ISBN 984-551-025-6

PROCEEDINGS OF THE SUPPORT GROUP MEETING OF THE INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

Dhaka, November 22, 1993

Sasakawa International Training Centre
ICDDR,B

Special Publication # 33
May 1994

ICDDR,B

DONORS' SUPPORT GROUP MEETING
NOVEMBER 22, 1993
AGENDA

9:00 a.m. : Opening Address
1) Mr. Timothy Rothermel
Chairman, Donors' Support Group, ICDDR,B
and Director, DGIP, UNDP, New York

2) Mr. Syed Shamim Ahsan
Secretary, Ministry of Health & Family Welfare
Government of Bangladesh

3) Mr. Md. Lutfullahil Majid
Secretary, Economic Relations Division,
Ministry of Finance, Govt. of Bangladesh
and Member, Board of Trustees, ICDDR,B

4) Dr. Maureen Law
Chairman, Board of Trustees, ICDDR,B
and Director-General
Health Sciences Division, IDRC, Canada

10:00 a.m. : The Impact of ICDDR,B's Recent Research
1) Matlab Studies and EPI
- Dr. Andres de Francisco, Chief Physician
Matlab MCH-FP Project, ICDDR,B
2) *Vibrio cholerae* 0139:
The 8th Cholera Pandemic
- Dr. R.B. Sack, Associate Director, CHD & LSD/
Dr. D. Mahalanabis, Associate Director, CSD, ICDDR,B

11:00 a.m. : Coffee Break

11:30 a.m. : Major Achievements in 1993 and Prospects for 1994
1) Overview - Dr. Demissie Habte, Director, ICDDR,B
2) BRAC-ICDDR,B Study
- Dr. M.A. Strong, Associate Director, PSED, ICDDR,B
3) UHEP & Urban Studies
- Dr. Kanta Jamil, Research Scientist, UHEP, ICDDR,B

12:30 p.m. : Sandwich Lunch

1:30 p.m. : Financial Statement 1993 and Budget 1994
- Professor A.S. Muller
Chairman, Finance Committee, ICDDR,B
and Professor of Tropical Health
Academic Medical Centre
Department of Social Medicine
Amsterdam, The Netherlands

2:00 p.m. : Strategic Plan: "To the Year 2000"
- Dr. Demissie Habte, Director, ICDDR,B

2:15 p.m. : Discussion - Donor Representatives

3:30 p.m. : Closing Address - Chairman, Donor's Support Group

-----o-----

ATTENDEES OF THE DONORS' SUPPORT GROUP MEETING

NOVEMBER 22, 1993

Name & Designation	Organization/Country
Mr. David Kaveny General Manager	American Express Bank Dhaka
Mr. Mirza Ejaz Ahmed	American Express Bank Dhaka
Dr. Christopher Kenna First Secretary (DA)	Australian High Commission Dhaka
Dr. Erhard Völzke First Secretary, Aid	Embassy of the F.R. Germany
Dr. Mehtab Currey Health & Population Adviser	AMOD, British High Commission Dhaka
Mr. David L. Piet Deputy Director	Office of Health & Population USAID, Dhaka
Mr. William R. Goldman Director	USAID, Dhaka
Mr. S.K. Ali Noor Population Specialist	USAID/Dhaka
Mr.Roshanally M.H. Hirji Chairman	Aga Khan Foundation, Dhaka
Mr. Brian Proskurniak First Secretary (Dev)	Canadian High Commission Dhaka
H.E. Mr. Jon J. Scott High Commissioner	Canadian High Commission Dhaka
Mr. Nick Roberts Counsellor	EEC Mission, Dhaka
Mr. Sigvard Schwartzman First Secretary (Health)	Swedish Embassy, Dhaka
Mr. Raymond Offenheiser Representative	The Ford Foundation
Mr. G. Baruffi	The World Bank, Italy
H.E. Mr. Xavier Van Migem Ambassador	Belgian Embassy, Dhaka
Mr. Reidar Kvam Asstt. Resident Representative	NORAD, Dhaka
Mr. T. Uesawa First Secretary	Japanese Embassy, Dhaka
Dr. P.K. Streatfield Country Representative	The Population Council, Dhaka

Mr. S.A. Karim	SDC, Dhaka
Dr. Peter Arnold Counsellor and Head of Development Cooperation	SDC, Dhaka
Dr. Hans Troedsson Medical Officer, CDD	World Health Organization Dhaka
Dr. Sophie de Caen Assistant Resident Representative	UNDP, Dhaka
Dr. Barbro Carlsson Acting Head	Health & Nutrition SAREC, Sweden
Dr. M. Kerker	SDC Headquarter, Switzerland
Mr. Timothy Rothermel Director,	Division for Global & Interregional Projects, UNDP New York
Dr. Caryn Miller Acting Deputy Chief	Applied Research Division Office of Health USAID/Washington
Dr. Kevin Callahan	USAID/Washington
Mr. James Bausch	ICHF Trustee

OPENING ADDRESSES

Dr. Maureen Law the Chairman of the Board of Trustees welcomed the donors and in particular the Government of Bangladesh whose 1993 contribution had assisted the Centre in dealing with the large number of diarrhoea cases appearing during the epidemic. She also especially welcomed Mr. Tim Rothermel from UNDP, the Chairperson of the Donor Support Group and mentioned his remarkable effort in coming all the way from New York just for the meeting despite the stress and difficulty involved. She said how pleased everyone was that he was able to come. Dr. Law then introduced and welcomed Mr. Ahsan, Secretary of Health from Bangladesh, Mr. Majid, Secretary of Economic Relations Division in the Ministry of Finance for the Government of Bangladesh and also Dr. Demissie Habte, the Director of the Centre.

Mr. Tim Rothermel, Chairman, Donors' Support Group then addressed the meeting. He welcomed the Secretary, Ministry of Health & Family Planning, the Secretary of the Economic Relations Division of the Ministry of Finance, Dr. Law the Chairman of the ICDDR,B Board of Trustees, other members of the Board of Trustees, Dr. Habte and the staff of ICDDR,B and all those present. He said that since the Centre's internationalization in 1978 the United Nations Development Programme has had the privilege of convening the annual meeting of the Donors Support Group. For a number of years these meetings had taken place in Geneva or New York in association with the meetings of UNDP's Governing Council. More recently, he said, the practice of convening the meetings in Dhaka had been introduced and he expressed great pleasure to be attending the meeting in Dhaka. He gave particular thanks to the hosts, the Government of Bangladesh, for the support and encouragement it had consistently provided to the Donors' Support Group. Another characteristic of recent meetings of the Support Group, he said, was the annual succession of advances that the Centre consistently achieved in terms of its management, staffing, scientific output, facilities and strategic planning. He felt confident in expressing, in Dhaka, on behalf of the donor community how greatly these steps were appreciated. He added that there seemed to be an unparalleled sense of confidence in the Centre and its future; for this Dr. Habte, the staff of the Centre , and its dedicated Board of Trustees shared the credit. One example of the work of ICDDR,B was the rapid characterization of the recent cholera pandemic which had broken out late last year in India and Bangladesh. Because of the Centre's epidemiologists, microbiologists, and clinicians this new pathogen had been identified and steps had been taken for its control. Without this unique multi-disciplinary team of investigators at ICDDR,B the recognition of the new epidemic strain of cholera would have been considerably delayed. It was, he said, a clear example of the advantage of having this unique health research organization located in this part of the world. He then touched briefly on three subjects which he felt to be of concern to the Centre and the consortium: First, the Centre's sustainability; he had heard many donors ask the question - for how long could they continue funding ? Could the Centre be maintained by the host country government ? Would they have to go on financing the Centre forever ? What about sustainability ?

It seemed to Mr. Rothermel that the sustainability issues and their more traditional interpretation were not relevant performance indicators for an international health research organization. Short of investing hundreds of millions of dollars in endowment funds to finance such centres in perpetuity, it was difficult to see how sustainability could be achieved. The savings in terms of lives and money which the work of ICDDR,B had generated more than financed its modest budget. The

development of ORS saved a million lives a year and an estimated 500 million dollars in hospitalization and IV costs. The withdrawal of the injectable cholera vaccine had also saved millions of dollars each year as had the Centre's work on family planning. International health organizations had to be judged to be sustainable when their outputs were relevant to the needs of the international community.

Mr. Rothermel then said a few words on the resource development strategy. As part of the attempt to improve the financing of the Centre, he said, an ambitious resource development strategy had been developed. The Centre was working with Mr. Jim Bausch who had previously worked at the Population Council and subsequently Save the Children Federation, USA, to implement the United States component of this strategy and to coordinate and launch the endowment fund there. This effort, he said, was typical of the renewed creativity and dynamism in the management of ICDDR,B and he hoped that all donor agencies would lend their active and, ideally, financial support to these resource development activities and the endowment funds.

He then mentioned the celebration of 25 Years of ORS. A million lives were being saved each year by the miracle solution. But still three million were lost each year to diarrhoeal diseases. The challenge to extend the boundaries of our knowledge of these killer diseases was still very much with us and we had also to find more effective ways to use the technologies that already exist, to improve systems of the supply of and generate additional demand for these technologies. For this reason Mr. Rothermel felt it heartening to see in the Centre's new strategic plan to the year 2000 an increasing emphasis on health systems and social science to address precisely these supply and demand issues.

Finally, he spoke of finances. Everyone in the room, he said, was aware of the overall no real growth of overseas development assistance; the growing number of countries competing for resources; the rising costs of international crisis management, and other factors all of which had an impact on the budgets which were available to support institutions like ICDDR,B. This, he said, was certainly a very painful situation in the case of the UNDP. Nevertheless, there were certain international efforts which because of their relevance, their contribution to human kind through scientific research and their potential for even greater achievement in the future deserved to be effectively insulated from these resource constraints. The International Centre for Diarrhoeal Disease Research, Bangladesh was at the top of the list of such international efforts and we hoped that it would receive the enhanced resources needed for all this.

Mr. Rothermel then thanked the meeting and called upon the Secretary of the Ministry of Health & Family Welfare to speak.

The Secretary, Ministry of Health & Family Welfare, Mr. Syed Shamim Ahsan, then addressed the meeting. He first relayed the greetings and best wishes of the Minister of the Health and Family Welfare who was in Nepal attending a meeting with the SAARC Ministers. The Minister, he said, regretted his inability to attend this meeting and had requested him to deputize on his behalf. Mr. Ahsan was delighted to say that the cooperation and friendship between the Government of Bangladesh and the International Centre for Diarrhoeal Disease Research had been closer than ever before. As all present were aware, he said, 1993 had seen the emergence of a new strain of bacteria known as 0139. This new organism had been responsible for an unprecedented epidemic of acute watery diarrhoea. It was probable that by

the end of the year the Centre's hospitals in Dhaka and Matlab Thana would have treated nearly 140,000 patients. In 1993 alone ICDDR,B would have saved the lives of some 15,000 to 25,000 Bangladeshis. The Government, he said, were very grateful to ICDDR,B for that. From the start of the epidemic the Government of Bangladesh recognizing ICDDR,B's unique and invaluable role in the nation's health care system had given all possible assistance to the Centre's hospitals. They have supplied personnel; they had supplied medicines; they had supplied IV fluids and drips; and they had also supplied cash of nearly US$ 100,000. The Secretary also reported that the Government had put in some effort for an additional allocation for the Centre and he hoped that his colleague, Mr. Majid, might be in a position to make some announcement in this regard to the meeting. The Government, he said, were continuing to help the Centre establish community based diarrhoea treatment centres which would reduce the burden on the hospitals. He said that the Government had given their full and unequivocal support to the Centre's request to other donors for emergency funding and he offered his sincere thanks to all those who had responded so swiftly and so generously to the request. The Government would continue to explore all possible avenue to secure additional government and donor funding for the Centre.

It should not be forgotten that the treatment of diarrhoeal disease had not always met with the success that it did today. Until 25 years ago, the death rate from diarrhoeal diseases had been appallingly high. Then, the pioneering work of the Centre had resulted in the development of Oral Rehydration Solution. The British Medical Journal, Lancet had hailed the discovery as "potentially the most important medical advance in the century." Events had shown, he said, that this had been something of a British understatement! It was estimated that ORS saved the lives of about one million children of the world each and every year. Even in an advanced country like the United States universal adoption of the ORS technology could prevent 200,000 hospital admissions and save about 500 million dollars a year. In this 25th Anniversary Year of the Miracle of ORS, he said, more people than ever had good cause to be thankful to the Centre and, of course, to the donors.

The Government of Bangladesh, he said, once again confirmed its wholehearted support for the Centre and its work. Time was too short, he said, to mention all of the Centre's numerous activities but he had noted that the Board presentation in the hall outside the auditorium gave a full and impressive picture. He singled out one of the centre activities for special mention - family planning. The Centre's work in this field, he said, had contributed enormously to national and global understanding of the critical components of effective, high quality family planning programmes. The work done in the present decade would do much to determine the ultimate level of the world's population. He said there was a pressing need for the type of results oriented research conducted by the ICDDR,B to guide national family planning programmes throughout the world.

Before concluding, the Secretary mentioned his disappointment to see that despite the acknowledged productivity and excellent management of the Centre the total contribution for 1993 remained lower than they had been in 1988. This was, he felt, a poor way to reward progress and excellence. He hoped that in the same way as the Government of Bangladesh was doing, other donors would look at every possible way to increase their contribution to ICDDR,B. The Centre was a valuable

international resource. Everyone, he said, must continue to invest in its future for the good of the world and the health of the generations that come after. He then thanked the meeting and called upon the Secretary of the Economic Relations Division of the Ministry of Finance to speak.

The Secretary of the ERD, Mr. Lutfullahil Majid started by mentioning the recently concluded November 1993 meeting of the Board of Trustees of ICDDR,B. The Board, of which he was a member, had discussed a whole.range of subjects, but he would try and confine himself to the problems related to the donors' meeting. The Centre's budget, he said, and the financing arrangements to implement projected programmes and other operations had come for review and discussions in the.Trustees meeting and the gap between expected income and expenditure reflecting a budget deficit was a matter of serious concern. Obviously in order to fulfil the mandate and to sustain its position as a Centre of excellence and one of the most important international health research institutions, ICDDR,B must have the necessary resources at its disposal. The Board of Trustees, he said, had considered and approved a number of proposals to augment the Centre's resources. One, he said, was to curtail expenditure. The Centre's efforts to curtail expenditure and the success achieved so far deserved the donors' commendation. Describing these efforts during the Board meeting, the Secretary said that the Director had stated that the cost reduction measures had reduced the Centre to its bare bones. Mr. Majid said that while the Government appreciated the Centre's efforts in these directions and also while they desired that the Centre's activities were not jeopardized they still urged the Centre to continue these efforts. The other major initiative which the Director had reported to the Board, was the undertaking of a resource development strategy to review and secure funds from the private sources in the USA and other regions. This was an extremely important and timely step. The Centre should however, he said, note the recent changes and turmoil in the world political and economic situation. The expansion of contributions from the traditional sources of official development assistance might not be possible in the future, he warned. The decision to scout for alternative sources therefore, he felt, was a wise step. The Secretary thanked the Ford Foundation for funding the review and said that the Government was looking forward eagerly to seeing its results. They also expected that the Centre would submit a report on its success at the next Board Meeting.

Mr. Majid then took the opportunity to thank the different donors for continuing their assistance reflecting their continuous confidence in the work of the Centre. He thanked the US Government for their substantial contribution and continuous support to the Centre since its transition from the Cholera Research Laboratory which was established with the US assistance at the beginning. Thanks were also due, he said, to the Centre's other bilateral donors such as Australia, Belgium, Canada, Denmark, Japan, Norway, the Netherlands, Saudi Arabia, Switzerland, Sweden and the United Kingdom. Contributions from the Arab Gulf Fund, Rockefeller Foundation, Ford Foundation, IDRC, Swiss Red Cross, Bayer AG and the UN agencies were also gratefully acknowledged. The Secretary gave special thanks to the People's Republic of China for making their first contribution in recent years to the Centre. The Secretary did feel that there seemed to be some scope to increase the contribution of the multilateral agencies and he appealed that this be considered by the concerned agencies. He endorsed the views of the Health Secretary

regarding the low level of contribution from donors . He said there also seemed to be some problem in the timely flow of approved funds from one or two agencies or because of differences between one or two agencies and he requested that these be resolved by mutual consultation.

The Secretary then mentioned that during discussions at the present meeting, in earlier ones, and also in the initial introduction of the Chairman of the present meeting, reference had been made to the sustainability of the situation. It had also been asked whether the international community should go on financing ICDDR,B forever and whether the Government should not bear the cost. He said that, after all, ICDDR,B was an international institution. The question of the Government taking over the entire responsibility naturally did not arise. The history of the Centre and the transition from the Cholera Research Laboratory to an international research centre and the Government's active role in establishing the Centre was well known and did not need any elaboration at this stage, he said. The statute that had created the international Centre provided for full freedom in its operation without any hindrance or obstacle from the Government. This had enabled the Centre to attract renowned scientists and research specialists in its Board of Trustees. This had also enabled the Centre to recruit highly qualified international professional staff. The Government's initial policy decision had, thus, helped the Centre to grow into one of the most important health research institutions with a reputation of excellence throughout the world. The Government and the people of Bangladesh were proud, he said, to host the Centre and took great satisfaction in the knowledge that the Centre's research activities had not only helped the teeming millions in Bangladesh but had also provided valuable information to health workers across the globe. The Government's commitment to the Centre had been adequately articulated by the Secretary, Health in the meeting and also by the Minister for Health who had addressed the June Meeting of the Board of Trustees. In the Board meeting the Trustees comprising renowned scientists from across the world had evaluated the achievements of the Centre. One achievement that had not been mentioned in the long list, he said, was the reputation that the Centre has gained among the millions of poverty ridden people of Bangladesh. The Centre and its hospitals including field operations during emergency were looked at as the last resort by people suffering from diarrhoeal disease. A news item in a Bengali daily newspaper a few days ago, he said, had vividly described the services provided by the Matlab hospital not only to the patients of the area but also to the people from about ten other surrounding districts. The Centre's activities in connection with the new virulent strain of *Vibrio cholerae* bore further testimony to its contribution to a country plagued with serious health problems. In short, he said, the Centre had made a place for itself in the hearts of millions of poor Bangladeshis which should also be seen as a very important achievement of the Centre and perhaps as even more important than the Government's commitment or the Centre's own achievements in other fields.

The Secretary said he had the privilege of being a member of the Interim Committee which had adopted the Ordinance established in 1978. He also had the privilege of attending the First Donors' Meeting in Geneva at WHO Office in February 1979 where the Memorandum of Understanding was adopted and signed by the donors. He said he was extremely pleased at the renewal of its association with the Centre which had now grown into an internationally reputed institution. In his long career of public service he considered the establishment and growth of the Centre as the most fruitful and personally satisfying experience. He said that the location of the Centre in a country where diarrhoeal disease was most common and endemic, was well justified. However, substantial financial contribution by Bangladesh was not

possible since it was one of the poorest countries in the world. It therefore sought and received the support of the international community. Despite its poor economic situation, the Secretary said, Bangladesh has made a considerable contribution in kind as had been explained by the Health Secretary and had also made a modest financial contribution. In recent years, he said, the economy of Bangladesh had started to show signs of improvement following improved macroeconomic management and the adoption of a widespread economic reform programme and agenda. The Government, he said, had started to achieve some modest success in their macro-management. Immediately following the improvement in the country's domestic resource situation the Health Minister, while attending the June Board meeting, had committed an additional amount of US$ 89,000 raising the contribution of Bangladesh to US$ 115,000 in 1993 from the previous low level of US$ 26,000 (this is all in cash). The Secretary also understood, although the Health Secretary had not mentioned it, that some additional contribution had been made for the epidemic relief programme in addition to the contribution mentioned before. The Secretary then announced, with pleasure, that the Government of Bangladesh had further decided to contribute Tk. 7.5 million or US$ 189,000 for Bangladesh fiscal year 1993-94. Since the Bangladesh fiscal year covered the period of July 1 to June 30 and the processing of this contribution would take some time (the budget was decided only yesterday when the Secretary took leave for the meeting and went to meet the Finance Minister) this contribution would be available for the 1994 programme of the Centre. He hoped that the Support Group would appreciate the efforts that the Government was making to support the Centre in continuation of its very good work despite the country's poor economic situation.

Before concluding, the Secretary thanked Dr. Habte, the Director of the Centre, who, he said, had provided an excellent guidance in its operations and was a fully dedicated person. The Government was very grateful to have him as the Director of the Centre in Bangladesh. The Secretary also expressed his thanks to the members of the Board of Trustees, who, he reminded the meeting, had gathered from all around the world and who were renowned in their own fields throughout the world for providing necessary guidance to the Centre which had come to the help of the poor Bangladeshis. He also thanked Dr. Law, the current Chairperson of the Board of Trustees. He then thanked the meeting in general for patiently hearing what he called his "long speech". He hoped he had not stretched the patience of the meeting but hoped that the news that he had brought had been good enough to be given at the meeting.

Mr. Tim Rothermel then thanked the Secretary for his very encouraging news as well as for his personal efforts in bringing it about. He then called on Dr. Maureen Law, Chair of the Board of Trustees to address the meeting.

Dr. Maureen Law said that based on the good news from the Secretary of the ERD, the Board of Trustees would excuse his brief absence from the meeting yesterday.

She said that as the Secretary had outlined for the meeting some of the financial constraints and needs of the Centre which she would not go into again. She said that what she would like to do was briefly tell the meeting that the Board had been meeting for the previous three days. The Board of Trustees had been satisfied with the performance of the Centre because, she said, it was important for the donors not only to know about the financial needs but to know that their money was being well spent by ICDDR,B.

During the Board of Trustees meeting, she said, they had received reports on the current activities and the immediate plans of all of the divisions at the Centre and they had seen the Centre's very energetic research programme. The Board had felt that it was moving definitely in the right direction and they were very pleased with what they had heard. They had been impressed again with the confident leadership and management of the Centre under Dr. Habte's direction and that during the meeting the Board had particularly focussed on the work of the Community Health Division. Recently, there was a review of that division. There were regular reviews of the other divisions at the Centre at the time of the Board of Trustees meetings she said. She felt privileged on this occasion to have been part of the review team for the CHD along with a couple of the other members of the Board of Trustees and two outside experts, Dr. Bryant and Dr. Morrow. This, she said, had been an extraordinary experience for her. It had been an opportunity to look in much greater depth the work of one of the divisions and, without particularly singling it out, she wanted to say that the review team had been absolutely impressed with a number of aspects of the work of that division. First of all, she mentioned the clinical services and said that the team had felt that these were being delivered not only with great professional competence but with a kind of sensitivity and compassion that was very very impressive. The team, she said, had visited Matlab, the slums in Dhaka, a research project in Mirzapur and had been uniformly impressed with the ambitious research agenda and the meticulous type of field work being carried out in these projects. She reported that, overall, the review team had been very satisfied with the work of the division and she felt sure that had they been reviewing other divisions the team would have been similarly impressed, but that she specially wanted to mention it since that was the one under the spotlight at this particular Trustees meeting.

She then mentioned an important development on the international health scene. The World Bank had published their World Development Report which was an Annual Report usually dealing with items like privatization and structural adjustment and things like that. This year it has focussed on health, she said, and she felt that although it was a very dense report and could not be summarized easily she would like to mention the central message of that report. This, she felt, was that it was worth investing in health and that even in the poorest countries investment in health, if done properly, was cost effective. The report, she said, identified an innovative way for looking at the burden that various diseases put on population in all countries and particularly in developing countries and it also tried to measure the cost effectiveness of a range of possible interventions for the important diseases affecting people. They had put together what they called "cost effective packages" instead of cost effective interventions, in health for developing countries and they had tried to cost these. In looking at these cost effective interventions, she said, and in looking at the programme of the Centre in terms of services and in terms of the research agenda there was a very very good match. In fact, she believed, that all the things that the Centre was researching and all of the services it provided would be reflected in those cost-effective interventions. She said that, at ICDDR,B we were contributing to an important research agenda focussed on the right issues in terms of their effectiveness and their cost effectiveness. She added that the Centre had made a great contribution to moving forward the kinds of approaches that had been described by the World Bank. She finished by saying that it had been a pleasure to have had the opportunity of participating in the meeting with the donors because it was this kind of partnership of the Centre with the donors that really would lead to success at ICDDR,B. She then thanked the meeting.

Mr. Tim Rothermel then thanked Dr. Law for her summary of the recent Board of Trustees meeting and for reassuring the meeting of the scientific relevance of the work done here at ICDDR,B.

THE IMPACT OF ICDDR,B's RECENT RESEARCH

Ensuring Vitamin A supplementation in early infancy

- presented by Dr. Andres de Francisco

Vitamin A deficiency is an important public health problem affecting millions of children in developing countries. Worldwide, a long list of countries, including Bangladesh, have been reported as vitamin A deficient.

Interventions aiming to reduce vitamin A deficiency include short and medium term strategies, such as food fortification and vitamin A capsules distribution, and long term strategies such as dietary improvement.

Observations carried out in the late seventies associated vitamin A deficiency with mortality. Pre-school children who had clinical signs of vitamin A deficiency, such as night blindness, were at a higher risk of death than their malnourished but non-vitamin A deficient counterparts. This prompted investigators to carry out interventions of vitamin A supplementation to reduce mortality. These studies, carried out in several developing countries, were successful. Most of the trials reported reduction of mortality in vitamin A supplemented children, and a meta analysis of published studies reports an overall reduction of 23 percent of deaths in children of about 6 months of age associated with supplementation.

Similarly, a large intervention trial in northern Ghana showed that vitamin A did not affect the number of episodes of infectious diseases experienced by a child in a year. It, however, reduced the severity of diseases, thus leading to a reduction of the burden on health services and to a lower mortality.

Therefore, vitamin A supplementation became an important health intervention in developing countries. All studies have been conducted in children above the age of six months. There is, however, a rationale for supplementing before that age. Vitamin A given early in infancy may have the potential of reducing mortality in infants, the highest risk age group.

Supplementation strategies for infants were then proposed. The most powerful health delivery system for infants is the Expanded Programme of Immunisation (or EPI). The EPI strategy reaches a high proportion of infants, and this prompted UNICEF and the WHO to recommend supplementation of vitamin A through the EPI Programme. However, as clinical trials had not been performed, the international community requested the ICDDR,B to carry out the first trials of supplementation at early ages.

A study was performed through the Maternal and Child Health and Family Planning Programme in Matlab. Infants were given 50,000 IU of vitamin A together with DPT at each vaccination contact, and a similar number of children was given a placebo together with the vaccines. The dose of vitamin A used was based on recommendations given by the international scientific community. None of the

investigators knew which child had received vitamin A until the end of the study. All infants were thoroughly examined for up to 8 days after supplementation and continued to be followed up through the programme.

A total of 98 infants received 1 dose of vitamin A at 6.6 weeks of age, 98 received the second dose at 11.3 weeks and 96 received the third dose at 15.9 weeks of age, in agreement with EPI specifications of vaccination schedules.

VITAMIN A SUPPLEMENTATION THROUGH EPI

Matlab MCH-FP Programme

Infants Supplemented:

		Vitamin A	Placebo	Total
Fontanelle	Yes	12	1	13
Bulged	No	84	94	178
		96	95	191

$X^2 = 8, 14$ $p<0.005$

The above overhead shows the outcome of the trial. The only difference seen at the examination of infants was a higher incidence of bulging of the fontanelle (the physiological hole present between the frontal and parietal bones of the head of young infants) in supplemented infants as opposed to placebo recipients. Vitamin A toxicity is known to produce a range of signs and symptoms, ranging from an increased intracranial hypertension manifested in adults as headache and in infants as a bulging of the fontanelle. In its more severe manifestations of toxicity, vomiting, irritability and convulsions can be expected. None of these extreme signs were seen in this study. However, the study clearly shows an association of fontanelle bulging with vitamin A supplementation which was interpreted as an early sign of potential vitamin A toxicity. The study goes on further to suggest that vitamin A supplementation may have a cumulative effect in infants, as seen by the fact that some infants had more than one episode of bulging of the fontanelle, mainly when receiving the third dose.

In summary, vitamin A supplementation at a dose of 50,000 IU is associated with an increased risk of bulging a fontanelle. Such episodes are transient and no other toxic effects were detected in this study.

The policy implications of this key finding of vitamin A supplementation programmes is that vitamin A, at a dose of 50,000 IU, should not be given to young infants. Further studies are currently ongoing at the Centre to assess the safety of a lower dosage of vitamin A. One recent interesting finding of our studies is an infant mortality reduction with maternal supplementation of vitamin A after delivery in breast-fed infants. Such finding will be further explored.

This findings were presented to the international community, and have had policy implications among the International Agencies.

Vibrio cholerae 0139: The 8th Cholera Pandemic
- presented by Dr. Sack

Lessons from the first seven pandemics of cholera.

1. Serogroups of V. cholerae have been known only for the 5th, 6th, and 7th pandemics. It is quite likely that serogroups other than 01 were involved in the earlier pandemics.

   The appearance of 0139 Bengal, represents the first major shift in serogroup of the organism in at least 100 years.

2. The length of the pandemics, although not described bacteriologically for most of them, varied from 6-23 years. The longest one has been the 7th (1960-present)

3. The El Tor vibrio replaced the "Classical" vibrio in India in one year, but in Bangladesh, the two biotypes remained together for nearly 25 years (1963-1986), before the "Classical" strains disappeared (nearly).

This strain is more virulent, in an environmental sense, than El Tor, and is replacing it rapidly.

Perhaps for this reason, this strain will move quickly; in less than one year, it has already reached most or all of Bangladesh, India, and has invaded: Burma, Thailand, Malaysia, China, Nepal, Pakistan, and Afghanistan.

There is essentially no cross-protective immunity from V. cholerae 01 infections, so most persons exposed to 0139 are susceptible.

When El Tor replaced "Classical" strains, both shared the 01 antigen, so endemic populations were at least partially protected.

The 0139 strain will probably replace 01 strains; it has already done so in India and most of Bangladesh. The same is expected to occur as it moves around the world.

As far as we know at present, the same control measures that have been used for 01 organisms will be effective for 0139 organisms, i.e., sanitation and hygiene efforts.
The 01 vaccine will clearly not be effective, however, and efforts to develop and field test 0139 vaccines need to proceed rapidly.

At this point, it is impossible to predict how long it will take to reach Africa and South America, but it is unlikely to take 10-30 years as El Tor did.

V. cholerae 01 & 0139 in Dhaka Hospital
- presented by Dr. D. Mahalanabis

- based on work by
  A.S.G. Faruque & S. Samiul Huque
  M.A. Salam & colleagues
  M.J. Albert & colleagues

Year	Estimated number of cholera patients (%)
1983	9,250)13%)
1984	8,550 (11.6%)
1985	6,375 (11.1%)
1986	12,750 (19.8%)
1988	13,759 (16.9%)
1989	2,600 (4.4%)
1990	3,575 (6.0%)
1991	16,625 (18.1%)
1992	12,950 (14.9%)
Total	100,600 (14%)

- A large religious gathering was held between 16-18 January, 1993 at a 4 sq. km area along a river (Turag) about 20 km from Dhaka City.
- The gathering was attended by about 2 million pilgrims from 60 countries.

---

9 months of 1993

Number in surveillance	=	4,089
Number of V.C. 0139 isolated	=	842 (21%)
Number of V.C. 01 isolated	=	98 (2%)
Estimated number of V.C. 0139 cases seen in 9 months	=	21,050

January - April 1993

Total number of patients	=	44,770
Number in surveillance	=	1,854
Number positive for V.C. 0139	=	502 (27%)
Number positive for V.C. 01	=	63 (3.4%)
Other	=	1,289

*(More than 12,000 estimated patients)

	V.C. 0139* n=502	Non-cholera n=1,289
Age -	<5 yr 17%	58%
	>15 yr 71%	33%
Sex -	Male 58%	61%
	Female 42%	39%

*(For patients with V.C. 01 33% are under 5 yrs and 29% are 15 yrs or more).

	V.C. 0139 n=502	Non-cholera n=1,289
Median duration to admission (quartiles):	14 hrs (8-28 h)	37 hrs (15-96 h)
Median duration of hospital Stay (quartiles):	18 hrs (8-26 h)	9 hrs (3-22 h)

	V.C. 0139 n=502	Non-cholera n=1,289
ORT at home:		
Packet ORS	72%	74%
Salt/Sugar	7%	5%
None	13%	
Antimicrobials at home	45%	57%

	V.C. 0139 n=502	Non-cholera n=1,289
Median monthly family income	2,150	2,500
Number eating from same cooking pot (Quartiles)	5 (4-7)	5 (4-7)

	V.C. 0139 n=502	Non-cholera n=1,289
In-house drinking water (Tap/Tube-well)	7%	10%
Sanitary latrine	31%	41%
House type: Cement floor	39%	46%

V.C. 0139 in children

	<5 yr n=85	15+ yr n=357
Dehydration on admission:		
Severe	19%	59%
Moderate	45%	27%
Mild/none	36%	14%
Required initial I.V.	53%	83%
Duration before admission:		
<12 hours	27%	48%
12-24 hours	13%	27%
>24 hours	60%	25%

V. cholerae 0139 & ABO blood group

	Blood group O	A	B	AB
V.C. 0139 (n=41)	64%	12%	24%	0
Other diarrhoea (n=43)	37%	26%	28%	9%
Healthy controls (n=1214)	34%	23%	35%	8%

BRAC-ICDDR,B COLLABORATIVE PROJECT IN MATLAB

- presented by Dr. M. Strong

The ICDDR,B and BRAC are working together in Matlab to identify the mechanisms of social change in rural Bangladesh.

This morning we will review:
* the ICDDR,B - its background and resources
* BRAC - its social and economic development package
* this collaboration - its aims and objectives
* the status of this project, especially of the baseline survey and ongoing research, and finally
* our plans for the future.

Since 1961 the ICDDR,B (formerly the CRL) has been conducting health research in Dhaka. In 1963 a field station was established in Matlab, about 55 km from Dhaka.

We have divided our Matlab site into two areas, a Treatment and a Comparison area. In Matlab we now have:
- facilities for clinical/hospital based research
- vital registration by DSS
- an MCH-FP project testing health interventions and service delivery

These are the major resources which we contribute to this collaborative project.

Demographic Surveillance System: Data collected includes dates, so that annual rates can be calculated; information related to the event, such as prenatal care, which are of research and evaluation interest; and identification information, so that people and families can be studied over time.

MCH-FP Record Keeping Book: This book, kept by the Community Health Worker, is an ongoing record of the family planning and health status of families in the area. Data on illness, nutrition, and family planning can help evaluate the impact of any intervention, including BRAC's.

Bangladesh Rural Advancement Committee (BRAC): Established in 1972, BRAC is also an established, mature organization. In 1991, BRAC decided to expand outward from Comilla into new areas, including Matlab thana. At that time, Dr. Habte (Director of ICDDR,B) and Mr.Abed (Executive Director of BRAC) decided to work together in the Matlab area.

BRAC's Rural Development Programme includes:

* village Organizations, made up of 50 men or women who are landless or sell labour, have functional adult education and savings components;

* non-formal Primary Education, based on small schools of 30 children, primarily girls, who have dropped out or have never attended formal school;

* Credit for productive purposes; and

* Skill training, such as poultry, sericulture, administration, and project management.

This package is now being established and implemented in selected villages in Matlab. There are 48 BRAC villages in the ICDDR,B area, with 86 Village Organizations and about 3,000 members.

Thus in Matlab there are now:

* the DSS, identifying all people and vital events
* the MCH-FP project, with its excellent health care and record keeping system
* a flood control embankment, a pure economic intervention
* BRAC operating in the villages shown, and
* a major baseline survey of the area.

The research objectives of this collaborative undertaking have been formulated at 2 Expert Group meetings of international and national experts. It was decided that these objectives should:

* be modest and feasible
* quickly compliment baseline survey
* be completed in the next 2-3 years.

Researchers should look at
* mechanisms of change,
* impact on health, economic, and social indicators, and
* management of intervention programmes.

Research should fall within the context of 6 major themes:
* empowerment of women
* empowerment of poor
* adult (especially women's) health
* child health
* economic change and
* education.

Let's look more closely at these major research themes:

1. Empowerment of women
   - how is it associated with group formation
   - selectivity of women who join VOs

2. Empowerment of poor
   - what existing survival strategies do the poor have?
   - how does BRAC intervention affect these?
   - examine the BRAC "model"

3. Adult health
   - describe current situation from existing data
   - examine link between credit, income generation, and health, especially:
     * resource allocation for health
     * health seeking behaviour
     * mobility of women

4. Child health
- study impact of BRAC intervention on proximate determinants:
    * maternal factors such as birth interval
    * environmental contamination
    * nutrient deficiency
    * injury
    * personal illness control, both prevention and cure

5. Economic change
- follow first cohort of credit recipients in one village
- examine time use patterns
- study income and expenditure: is health a priority?

6. Education
- effects of BRAC schools on education and health
- mechanisms behind these changes
- long term impact of BRAC schools

Two workshops have identified research methodologies and trained researchers here, especially in qualitative methods. These were a "Training Workshop for Qualitative Research", held 26 June - 15 July by Bert Pelto and Karabi Battacharyya, which looked at:

* basic qualitative methodology
* exploration of BRAC inputs
* further develop research plans
* explore key concepts through field data.

The "BRAC-ICDDR,B Methods Workshop" was held 3-4 June at Harvard University by Lincoln Chen and others. This resulted in two concept papers:

* "Assessing Change in Women's Lives"
* "Unpacking the Black Box" of linkages between socio-economic determinants and health outcomes

Current activities include

* quantitative studies using existing data
* qualitative research in selected villages
* analysis of the baseline survey .

In conclusion, this BRAC-ICDDR,B Collaborative Project in Matlab has focused attention on the need to identify and develop an understanding of the mechanisms of social change through which any outcomes or impacts of the BRAC programme might be explained.

URBAN HEALTH EXTENSION PROJECT (UHEP)

Purpose:

* Provide services to the communities living in the slums of Dhaka, through the urban volunteer system.
* Conduct research to provide information on the family planning/health needs and constraints of the population in the slums.

Urban Volunteer Programme (1986-91)

Objectives:

Test the feasibility and impact of recruiting women volunteers from the slums to provide preventive health care and referral information to the slum residents.

Volunteer services:

* Diarrhoea (education, motivation, referral, ORS distribution).
* Immunization (education, motivation, referral).
* Nutrition (education, referral).
* Family Planning (education, motivation, referral).

Evaluation of the volunteer service delivery system

Conclusions:

a) Feasible to recruit and train largely illiterate and semi-literate women from the slums as health volunteers, and they stay with the programme.
b) Volunteers effectively improved mothers' knowledge and practices in the project's four intervention areas.
c) The impacts were most pronounced in areas where both volunteer and NGO services were available.
d) Volunteers serve as links between the community and services, but are inappropriate to be considered as 'independent' service providers.

UHEP (April 1992 - mid 1994)

Activities and accomplishments:

1. Document the lessons learned from the UVP/UHEP phases of the project.
2. Analysis of data to understand the FP/health needs of the population, and the availability and utilization of the FP/health services in the slums.

Sources:

The Urban Surveillance System
Special Studies
(using quantitative and qualitative methods)

Research areas:

- Family planning
- FP/health services
- Infant feeding practices
- Socio-economic conditions and environment
- Population mobility

Maternal/child health
Causes of death
Diarrhoea and treatment
Immunization
Maternal nutrition
Vitamin A supplementation
Maternal morbidity
Low birth weight and peri-natal outcome

3. Dissemination:
- Seminars/workshops/conferences at ICDDR,B, national and international levels.
- Working papers.

4. Technical assistance/collaboration.

5. Preparation for the next phase (1994-1997):

The Urban FP-MCH Operation Research Project Proposal:

Develop a FP-MCH service delivery mechanism for the urban population through operations and applied public health research in collaboration with the GoB and NGOs.

- Agreement between Concerned Women for Family Planning (CWFP) and UHEP.
- Establishing linkages with GoB, NGOs and other agencies.
- Workshop on the proposal development.

Future plans (1994...)

Urban FP-MCH Operations Research Project:

A. Improving the management of urban MCH-FP services.

B. Increasing the effectiveness and utilization of MCH and family planning services among the underserved.

C. Increasing the potential sustainability of urban MCH-FP programmes.

Elements:
* Focus on NGOs-the major service providers in the urban areas, and use multiple sources of existing health care.
* Develop coordination mechanisms, localized planning.
* Primarily work with CWFP in a limited geographical area, namely, Dhaka City Corporation's Zone 3 (CWFP and UHEP activities overlap); develop service system for the population on Zone 3 with particular focus on the urban poor.
* ICDDR,B will not operate the service delivery system, others will. ICDDR,B will provide planning, management, and evaluation of technical assistance to service providers as well as carry out evaluation, coordination, dissemination.
* Project will not test a completely designed system, but will develop it gradually.
* Develop a system with replicable elements and emphasis on policy impact.

STRATEGIC PLAN: TO THE YEAR 2000

Professor Habte introduced the draft strategic plan. He said that international health problems should be seen in the context of a situation where, despite the availability of health technologies to tackle many of them, large segments of the world's population failed to benefit from these technologies and that this was due to a lack of appreciation that health problems have social and behavioral determinants as well as biological. This was, he said, resulting in the design of inappropriate health interventions. Additionally, economic constraints prevailing in most of the developing world prevented provision of an adequate infrastructure of health services to the population. Where these existed, he said, there were gross inequities of access and the system was bedeviled by poor management and lack of sound policy. The Centre's staff, he said, had this hanging over their heads a little like the sword of damocles. On the other side of the balance, the Director said, one had to look at the Centre's comparative advantage and accumulated experience. The Director did not go into the detail but sufficed to say that the Centre considered itself as a centre of excellence in diarrhoeal diseases and considered itself to be probably the foremost Centre for research on cholera in the world. This, he said, was one comparative advantage enjoyed by the Centre. Secondly, he said, the Centre also considers itself as a centre of excellence in longitudinal demographic data collection and the use of these data for understanding health and disease. It had an infrastructure of both services as well as research facilities that had developed over the years specifically to address the health problems that were facing Bangladesh. The Director believed that one of the Centre's unique advantages was that it was placed in a country where these problems were very high in magnitude.

Professor Habte said that, thinking of the global health situation and looking at the comparative advantage of the Centre and its accumulated experience, the Centre had decided to limit its involvement to a critical cluster of health problems affecting the majority of the world. These, he said, could be grouped under child survival, women and reproductive health and application and policy.

In view of the Centre's particular strength the Centre's major attention in child survival would be devoted to continued development of health technologies that would lead to a marked reduction in morbidity and mortality from diarrhoeal diseases. Diarrhoeal diseases, he said, did not exist in isolation and there were a certain number of diseases which the Centre would be studying. The Centre's experience had been that severe diarrhoeal diseases were complicated by pneumonia in as high as 15-20% of the cases. This, he said, had allowed the Centre to delve into the problem, which, as he had said earlier on was, by some estimates, the leading cause of death: acute respiratory infection. However, the Centre was careful only to involve itself in the study of pneumonia in areas of its comparative advantage, which was community based studies.

Nutrition, he said, was an underlying factor in morbidity and mortality all over the world, especially for children and mothers. One would not require any justification to go into the study of nutrition but again taking the Centre's comparative advantages it would be concentrating in nutrition primarily in the nutritional management of children with sickness, and particularly with diarrhoea, and in the study of micro-nutrients of which the meeting had already heard.

The Director then spoke on the second major area, of the three areas in which the Centre was involved. This, he said, revolved around family planning and reproductive health. The Centre would continue to conduct operational research to strengthen the delivery of family planning services to communities and hoped that this would have some check on uncontrolled population growth. Almost all of the research activities in this area, he said, would be operational research or applied research. It would be done both in the rural and urban population. One could not be involved in family planning without reference to the fact that in a country like Bangladesh the maternal mortality rate was unacceptably high. The Centre, he said, would like to conduct operational research in collaboration with the Government health services to produce an infrastructure of emergency obstetric services that would lead to reduction of maternal mortality. The Centre would start that in Matlab and as the Extension Project experience had shown, if successful, it might be possible to transplant that finding elsewhere in the country. The Centre would consider the studying of some aspects of reproductive tract infections or sexually transmitted disease since they were a component of family planning programmes. The Centre, he said was acutely aware that we would not be able to solve all the health problems related to reproductive tract infections and STDs but nevertheless would again use its comparative advantage to look into some particular problems.

The third area, the Director said, the other part of the tripod, was the area of application and policy. It had been said over and over again that there were a lot of available health technologies. The problem was that there was a failure to apply them and that this in itself required a scientific set of disciplines to solve it. That, he said, was an area in which the Centre had particular expertise, the delivery of family planning services, and it hoped to evolve some competence in health systems research that could then be applied to issues like urban health care delivery as well as the rural health care delivery. The training, he said, was an integral activity of the Centre's overall mandate. The Centre would evolve a strategy in its training activities that would contribute significantly to building research capacity in the developing world through the development of health research manpower. Accordingly the training activities will be modelled along those lines. This would require building capacity within the Centre to be able to do that.

That basically constituted the Strategic Plan, the Director said. The important aspect that would, of course interest the donors was the finance. That had been responded to in part, and the Director did not think that he needed to go into it. However, the Centre foresaw over the next five years that it would continue to depend on the current mix of funds that it received; it was not likely that there was going to be a radical shift. There might be some additional funds derived from competitive grants but at least to the year 2000, the Centre would continue to depend on the same mix of funding that it had to date.

The Director mentioned that this was the sixth or fifth draft of the Strategic Plan. The purpose of presenting it today had been to solicit opinion from those present. The Director appreciated that many of the donor community had received the Strategic Plan only very recently, if at all but said that any feedback would be appreciated.

Mr. Tim Rothermel then thanked Professor Habte and said that the issue of strategic planning at ICDDR,B was now of particular concern to the donor support group and all were grateful to Professor Habte for the work that had gone into the plan. He called for questions or comments for Dr. Habte on what he has just

presented or in the process to be followed if this plan was further developed? It was decided that the Strategic Plan should be fully discussed by the meeting at this point.

Mr. Bill Goldman of USAID confirmed that he had received a copy of the Strategic Plan and had reviewed it hurriedly. His comments, he said, would be based on the fact that he had read it.

USAID, he said, were very impressed by the focus on applied research, applied health systems research, and also the priority given to application, utilization and policy. In fact, he said, there had been a comment made that morning about commending the Centre for following the World Bank Development Report on Health. Mr. Goldman, however, wished to commend the World Bank and the World Development Report for coming up with approaches on cost effectiveness that had been tested and were ongoing at ICDDR,B for some time. The USAID interpretation of the table in the strategic plan, he said, was one that did have concentration on diarrhoeal diseases and family planning and they saw that as being quite appropriate and taking advantage of the history, experience and resources of the Centre. However, USAID felt that upon reading the document it appeared a little more nebulous in terms of indicating where the emphasis would be in the future and it looked as if the proposal was extremely ambitious including a number of possible problem areas and perhaps it might be necessary for the Centre to think about how to come up with more specific priorities which would reflect the statements that Dr. Habte had just made about priorities.

USAID also had some questions with regard to the comprehensiveness of the strategic plan and felt that on the financial side there needed to be some more thought given. Also, on the human resource side - where would the resources come from and where would they go specifically to support the priorities? What effect would this have on the structure of the organization?

Finally Mr. Goldman referred to the process of putting the plan together. The document, he said, had some elements of a strategic plan, it also seemed to have some elements of a public relations document which pointed out a lot of the past efforts. Very correctly, he felt, the achievements of the organization deserved substantial attention and these were recognized by USAID. It did, however, seem to USAID that the plan was a combination of those kinds of documents. Dr. Habte had mentioned, he said, that the Centre had gone through six iterations of the document. Mr. Goldman felt sure that the Centre didn't want to hear a recommendation to the effect: "what about another one?". However, the question which did arise, was, could the Centre perhaps have a facilitated session by some professional group that has had experience in facilitating these kinds of activities to discuss the document. Perhaps this would enable all the ideas to be put together from each of the six iterations. USAID would be interested, he said, to hear what the Centre thought about having a meeting of this kind.

Professor Demissie Habte thanked Mr. Goldman and asked that he give a copy of what had been said. He said the Centre certainly would be interested in the did, indeed, such an initiative had been discussed at the Board of Trustees meeting. There would, he said, certainly be at least one, if not more, versions of the plan before it became final.

Dr. Chris Kenna of the Australian High Commission introduced his comments as being made on the basis of not having read the strategic plan. He asked the meeting to bear with him.

He felt it was very impressive that the Centre had embarked on this exercise. Having seen the range of activities that were underway within ICDDR,B at the moment and having noticed the spread of activities with 37% of protocols devoted to diarrhoeal research and the rest from other areas, he wondered if it was that sort of mix that ICDDR,B saw for itself in the future or was there some sort of idea of reducing further the diarrhoeal effort. He was interested to know whether the Centre was happy with the mix and where it was going? Related to that question, he said, in a competitive research funding environment, how did the Centre see itself being able to really demonstrate that it had got the comparative advantage in one area or another ? Dr. Kenna finished by saying it was obviously a very important exercise that the Centre was engaged in.

Professor Demissie Habte replied saying he thought there are a few areas where the Centre knew it needed to continue to be a centre of excellence and these were diarrhoeal diseases, family planning, operations research and longitudinal data collection. He then invited Dr. Maureen Law to say a few words.

Dr. Maureen Law, Chairperson, Board of Trustees, commented that the question of the scope of the research agenda of the Centre was one that had concerned the Trustees quite a bit. They recognized that extending beyond diarrhoeal diseases into the areas that the Centre was now involved in was useful.

She said she had been slightly worried by some comments in the morning session because they seemed to her to have been maybe suggesting that the Centre should be moving even beyond the current range of activities into new things and she thought that the Centre should take care to see that it made sure it remained a centre of excellence in the areas that the Director had mentioned and only move into other areas very cautiously to compliment that agenda where clearly there were strong inter-relationships with the key areas of activity of the Centre but not into activities that went beyond that. So, she said the question of focus was an important one for the Trustees, and she felt that in general, the Trustees felt that the current activity mix at the Centre was about right.

Mr. Tim Rothermel then invited further questions.

Dr. Kerker, from SDC in Berne, said he would like to make a short statement which, he said, would be followed by some questions. Firstly he expressed his admiration for the staff of ICDDR,B and for the clinical and scientific work done in the last year. After his first visit at the Centre and the days he spent at Matlab, he was really impressed with the wide range of activities and was convinced at the same time that SDC was not only investing in a good programme but that it was really an honour to be one of the supporting agencies of ICDDR,B.

Equally, he mentioned the Director, Demissie Habte, for his effort in presenting an elaborate strategic plan to the year 2000 to which his predecessor, Dr. Immita Cornaz, at the 1991 donors' support group meeting had referred to as a crucial instrument for a sound and reasonable orientation of the Centre. After his first reading of the document Dr. Kerker made the following preliminary comments.

SDC, he said, fully supported the idea of a holistic approach for health development as expressed on page 2 of the document that effective health care is dependent on three crucial components: physical and socio-cultural environment, technology as well as policy and implementation management. SDC, he said, had always tried to balance the Centre's activities more towards the field of social, cultural and behavioural aspects of health and towards more control of how to implement existing technological knowledge.

If one spoke now, he said, of a logical extension of earlier work towards the year 2000, Dr. Kerker was still convinced that this extension should go in the direction of the two components mentioned above and less in the direction of new diseases and health problems. There were, for instance, some critical voices at the Centre who doubted the epidemiological impact of the diarrhoeal disease technology developed here, despite increased clinical successes, so long as there was no sustained change in certain behaviours of the population. In SDC's view, only more knowledge on how to change attitudes and how to implement this knowledge can bring a real breakthrough. This knowledge, he said could be very well acquired dealing with the diseases actually focussed on at the Centre. He felt it was very well possible that this knowledge was valuable for other diseases or problems that were transferable to other areas.

However, SDC feared that an amplification of activities towards other diseases might compromise this benefit. He noted that behavioural study protocols made up only 6% of the Centre's total at the moment. It was not clear from the document, to what dimension the Centre would extend this part; would it stay 6%, or would it perhaps go up to 30%, or what would happen?

An issue, he said, which deserved special attention of course was HIV/AIDS. As everyone knew, the problem or cause of this disease again lay in the behaviour of people and the only possibility of influencing the spread of it was behavioral change. The first step towards this goal, he said, was the commitment of politicians and health policy makers to action; for instance, in the form of information campaigns, etc. It was Dr. Kerker's view that ICDDR,B as the country's leading epidemiological surveillance agency, should accept responsibility for focusing the awareness of AIDS and to sensitize the politicians and health professionals to go for action. The expected low prevalence for HIV in Bangladesh was not only a chance but an obligation for action now. Already existing knowledge at ICDDR,B about beliefs and behaviors in the field of fertility and sexuality, detailed instance by the books of Aziz and Maloney in 1981 and 1985, could again be very valuable as a basis for this work. The extension of the scope, he said, was in a certain sense relative too because ICDDR,B was already in the field to a certain extent.

Finally, Dr. Kerker mentioned ENHR, the concept of Essential National Health Research. He said that it tried to promote the establishment of a national research agenda through a process of consensus between researchers, policy makers and community representatives. It was established in an increasing number of countries and accepted as a major tool to achieve health development by the public health community. He said that ICDDR,B was already committed to the concept, but SDC would wish to see an adjustment of the Centre's research agenda towards the national research plan, if one existed. As an international research centre, ICDDR,B had not only to play a role in the national ENHR efforts, but equally in the context of the international development of this movement. The Centre could fulfill this role, he felt, through a function of dissemination and training of researchers as this aspect

was very important in SDC's view. For this reason, SDC was very much in favour of the strengthening of this area through improvement of the training skills of certain Centre staff and through modernization of the communication technology.

Dr. Kerker noted two points which he felt were not covered by the document, for instance: what would be the human resource effect of the new strategy? Little was known about that and one did not want to, once again, see over-manning of the Centre as he understood had once been the case. Dr. Kerker said he would really appreciate an assessment of the various focusses to see how the diarrhoeal disease at 37% of the Centre's research would develop, how the nutrition part will develop and finally how the social science part would develop.

Mr. Tim Rothermel thanked Dr. Kerker for a very comprehensive donor statement. He then invited Dr. Habte to comment.

Dr. Habte said he also was very grateful for Dr. Kerker's comments and said he had very little to add to it. In the HIV, he felt the Centre was probably concentrating on the advocacy and not the utilization area and that was the direction it would continue to go, but the Centre was a bit shy, he said, and would want to go very carefully.

He added that the further development and strengthening of the Centre's social sciences and social and behavioural science expertise was an undertaking which would start in full swing from January 1994. In the past the Centre had expertise but it had been limited and that had been reflected in the research output. The Director concurred with Dr. Kerker and knew nobody at the Centre would disagree with the fact that this aspect of health had been neglected for far too long.

Ms Gigliole Baruffi of the World Bank said she wished to endorse the views of the previous speakers in congratulating the Centre for the work, the excellent work, that it had been doing for several years and this year as well. She said that she really enjoyed coming to the Centre and participating in discussions, workshops or meetings.

She felt the Centre should be careful not to dilute its interventions and activities in the future by spreading itself too thinly. Ms Baruffi said that she wished to stress nutrition component of the Centre's work. With regard to the Centre's study of nutrition in relation to diarrhoea she felt the Centre could go further and suggested the Centre study the total calorific aspect of nutrition, as well as the micro-nutrient aspect, particularly in respect of the nutrition of children and the factors in the family and society that contribute to malnutrition. Ms Baruffi felt that such research would be of great benefit to other countries as well as in Bangladesh. She congratulated the Centre and called its work "fantastic."

Dr. Kvam of NORAD said he wished to express NORAD's congratulations to the Centre and its staff, and the Board of Trustees, for the excellent work that had been carried out. NORAD, he said, had been impressed with the rapid and professional way in which the Centre had dealt with the outbreak of the cholera epidemic. In the context of emphasis and focus, he was also very happy to see that there seemed to be an increasing attention paid to areas of social and economic concern in the work done by the Centre. The collaboration between the ICDDR,B and BRAC in Matlab was a good example of this, he felt. He said he would hope that this work could go further so that knowledge related to socio-economic issues could have an impact on the institution as a whole and its way of doing research and combatting

disease. For instance, he said, he did think that the very impressive data base system for the demographic surveillance system might be improved even further by systematically incorporating data of a more qualitative kind.

Turning to gender issues, which, he said, were of particular concern to NORAD, he had noted that morning that the reasons given for the preponderance of male patients at hospitals, also included socio-economic and cultural factors. Dr. Kvam hoped that these issues were addressed adequately to improve the quality of care for women as well as for men. He suggested that a more focussed approach, perhaps on gender, using the social science resources available at the Centre, might have a direct and positive result on the more clinical work that the Centre was doing. This emphasis on gender, he said, was, of course, related to the population and women's reproductive health programme, where NORAD felt that a strong focus on needs and demands should complement and improve the delivery of systems, services, and supplies.

Dr. Kvam said he fully appreciated the caution expressed by the Chairman of the Board of Trustees about the need for focus, and understood that ICDDR,B needed to avoid stretching their resources too thin, but given that the Centre was committed to a multi-disciplinary approach, he hoped that sufficient resources and emphasis were allocated to these broader aspect and to this more holistic understanding of how economic, social and cultural issues affect health.

Dr. Maureen Law felt that the project needed a bit of refinement to mention the point that a lot of studies in fact involved socio-economical behavioral factors would be categorized as being in the diarrhoeal disease group or in the nutrition area. She said that it was a little bit unclear from the pie chart that there was probably more going on at the behavioural side than might be realized and if one thought that all of the behavioral studies were just in one group. There would, she said, be more studies where it was a bit difficult to say whether it was strictly related to nutrition or diarrhoea or something else because they have had some more general application among several of the categories. This final note, she said, was a result of having looked in some detail at the work plans for the Community Health Division during the review that week. She said that in fact at least in that division, there were quite a lot of studies that involved the behavioral side and she felt the donors would be quite pleased to look at or plan from that perspective.

Dr. Reidar Kvam of NORAD thanked Dr. Law for this information and said that he was glad to hear this. He said that NORAD felt that even more important than the quantity of social science studies was how well it was integrated into the overall work of the Centre. How much this contributed to holistic understanding of how things fitted together. However, he was very glad to hear that there were a number of initiatives being taken on this.

Dr. Kim Streatfield of The Population Council, said he would like to make a comment about the pie chart that Dr. Habte presented that morning which had indicated the proportion of research protocols which fell under different headings: diarrhoeal diseases 37%, social and behavioural studies to about 6% maybe. It had seemed to Dr. Streatfield at the time that it was something of an artificial distinction and he hoped that many of the social and behavioural studies would actually be part of the study of diarrhoea, particularly in a Centre like this and they could fall equally under other child survival headings and reproductive health headings. This, he said, led him to consider two points. One was whether the number of research protocols

was a useful indicator of how to look at the balance of effort within the Centre. But Dr. Streatfield wondered whether there could be other indicators that could be presented that could give a clearer picture of how much effort was going into different areas of research and other activities. He suggested that one such indicator could be the number of dollars allocated to these research protocols, or it could be the number of person months of effort by the research investigators and so on. He felt there must be many other indicators, as well, which would give a better feeling for where the effort was actually going.

Returning to his first point again on social and behavioural science being linked to other activities such as the clinical aspects of diarrhoea and the current cholera epidemic, Dr. Streatfield said that it was not clear to him whether any of the research protocols under social and behavioural science at that time were linked to the cholera epidemic. It seemed to him that if one could view the cholera epidemic positively as an outstanding opportunity for the social scientist to be actually exploring both the health education requirements. We were dealing, he said, with the 140,000 patients who were going to pass through ICDDR,B's hospital during 1993. How much did the Centre know about what people understood to be the causes of this diarrhoea, this particular cholera epidemic? Did they see it as being different to the 01 epidemic? Did they see the transmission patterns as being different, or the behavioral patterns or the preventive behaviors and so on, that they had in their minds when they left the hospital? Were they any different to what was in their mind before they arrived on the doorstep and so on.

Dr. Streatfield imagined there must be amongst the Centre's behavioral sciences staff somebody who had a research protocol on this at the present time, but it seemed to Dr. Streatfield to typify the way in which social science should be getting itself integrated with the clinical aspects of what the Centre did so well.

Dr. Habte agreed with this. He felt that the pie chart was a bit misleading because sometimes it was not possible to categorize. It was, he said, a civil attempt to save the Board of Trustees from his reading the full report and an attempt to provide an overview for the donors' representatives. But as Dr. Streatfield suggested the Centre would try to develop a slightly more sensitive system.

Dr. Caryn Miller of USAID/Washington added a short comment. People had put forth, she felt, some very good suggestions as to how some of the research should be designed in a more multi-disciplinary fashion and how one might consider becoming more involved at some level in HIV/AIDS but all of this really represented, she said, expansion rather than focus. She felt the meeting needed to come back to that, and in that regard, what nobody had said was that there might be some things that should be discontinued. She felt that this was one thing that the Centre needed to think through much more carefully. They did have a certain comparative advantage but that comparative advantage should be used to look forward and to look into some new approaches while at the same time re-examining some of the previous areas in which work was done to see if those could be more profitably discontinued at this point in time. One example, she suggested, might be the different variations on ORS. Maybe a higher priority was to have multi-disciplinary research and to have more resources going to that as opposed to further resource of new formulations of ORS.

Mr. Graham Wright of ICDDR,B, said that he knew that donors had received the Strategic Plan late and therefore, perhaps, had not had enough time to give it careful consideration. From Centre's management point of view, he said, it was extremely important for the donors to look at it and consider it carefully and give the Centre their comments in writing. He said the Centre valued them extremely highly and would like to include their comments in the next iteration.

After ascertaining that there were no more questions or comments **Mr. Rothermel** said that having been involved in this donor meetings since before most people around this table were born it had been one of the most enlightening and informed discussions that he could recall. He sincerely thanked everyone for the very valuable discussions. For Dr. Habte and for the members of the Board he added that UNDP had read the Strategic Plan draft at 4.00 am that morning and had passed on some comments to Dr. Habte but, on behalf of UNDP he would join the others in congratulating the Centre and its work and all the others that have been associated with the effort. Mr. Rothermel then invited general discussions asking that the focus be on financial issues.

In that context he recorded the meeting's appreciation to the Government of Bangladesh which had earlier today has announced its very generously increased contributions.

DISCUSSION

The general discussion was opened by **Dr. Chris Kenna of the Australian High Commission**. He spoke of his great pleasure being back again at another donor's meeting and his great pleasure to hear all the excellent presentations that morning which had given a sense of energy and the vitality of the organization. It was always nice, he said, to hear words of praise for the Director and the staff of the Centre and he added to that a record of his enjoyment at hearing Professor Jack Caldwell sing the praises of the Demographic Surveillance System. Australia, he said, was very impressed by the range and quality of ICDDR,B's activities. He was impressed in particular with ICDDR,B's evaluation methodology and practices and appreciated the way his office was kept fully informed about the Centre's activities. Australia also welcomed the efforts that ICDDR,B took to disseminate the research findings that it undertook. In a competitive funding environment, he said, Australia would encourage ICDDR,B to continue this very good work. Australia, he said, trying to provide support to ICDDR,B under a range of headings. Obviously one was through the core funds but Australia had found that there were some other opportunities to provide some assistance. For example, in response to the cholera epidemic, they were able to provide some additional local funding mainly for treatment related costs. They also provided the opportunity for ICDDR,B staff to undertake tertiary training in Australia and he stressed that these were competitive awards. It really was a credit to the staff at ICDDR,B who competed and won these awards. There was also a good prospect that Australia would be able to direct some additional funds to support ICDDR,B's family planning interventions. This was not yet finally approved but there were some very good signs. Dr. Kenna felt that the Director and staff deserved a lot of credit for the way things have been moving in the last few years. He said it was quite clear that anyone who had attended the very enjoyable dance/barbecue the previous week-end would have got a sense of an organization that was happy and productive. Having heard the range of activities that are on the way at the Centre. Dr. Kenna, speaking purely as an observer wondered whether the name of the Centre should be amended to the International Centre for Diarrhoeal and Applied Social Science Research. He felt that it was a question of how the Centre wanted to see itself internationally. Obviously, he said, the Centre had got excellent comparative advantage in the areas it was already involved in. Dr. Kenna then gave his congratulations to everyone and thanked the Centre for a very informative day.

His Excellency Mr. Jon J Scott, the Canadian High Commissioner began by saying that it had been his experience that Canadians acquainted with the work of the ICDDR,B generally did find its work admirable. Its research record continued to advance and provide new insights into problems which had global implications and new challenges to the science of disease detection, identification, treatment and prevention had emerged. The interest of Canadians in this, he thought, was best illustrated by the Chair of the Board of Trustees, distinguished physician and public servant Dr. Maureen Law as well as the Chair of the Programme Committee Dr. D. Hamilton of McGill University. He said, McGill University still maintained its reputation as a premier Canadian University, in many regards, much to the chagrin of Dr. Law and himself who studied elsewhere. Canada also notes the Centre's interest in fostering further Canadian connections. Dr. Habte's recent visit to Ottawa took place only a few weeks ago. The Canadian International Development Agency continued to place increasing importance on the governance of international NGO's which it supported and in this respect Canada joins other donors in supporting the

management direction of the ICDDR,B as among other things confirmed in the World Bank Report on Health. The Centre's international Board of Trustees continued to provide direction to the Centre and was well attuned to donor concerns and interest which were discussed semi-annually with appropriate recommendations adopted. The outbreak of 0139 had accorded the Centre with the opportunity to mobilize its highly skilled resources not only to the benefit of the people of Bangladesh but for its surrounding countries as well, and clearly the Centre continued to display international relevance in its research and findings. Canada noted with satisfaction the Centre's willingness to move quickly to assist other regions of the world to provide training to foreign health care workers. On the High Commissioner's first visit to the Centre, he said, he had noticed a large group of African Trainees in Microbiology.

He mentioned that Canada had recently undergone a national election which had resulted in change of Government. Not only that, he said, but it resulted in the complete and utter changes to the composition of the Parliament and new concerns centred on relations between the different regions of Canada, and economic growth and unemployment. The Liberal government came to power on a platform which included a pledge to maintain the present level of overseas development assistance despite economic difficulties. At the same time it promised a major review of foreign policy including foreign assistance. There were no details available on this but over the next year some major studies would be undertaken with significant policy implications. It was really too early to say what this held out for Bangladesh or for the ICDDR,B although CIDA's present package of core funding for the Centre would end in 1994. Canada was presently considering a new multi-year support package which they would share with the Centre as soon as it was available. In previous years, Canadian support was around 8% of ICDDR,B's total income. Canada was particularly pleased that the Government of Bangladesh had announced its increased funding to the Centre and hoped this trend towards increased funding would be maintained. The ICDDR,B continues to accord Bangladesh an international reputation for excellence in research and field interventions and provided direct benefits to the people of Bangladesh through its hospital and outreach services. He noted the Centre's efforts to diversify its funding base, including the move towards establishing endowment funds for both the hospital and the Centre's operations. It was Canada's wish that donors would consider continued funding for the Centre particularly in its area of its core activities and he wished to reiterate Canada's commitment to continue Canadian support in the future. He closed by adding that there was an element of sentiment in some of the Centre's work. It had been mentioned very briefly that morning and again in the afternoon. He felt it was important not to overlook the fact that many individuals in particular support the work of the ICDDR,B because of its direct relevance in giving meaning to the lives of so many people. It was really hearts and science put together in a way to which he knew the Bangladeshis responded most favourably.

Professor Chen Chunming, who served on the Board of Trustees of the Centre then spoke on behalf of **The People's Republic of China**. She felt that at that moment she was not in a position to speak on behalf of her country but said that the donation from China had been small because China was still a developing country. It had been an expression of the appreciation of China to the Centre. She hoped that China would continue to donate even if it was a very small amount.

Mr. Nick Roberts of the European Community (EC) began by saying that he believed that it was the first time the European Community had been represented at such a donor meeting of ICDDR,B and he hoped that it would be the beginning of a longer term relationship. This, he said, remained to be seen. The EC had a number of member states represented at the meeting, he said, and the EC were aware that they had been supporting ICDDR,B for a number of years. He was also aware of ICDDR,B's important links with European research institutions. Mr. Roberts thought these were important reasons for the EC to consider supporting the work of ICDDR,B. In addition, he said, the EC recently developed a new cooperation strategy with the Government of Bangladesh with a important emphasis on health and population which was a new emphasis for the European Community. This was also reflected in a world wide change of policy from the European Community. There had been some initial discussions with the Centre and was not yet clear how these would proceed. They had raised the issue with the Government in recent working group sessions on the strategy at the beginning of the month and have had very positive indications from the Government that they would welcome support for the Centre. This strengthened the Centre's position considerably. Over the next few months Mr. Roberts hoped to develop these discussions into a more serious commitment and the EC really looked forward to a regular association with the Centre.

Mr. Raymond Offenheiser, Representative of the Ford Foundation said that shortly after arriving in Bangladesh two years ago he had been introduced to rather extensive files on the Centre. It had taken him, he said, some time to go through them but after he had been able to do so he felt that one of the most interesting documents he found in there was a report he believed, by Dr. Senaratne about the prospects for establishing a social science capability in ICDDR,B. He could not remember exactly when that had been done but perhaps in 1984 or thereabouts. That particular study was encouraged by Mr. Offenheiser's predecessors at the Ford Foundation and this had been an area that the Ford Foundation particularly had taken an interest in from a period probably even predating that 1984 study. Thus, the Ford Foundation, he said, was very, very pleased at this point in time to know that this social science initiative was being launched in the coming year. It was an area that Mr. Offenheiser thought Ford would continue to be active in supporting core costs as well as specific initiatives as time goes on. Ford were also excited as well about the complementary activities that were going on in the BRAC-Matlab project and that was also an area where Ford would continue to be involved and interested as time went by. As was probably the case of many other agencies around the table, Ford had also been concerned about the HIV-AIDS pandemic and particularly about the emergence of an HIV-AIDS problem in Bangladesh. They were, therefore, quite pleased at the decision of the Board to take on the issue, albeit in a limited and strategic way and they thought that one could already see a response on part of the Government of Bangladesh that might not have occurred without a series of important actions by some of the donor agencies here as well as ICDDR,B. Ford, he said, looked forward to seeing how the programme evolved and were anxious to see what sort of local response there was to the meeting next week at ICDDR,B.

Finally, he said Ford was one of the smaller donors at ICDDR,B even though they had a long history. He said that Ford saw their role as perhaps a strategic funder with regard to new initiatives at ICDDR,B. Although their funding was quite small he said he thought a perfect example in an area where Ford might make a strategic

contribution was in the area of the Capital Fund Development. Ford felt that the initiative under Jim Bausch's leadership was off to a great start and they hoped that the fund raising effort in the United States would prosper. Ford, he said, expected to lend continued financial support to the strategic aspects of the exercise as well as providing a variety of other kinds of potentially moral and logistic support to the exercise in the US where they had have some knowledge of the funding community.

The Representative of the ICHF, Mr. Jim Bausch said he felt it was just the kind of enthusiasm and appreciation expressed by the donors around the table that the ICHF wanted to allow others to participate in. With regard to the Ford Foundation Capital drive in the USA he felt that those around the table could do a few things to help. As the representative of the Ford Foundation had noted by underwriting some of the strategic planning for the work and lending expertise in getting in touch with new donors and from time to time if there was a donor in the area where any of those present were resident, the ICHF might even call on them to say some of the very things that they had said at the meeting. They were, he said, very powerful things and it was a very powerful message and a compelling one to get across. He felt sure, that the Director would not mind if current donors in addition to keeping up their excellent core support and project support also wished to contribute to the new fund. In terms of ICHF he felt it was interesting to note that in their very Charter they had a very peculiar plank that was approved by the Internal Revenue Service that took them some time to get through. In addition to raising and disseminating funds generally for children's health projects, they had a specific mandate in their Charter to raise funds for ICDDR,B. After being present for the meeting, it would, he said, be all the more easy to do that.

Mr. T. Uesawa, First Secretary, Japanese Embassy, said he felt it was a good occasion for the Japanese Government to express their comments on the new activities as well as their position regarding their cooperation with the Centre. Many donors were present so he felt it was a good opportunity. He commented on the activities of the Centre. First of all, he said, Japan wished to express their high appreciation of the overall successful achievements of the Centre and its staff as well as of the other donors who had been a part of the Centre's success not only within Bangladesh but also internationally. Japan, as those present were aware, gave annual donations to the Centre. In addition to that they had started to send Japanese researchers to this Centre. This kind of variation of Japan's cooperation might widen their scope of cooperation so their commitment is very sure. Secondly, he said, the Japanese Government was very interested, generally speaking, in cooperation with the Centre in the area of population which had been a very major issue internationally and the subject of many debates in various international forums. Therefore, the Japanese were very interested in the Matlab project. At this stage they could not make any commitment but he did say that the Japanese Government had been exploring the possibility of cooperation to the Matlab MCH-FP project and that a positive answer might be forthcoming sooner or later. Mr. Uesawa's third point was that Japan felt that the public relations of the Centre was very important. They recalled that at the previous year's donor meeting a resource development strategy was presented with some suggestions, such as the establishment of the ICDDR,B Desk in the United States and the United Kingdom. Also the production of a booklet on the Centre in Japanese. Japan felt these efforts should be encouraged and be realized as soon as possible. Finally the Government of Japan were of the opinion that the Centre should take part, if possible, in the United

International Conference on Population and Development to be held in Cairo in September in 1994 in order that it could make a substantial contribution to that conference given the Centre's internationally famous achievements.

Mr. Tim Rothermel then asked Dr. Habte if he would like to respond to Mr. Uesawa's presentation. Dr. Habte informed Mr. Uesawa that the booklet in Japanese was on its way and that the Centre would participate in the Cairo Conference.

Dr. Reidar Kvam of NORAD congratulated the Centre for its advances and successes achieved under the excellent leadership of Dr. Habte. He also congratulated the Government of Bangladesh for having shown a renewed and increased interest in supporting the work of the Centre. The Representative of the Ministry of Health & Family Welfare he said, had, that morning, urged all donors to explore all avenues to secure additional government and donor support for the Centre and he was glad to see that the Bangladeshi Government has done so. In that context, he was happy to say that NORAD and the Norwegian Government had been supporting ICDDR,B since the mid-80's and hoped to continue doing so. Unfortunately their contribution was limited to a small, special budget allocation for grants outside of their normal country programme where health and family planning was a major sector of bilateral cooperation. He had, however, noted the words from both the Minister of Health and Family Welfare as well as the Secretary of ERD when they had said that they hoped additional support could be forthcoming. Since NORAD was a bilateral agency working through ERD they would of course be happy to consider a request from ERD for future support to the Centre. This, he said, would naturally depend on the priorities of the Government of Bangladesh in how they wished to utilize the bilateral funds within the total framework of Norwegian support to Bangladesh. He concluded by mentioning what NORAD's current levels of support were. During 1993 their support to the Centre was in different areas. They continued their support to the MCH Family Planning and Record Keeping project in Matlab and had agreed to a grant of Tk. 4.5 million for this year (approx. US$113,000). They were, he said, able to get some additional support for emergency relief to combat the cholera epidemic and over the year had approved three separate grants towards this totalling about US$145,000. Finally they were beginning a programme of collaboration on HIV and AIDS related activities and had just made an initial starting donation there of approximately US$ 10,000 for this 1993. For 1994 and onward,s they had agreed that NORAD would give a grant for a 3-year period to support the entire budget of the Epidemic Control Preparedness Programme, a total of approx. US$ 380,000. This was of particular relevance to them since they might from time to time be able to add to this by using funds earmarked for relief, to complement the more long term development aspect and the confidence building element of this programme. He said that NORAD remained enthusiastic about the opportunity to be a part, although a small one, of the Centre's excellence.

Dr. Mehtab Currey, ODA, said she wanted to borrow the first part of Dr. Chris Kenna's speech to allow her to cut short most of her congratulations to the Centre for the very good work. On the strategic plan, she promised to send ODA's written comments.

She felt that ICDDR,B's past work was really best recognized, and its current work, was really best recognized this morning by governments' commitment and contribution. There was not much she could say beyond that. ODA also very much

appreciated the Centre's work on the recent epidemic. ODA continued to be concerned by the future trend and hoped that the Centre would keep it informed and ask for any help it might need again. Dr. Currey wanted to focus on the specific areas that ODA was funding from its headquarter's funds. ODA was putting substantial funds into the DSS, which was a very critical part of ICDDR,B. ODA had a report from a recent consultancy that showed it had provided, and the report was very very satisfactory. ODA was very happy with the way things have progressed here.

There were one or two points, which the consultancy report did not cover, that Dr. Currey wanted to note and hoped to receive a report on at some point. In the agreement on the DSS, ODA had required some conditions, including that ICDDR,B would look at switching over from a two week to a four week cycle for the household visits. The consultancy had provided ODA enough information on that and ODA was very happy with the attempts to restructure the DSS. Another condition was that ICDDR,B would seek to meet the full recurrent costs of the DSS from core funds, from the second quarter of 1996 onwards, and also that it would examine the feasibility of charging users of the DSS data. So at some future date, if ICDDR,B could let ODA know how it was progressing on those areas it would be appreciated.

In terms of the future direction, ODA was certainly very happy with the continued focus on diarrhoeal diseases and hoped that links both with international and national institutions, would continue, and be strengthened. ODA also hoped that the urban health focus would be strengthened and wanted to see future collaboration in that area. ODA wanted links developed within the national system and the Centre to act as a policy reference point, for urban development.

The funding to DSS certainly would continue as it was a three year agreement. In ODA's core funding, there had been an increase for this year over the last year and ODA hoped for 1994 that it would be able to continue at the same level. Dr. Currey wanted again to bring in a word of caution as a few other donors had done, that the environment for research funds was increasingly competitive. At present ODA was also very happy to be considering additional funding. There was one particular research proposal that it was very close to putting in funds for and there were two others in the pipeline for development and ODA hoped to see those mature.

Most of ODA's funds to ICDDR,B had been from HPD central and although the Aid Management Office here had been looking at providing bilateral funds. Dr. Currey hoped to be able to access central funds for ICDDR,B rather than make it vulnerable to the fluctuations of bilateral funding.

Dr. Kim Streatfield of the Population Council said that he should first point out, as he had done in the previous year, that the Population Council did not normally regard themselves as donors in the financial sense but they had a long history of seconding both the Project Director and Associate Director of the MCH-FP Extension project. The project had been initiated with Jim Phillips back in 1981-82 that looked as though it would continue for quite a number of years yet. The Population Council had more recent forms of collaboration through the Operations Research and Family Project for the Asia Region which provided both research funding and some forms of technical systems, and worked with both ICDDR,B and other agencies in Bangladesh. They had research awards and training programmes and research methodology training programmes in reproductive health which collaborated with ICDDR,B as part of the reproductive health network and the five

institutions in that network. Since opening an office here approximately two years ago, they had quite a lot of contact and very positive relationship with ICDDR,B and felt that was likely to continue both in the current form and hopefully, as they expanded, the Council would increase its operations in South Asia. In the last two years, he said, they had opened offices in Pakistan, Bangladesh and were currently in the process of doing that in India. Early in 1994 they will be closing the Thai office and there was quite a clear-cut shift into South Asia and out of South East Asia. He believed that the Council would be around for a long time and hoped to continue the collaboration with the Centre.

It is very interesting, he said, to see both sides of the biomedical and clinical work, with social science struggling to get its foot in the door of what had previously been pretty much a hard science centre. As a former physiologist and hard sciences born again social scientist, Dr. Streatfield could sympathize with the difficulties of integrating social science into the bio-medical arena - it was very easy, he said, to allocate a few bodies to sit in an office and do a bit of social science; it was not so easy actually to incorporate and integrate those sciences, and those approaches in ways which formed a kind of synergistic reaction where both parties benefitted. He felt sure that it would happen in the long term. The atmosphere was much more positive in the ICDDR,B now, than in many other places he had been where there was a kind of a token social science element. He did not feel the ICDDR,B social science initiative, was 'tokenism' at all.

Mr. Sigvard Schwartzman from the Swedish Embassy, commended the work of the Centre during the foregoing year which had been presented during the morning and also in the afternoon. He knew that this was due to the concerted efforts of a number of staff members as well as the excellent leadership of Professor Habte. Over the last years, he said, Sweden had been very satisfied with the activities going on in the Centre and the mix of the problem solving research projects which also included a number of joint research projects which seemed to be a very fruitful way to produce valuable research. He wished, he said, to underline what had been emphasized at the meeting, that it was important to utilize all possible means of disseminating the results, including going beyond the scientific publications which was the normal way. As had been mentioned earlier, he said, he wished to congratulate the Centre for the work performed during the previous years specially in the field, in the area of identification of the new cholera strain. It certainly showed that earlier investments had been correct in stating that capacities had been available to handle new situations like the emergence of 0139. He also endorsed what Norway had said and that Sweden too would like to see that there was a strong focus on social science activities integrated into various research plans for the future. He also endorsed the plans of the emphasis in the field of health systems research and felt that this could be further explored for future research activities.

Ms. Barbro Carlson representing the Swedish Agency for Research Cooperation (SAREC), started by saying that they had a special mandate to support research and research capacity building and these were usually long term undertakings. That means that the Centre had received support since 1980-81 with an exception of a few years in the mid-80's. She felt that SAREC had been responding to the request from the Secretary, Ministry of Finance to increase the support for the next 3-year period and she was happy to be able to announce that SAREC had recently agreed to a three-year grant of 2.5 million Swedish Kroners (approximately US# 300,000 per year). On top of that, SAREC were also supporting special projects in cooperation with Swedish institutions and that added up to about

750,000 kroners for a three year period. Roughly half of that, she said, went directly into the Centre's activities and the rest was for training purposes, mainly within the Swedish institutions. Unfortunately the Swedish currency had serious problems keeping its value against the US dollars during the previous years which actually meant that the contribution rather would remain at the same level as before. She added SAREC's concern for the future regarding the possibilities of recruiting funds from donors. SAREC were, more or less, facing economical constraints in Europe and also in the whole of the western world and there was little hope that increased funds could be raised from the existing donors. Recruitment of new donors would probably be the solution and she could see a need for more focussed research agenda for the future, rather than counting on expansion of financial support. She felt the Centre needed to focus on its research agenda and that might be a bit deleterious for some of the programmes. However, she did feel the Centre could still expand its research even if more financial support was not forthcoming.

Dr. Peter Arnold, representative of Switzerland and SDC said that as most had already been said he would restrict himself to some points concerning SDC's funding. SDC's present funding agreement, he said, was expiring in just over one year. In order to prepare SDC's new contribution, and, there probably would be a new contribution, they would have to meet with the Centre's management very soon to review past experiences and talk about mutual expectations and future plans. One of the pieces of resistance of these discussions surely would be ICDDR,B's strategic plan "To the year 2000." SDC welcomed the existence of this valuable document which, after the funding strategy presented last year, proved how much the capacity of strategic thinking was developing in ICDDR,B. SDC would study it; they had already made short comments; they would study the document carefully and provide, in due time, further comments in writing.

SDC were very pleased and encouraged, that ICDDR,B was increasingly looked at by implementors of preventive health projects as a resource base for project-related research and investigations. SDC was involved, as a funding agency, in rural water supply and environmental sanitation projects both through the Government and UNICEF and through NGOs, precisely, the NGO forum. Interesting studies related to the negative health incidence of using contaminated water and practicing open defecation had been carried out by ICDDR,B teams on behalf of UNICEF/DPHE and CARE for example. SDC were, of course, glad that this had happened as they have always advocated that the links between ICDDR,B and community health activities in Bangladesh should be strengthened and that ICDDR,B should build up its own capacity and expertise in the field of environmental and social sciences to achieve a global understanding of health problems and potential solutions.

The fact that only the death rate had decreased in Bangladesh but not the global incidence of diarrhoea, proved that the world was still a long way from the final goal of a healthy population capable of protecting themselves against major causes of illness. Thus, same would also be true, he said, with the last cholera epidemic. SDC congratulated ICDDR,B on having so quickly reacted and identified the new strain and developed treatment. However, he said, we were still a long way from achieving the final goal which was to avoid that disease spreading. In fact the contrary was the case; it was spreading and no answer had yet been found. Vaccines might be one of the solutions, he said, but surely not the only one.

The knowledge about human and cultural pattern leading to unsafe sanitation behaviour and how to change this drastically was still insufficient. Presently there

was a big national movement going on called social mobilization for sanitation with the goal of achieving total sanitation, latrine coverage of the country until the year 2000. SDC advocates that ICDDR,B should more closely be associated with this national plan and should develop its own systematic programme and research strategy in close collaboration with the major partners practically involved in this field. SDC would be happy, he said, if it could, through its project funding, establish a bridge between ICDDR,B and these programmes.

The final goal of research, he said, should be the transforming of research into action. That was written very prominently in the strategic document and should be the whole. The whole document should in fact be elaborated around that point, he said; how to transform research findings into action and impact.

Mr. Michael Constable, the UNDP representative spoke on behalf of the Resident Representative, Ms Watanabe, who would have liked to have been here today, he said. He thanked ICDDR,B for the presentations that were made during the week. They had been very interesting and very informative, he said. They had also pointed to the excellent and timely work being done by ICDDR,B.

Mr. Constable spoke on behalf of UNDP, Dhaka, seeing as the Chairman was a little more qualified than him to speak on UNDP, New York. At this point in time UNDP, Dhaka had a very small programme in the health sector which was mostly related to primary health care. They were, however, together with the Government of Bangladesh, about to begin their mid-term review of the country programme and already envisaged certain new directions that UNDP Dhaka would be taking, which included more interventions at the local level, both with the local Government, with NGOs, with the community. In heading towards those directions, UNDP were hopeful and would be reviewing with ICDDR,B on how UNDP and ICDDR,B could collaborate in these areas.

He pointed out that UNDP and the Centre were already working together with ICDDR,B in HIV AIDS in Dhaka particularly with the STD AIDS Network where ICDDR,B was chairing the technical subcommittee and UNDP was the secretariat. He felt there was going to be some interesting work done there as well as through the upcoming programme for the Bangladesh AIDS prevention and control programme where UNDP as well as other donors were going to be involved.

Mr. Rothermel added that UNDP hoped to continue its contribution to the core of the programme as well as to facilitate the contributions to the AGFUND.

Mr. Bill Goldman of USAID, Dhaka congratulated Dr. Habte who had got more different donors to contend with than there were in the World Bank Consortium and they all seemed very happy. Many of them had different ideas on priorities, and some of them wanted the Centre to focus on specific things. USAID, he said, would like that also but felt sure the meeting would have a few ideas as he talked of the long term.

On the subject of funding, he said, there had been a comment that morning that donors should continue to invest in the ICDDR,B and its work because it was a good thing, it was a good investment. There would be continued investments because ICDDR,B was doing a good job. USAID/Dhaka had been supporting ICDDR,B for over 20 years and their current investment level was quite high. This year the Agency was putting in more than US$ 3 million, mostly into applied research and

believed that it has been an excellent investment historically and still believed that the payoffs were in the use of the research.

But, also as had been mentioned that morning, times were tough in the developed world and economic growth was slow and unemployment was high. It was certainly true in the United States. Foreign aid had never been that popular in the US and there were increasing demands on limiting and shrinking foreign aid budget, demands from the very strong interest the US government had in development of the ex-soviet countries and peace in the Middle East. The budget and funds for Bangladesh had to compete with these.

What did all that mean? Well, after 18 months and a change of administration, USAID almost finally had new strategies and new budget levels and was having significant cutbacks, especially in some of the overseas programmes. USAID's staff were being cut out of 21 countries and it looked as if there would be more to come. In addition to that, the Agency was taking some fairly substantial cuts in development of operating expenses.

In terms of Bangladesh the prognosis was fairly good from what Mr. Goldman understood. Because USAID/Dhaka was working in the field and his colleague (Dr. Miller) was from headquarters, she might have some more to add to this statement.

USAID/Dhaka's assistance to ICDDR,B was through a large project agreement it had with the Government, the family planning health services project which was to continue until August 1997, under which USAID/Dhaka had a fairly substantial commitment to ICDDR,B at the country level, at around $2 million per year for applied health systems research. Historically USAID/Dhaka's assistance has been through Matlab and more recently through the MCH-Family Planning Extension Project and the Agency was currently working with the Centre, negotiating to develop an urban counterpart to that activity. The Agency believed the two of them together could form a strong basis for an applied research programme for strengthening health and family planning systems, looking for more cost effective ways to deliver services. In the urban health area, family planning was increasingly important, in fact over the next twenty years the urban areas which comprise only 20% of the population today would grow faster in absolute numbers than the rural areas.

In addition to that, USAID's office in Washington was providing substantial support, i.e., $1.7 million this year and of that, $600,000 went to core support, which the Centre welcomed very much and the rest went to a variety of research, vaccine development and training activities.

In addition USAID provided substantial support as short and long term technical assistance, consultant assistance to these programmes through the Population Council, and also through Johns Hopkins University.

USAID was also delighted to see the contribution of the Government. In addition to that, USAID was prepared to help meet the deficit in spending for the additional demand put on the hospital for the cholera emergency treatment up to around $500,000 in local currency, if the Government would agree to that use and which was under negotiation now.

It was USAID/Dhaka's impression that the Board and the management of the organization were functioning very well together. Management did what you would hope they would do and the Board did what one would hope the Board would do. But times are good now and we believe that Dr. Habte was doing an excellent job and that makes the Board's job very easy. However, in the Centre's strategic planning, it needed to take into account the issue of governance of the Board and being sure of its long term sustainability in terms of Board responsibilities and functions, which must be clearly laid out in the plan.

Mr. Goldman wanted to reiterate, and many of the other donors had brought the same point up, how important utilization of research was to USAID. At the field level, that did not necessarily mean that one needed to have elaborate research reports that take time to develop in a very careful fashion. Often the development of relationships with key Government officials and others in the private sector that were involved in implementing these important family planning, child survival health programmes was, at least, as important. For example, participation on the recent action plan committees to strengthen the population programme: ICDDR,B staff had been participating in these and that had been very useful.

This also brought up the importance of the Centre and its staff working to develop these important relationships and coordination and linkage with the various programmes. For example, the importance of developing close relationships with the Government's diarrhoeal disease control programme as the Centre got more involved in that area.

Dr. Caryn Miller, USAID/Washington stated that she had come from Washington and was more concerned with the global implications aspects of the role of ICDDR,B and so the funds that USAID/Washington allocated generally to ICDDR,B were applied research funds, less operational research funds, and more and more biomedical research. Also they allocated funds for social science that would contribute to overall global policies and have implications for not solely Bangladesh, but a variety of different countries in different situations.

As such, she wanted to commend ICDDR,B for their contribution to many of the global issues that are now facing the world and the contributions, and potential contributions, to global policy. She believed that some of what the meeting heard in the morning with regard to Vitamin A was an example of that. ICDDR,B had performed several of their seminal studies in Vitamin A research that now would go onto multi-centre trials in six or seven different countries, both for the under six month supplementation and maternal supplementation. That would without a doubt set global policies as to Vitamin A under six months of age which Dr. Miller thought had a lot of implications for general morbidity and probably mortality.

Other examples of this were ICDDR,B's participation in a persistent diarrhoea multi-centre trial, which again had global implications for the treatment of persistent diarrhoea.

There were a number of examples of these but there was one thing that the donors could do a much better job of, what they needed to do was to go back home or to their office and really preach the word to other people as well.

USAID/Washington had also been very pleased with ICDDR,B's participation in a group that it funded. USAID/Washington funded three or four different institutions in diarrhoeal and respiratory disease. These being WHO, Harvard University, Johns Hopkins, and ICDDR,B. ICDDR,B had played a very active role in the coordination and collaboration meetings that had been held every six to eight months, and this had been particularly valuable instead of waiting until findings were published and then finally discussing them. This group was able to discuss them as they were in progress and then to decide more or less who should do what, and therefore defining complementary roles which was particularly important as resources became more of an issue.

Dr. Miller wanted to make one other statement. The previous donors' support group meetings had some discussions about gender issues and Dr. Miller wanted to commend again the institution for identifying such wonderful qualified women to put on the Board, which was not the case four years ago when she first started coming to these meetings.

Dr. Baruffi from the World Bank said that the World Bank did not contribute directly to ICDDR,B as the funds of the World Bank went through the Bangladesh Government and become Bangladesh Government money and property. She wanted to mention, as many of the donors had done, the satisfaction of hearing that the Government had decided to increase this quota to ICDDR,B. The World Bank was also very happy to hear that all the other donors were very committed to support the work of ICDDR,B.

The World Bank, both here in Bangladesh and internationally, had mentioned that the World Development Report was based on many of the experiences and the research done by ICDDR,B and other centres throughout the world and in very close collaboration with help of WHO. So it was really was an international report that had come out of the collaboration and the contribution of many workers in the health field.

Here in Bangladesh, the World Bank was very happy to work closely with ICDDR,B and to benefit from the experience and research that ICDDR,B had in order to apply this to projects in the national programme.

Dr. Troedsson of WHO, wanted to express his appreciation for the excellent and very good collaborative relationship that existed between WHO and ICDDR,B in the work here in Bangladesh. He was sure this would continue in the future too. Concerning training, and the training activities performed by ICDDR,B, Dr. Habte had mentioned earlier this morning that ICDDR,B wanted to reduce its involvement in the ordinary case management training. WHO was aware of this and were in the process of assisting the Government of Bangladesh through the national CDD programme to start a nationwide training programme under which they were training trainers to take over the case management training in national institutions and health facilities. Still, WHO would rely on ICDDR,B for specialized training such as laboratory cases and so on. For the contribution and support by WHO he asked Dr. Henderson to continue.

Dr. Henderson - WHO, noted that both WHO and UNICEF had the privilege of permanent seats on the Board of Trustees and since Jon Rohde representing UNICEF on the Board was not present Dr. Henderson took the opportunity to speak for him because he and Dr. Rohde saw absolutely eye to eye on everything and

there would be no problem in his doing so. There was no question about the fact that both WHO and UNICEF did see the ICDDR,B as a unique global resource and as an institution which had been built and strengthened over the years. This was particularly true under Dr. Habte's leadership which had made this good institution an absolutely superb instrument of the present time. The donors needed to look at the Centre's evolution in the future - Dr. Habte would not be with us forever - and he was taking steps now to set the foundation for the growth and evolution of the Centre containing its costs, sharpening its focus, making sure it remained relevant in a world that changes everyday, every week, every month. Speaking as a member of the Board of Trustees, Dr. Henderson noted that during the last three days, the Board had full confidence that the Centre's management was taking aggressive and appropriate leadership steps to assure that the Centre's future would be well protected and that Dr. Habte and the Centre staff at the present time had made the Board's activities very very easy indeed. The Board had simply been able to support him and encourage him in his future. Having said that Dr. Henderson was impressed by the warm support that Dr. Habte had been offered but also the warnings that he continued to get about the future funding of the Centre. The chief difficulty for anybody directing this Centre was that of trying to continue good activities never knowing where the next dollar was coming from and Dr. Henderson was sure that donors here would know the difficulties and would fight as hard as they could for multi-year funding to make the Centre's management even more efficient and more effective than it currently was.

Tim Rothermel thanked Dr. Henderson very much and asked Dr. Muller if he would like to say a word.

Dr. Lex Muller/Netherlands (Member of ICDDR,B Board of Trustees) said that like in many other countries, the Government of the Netherlands was under heavy political pressure to cut down staff and that was the reason that the staff of the Dutch embassy in Dhaka was quite small and nobody could be here today because they were engaged in the biannual/bilateral discussions with the Government of Bangladesh. But the Government of the Netherlands was presently considering for the first time core support to the Centre.

Tim Rothermel asked Dr. Habte if he had any remarks at this stage.

Dr. Habte noted that these were times that take place once or twice a year and that provided sufficient energy for ICDDR,B to store in its system so as to keep it going for six months. It was not a problem to work hard so long as your work was appreciated. He considered it misleading if ICDDR,B staff take all the acclaim for the turnaround the Centre has gone through over the past years. Yes, Dr. Habte and his colleagues have contributed somewhat but he thought the donor community as well as the Board of Trustees had been equally responsible. The donor community had been expressing their dissatisfaction and indicating new directions which the management ought to take and the Board of Trustees had been very firm to make sure that the Centre followed what was rational. So the acclaim and the praise that was being showered on the Centre was to be shared by amongst all here. He wanted to thank firstly to the Board of Trustees for conducting such a successful meeting and secondly to all of the delegates to the Donors' Support Group Meeting, especially for those who had come long distance and particularly Tim Rothermel. Tim had come yesterday from New York for this meeting and was flying out tonight back to New York and, as the meeting could see, not a drop of jet-lag or anything was evident in him.

Mr. Tim Rothermel thanked the meeting very much. He said that he wanted to thank all of those around the table as members of this the Support Group for what had been an extraordinarily constructive, and the thoughtful and substantive observations that had been made particularly during this second session. He thanked Dr. Habte and particularly his colleagues who made excellent presentations this morning and joined him in thanking the members of the Board of Trustees. UNDP was undergoing some reorganization and he did not know if he would be around next year - so this could be his last time. It had been a great pleasure to be with the Support Group and ICDDR,B and he again thanked everyone present.