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# **DFID**

# HEALTH

# RESOURCE

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Title: Building the Knowledge Base for Attaining  
Equitable Health in Poor Countries

A DFID Project conducted by the  
Centre for Health and Population Research (**ICDDR.B**), Dhaka.

November 2001 – December 2006

## **PROJECT COMPLETION REPORT**

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The DFID Health Resource Centre (HRC) provides technical assistance and information to the British Government's Department for International Development (DFID) and its partners in support of pro-poor health policies, financing and services. The HRC is based at HLSP's London office and consists of an international consortium of four organisations: HLSP Ltd, UK; Ifakara Health Research and Development Centre, Tanzania (IHRDC); ICDDR,B - Centre for Health and Population Research, Bangladesh and Sharan, India.

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## EXECUTIVE SUMMARY

DFID's support to ICDDR.B (the 'Centre') has been a long-term exercise, providing continuity of funding through 5 year grants. In 2000, discussions centred around a support mechanism consistent with UK policy on international development and with the Centre's own vision, mission and strategic intent. A project designed in early 2001 with the title of: Building the Knowledge Base for Attaining Equitable Health in Poor Countries, was approved and started in November 2001. This Project Completion Report (May, 2007) considers achievements made, risks encountered, and the lessons learned since then.

A major thrust of the project has been on financially supporting basic and applied research conducted within the Centre, often in combination with other development partners and government, and not infrequently carried out with other agencies. Its focus has been on poverty and health, the priority areas identified those of safer motherhood, neonatal health, child care, tuberculosis, the disease burden of adults, and the measurement of 'poverty and health'. This Report notes progress across all fronts, accompanied by the production of peer-reviewed journal articles, monographs, working papers, conference presentations, and workshops to disseminate research findings.

To accelerate the quantum and quality of poverty-related research, a second aspect of the project has been devoted to capacity building within the research community. Annual internships were created in the Centre, occupied by secondees from other Bangladeshi institutions to work on poverty / equity issues; and, a regional fellowship was also created and filled. Capacity building through training courses, and the development of a Centre-based web-site, further contributed, a key feature being the co-operation of other stakeholders and partners in these various initiatives.

A third thrust of this project has seen efforts made to develop information and communication on equity / poverty research to inform policy and practice, both in Bangladesh and internationally. This issue is a complex one, relying heavily on the commitment of researchers to communicate effectively with policy makers and service providers; and, upon the latter wishing to re-shape their policy directions and service arrangements in response to research findings. This aspect proved the most challenging for the project to deliver.

A fourth aspect of the project has been to provide core funding to the Centre to enable it to strengthen its own management systems and capacity, to deliver its strategic plan. Specific elements of that support have involved the creation of a job classification and evaluation system, a performance management framework, an integrated management information system, and the creation and operationalisation of a gender equality policy. Progress on all these fronts has been significant.

Earlier this year, the Centre celebrated the 40<sup>th</sup> anniversary of its Health and Demographic Surveillance System (HDSS). The fifth and final aspect of the project has been to provide financial support to HDSS's continuation and development. Much progress can be noted over the last five years to improve routine information requirements and respond to ad hoc requests for research data support. The full potential of this system has still to be realised perhaps, but significant steps have been taken to improve the reliability and timeliness of data and epidemiological reports, and to extend coverage increasingly into poverty / equity issues.

Progress, or the lack of it in a few instances, has to be set alongside the environment in Bangladesh. A raft of concerns e.g. political, institutional, meteorological, are faced continuously which, realistically, would rate the project's probability of risk as 'medium to high'. At the same time, the Centre has operated successfully in that environment for over thirty years. Nonetheless, the realities of these concerns have necessarily affected the pace of project implementation.

Overall the project has made good progress towards purpose completion, and with many outputs achieved to a high degree. Even so, developing the capacity for poverty-related research in Bangladesh and internationally, is not ultimately a responsibility of the Centre's alone; nor can a single institution, based in the developing world, make major inroads on its own to influence the regional and global picture.

The lessons learned are seen in terms of: determining attribution or association of 'gains made'; of seeking to achieve a balanced research portfolio; of recognising the lead time from hypothesis to changing practice; and, further, of ensuring that research programmes do have robust monitoring and evaluation frameworks in place by which to assess progress made, and to take corrective action if and where necessary. The final lesson learned is that development partners such as DFID can and do play a very critical role in the development and viability of south-based research institutions, by means of supporting core funding and through the priorities they mutually attach to seek equitable and cost-effective solutions to the major burdens of disease and ill-health in poor countries.

## 1. PROJECT ACHIEVEMENTS

### 1.1. Overall Achievements: Project Scoring Assessment

This Report provides an external assessment of project achievement, and offers key lessons for future applications. The Project Memorandum (PM) was drafted in June 2001, and the Project launched in November of that year, with an overall approved budget of £5m (2001-2006). Its stated PURPOSE was to improve health by establishing an expanded national and global knowledge base to influence policy and practice on attaining equitable health. This was to be carried out through four main sets of activities (OUTPUTS), later extended to five in order to explicitly recognise the importance of also strengthening the Centre's existing Health and Demographic Surveillance System (HDSS).

This PCR has been completed in the UK, based primarily on the Work Plans and Annual Reports submitted by ICDDR.B (the 'Centre') over the five years, with close examination of other key documents i.e. The Mid-Term Review Report 2004, the AusAID Multi-Lateral Review 2006. Briefing / consultation sessions have also taken place (by phone) with the Central Research Department UK; the DFID Health and Population Office, Dhaka; and, the Poverty and Health Programme ICDDR.B, before the finalisation of this report.

### 1.2. Generating New Knowledge (Output One)

The first Output of the Project Memorandum (PM, 2001) referred to *the generation of new knowledge*. The PM stated that the project would engage in new research, to: generate a coherent body of new knowledge on poverty and health, equity, and cost-effective strategies, particularly in relation to safer motherhood, neonatal health, child care and development, tuberculosis, and the burden of disease among adults in poor countries. A Programme would be established that focused on equity and health, across the Centre's Divisions; further, the HDSS would be strengthened to support research on measurement of poverty and health, the burden of disease, and on the interface between care providers and communities. The measurable indicators (OVIs) were to be the traditional ones used for recording research output, namely: the production of working papers and articles, especially in peer reviewed journals.

#### 1.2.1 Safe Motherhood

Here, the key research focus of this aspect of the project would be on improving the quality of, and access to, skilled attendants at birth, by working with partner institutions. The project evaluated two home-based skilled birth attendants' programmes provided in both urban and rural areas, run by non-governmental organisations, in terms of: knowledge and competencies, referral patterns, sustainability. Results revealed that a wide gap exists between evidence-based standards and provider competence, with implications for refresher training and demand-led initiatives to increase coverage. Inequality was found to be present for all types of maternal and neonatal care services, both facility and community-based. Establishing an effective referral linkage, with a comprehensive EOC facility, was seen to be a crucial.

Increased utilisation of maternal and neonatal healthcare services was observed, but even free government services were used more by the relatively better off, and retention of trained staff was a problem particularly in rural areas. This evidence challenged a parallel-funded BCC strategy, aimed at raising community awareness about pregnancy danger

signs, pregnancy planning, nutritional needs, and availability of a range of maternity services in the community. A monitoring system has been introduced to capture data from health facilities, though impact studies have yet to be completed on maternal mortality concerns and on how best to protect the poor.

### *1.2.2 Neonatal health*

Two large community-based research projects were to be launched on neonatal health survival, supported in part by DFID monies. The first, on testing alternative service delivery models, including a package of pregnancy, delivery and new-born services, management of neonatal infections and behaviour change communication; the second, would evaluate the effect of food and micro-nutrient supplementation during pregnancy, on foetal growth and birth weight. Funding would also permit an assessment of the effect of institutional support on neonatal survival, morbidity and feeding practice, and help develop simple clinical management protocols for managing hospital neonates.

Breast feeding interventions have since been developed and implemented as part of the Maternal and Infant Nutrition Intervention in Matlab (MINIMat study). Follow-up of the infant cohort has taken place to assess the effect of the intervention; data entry and analysis continues but is not yet complete. Clinical staff from Matlab have been trained in kangaroo mother care of neonates in both hospital and sub-centre settings. Plans have been approved to start staff training of the Matlab Integrated Management of Childhood Illness (IMCI) Evaluation Study. Versions of the clinical management protocols for sick neonates in referral facilities have been produced and finally introduced.

### *1.2.3 Childcare practice and development*

A key research focus was to be on developing and evaluating strategies for strengthening childcare practices, especially in community settings.

The Child Development Unit (CDU) was supported by the Project to develop its research capacity, to enable it to examine the effects of nutritional deficits, infections, toxins in the development of children. For instance, the CDU developed a proposal to assess the effects of iron supplementation and/or psycho-social stimulation development of malnourished children, with work starting in 2006. One intention of this project has been to help support the development of GoB policy on early childhood development at the community level. Similar research work, within the hospital level, has already been completed and reports issued.

Interventions have taken place as part of the Matlab IMCI Evaluation Study to improve childcare practices relating to feeding and caring, childcare seeking, for childhood illness. Data analysis was not completed by the end of 2006. Nonetheless, after IMCI was introduced, utilisation rates were seen to triple, from 0.6 to 1.8 visits / child / year. Two new research studies were initiated: one examines the correlation of arsenic exposure during pregnancy or infancy with the development of pre-school and school age children; the other, examines the efficacy of community-based follow-up programmes with food supplementation, psycho-social stimulation, and both. Both studies are still in progress.

#### *1.2.4 Reducing the burden of tuberculosis*

The key research focus envisaged clinical trials of community-based strategies for TB case detection and diagnosis, particularly in children, and determining their cost-effectiveness in both urban and rural settings. In addition, an assessment of the socio-economic consequences of adult TB at the household level was to be made.

TB surveillance at Matlab has continued by means of a community health research worker programme, with referral of all suspected TB cases and drug susceptibility testing being regular features. Data have been collected of all hospital TB cases also, and allowed the comparison of TB detection rates with both active and passive surveillance. TB cases were found to be likely to occur in some specific clusters of the Matlab area. To assess the health and economic consequences of TB, families with and without the incidence of TB were followed-up to better understand the risk factors, healthcare-seeking patterns, and TB's relationship to socio-economic conditions, given that TB was found to be much more common among poor people than among the non-poor.

A further study was designed and implemented to establish a TB surveillance system in urban slum areas, capturing data on patient referral, compliance to treatment, treatment, and follow-up. Again, family studies were conducted to understand the transmission pattern of TB, and the effects of gender and poverty on TB incidence, as well as the impact of the disease on the family. Detailed analyses were conducted to better understand the costs (direct and indirect) incurred due to illness in the family. A pilot study tested the diagnostic criteria for childhood TB, with a small scale programme for screening, diagnosis, enrolment and treatment of children.

Results on the above have been disseminated through conferences, seminars and publications, and shared with the national TB Control Programme

#### *1.2.5 Disease burden in adults*

The effort here was to be on strengthening the capacity of the HDSS to address communicable and non-communicable diseases affecting adults, especially the elderly, judged to be imposing an increasingly heavy burden on the health care system.

Priority conditions identified were diabetes, cardio-vascular problems, hypertension, selected mental health conditions, each requiring the development of screening instruments alongside appropriate measures of socio-economic status. Considerable effort has gone into developing effective questionnaires to diagnose and assign causes of death e.g. through verbal autopsy tools, and to determine health expenditures and non-financial care support for episodes of illness. Specific diseases with implications for poverty have been targeted and studies completed to determine their morbidities, and gender, geographic and economic inequities of health service utilisation. Age, sex, literacy and socio-economic status were significantly associated with suffering, from both communicable and non-communicable diseases. Adverse health outcomes were found to be disproportionately higher in women.

#### *1.2.6 Measuring poverty and health*



This aspect reviewed the literature on indicators of measurement of poverty and of health, the conceptual frameworks linking poverty and ill-health, the poverty reduction impact of various health and non-health interventions. A cross-Divisional poverty and health measurement group was formed in the Centre. Subsequently, a number of tools and indicators for measuring poverty were made available for use in research investigations and surveys, and in monitoring how well health services are doing in terms of reaching the poor.

Early studies included a utilisation review of hospital admissions, based on gender, aetiology, socio-economic characteristics of patients presenting, following the move to user charges. Significant reductions in children presenting from the poorest socio-economic strata were identified and quantified. Internationally, an analysis was completed of poverty reduction strategies and on the feasibility of attaining the MDGs in a number of low income countries. Data from the Bangladesh HIES was analysed to examine the importance of socio-economic factors as determinants of health and health-seeking behaviour; data from the Child Nutrition Study revealed marked socio-economic inequalities in child nutrition status in Bangladesh. With national and international partners, the project supported work to understand the social and cultural construction of wellbeing in four developing countries. Early results show a high degree of consensus across countries in respect of domains of quality of life and satisfaction, the most important of these being affiliation, material wellbeing, and relations with the community; significant differences existed according to age and gender, however. The project also contributes to another DFID initiative by which health systems can better serve the disadvantaged; this investigation examines socio-economic interactions on the wellbeing of the poor in five countries, including Bangladesh (2005-10).

### *1.2.7 Strengthening research capacity*

Staff have been recruited in the fields of economics, anthropology, gender, to initiate or complement ongoing work in such research areas as: cost-effectiveness of community-based interventions; equity of different mitigation options for arsenic consumption; demand-side financing issues; improving access to basic obstetric care in rural Bangladesh; targeting of the poorest for health interventions versus universal coverage; domestic violence against women and their help-seeking behaviour.

A regional research fellow completed his 2-year fellowship in 2006, analysing poverty reduction strategies in low income countries and assessing prospects for attaining the MDGs. Within Bangladesh, his research included a community analysis of the relationship between children's health status, health care seeking behaviour, and poverty. A number of national research fellows, seconded from their home institutions, have completed fellowship programmes annually based in the Centre.

### *1.2.8 The Poverty and Health Programme.*

Project co-ordination is based in the Public Health Services Division. The Programme has also organised training courses and workshops, round table seminars, and is now the focal point for collaboration on poverty and health issues within the Centre, and with institutions and public bodies within and outwith Bangladesh. Bi-monthly meetings are held by the programme across the Divisions of the Centre to mainstream poverty and health issues. Quarterly issues of the Equity Dialogue newspaper and of the bibliographic alert on

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Poverty, Health and Inequity were launched through the programme, and a series of Equity Watch papers. Collaboration with the Bangladesh Health Equity Watch continues, with support given to the publication and dissemination of equity-related materials. A civil society initiative, the Bangladesh Health Watch, was launched in 2006 also.

### 1.3. Capacity Building and Promotion of Poverty-Focused Research (Output Two)

The second Output was that of: *promoting poverty focused health research and capacity building in Bangladesh and internationally*. This Output was to be achieved by: expanding the human resource base; by offering time limited research fellowships (internships) to developing country researchers; through the conduct of workshops and seminars; and, through co-ordinating IT / web-based training activities. The OVIs deemed relevant were: collaborative projects funded; numbers of conferences and workshops held and participant numbers; numbers of training events and numbers trained; and, numbers of reports, articles etc produced on poverty and equity issues.

#### 1.3.1 *Internships and research associate opportunities.*

Six 'poverty and health' fellows completed their one year assignments in the first quarter of 2004, with a further three completing by August 2005. Each fellow developed a research project with their supervisor and with their home institution; a requirement aimed at strengthening the subsequent networking of institutions involved in poverty research. A two year regional fellowship was awarded to a secondee from the Pakistan Institute of Development Economics, and completed in 2006; collaborative links continue.

#### 1.3.2 *Training courses in poverty-focused health research.*

Training and educational courses were held on the following: measuring poverty – the economic dimension; benchmarks of 'fairness' for healthcare reform; health and demographic surveillance systems and longitudinal data analysis; management of severe childhood malnutrition; exploring poverty and health using PRA techniques; poverty and health. Many of these events were launched in collaboration with other agencies e.g. BRAC, BHEW. This initiative can be seen as an integral part of poverty training and research staff development within the Centre itself; wider participation, both nationally and regionally, has turned out to be more muted so far.

#### 1.3.3 *IT / web-based training*

The new Computer Training Laboratory was completed in June 2002, and has been in extensive use since, not least in training staff in office software, bibliographic search processes. Opportunities to train staff in the development of distance learning versions of in-house poverty and health modules has not progressed, however, though the laboratory itself has been used significantly in respect of the various courses identified above, and on generic research modules more widely e.g. SPSS, advanced research courses. The Centre's own website now has a dedicated section on Poverty and Health, maintained through, and by, the project office.

#### 1.3.4 *Improved human resource base for training*

It was envisaged that relevant Technical Training Unit staff would be encouraged to go on training courses to develop expertise in modern training methods. However, no such partners were identified until recently, and their participation in 'training the trainers' courses organised by the Asian Institute of Technology, Bangkok will now take place in 2007.

#### 1.4. Getting Research into Policy and Practice (Output Three)

The third Output was defined as: *effective communication of new knowledge and improved capacity for influencing policy and practice in Bangladesh and internationally.*

The focus was to be on equity in health, by means of strengthening the human and physical resources of the Centre to better understand the processes of policy making, and to develop modalities for communication and dissemination of research findings. OVIs of achievement included: fora for the discussion of research findings and to translate these into policy and practice; the production of reports / articles and their subsequent citation; engagement with policy makers and local communities on a 'change agenda' following production of research findings.

##### 1.4.1. *Development of a Resource Unit*

The Centre established a Resource Unit within the Library, with the appointment of a dedicated staff member and the purchase of additional infrastructure and equipment. In parallel, the AV Unit was strengthened and an assistant appointed. Health and poverty materials have been made more widely available in hard copy, and increasingly electronically. Library users include the Bangladesh Health Equity Watch Secretariat, who are assisted in the compilation of their publication: *Bibliographical Alert: Health, Poverty and Equity*. The complete catalogue of the Centre's Library is now available via the Centre's website to external users. The Centre's institutional repository is under development, to create a central location for the Centre's entire research output including materials relevant to poverty and health.

##### 1.4.2. *Production of newsletters and health policy analyses*

An early start to this work was delayed but, by the end of year 2, two issues of the news letter *Equity Dialogue* had been produced and made available in hard copy and on the Centre's website. This newsletter continues to be a joint production between the Poverty and Health Programme and the BHEW. A special issue of the Centre's own *International Journal of Health, Population and Nutrition* was devoted to health equity.

##### 1.4.3. *Round table discussions*

The project launched an annual series of round table meetings, bringing together researchers and policy makers on poverty-focused health research matters. Introduced as an international forum, in conjunction with Centre staff, attendance at these meetings has increasingly included participants from several local NGOs and government departments.

Speakers from outside the Centre have been lead persons e.g. LSHTM, Karolinska Institute, Bath University, BIDS.

1.4.4. *Further development of web page and IT-based communication of new knowledge*

The Poverty and Health Programme created its own site within the Centre's overall website, and provides information on its range of activities and publications. Eleven different categories of information feature, including, crucially, details of how to locate and access other relevant websites maintained by international agencies and research institutions. The site is also the home of the Bibliographical Alert, the Equity Watch Papers, the Equity Dialogue Newspaper, though these do need a regular updating. The Centre's website also includes poverty and health matters, including its own IJHPN.

1.5. Strengthening ICDDR.B 's Institutional Capacity (Output Four)

The fourth Output was that of: *increasing the capacity of the Centre to contribute to poverty-focused health research*. Expected outcomes under this heading included: recruitment of additional scholars; a review of the labour profile of staff coupled with a move to develop a new job classification system; a review and revision of the performance appraisal system; and, a strengthening of the staff development system. The OVIs mentioned in the PM included: a human resource development plan completed and implemented; an integrated, financial, personnel and project MIS in place and functioning; an increase in research activity 'in-house' focusing on poverty and equity; and, a growth in networking on health equity issues.

1.5.1. *Comprehensive job classification and evaluation system*

The project has supported the Centre's task to design and implement a job classification system for all posts in the Centre, into job families that would reduce job titles, specify educational, skills and experience requirements for posts, and create career pathways for both scientific and non-scientific staff. Initiated in 2001, the new system was fully operational by 2004, and has moved towards a merit-based remuneration system. Further development has taken place since to define the core competencies required to be, and core values expected of, an effective staff member.

1.5.2. *Performance management system*

In 2003, the Centre undertook a major review of its salary structures and benefit packages. Recognition that the way forward lay through the introduction of a new performance management system, was endorsed by the Board of Trustees in May 2005. Subsequent work has taken place to develop the tools and to induct staff into the performance management approach. Piloting of the new system is scheduled for 2007, with full implementation envisaged for later in the year.

### 1.5.3. *Gender equality*

In 2002 the Centre formed a Gender Equality Committee to address gender issues within the organisation. This resulted in the approval of a Gender Policy document in June 2003. Subsequent steps have been taken towards its implementation e.g. through revised appointment procedures and training, to mainstream gender throughout its work. A gender Organisational Review took place in 2004 and an action plan agreed upon. The selection and appointment systems have been revised, resulting in changes to staff rules and regulations on services, rights, duties and obligations.

### 1.5.4. *An integrated MIS*

The value of integrating separate systems for personnel, finance, and projects / programmes was well recognised within the organisation, with early steps taken to evaluate different software products. This resulted in the purchase and customisation of Navision Attain, and subsequent development work in both offices of Finance and Human Resources to integrate their respective systems. The system commenced life in February 2004 and has required a complete change in procedures. A number of steps have been taken since, to improve and develop the system; and, in 2006, an external post-implementation review was carried out, and its recommendations taken on board

## 1.6. Support of the HDSS (Output Five)

ICDDR.B subsequently created a fifth Output, that of: *strengthening the existing Health and Demographic Surveillance System (HDSS), to better support the purpose of the project*. HDSS had been functioning at Matlab since 1966, (and, more recently, also in an urban site of Kamalapur, Dhaka). Previous evaluations of the system had identified the underutilisation and yet unique potential of HDSS to generate new knowledge on social aspects of health, the inter-relationship between poverty and health, and on health equity. Much of the research envisaged under Output 1 would be undertaken within the HDSS areas, and other outputs would also rely heavily on the HDSS for their activities. Matlab was judged to be pivotal to continuity of data, to test out new approaches, to identify new areas of research, and develop new understandings of poverty-related diseases and conditions. Yet, sustainability of HDSS was a continuing concern to the Centre, although support from DFID and other DPs had been forthcoming previously; now, the key to its continued funding by DFID was to be in respect of 'building the knowledge base'. No separate OVIs were identified for this Output, though achievement would be reflected through Outputs 1-4 inclusive.

HDSS is a unique system created some 40 years ago, to capture data (initially in flat book form, more recently electronically), specifically pertaining to the Matlab area and, in some instances, beyond. It provides a data base for research that rarely exists elsewhere in the world, especially in the developing world. Much of the field research conducted by the Centre's scholars relies heavily on the data sets created and continuously updated, and on the system's capacity to undertake specific enquiries or extend its data sets into national and international collaborative work. Approximately 20% of project funds has been allocated to strengthening this technical system over the 5 years, in terms of: data collection, including training; data entry and error checking; data bases; data subset



extraction; documentation; GIS; dissemination; data archiving; and, finally, specific reviews of data variables to be collected.

Much progress can be noted, in terms of: improving the cost efficiency of data collection methods; and, in improving the timeliness of, and access to, the demographic surveillance data. Reliance on this data by researchers in all the Divisions has been noted, as has the system's flexibility to handle special requests over and above routine requirements e.g. spatial data collection and mapping through GIS: on cholera incidence; on arsenic; on NCD risk factors; verbal autopsy causes of death; the household socio-economic census. Major resolutions coming from a recent staff retreat (Dec 2006) have highlighted the continuous need to further improve the reliability and timeliness of routine surveillance reports, as well as to realise the scope / potential for greater engagement in research activities alongside this work.

## 2. RISK MANAGEMENT

The PM identified three potential groupings of risk (technical and social, institutional, political and natural), and graded all individual risks in respect of their probability of occurrence, and their potential impact. The overall risk of the project was considered **low-medium**, with 50-60% of the ten risks identified being considered 'medium' for both probability and impact.

For a project in Bangladesh, such a relatively low rating may be viewed as surprising. The political history of Bangladesh is such that frequent changes in the political scene, the record on governance issues, and the frequency with which democratic rights are expressed through civil unrest, should have suggested that a high risk be attached. For instance, frequent changes in the civil service, coupled with changes of government, make continuity of a policy dialogue on equity matters a less than assured process.

Further, Bangladesh has been faced increasingly with significant environmental threats e.g. floods, earth tremors, and disease epidemics e.g. cholera. Again, the PM assessment of their probability of occurrence should perhaps have been seen as 'high' (not as 'low'). Other risks identified in the PM were in respect of partnerships faltering, whether with other research institutions, non-government service providers, or communities. In each of these areas, the Centre has a long history of service so that the risk factors were rated as 'low risk'. This has broadly proved to be the case, and some 25-30 organisations have engaged in one or more aspects of the project's work.

Overall, one questions the initial assessment, and places the probability firmly in the category of '**medium**', with the grouping of 'political and natural' in the '**high**' category. Their impact would suggest that Output 1 (generation of new knowledge) and Output 3 (getting research into policy and practice) may have been the most affected, with Output 3 severely compromised through political uncertainty and bureaucratic inertia. The concern is most pronounced on the government side, rather than through non-governmental agencies with whom this project has also been heavily engaged.

Admittedly, from the perspective of the Centre, none of the above risks would have been perceived as new or extra-ordinary, and managing the risks would have been seen (simply) as the conduct of normal business. Notwithstanding, it does need to be recognised that the Centre has continued to operate in a challenging environment, and any judgement on the pace of project implementation has to be cognizant of that reality.

### 3. LESSONS LEARNED

#### 3.1. ICDDR.B's autonomy: a mixed blessing?

A perceived real strength of the Centre is its independent status, as an international research organisation of long standing, with clear governance structures and ethical standards. That very autonomy can, nonetheless, provide its own challenges. For instance, it is not perceived as a government-funded institution, though it is in receipt of monies from the government. Yet, it has no automatic right of access to the organs of government, nor to the overall government decision-making process. Likewise, it is not an integral part of any south-east Asia alliance, and cannot expect to be seen as 'nesting' inside the organs of any of the international bodies e.g. the UN family, that have their own regional structures and offices. In consequence, when research is commissioned in order to ultimately influence policy and practice, nationally and regionally, the Centre cannot be assumed to automatically enjoy existing and well defined channels of communication by which this process may occur. For the Centre to engage increasingly in such work, is likely to involve it in significant transaction and time costs; meeting those costs needs to be built into the equation of research funding, with clear modalities for so doing.

#### 3.2. ICDDR.B: a multi-product firm and balancing act?

The Centre currently provides a range of services and activities, in: research, clinical service delivery, education and training, advisory support, and consultancy services. This presents challenges in its attempt both to be financially solvent, and to grow organically. Hence, in determining any future support to ICDDR.B, donors may have to recognise that core business costs do need to be funded one way or another, in addition to programmatic or project funding. This project was indeed a mix of measures aimed both at institution building and development, and at targeting basic and applied research on 'poverty and health', with a desire to ultimately ensure that research findings did feed into policy, programmes and practice.

#### 3.3. Priority setting of new research: a multi-method approach?

In early 2004, the MTR observed that the allocation of funds to each of the research priority areas might have been seen initially as an equitable allocation of monies, but that 2 years into the 5 year programme early progress/results would suggest a radical realignment be entertained. The final expenditure figures conclude that this step was not taken, suggesting perhaps that the research programme may have had a certain rigidity once approved, that then frustrated attempts at mid-term corrections in order to optimise the yield from research grant income. Certainly, the research process is often a protracted affair: that is, from the formulation of a research hypothesis to the production of results and their dissemination. This timeframe may well be even longer in a developing country setting, and for good reasons. A successful blending, therefore, both of funding basic research alongside other research approaches to model and/or analyse existing knowledge, might be the only sensible way forward.

### 3.4. Getting research into policy and practice: an inexact science?

A range of strategies and tactics has been employed to increase the receptivity of policy bodies and service providers to take on board the results of investigations, including: bringing stakeholders directly into the research design process; periodically monitoring progress and reporting in a transparent manner; disseminating results in ways that are customised to the clients' needs and expectations. Yet, researchers may be relatively ill-equipped or unmotivated to engage outside of their chosen domain. Likewise, organisations that are hosts to the research activity, and who may be expected to benefit directly from the investigation, do have their own organisational culture, receptive or otherwise to the research efforts made. Risk analysis of these factors and their mitigation, will likely require more prominent professional attention than has hitherto been anticipated, and DFID itself has a responsibility and a key role to play in this regard.

### 3.5. Monitoring and evaluation: transparent and robust?

In any PM design, a draft set of OVIs is often generated through an initial brainstorming exercise. Less guaranteed is its subsequent use in 6 monthly and annual review reports. Annual reports from different parts of the Centre have tended to be somewhat descriptive, of varying quality and depth of information sharing, and with few action points raised explicitly for resolution and decision. In future, perhaps, a more robust research management approach will require a monitoring and evaluation framework approved in advance, with specific indicators identified and an explicit agreement to have these monitored annually. Also, an internal 5 year PCR could usefully be prepared by the grantee as an input to an externally conducted PCR. Elevating the worth of the annual report to that of a major internal management tool will have its own budgetary consequences, however, as well as challenging a research community to be more businesslike on matters of public accountability. Yet, this needs to be seen to be 'best practice' to be adopted.

### 3.6. Output to purpose: attribution or association to an equity / poverty focus?

The PM recognised that, while the overall purpose should be on supporting ICDDR.B to expand the knowledge base, the reality of the Centre's own position in 2001 had also to be acknowledged. Firstly, support was deemed necessary to further develop the Centre and its management systems (hence, Output 4). Secondly, overall support to the HDSS (Output 5) was also perceived to be critical: it provided the platform on which sentinel and other studies become possible, and the longer it runs the more valuable it becomes. A fully functioning system can then be utilised for poverty/equity studies: and, 'flexed' to incorporate other data sets not hitherto available. They were, and are, to be considered as a necessary core investment. The corollary of these aspects of support is that their linkage (**association**) to the poverty and equity agenda will be less direct and tangible, than other aspects of the Programme. In contrast, the other three Outputs have had a direct poverty / equity **attribution**. Firstly, in respect of widening and deepening the Centre's basic research efforts by employing the twin lenses of poverty and equity. Secondly, in terms of placing research results into the various domains (policy formulation, new modalities of service provision, education and training). Thirdly, in developing a capacity for research directed at equity and poverty issues in developing countries. To date, major strides have



been made in maintaining this focus while recognising that 'new' knowledge is a necessary but not sufficient condition for changes in policy and practice.

## ANNEX 1: REFERENCES

- ICDDR.B Project Memorandum: Building the Knowledge Base for Attaining Equitable Health in Poor Countries, 20 June, 2001
- ICDDR.B Work Plans and Annual Reports (2002-7) as below:
- Year One
- Six Monthly Report (Nov 2001-May 2002)
  - Annual Report (Nov 2001 – Oct 2002)
- Year Two
- Narrative Report of Activities (Nov 2002 – Nov 2003)
  - Detailed Annual Report (Nov 2002 – Nov 2003)
- Year Three
- Work Plan (Nov 2003 – Nov 2004)
  - Narrative Report & Detailed Semi-annual Report (Nov 2003 – Nov 2004)
  - Narrative Report and Annual Report (Nov 2003 – Nov 2004)
- Year Four
- Work Plan (Dec 2004 – Nov 2005)
  - Narrative Report and Detailed Semi-annual Report (Dec 2004-May 2005)
  - Narrative Report and Annual Report (Dec 2004 – Nov 2005)
- Year Five:
- Work Plan and Budget (Dec 2005 – Aug 2006)
  - Narrative Report and Annual Report (Dec 2005 – Dec 2006)
- ICDDR.B Final Financial Report, April 21, 2007
- HSRC/DFID Building the Knowledge Base: An Output to Purpose / Activity to Output Review, January, 2004
- AusAID ICDDR.B :A Multi-Lateral Assessment and Review, Final Review Report, 22 August, 2006
- DFID/DPs Development of a Unified Monitoring and Evaluation Framework (MEF): Working Guidelines, April 2007