women Deliver Conferences in 2013 and 2016 and the Global Family Planning Summit in 2017. HRP's participation in high profile conferences, technical meetings and processes aimed both at presenting and discussing research evidence and to build working partnerships with relevant initiatives and multi-country projects.

There were few outputs in the area of SRHR in humanitarian settings for the period under evaluation. The full list of outputs on SRHR in humanitarian settings is available in Annex 3. Three systematic reviews were published; one in 2015 and two in 2018. [24,25,26] The 2015 publication focused on women's, children's, and adolescents' health in situations of crises. Available evidence on the particular needs of adolescents was analysed and recommendations mapped out. An evidence brief on improving family planning services in humanitarian settings was released in 2017. HRP also delivered high-level advocacy and coordination on integration of SRHR issues in humanitarian responses at the World Humanitarian Summit and the Women Deliver conferences. Key informants reported that SRH in humanitarian settings was a thematic area with very limited resources until the end of 2016 which resulted in a few stand-alone outputs. It was only after the launch of the first progress report of the Global strategy for women's, children's and adolescents' health in July 2017 that a portfolio on SRHR in humanitarian setting was progressively established. At the time of the evaluation in 2018, numerous initiatives had been initiated:

- HRP was developing a monitoring and evaluation framework to facilitate standardised tracking of SRHR in humanitarian settings and to increase accountability;

- an approach for the adaptation of WHO Guidelines on SRHR to humanitarian settings had been developed;
- a research protocol for a multi-country study on SRH services for adolescent girls and young women was submitted for approval;
- HRP led on WHO's input for the updated Minimum Initial Service Package (MISP); and
- HRP had convened an international technical consultation for Research on Sexual and Reproductive Health and Rights in Humanitarian Settings in 2018.

Two key informants stressed the duration of research approval processes as a particular obstacle for HRP's work on SRHR in humanitarian settings. The current average duration of one year is too long for being competitive. To date (December 2018), the HRP project portfolio website does not include any project on SRHR in humanitarian settings.

Outcomes and impact

HRP's Theory of Change has only one outcome: 'Sustainable change in national and international policy and public health programmes.' The results framework, however, does not monitor or report any results beyond the output level. The annual reports and highlights as well as the technical reports to STAG focus primarily on the output level with isolated references to changes at outcome level. Our main data sources for exploring HRP's outcomes in the thematic ASRHR were key informant interviews, technical reports to STAG and the online-survey.

HRP works with different entry points to contribute to translating its outputs into sustainable policy or programme changes at the global, regional and country level. The AGH carried out targeted influencing work at strategic high-level meetings and convened technical consultations to advocate for evidence-informed ASHRH programmes, to mitigate backlash and to support favourable policy frameworks.

Through consultative processes, the programme provided instrumental input to the following global strategies, guidelines and policy frameworks:

- The chapter on adolescents of the UN Every Woman Every Child (EWEC) Strategy 2016-2030; [2]
- the Country Implementation Toolkit of the EWEC Strategy 2016-2030;
- the revised edition of the International Technical Guidance on Sexuality Education under the leadership of UNESCO; [27]
- the UN Committee on the Rights of the Child General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence; [28]
- the Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to support country implementation; [29] and
- the resolution 29/8 on strengthening efforts to prevent and eliminate child, early and forced marriage of the 29th Human Rights Council meeting in 2015.

At regional level, collaborative work of HRP and the Inter- Parliamentary Union (IPU) in engaging regional and national decision makers to address child, early and forced marriage (CEFM) resulted in the finalisation of a Pan African Parliamentary resolution on gender-based violence in 2013.

To drive country level action, the AGH team used strategic opportunities within mechanisms of the Global Financing Facility (GFF), the Global Fund to fight AIDS, Tuberculosis and Malaria, FP2020 and the UN Child Marriage project. The GFF supports resource mobilisation coordination of key partners supporting the implementation of the EWEC Strategy. HRP provided technical support to several countries (Ethiopia, DRC, Kenya, Liberia and Malawi) in the development of investments cases to ensure the effective integration of ASRHR in their funding proposal. In Liberia, for example, HRPs' support was reported instrumental in securing a US$16 million grant from GFF to improve the quality of primary and secondary health care

services, with a focus on reproductive, maternal, newborn, child and adolescent health (RMNCAH) (see textbox).

HRP also engaged with the FP2020 platform to carry out its influencing work for scaling up evidence based ASRHR. The Family Planning Summit held in London in 2017 resulted in country level commitments for strengthening ASRHR. After the summit, FP2020 organised regional workshops bringing together countries to support the operationalisation of the commitments. HRP provided technical support during these workshops and contributed to ensuring that countries integrated evidence-based good practices for ASHRH in their country implementation plans.

SUPPORT OF THE LIBERIA MINISTRY OF HEALTH IN DEVELOPING THE GFF INVESTMENT CASE

Under the leadership of Liberia's MOH, an RMCH investment case was developed in 2016. WHO HQ and other partners were approached to provide inputs on ASRHR. HRP/WHO advocated for the integration of a whole-of-market approach to maximise access to contraceptives which was accepted. The funded investment case includes a tailored approach to ASRHR with emphasis on access to contraception and on health system strengthening. The testing of the whole-of-market approach will be piloted in two counties of Liberia.

Through Global Fund initiatives, HRP has provided technical support to projects in DRC and Malawi. The projects drew on holistic approaches to HIV programming among adolescent girls which led to improved HIV awareness and prevention behaviour and improved performance of SRH services for adolescents in health facilities.

According to respondents of the online survey conducted for the evaluation, HRP also played an instrumental role in updating the ASRHR policy in Mongolia. In Myanmar, HRP contributed to the revision of the national strategy on adolescent health in 2015. In India, HRP was part of a national working group to support and monitor the implementation of the country's National Adolescent Health Programme. According to interviewed key informants, one of the constraints in achieving greater influence in supporting evidence-based ASRHR programmes and policies at country level is limited interest and financial and technical capacity of WHO Country Offices.

We did not find evidence for changes at policy and programme level in the thematic area of SRHR in humanitarian settings. This is not a surprising finding considering that this is an emerging portfolio with few outputs prior to 2018.

In sum, there is substantial evidence that HRP's engagement in influencing global, regional and country level decision resulted in improved ASRHR policies and programmes. Due to the lack of systematic outcome monitoring and documentation, the methodological approach used for this evaluation did not allow to outline an exhaustive list of changes that the Programme contributed to.

CONCLUSIONS AND FUTURE PERSPECTIVES

CONCLUSIONS

Has HRP contributed to new evidence, consensus-building and guidelines in ASRHR and adolescents in difficult circumstances? To what extent has HRP (in all work streams including in SRHR in humanitarian contexts) addressed SRHR issues and priorities of adolescents in low- and middle-income countries?

The Programme has produced multiple outputs with specific focus on ASRHR. This includes an impressive number of scientific publications, a stable track record of new research grants, several technical publications and policy briefs as well as the convening or providing inputs to numerous conferences and consultations. Progress was made in testing and disseminating new interventions, as for instance in a multi-country study of using mobile phone technology for reaching adolescents with youth-focused SRH information. ASRHR products are consistently relevant and address priority needs of adolescents in low- and middle-income countries. The priority setting processes conducted during the period under

evaluation sought extensive input from external stakeholders from all WHO regions. The ASRHR research products were of good to exemplary quality and aim consistently at meaningful integration of gender, equity and human rights parameters. This has led to satisfaction and continued interest of donors in HRP's ASRHR portfolio and to high solicitation by external stakeholders.

The portfolio on SRHR in humanitarian setting was only built up during the last year of the evaluation period. Currently, several initiatives are under way, strategic partnerships are being brokered and three systematic reviews have been published. There is a strong focus on adolescents and on gender and equity dimensions in this emerging portfolio. At the time of the evaluation, there was not yet an approved research project in SRHR in humanitarian settings.

What are the capacity-building outcomes in adolescent SHRH research that were achieved with HRP support?

The evaluation found no evidence that research capacity strengthening (RCS) in the thematic area of ASRHR was a focus of activity under the HRP Alliance during the evaluation period. To date, RCS in ASRHR has mostly taken place as an embedded component of research implementation at country level or taken place through the dissemination of tools and participation in communities of practice. In addition, an annual e-course on ASRHR was implemented in collaboration with the Geneva Foundation for Medical Education and Research. The outcomes of these activities were not monitored or reported.

Has HRP adopted and used effective communication and advocacy tools for mobilising and engaging adolescent and young people in an agenda for SRHR? Is HRP recognised as a global leader in a broad network of partners for adolescent SRHR, including researchers, implementers, policy-makers and advocates?

HRP has played an influential role in feeding evidence into discussions on ASRHR at high-level global and regional meetings. The Programme has demonstrated a strong ability to foster inter-institutional links and build consensus on ASRHR subjects which has led to joint engagement and ownership by involved UN organisations and other partners. The extensive use of diverse communication channels and the influential positioning of HRP's ASRHR lead scientist on social media and as a global advocate for ASHRH have also been a catalyst for engaging with policy makers, donors, academics, implementers and youth groups. The production of communication products using non-technical language and their dissemination on social media has enabled to extend the reach of the Programme beyond technical and academic audiences. The evaluation results show consistent evidence that HRP is perceived as a key player at global level for ASRHR with a broad network of partners and collaborators.

Did the efforts of HRP in any of its work streams contribute to national, regional or global policy or programme changes that improved the availability and access of adolescents to SRH services?

Despite limited human and financial resources, there is evidence that the Programme made effective use of its outputs including its normative guidelines to strategically influence evidence-based ASRHR policies and programmes through mechanisms of global initiatives. This has led to policy revisions or new policies in several countries as well as improved or scaled up ASRHR programmes at regional and country level. At global level, the Programme has made instrumental contributions to shaping influential resolutions, strategies and guidelines such as the adolescent component of the EWEC strategy or of the International Technical Guidance on Sexuality Education.

The lack of systematic outcome tracking makes it challenging to establish a full view on all outcome changes that HRP contributed to. The approach to influencing policies and programmes, however, has produced documented results in the area of ASRHR.

For the period under evaluation, no outputs were planned or implemented in the area of publishing global or regional estimates on ASRHR or on developing, testing and disseminating new interventions. While

progress has been made in understanding the effectiveness and efficiency of interventions in improving ASRH, there is still a need for more evidence on how to implement effective and equitable programmes at large scale in situations with limited resources.

LESSONS LEARNT

Using global platforms such as FP2020 and global health initiatives such as GFF has proven an efficient strategy for supporting countries in moving forward with adopting evidence-based ASRHR policies and programmes. The approach is, however, not systematically documented. The capacity in most WHO Country Offices to provide technical support to governments in the area of ASRHR is limited and there are additional partners at country level that can provide a platform for translating the knowledge on ASRHR generated by HRP into programmes and policies.

The expertise and focus of activities of the five current regional LID hubs of the HRP Alliance tends to be in more traditional SRHR areas such as family planning, maternal and perinatal health. Research capacity strengthening in emerging fields such as ASRHR and SRHR in humanitarian settings is not their priority focus. An effective programme of strengthening the capacity in ASRHR research and in SRHR research in humanitarian settings requires a stronger network of research partners that are specialised in these areas.

SRHR in humanitarian settings is a new work area for HRP that cuts across its entire SRHR research agenda. The Programme has just started to build a portfolio of activities in this area with limited staff resources. The sexual and reproductive health and rights of adolescents in humanitarian crisis situations is a major issue of concern, but it is not yet clear to what extent HRP has the resources and capacity to achieve global leadership in this field.

RECOMMENDATIONS

1. To increase accountability and to enhance learning, HRP should revise the Programme's monitoring system. The revised system should disaggregate output targets by thematic area and require systematic tracking and documentation of the Programme's outcomes.
2. In order to achieve the outcome of sustainable changes in national policies and programmes for ASRHR, HRP should intensify its engagement with programme implementing organisations, including the UN cosponsors and INGOs, in order to strengthen the financial and technical support they provide to governments with the evidence generated by the research of HRP and its research partners.
3. To build sustained capacity for research and technical expertise in adolescent SRHR and 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.
4. 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.

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ANNEXES

ANNEX 1: KEY INFORMANTS INTERVIEWED*

CHANDRA-MOULI, Venkatraman	**Scientist (AGH), HRP/ WHO**
GARCIA MORENO, Claudia	Medical Officer (AGH), HRP/ WHO
KHOSLAN, Rajat	Former Human Rights Advisor HRP currently seconded to OHCHR
KOBEISSI, Loulou	Medical Officer (AGH), HRP/ WHO
KOLLER, THEODORA	Equity Officer, GER Team, WHO
O'HANLON, Lucinda	Human Rights Advisor, HRP/WHO
PLESONS, Marina	ASRHR consultant (AGH), HRP/WHO
ROSS, David	Medical Officer, MCA, WHO
SAY, LALE	AGH Team Coordinator, HRP/WHO

**This list includes all stakeholders interviewed specifically for case study 4*

ANNEX 2: LIST OF ASRHR-SPECIFIC OUTPUTS BY INDICATOR

Note:

- No ASRHR-relevant outputs were reported under Indicator 1.2: global/regional estimates published.
- Indicator 3.1 (research centres strengthened through HRP grants) cannot be disaggregated by programme theme.
- Duplicates under indicator 1.1 (scientific articles) and 2.1 (systematic reviews) were removed.

INDICATOR 1.1: # OF SCIENTIFIC ARTICLES PUBLISHED	
2013 - 2014	1. Women's perspectives on marriage and rights in Morocco: risk factors for forced and early marriage in the Marrakech region. Published online: 09 Oct 2014, Culture, Health & Sexuality 2. Identifying and overcoming barriers that adolescents in low- and middle-income countries face in obtaining and using contraception. V Chandra-Mouli, D McCarraher, N Williamson. Entre Nous 2013, 79, 12-13. 3. Scaling up comprehensive sexuality education in Nigeria: from national policy to nationwide application. Huaynoca S, Chandra-Mouli V, Yaqub N Jr. & Denno DM. Sex Education (2013) 4. Strategies to sustain and scale up youth friendly health services in the Republic of Moldova BMC Public Health 2013, 13:284 5. Standardizing and scaling up quality adolescent friendly health services in Tanzania BMC Public Health 2013, 13:579
2015 - 2016	6. Adolescent health experience after abortion or delivery (AHEAD) trial: formative protocol for intervention development to prevent rapid, repeat pregnancy. Reprod Health. 2015; 12: 111. Published online 2015 Dec 1. 7. An analysis of adolescent content in South Africa's contraception policy using a human rights framework. Journal of Adolescent Health, Volume 57, Issue 6, 617 - 623 8. Assessing youth-friendly-health-services and supporting planning in the Republic of Moldova. Reproductive Health 2015, 12:98 doi:10.1186/s12978-015-0088-6 - Published: 30 October 2015 9. Documenting good practices: scaling up the youth friendly health service model in Colombia. Reproductive Health 2015, 12:90 doi:10.1186/s12978-015-0079-7 - Published: 18 September 2015 10. Research priorities on ending child marriage and supporting married girls Reproductive Health 2015, 12:80 doi:10.1186/s12978-015-0060-5 - Published 3 Sept. 2015

INDICATOR 1.1: # OF SCIENTIFIC ARTICLES PUBLISHED	
	11. Adolescent/Youth Reproductive Mobile Access and Delivery Initiative for Love and Life Outcomes (ARMADILLO) Study: formative protocol for mHealth platform development and piloting. Reproductive Health 2015, 12:67 12. Programa Geração Biz, Mozambique: how did this adolescent health initiative grow from a pilot to a national programme, and what did it achieve? Reproductive Health 2015, 12:12 13. Adolescent first births in East Africa: disaggregating characteristics, trends and determinants. Reproductive Health 2015, 12:13 14. Millennium Development Goal 5 and adolescents: looking back, moving forward Arch Dis Child. 2015 Feb;100 Suppl 1:S43-7. 15. The world has much to do to achieve the International Conference on Population and Development's adolescent-health objectives. Sexual & Reproductive Healthcare 6 (2015) 1–2 16. The success factors of scaling-up Estonian sexual and reproductive health youth clinic network - from a grassroots initiative to a national programme 1991–2013. Reproductive Health 2015, 12:2 17. Implementing the United Kingdom's ten-year teenage pregnancy strategy for England (1999-2010): How was this done and what did it achieve? Reproductive Health 2016 13:139 18. Biomedical technologies for the prevention of sexually transmitted infections and HIV for adolescent girls and young women . Trans R Soc Trop Med Hyg 2016; 110: 499–501 19. Early adolescent childbearing in low- and middle-income countries: associations with income inequity, human development and gender equality .Health Policy and Planning, 2016, 1–6 20. Sexually Transmitted Infection Services for Adolescents and Youth in Low- and Middle-Income Countries: Perceived and Experienced Barriers to Accessing Care. Journal of Adolescent Health 59 (2016) 7-16 21. Lessons learnt from the CERCA Project, a multicomponent intervention to promote adolescent sexual and reproductive health in three Latin America countries: a qualitative post-hoc evaluation 22. The Tarunya Project's efforts to improve the quality of health services in Jharkhand state, India: a post-hoc evaluation. Int J Adolesc Med Health 2016; aop 23. Implementing the United Kingdom Government's 10-Year Teenage Pregnancy Strategy for England (1999–2010): Applicable Lessons for Other Countries. Journal of Adolescent Health 24. Monitoring adolescent sexual and reproductive health. Bulletin of the World Health Organization 2016;94:159. 25. Do efforts to standardize, assess and improve the quality of health service provision to adolescents by government-run health services in low- and middle-income countries, lead to improvements in service-quality and service-utilization by adolescents? Reproductive Health 2016 13:10 26. Feasibility and acceptability of delivering adolescent health interventions alongside HPV vaccination in Tanzania. Health Policy Plan. (2016) First published online: January 14, 2016 27. Reorienting adolescent sexual and reproductive health research: reflections from an international conference Reproductive Health 2016, 13:3 28. Scaling up sexuality education in Senegal: integrating family life education into the national curriculum Sex Education. Published online: 06 Jan 2016
2017 - 2018	29. A never-before opportunity to strengthen investment and action on adolescent contraception, and what we must do to make full use of it. Reprod Health (2017) 14: 85. 30. Programme Reporting Standards (PRS) for improving the reporting of sexual, reproductive, maternal, newborn, child and adolescent health programmes. BMC Medical Research Methodology (2017) 17:117 31. Looking back and moving forward: can we accelerate progress on adolescent pregnancy in the Americas? Reproductive Health 2017 14:83 32. Country-specific data on the contraceptive needs of adolescents. Bulletin of the World Health Organization 2017;95:166. 33. The health status of adolescents in Ecuador and the country's response to the need for differentiated healthcare for adolescents. Reproductive Health 2017

INDICATOR 1.1: # OF SCIENTIFIC ARTICLES PUBLISHED	
	34. Interventions for Preventing Unintended, Rapid Repeat Pregnancy Among Adolescents: A Review of the Evidence and Lessons From High-Quality Evaluations. Global Health: Science and Practice Vol. 5, No. 4 - December 28, 2017 35. Who meets the contraceptive needs of young women? A cross-sectional study of first providers of family planning in sub-Saharan Africa. Journal of Adolescent Health 2017 36. Assessment of country policies affecting reproductive health for adolescents in the Philippines. Reproductive Health 2018 15:205 - Published: 12 December 2018 37. Trends in adolescent first births in five countries in Latin America and the Caribbean: disaggregated data from demographic and health surveys. Reproductive Health (2018) 15:146 Published: 29 August 2018 38. Investing in sexual and reproductive health and rights of women and girls to reach HIV and UHC goals. Lancet Glob Health Published Online July 18, 2018 39. What Did It Take to Scale Up and Sustain Udaan, a School-Based Adolescent Education Program in Jharkhand, India? American Journal of Sexuality Education Volume 13, 2018 - Issue 2 - Published online: 30 April 2018 40. Research gaps and emerging priorities in sexual and reproductive health in Africa and the eastern Mediterranean regions. Reproductive Health 201815:39 - Published: 5 March 2018 41. Addressing Gender Socialization and Masculinity Norms Among Adolescent Boys: Policy and Programmatic Implications. Journal of Adolescent Health Volume 62, Issue 3, Supplement, March 2018, Pages S3–S5 42. Building Support for Adolescent Sexuality and Reproductive Health Education and Responding to Resistance in Conservative Contexts: Cases From Pakistan. Global Health: Science and Practice February 2018, GHSP-D-17-00285;

INDICATOR 1.4: # NEW RESEARCH PROJECTS FUNDED/ APPROVED BY RP2	
2014	1. A65894 – Adolescent health experience after delivery (AHEAD) trial – preventing rapid, repeat pregnancy. 2. A65892 – Adolescent/youth reproductive mobile access and delivery initiative for love and life outcomes (ARMADILLO) – formative protocol for adaptation, development and pilot-testing research for preparation of ARMADILLO platform for multi-site research trial. 3. A65000 – Global early adolescent health study." 4. A65000 – Sexual behaviour and contraceptive practices among adolescent university students (Upper Myanmar).
2015 - 2016	5. A65 – Empowering adolescents towards better reproductive health 6. A65894 – AHEAD – Adolescent Health Experience After Delivery – preventing rapid, repeat pregnancy, Malawi 7. A65893 – ARMADILLO – Adolescent / Youth Reproductive Mobile Access and Delivery Initiative for Love and Life Outcomes, Kenya
2017	8. A65894 – AHEAD – Adolescent Health Experience After Delivery – preventing rapid, repeat pregnancy, Malawi 9. A65892/ A65893 / A65901 – ARMADILLO – Adolescent / Youth Reproductive Mobile Access and Delivery Initiative for Love and Life Outcomes, Kenya

INDICATOR 2.1: # OF SYSTEMATIC REVIEWS PUBLISHED	
2013 - 2014	1. Comprehensive adolescent health programs that include sexual and reproductive health services: a systematic review. Journal of Public Health: December 2014, Vol. 104, No. 12, pp. e23-36.

INDICATOR 2.1: # OF SYSTEMATIC REVIEWS PUBLISHED	
	2. Chandra-Mouli V, McCarraher DR, Phillips SJ, Williamson NE, Hainsworth G. Contraception for adolescents in low and middle income countries: needs, barriers, and access. Reprod Health. 2014;11:8
2015 - 2016	3. Chandra-Mouli V, Lane C, Wong S. What does not work in adolescent sexual and reproductive health: a review of evidence on interventions commonly accepted as best practices. Glob Health Sci Pract. 2015;3(3):333-40. 4. Denno DM, Hoopes AJ, Chandra-Mouli V. Effective strategies to provide adolescent sexual and reproductive health services and to increase demand and community support. J Adolesc Health. 2015;56(1 Suppl):S22-41. 5. Hindin MJ, Bloem P, Ferguson J. Effective nonvaccine interventions to be considered alongside human papilloma virus vaccine delivery. J Adolesc Health. 2015;56(1):10-8. 6. Sarkar A, Chandra-Mouli V, Jain K, Behera J, Mishra SK, Mehra S. Community based reproductive health interventions for young married couples in resource-constrained settings: a systematic review. BMC Public Health. 2015;15:1037. 7. Chandra-Mouli V, Chatterjee S, Bose K. Do efforts to standardize, assess and improve the quality of health service provision to adolescents by government-run health services in low and middle income countries, lead to improvements in service-quality and service-utilization by adolescents? Reprod Health. 2016 Feb 6;13:10. 8. Svanemyr J, Amin A, Robles OJ, Greene ME. Creating an enabling environment for adolescent sexual and reproductive health: a framework and promising approaches. J Adolesc Health. 2015;56(1 Suppl):S7-14. doi:10.1016/j. jadohealth.2014.09.011. Review 9. Temmerman M, Khosla R, Bhutta ZA, Bustreo F. Towards a new Global Strategy for Women's, Children's and Adolescents' Health. BMJ. 2015;351:h4414.doi:10.1136/bmj.h4414. Review. 10. Zeid S, Gilmore K, Khosla R, Papowitz H, Engel D, Dakkak H et al. Women's, children's, and adolescents' health in humanitarian and other crises. BMJ. 2015;351:h4346. doi:10.1136/bmj.h4346. Review. 11. Gonsalves L, Hindin MJ. Pharmacy provision of sexual and reproductive health commodities to young people: a systematic literature review and synthesis of the evidence. Contraception. 2016 Dec 23. pii: S0010-7824(16)30540-6. 12. Hindin MJ, Kalamar AM, Thompson TA, Upadhyay UD. Interventions to Prevent Unintended and Repeat Pregnancy Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature. J Adolesc Health. 2016 Sep;59(3 Suppl):S8-S15. 13. Hindin MJ, Kalamar AM. Detailed Methodology for Systematic Reviews of Interventions to Improve the Sexual and Reproductive Health of Young People in Low- and Middle-Income Countries. J Adolesc Health. 2016 Sep;59(3 Suppl):S4-7. 14. Kågesten A, Gibbs S, Blum RW, Moreau C, Chandra-Mouli V, Herbert A, Amin A. Understanding Factors that Shape Gender Attitudes in Early Adolescence Globally: A Mixed-Methods Systematic Review. PLoS One. 2016 Jun 24;11(6):e0157805. 15. Kalamar AM, Bayer AM, Hindin MJ. Interventions to Prevent Sexually Transmitted Infections, Including HIV, Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature. J Adolesc Health. 2016 Sep;59(3 Suppl):S22-31. 16. 27. Kalamar AM, Lee-Rife S, Hindin MJ. Interventions to Prevent Child Marriage Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature. J Adolesc Health. 2016 Sep;59(3 Suppl):S16-21. 17. Neal S, Ruktanonchai C, Chandra-Mouli V, Matthews Z, Tatem AJ. Mapping adolescent first births within three east African countries using data from Demographic and Health Surveys: exploring geospatial methods to inform policy. Reprod Health. 2016 Aug 23;13(1):98.
2017	18. Chandra-Mouli V, Patel SV. Mapping the knowledge and understanding of menarche, menstrual hygiene and menstrual health among adolescent girls in low- and middle-income countries. Reprod Health. 2017 Mar 1;14(1):30. 19. Hoopes AJ, Agarwal P, Bull S, Chandra-Mouli V. Erratum to: Measuring adolescent friendly health services in India: A scoping review of evaluations. Reprod Health. 2017 Mar 16;14(1):43.

INDICATOR 2.1: # OF SYSTEMATIC REVIEWS PUBLISHED	
	20. Norton M, Chandra-Mouli V, Lane C. Interventions for Preventing Unintended, Rapid Repeat Pregnancy Among Adolescents: A Review of the Evidence and Lessons From High-Quality Evaluations. Glob Health Sci Pract. 2017 Dec 28;5(4):547-570.

INDICATOR 4.1: # NEW OR UPDATED GUIDELINES ISSUED	
2013 - 2014	none
2015 - 2016	1. What works to improve young people's sexual and reproductive health.
2017 - 2018	2. Responding to children and adolescents who have been sexually abused – WHO clinical guidelines 3. Programme reporting standards for sexual, reproductive, maternal, new-born, child and adolescent health 4. WHO recommendations on adolescent sexual and reproductive health and rights 5. Guidance on ethical considerations in planning and reviewing research studies on sexual and reproductive health in adolescents 6. The Global Early Adolescent Study (GEAS) Tool Kit 7. International technical guidance on sexuality education. An evidence-informed approach

INDICATOR 5.1: # POLICY BRIEFS/GUIDELINE DERIVATIVES ISSUED	
2014	1. Factsheet on adolescent pregnancy
2015 - 2016	2. Global plan of action: Health systems address violence against women and girls – booklet 3. Child, early and forced marriage legislation in 37 Asia-Pacific countries
2017 - 2018	4. Reducing early and unintended pregnancies among adolescents – evidence brief 5. The importance of sexual and reproductive health and rights to prevent HIV in adolescent girls and young women in eastern and southern Africa

INDICATOR 5.2: # REGIONAL OR INTERNATIONAL CONSULTATIONS CONVENED OR SUPPORTED FOR SYSTEMATIC INTRODUCTION OF POLICY OPTIONS	
2014	1. Girls not brides global meeting. Asian NGO representatives. New Delhi. 2013 2. National Adolescent Health Programme and the National Adolescent Health Consultation, 7-9 January, New Delhi, India. 3. Conference on promoting and caring for sexual and reproductive health in adolescents, 11-13 January, Cuenca, Ecuador. 4. UNESCO launch of document on good practices on menstrual education, 13 March, New York, USA. 5. Interagency meeting on current evidence, lessons learned and best practices on preventing pregnancy in adolescents in Latin America and the Caribbean, 17-19 March, Managua, Nicaragua. 6. 6th International seminar on adolescent health in Portuguese-speaking countries, 31 March, S∨£o Paulo, Brazil. 7. International Best Practices consortium meeting on adolescent sexual and reproductive health, 2-3 June, Washington, DC, USA. 8. The Girl Summit and pre-summit meeting on research on FGM/C and CEFM, 21-22 August, London, England.

INDICATOR 5.2: # REGIONAL OR INTERNATIONAL CONSULTATIONS CONVENED OR SUPPORTED FOR SYSTEMATIC INTRODUCTION OF POLICY OPTIONS	
	9. Regional seminar for Asia-Pacific parliaments on "Ending the cycle of violence against girls in Asia-Pacific", organized by the Inter-Parliamentary Union, 23-25 September, Dhaka, Bangladesh 10. Regional programme managers' meeting on adolescent health, international inter-ministerial meeting on the demographic dividend, 27-28 November, New Delhi, India 11. International Conference on Adolescent sexual and reproductive health and wellbeing. Gent. Belgium.
2015 - 2016	12. Launch of a Special Supplement to the Journal of Adolescent Health, 19 February, Amsterdam, Netherlands 13. 4. Stakeholder consultation on the renewed Global Strategy for Women's, Children's and Adolescents' Health, 26-27 February, New Delhi, India 14. PAHO regional consultations on the draft WHO Global plan of action to strengthen the role of the health systems to address interpersonal violence, in particular against women and girls and against children, 26-27 February, Washington DC, USA 15. Fifty-ninth Commission of the Status of Women, Special Panel to mark the launch of The Lancet series on Violence against Women and Girls, 9-20 March, New York, USA 16. WHO Western Pacific Region and South-East Asia Region regional consultations on the draft WHO Global plan of action on strengthening the role of the health systems in addressing interpersonal violence, in particular against women and girls, and against children, 23-24 April, Bangkok, Thailand 17. WHO Eastern Mediterranean Region regional consultations on the draft WHO Global plan of action on strengthening the role of the health systems in addressing interpersonal violence, in particular against women and girls, and against children, 28-29 April, Cairo, Egypt 18. Stakeholders' Consultation on the Renewed Global Strategy for Women's, Children's and Adolescents' Health, 5-7 May, Johannesburg, South Africa 19. Africa Regional Meeting on Digital Health for Overcoming Barriers to Ending Preventable Child and Maternal Deaths and Achieving Universal Health Coverage, 12-15 May, Lilongwe, Malawi 20. UNICEF meeting to agree on indicators for child marriage. New York. 21. Global stakeholder consultation on the draft WHO global plan of action on strengthening the role of the health systems in addressing interpersonal violence, in particular against women and girls and against children, Informal consultation with NGOs, academics, UN Partners and Member States, 3-4 June, Geneva, Switzerland. 22. WHO African Region regional consultations on the draft WHO Global plan of action to strengthen the role of the health systems to address interpersonal violence, in particular against women and girls and against children, 1-2 July, Harare, Zimbabwe 23. WHO and WHO Regional Office for Africa regional meeting to take stock of the progress made in adolescent sexual and reproductive health and rights in the 20 years since the International Conference on Population and Development, 6-7 July, Brazzaville, Republic of Congo 24. The World Congress on Paediatric and Adolescent Gynaecology. Italy 25. Global stakeholder consultation on the draft WHO global plan of action on strengthening the role of the health systems in addressing interpersonal violence, in particular against women and girls and against children, Formal Consultation with Member States, 2-4 November, Geneva, Switzerland 26. World Humanitarian Summit, 23-24 May, Istanbul, Turkey 27. FIGIJ World Congress of Paediatric and Adolescent Gyneacology, 25-28 June, Florence, Italy 28. 2nd WAHO good practices Forum, Preconference on Adolescent Health, 25-29 October, Cv¥te d'Ivoire 29. JHPIEGO consultation on ASRH. Baltimore, USA.
2017 - 2018	30. Eastern and Southern Africa Regional Meeting on ARV-based HIV prevention for adolescent girls and young women, 1-3 February, Windhoek, Namibia

INDICATOR 5.2: # REGIONAL OR INTERNATIONAL CONSULTATIONS CONVENED OR SUPPORTED FOR SYSTEMATIC INTRODUCTION OF POLICY OPTIONS	
	31. Working group on the health and human rights of women, children and adolescents, 13 February, Geneva, Switzerland 32. Global Adolescent Health Conference: Unleashing the Power of a Generation, 16-17 May, Ottawa, Canada 33. "Reproductive health of teenagers and youth" international conference, 26-29 June, Moscow, Russia 34. The importance of sexual and reproductive health and rights (SRHR) to reach HIV fast-track goals and Universal Health Coverage for women and girls, 25 -27 October, Wilton Park, UK 35. The International Association for Adolescent Health, 11th World Congress on Adolescent Health, 27-29 October, New Delhi, India 36. West Africa Regional- Adolescent Girls¬¥ initiative. Dakar. 2017

12.TERMS OF REFERENCE

TERMS OF REFERENCE – PROGRAMME EVALUATION

1. BACKGROUND

The Special Programme of Research, Development and Research Training in Human Reproduction (HRP) were established by the World Health Organization in 1972 to coordinate, promote, conduct and evaluate international research in human reproduction. In 1988, the United Nations Development Programme, the United Nations Population Fund and the World Bank joined WHO in forming a cosponsored United Nations programme with an explicit mandate for:

- the continued assessment of existing technologies and the acceleration of the development of new technologies in fertility regulation;
- the building-up of national self-reliance in research on all aspects of human reproduction in developing countries to meet their specific needs in primary health care;
- promoting scientific and technical cooperation between developed and developing countries, and between developing countries;
- coordination of the global, research effort in the field of reproductive health;
- promoting ethical practices in the field of human reproduction research to protect the health and rights of individuals in different social and cultural settings…" 1

In 2012, The United Nations Children's Fund joined as cosponsor. As the main instrument within the United Nations system for research in human reproduction, HRP brings together health care providers, policy-makers, scientists, clinicians and consumer and community representatives to identify and address priorities for research aimed at improving sexual and reproductive health. Since 1998, HRP has functioned within the WHO Department of Reproductive Health and Research.

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

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

In order to ensure its effectiveness and efficiency in carrying out this mandate, HRP is been subject to periodic independent external evaluations, commissioned by the Special Programme's Policy and Coordination Committee (PCC). These evaluations are carried out in order to ensure the efficiency and accountability of the Special Programme, as well as to respond to specific requirements of its donors and cosponsors.

1.1 HRP External Evaluation 1990-2002 (presented in 2003)

In 2002 a comprehensive evaluation was conducted, covering the period 1990-2002. This evaluation was considered by PCC at its 16th meeting on 30 June-1 July 2003. The executive summary is available at: http://whqlibdoc.who.int/hq/2003/WHO_RHR_HRP_03.14.pdf

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

The 1990-2002 external evaluation was a wide-ranging, comprehensive study designed to address four key issues: (1) the relevance and effectiveness of Programme-supported research in reproductive health; (2) the dissemination, global use and impact of the results of the Programme's reproductive health research; (3) reproductive health research capacity strengthening by the Programme and the use and impact of the Programme's work at country level; and (4) the Programme's governance process, management, administration and efficiency. Conclusions and recommendations made by the external evaluation team were based on document review, citation analysis of selected publications, seven country visits, and input from more than 300 informants, of whom 249 provided detailed information through face-to-face interviews and e-mail questionnaires. Two thematic case studies (one on emergency contraception and one on mainstreaming gender and women's perspectives) were also performed, which provided further in-depth information on specific aspects of the Programme's work.

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

1.2. HRP External Evaluation 2003-2007 (presented in 2007)

In 2003, the HRP Standing Committee and the Policy and Coordination Committee asked for an evaluation focussing specifically on the impact of the Programme on global public goods.

Public goods are generally defined as those goods that "produce benefits that are non-rival (many people can consume, use, or enjoy the good at the same time) and non-excludable (it is difficult to prevent people who do not pay for the good from consuming it). If the benefits of a particular good accrue across all or many countries, then this is deemed a global or international public good." The International Task Force on Global Public Goods has made the above definition operational as follows: "International public goods, global and regional, address issues that: (i) are deemed to be important to the international community, to both developed and developing countries; (ii) typically cannot, or will not, be adequately addressed by individual countries or entities acting alone, and, in such cases (iii) are best addressed collectively on a multilateral basis." Both in terms of its mandate and the nature of its outputs, as well as with respect to its modus operandi, the Special Programme is without doubt a major contributor to global public goods, thus this was the suggested focus of the evaluation.

The evaluation focused on five programme achievements that fulfil the criteria of global public goods and lent themselves to an in-depth analysis of inputs, outputs, and outcomes and, where possible, impact on sexual and reproductive health status and contribution to achievement of MDGs, including poverty alleviation. The five technical case-studies were:

- promoting family planning: long-term safety and effectiveness of copper-releasing intrauterine devices;
- promoting family planning: improving the quality of care in family planning in China;
- medical (non-surgical) induced abortion;
- improving maternal and newborn health; and
- knowledge synthesis and transfer.

In addition, a study of HRP's governance and management was carried out.

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

The resulting evaluation summary and the six case studies are available at: http://www.who.int/reproductivehealth/hrp/governance/evaluation2007/en/

1.3. HRP External Evaluation 2008-2012 (presented in 2013)

The latest evaluation, covering the period 2008–2012 was requested by the World Bank at the 71st meeting of the standing committee in June 2011. At this meeting, the cosponsors agreed on draft terms of reference, elaborating an approach that would review the comparative advantage of HRP and its impact in improving outcomes and influencing evidence-based changes in SRH policies and programmes, as well as carrying out a number of case-studies. The standing committee also recommended the establishment of a PCC External Evaluation Committee (PEEC), to include: the chair and vice-chair of PCC, one representative of the HRP financial contributors, the chair of RHR's STAG, and one representative of the four HRP cosponsors, in order to oversee the process of the evaluation. Terms of reference for the evaluation were subsequently shared with PCC members for feedback and finalised at the 72nd meeting of the standing committee in December 2011.

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

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

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

The resulting evaluation summary and the six case studies are available at: http://www.who.int/reproductivehealth/hrp/governance/evaluation2012/en/

2. TERMS OF REFERENCE FOR THE HRP EXTERNAL EVALUATION 2013-2017

The objectives of the 2013-2017 HRP external evaluation is to provide information on the relevance and fulfilment of HRP's objectives vis a vis the broader context of the promotion of Sexual and Reproductive Health and Rights in developing countries and beyond in particular and of Global Health and Wellbeing more in general, its efficiency and effectiveness, its comparative advantage within the (reforming) UN-system and beyond and the impact and sustainability of its work. Also, an assessment of the Programme's governance process and management constitutes an important objective of this evaluation. In doing so the evaluation will provide information that is credible and will enable the continued incorporation of lessons learned into the decision-making process of both the Special Programme and, its cosponsors, Member States in PCC, and other cooperating parties.

The evaluation will be carried out in 2018 and presented to HRP Scientific and Technical Advisory Group in February 2019, and a final report can be presented to the HRP Policy and Coordination Committee in March 2019.

In view of the positive feedback received from PCC on the process followed in the previous evaluation, it is proposed to follow a similar process for 2013-2017 in order to examine in depth a number of the critical programme areas and outputs which have not been examined recently.

2.1 Method of work

2.1.1 Content and structure of the report

It is envisaged that the report would consist of an introductory, overview section followed by in- depth studies of selected topics.

The introductory chapter would give the background to the Programme and its modus operandi, including the rationale for its existence, its governance and the consultative mechanisms it employs for defining and prioritising its work programmes and for the scientific and ethical review of planned, ongoing and completed activities. The introductory chapter will also describe the overall frame of reference that the Programme uses in pursuing its mission and vision such as through its co- sponsorship by multiple UN agencies and its on-going portfolio review, but also through the role it was assigned to and was able to craft for itself in the implementation of: the United Nations Secretary General's Global Strategy for Women's, Children's and Adolescents' Health, the Programme of Action of the International Conference on Population and Development, and, last but certainly not least, the 2030 Agenda for Sustainable Development, including the SDGs.

As its core the evaluators will assess the work of the Programme in its entirety through the application of the 5 DAC-criteria for evaluating Development Assistance (relevance, efficiency, effectiveness, sustainability and impact) as separate but also interrelated dimensions.

An assessment of the efficiency and effectiveness of HRP's governance and management will follow. This will review, inter alia, the extent to which HRP management has responded to the recommendations of previous evaluations and to the guidance by the PCC. This will also review the participation of the HRP-cosponsors, and possible overlap of activities with PDRH and with other parts of the wider RHR-Department that is hosting HRP. This should contribute to better co- ordination, collaboration and avoid unnecessary duplication of activities.

This will be followed by a number of case studies that will again provide separate and interrelated assessments of the relevance, efficiency, effectiveness, sustainability and the impact of the work of the Programme. All case studies will also look at:

- Mechanisms for dissemination of evidence, including the work of PDRH, generated at regional and country levels as a part of the assessment of HRP's impact;
- The development of relevant partnerships;
- Attention for representation of communities and patient perspectives in HRP- research;
- Sufficient and adequate attention for ethical issues in HRP-research;
- The emerging attention for quality of care-concerns as a systemic determinant of health.

An executive summary will be prepared in order to share the findings in a concise manner to among stakeholders, potential partners and other interested parties. This summary will be no longer than 10 pages.

The structure of the external evaluation report, which in its entirety, though excluding annexes, will not consist of more than 140 pages, as follows:

1. Executive Summary
2. Introduction
3. Overall assessment of HRP's
   a) Relevance
   b) Effectiveness
   c) Efficiency
4. Efficiency and effectiveness of HRP's governance and management
5. Assessment of thematic areas through the following in-depth case studies
   a) HRP's work on 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 *Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health*;
   b) HRP's work on comprehensive maternal and perinatal health, including postpartum contraceptive use;
   c) HRP work on gender, equity and rights, including broader work from a '*leave no one behind perspective*';
   d) More recent work streams within HRP, such as adolescent SRHR, SRHR in humanitarian settings and health emergencies, from a flexibility and fitness for purpose towards the future perspective

2.1.2 Process of the evaluation

The evaluation will be carried out in accordance with "DAC Criteria for Evaluating Development Assistance", issued by the Development Co-operation Directorate (DCD-DAC) of the OECD: http://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm.

It is proposed that the overall evaluation process be coordinated by an Evaluation Team Leader, an independent expert who would also prepare chapters 1 – 4. This person would be nominated by and report back to the External Evaluation Subcommittee (see below). Each case study would be carried out by an independent expert in the specific field; production of these case studies will be coordinated by the Team Leader. The logistics of the evaluation, including travel and other arrangements, will be supported by the secretariat of HRP.

It is anticipated that most of the external evaluation can be conducted through desk review of materials and consultation by tele- and video-conferencing and other electronic means with relevant Programme staff and key respondents in other organisations (multilateral and bilateral agencies; professional and other non-state actors; civil society representatives), scientists and programme managers at national level, etc. Nevertheless, for each case study funds are included in the budget to support one visit to the Programme in Geneva and one country visit, if deemed essential.

A subcommittee of PCC, entitled the External Evaluation Subcommittee (EES), will be established to direct the evaluation. EES will consist of PCC Chair, the STAG and GAP Chairs, one representative of the cosponsors, and a maximum of two additional PCC members. All members should be free of any conflict of interests taking on their role. The EES will perform the following functions:

- Finalising the terms of reference of the evaluation, based on the input of PCC members;
- Selecting the evaluation team;
- Reviewing and approving the terms of reference, methodology, and draft reports of the various evaluation components;
- Providing overall direction to the evaluation.

The logistics of the evaluation, including travel and other arrangements, will be supported by the secretariat.

2.1.4 Timeline

2017 June-August: PCC reviews and approves terms of reference and appoints the "External Evaluation Subcommittee" (EES)

2018 February-March: Call for proposals and the issuing of contracts for engaging evaluators selected by EES

2018 April-October: The evaluation team conducts the evaluation

2018 November-December: Completion of first draft of the evaluation exercise, submission to EES for initial feedback

2019 February: Lead Evaluator presents a provisional evaluation report to STAG and GAP. STAG and GAP include recommendations about the scientific, technical, gender and rights elements of the evaluation in their annual reports to PCC

2019 March: Lead Evaluator presents a second version of the provisional evaluation report to PCC. PCC makes recommendations based on the evaluation and the STAG and GAP recommendations. Lead Evaluator reviews all recommendations and writes final evaluation report.

2019 April: HRP initiates actions following PCC recommendations

TERMS OF REFERENCE – CASE STUDIES

Each case report should include an executive summary (stand-alone) of maximum one page and a methodology section, followed by the content sections as described below. In total, including the summary and references, the reports should be no longer than 10-15 pages. Annexes can be added, but when essential to the understanding need to be incorporated into the core text of the case report (to allow stand-alone presentation).

The report should have an analytical rather than a descriptive focus and not only show the degree of achievement of HRP but also address how HRP could do better in the future.

The evaluation will be carried out in accordance with "Evaluating Development Co-Operation: Summary of Key Norms and Standards" which was issued in 2010 by the Network on Development Evaluation of

the Development Assistance Committee (DAC), of the OECD. http://www.oecd.org/dataoecd/12/56/41612905.pdf. The coordinators of the EE made sure that the template allows for responding to the DAC criteria for evaluating development assistance (Relevance, Effectiveness, Efficiency, Impact and Sustainability). Terms for this assessment (impact, input, output. outcome, etc) are defined in the DAC Glossary of Key Terms in Evaluation and Results Based Management http://www.oecd.org/dataoecd/29/21/2754804.pdf.

The general template is to be understood giving guidance regarding key questions. Together with the evaluation coordinator in charge, the template should be interpreted and adapted specifically for each case study. Case reviewers shall receive an initial briefing from their respective evaluation coordinator and work closely with a designated Focal Person from the HRP secretariat.

Not all questions are equally relevant for each case study and therefore- while respecting the proposed structure- not all sub-questions must be addressed or given equal weight. The focus of the report should be on outcomes, impact and the future. An implicit guiding question should be "by investing into HRP, how has the world/region/country changed". While achievements shall be highlighted, the report should include a critical analysis, including also information on main factors that have enabled and hindered achievements and on where there is room for improvement ("what can HRP and the cosponsors/donors learn to improve the programme's performance and the use made of its achievements in the future"). The case reviewers are asked not to go into extensive details when describing the process. Highlighting process elements that are unique to how HRP has conducted its work may be relevant in some instances, e.g., use of "convening power" to efficiently obtain outside technical expertise

PROPOSED REPORT STRUCTURE:

1. **Executive Summary (max 1 page)**
2. **Introduction including short Reference to Outcome (max ½ page)**
3. **Methodology (max ½ page)**
4. **Rationale (max 1 page)**
5. **Process (max 1-2 pages)**
6. **Outputs (max 2 pages)**
7. **Outcomes (~2 pages)**
8. **Impact (1-2 pages)**
9. **Value added of HRP contribution (including cost effectiveness if information is available) (1-2 pages)**
10. **Future-Conclusions-Recommendations (~2 pages)**
11. **List of References**
12. **Annexes**

1. Introduction
2. Methodology
3. Rationale
    a) Brief description of underlying problem/issue
        - Global significance of issue
        - Context and relevance also linked to goals and targets from the 2030 sustainable development agenda and the Global Strategy for Women's, Children's and adolescent health
        - Extent to which it is public good
    b) Why did HRP become active in this field?
        - link to HRP mandate and identified priorities

- HRP's comparative advantage
- relevance to low income countries

4. Process
   a) What HRP did - and how?
      - brief chronology- milestones
      - interaction with various stakeholders, including investigators, affected communities, policymakers
      - strength and quality of research design
      - integration of human rights and gender equality perspectives in research design, implementation and final conclusions concerning research results
      - capacity building for PIs and other study participants
      - monitoring, SOP, data management
      - supervision, QA
   b) Inputs
      - financial resources (HRP, co-financing and leveraged funding for specific outcomes
      - human resources (HRP, collaborating centres, others)
      - material, equipment support
      - technical support
   c) What were the contributions of other stakeholders (countries, agencies, donors, scientific groups, affected communities, etc) to that work? In this context, what were the contributions of cosponsors and other UN-agencies and what elements of multisectoral collaboration were eventually addressed?
5. Outputs
   Possible output categories:
   a) Immediate outputs
      - publications, electronic and print
      - presentations at conferences
      - local/regional workshops
   b) Training workshops, incl e-learning
   c) Updated meta-analysis
   d) Generation of new research questions
   e) Individual and institutional capacity building
      - Sustainability
6. Outcomes
   Possible outcome categories—public goods documented and those projected
   a) Development of guidelines for improving quality of service delivery
      - expert technical consultations, convening power
   b) Extent of changes in policy and adoption of evidence-based practices (public, private)
      - Directly attributable to HRP's work
      - Indirectly attributable to HRP's work
   c) Technologies/products/interventions developed or improved
      - uptake by public, NGO or commercial/private sectors
   d) Donor and national investments committed to uptake and scale up
      - Sustainability
   e) To what extent can the public good be attributed to HRP's work?

7. Impact

   Possible impact categories--give evidence of impact and/or rationale for anticipated impacts. Use quantitative measures wherever possible.

   a) Contribution to SDGs
   b) Contribution to ICPD agenda
   c) Contribution to poverty reduction and women's, children's and adolescents' health
   d) Access to goods (e.g. new family planning methods, information tools, guidelines, etc), services (e.g. antenatal care according to revised schedule, safer abortion services, quality FP services, etc)
   e) Potential impact of new evidence and knowledge
   f) Potential cost savings to beneficiaries (individuals and national programme)
   g) What are potentially harmful impacts of introducing product/technology/intervention- how were they addressed by HRP during research phase and how followed up during implementation in real setting
   h) To what extent can the public good be attributed to HRP's work?
   i) Contribution to strengthened health systems and to the SDG's and their targets?

   Whenever possible, analyse and explain how and why HRP research had or didn't have the impacts listed.

8. Value added of HRP contribution

   a) Counterfactuals, what would have happened if this initiative had not been done
   b) How could resources be used more effectively?
   c) Other information on cost effectiveness, if available

9 Future

   d) Conclusions regarding findings and process, benefits
   e) Lessons learned
   f) Recommendations for future research and further scaling up.