Understanding the Role of Evidence in Policy Making in Bangladesh

Report 1: An Analysis of Interviews with Health Sector Decision Makers

Part of:
Bridging the know-do gap: strategies to enhance the capacity to apply health policy and systems research into evidence-informed policy making in Bangladesh

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INTRODUCTION

In the first phase of the project, Bridging the know-do gap: strategies to enhance the capacity to apply health policy and systems research into evidence-informed policy making in Bangladesh, the objective of the ICDDR,B team was to assess the amount of engagement between researchers, policy makers and other key stakeholders in Bangladesh and explore how far the receptor roles have been established, to receive and use research findings.

Many factors affect the policy making process: political, economic and social factors all affect how policies are made, and who makes them, at all levels, global and national. Figure 1, which was originally created by the EPPI Centre (University of London), presents one view of the small role that research evidence can play in the complex set of competing factors such as resources, lobby groups, values and political judgements, which determine policy making. Good policy environments and strong governance systems strengthen the policy makers’ ability to facilitate and implement uniform, universal policies (WHO AHPSR, 2007). Policy making processes are complicated processes where there are many ‘actors’ at each stage. Civil society groups and media are most likely to be involved at the agenda-setting stage, and work with academic or research institutions at the formulation stage, drawing from their own experience or research. National governments depend on the flow of funds and priority setting by both local and international donors. Figure 2 presents a more complex conceptual model of the plurality of stakeholders and influences to the process as described previously.

Evidence is used in policy making processes depending on how open the policy making is, and the power of the different actors. Policy makers may choose to make limited or no use of evidence for many reasons, such as lack of support from elites, strong opposition from powerful governments, and lack of resources to implement the suggested policies systematically. They are also faced with countless tasks and issues, and are under pressure to find solutions quickly. Research might slow down this process, contradict beliefs and existing policies or be perceived to be irrelevant (WHO AHPSR, 2007). The evidence may not be synthesized and presented in an acceptable format and, thus, be ignored. All of these are challenges in using evidence to enhance to policy making processes.

Much of the above analysis presents a generic picture. It could, however, be important to recognize that the role research can play might vary in different categories of policymaking (Hanney et al. 2003). Lomas (1990) argues that a useful threefold distinction can be made between ‘legislative, administrative and clinical’ policies. Evidence is growing that in some health care systems, such as that in England, structures are being created to generate more extensive clinical policies; these structures are playing a receptor role by explicitly receiving and making use of research evidence (Hanney et al. 2007). It can often be even more difficult for research to play a role in relation to policies about health systems.
To understand the policy making process in Bangladesh, we present an overview of the health system and its various actors. The formal health structure in Bangladesh is such that the Ministry of Health and Family Welfare is mandated to formulate policies in collaboration with two directorates, which are Health and Family Planning, development partners (donor and NGOs), other related ministries/departments and civil society (which is an emerging and yet to be fully empowered stakeholder group). The two directorates are responsible for implementation of programmes based on strategic planning. There are several policy documents (Health Policy, Population Policy, Revised Drug Policy, HNPSP (Health, Nutrition, and Population Sector Programme), and the Food and Nutrition policy which are available for reference.

The ministry is headed by one Minister/advisor assisted by a State Minister. The Secretary heads the secretariat under the ministry. He is assisted by one Additional Secretary and about seven or eight Joint Secretaries (JS). There are 13-15 deputy secretaries and assistant secretaries. Each of the Joint Secretaries is entrusted with specific areas to oversee as below. The highlighted ones are more relevant to policy planning process and include: a Joint Secretary for WHO and Public Health; JS for Hospitals and Gender Issues; Joint Chief of Planning; Joint Chief of the Health Economics Unit; Joint Secretary for Development of Family Welfare; Joint Secretary for Coordination; a Joint Secretary for Administration and Programme Management and a Joint Secretary for FMD.

The Ministry of Health and Family Welfare in Bangladesh divides into a bifurcated structure based on traditional priorities when the system was developed. There is a Directorate General of Health Services and a Directorate General of Family Planning. Within the Ministry of Health and Family Welfare (MoHFW) there exists a Director -Planning and Research of DGHS and...
DGFP- along with the respective Director General who plays a key role in policy planning process. Further under the HNPSP, a DFID supported body has been created recently known as the Program Support Office (PSO) to facilitate policies and programmes. The Health, Nutrition and Population Sector Programme is the largest health sector programme in the world with an estimated annual budget of US$ 4 billion. The HNPSP undergoes a Mid-term Review and Annual Review by external teams, which also play a critical role in policy advocacy.

Further non-government organizations play a huge role in the delivery of healthcare services to the population of Bangladesh. BRAC touches the lives of 110 million Bangladeshi citizens with their army of 30,000 village health workers, Shastho Shebika. Other large NGOs include Save the Children, DSK and other programmes under the umbrella organization, PLAN. Little is known as to how these organizations receive up-to-date information both from health research and health policy, but we note the general accounts about the importance of NGOs being fully involved in the research loop in low and middle income countries (Delisle et al 2005). Further, a large scale social franchising operation (Smiling Suns Franchise Programme) is scaling up in both the rural and urban areas and is expected to have a network of more than 7000 employees serving a population of 22 million.

The objective of this exercise was to gather information as to the current manner in which stakeholders interact, and how much research and evidence is used in the policy making process. We have explored the priority setting processes, and attempted to determine the interface between research and policy making, as well as the role of the ‘receptors’ of health research, i.e. bodies or individuals within the policymaking system who receive and use research evidence (Hanney et al 2003).
Figure 2: Conceptual framework for evidence-informed health policy-making

National context

- Political and governance systems
- Economic and social conditions
- Educational levels and supply of graduates
- Basic research infrastructure

Influences

- Ideology and values
- Ability to use evidence
- Personal experience and intuition
- Interests
- External influences

Research outputs

- Research priority setting
- Knowledge and general dissemination
- Evidence filtering and amplification
- Policy making processes

Policy messages

External funders

External research institutions

External advocacy organizations

Decision and research culture, regulations and legislations

Organizations

- Funding bodies
- Research institutions
- Media
- Advocacy organizations
- Think tanks
- Government bodies

Organizational capacity

Leadership and governance

Resources

Communication and networks

Source: WHO AHPSR 2007
RESEARCH QUESTIONS

- What is the policy making process?
- What is the level of engagement between the different actors of the policy making process?
- How much research is used in the policy making process? What are the main constraints?

METHODS

Identification of respondents

Key stakeholders of health systems were identified according to four different categories: government, non-government organizations, academic/research institutions, and civil society watch groups/think tanks. Twenty semi-structured, in-depth interviews were planned among the producers and users of research-evidence. Respondents were chosen upon the basis of their experience in research, policy making and program management. Line directors, program manager, their deputies, and the directors of research were chosen. All respondents were contacted beforehand by telephone or email for consent and for an appointment for an interview.

Data collection and analysis

After a preliminary meeting with the Director General of Health Services to obtain permission to conduct the study, an official letter of request was sent to the Directorate General of Health Services seeking approval, which resulted in the production of a letter of support for the project and instruction for permission. A total number of 14 interviews were conducted with representatives of multiple sectors that influence healthcare decision making in Bangladesh to include public, private and non-state representatives as well as key players in public health research. Nine of the interviews were from the government sector, and five were from the non-state sector. Formal consent was taken verbally from all respondents after explaining the purpose of the interview. Interview respondents were informed that the interview would be audio recorded, but that their names and designations would remain confidential. The interviews took place primarily in the offices of the health experts, although one was conducted at the home of the respondent and one at a restaurant. The average duration of the interviews was 45 minutes but the one at the restaurant took one and half hours and the one at the respondent’s home took two hours.

Taped in-depth interviews were transcribed and translated into English (as needed). Interviews were then coded manually, drawing on specific themes, ideas and expressions.
One researcher did not give an interview because of being abroad presenting a case study at an international conference, but provided the case study to demonstrate his role in providing evidence for and engagement with the policy making process. To further the analysis, one member of the research team (TK) prepared a similar case study example based on her experience. The case studies appear in boxes below.

**RESEARCH TOOL**

A semi-structured questionnaire was used for the interviews, consisting of 29 questions. This questionnaire was modeled on a questionnaire originally developed by a team at Brunel University, led by Stephen Hanney, to capture the utilization of health research in policy making (Hanney et al 2003). The questionnaire was modified to be in context with local settings. Some of the questions were repeated intermittently in order to triangulate the responses.

**FINDINGS**

**The policy environment**

Several questions were asked to attempt to elicit and capture the major themes surrounding the policy making environment. The findings are grouped according to the most frequently given responses.

**A top-down approach**

In all of the interviews with the public sector actors, the response was clear that policy making in Bangladesh is done at the senior levels. In an in-depth interview, one the government official said, ‘The policy comes from a very top level and it is a very centralized system. We have operational plans that we revise from time, but more often than not, it’s a ‘cut [and] paste job’, without any real inputs.’ In itself, of course, the existence of the top-down approach to policy making does not necessarily rule out the scope for research to influence policy. It depends on who those at the top making the policy turn to for advice.

The policy making process was highlighted during an interview. ‘Policy formulation in Bangladesh generally follows certain steps. First the government will typically make a committee, and then the work is done by the group. The committee formulates a draft and then the draft is presented and approved at the committee meeting. Finally, the document is given to the Ministry by the committee. When there isn’t planning to make improvements with that objective, we analyze the current situation and make recommendations for improvement.’

A senior, non-state actor involved in the policy process shed some more light on it. ‘The process of policy making is an internal affair. Government tries to show that it involves stakeholders however this is more lip service rather than genuine intent but this does not mean that the policy
framed by government is anti-social or anti-poor but... it is not in the culture even among educated people to engage in a participatory process.'

According to another non-state sector stakeholder, other forces also have a large part in policy making. ‘In the public–private partnership spheres, there are various factors at play researchers come from one standpoint, policymakers have a certain goal and the donors set a certain standard with an immense amount of pressure. The planning commission is a big part of the Ministry and much of the non-state projects and programmes are planned for public sponsorship through them.’

Main policy actors

Among the interview responses there was quick consensus that ultimately the decision to approve policies rests within the highest level of the government. As one official noted, ‘The DGHS is the final authority for all new policies. Policy making is done locally and by committee. There is a Policy Making Group that consists of the DGHS, the Minister of Health, and the Health Secretary. There are technical groups for strategic design that includes a broader array of experts in different areas—so different groups for difference items like IMCI for child health or primary healthcare but ultimately it is the Policy Making Group as I described.’

Almost all the respondents had the same opinion. ‘No particular person influences how policy is made, as a whole there is discussion and the steering committees may not always know how the issue was brought to the surface. However, the main policy makers on any topic are ultimately the Minister for Health and the Health Secretary but they are the ones who form the committee.’

Another respondent added on the role of retiring officials, ‘Though collaborative in nature, the policy making process is a top-down approach. Often exiting and retiring high officials start a program as sign of legacy.’

A non-state sector actor commented, ‘The system is severely political, as a result it’s difficult to accomplish much. However, there are agents inside the system who want to bring about change who understand the good work that is done and ready to cooperate. There are sufficient structures, and on paper they are legitimised, but again due to the political nature of the system, much of it is goes wasted.’

One respondent talked about the role of bureaucrats. ‘All of the different groups [Ministers, lobby groups, legislatures, academics, professionals] influence and in that order but you did not mention the bureaucrats: the government, actually the policy makers are the bureaucrats. The policy making authority is the ministry. The initial idea comes to the Ministry and is handed down from Minister to Secretary to joint secretary to assistant secretary and then a brief is made. The Ministry has great power. No policy decisions can be made by bypassing the bureaucratic chain.’

The Bangladesh Medical Association was mentioned in several interviews for their role in bringing attention to issues and demanding policy action. “In current times they have lots of
problems and demands and thoughts and they throw it to the Ministers and the political atmosphere and it comes to us as a demand.”

The role played by researchers and planners was also discussed. ‘There are planning commissions, there are forums and platforms for interaction between researchers and policymakers, but there are other forces also at play, that often influence decisions more than they should. Look at donor parties, they put a severe amount of pressure on both the State and the NGOs to confirm to their standards and these often dictate what research is used and what policy is formed. The Ministry is a very complex organ most of the policies are created by the policy branch under the direction of the higher echelons. Researchers are consulted, but more often they are those who are supported by the state, non-state researchers are often polarized.’

In terms of the collaboration between researchers, policy makers and stakeholders, a senior public official noted that ‘Policy is influenced by health officials in the country and by international experts like UNICEF and by the results of the IMCI work. These SafeMotherhood strategies had the DGHS as the final authority with approval for the Ministry but it was based on results from the civil surgeons at the District level and the Line Directors at the National level. These players from around the country can participate in strategy development but not in policy making.’

About the lack of coordination between stakeholders, another respondent said, ‘All (the actors) have the capacity to influence policy, but they do not work in a collaborative or integrative manner rendering each other as opposing sides, when clearly if they all worked together, like lobby groups and legislatures academics and professionals, the outcomes would be much different.’

**The priority setting process**

When asked about the priority setting process in the role of policy formulation, it emerged that there is no clear priority setting process for issues and agendas. Recurrent themes were funding, political will and external influences. Occasionally these themes intermingled according to respondents.

One respondent noted that in most cases it is dictated by the availability of funds or the specific direction dedicated to sets of funds. ‘In the case of the DGHS, we have the Line Directors influencing the program managers. They tell us how to prioritise. We have a core fund, donors’ money and bilateral funds. It’s quite complicated to prioritise as it is not only dictated by what we need, but also by the amount of funds we have.’

The priority setting process can also be political. This fact was echoed by several respondents. ‘Mainly what political party is in power, how they decide to allocate the funds, and what
feel is important sets the priority for policy making. Too often, it is self-interest of individuals, which dictate agendas in the operational plans.’

Other factors also affect the priority setting process. The Millennium Development Goals are one of them, and current policy goals are in line with these, especially for Child Health and Maternal Health, as these sections are also part of the HNPSP. National goals are taken into account for policy prioritization. ‘Decisions and the way forward were based on national goals—not so much on research, although sometimes they are based on funding.’

One public sector respondent replied that the policy agendas can also be need based, and data from the management information systems [MIS] often illuminate the need for a priority issue. ‘Governments always look at the prevalence of disease and design policies and programs accordingly.’

External forces also play a role in priority setting. ‘Often donor countries bring their ideas and ask for issues to be placed on the agenda, sometimes there are national studies that reveal issues to be considered. While policy makers have a stronghold over the process their capabilities are often influenced by forces that they rely on. The State relies on a lot of foreign funding, and the policies or projects have to meet the foreign standards to secure those funds and resources support.’

As one non-state sector respondent in explaining how priorities are set said, ‘My experience is that this, in a way, is like Gill Walt’s theory about the framework of three streams, problem stream, funding stream, and an institution stream. Three layers on top of each other, if you look through you have to align the layers to look through for a common understanding by all players and that is a problem, that everyone must understand that there is a solution and third that there must be finances around to implement those solutions. Only when the three conditions are met can it be put on the agenda and translated into policy.

Evidence-policy interface

A subset of questions focused on the issue of how research factors into decision making in Bangladesh. The recurrent themes were around the use of research and how evidence is communicated to the decision makers.

The role of research in policy making

There were mixed responses on the role that research plays in policy making. When it was used it was not always used in an organized fashion. However, in many cases respondents could identify one instance when research was used to inform the development of policy or at least of national guidelines such as with the national scale up of zinc and revisions to the demand side finance voucher scheme for maternal health.
According to one government official, research is always contracted. ‘Consulting firms are contracted to do non-partisan investigative research and submit reports on plan of actions. They are also contracted for reviews and assessments of completed projects.’

In one case, a Medical Waste Management design had direct links with research. The manager said, ‘At that time I was given a research done by the World Bank in Bangladesh and in that research, how the upazillas [subdistricts] were at the period was there and their quantities of waste, based on that I initiated the initial work plan. In fact I have done another research in 2005. I looked at the status of waste amount of waste the systems available and the Knowledge, Attitude, Practices of persons involved and their opinions involved in terms of what they wanted to see in the future.’

In the case of the demand side finance voucher scheme for maternal health, there was a rapid assessment conducted. The findings of the rapid assessment directly resulted in policies. ‘We have been using findings such as this, and also our own knowledge to start policies. Policies can change in the middle of programs. We have been using research to make programmatic changes. We identified mothers from upazillas and started an ID card system, based on research.’

In an attempt to explain how research can inform policy, one respondent replied, ‘So the ministry might say, “There is no problem,” or it is worse—or they look at a foreign country and say, “Oh, let us try this and do a pilot—like in India.” [So] we do a pilot, we involve government so that their understanding of the problem and the do-ability of the solution the government can understand it through its own people. Suddenly people are euphoric and start doing things. It is not happening very often because it is a lengthy process and due to staff transfers you just manage to convert people and then they are leaving and things are disrupted.’

One official added, ‘In the ongoing HNPSP, we always have mid-term reviews. The review teams always use research from the field. Based on this, our team has said, that in terms of MDG 5, maternal health, we won’t be able to meet the target. We found that we have problems with retention of doctors. We have now decided to have doctors shifted to the hard to reach areas. All this was found through different research available.’

Another respondent commented on the use of research in the HNPSP. ‘You know, the government health programmes are mainly done by a programme called HNPSP, so every year there is a review called the Annual Programme Review done by a joint evaluation team (both external and internal) but independent of the programme implementer and the donors. One unit is the Monitoring and Evaluation in the MoH and one is Health Economics Unit in MoH and there are information sources like the MIS both in Health and Family Planning. And there are health managers in different places and directors for implementing those programmes so the evaluation team consults the individuals and the reports and sources and makes recommendations to re-plan the programme and to set priorities. These are examples of how priorities are set and how
information is gathered and how the equities and benefits of health are measured. Again, there are surveys done and the evaluators take these into consideration."

There are disagreements about the effective role of research. ‘I can’t think of how research is used. Sometimes it might be that certain reports get sent to us, and then we’ll take a decision. But there certainly is no organized way to sort out what is important and what isn’t. The use of research, even to those of us who are involved in research is very questionable. Of course, reports get sent to us, and from time to time we look at them. But we don’t have the time. Also, there is no proper monitoring and evaluation of research done, hardly ever in Bangladesh, so it is impossible to decide what actual, valid research is. In most cases, policy makers won’t take the time to read through the findings, or they are too complicated. So the use of research is dubious, scant at most.’ Another respondent claimed that policy making is ‘not based on research.’

A government policy maker said, ‘This is the weakest part of our policy because actually our policy is not that much dedicated to research findings. Our policy is not that much research dependent but rather it is thought dependent. Someone has a thought and we prepare policy in that way. It is true that it is not always research based and this is the weakest part of the process. If you ask me I am in doubt of some example of a policy that is based on research. But, now the time has changed as you may have heard about the community clinic initiative—a doctor has been given the task to do some research for the necessity for the training needs of the government workers and some other issues and depending on the findings we are going to develop the committee to develop policy. However, in the past I would not say very much about research findings that have gone to the policy making.’

**Communication of evidence**

Respondents were asked to explain how they learned about research findings or how new ideas were communicated to them as well as to describe the best format for receiving new information. Sources that emerged repeatedly included internally generated information; working papers from ICDDR,B, international conferences and seminars; and from the civil society initiative Bangladesh HealthWatch. ‘News articles, opinions and information are all considered, sometimes information gathered from international state-level forums.’

In terms of a suitable format, one public sector respondent said:

‘All types of mediums are used for communicating the evidence, but recently, the attention has been drawn to policy briefs, and 1-2 page briefs are a very useful tool of communication,’ said one respondent.

Another respondent agreed. ‘There needs to be that orientation and sensitization to understand research for what it is and then to effectively utilize it and implement it. Currently, briefs and summaries are working quite effectively in pushing forwards a synopsis of the ideas and issues
that need to be addressed. Direct contact between the two groups can make them more receptive, constant interaction and frequent collaboration.’

Many respondents stressed on the use of television and news articles to present evidence or raise issues. ‘Televisions and newspapers have the ability to stir up a topic so that it comes to national interest and make people sit up and notice. There are disseminations and working papers presented, but again, it’s hard to tell whether the message is carried to the policy level, or ends when the seminar ends.’

Another respondent said, ‘It is coming from everywhere from television, the internet, the newspapers If we read the papers and the internet we get information. If we go to the conference we learn many things from different experts from different countries of the world. So, yes, our ideas come from both but I think that media is number one. I would say that most of the policy making ideas come from problems that are exposed. So, yes, the media is the source. From the international conferences we get more good evidence ideas.’

A non-state researcher said about the media, ‘Media plays a significant role, but they are not appropriately sensitized to the issues, they are quite responsible in bringing up various issues, but they lack a degree of orientation to adequately highlight the issues at concern.’

Multiple respondents in the public sector highlighted the importance of the MIS reports, which detail the working of the public sector. ‘In respect to the MIS findings, those health complexes to which most of the patients are going have a requirement to increase their beds so based on those we are recommending those hospitals as priority need to be upgraded first and others later on –so MIS reports are in fact very important. We are getting District Level Manager and Upazilla Level Manager feedback and trying to accommodate those things in the policy. Evidence comes from conferences and meetings with field level personnel, the media—sometimes they identify things outside of the usual channel and they are regularly scrutinized; the MIS reports are very important.’

Further on the MIS reports, a senior public official noted, ‘We use information from the MIS,” and that “it illuminates issues and brings them to the agenda.” Specific reports that were mentioned included the Health Bulletin and the Vacancy Report. Another important source of information was from a civil society organization called Bangladesh HealthWatch, which produces an annual report on a health systems area of interest such as governance or human resources for health. It is worthy of note that only a single respondent, an ex-patriot chief of party to a large non-state sector service delivery programme, even mentioned finding information from peer reviewed scientific papers.

**Challenges to Using Evidence in Policy Making**

There were several recurrent gaps and major challenges identified during the course of the interviews. Primarily these focused on a lack of time both in terms of daily activities and in
terms of time in position as well as the lack of orientation to research on behalf of the policy makers.

From a policy maker’s perspective, lack of time is a serious issue. ‘Policy makers are very busy people. They do not necessarily have the time to absorb everything that is being said. It has to be presented to them in a form that they can look at it quickly. I wouldn’t say there’s no willingness to participate, it is just that it’s too few people trying to do too much in a short time.’

Several public sector respondents noted that there was not sufficient ‘push’ from the researchers’ side. ‘Researchers think that as long as they have international publications, it’s enough, but the research is actually not being put to any use, except to generate more research. If it does not reach the policy level, then what is the point? Policy makers are busy people. Findings need to be handed to them in a way that they can absorb it. Communication channels need to be opened so that research and policy can work in a collaborative way.’

Lack of training and lack of time in position may also diminish the ‘receptor’ capacity of the policy makers. ‘There is a willingness to participate if given the opportunity to go ahead. There is a lot of training, in fact, those may not be properly utilized or the right persons are not chosen for the training, but whoever is going for the training may not be disseminating the training to others. This is the problem here. People are not kept at the job after training. People switch from perhaps one ministry to another at some levels but within the DGHS, there may be someone with the proper training at the proper place at the proper time. Often in the DGHS people are here waiting for their promotion at the end of their working life and may not have the proper training or the time to deliver anything.’

Another respondent voiced the same thoughts. ‘I would say overall there is very low ability to absorb and use research in policy making. I think most officials have not had any training in research methods and they stay too short in their places to do so. You could argue that people in the Ministry get shuffled around the various ministries but really you need the same skills in each ministry—so that each would have a basic training in policy analysis.’

One respondent said, ‘I would say you can only absorb this information (evidence) and adapt it if it is a collective process. It cannot be a solo exercise. The information can be absorbed at different levels at different stages and at different pieces. For example, the zinc. It is more an aggregrarious process—it is social and the training.’

There are gaps in the policy making process as well as the research process. ‘In general I find if you can identify your process champion the best evidence and nobody is listening and nobody is doing anything about it. If you have a process champion it depends on him—if he has a scientific background or academic background you get more evidence otherwise there might just be meetings and discussions. This is the art of being an advisor to judge which approach to use in which situation. Research evidence takes time—so this is the highest level of evidence you can provide but if it is not required you should not force it out but if you have it you should use it.'
When we plan to address changes in policy we design instruments which give me the liberty to enter into negotiations with the policy makers pre-prepared in whatever direction the discussion may be going.’

In praise of research from some sources and weary of research from another, a non-state sector player noted, ‘I think the non-state actors very much try like ICDDR,B to create evidence and come up with data. However this data is not always appropriate because especially research form NGOs does not give the real cost so the government gets presented with the evidence but not with the real cost to implement it. [Some other research organizations] gave evidence in the voucher scheme but there seemed to be a lot of plagiarism involved but it was a nine month study but you cannot give a woman a voucher and say halfway through the pregnancy that time is over but there was no documentation of unit cost of management so government does not have a clue of what it means to scale up. The non state actors do efficacy studies but the government does not get help or insight into what it means to scale up nationally—which is the most important thing for government because of the rigid budget process’

The culture of ‘mistrust’ among researchers and policy makers is cited by some respondents. ‘Policy makers lack aesthetic skill to utilize researchers and incorporate their work, the bureaucratic and technocratic nature of the system doesn’t give room for such incorporation. Policy makers come to dissemination seminars just to show their faces. Policymakers and researchers must be integrated at the inception levels of research and programme setting and policy formulation, a certain degree of leadership and ownership bestowed can offer a more successful result. Traditional hostility exists between researchers and policymakers; it hinders any cooperation that can be there. Being involved in the early stages giving them that part in the ownership and developing their skills to understand and properly utilize research evidence.’

There are suggestions on narrowing this gap. ‘If policy makers are trained on how to use research, made aware of the evidence that exists, and if the evidence can be presented in a short, acceptable format, that does not need much time to look through, then it’s already getting a step ahead.’
**From the Researcher #1: Anemia in Bangladesh: from evidence to policy**

An example of informing policy through evidence-based research has been set by the Mainstreaming Nutrition Initiative of the Nutrition Programme at ICDDR,B in 2008 after a review of the anaemia control programme of Bangladesh. The results received front page coverage in the leading newspaper *Prothom Alo*, after which the Ministry of Health and Family Welfare requested ICDDR,B to organize a seminar on the issue. Held in November 2008, the event was attended by the Health Advisor and members of academia, NGO and researchers, and a set of recommendations came out from the seminar and actions are now being taken at different levels. The results of the latest surveys (2004) reveal unacceptably high levels of anemia in the population. The prevalence of anemia among young infants is more than 90 percent, while 40 percent of women are anemic during pregnancy. Low rates of exclusive breastfeeding, inappropriate complementary feeding, and repeated infections that impair absorption of iron are responsible for the high anemia burden among young infants. The coverage of iron-folic acid (IFA) supplementation during pregnancy is still low at 50 percent. The results of the review and probable solutions were discussed with officials of the FGFP. They were also disseminated through seminars, first with officials of the various agencies of the Ministry of Health and Family Welfare and then with officials of the Directorate General for Family Planning (DGFP). This resulted in several policy decisions. For reducing anemia in young infants, the National Nutrition Programme is now piloting multiple micronutrient powder for home fortification of food in several sub-districts. The DGFP has decided to distribute MNP through its field staff and to distribute IFA tablets in polythene sachets or small containers for improving intake compliance.
Diarrhea remains a leading cause of morbidity and mortality in developing countries, killing nearly 2 million children every year. Research, much of which was originally conducted at ICDDR,B, has shown that zinc provides a very effective treatment for diarrhea among children under five years of age by reducing the severity and duration of diarrhea as well as the likelihood of future episodes of diarrhea and the need for hospitalization. In addition, early studies suggest zinc treatment may have a positive impact on childhood pneumonia, which is the leading cause of death among under-five children living in developing nations. Therefore, zinc treatment holds tremendous potential as a global public health intervention and can play a significant role in attaining the Millennium Development Goal #4 of a two-thirds reduction in under-five mortality by 2015. In 2003, ICDDR,B received a fund from the Bill and Melinda Gates Foundation for scaling up activities to allow children under five in Bangladesh to benefit from zinc treatment. The Scaling Up Zinc treatment for Young children with diarrhea in Bangladesh (SUZY) project has been, a partnership between the public-private and research sectors, is attempting to provide zinc treatment for diarrhea on a large scale, targeting the entire under-five-year-old population of Bangladesh. It has been estimated that zinc treatment could save the lives of 30,000 to 75,000 children per year in Bangladesh alone.

As a first step, the Ministry of Health and Family Welfare (MOHFW) in collaboration with the SUZY team developed two committees: (1) a National Advisory Committee, headed by the Health Secretary and (2) a Planning and Implementation Committee, headed by the Joint Secretary, Public Health and WHO. These two committees were formed to have an impact on policy making. The National Advisory Committee of MoHFW approved the policy on using zinc in addition to ORS for under-five children suffering from diarrhea on 13 September 2006 and revised the National Diarrhea Treatment Guideline to incorporate zinc treatment in it. The committee suggested involving Bangladesh Pediatric Association for their technical opinion and Directorate General of Health Services (DGHS) to augment the scaling up process. In total there were five policy changes with regard to the national scale up of zinc in Bangladesh to include the 20 mg dispersible zinc tablet formulation’s approval by the Bangladesh Drugs Administration (BDA), the approval for branding the product as “Baby Zinc,” obtaining an over-the-counter (OTC) sales waiver and permission to proceed with a mass media promotion of Baby Zinc, pending BDA approval of content. Each of these approvals was considered essential to a successful scale up campaign in Bangladesh.
LIMITATIONS

The interviewers were faced with many challenges throughout the process of data collection, which may serve as limitations to the research findings as they hampered the number of interviews conducted. An initial list of interviewees was created by relying on government websites and previous project experience. But the official government websites had not been updated to reflect that all the posts had been changed with the transition to a new government in January 2009. The shifting of key players with in the health sector under the new government continued through April 2009. A new list was developed with more accurate information but the unfamiliarity between the research team and the newly appointed government officials as well as current events in Bangladesh to include a cyclone lead to further delays. However, during the summer period of 2009, a significant number of retirements within the Ministry of Health and Family Welfare further hampered efforts to engage with policy makers.

Another key limitation was access to the government officials. Despite receiving the letter of support from the Director General for Health Services, it remained difficult to get appointments. Members of the research team would schedule appointments in advance. On the day of the appointment they were often told to confirm the time of the appointment throughout the day and other times the would-be respondent would have been “summoned to the Ministry” at the time of the appointment. All of this reflects the uncertainty in the schedule of the government officials.

Another factor that contributed to the challenge of collecting data was the relatively young age of the health policy fellows engaged in this project. In some instances, the policy fellows waited for hours while the officials stayed busy. In many cases, interviews were interrupted by people coming in and distracting the respondents. In two instances, a meeting time was fixed, but the respondents had left for another meeting, even though the junior research team member had arrived on time. These same challenges were not encountered by the more senior members of the research team.

DISCUSSION

Despite initial difficulties in the process of securing the interviews, when the health policy makers were engaged, they were very eager to address the issues and provided a large quantity of information. In general, the respondents showed strong awareness on the topics of communication of evidence and gaps. Most respondents were aware of some of the other key issues surrounding translation of research findings and evidence into policy making. In most cases, the respondent was able to identify a specific issue where research findings had been incorporated into programme development or policy. The national scale up of zinc was the most frequently mentioned example. Other examples were the demand side finance voucher scheme for maternal health, the new SafeMotherhood guidelines, the forthcoming Mental Health Policy, and in one instance, the waste management programme. In some cases the respondent could not identify an example of how evidence was used in policy making, which demonstrates the complexity of inputs contributing to decision making in the health sector in Bangladesh as
highlighted earlier in Figure 1. Other factors mention included pressure groups like professional organizations, habits and traditions, and political judgement were highlighted as playing a greater role than research evidence.

The two case studies provided by researchers illustrate that research can impact decision making and health programme development in Bangladesh. However, in the case of the SUZY Project, many of the public sector champions have either retired or moved to new positions after the installation of the new government in January 2009. To that end, it is unclear if the same sort of sponsorship would happen now or how other important knowledge items could be translated into policy and action.

It is worthy of note that in many of the interviews there was much confusion over the word ‘evidence.’ The words ‘research’ and ‘research findings’ were often substituted by the research team members during data collection.

As pointed out by respondents, the policy making environment in Bangladesh is a very closed one, with a bureaucratic chain of government and top-level officials making all the final decisions. Many analytical frameworks derived from European and North American settings assume in low income countries, policy processes and feedback mechanisms are based on the same principles as those of developed countries and rely on analysis and conclusions drawn from research. As illustrated by Figure 1, based on experience in the UK, such analytical frameworks can exaggerate the role research has traditionally played in developed countries. Furthermore, they are not always applicable to low income countries. As one senior respondent noted approaches “must be compatible with low income countries…suitable for Bangladesh.” Often, the political process discourages the inclusion of think tanks, civil societies and academic and research institutions. Numerous respondents noted the lack of lobbyists in Bangladesh but did point to the power of groups like the Bangladesh Medical Association in their capacity to influence items on the policy agenda. The power of equivalent groups has often been noted in developed countries, including the USA (Alford 1975). Indeed, such examples of state/interest group relationships have been used to inform the development of concepts such as ‘policy communities’ in which the long term relationships between the government officials and the representatives of leading interest groups are particularly powerful (Rhodes and Marsh 1992). Depending on the nature of the particular policies under consideration, such relationships might either provide a conduit through which research ideas could be brought to the attention of policy makers, or they could be a powerful barrier to the evidence from research (Hanney et al. 2003).

In Bangladesh there is a lack of lobbying traditions, interest groups such as consumers or patient organisations, and public debate about health care that could push for the use of research in policymaking. There are external forces such as donors, who are primarily responsible for agenda-setting and prioritization, and bureaucratic strongholds that do not allow outside research to penetrate in. Funding, and not often research, dictates national goals. Some countries conduct formal consultative and analytical processes to make the process of policy making more
decentralized (WHO AHPSR 2007). Although decentralized planning and decision making have long been under discussion in Bangladesh, no implementation has occurred in this area as of yet.

Among our findings, numerous reasons have been cited as to why research is not used in policy making. Lack of time for policy makers, the absence of presentable formats of research, a lack of orientation to research, and traditional ‘mistrust’ between policy makers and researchers are some of them. The reason why research and policymaking to a large extent lead separate lives has been explained by the different worldviews of researchers and policymakers (Brownson et al, 2006). Often research is only one source of information among many for policymakers, and consequently, the contribution of researcher may be neglected. Moreover, research results are not always clearly presented, making the information inaccessible. Our findings also reflect other obstacles as pointed out by Petticrew et al. such as the researchers' lack of knowledge of the policymaking process, stakeholders' lack of ownership of the research agenda, and inappropriate institutional framework linking stakeholders and researchers (Petticrew et al 2006). The findings seem to support the belief that policymaking is rarely a linear and rational process where problems are identified and followed by informed decisions that are later implemented and evaluated. Often there is a need for a "window of opportunity" for research to have an impact and the timing for that is unpredictable, yet crucial (Kingdon 1995).

According to the respondents, the best evidence would be presented in the form of short briefs, or summaries. Some respondents also stressed the importance of direct contact and dissemination meetings. Only one interview respondent mentioned scientific publications; whereas many others commented on locally available sources of information such as reports generated from the Management Information System or working papers generated by a local research institution (ICDDR,B). However, almost all of the respondents stressed the role of the media as having the highest level of impact in creating policy maker awareness of an issue. Our findings are similar to those from another low income country that concluded, ‘According to our final major finding, the communication between the Lao researchers and policymakers could be improved, if links between them were strengthened. Links, such as networks or media, trusted "dissemination agents" or "translators", between researchers and policymakers are central in communicating research results both at the national and international level’ (Jönsson et al 2007). Nevertheless, experience from developed countries suggests that the way the media cover a public health topic may be quite different from the way the scientific evidence is framed (Hargreaves et al. 2003). There are differing levels of media fairness, bias and freedom, which need to be understood in analyzing the agenda-setting role of the mass media (Brown and Walsh-Childers 2002).

Another issue that emerged both with the collection of data, when the list of respondents had to be changed because of changes made within the human resources of the government offices; and again as a barrier to using evidence to policy from the respondents themselves was the high amount of personnel turnover within the public sector. In an Annual Program Review of the HNPSP, it was mentioned: ‘even though human resource issues have been repeatedly mentioned in many policy documents as being the main weakness of the Government health system, the
review team were surprised by the absence of HR related policies and strategies in the HNPSP. This is not a satisfactory situation in our opinion: issues such as high staff turnover, lack of accountability of service providers and low staff performance, among many others, should receive greater attention in a sector programme like the HNPSP (APR 2006). With lack of continuity in the staff, it is difficult for policies to be formulated and implemented in the long run, and harder also for decision makers to learn how to use research findings.

RECOMMENDATIONS

To enhance the use of evidence in policy we recommend that researchers build on current approaches such as including policy makers and leading interest groups particularly the Bangladesh Medical Association in their dissemination seminars. A systematic way of presenting relevant evidence to policy makers must be developed, preferably in the form of 1-2 page research briefs or summaries. Personal contact should be established by arranging round-tables and discussions, so that policy makers also feel like they are contributing to the research issues, strengthening reciprocity.

We recommend that researchers include public and non-state sector decision makers as collaborators in primary research as possible or invite them or otherwise keep them informed of the launching of new research activities taking place in the policy makers’ area of expertise.

We recommend that the decision makers attempt to include subject matter expert researchers from reliable institutions in the committees that formulate strategies and policies.

Careful analysis should be undertaken of how far the media should be engaged as a ‘research push’ tool in which policy makers can be informed of new evidence and issues of critical interest and potential solutions to these problems. Possibly a collaborative program could be formed with the media, in which reporters and scientists work together for a topic of national importance; building awareness and creating the opportunity for the issue to become part of the political agenda.

Recommendations should be made to government about the importance of continuity in staff and the negative impact of staff turnover on the policy making process. A policy brief should be produced and circulated to MoHFW officials describing successful examples of evidence-to-policy programs in other low income countries to support action in the uptake of staff continuity as an issue.

Further, more structural developments should be considered to see how far evidence can be produced for, and absorbed by, policy making bodies. This could involve discussions around the development of a “call centre” or “research on demand” situation in which policy makers or decision makers would have the ability to request factual and globally available information about important health issues, particularly as these issues might appear in the media at flash
points. The development of such a model would have to emerge with the full support of the Ministry. It could also involve the development of specific units, or receptor bodies, that would receive and make use of research evidence. The requirements of different types of policy making also need to be considered, and it is possible that such structures should first be created in relation to clinical policies.

Finally, in terms of how best to conduct the type of analysis performed in this study, we recommend that senior researchers be engaged for first contact with policy makers. Although both of the policy fellows are well-educated, engaging and highly capable, their difficulties in gaining access to key decision makers must be noted. In the future, senior research team members must accompany junior team members during engagements.

References:


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