

# IDS Bulletin

Transforming Development Knowledge

Volume 50 | Number 1 | May 2019

## EXPLORING RESEARCH–POLICY PARTNERSHIPS IN INTERNATIONAL DEVELOPMENT

Editors **James Georgalakis** and  
**Pauline Rose**



<b>Notes on Contributors</b>	iii
<b>Foreword</b> Diana Dalton	ix
<b>Introduction: Identifying the Qualities of Research–Policy Partnerships in International Development – A New Analytical Framework</b> James Georgalakis and Pauline Rose	1
<b>Rethinking Research Impact through Principles for Fair and Equitable Partnerships</b> Kate Newman, Sowmyaa Bharadwaj and Jude Fransman	21
<b>Pathways to Impact: Insights from Research Partnerships in Uganda and India</b> Rachel Hinton, Rona Bronwin and Laura Savage	43
<b>Exploring Partnerships between Academia and Disabled Persons’ Organisations: Lessons Learned from Collaborative Research in Africa</b> Maria Kett, Mark T. Carew, John-Bosco Asiimwe, Richard Bwalya, Anderson Gitonga, Boakai A. Nyehn, Joyce Olenja, Leslie Swartz and Nora Groce	65
<b>Layered and Linking Research Partnerships: Learning from YOUR World Research in Ethiopia and Nepal</b> Vicky Johnson, Anannia Admassu, Andrew Church, Jill Healey and Sujeeta Mathema	79
<b>Fundamental Challenges in Academic–Government Partnership in Conflict Research in the Pastoral Lowlands of Ethiopia</b> Mercy Fekadu Mulugeta, Fana Gebresenbet, Yonas Tariku and Ekal Nettir	99
<b>Regional Research–Policy Partnerships for Health Equity and Inclusive Development: Reflections on Opportunities and Challenges from a Southern African Perspective</b> Nicola Yeates, Themba Moeti and Mubita Luwabelwa	121
<b>How Did Research Partnerships Contribute to Bangladesh’s Progress in Improving Lives?</b> Mushtaque Chowdhury	143
<b>Glossary</b>	151

# How Did Research Partnerships Contribute to Bangladesh's Progress in Improving Lives?\*

Mushtaque Chowdhury<sup>1</sup>

**Abstract** The last few decades have seen tremendous progress in improving the lives and livelihoods of people around the world. In almost all sectors of development, Bangladesh has done enviously well. One of the important change agents in this impressive development has been non-governmental organisations (NGOs). This article looks at BRAC as an important actor in Bangladesh's development and how it contributed to the changes by working in partnership with likeminded entities. Such partnership has spanned across governments, NGOs, research and academic institutions, and development partners. It presented an example of how an independent research outfit contributed to improving BRAC's programme quality and its delivery, leading to spectacular results.

**Keywords:** partnership, NGO, BRAC, research, implementation, poverty, health, Bangladesh.

## 1 Introduction: Bangladesh in recent decades

The last few decades have seen tremendous progress in improving the lives and livelihoods of people around the world. However, this progress has been uneven. Some societies have gained more than others. Bangladesh is one of the countries that has gained significantly. In almost all sectors of development, Bangladesh has done enviously well. Starting with a high base, the headcount poverty has reduced from about 60 per cent in the 1980s to just over 20 per cent now. In social development, progress has also been spectacular. Over 95 per cent of children now enrol in primary schools. The fallen dropout rate means that more children now complete primary education and move to secondary education than before.

The infant and child mortality rates have also fallen. At the time of Bangladesh's independence in 1971, one in five children would not see their fifth birthday, which is now only a part of history. The infant mortality rate is now less than 30 per 1,000 live births. Equally, the

© 2019 The Author. *IDS Bulletin* © Institute of Development Studies | DOI: 10.19088/1968-2019.110

This is an Open Access article distributed under the terms of the Creative Commons Attribution 4.0 International licence (CC BY), which permits unrestricted use, distribution, and reproduction in any medium, provided the original authors and source are credited and any modifications or adaptations are indicated.

<http://creativecommons.org/licenses/by/4.0/legalcode>

The *IDS Bulletin* is published by Institute of Development Studies, Library Road, Brighton BN1 9RE, UK

This article is part of *IDS Bulletin* Vol. 50 No. 1 May 2019 'Exploring Research–Policy Partnerships in International Development'; the Introduction is also recommended reading.



maternal mortality ratio has also been reduced from over 600 in the 1990s to less than 200 per 100,000 live births. The number of children a woman bears in her lifetime, represented by total fertility rate, has dropped from over six in the 1970s to 2.3, which is just above the replacement level. Life expectancy, a composite indicator, has increased by over 40 per cent to over 70 years.

Of special note here is the gender dimension. Until about the 1980s, Bangladesh was one of the few countries in the world where women lived a shorter life than men. Fortunately, this has been corrected with women living two years more. With affirmative actions taken by the government and NGOs, many women have been brought into the mainstream of development, not only as passive receivers, but as actors in their own development and empowerment.

A few years ago, *The Lancet* devoted a full series on the Bangladesh story (*The Lancet* 2013). According to its editors, Bangladesh represents 'one of the great mysteries of global health'. The series, which traced some of the reasons for this, also identified challenges that the country and the society will have to confront in the future. It identified NGOs as an important actor in this and BRAC was often referred to in most of the papers and commentaries. BRAC's interventions have spanned across many areas of development including primary education, health care, women's empowerment, and microfinance, and are thought to have touched the lives and livelihoods of the majority of Bangladesh's 160 million people. As alluded to later, for example, BRAC's health programme on tuberculosis (TB) control is implemented in two thirds of the *upazilas* (sub-districts) of Bangladesh, and its microfinance programme has over 6 million borrowers. It is considered as a 'learning organisation' in the sense that it learns from its own experiences and scales up to reach as many people as possible (Korten 1980).

## **2 BRAC in partnerships**

BRAC believes and works in partnership with likeminded entities. Such partnership has spanned across governments, NGOs, research and academic institutions, and development partners. The following gives a quick run-down of the types of partnerships that BRAC has forged in implementing its development interventions.

**1 Partnership with other implementing organisations:** A good example is the work that BRAC does in collaboration with governments. Such partnerships happened especially in the areas of education and health. Since the 1990s, BRAC has implemented a programme to combat TB in Bangladesh. TB remains one of the major killers, particularly for those in their productive years. In a unique arrangement, the national TB control programme using the Directly Observed Treatment, Short Course (DOTS) is implemented through NGOs. In this, NGOs implement the programme at the grass-roots level while the government supplies the drugs and diagnostics, and provides the oversight and supervision. As part of

its role as a principal recipient of the funds from the Global Fund to fight AIDS, Tuberculosis and Malaria, BRAC contracted out implementation of the programme in a third of the country to NGOs, while BRAC itself implements it in the other two thirds. This programme has earned global recognition for its impressive outcomes in terms of case identification and treatment compliance.

- 2 Partnership between two research entities:** BRAC's Research and Evaluation Division (RED) has collaborated with other internationally known research outfits. An example is the partnership between RED and the London School of Economics. This collaboration measured the impact of BRAC's celebrated 'graduation programme' for the ultra-poor. Using a randomised controlled trial (RCT), the collaboration found measurable impact of the programme on the employment and income of ultra-poor households, both at short and longer terms. In another example, RED collaborated with the Bangladesh-based International Centre for Diarrhoeal Disease Research (icddr;b) over a ten-year period to measure the impact of BRAC's microfinance and primary education programmes on health outcomes. It made significant contributions in understanding the mechanism of health impacts triggered by actions in the non-health sector (the so-called 'social determinants of health'). A series of papers was published from this research collaboration.
- 3 Partnership between two academic institutes:** The partnership between RED and the Institute of Development Studies (IDS) helped develop and improve the capacity of RED staff in specific skill areas. In the 1980s, RED and IDS forged a collaboration which helped RED staff gain skills on how to use participatory rural appraisal (PRA) and rapid rural appraisal (RRA) as 'quick and dirty' methods in social science research and programme evaluations. This led RED to become a hub for practising and promoting such methods in the country. In another example, the BRAC University James P. Grant School of Public Health has collaborated with a number of overseas universities in implementing its Master of Public Health (MPH) programme. Under this, faculty from universities such as Columbia, Harvard, London, Makerere, Stanford, Karolinska, and the Public Health Foundation of India (PHFI) have been co-teaching, which has helped raise the standard and prestige of BRAC University as a centre of excellence in public health teaching.
- 4 Partnership between a research outfit and implementation programmes:** There is no dearth of good ideas but where the world of development struggles is in their implementation. However noble and nice the idea is, it is of limited value unless it is implemented well and shows good outcomes. In Section 3, I describe how a good idea that was identified and implemented well through a learning approach has led to impressive outcomes (Chowdhury 2014).

### 3 Partnership for better implementation of interventions: the case of Oral Rehydration Therapy (ORT)

Until the early 1980s, diarrhoea was a major killer in Bangladesh, particularly for children. According to an estimate, 250,000 children were dying every year from diarrhoeal dehydration. Oral Rehydration Therapy (ORT) as the treatment of choice for diarrhoea had already been discovered at the erstwhile Cholera Research Laboratory in Dhaka, but its use was confined only to within the four walls of hospitals, as the World Health Organization (WHO) was not recommending its use on a mass scale, fearing its misuse. In 1979, with support from the icddr, BRAC developed a home equivalent of ORT. ORT is nothing but a mixture of salt and sugar in water. Through some trial and error, it was discovered that a pinch of common table salt and two scoops of *gur* (local brown sugar or molasses) when mixed in half a litre of water made a solution which was very close to the WHO-recommended ORT.

As the ingredients of salt and *gur* were commonly available in almost every home, BRAC decided to teach this to every mother in Bangladesh. Women health workers were trained and sent to teach ORT to every mother through face-to-face sessions. Initial piloting concentrated on making sure that the mothers learned the preparation well enough as deviation in the recommended measures would render the solution either ineffective (if too little salt and/or sugar is added) or dangerous (if too much salt is added). BRAC introduced a number of innovative systems in implementing the programme. One of them was the incentive salary. A health worker was paid based on how well she taught the mothers. A month after teaching, monitors visited the mothers, asked them to prepare a solution in front of them, and saved a sample of the solution for analysing the amount of salt in it. The health worker received no payment if her solution was not within a 'safe and effective' limit. This way, the health worker devoted her maximum efforts in making sure that the mothers she taught remembered it correctly.

Over the decade of the 1980s, BRAC workers taught this method to over 14 million mothers in as many families. Called the Oral Therapy Extension Programme (OTEP), this was the largest ORT programme ever undertaken anywhere (Chowdhury and Cash 1996; Gawande 2013). The outcome is that it contributed significantly to the drastic fall in child mortality in Bangladesh. ORT is now a part of the local culture in the sense that mothers transmit this knowledge down to their children. And finally, Bangladesh now has the highest use rate of ORT in the world. According to the Bangladesh Demographic and Health Surveys, over 80 per cent of diarrhoeal episodes are treated with ORT! But what has been the contribution of research in this and what contributions did partnerships make? We discuss this in the following section.

#### 4 Improving implementation: the role of partnerships

There are two critical markers for the successful implementation of an ORT programme:

- Mothers' ability to make a 'safe and effective' solution and its sustenance; and
- Use of the ORT solution in the case of diarrhoeal episodes.

RED played an important part in the implementation of OTEP. It is perhaps not an exaggeration to say that this partnership between RED and OTEP contributed immensely to the success of the intervention. From the pilot phase to the time it scaled up to reach the whole country, RED researchers carried out numerous investigations to understand the implementation and help OTEP instil mid-course corrections. It is perhaps worthwhile to mention a few examples of such contributions.

##### 4.1 Changing the ORT formula

The original formula for homemade ORT that BRAC came up with, as mentioned above, was one pinch of salt, two scoops of *gur*, and half a litre of water. Staff monitoring the teaching found a high concentration of salt in the solutions prepared by mothers in a particular area. It was discovered that due to faulty teaching, the mothers were mixing the ingredients wrongly – instead of one pinch of salt and two scoops of *gur* they were mixing two pinches of salt and one scoop of *gur*, leading to a hypertonic solution. Obviously, mothers were confused. BRAC did some further experiments and found that if the mothers used one fistful instead of two scoops, it gave similar results in terms of the amount of sugar in the solution. OTEP thus changed the formula from 1+2 to 1+1. There was no confusion afterwards.

##### 4.2 Research to understand the usage of ORT

Early studies found that less than 10 per cent of diarrhoea cases were treated using ORT. This was very frustrating for BRAC as the assumption was that once the technology was transmitted to mothers they would start using the solution without fail. This was particularly so when it was already known that mothers were making the ORT solution correctly, at least from a medical science perspective. There was, however, an imperative and immense need to understand the dynamics of use from a social science perspective and to find out why the know-do gap existed.

**Gap in messaging:** Water is a most important part of the ORT. The health worker while instructing a mother gave the following message: 'When your child has diarrhoea, give her ORT. This solution can be made by mixing one pinch of salt and one fistful of *gur* into half a litre of pure water'. In the 1980s, when OTEP was implemented, 'pure' water was not available to every household in rural Bangladesh. As the message emphasised 'pure' water, mothers who did not have ready access to it did not use it. This was a major issue and BRAC consulted Richard Feachem of the London School of Hygiene and Tropical

Medicine, an authority on ORT. He responded by saying that 'pure' water was not at all necessary to make ORT and indeed, any water (even dirty water) was better than no water. What was important was to replace the lost fluid. BRAC changed the message and instructed mothers to mix the ingredients into their 'drinking water' (instead of 'pure water').

**Lack of male involvement:** Another research study found that men were not supportive of ORT. OTEP was essentially a women-to-women programme (health workers were all women who taught only women inside houses) and men were hardly involved. This created suspicion among men, the traditional family decision-makers. Even when the women were fully convinced of the value of ORT, they hesitated to use it as their male members were not aware of ORT. This led to a total overhaul of OTEP, with male workers included in the team of health workers. While the female workers taught women, the male workers met the menfolk in bazaars, mosques, temples, and schools.

**Increasing the trust of health workers:** Research found that the health workers who were entrusted to teach mothers were themselves not convinced of the effectiveness of ORT as a treatment for diarrhoea. When they themselves had diarrhoea, they were found to seek a remedy from local village doctors instead of using ORT. This was important because if the teacher is not convinced of what she is saying and does not have trust in it, how can she convince others? As a response, all the workers were brought to the diarrhoea treatment centre of icddr in Dhaka for them to see how ORT worked in the body. Seeing is believing, and after this demonstration, they developed more trust in ORT and were able to teach mothers more confidently.

**Cultural perception of diarrhoea:** Ethnographic research found that villagers perceived four types of loose motions, all of which resembled diarrhoea. To them, they were separate illnesses with distinct causes and aetiology. One of the types, for example, was '*dud haga*'. In local terminology, *dud* means milk and *haga* means stool. The cultural belief was that if a mother's milk gets 'polluted' and her baby sucks it, the baby would have *dud haga*. Mothers do not consider this as diarrhoea. But how was this perception related to the use of ORT? In fact, there was a fourth type which the mothers call '*daeria*' which resembled severe cholera-like diarrhoea. When the health worker instructed a mother, she asked her to use ORT when her child had 'diarrhoea' but the mother perceived this to have meant *daeria* (severe watery stools). As the *daeria* cases were very small in number (less than 10 per cent of all cases), a high proportion of use in this category could not raise the average. The OTEP quickly modified the message to reflect the new knowledge: 'Use ORT when your child has *dud haga*, *ajirno*, *amasha*, or *daeria*'. The local terms for the different types of diarrhoea varied from region to region within the country, and one of the first tasks for the health worker teams when they came to a new village was to discover the local terms for use as they instructed on ORT.



## 5 Concluding remarks

According to BRAC, they do research not just for research' sake but to solve a problem or to improve delivery of interventions. The above example shows how an independent research outfit can contribute to improving programme quality and its delivery. This was possible because of a unique partnership between RED and OTEP. This partnership grew from mutual trust and respect, benefiting both. OTEP saw the value of the RED inputs and RED saw how their inputs were being valued by OTEP. Partnership may also mean pains. In the beginning, some of the OTEP staff were sceptical and sensitive of what RED researchers were saying about their programme and at times this led to some tensions. As trust was built, benefits triumphed and pains were forgotten. What is required is the determination and patience from the part of the partners.

## Notes

- \* This issue grew out of the Impact Initiative for International Development Research which seeks to maximise impact and learning from ESRC-DFID's Joint Fund for Poverty Alleviation Research and their Raising Learning Outcomes in Education Systems Research Programme.
- † This article draws from the inaugural keynote speech delivered by the author at the ESRC-DFID conference 'Power of Partnership: Research to Alleviate Poverty', held in New Delhi, 3–5 December 2018.
- 1 Vice Chair, BRAC, Dhaka and Professor of Population and Family Health, Columbia University, New York. In the past, Mushtaque Chowdhury was the evaluation manager for OTEP, the case extensively reviewed in this article.

## References

- Chowdhury, A.M.R. and Cash, R.A. (1996) *A Simple Solution: Teaching Millions to Treat Diarrhoea at Home*, Dhaka: University Press
- Chowdhury, M. (2014) 'The Mantra of Delivery', *Stanford Social Innovation Review*, 26 November, [https://ssir.org/articles/entry/the\\_mantra\\_of\\_delivery](https://ssir.org/articles/entry/the_mantra_of_delivery) (accessed 7 January 2019)
- Gawande, A. (2013) 'Sharing Slow Ideas', *The New Yorker: Annals of Medicine*, 29 July, [www.newyorker.com/magazine/2013/07/29/slow-ideas](http://www.newyorker.com/magazine/2013/07/29/slow-ideas) (accessed 27 March 2019)
- Korten, D.C. (1980) 'Community Organization and Rural Development: A Learning Process Approach', *Public Administration Review* 40.5: 480–511
- The Lancet* (2013) *Bangladesh: Innovation for Universal Health Coverage*, [www.thelancet.com/series/bangladesh](http://www.thelancet.com/series/bangladesh) (accessed 7 January 2019)

This page is intentionally left blank