Chapter 2

Overall assessment of HRP’s relevance and effectiveness

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Abbreviations

BTN  “Beyond the numbers”
CDC  Centers for Disease Control and Prevention
CHNRI  Child Health and Nutrition Research Initiative
CIRE  Continuous Identification of Research Evidence
CSO  civil society organization
CVC  Core Voluntary Contribution
DMT  Decision-making tool for family planning clients and providers
EPC  “Effective perinatal care”
FGM  female genital mutilation
GAP  Gender and Rights Advisory Panel
GBV  gender-based violence
GCP  good clinical practice
GRR  WHO Gender and Reproductive Rights team
GTZ  German Development Agency
HPV  human papillomavirus
IPPF  International Planned Parenthood Federation
MCA  Department of Maternal, Newborn, Child and Adolescent Health
MDG  Millennium Development Goal
MEC  Medical eligibility criteria for contraceptive use
MPH  Improving Maternal and Perinatal Health (team)
MTCT  mother-to-child transmission
MTSP  medium-term strategic plan
NASG  non-pneumatic anti-shock grament
NGO  nongovernmental organization
OHCHR  Office of the High Commissioner for Human Rights
PEEC  PCC External Evaluation Committee
PCC  Policy and Coordination Committee
PDRH  Programme Development in Reproductive Health
PPH  postpartum haemorrhage
RAP  regional advisory panel
RHL  Reproductive Health Library (WHO)
RHR  WHO Department of Reproductive Health and Research
RP2  Research Project Review Panel
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>RTI</td>
<td>reproductive tract infection</td>
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<tr>
<td>SPP</td>
<td>WHO/UNFPA Strategic Partnership Programme</td>
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<tr>
<td>SRH</td>
<td>sexual and reproductive health</td>
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<tr>
<td>STAG</td>
<td>Scientific and Technical Advisory Group</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>TDR</td>
<td>Special Programme for Research and Training in Tropical Diseases</td>
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<tr>
<td>UK</td>
<td>United Kingdom of Great Britain and Northern Ireland</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNECA</td>
<td>United Nations Economic Commission for Africa</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Education, Scientific and Cultural Organization</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNIFEM</td>
<td>United Nations Development Fund for Women</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization</td>
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1 Introduction

This chapter reviews the overall relevance and effectiveness of the United Nations Development Programme (UNDP)/United Nations Population Fund (UNFPA)/United Nations Children’s Fund (UNICEF)/World Health Organization (WHO)/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP); its research; its comparative advantage and the value added by its location within WHO; its work on norms and standards; its monitoring of global trends in sexual and reproductive health (SRH); its work related to the SRH/HIV research agenda; and how it communicates its products to its clients.

1.1 A note on language

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

2 Methods

The process for the evaluation began in Geneva, with preliminary consultations and interviews with senior staff of the Programme, as well as WHO staff in other related departments including: the Family and Community Health Cluster; HIV Department; the Special Programme for Research and Training in Tropical Diseases (TDR); the Global Management Cluster; the Partnership for Maternal, Newborn and Child Health; and, the Alliance for Health Policy and Systems Research. The evaluation team also met with the subcommittee of the Policy and Coordination Committee (PCC) charged with overseeing the evaluation (PCC External Evaluation Committee – PEEC). In addition, an e-mail was sent to all staff of the WHO Department of Reproductive Health and Research (RHR), inviting their input and suggestions, and as a result a number of staff members submitted information on their work and ideas for the evaluation process.

This was followed by a review of all relevant documentation produced by the Programme over the past 5 years.

For Chapters 2 and 3 of the evaluation – the overall assessment of HRP and its governance, administration and management – a 65-point questionnaire was then developed and sent out in full confidence to over 400 key informants. Informant categories included the following: directors of national SRH programmes; PCC members; PCC observers; HRP technical committee members (the Scientific and Technical Advisory Group (STAG); the Gender and Rights Advisory Panel (GAP); regional advisory panels (RAPs); and the Research Project Review Panel (RP2)); current and former headquarters, and regional and country staff of the cosponsors; organizations with an interest either in carrying out SRH research or in using the results of such research; and individual experts in the field of SRH. Although there was insufficient time or resources for full pretesting of the questionnaire, it was reviewed by a number of experts before being distributed.

Subsequently, a much shorter questionnaire on the relevance and the use of HRP’s products in national SRH programmes was sent to all UNFPA country offices. The rationale here was that, of all the cosponsors, UNFPA’s mandate in terms of substance coincides most directly with the mandate of HRP. Thus, UNFPA would be in a good position to identify examples of the utilization of HRP’s products in countries. The results are reported in Sections 5 and 10.
A citation analysis was also commissioned as part of the evaluation and the results of this are also summarized in Section 10.1.

As the evaluation progressed, it became apparent that it was not always easy to distinguish between the outputs of HRP and the outputs of the Programme Development in Reproductive Health (PDRH). Publications citing achievements of HRP often appeared to include work carried out by PDRH. Operationally, the relationship between HRP and PDRH is very important; in essence, HRP does the research and normative work, and PDRH takes HRP’s products and promotes and applies them in countries through various mechanisms. However, in terms of monitoring and evaluating the work of these two arms of RHR, the distinction between who does what needs to be made clearer.

**Recommendation**

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

### 3 Recent challenges

Every fund, agency or programme goes through periods of instability and change. The way in which they respond is often a test of their fundamentals. Over the past five years, HRP has faced a number of challenges including:

- a substantial delay from January 2009 until December 2010 in the appointment of Dr Paul van Look’s successor as director of HRP;
- the WHO hiring freeze at a time when a larger than normal cohort of senior HRP staff were retiring;
- introduction of a new process for the allocation of WHO core budget resources;
- introduction of the new WHO ORACLE management system and the decentralization of some WHO administrative functions;
- the proposal to rationalize and possibly aggregate a number of WHO research programmes;
- the WHO decision to move Making Pregnancy Safer, formerly part of RHR, not back into RHR but as part of the Department of Maternal, Neonatal, Child and Adolescent Health;
- major changes in the long and well-established HRP process for ethical review;
- the increasing complexity of the global health architecture and HRP’s need to both adapt to, and service, parts of this new and changing architecture;
- the fall of the US dollar against the Swiss Franc;
- continuing pressure for HRP to take on a number of new areas of work or increase its work in certain areas – such as research on gender, sexual and reproductive rights, sexuality, adolescents, SRH in emergency and crisis situations, the cost effectiveness of SRH, and the SRH of sexual minorities and people with disabilities, and implementation research, to name but a few. All of these occurred without a corresponding increase in funds, and amidst a global financial crisis followed by the Euro crisis, which led donor countries, foundations and cosponsors to review and reconsider their budgets and aid priorities;
- on top of all this, in 2011 the Programme underwent an internal restructuring to streamline its research development and its research-capacity-strengthening
processes, and it is once again in the process of handing over its leadership to a new
director, who was fortunately appointed, on this occasion, early enough to allow a 3–
4-month period of overlap.
Throughout this period, HRP has clearly demonstrated that it is a mature and focused
programme. The difficulties it had to bear, it tolerated and adapted to; those that could have
changed it for the worse, it resisted; and those that were negotiable, it negotiated in such a
way as to maintain its overall purpose and mandate.
As will be documented in the following sections of this chapter, the Programme continued to
produce many important global public goods in the area of SRH between 2008 and 2012, albeit
at a somewhat reduced level due to budgetary constraints. This is largely due to three factors:
the dedication and excellence of its staff; the leadership and determination of its directors in
making the necessary decisions to ensure that HRP continued to move forward; and its
fundamentally sound governance and technical oversight systems, based on its Memorandum
of Understanding (see Chapter 1 Annex 2).
So, ultimately, because of a robust business model, and an ability to adapt to change, HRP was
able to weather the storm and to continue to function very effectively. In the words of one its
former directors, “HRP continued to do well, in order to do good”.
Continued and increased financial and political support, from donors and cosponsors, will
ensure in the future that HRP becomes an even stronger force for change in the world, and an
essential component in the assistance countries need in order to attain the Millennium
Development Goals (MDGs), and particularly, but not exclusively, the targets for MDGs 4
and 5.

4 The questionnaire

In order to gather information and opinions from as wide as possible a variety of persons with
knowledge of the Programme, a confidential questionnaire was sent to a group of 416
individuals; 166 persons (39.9%) either fully or partially completed the survey, and a further 10
respondents declined to take the survey for various reasons, but most commonly because of a
lack of more recent knowledge of HRP’s work. From here on, this group will be referred to
collectively as the “respondents”.
The percentages of the different categories of respondents are given in Figure 1. The single
largest group of respondents was from the category “member of an HRP technical committee
(STAG, GAP, RAP or RP2)”. These numbered 67 and represented a response rate of over 50%.
The next largest group was for “current or previous staff member of a cosponsor
organization”. There were 20 such responses, representing a response rate of just over 25%.
Other respondents were representatives from programme countries (9% of respondents) and
donors (6% of respondents).
Categories of respondents – responses to the question “Please indicate the one category that best describes your relationship to HRP”

The majority of respondents, 54%, had been familiar with the Programme for 10 or more years, the majority of these for more than 15 years. A further 22% each made up the categories 0–4 years and 5–9 years.

Length of time respondents had been familiar with the work of HRP
The analysis that follows is based not only on responses to the questionnaire, but also on an extensive review of HRP documentation, interviews with programme staff and additional discussions with other stakeholders and interested parties.

5 Global public health goods

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

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

Public health goods created by the Programme include: the results of its research published in peer-reviewed journals; guidelines; policy briefs; programmatic and policy documents; technical guidelines; systematic evidence reviews; global trend analyses in the area of SRH; an electronic journal for the dissemination of evidence and guidance; and new methods of fertility regulation and new technologies in other areas of SRH. For the purpose of this evaluation report, these outputs will from now on be collectively referred to as the “products” of the Programme.

An additional global public health good created by the Programme is the many worldwide institutions whose research capacities have been strengthened over the years. This enables these institutions to participate and contribute to the implementation of HRP’s global research agenda, as well as becoming a national public health good, contributing to the implementation of national SRH research agendas. As an example, a number of centres in Africa, including in Zambia and Zimbabwe, are now taking part in the multicentre maternal mortality research project. Some of the more mature centres now play a regional role as a resource centre for the research community in their regions, and as a regional ambassador for HRP, charged with disseminating HRP’s products.

5.1 Priority setting

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

Relevance and effectiveness require a sound and systematic approach to priority setting. HRP periodically reviews and assesses its priorities, by engaging groups of experts to assist in identifying, categorizing and ranking research issues. This process, along with the WHO Global reproductive health strategy, adopted at the World Health Assembly in 2004 (1), informs the Programme’s medium-term strategies and biennial budgets and workplans, which are then reviewed by STAG and approved by PCC.

The most recent exercise was the development of the 2010–2015 medium-term strategy and involved consultations at both global and departmental levels. At global level, the consultative process involved all regions and identified priorities in the five key thematic areas that form the pillars of the SRH strategy: promoting family planning; improving maternal and perinatal health; preventing unsafe abortion; controlling sexually transmitted and reproductive tract infections; and sexual health, gender, reproductive rights and adolescence. Simultaneously, in collaboration with the Global Forum for Health Research, a consultation was carried out among individuals and organizations, which informed the Medium-Term Strategic Plan (MTSP) 2010–2015. The MTSP was then finalized during two RHR staff retreats. Subsequently, at departmental level, each thematic area of work developed consultative strategies to set more
operational priorities within the framework set by the Global reproductive health strategy (1) and the MTSP.

The Promoting Family Planning team used a process based on the Child Health and Nutrition Research Initiative (CHNRI) priority-setting methodology, in order to identify areas of research for improving the quality of, access to and use of family planning; for new family planning technologies; and for reducing unmet need for family planning. Researchers, representatives of programme countries, technical agencies, donors, service providers and the private sector all contributed to this process. The results were subsequently discussed with stakeholders, who then assigned weighted scores within various areas such as epidemiological research, social science research, health policy and systems research, implementation research and research on contraceptive technology.

Occasionally, priorities are triggered by unpredictable events, such as new research findings. A recent example of this was the publication of a study on the relationship between hormonal contraception and HIV transmission, which prompted HRP to convene a technical consultation to review all published research in this area. The meeting resulted in evidence-based guidance on the use of hormonal contraceptives and HIV transmission, as well as recommendations for further research in this area.

The Improving Maternal and Perinatal Health (MPH) team organizes a consultation every 4 years, involving major collaborators such as academic institutions, donors, representatives of WHO regional and country offices, and international nongovernmental organizations (NGOs). Participants discuss progress and review a background document, prepared by the MPH team in Geneva, which highlights proposed research initiatives for the future. Space is given for the discussion of additional proposals. These consultations took place in Malaga, Spain in 2008, and in Hua Hin, Thailand in 2012.

Maternal and perinatal health normative guideline work is prioritized through a survey of stakeholders, including governments, and WHO and UNFPA regional and country offices. Guideline panels are also used for identifying priority knowledge gaps that require new research. National workshops were conducted in six countries, to determine implementation/scaling-up priorities for evidence-based maternal and perinatal health interventions.

The Sexually Transmitted Infection (STI) team developed a log-frame in 2006, through a series of consultations and an STI consultative meeting. This has remained the main instrument that guides the STI workplan. A consultation to review with stakeholders the STI research strategy is planned for early 2013. STI normative work is guided by the STI global strategy (2) and by regional meetings.

The Gender and Reproductive Rights team (GRR) receives guidance on priority issues, primarily from GAP, but also from historical reviews and expert meetings, and sometimes from STAG itself.

GAP has played a key role in guiding the work of GRR. They call for reviews and prioritization of the work, as was the case with human rights some years ago, and, more recently, GAP specifically requested a review of the work on female genital mutilation (FGM). GAP also asked for prioritization of specific issues, such as gender-biased sex selection and sexual health/sexuality. An expert group meeting subsequently made recommendations on how GRR could best contribute in this area.

The Preventing Unsafe Abortion team relies on expert groups with specific expertise on monitoring, guidelines and research.
Proposals for research priorities from each of the five thematic areas are also guided by a log-frame before receiving further guidance from the respective RAPs and STAG. As requested by PCC, these proposals also include three separate levels of priority (V: vital; E: essential; and I: important), based on criteria such as: comparative advantage, public health impact, ongoing implementation and dedicated funding. This enables an even more detailed review according to priorities within each area of work, and is also used to guide the disbursement of programme funds by the secretariat as costs and income fluctuate over time.

The priorities of the Programme are also affected by recommendations from its technical oversight mechanisms, STAG and GAP. A review of their recommendations over the last 5 years reveals a more or less continuing pressure on the Programme to do more and add to its agenda, but generally in the absence of either new or additional funds or identification of areas of work that should receive less attention. Only one recommendation in 5 years encouraged the Programme to discontinue work in a specific area. This puts pressure on the Programme to do more with no additional funds, and may thus diffuse rather than focus HRP’s work.

Respondents were asked about the influence of programme countries and donors on HRP’s priorities (see Table 1).

Table 1
The influence of programme countries on HRP’s priorities

<table>
<thead>
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<th>Influence</th>
<th>Percentage of respondents</th>
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<tr>
<td>1 – very much</td>
<td>7.0</td>
</tr>
<tr>
<td>2</td>
<td>44.3</td>
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<tr>
<td>3</td>
<td>28.7</td>
</tr>
<tr>
<td>4</td>
<td>12.2</td>
</tr>
<tr>
<td>5 – not at all</td>
<td>7.8</td>
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<tr>
<td>Total (n = 115)</td>
<td>100.0</td>
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Only 7% of respondents felt that programme countries have a strong voice in determining HRP’s research priorities, and only just over 50% gave a rating of “1” or “2” in answer to this question.

When it comes to the influence of donors, 25% of respondents felt that they had too much influence over HRP’s agenda, though 69% felt that the influence of donors was about right.

Overall, over 70% of respondents gave a rating of “1” or “2” in answer to the question: “Do the research priorities and programmes supported by HRP address SRH issues most likely to assist programme countries to achieve MDG targets?”.

Table 2 shows that less than 20% of respondents considered HRP’s priority-setting mechanisms to be “very strong”, though a further 43% gave this question a rating of “2”. In providing further comments on priority setting, a number of respondents felt that priorities were too donor driven or driven by the interests of individual staff; that STAG should play a stronger role in ranking priorities and carrying out in-depth reviews of specific areas of work; and that HRP’s agenda was still too biomedical and needed to move towards implementation research.

Overall, there was an impression that, with the loss of steering committees and specialist panels, the process of priority setting could be strengthened and more focused on a smaller number of critical policy- and programme-relevant questions.
Table 2

<table>
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<th>Strength</th>
<th>Percentage of respondents</th>
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<tr>
<td>1 – very strong</td>
<td>17.9</td>
</tr>
<tr>
<td>2</td>
<td>43.4</td>
</tr>
<tr>
<td>3</td>
<td>24.5</td>
</tr>
<tr>
<td>4</td>
<td>12.3</td>
</tr>
<tr>
<td>5 – very weak</td>
<td>1.9</td>
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<tr>
<td>Total (n = 106)</td>
<td>100.0</td>
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</table>

One question asked of respondents was concerned with missed research opportunities. Almost all respondents replied to this question, indicating a wide variety of subjects, some very specific and some very general. Many informants responded in terms of areas that should receive more emphasis rather than in terms of missed opportunities. Three particular issues were cited more often than any other. These were implementation research, research on adolescents and research on the social determinants of SRH. Respondents also noted research on abortion as a continuing critical area of work for the Programme, and one where its comparative advantage was paramount.

Conclusion

HRP cannot be expected to research or solve all issues related to SRH. In general, it appears that different thematic areas within the Programme use different methods to identify priorities, and some of these are more rigorous and more inclusive than others. These processes may need to be strengthened to enable the Programme to focus on a smaller number of critical policy- and programme-relevant questions. Respondents gave the general impression that programme countries should have more influence on the setting of HRP’s research priorities and donors a little less, but that, overall, priorities were generally in line with what needed to be done. However, a number noted that it was important for the Programme to keep its ear to the ground and listen and take note of what the real issues were. A number of respondents indicated that the Programme might need to focus more on research that is likely to have an impact in the short term (for example STI prevention, and its work on magnesium sulfate for pre-eclampsia and eclampsia), while maintaining at a more moderate level other areas of work that could have a major impact, but in the much longer term (for example, male contraception). Respondents identified implementation research, research on adolescents and research on the social determinants of SRH as three areas to which the Programme might wish to give greater attention.

Recommendations

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

In its overall programme of work, HRP should consider giving higher priority to implementation research, research on adolescents and research on the social determinants of SRH.
5.2 Geographical focus

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

One often-cited barrier to undertaking research in the poorest countries is the lack of both human and institutional resources. However, through its research-capacity-strengthening grants, and its Biostatistics and Data Management unit, HRP has been instrumental in developing methodologies to undertake research in resource-poor settings, supporting the process of design, implementation, monitoring, data management and processing, and publication, while ensuring that good clinical practice (GCP) guidelines, standard operating procedures, and data-quality standards are maintained.

Two such recent examples are:

- a study on the “Effect of non-pneumatic anti-shock garment (NASG) in the treatment of postpartum hemorrhage”. The study was a cluster randomized trial conducted in 38 rural clinics in Zambia and Zimbabwe, designed to test the effectiveness of the NASG to reduce maternal mortality among women arriving in clinics in hypovolaemic shock due to severe postpartum hemorrhage (PPH). The device acts by channelling blood to the brain, heart and lungs, and has the potential to keep women alive during transportation from lower-level facilities or from the community to referral hospitals;

- “a demonstration project for the implementation of the WHO antenatal care model in Mozambique”. This is a study being conducted in 10 large hospitals across the country that provide antenatal care. It is testing the impact of an intervention to improve the quality of antenatal care by improving the detection, treatment and prevention of major health conditions, such as hypertension, anaemia, HIV/AIDS, malaria, and congenital syphilis, during pregnancy. The first phase of this research identified deficiencies in the supply chain as the main limiting factor for the delivery of antenatal care with an adequate level of quality. An interventions package is now being deployed, which consists of an innovative, sustainable and simple system of commodities, kits and checklists to strengthen the supply chain and empower the nurses that provide antenatal care services.

The commonalities between these two projects are that the research questions are highly focused on problems relevant to resource-poor settings, and could not be implemented, or would not provide a relevant answer if undertaken in more developed settings. Robust research designs and methods have been deployed using innovative tools and technologies to assure compliance with GCP, including data quality assurance, patient’s safety and confidentiality, and adequate trial monitoring. The studies were conducted within the health system, and under conditions that reflect the routine delivery of care.

In promoting and introducing its products, HRP continues to be open to collaboration with all countries in all regions, on the basis of the past work it has undertaken and future opportunities. In overcoming barriers to improving SRH policies and programmes in countries, the Programme has developed specific methodologies, such as the WHO Strategic Approach, and specific collaborations such as the Strategic Partnership Programme (SPP) with UNFPA. For example, the SPP introduced guidelines that HRP had developed in family planning, maternal and newborn health and STIs/reproductive tract infections (RTIs), using a systematic approach. Within the SPP, a number of countries were defined as “countries of intensive focus”, and these were closely followed up in adaptation and implementation of guidelines after their systematic introduction.
In order to consolidate this process, HRP identified a number of countries for “strategic focus”. The criteria used to select these countries included: high levels of maternal mortality and unmet need for family planning; a broad vision of reproductive health in country programming; commitments made by the government to the United Nations (UN) *Global strategy for women’s and children’s health* (3), especially related to family planning; the existence of resources/champions to lead and collaborate joint efforts; countries of intensive focus in the UNFPA/WHO SPP; RHR/HRP’s comparative advantage of long-term collaboration; and the potential to scale-up with availability of in-country resources.

As a result, six countries from the African Region, and three each from other regions fulfilling the above criteria were selected. These are:

- **African Region**: Benin, the Democratic Republic of Congo, Guinea, Kenya, Nigeria, Zambia;
- **South-East Asia Region**: Bangladesh, Myanmar, Nepal;
- **Western Pacific Region**: Cambodia, the Lao People’s Democratic Republic, Viet Nam;
- **European Region**: Republic of Moldova, Tajikistan, Ukraine;
- **Eastern Mediterranean Region**: Afghanistan, Pakistan, Yemen;
- **Region of the Americas**: Peru, the Plurinational State of Bolivia, Guatemala.

In comparison, the MDG “countdown to 2015” lists 73 countries with the highest burden of maternal mortality, including the 49 least developed countries, and the H4+ initiative has identified, as their primary focus, a subgroup of 25 of these countries with the highest rates of maternal mortality. This listing also reflects, to a large degree, those countries with high unmet demand for family planning, poor access to SRH services and high rates of HIV infection. Only 9 of the 21 strategic focus countries of HRP are on the H4+ priority list of 25 countries. However, of the six countries in Africa, five are on the list; of the three in the Eastern Mediterranean Region, two are on the list; and for both the Western Pacific Region and the South-East Asia Region, only one out of the three are on the list.

**Conclusion**

It does appear that HRP focuses its work on a set of strategic countries, and has developed methods to undertake research in low-resource settings that ensure quality of research design, implementation and good clinical practice. However, it should align its focus countries more to those targeted by other global initiatives for SRH.

**Recommendation**

For HRP to maximize its potential impact, it needs to strengthen its focus on research questions that will benefit the least developed countries and those furthest from the MDG targets, and on undertaking this research wherever possible 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.

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

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

Globally, HRP does not attempt to map the SRH research landscape in any systematic fashion, and neither does any other organization. It is generally agreed that this would be costly and would need to be updated every few years, and that most organizations would not use the information in planning their own research priorities. Its value added would therefore be minimal. The more informal strategy used by the Programme – maintaining a broad overview of the major areas of work being pursued by the global SRH research community through its many formal and informal contacts with them – appears to generally avoid unnecessary and costly duplication of efforts. A good example of this is microbicide research and development, where other organizations are making major investments, and the Programme has decided not to give this priority, instead focusing on the special regulatory and introductory considerations needed for these products.

However, in the context of monitoring the implementation of the WHO Global reproductive health strategy (1), which is done by RHR every 2 years, and reported to the World Health Assembly, data are collected to ascertain the extent to which selected research products of HRP are being used or have been integrated in health systems, in countries. Examples include the use of magnesium sulfate, focused antenatal care, emergency contraception, and early detection of cancer of the cervix with acetic acid-aided visual inspection.

As can be seen from Table 3, over 80% of respondents gave HRP a rating of “1”, “2” or “3” for the way in which it coordinated its work with research going on in other institutions. Comments by respondents ranged widely, from “excellent” to “a lost opportunity”; there was an overall feeling that more coordination was needed, but that it was now even more difficult because of the greater number of actors in the field and would therefore require more resources.

Table 3

Respondents’ views on the effectiveness of HRP in coordinating research with other institutions

<table>
<thead>
<tr>
<th>Effectiveness</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – highly effective</td>
<td>16.1</td>
</tr>
<tr>
<td>2</td>
<td>39.3</td>
</tr>
<tr>
<td>3</td>
<td>27.7</td>
</tr>
<tr>
<td>4</td>
<td>15.2</td>
</tr>
<tr>
<td>5 – not at all effective</td>
<td>1.8</td>
</tr>
<tr>
<td>Total (n = 112)</td>
<td>100.1(^a)</td>
</tr>
</tbody>
</table>

\(^a\) This percentage over 100% is due to rounding.

Within WHO, coordination of research is perhaps most important with TDR and the Department of Maternal, Newborn, Child and Adolescent Health (MCA). It is notable that, towards the end of 2009, there was more formal collaboration among research entities based in WHO, as well as those in Geneva outside WHO. Monthly meetings of these groups shared research in progress, and a key product was the joint publication in *PLoS Medicine* on defining research to improve health systems, which discussed implementation, health systems and operations research (4). In addition, HRP, TDR and the Alliance for Health Policy and Systems Research have a joint mechanism for coordination of implementation research through the Implementation Research Platform.
TDR is undergoing a major reorientation towards implementation research, and if HRP also decides to move in this direction, then increased and perhaps more formal coordination mechanisms with TDR will be needed.

MCA has within its mission statement the following item: “Generate and synthesize evidence and define norms and standards for maternal, newborn, child and adolescent health”. Its work includes basic research, clinical trials and implementation and health-systems research in this area. In HRP, the MPH team has as one of its key objectives: “... developing, assessing and implementing effective interventions” and “... addressing barriers to improving access to quality maternal and perinatal health care ...”.

Conclusion

Given that organizations undertaking research on SRH seem often to have their own agendas, sometimes driven by their donors, a global platform for sharing information may be a sufficient alternative to a more formal attempt at coordination. There would seem to be considerable opportunity for duplication of effort between HRP and MCA, particularly in the areas of maternal and perinatal health and adolescents, which perhaps require stronger efforts in coordinating the planning and implementation of research activities between these two groups. With increasing focus on implementation research, TDR and HRP may need to develop stronger mechanisms for coordination.

Recommendations

There is a need for a more formal mechanism for coordination of research between HRP and MCA, particularly in the areas on maternal and perinatal research, and research on adolescent SRH; and between HRP and TDR on implementation research.

HRP should consider developing an e-platform to enable organizations engaged in research on SRH to share information on their current work and future plans.

5.4 Selected highlights

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

What follows is a brief review of HRP’s work in each of its main substantive areas since 2008. (Institution strengthening is not included here, since it is the focus of one of the four individual case-studies undertaken for the evaluation – Chapter 5, Research-capacity strengthening and network building.) In addition, a further case-study examines the Programme’s record on evidence generation and synthesis to improve family planning, prevent unsafe abortion and prevent and control STIs and RTIs (Chapter 4).

5.4.1 Promoting family planning

HRP carried out the research and the systematic reviews of clinical and epidemiological evidence needed to develop a guideline entitled *Medical eligibility criteria for contraceptive use* (MEC) (5). This offers guidance on the safety of using 19 different methods of contraception for women and men with specific characteristics or medical conditions. It is one of HRP’s four cornerstones of family planning guidance, the others being: *Selected practice recommendations for contraceptive use* (6); *Family planning: a global handbook for providers* (7); and, *a Decision-making tool for family planning clients and providers* (DMT) (8).

The MEC won the first prize in the Obstetrics and Gynecology category of the 2011 British Medical Association Book Awards.
In order to implement this guidance, the MEC were re-formatted as a simple “wheel” (the MEC wheel) (9), in association with the INFO project at Johns Hopkins University, the Partnership for Communication for Family Health in Jordan, and the University of Ghana Medical School. The MEC wheel converts the recommendations into a single hand-held tool that can be used directly by service providers when counseling clients on choice of contraceptive method. The MEC wheel has already been adapted, translated into 24 languages and printed and distributed in all regions. There is evidence of its use in over 80 countries, and this is clearly a minimum figure, since it is not based on a universal survey. The information comes from WHO sales figures (over 135,000 copies in 38 countries); replies from respondents (28 additional countries), and the UNFPA survey (14 additional countries). The MEC wheel is also available in a computer-based electronic version for training or demonstration, and as a mobile phone app, which allows family planning providers even greater access than through traditional paper or electronic formats.

The MEC are subject to continuous updating through a systematic mechanism known as CIRE (Continuous Identification of Research Evidence). A weekly review of the family planning literature, carried out jointly by HRP and the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia, United States of America (USA) enables early identification of any new evidence or issues that would affect the recommendations.

HRP’s work in the area of family planning also includes initiatives in the area of infertility. These range from research to simplify clinic methods for managing infertility in low-income settings, to regular updating of the WHO laboratory manual for the examination and processing of human semen (10). This publication is a laboratory guide used, for example, in the clinical evaluation of infertility. The manual, released in its fifth edition in 2010, draws on the expertise of a wide group of HRP’s collaborators in the field of male reproductive health, and is the document most frequently downloaded from the WHO web site. It is already available in six languages (Chinese, English, German, Italian, Japanese and Turkish), and additional translations are under way. Over 4500 copies of the fifth edition have already been sold, and more than 500 copies distributed free of charge in programme countries. As of the end of 2012, downloads from the HRP web site number 27,500.
Boxes 1 and 2 present utilization headlines for these publications.

**Box 1. Utilization headlines for MEC, the MEC wheel and the decision-making tool**

In Mexico, the Ministry of Health disseminated 10 000 copies of the MEC wheel (9) and evaluated its use in clinical settings. Preliminary results from the sample of 161 doctors interviewed found that 80% said they had used the wheel in the last 2 weeks and, among users, 84% found it easy or very easy to use, and 91% found it useful or very useful in their work.

In the Americas, in collaboration with the Centro Latinoamericano de Perinatologia/Salud de la Mujer y Reproductiva, 5000 Spanish language copies of the DMT (8) and Family planning: a global handbook for providers (7) were distributed among 18 countries. As a result, a number of countries, including Cuba, Guatemala and the Plurinational State of Bolivia, either updated existing or implemented new family planning service norms.

In Argentina, Brazil, Paraguay, Peru and Venezuela, the MEC (5) and the MEC wheel (9) are being reprinted and used. In Argentina and Venezuela, the governments are underwriting the costs, and in other countries support is being provided by UNFPA.

The DMT (8) and Family planning: a global handbook for providers (7) were used as the basic documents in a workshop for 15 English- and Dutch-speaking Caribbean countries. Participants, who came from ministries of health and NGOs providing family planning services, developed draft workplans for the use of these guides in their national programmes.

Chile has used HRP products in the development of its national norms on fertility regulation, for the provision and use of contraceptives in the national health system.

The MEC (5) have been used to develop national family planning service-delivery standards, and preservice and in-service family planning training for all levels of providers in the United Republic of Tanzania.

In the Philippines, the UNFPA country office financed the adaptation, translation and printing of 40 000 copies of the MEC wheel (9).

In a number of countries in Asia, notably Bangladesh, China, Indonesia, Mongolia, Myanmar, Solomon Islands, Tonga, Vanuatu and Viet Nam, HRP’s family planning guidance tools have been used to formulate/update reproductive health policies, update standards and national guidelines, improve training curricula, conduct training activities, develop advocacy materials and promote service-delivery improvements. Many of these came about as a result of the WHO/UNFPA SPP, which, until 2008, provided HRP with additional funds for the introduction, adaptation and dissemination of its evidence-based guidelines in countries.

The Mongolian version of the DMT has been widely distributed throughout the country and is regularly used in family planning clinics.

Myanmar simplified the DMT (8), which is now used by community health workers.

In Nepal, the Ministry of Health has expanded the use of the DMT to 40 villages in four districts.

The DMT (8) has been translated into Lao and is being used in orientation workshops for service providers.

The MEC (5) have been used to revise clinical family planning protocols in the States of Uttar Pradesh and Bihar in India.

Sri Lanka has adapted the MEC wheel (9) for use in its national programme.

The MEC (5) and the DMT are both used in Iran to improve the quality of family planning information and care.

The MEC (5) have been used to develop and/or revise national guidelines in Latvia, Romania, Turkmenistan and Uzbekistan.

Armenia, Azerbaijan, Kyrgyzstan, Latvia, Lithuania, the Russian Federation and Serbia, among several other countries in the European Region, have translated and printed the MEC wheel (9), and then used it for improving the quality of family planning services at primary health care.

The MEC (5) is used in many high-income countries, such as the United Kingdom of Great Britain and Northern Ireland (UK) and USA, to inform national guidelines and decisions made by drug regulatory authorities.
Box 2. Utilization headlines for other HRP family planning products

As a result of HRP’s research, Afghanistan changed its policy to enable trained nurses and midwives to insert intrauterine devices, thus greatly expanding the availability of this method.

The Sichuan Family Planning Research Institute in Chengdu, China, which received long-term institutional strengthening grants from HRP, established non-scalpel vasectomy in China and is now recognized as the national reference centre for training and dissemination, and as an international training centre.

Using evidence-based family planning guides and tools developed by HRP, a master training of family planning trainers was carried out in Iraq with collaboration from the Ministry of Health in Jordan.

In developing national guidelines and standards, Turkey uses the guidance and recommendations from WHO/HRP’s publications on family planning, and, more generally, uses HRP’s products as a reference point on all other SRH interventions.

The International Planned Parenthood Federation (IPPF) works with its member affiliates in all countries to promote the adaption and adoption of HRP guidance on family planning, as well as broader guidance on all SRH issues. Member affiliates extend and expand this process by working with the national authorities to promote the use of HRP’s products.

A survey of programme countries in 2011 revealed that around two thirds of those responding had included emergency contraception as one of the family planning methods available in public programmes.

Over 80% of respondents felt that the MEC (5) had been used to strengthen SRH policies and/or programmes.

Conclusion

HRP’s MEC (5), the MEC wheel (9) and the DMT (8) are being widely used in many programme countries throughout the world, and are undoubtedly having a positive impact on quality of the SRH of individual women, men and adolescents. Other HRP products are also expanding the availability of family planning technologies.

Recommendation

To further strengthen its effectiveness, the Programme should examine if and how the CIRE approach could be used for the other thematic areas of HRP’s work.

5.4.2 Maternal and perinatal health

In the area of maternal and perinatal health, HRP has addressed some key questions of high relevance between 2008 and 2012, and as a result has produced a number of global public health goods, many of which are already being used in programme countries.

Management of the third stage of labour

HRP undertook research on the management of the third stage of labour, which demonstrated that in situations where injectable uterotonic (primarily oxytocin) were available, the use of misoprostol did not have any additional benefits in preventing PPH. Additional research in this area showed that controlled cord traction was safe in hospital settings but could be omitted, if injection of oxytocin was available, in situations where skilled birth attendants were not present. After publication of the results in peer-reviewed journals, the WHO guideline on PPH treatment and management has been updated and is in press, and further dissemination of the guidance has started. A meeting cosponsored by the United States Agency for International Development (USAID) and the Maternal and Child Health Integrated Project in Dhaka, Bangladesh, with over 300 participants from various programmatic backgrounds, presented the results and their implications for national programmes. USAID is also issuing a technical note to all its country offices and contract agents, to change their approach on management of the third stage of labour.
The recommendations on misoprostol were subsequently incorporated into the 17th edition of the *WHO Model list of essential medicines* (11), a reference guide widely used by programme countries in determining national drug formularies.

**Optimizing maternal and newborn care**

HRP undertook the research and analysis that enabled the development of evidence-based recommendations to facilitate universal access to key, effective maternal and newborn interventions through optimizing the roles of health-care workers. These recommendations are intended for health policy-makers, managers and other stakeholders at regional, national and international levels and can be adapted to specific national contexts. The guideline: *WHO Recommendations for optimizing the delivery of key maternal and newborn health interventions* (in press) makes a total of 128 recommendations, 25 of which are for lay health workers, 27 for auxiliary nurses, 22 for auxiliary nurse-midwives, 17 for nurses, 13 for midwives, 8 for associate clinicians, 8 for advanced associate clinicians and 1 for non-specialist doctors.

Two launch meetings have already taken place in 2012, the first with WHO Regional Office for Africa, in Addis Ababa, and the second at the International Federation of Gynecology and Obstetrics conference. The Reproductive Health Supplies Coalition is considering the production of a policy brief, and supporting further dissemination. This guideline provides the scientific basis for various task-sharing and task-expansion activities by different categories of health-care workers in different clinical settings. It will ultimately result in greater access to appropriate and safe maternal and newborn care for women.

**Maternal “near-miss”**

HRP developed a standardized definition of maternal “near-miss” (12), and created criteria for its identification, in order to improve monitoring of maternal care. This allows assessments of the management and response to complications occurring during pregnancy and the intrapartum period, and thus serves as a barometer of the maternal care system. By standardizing the definition, the robustness of the evidence base is improved, and programme managers are better able to monitor and assess performance in health-care facilities.

The Programme also undertook a multicountry survey on maternal and newborn health (13). This study, conducted in over 350 health facilities in 29 countries aims to evaluate the quality of care in health facilities, through examination of the prevalence of maternal “near-miss” cases. The findings of the study will enable a more comprehensive dialogue with policy-makers, programme managers, professional associations and civil society, to promote best practices, improve quality of care and achieve better health for mothers and children. A facility-level monitoring tool with indicators has already been published.

HRP carried out the research showing the effectiveness of magnesium sulfate in the treatment of pre-eclampsia and eclampsia, and subsequently ensured that it was included in the *WHO Model list of essential medicines* (11).

Other important evidence-based guidelines on maternal and perinatal health include: *WHO Recommendations for induction of labour* (14); *WHO Recommendations for prevention and treatment of pre-eclampsia and eclampsia* (15); and *Managing complications in pregnancy and childbirth* (16). All of these, as well as all other HRP guidelines and systematic reviews, are available through the *Reproductive Health Library* (RHL) both online and as a CD-ROM.

Finally, HRP has initiated collaboration with the inventor of the Odon Device, a low-cost, easy-to-use technological innovation to facilitate operative vaginal delivery and minimize trauma to
the mother and baby. The device has great potential for use by mid-level health-care providers in low-resource settings, and is currently in early clinical trials in Argentina and South Africa. Box 3 presents utilization headlines for maternal and perinatal care products.

### Box 3. Utilization headlines for maternal and perinatal care products

In order to have a criterion-based clinical audit method for improving the quality of maternal care, the HRP near-miss monitoring tool is being used in Peru as a national policy for the surveillance of severe maternal morbidity.

Using the results of HRP’s research, national-level interventions for the improvement of maternal, newborn and child health were introduced in Brazil, Chile and Mongolia.

Maternal near-miss has been adopted for use in Uganda.

Using evidence-based guidelines developed by HRP, Myanmar has adopted a new national policy on active management of the third stage of labour.

Definition of maternal death, and maternal death audits have contributed to improving maternal care in Mozambique, and in training health-care providers in Pakistan.

In Mozambique, during the implementation of a cluster randomized trial, it became apparent that shortages and rupture of stocks of commodities prevented implementation of the model, and this led the Ministry of Health to develop an intervention to address commodity supply issues.

Fifteen other countries are implementing the antenatal care model developed by HRP, which halves the expense and the time women spend in accessing services, without compromising the quality of care received.

A survey of programme countries in 2011 revealed that 95% of those responding had registered magnesium sulfate in their national lists of essential medicines.

As can be seen from Table 4, almost 90% of respondents cited the global estimates as having an impact on programmes and policies. For the other three products, over 60% gave a positive response, with a much higher proportion of “Don’t knows”, most likely because these products are relatively new in the HRP “pipeline”.

### Table 4

<table>
<thead>
<tr>
<th>Product</th>
<th>Percentage of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global maternal mortality estimates (17)</td>
<td>88.9% 2.2% 8.9% 100.0%</td>
</tr>
<tr>
<td>Maternal near-miss definition/criteria (12)</td>
<td>63.4% 3.0% 33.6% 100.0%</td>
</tr>
<tr>
<td>Recommendations on maternal and newborn health interventions (in press)</td>
<td>65.4% 3.8% 30.8% 100.0%</td>
</tr>
<tr>
<td>Multicountry survey on maternal and newborn health (13)</td>
<td>60.7% 5.2% 34.1% 100.0%</td>
</tr>
</tbody>
</table>

#### 5.4.3 Preventing unsafe abortion

Every year, approximately 22 million unsafe abortions take place globally, and 98% of these occur in low- and middle-income countries. The global rate of unsafe abortion has remained somewhat unchanged since 2003, though the absolute numbers have increased by 2 million between 2003 and 2008. Complications of unsafe abortion are estimated to result annually in 47 000 deaths, and an additional 5 million women suffer from a subsequent disability. Globally, 1 in 8 maternal deaths are attributable to abortion, and in Eastern Africa this rises to 1 in 5.

**Technical and policy guidance on safe abortion**

HRP updated and published in 2012, *Safe abortion: technical and policy guidance for health systems* (18), a document that provides a set of the latest evidence-based recommendations. The document was developed with inputs from various groups of experts as well as
information from Cochrane systematic reviews. All available evidence was appraised and graded using a standardized approach. The evidence and recommendations then went through a final review at a technical consultation at WHO. The document is an essential tool for support to countries, including strategic assessments on unintended pregnancy and abortion; development and revision of national standards and guidelines for comprehensive abortion care; and technical opinions on restrictive laws and parliamentary amendments. A review and update will take place in 4 years.

In parallel, a companion document, Clinical practice handbook for safe abortion care is being developed by the Programme.

**Mid-level providers for safe abortion**

Randomized controlled equivalence trials conducted by HRP showed that trained mid-level health-care providers can administer early surgical abortion (South Africa and Viet Nam) and medical abortion (Nepal) as safely and effectively as doctors. These findings have a major impact on preventing unsafe abortion and related morbidity and mortality. In countries where abortion is not against the law, it potentially expands access to safe abortion through mid-level providers, especially in remote areas where doctors are in short supply, and for poor women who are unable to afford doctors’ fees.

Box 4 presents utilization headlines on unsafe abortion.

**Box 4. Utilization headlines on unsafe abortion**

Between 2008 and 2011, HRP collaborated with eight countries that wished to better address the issue of unintended pregnancy and abortion. Using the strategic approach, a strategic planning and policy and programme implementation tool previously developed by HRP, which includes assessment, introductory and scaling-up phases, these eight countries have now made considerable progress towards the goals they themselves set.

Four countries in Africa identified similar barriers to safe abortion and pregnancy prevention. These included poor implementation of existing laws, which limited women’s access; lack of knowledge about the legal status of abortion by both clients and providers; costly, clandestine systems for abortion; inadequate post-abortion care; weak family planning information, education and service systems; and religious, social and cultural barriers. A recent follow-up review concluded that the commitment and actions of governments and civil society stakeholders with regard to reducing abortion-related deaths and injuries had significantly increased.

In the Republic of Moldova and Ukraine, HRP’s strategic approach enabled: the development of national standards and guidelines on comprehensive abortion care; revision of preservice training curricula based on the national guidelines; and the development of model services. In Kyrgyzstan, the strategic approach led to development and approval of a new national clinical protocol on comprehensive care for unwanted pregnancies; the introduction of a client-oriented approach in clinics; and, the development, testing, approval and implementation of new training curricula.

Using HRP guidelines, the former Yugoslav Republic of Macedonia developed national norms and standards for abortion care in response to a previously undertaken strategic assessment exercise.

HRP safe abortion guidance has been used to improve the quality of abortion care in Romania and the Russian Federation.

In 2012, Bangladesh adapted the HRP document Safe abortion: technical and policy guidance for health systems (18) as the basis for updating their national menstrual regulation services guidelines.

The Programme provided technical assistance to Nepal for scaling up the introduction of methods of medical abortion developed by HRP.

Based on the original study carried out in Nepal, South Africa and Viet Nam, an ongoing operations research project is assisting 30 countries to expand access to medical abortion in low-resource settings, again using the strategic assessment approach.

The Ministry of Health in Colombia used HRP guidance documents to develop national guidelines on abortion.

The Ministry of Health in Argentina is training health-care professionals using the project team that undertook the research related to improving post-abortion care, including use of family planning.
A total of 82.2% of respondents felt that safe abortion guidance had strengthened SRH programmes or policies, and two out of every three felt that research on using mid-level providers for carrying out safe abortion had had a similar outcome.

Conclusion

This work clearly demonstrates how HRP develops and uses products to facilitate outcomes in programme countries, such as improved standards of care, which have an impact on the health and lives of women. This is also a clear example of the comparative advantage of HRP – its ability to work in sensitive areas with the complete confidence of countries.

5.4.4 Prevention and control of sexually transmitted and reproductive tract infections including gynecological cancers and infertility

Sexually transmitted and other reproductive tract infections

The HRP publication Sexually transmitted and other reproductive tract infections: a guide to essential practice (19) is a reference manual and a resource to educate and remind health-care workers of the need to consider STIs and RTIs when providing other SRH services. It is used widely for preservice and in-service training; as a source of up-to-date, evidence-based recommendations; and as a starting point for improving policies and programmes for the prevention and management of STIs/RTIs.

Rapid test for syphilis

Syphilis screening in pregnancy is more effective in preventing stillbirths than any other pregnancy intervention besides comprehensive emergency obstetric care, and costs less per pregnant woman than nearly any other intervention.

HRP, in collaboration with TDR, developed a point-of-care rapid test for syphilis that can be administered by any trained antenatal care provider. The test provides an immediate result and thus the possibility of immediate treatment. Evidence has shown that introduction of the rapid test can increase the coverage of syphilis screening in antenatal settings. Research has also included field-studies to better understand implementation, acceptability and scaling-up issues.

The Programme is currently developing an advocacy tool for investing in this intervention: Investment case for eliminating congenital syphilis: promoting better maternal and child health and stronger health systems.

Preventing cervical cancer

HRP has assessed the acceptability and feasibility of implementing a “see and treat” approach to cervical cancer, using visual inspection with acetic acid and cryotherapy. With some basic training and the addition of some minimal equipment and supplies, the test can be administered by nurses and midwives and the treatment can be provided at a single visit. These services are now being scaled up in the six countries where the research was originally conducted, and five of the six have already developed national plans.

Other guidelines produced include: technical guidelines on Strategies and laboratory methods for strengthening surveillance of sexually transmitted infections (20); and on Use of cryotherapy for cervical intraepithelial neoplasia (21).
Box 5 presents utilization headlines on STI/RTI products.

Box 5. Utilization headlines for STI/RTI products

In four Central Asian countries (Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) and in partnership with UNFPA country offices, guidelines developed by HRP were used for the integration of family planning and management of STIs at primary care level.

The Programme provided support to Rwanda, the United Republic of Tanzania and Zambia to strengthen their national programmes for cervical cancer prevention, including the introduction of human papillomavirus (HPV) vaccine.

Using the results of its research, the Programme has ensured the updating of the WHO essential medicines list (11), to include the relevant antibiotics for resistant STIs.

A total of 77.6% of respondents felt that the HRP manual Sexually transmitted infections and other reproductive tract infections: a guide to practice (19) had been used to strengthen SRH programmes or policies in countries.

5.4.5 Sexual health including adolescence, gender and sexual and reproductive rights

A standardized methodology for measuring violence against women

HRP contributed to the development of a standardized methodology to assess violence against women, particularly intimate partner violence (physical, sexual, emotional and controlling behaviours) and its health consequences, as well as risk and protective factors. Standardizing such measurement has enabled comparative studies across and between countries, and facilitated the use of such data for policy-making and programming.

This training programme aims to promote the integration of gender equality and human rights in reproductive health policy, programmes and research. It has been translated into multiple languages and adapted in different ways.

Interagency statement on preventing sex selection

The Office of the High Commissioner for Human Rights (OHCHR)/UNFPA/UNICEF/UN Women/WHO statement, Preventing gender-biased sex selection (22) highlights the public health and human rights dimensions and implications of the problem and provides recommendations on how best to take effective action.

Box 6 presents utilization headlines for HRP gender and adolescent products.

Box 6. Utilization headlines for HRP gender and adolescent products

The Global strategy to stop health care providers from performing female genital mutilation (23) is credited with strongly influencing a Kenyan Law against FGM, passed in Parliament in October 2011.

The Ministry of Health in Senegal used the results of HRP’s research to develop its first action plan for improving adolescent SRH services.

In Panama, the national education policy changed as a result of research undertaken by an HRP collaborating centre. Teachers are now trained to discuss issues of sexuality with students, and pregnant schoolgirls are allowed to continue their studies.

Research in Shanghai, China found that young people considered a dedicated web site to be the best way of improving their knowledge about SRH. The web site is now part of the life education programme for secondary school students.

The tool for examining laws, regulations and policies in relation to SRH and human rights (unpublished) and its adaptation for adolescent SRH was applied in Moldova, Sri Lanka and Tajikistan.

Gender training carried out in China, Myanmar and Sudan led ministries of health to examine how to integrate gender and human rights issues into reproductive health policies.
A total of 62.1% of respondents felt that the HRP guideline Gender and rights in reproductive health: a training manual for health managers (24) had strengthened SRH programmes or policies in countries.

5.4.6 The UNFPA country office enquiry

In order to assess more objectively and quantitatively both the use of the Programme’s products in countries, and its modes of communication, a short questionnaire was sent to all UNFPA country offices. The rationale for choosing UNFPA was that it is the HRP cosponsor, whose substantive mandate corresponds mostly closely with that of the Programme. Thirty-four replies were received by the deadline, a response rate of just over 30%.

The first question enquired about the use of the Programme’s products to strengthen SRH policies and/or programmes in their countries. Table 5 indicates the proportion of respondents who gave a positive response for each of the products listed.

Table 5

<table>
<thead>
<tr>
<th>Product</th>
<th>Positive responses (%)</th>
<th>“Don’t know” (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEC (5)</td>
<td>88.2</td>
<td>12.1</td>
</tr>
<tr>
<td>The MEC wheel (9)</td>
<td>55.9</td>
<td>33.3</td>
</tr>
<tr>
<td>Kesho Bora study results (25)</td>
<td>8.8</td>
<td>60.6</td>
</tr>
<tr>
<td>Maternal mortality estimates (17)</td>
<td>82.4</td>
<td>3.0</td>
</tr>
<tr>
<td>Maternal near-miss definition (12)</td>
<td>55.9</td>
<td>30.3</td>
</tr>
<tr>
<td>Safe abortion guidance (18)</td>
<td>61.8</td>
<td>18.2</td>
</tr>
<tr>
<td>Research on mid-level providers for abortion</td>
<td>20.6</td>
<td>36.4</td>
</tr>
<tr>
<td>Optimizing delivery of maternal and newborn health interventions (28)</td>
<td>67.6</td>
<td>27.3</td>
</tr>
<tr>
<td>Multicountry survey of maternal and newborn health (13)</td>
<td>35.3</td>
<td>51.5</td>
</tr>
<tr>
<td>RHL</td>
<td>55.9</td>
<td>27.3</td>
</tr>
<tr>
<td>STI guide to essential practice (19)</td>
<td>76.5</td>
<td>15.2</td>
</tr>
<tr>
<td>Gender and rights training manual (24)</td>
<td>52.9</td>
<td>27.3</td>
</tr>
</tbody>
</table>

More than two thirds of respondents gave a positive response to four products – MEC (5); maternal mortality estimates (17); Optimizing delivery of maternal and newborn health interventions (28); and the STI guide to essential practice (19). Over 50% responded positively on 9 of the 12 products. For those products with low ratings, “Don’t know” responses were correspondingly high, Kesho Bora (60.6%) (25); research on mid-level providers for abortion (36.4%); and, the multicountry study on maternal and newborn health (51.5%) (13).

Respondents elaborated their responses by giving many instances of where these products had been used to inform the development of national policies and strategies; to guide the development of national norms, standards and clinical protocols; to update training curricula; to strengthen training programmes; to improve the quality of service delivery including counselling; and to launch national initiatives such as on reducing maternal mortality.

Two particularly detailed responses from Nigeria and Tajikistan are provided in Boxes 7 and 8.

The second question enquired about the effectiveness of HRP in providing guidance on norms and standards. Over 80% of respondents gave a rating of “1”, “2” or “3” for the effectiveness of the Programme’s work in this area.

The final questions in the UNFPA survey related to modes of communication, and suggestions for their improvement, and these findings are reported in Section 10 of this chapter, on the efficiency and effectiveness of HRP’s communication.
Box 7. UNFPA Nigeria response

Nigeria used the MEC (5) in its review of the national family planning protocol, and the MEC wheel (9) is used by family planning providers. HRP’s products in the area of maternal and neonatal health helped focus greater national attention on maternal mortality, and were used in the development of the national maternal, neonatal and child health strategy, 2012–2017 (27). HRP’s documents, including the one on safe abortion (18) have been used in the development of the country’s reproductive health policy, and for the training of mid-level health workers. The national STI training manual was guided by HRP’s guide to essential practice for STIs (19). The gender training manual (24) is used in the training of health-care providers on how to mainstream gender in the provision and management of reproductive health services. The RHL is a continuing source of information for updating training manuals, and was also used as a resource in the development of the national reproductive health policy.

Box 8. UNFPA Tajikistan response

The UNFPA country office assisted various capacity-building initiatives for the MEC (5), including training of trainers, and subsequent training of service providers. The MEC wheel (9) was printed and disseminated widely throughout the country.

Between 2008 and 2012, the UNFPA country office in Tajikistan conducted a number of national capacity-building activities to implement evidence-based strategies to optimize delivery of key maternal and newborn health interventions, including Beyond the numbers/BTN, an audit of maternal near-miss cases, and Effective perinatal care/EPC. As a result of these interventions, the coverage of maternal and neonatal care was increased, and the quality of service was improved.

BTN started in 2008 with a confidential enquiry into maternal deaths and a near-miss analysis, and subsequently a strategic partnership was established between WHO, USAID and the German Development Agency (GTZ), to implement the findings. EPC introduced a set of effective perinatal care technologies through updating training curricula, training of trainers workshops, cascade training, and follow-up monitoring and mentoring. As a result, there was a decrease in the number of deliveries with complications; early neonatal mortality and morbidity decreased; skilled birth attendance increased; facility-based deliveries increased; and bleeding, postpartum infection and haemorrhagic shock declined.

Using HRP guidelines, the UNFPA country office was also able to provide input to the development of the National Strategy on Safe Abortion, recently approved by the government. National standards on safe abortion were developed and are being implemented.

Using HRP guidance on STIs, training modules on STIs were updated and used for basic and in-service training.

The Gender training manual (24) was used to conduct a number of training sessions for health managers, and subsequently UNFPA supported the establishment of safe rooms in health-care facilities for victims of gender-based violence (GBV).

Conclusion

This far from comprehensive review of just a sample of HRP’s products revealed evidence of their use in over 130 programme countries. The UNFPA country office enquiry found that four critical products – MEC (5), maternal mortality estimates (17), optimizing delivery of maternal and newborn health interventions (28), and the STI guide to essential practice (19) – had been used in more than two out of three countries. A more comprehensive survey would surely find many additional examples of country use.

It would appear that many countries are making very good use of HRP’s products in strengthening their SRH programmes, but that even more could be benefiting. This will require investment in a new communication and uptake strategy for all the Programme’s products, and investment in an introductory strategy to be able to demonstrate in a limited number of countries how some of HRP’s products can be incorporated into SRH programmes (see Section 10). These “success story” examples can then be used to leverage the larger funds of multilateral and bilateral donors, including the cosponsors and foundations, for use in additional countries for similar purposes.
5.4.7 Overall conclusions and recommendations

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

Recommendation

The Programme should commission a periodic review of the utilization of its products in programme countries, and estimates of their potential or actual impact. Such a review should also identify the source of funds, whether from national governments, cosponsors, other international donors, bilateral donors, foundations, NGOs, etc., that were used to support the introduction. Such a review will demonstrate the value of investing in HRP and thus further strengthen its fundraising ability.

6 Comparative advantage

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

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

Some examples of HRP’s comparative advantage include its work on preventing unsafe abortion, and on adolescent SRH, and violence against women.

HRP’s work on unsafe abortion includes methods for non-surgical termination of pregnancy; monitoring global trends on unsafe abortion; advocacy and programme research to increase the use of family planning methods in countries where abortion has traditionally been used as a method of regulating fertility; research on mid-level health personnel as providers of safe abortion services; and dosage studies of mifepristone and misoprostol by vaginal or sublingual administration.

In the area of adolescent SRH, HRP’s research continues to legitimize work in this area, and to demonstrate the need to deal openly with the issue. Countries that have collaborated with the Programme in the area of adolescent health have strengthened their capacity to confront and address the issues of SRH among young people. In the area of sexuality education, the Programme has supported the development of models and materials for sexuality education, which can be adapted for use in countries.

In the area of violence against women, the Programme has been instrumental in developing consensus on a number of issues, for example, the elimination of FGM (29); the medicalization of FGM (30); violence against women (31); and preventing gender-biased sex selection (32).
6.1 Respondents’ views on HRP’s comparative advantage

On a scale of 1 to 5 (1: highly effective to 5: highly ineffective), the following proportions of respondents gave HRP’s comparative advantage characteristics a rating of “1” or “2”:

- neutrality – 78.3%;
- convening power – 78.2%;
- WHO seal of approval – 84.0%;
- ability to address any SRH issue however sensitive – 80.8%;
- commitment to the highest standards of research – 76.0%.

These figures clearly confirm the confidence respondents have in the comparative advantage of HRP.

In its decisions on proposed research, STAG is guided by a number of principles, including quality of proposed research, likely impact, and areas of research neglected by other organizations engaged in SRH research. Application of this last principle additionally strengthens the comparative advantage of HRP.

Respondents were also asked if other organizations existed that could fulfil a similar function to HRP. Over 87% of respondents indicated that there was no other such organization.

Responses to the question concerning HRP’s convening ability are given in Table 6.

Table 6  
Effectiveness of HRP in convening groups of experts

<table>
<thead>
<tr>
<th>Effectiveness</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – highly effective</td>
<td>45.3</td>
</tr>
<tr>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td>3</td>
<td>14.5</td>
</tr>
<tr>
<td>4</td>
<td>4.3</td>
</tr>
<tr>
<td>5 – not at all effective</td>
<td>2.6</td>
</tr>
<tr>
<td>Total (n = 117)</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As can be seen from Table 6, an overwhelming proportion of respondents (over 78%) gave a rating of “1” or “2” for HRP’s convening ability. Respondents also felt that HRP could be doing a number of things more or better to use its comparative advantage. These included: strengthening the communication and marketing of its products to programme countries, directly and through international and regional partners, to better translate knowledge and evidence into action; carrying out more implementation research; and strengthening collaboration with research institutions. Overall, respondents felt that preventing unsafe abortion was one very specific area where HRP had a major comparative advantage over other organizations.

Conclusion

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

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

HRP’s work in the area of norms and standards results in various types of publication, including: technical (clinical) guidelines, programmatic and policy documents and policy briefs. These set global standards for policies, programmes and clinical practice in SRH. In the past 5 years the Programme has produced 86 such documents, including 16 clinical guides, 51 programmatic and policy documents and 19 policy briefs (see Box 9).

Box 9. Headline examples of the Programme’s work on norms and standards over the last 5 years

- The four cornerstones of family planning, including the MEC (5)
- WHO/HRP statement on hormonal contraception and the risk of HIV infection (33)
- Fifth edition of the WHO laboratory manual for the examination and processing of human semen (10)
- WHO recommendations for prevention and treatment of pre-eclampsia and eclampsia (15)
- WHO recommendations for induction of labour (14)
- A framework for the standardized classification and quantification of causes of maternal mortality: contributing; underlying; and immediate (34)
- WHO guidelines for the management of postpartum haemorrhage and retained placenta (35)
- Safe abortion: technical and policy guidance for health systems (18)
- Sexually transmitted and other reproductive tract infections: a guide to essential practice (19)
- Global reference for fetal- and birth-weight percentiles (36)
- The OHCHR, UNFPA, UNICEF, UN Women, and WHO interagency statement on Preventing gender-biased sex selection (22).

In addition HRP, in collaboration with its partners, standardizes SRH terminology, contributes to relevant sections of the WHO model list of essential medicines (11), ensures that essential reproductive health commodities are added to the WHO Essential Medicines Prequalification Scheme, provides global reference standards in the area of SRH, updates relevant sections of the International statistical classification of diseases and related health problems (37), specifically Chapters 14–16 on SRH, including developing standard definitions of items such as a skilled birth attendant, and how to interpret this definition in different country settings.

For example, HRP’s input to the WHO model list of essential medicines (11) includes the following:

- the use of misoprostol was expanded and clarified, particularly its role in the management of incomplete abortion and miscarriage, in the 16th edition;
- in the next edition, issued in 2011 (11), the use of misoprostol was further clarified with regard to PPH and induction of labour, again on the basis of research undertaken by the Programme;
- also as a result of an HRP review of evidence and advice from a technical consultation, ethinylestradiol was determined not to be an essential medicine and was removed from the model list in the latest (2011) edition (11).
Respondents’ views of HRP’s work on norms and standards are presented in Table 7.

Table 7

<table>
<thead>
<tr>
<th>Effectiveness</th>
<th>Percentage of respondents</th>
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<tbody>
<tr>
<td>1 – highly effective</td>
<td>33.1</td>
</tr>
<tr>
<td>2</td>
<td>42.1</td>
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<tr>
<td>3</td>
<td>14.9</td>
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<tr>
<td>4</td>
<td>5.8</td>
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<tr>
<td>5 – not at all effective</td>
<td>4.1</td>
</tr>
<tr>
<td>Total (n = 121)</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As can be seen from Table 7, overall, on a scale of 1 to 5, where 1 is highly effective, more than 75% of respondents gave a rating of “1” or “2” for the Programme’s work on norms and standards.

Many respondents felt that the work undertaken by HRP on the development of evidence-based norms and standards was critical, and an area that was uniquely appropriate for WHO. Respondents also felt that the process of developing guidance was occasionally somewhat cumbersome, and needed to be simplified and expedited whenever possible, without losing any of its rigour.

A total of 52.9% of respondents felt that HRP should do more work on norms and standards, while a further 35.3% felt that the proportion of this work was “about right”.

A total of 87.2% of respondents felt that the maternal mortality estimates had been used to strengthen SRH policies or programmes in countries, and 67.6% responded similarly on HRP’s work on the criteria/definition of maternal death near-miss.

Conclusion

HRP continues to be the gold standard for developing, monitoring and updating the evidence-based norms and standards required to guide SRH policies, strategies, programmes and clinical practice. Policy statements, programme guides, clinical guidance, and evidence summaries issued by WHO/HRP are key reference materials for governments when developing or revising SRH policies and programmes. As an entity within WHO, the credibility of HRP among Member States is assured, and its materials thus receive far greater attention, and have a larger global health impact than similar issuances by any other institution.

8 Monitoring of global trends in sexual and reproductive health

Does HRP continue to monitor important global trends in SRH?

A few examples of HRP’s important work in the area of global trends follow.

8.1 Global maternal mortality estimates.

HRP, in collaboration with the WHO Health Information and Statistics Department, UNICEF, UNFPA and The World Bank analyses maternal mortality levels on a routine and continuing basis. The updated maternal mortality estimates (17) allow for trend analysis to determine the progress towards attaining MDG 5a. The methodology and process undertaken for these estimates is intended to ensure both international comparability and ownership by countries, and provides a starting point for building capacity in-country on improved systems for data collection and analysis. The estimates also include an analysis of regional trends.
8.2 Global estimates of unsafe abortion

In 2011, HRP published the sixth edition of the global estimates of unsafe abortion and associated mortality (38), a document aimed at policy-makers and programme managers, to continue to raise awareness of the human tragedy of unsafe abortion suffered by women, and particularly poor and marginalized women in low- and middle-income countries. The document highlights the urgency of preventing unsafe abortion and provides policy and programme recommendations for its prevention. The report also concluded that in countries where abortion laws were more liberal, rates of abortion were lower. Infertility due to unsafe abortion or maternal sepsis was identified as the fifth ranked disability, based on prevalence, in low- and middle-income countries for women aged 0–59 years.

The Programme was also a key partner of the scientific team that developed preterm birth estimates – the team consisted of experts from HRP, the London School of Hygiene and Tropical Medicine and Save the Children. The input from HRP was particularly important in engaging and assisting countries in providing more data, understanding methods and supporting their capacity in improving measurement of preterm births.

The Programme also contributed to the development of publications covering global estimates of stillbirths – *National, regional, and worldwide estimates of stillbirth rates in 2009 with trends since 1995* (39) as well as estimates of the global burden of STIs in 2010 (40).

The July 2010 progress report on the implementation of the WHO reproductive health strategy (41) noted in a survey of countries that: 85% reported integrating the WHO focused antenatal care approach in national reproductive health programmes; 80% of the countries had registered magnesium sulfate for use in pre-eclampsia; and 50% had included emergency contraception as part of their family planning method mix. The percentage of countries reporting implementing new cervical screening protocols was somewhat lower (n total, 57 countries reported).

The report also noted uneven progress in reduction of maternal mortality; that unmet family planning need was still high; that antenatal care and skilled birth attendance had increased in urban areas, with little change in rural areas; and that less than 50% of men aged 15–24 years reported using a condom when engaging in high-risk sexual behavior.

HRP, in collaboration with UNFPA, defined a number of indicators on health outcomes and processes at national and subregional levels, as well as indicators to assess integration of HIV/AIDS and SRH programmes and services (42).

From Table 8, it can be seen that over 70% of informants gave a rating of “1” or “2” for HRP’s work on monitoring global trends in SRH.

<table>
<thead>
<tr>
<th>Effectiveness</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – highly effective</td>
<td>24.0</td>
</tr>
<tr>
<td>2</td>
<td>48.8</td>
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<tr>
<td>3</td>
<td>18.2</td>
</tr>
<tr>
<td>4</td>
<td>9.1</td>
</tr>
<tr>
<td>5 – not at all effective</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Total (n = 121)</strong></td>
<td><strong>100.1</strong></td>
</tr>
</tbody>
</table>

Conclusion

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

9 The sexual and reproductive health/HIV research agenda

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

There are clear bidirectional links between SRH and HIV-prevention policies and programmes. These can be used for example to: promote male and female condom use to prevent STIs, including HIV infection, and unintended pregnancy; decrease mother-to-child transmission (MTCT) of HIV; improve access to and uptake of key HIV and SRH services; improve access for people living with HIV to sexual and reproductive health care that protects their rights and respond to their needs; reduce HIV-related stigma and discrimination; increase the response to and prevention of GBV; improve coverage of underserved and marginalized populations; and decrease duplication of efforts, and thus competition for scarce resources.

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

9.1 Selected highlights

9.1.1 Rapid assessment tool for sexual and reproductive health and HIV linkages: evidence review and recommendations

HRP collaborated with IPPF, UNFPA, WHO, UNAIDS, the Global Network for People Living with HIV/AIDS, the International Community of Women with HIV/AIDS, and Young Positives, to develop a rapid assessment tool for SRH and HIV linkages at policy, system and service levels. The tool has promoted and enabled dialogue and collaboration between the HIV and SRH areas, which are often separated in national programme contexts. The tool has now been used in over 45 countries and the process, results and outcomes have been summarized in individual country briefs, which are then used as the basis for further action.

The Kesho Bora Study

The Kesho Bora Study (25) was a landmark piece of research led by HRP, using its own funds and leveraging additional funds from partners. It showed that giving mothers a combination of antiretroviral drugs during pregnancy, delivery and breastfeeding cut HIV infection in infants by 42%. The findings of the research increase the range of treatment options available to mothers living with the virus, and offers them hope that, if they so wish, they have a greater chance of breastfeeding their babies without passing on HIV. As a result of the study, Malawi and South Africa have adopted a new regime for preventing MTCT of HIV, and the findings have changed WHO’s recommendations on infant feeding and led to new drug-combination approaches in global efforts to eliminate MTCT of HIV.

Collaboration with the Global Fund

HRP continues to advocate for and provide assistance to programme countries in preparing proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria, particularly in the areas of: unmet needs and opportunities for linking SRH and HIV prevention and care; and opportunities to address violence against women and girls. The proportion of proposals with
an element of SRH has increased from under 40% in the first round to 90% and 65% respectively in the last two rounds.

**Collaboration with the WHO HIV/AIDS department**

Current and future work of the WHO HIV/AIDS department includes specific deliverables that require contributions from HRP. These include: a generic protocol for operational research to understand the performance and impact of use of dual point-of-care tests for HIV and syphilis; guidance on the evaluation, specifications and procurement of female condoms; tools for monitoring condom quality during storage; technical guidance on microbicides; clinical guides and tools for family planning for persons living with HIV; clinical guides and tools for counselling on testing for HIV in family planning clinics; policy and programme guidance for prevention of MTCT of HIV; guidance on infant feeding and transmission of HIV; guidelines on the prevention and management of STIs; an updated package for HIV treatment, prevention and care among young people; and evidence, tools and guidelines to address gender-based inequalities in HIV response for most-at-risk populations.

**Collaboration with UNAIDS**

Collaboration between HRP and UNAIDS includes areas such as: a discussion paper on male involvement in the prevention of mother-to-child transmission of HIV, which also indentified gaps in knowledge and areas for further research; the technical meeting on hormonal contraception and HIV risk (33), which provided clear guidance on this issue; development of a counselling tool on reproductive choices and family planning for people living with HIV (43); and guidance on issues such as male circumcision and HIV (44).

As shown in Table 9, over 85% of respondents gave a rating of “1”, “2” or “3” for HRP’s effectiveness in contributing to the SRH/HIV research agenda. Comments from respondents suggested a need for HRP to be more proactive in this area (for example, as it had been over the issue of HIV infection and hormonal contraception); to forge stronger links with the WHO HIV/AIDS department and with UNAIDS (the latter perhaps now facilitated by UNAIDS becoming a permanent member of PCC); and for a greater focus on barriers and implementation issues relating to the integration of SRH and HIV programmes at country level. There was also some indication that the regional panels are increasingly generating more research on SRH/HIV issues.

**Table 9**

<table>
<thead>
<tr>
<th>Effectiveness</th>
<th>Percentage of respondents</th>
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<tbody>
<tr>
<td>1 – highly effective</td>
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<td>2</td>
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<td>3</td>
<td>21.6</td>
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<tr>
<td>5 – not at all effective</td>
<td>1.7</td>
</tr>
<tr>
<td>Total (n = 116)</td>
<td>100.1*</td>
</tr>
</tbody>
</table>

*This percentage over 100% is due to rounding.

**Conclusion**

The Programme continues to play an important role in shaping and implementing the SRH/HIV research agenda and should continue to strengthen links with HIV/AIDS research partners.
10 Efficiency and effectiveness of HRP’s communication

HRP communicates with its clients in a number of ways and through a number of mechanisms. Most of these involve its publications, which can be classified into nine separate categories as follows:

- policy briefs, highlighting the policy implications of new research findings, such as *Programmatic and research considerations for hormonal contraception for women at risk of HIV and women living with HIV – policy implications* (45);
- monitoring and evaluation reports, such as *Trends in maternal mortality: 1990 to 2010, WHO, UNICEF, UNFPA and The World Bank estimates* (17);
- advocacy documents, such as *Providing the foundation for sexual and reproductive health. A record of achievement* (46);
- peer-reviewed articles, including systematic evidence reviews;
- fact sheets, statements and information notes, such as *Emergence of multi-drug resistant Neisseria gonorrhoeae – threat of a global rise in untreatable sexually transmitted infections* (47);
- newsletters, such as the *Reproductive Health Update*;
- multimedia (videos, exhibits, posters, apps), such as the RHL DVD, and HRP videos on YouTube;
- clinical guidelines, such as: *WHO recommendations for prevention and treatment of pre-eclampsia and eclampsia* (15);
- programme and policy documents, such as *Beginning with the end in mind: planning pilot projects and other programmatic research for scaling up* (48).

For the main six categories, the Programme has produced 477 such documents over the past 5 years, of which further details are given in Table 10. By far the largest output of HRP is its peer-reviewed articles, and these increased from 52 in 2008 to 127 in 2011 and 80 in 2012. Respondents cited peer-reviewed publications and clinical guidelines as the most effective channels for communicating HRP’s results.

<table>
<thead>
<tr>
<th>Document type</th>
<th>Number produced 2008–2012</th>
</tr>
</thead>
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<tr>
<td>Clinical guidelines</td>
<td>16</td>
</tr>
<tr>
<td>Programme and policy documents</td>
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</tr>
<tr>
<td>Policy briefs</td>
<td>19</td>
</tr>
<tr>
<td>Monitoring and evaluation reports</td>
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</tr>
<tr>
<td>Advocacy documents</td>
<td>15</td>
</tr>
<tr>
<td>Peer-reviewed articles</td>
<td>361</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>481</strong></td>
</tr>
</tbody>
</table>

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Table 10

<table>
<thead>
<tr>
<th>Document type</th>
<th>Number produced 2008–2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical guidelines</td>
<td>16</td>
</tr>
<tr>
<td>Programme and policy documents</td>
<td>51</td>
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<tr>
<td>Policy briefs</td>
<td>19</td>
</tr>
<tr>
<td>Monitoring and evaluation reports</td>
<td>19</td>
</tr>
<tr>
<td>Advocacy documents</td>
<td>15</td>
</tr>
<tr>
<td>Peer-reviewed articles</td>
<td>361</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>481</strong></td>
</tr>
</tbody>
</table>

2 The *Reproductive Health Library* is an electronic journal, cumulative over time, which publishes evidence syntheses on a variety of key SRH topics and includes comments on the application of the evidence to low-resource settings by experts from programme countries. It is also a conduit for dissemination of all the guidelines, norms and standards developed by RHR/HRP. The RHL CD-ROM was published in April 2011 with 193 Cochrane reviews. Since then, the online version has been expanded with two to three new and updated titles per month. RHL continued to rise in rank within the family of WHO web sites: of the 211 WHO unique web addresses, RHL moved from rank 15th in terms of number of sessions per month in 2010 to 7th in November 2011. At the end of 2012 it ranked 11th, but remained the second most visited site outside of WHO corporate pages. There are approximately 17 000 visits per month and over a million page views per month. The most downloaded document in 2011 was the SUPPORT project summary on the effectiveness of task-shifting programmes on maternal and child health outcomes, with 7800 downloads. The RHL Facebook social networking site was launched in late 2011 to increase exposure to a younger generation of SRH workers and is visited more than 50 000 times each month. Additionally, a YouTube channel was created in April 2012 and has received in excess of 65 000 video views per month since its launch.
A somewhat subjective review of the titles of the peer-reviewed publications would appear to indicate that these are generated by both the Programme’s global research agenda and the support it provides to research-capacity strengthening. Some research papers are highly country specific, and others address issues that are clearly of more interest to the individual researchers than to the global agenda. The undertaking of research is an essential element of research-capacity strengthening, but such research cannot always be expected to reflect global research needs.

Recommendation

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

HRP continues to undertake high-impact randomized trials, the type of research that answers key questions and provides the core evidence for clinical practice guidelines. This research is vital in determining the standards for the practice of evidence-based medicine and public health. A few examples of such high-impact work undertaken by the Programme since 2008 are given in Box 10. All of these led to new recommendations for clinical practice, which are being adopted by countries.

**Box 10. Headline examples of HRP’s high-impact research**

10.1 Bibliometric analysis of HRP’s papers

To provide more evidence of the quality and impact of the HRP’s work, the evaluation team requested the Programme to commission a bibliometric analysis of its peer-reviewed publications. The analysis was contracted out to Thomson Reuters in the UK and the report is briefly summarized in this section. Chapter 8 provides more information about the analysis.

Citations to prior work are a normal part of publication, and reflect the value placed on the work by later researchers. Highly cited work is recognized as having a greater impact and being highly correlated with other qualitative evaluations of research performance. Citation analysis has to be used with some caution; it is more rigorous for science and technology and less so for social sciences and the humanities. Citations generally increase over time, so very recent publications will generally have fewer citations. Normalization is usually done by reference to relevant global averages for the particular field.

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

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

Overall, the normalized citation impact of HRP publications has risen from an already impressive level of 1.42 during the period 1990 to 2007, to 2.14 between 2008 and 2011, indicating a significant improvement in the impact of the Programme’s research. The proportion of papers that are highly cited (those papers that belong to the world’s top 10% of the most cited papers relative to the journal category and year) also increased between these two periods, from 16.5% to 18.3%.

Sixteen of the 20 most commonly used journals for HRP publications are in the top quartile, according to journal impact factor. Acceptance by such journals is an indicator that the publication is more likely to have a greater impact. This provides further evidence of the impact of the Programme.

All these indicators of research performance are significantly above world averages and clearly reflect high-quality research, and research that is well regarded among the international research community.

In terms of collaborations between countries, the study calculated collaboration indices at two different thresholds: at least one paper per year on average over the period, and at least one paper every two years on average over the period. For the higher-threshold index, there were no collaborations with low-income countries during the period 1990–2007, but for the period 2008–2011, five countries (Bangladesh, Burkina Faso, Nepal, Uganda, and Viet Nam) all published at least four collaborative papers with the Programme. For the lower-threshold index, there was an increased level of collaboration with some middle-income countries in Asia and Latin America over the two periods, but again the major change was the increased involvement of low-income countries, from one in the earlier period (Kenya) to eight in the period 2008–2011 (Bangladesh, Burkina Faso, Cambodia, Ethiopia, Kenya, Nepal, Uganda and Viet Nam). This analysis provides clear evidence of the increased involvement, particularly of low-income countries, in the Programme’s work.

The Thomson Reuters analysis also carried out an author analysis. This indicated that over the period 1990–2011, the proportion of papers where all authors were from programme...
countries fell from 23.2% to 13.7%, while at the same time, the proportion of papers where any author was from a programme country increased from 43.4% to 63.9%. A possible explanation for this is that as institutions matured over the years with the support provided by HRP for research-capacity strengthening, they have increasingly been part of the international collaborative research community, taking part in HRP’s global research agenda as well as the international research agendas of other organizations.

Finally, since 2008, data have been collected on the countries of residence of first authors, and the analysis showed that during the period 2008–2011, 40% of all papers had a first author from a programme country. This is below the 2011 level for TDR, which currently stands at 61%, and reflects the need for the Programme to strengthen its efforts to involve institutions in programme countries.

10.2 HRP’s channels of communication

The questionnaire asked for opinions about the effectiveness of various groups in communicating HRP’s products, using a scale of 1–5 (1: highly active, 5: minimally active). The majority of respondents gave negative ratings. The figures in parentheses indicate the proportion of respondents who gave a rating of “3” or lower in relation to the level of activity in disseminating the products of the Programme: WHO country offices (72.2%); WHO regional offices (66.3%); WHO headquarters (59.1%); regional advisory panels (52.6%); cosponsors (55.2%); and donors (58.2%). All these figures indicate considerable room for improvement on the part of cosponsors and donors in helping to communicate the publications of HRP.

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

Many respondents suggested that cosponsorship should become much more of a “two-way street”. As well as providing HRP with political and financial support, the cosponsors needed to become “champions” for the Programme’s products, playing a stronger role in disseminating the products and integrating them into their own development assistance programmes.

Findings from the UNFPA survey, which also sought views on the effectiveness of different communication documents, were somewhat similar.

As can be seen from Table 11, clinical guidelines, programme and policy documents, fact sheets and statements, advocacy documents, and policy briefs were the materials UNFPA offices felt were most effective in contributing to the improvement of national programmes.
Table 11

Effectiveness of different types of communication documents

<table>
<thead>
<tr>
<th>Document type</th>
<th>Percentage of UNFPA responses giving an effectiveness rating of “1”, “2” or “3” (1: highly effective; 5: not at all effective)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer-reviewed articles</td>
<td>54.4</td>
</tr>
<tr>
<td>Advocacy documents</td>
<td>69.6</td>
</tr>
<tr>
<td>Clinical guidelines</td>
<td>75.8</td>
</tr>
<tr>
<td>Programme and policy documents</td>
<td>75.7</td>
</tr>
<tr>
<td>Training materials</td>
<td>63.6</td>
</tr>
<tr>
<td>Newsletters</td>
<td>45.4</td>
</tr>
<tr>
<td>Policy briefs</td>
<td>66.7</td>
</tr>
<tr>
<td>Global estimates</td>
<td>51.5</td>
</tr>
<tr>
<td>Fact sheets and statements</td>
<td>72.8</td>
</tr>
<tr>
<td>Conference presentations</td>
<td>54.5</td>
</tr>
<tr>
<td>RHL, CD-ROM</td>
<td>57.6</td>
</tr>
<tr>
<td>Press releases</td>
<td>57.6</td>
</tr>
</tbody>
</table>

In elaborating on their replies, there were many suggestions to improve communication between HRP and UNFPA country offices and national counterparts, the most common being the need to develop and keep up-to-date lists of key stakeholders at country level, such as national SRH managers, national NGOs, universities, training schools, CSOs and professional associations, and ensure that these groups were systematically kept informed of all new developments and products. Other suggestions included: greater use of social media channels; regional workshops for introductory activities; and web site linking. But the overall clear message was the need for HRP to strengthen its communication strategy to guide the dissemination of its products at country level, to better ensure their use.

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

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

Up until 2007, HRP had two direct mechanisms for promoting the use of its products in countries. These were: a well-funded Department for Programme Development in Reproductive Health (PDRH), and a well-funded Strategic Partnership Programme (SPP) with UNFPA, in the amount of over US$ 6 million between 2003 and 2007.

An external evaluation of the SPP in 2007 (UNFPA unpublished document) found that it had used, and promoted with national authorities, a systematic process for the adaptation, adoption and introduction of evidence-based guidelines in national programmes. The SPP always involved governments, mainly ministries of health, from the outset (thus ensuring national ownership); translated evidence into practice; validated a model for use with other guidelines; and validated a model that could be drawn upon by other organizations for the introduction of their guidelines.

With the end of the SPP in 2008, and the funding constraints in PDRH that followed from 2008 to 2011, brought about by changes in WHO core funding policies, the introduction of HRP’s products in countries waned, and the potential impact of its products was compromised. HRP started to lose a substantial amount of its ability to ensure that its products were translated into use at country level.
Trends in income for PDRH are presented in Figure 3. PDRH income rose rapidly from US$ 9.2 million in 2000–2001 to US$ 25.0 million in 2006–2007, an increase of over 170%. During this period, its income consistently exceeded its full budget level. Since 2006–2007, PDRH income has fallen by around 16% to levels of US$ 20.4 million and US$ 21.0 million respectively in the last two biennia. In 2008–2009, income did not reach the contingency budget. In 2010–2011, income was between contingency and full budget levels.

Between 2006–2007 and 2010–2011, national governments decreased their contributions by US$ 6.6 million (38%), and UN system agencies, programmes and funds decreased their contributions by US$ 3.6 million (65%). Fortunately, foundations increased their contributions fourfold over the same period, to a level of US$ 8.2 million, to bring some stability to the PDRH funding situation.

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Major bilateral donors in 2006–2007, such as Denmark, Finland, the Netherlands, Norway, Sweden and the UK, combined to provide US$ 12.0 million of funding to PDRH. Subsequently, as requested by WHO, they included this funding in their core support to the WHO budget. However, they have not seen their previous PDRH contributions reflected in increased WHO Core Voluntary Contribution (CVC) support to PDRH. WHO CVC support to PDRH amounted to US$ 2.5 million in 2008–2009, and US$ 3.5 million in 2010–2011. This represents “lost” funding to PDRH of US$ 9.5 million and US$ 8.5 million respectively in the last two biennia. PDRH’s income declined by 16%; had previous funding mechanisms been maintained, it might have increased over the same period by more than 20%, to a level of around US$ 30 million.

Fluctuations in income to PDRH from different donor groups present an additional challenge to the work and management of PDRH, since a large proportion of the new funding in the last 5 years is specified rather than flexible.

As can be seen from Table 12, flexible funding to PDRH has fallen dramatically in the last three biennia, from 56.0% of total income to 26.3% of total income. Specified funds now make up almost three quarters of income to PDRH.
Table 12

**PDRH flexible and specified income, 2006–2011**

<table>
<thead>
<tr>
<th>Biennium</th>
<th>Flexible income</th>
<th>Specified income</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>US$ million</td>
<td>US$ million</td>
<td>US$ million</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>2006–2007</td>
<td>14.0</td>
<td>11.0</td>
<td>25.0</td>
</tr>
<tr>
<td>2008–2009</td>
<td>6.5</td>
<td>14.0</td>
<td>20.5</td>
</tr>
<tr>
<td>2010–2011</td>
<td>5.5</td>
<td>15.4</td>
<td>20.9</td>
</tr>
</tbody>
</table>

One of the major consequences of this trend is that, over the past 6 years, flexible income has increasingly been used to pay for staff salaries. In 2008, PDRH had 35 posts. In 2012, it was reduced to 22 posts. Since 2010, all flexible PDRH funding has been used to pay staff salaries. With no flexible funds for activities, these staff have continued to implement projects funded by individual donors, rather than doing the core work of RHR – promoting and introducing HRP’s products in countries. A further consequence of the loss of core PDRH funding is that, while up until 2008, the costs of STAG and GAP were shared between HRP and PDRH, since 2009 this has not been possible, and the full cost has been underwritten by HRP.

As can be seen in Table 13, the vast majority of respondents gave a very strong indication of the negative impact of the reduction in PDRH funding on the promotion and utilization of HRP’s products. More than 70% gave a rating of “4” or “5”.

Table 13

**Respondents’ views on how the reduced funding to PDRH has affected the promotion and utilization of HRP’s products**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – not at all</td>
<td>3.6</td>
</tr>
<tr>
<td>2</td>
<td>8.3</td>
</tr>
<tr>
<td>3</td>
<td>17.9</td>
</tr>
<tr>
<td>4</td>
<td>36.9</td>
</tr>
<tr>
<td>5 – very negatively</td>
<td>33.3</td>
</tr>
<tr>
<td>Total (n = 84)</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Conclusion**

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

Objective indicators of HRP’s research performance are significantly above world averages and clearly reflect high-quality research, and research that is well regarded among the international research community. However, the Programme needs to do more to increase the direct and lead involvement of programme countries in its work.

The Programme also needs to be a global leader in efforts to develop and evaluate more effective ways of communicating and introducing the knowledge it develops into SRH policies and programmes. However, with the end of the SPP and the severe cutback in funding to PDRH, the Programme has lost a substantial portion of its ability to ensure the communication and uptake of its products. Over the past few years, some ad hoc solutions have been used to address this issue, but none of them were universally acceptable or viable in the longer term. It is thus a matter of urgency that donors and cosponsors find a more permanent solution.

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

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

The larger task of introduction and uptake falls to national governments, the cosponsors, donors, foundations, CSOs and other. All these groups have internal responsibilities to use the uptake “success stories” demonstrated by HRP, and to channel their funds for the same purpose in the countries where they work, to ensure wider and greater impact of the Programme’s products, as well as greater value of their own investments.

Such a process would ensure that the value of HRP’s products is maximized. It would also enable the Programme to more clearly demonstrate the relationship between the funds invested in an area of the work and the results of that investment at country level. It would also be possible eventually to track the cascading effect of the Programme’s work as its products are picked up and used by cosponsors, bilateral donors and others, in their programmes of development assistance.

**Recommendations**

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

HRP needs to develop, invest in, and implement a strategy for the utilization of its key products into a limited number of countries, to demonstrate their potential or actual impact, and to thereby leverage and guide the use of the funds of national governments, cosponsors, bilateral agencies, CSOs, foundations and others in their support to national SRH programmes.

The PCC will need to provide guidance on the source of funding for HRP’s communication and utilization work.

HRP donors and cosponsors need to review and strengthen their systems and processes for utilizing HRP’s products in their own programmes of development assistance, in order to maximize the value of HRP’s global goods.
References


