ISBN 984-551-035-3

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

PROCEEDINGS

of

the Donors' Support Group Meeting

Dhaka, 22 November, 1994

Sasakawa International Training Centre Auditorium
ICDDR,B

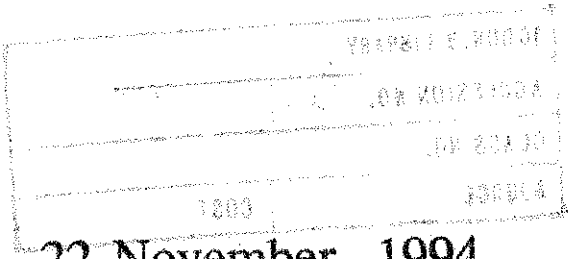
Special Publication # 40
April 1995

ISBN 984-551-035-3

PROCEEDINGS

of

the Donors' Support Group Meeting



Dhaka, 22 November, 1994

Sasakawa International Training Centre Auditorium
ICDDR,B

Special Publication # 40
April 1995

DONORS' SUPPORT GROUP MEETING

22 NOVEMBER, 1994

AGENDA

9:00 a.m.	:	Opening Address 1) Ms. Eimi Watanabe Acting Chairperson, Donors' Support Group, ICDDR,B and Resident Representative, UNDP, Dhaka 2) Mr. Syed Shamim Ahsan Secretary, Ministry of Health & Family Welfare Government of Bangladesh and Member, Board of Trustees, ICDDR,B 3) Mr. Md. Lutfullahil Majid Secretary, Economic Relations Division, Ministry of Finance, Govt. of Bangladesh and Member, Board of Trustees, ICDDR,B 4) Dr. Yagob Y. Al-Mazrou Acting Chairperson, Board of Trustees, ICDDR,B and Assistant Deputy Minister for Preventive Medicine Ministry of Health ,Government of the Kingdom of Saudi Arabia
10:00 a.m.	:	Some Achievements in 1994 and Prospects for 1995 1) Overview - Dr. Demissie Habte, Director, ICDDR,B 2) Re-establishment of exclusive breast-feeding - Dr. Rukhsana Haider 3) Family Planning from Matlab to Cairo - Dr. Michael A. Strong
10:50 a.m.	:	Presentation of the new Matlab book:: 'Women, Children and Health' - Dr. Vincent Fauveau
11:00 a.m.	:	Coffee Break
11:30 a.m.	:	Some Achievements in 1994 and Prospects for 1995 (cont.) 1) Information Technology Strategy Update - Dr. C. Chirapaisarnkul of AIT 2) Advances in Diagnostic Tests and Vaccinology - Dr. R. Bradley Sack 3) Response in Rwanda - Dr. A.K.M. Siddique
12:30 p.m.	:	Sandwich Lunch
1:30 p.m.	:	Financial Statement 1994 and Budget 1995 - Jon Rohde Chairperson, Finance Committee, ICDDR,B and Resident Representative, UNICEF in Delhi
2:00 p.m.	:	Strategic Plan: "To the Year 2000"; new structure and current constraints - Dr. Demissie Habte, Director, ICDDR,B
2:15 p.m.	:	Discussion - Donor Representatives
3:30 p.m.	:	Closing Address - Chairperson, Donor Support Group

Table of Contents

Participants in DSG meeting

Chairperson	: **Ms. Eimi Watanabe** Resident Representative UNDP, Dhaka, Bangladesh
Representative of the host country	: Mr. Syed Shamim Ahsan Secretary, Ministry of Health & Family Welfare Govt. of the People's Republic of Bangladesh
Acting Chairperson of the BOT	: Dr. Yagob Y. Al-Mazrou
Director	: Professor Demissie Habte, M.D.

Trustees

Mr. Syed Shamim Ahsan
Dr. Y.Y. Al-Mazrou
Maj. Gen. (Retd.) M.R. Chowdhury
Prof. D. Habte
Prof. J.R. Hamilton
Mr. Md. Lutfullahil Majid
Prof. P.H. Makela
Dr. Jon Rohde

Name of Donors' representative	Country/Organization
1. Ms. Fabia Shah	AIDAB/Australia
2. Ms. Roushan Akhter	AIDAB/Australia
3. Dr. Charoen Chirapaisarnkul	AIT/Bangkok
4. Dr. D. Ceuninck	BADC
5. Mr. Vital Kellens	Belgian Embassy
6. Mr. Albert Felsenstein	BADC/ICDDR,B
7. Mr. Jon J. Scott	Canadian High Commission/Dhaka
8. Mr. Brian Proskurniak	Canadian High Commission
9. Mr. Nick Roberts	European Union
10. Mr. Niels von Keyserlingk	GTZ
11. Mr. Raymond Offenheiser	Ford Foundation
12. Ms. Gabrielle Ross	Ford Foundation
13. Mr. Muhammad Ischak	Indonesian Embassy
14. Mr. T. Uesawa	Japanese Embassy
15. Mr. A.R.M. Schutte	Netherlands Embassy
16. Ms. Rita Imanuel-Rahman	Netherlands Embassy
17. Mr. Karl Eric Hagstrom	Swedish Embassy
18. Ms. Hellen Ohlin	SAREC/Sweden
19. Dr. Peter Arnold	SDC/Switzerland
20. Dr. Mehtabunisa Currey	ODA/Dhaka
21. Ms. Eimi Watanabe	UNDP
22. Dr. Caryn Miller	USAID/Washington
23. Mr. Sk. Ali Noor	USAID/Dhaka
24. Mr. Richard Greene	USAID/Dhaka

OPENING ADDRESSES

Ms. Eimi Watanabe, Chairperson, Donor Support Group (DSG) welcomed Mr. Majid; Mr. Ahsan; Dr. Al-Mazrou; representatives of the Board of Trustees; representatives of the donor community and all other participants. On behalf of the DSG and on behalf of the UNDP she expressed her pleasure and honour at being given the chair in the meeting of the Donor Support Group of ICDDR,B. It was with particular pleasure that UNDP had this role and honour of chairing the DSG meeting. UNDP globally promotes capacity building and also supports strengthening of institutions and, in this connection, had been associated with ICDDR,B since its early days of 1978. UNDP considers ICDDR,B one of the most successful examples of institution building, an example where an institution had an impact globally on improving the well-being of humans around the world. So it was with particular pleasure that UNDP honoured and treasured this association with ICDDR,B.

This year (1994) had been a particularly eventful year for ICDDR,B. In February, a major event - the celebration of 25 years of ORS was observed in the presence of the Prime Minister of the People's Republic of Bangladesh, the Health Minister as well as heads of several UN agencies - Mr. James P. Grant, Executive Director UNICEF; Mr. James Gustaf Speth, UNDP administrator; as well as Miss Margaret Carpenter, Assistant Administrator of USAID; Dr. J.L. Tulloch of WHO; and Mr. F.H. Abed, Executive Director of BRAC. All these institutions along with ICDDR,B had a major role in propagating the use of ORS. Although the celebration of the 25 years of ORS was indeed a memorable and eventful day, it also reminded everyone that while the achievements of saving up to a million lives through the knowledge and use of ORS/ORT was very very significant, but still 2-3 million children continue to die each year through diarrhoeal diseases, largely due to the failure of finding ways to persuade parents to use ORS effectively and at the right time. So there was still challenge ahead of us.

This year also saw the Centre in the limelight when a team of 8 from ICDDR,B rushed to help the Rwandan refugees in Goma, Zaire, and within a few days of their arrival the ICDDR,B team was able to correctly diagnose the strain of cholera in Rwandan refugees. Due to this timely intervention of ICDDR,B, the case fatality rate among the refugees in the camps was quickly reduced from about 20% to 2%. This indeed was a very very remarkable achievement and an international contribution of ICDDR,B. This year also saw the Centre contributed in a significant way to the Cairo International Conference on Population and Development and to the recent Vitamin A Conference in Thailand as well. Moreover, the year also saw the publication of the Centre's Strategic Plan "To The Year 2000" which has 3 key components - Child Survival, Population and Reproductive Health, and Application and Policy. This strategic plan has already won acclaim and recognition from many people in the international health community from donor organisations, health and population scientists, and agencies throughout the world.

It was clear that in all areas highlighted in the Strategic Plan (namely Child Survival, Population and Reproductive Health, and Application and Policy), it is the Centre's multi-dimensional approach that is critical to finding lasting solutions to the problem. Because the problems of the vicious cycle of infection and malnutrition, the problems of reproductive health and safe motherhood in the region were to do with behaviour, attitudes, and values. So the solutions to these problems must be also corroborated with the social science perspective as well as the medical perspective. That was why the Centre's multi-sectoral, multi-dimensional approach had particular relevance to these areas. Ms. Watanabe hoped that in particular the Centre's work in the years to come would address the issue of the vicious cycle of malnutrition and infectious diseases. Those working in the South Asia region somehow came to accept the rate of malnutrition in young children or women as almost being normal, but it was not. The rates were unacceptably high and she hoped that the Centre's work would address this issue in a very very significant way.

Thus the challenges before the Centre were many. We were in a global financial environment which was perhaps not so conducive to growth and development. Everyone knew about the competing needs for

overseas development aid. Those in the UN system, particularly agencies such as UNDP, were facing a critical situation, but institutions like ICDDR,B which are at the forefront of research, which gives immediate benefit to child survival and reproductive health, must continue to receive donor support. Under Dr. Habte's dynamic leadership, the Centre had explored and were implementing innovative ways to expand its financial base. For instance, the Centre has broadened its donor base in both developed countries, including the Swiss Red Cross, the European Union, and Germany, and in developing countries, including China, Sri Lanka, and South Korea. Efforts were also underway to further improve the Centre's ability to attract competitive grants. The Hospital Endowment Fund continued to grow and has just received a pledge of $3 million from the Government of Switzerland. The planning and initial documentation had been completed for the Centre Fund endowment campaign to raise money in North America, Japan, and later in Europe. These were some of the innovative ways through which the Centre was trying to raise additional resources. However, for its main core funds, the Centre had to continue to depend on the traditional donors - the governments, the multi-lateral and bilateral agencies, and the Centre looked for strong continued support from the delegates of these agencies.

Mr. Syed Shamim Ahsan, Secretary, Ministry of Health and Family Welfare said that perhaps most of the delegates knew he had ceased to be a Government servant, effective two days back. He informed that he would step down as a member of the Board of Trustees after the meeting. He thought that he would be failing in his duty if he did not mention on this occasion the role that ICDDR,B had been playing for the betterment of mankind in general and of those in Bangladesh in particular. On behalf of his ministry he wanted to put it on record the Government's gratitude for the assistance and help that it had always called upon and it had always received. There were moments when he was working as the Health Secretary when the Government fell back on ICDDR,B. The management, under the leadership of Dr. Habte, never turned the Government away. It was crucial at certain points as help was needed and that help was always forthcoming. The Centre, in the recent past, had done remarkably good work, and more importantly from the Ministry's point of view the relationship that the Ministry and the Centre had developed was something that everyone concerned should cherish and nurture.

Ever since the Centre had received the leadership of Dr. Habte, a wonderful bridge had been built between the sphere of activities of the Ministry and of ICDDR,B. Today the two institutions proudly stand at a point where they extensively and intensively collaborate with each other. The Government had, in the past, called upon the ICDDR,B to collaborate. Those who had spent years at the Centre knew what used to happen in the past. Today the scenario was different. There are a number of ventures that ICDDR,B had launched where the Government played a leading role. The leading role was not for the sake of control, but it was so that the research undertaken gave due dividends and helped in formulation of policy towards betterment. Mr. Ahsan congratulated Dr. Habte and his team once again for the excellent work that was being done at the Centre. He had the mandate of his Ministry to inform the meeting that the Government would continue all out support to the Centre to the best of its ability.

Mr. Lutfullahil Majid, Secretary of Economic Relations Division, Ministry of Finance said that it was the second time he had the honour and privilege of addressing the donor support group meeting and it was indeed a pleasure to do so for such a Centre of Excellence. He agreed with Mr. Ahsan who had very properly outlined the Government's commitment to the Centre. He added that it was indeed a great pleasure to see the relationship between the Centre and the Government improving over the last several years particularly during the short period of Mr. Syed Shamim Ahsan as Secretary, Ministry of Health and Family Welfare of the Government of Bangladesh.

Mr. Majid had been associated with the Centre at least from the days of its internationalization in 1978. There was an interim committee during those days which was headed by the then representative of UNDP, and it gave him great pleasure to see that Ms. Watanabe, the current resident representative of UNDP, had taken over the responsibility of chairing this donor support group meeting. The Government of Bangladesh and its people were grateful to the Centre for the humanitarian services that the Centre had provided in time of emergency, disaster, and treatment. The perspective of the common people about

the excellence of the Centre was somewhat less informative. But the trust and confidence that they had on the Centre, was reflected by the number of patients that come to the Centre. Mr. Majid echoed Mr. Ahsan who had explained the confidence of the Government in the Centre and had very succinctly pointed out that the Government, in times of emergency, always fell back upon the Centre and that the Centre had never failed to provide the necessary support in turn. In addition to these direct benefits that the Government and the people of Bangladesh were deriving from the Centre, there had been other intangible benefits as well. These had been already mentioned by Ms. Watanabe in her opening statement.

Mr. Majid went on to say that the number one event in 1994 was the celebration of the 25 years of ORS held in February, and it was attended among others by the heads of five UN agencies. It was a big event on the part of the Centre. These types of events and the achievements of the Centre improved the image of Bangladesh in the international arena, particularly in respect of research and programmes in health and population. In addition to that, the participation of the Centre in treating the Rwandan refugees in Goma, Zaire, also further enhanced the image of the Centre, and indirectly the image of the host country itself. So the Government was once again very pleased and very grateful to have the Centre located in Bangladesh. The country had benefitted immensely from the activities and from the performances of the Centre.

Mr. Majid said that the commitment of the Government of Bangladesh would continue to be there. The Government praised the Centre and appreciated its performances. It was grateful for the Centre's operations and despite its very limited resources was continuing to provide whatever help it could give. The cash contribution of the Government to the Centre had been increased several-fold, and this would continue to be reflected in the future budgets. The Government would continue to make contributions in kind as well. The Government had also allowed the Centre to get the benefit of bilateral contributions from the bilateral framework. The official development assistance under a bilateral framework was supposed to be used only by the receiving Government but in this case, in the case of the Centre, the Government had allowed wherever necessary, the use of bilateral assistance for the development programmes of the Centre, and this policy would continue to grow. Generally the Government did not allow such a policy, he added. In the past, it had problems with regard to channelling of funds directly under bilateral framework. It may be mentioned that nowadays the Government was getting a lot of requests for NGO support but it was extremely difficult for it to accept these requests for direct channelling of funds to any non-government organisations because of procedural problems. Yet in respect of the Centre the Government had done that and hoped that this would continue.

The third point was with regard to the Director's request to the Minister for Finance regarding allowing the Centre to have exemption from paying income tax for the national staff. This was discussed in detail in the Ministry of Finance. It was found that direct exemption would not be possible since it would distort the Government's taxation policy framed after long deliberations and long considerations. This had other implications, with our donors, particularly the World Bank, the IMF, etc. where the Government was bound by certain policy and principles, and therefore the direct exemption was not possible. At the same time, the Minister for Finance expressed his deep sense of appreciation about the activities of the Centre and he suggested that instead of directly exempting the Centre from paying income tax for the national staff, he would rather increase the cash contribution to the Centre. He had approved a proposal for increasing the cash contribution by about US$125,000 in addition to the contribution which had been increased recently. The Finance Minister had approved it but this had still to cross certain barriers in the sense of the bureaucratic analysis and procedures.

The fourth point was about the proposed endowment fund. The Government had discussed the endowment fund and supported this initiative of the Centre. If Dr. Habte made a proposal, approached the relevant authorities of the Government, i.e., the Finance Ministry, they might consider a possible contribution from the Government to this endowment fund. So this was something which Dr. Habte and Mr. Majid would have to work on together and find out the best way as to how to get this contribution. Mr. Majid concluded by saying that the Government was aware of the importance of the Centre, its work in the

country and the work outside the country which further enhanced the image of the country in the international arena, and was therefore grateful for the Centre's presence in Bangladesh. The Government would continue to provide support to the excellent achievements and performances of the Centre.

Dr. Yagob Al-Mazrou, the acting chairperson of the Board of Trustees, welcomed all to this meeting of the 1994 Donor Support Group and hoped that it would be as successful as the previous meetings. During the last Board meeting the Trustees had received detailed reports of the work done in the Centre as well as the immediate plans for all the divisions. During the past few months of this year the Centre had sent out to all of the donor agencies and many research institutions all over the world, the final version of its Strategic Plan "To The Year 2000". This plan outlined important challenging programmes of work for the next 5 years. The plan highlighted diarrhoeal disease and family planning as the two most important areas for the Centre and also emphasised social science, health services and policy research. The biennial work plan for 1995-96 had been prepared on the overall context of the Strategic Plan and he was pleased to see that the ideas of the 5 year plan were well reflected in this work plan. He hoped that the donor community would share the concern of the Centre for health and population issues facing the world and would join in financing of its work plan as well as strategic plan on a long term basis. There were clear signs of the research programmes and achievements of the Centre which had been successfully completed under the leadership of Dr. Habte and his group during the last year.

First, an improved model of shigellosis in adult rabbits to facilitate vaccine development, second, in collaboration with a company in the United States, a rapid test for both *V. Cholerae* 0139 and 01 was meant to be used for field work in remote areas. Third was the discovery that blue-green algae was a reservoir of vibrio 01; which provided an answer to a question which had not been answered for a long time. Previous speakers had talked about the celebration of 25 years of ORS and the Centre and its staff should be proud of this discovery. Further research on vitamin A supplementation to infants had demonstrated that high doses given during the first 6 months of life caused transient side effects. Several additional studies were undertaken in this regard and the results were disseminated to the national health policy in a seminar in October this year. Thirty years of demographic studies in Matlab on a population of around 200,000 have a worldwide impact in advancing appreciation and understanding of the demographic characteristics of the rural population. It was now well demonstrated that the moderately educated rural female health workers, when carefully trained, could dramatically increase upon the prevailing rises of contraceptives in an area where the demand for such contraceptive and family planning was apparently quite low. These lessons had been effectively transferred to the Government of Bangladesh in the first place and then worldwide. The lessons from Matlab family planning had been and were used by different international agencies, different countries, and the high point of this had reached the Cairo Conference on Population and Development where the Director and scientists from the Centre had participated.

Lastly, he pointed out that in spite of the acknowledged productivity and excellent management of the Centre, the total contribution from the donors made the difference and it needs to be increased significantly if the same level of excellence were to be maintained. In this context Dr. Al-Mazrou wanted to acknowledge the deep sense of gratitude to the Government of Bangladesh which had raised its annual contribution manyfold. This was a clear commitment on the part of the host Government to make the Centre a financially sustainable organisation. He hoped that the other donors would look at all possible ways to increase their contributions to the Centre in the same manner. He congratulated the Centre also for finalising the resource development strategy, which aimed at raising donations for the Centre Fund campaign. Effective implementation of this strategy would lead to a long term stabilisation of the Centre's cash flow problems. This would enable the Centre to be financially viable and sustainable organisation of excellence. Finally, on behalf of the members of the Board of Trustees he thanked Mr. Ahsan for his great contribution within the Board and for his efforts to build a strong and positive relationship between the Centre and the Government of Bangladesh. He congratulated the Centre management and the staff for doing an excellent job, and thanked everyone from the donor groups present on the day.

SOME ACHIEVEMENTS IN 1994 AND PROSPECTS FOR 1995

Overview

Dr. Demissie Habte contended that Mr. Majid had been too shy to make one other announcement of the contribution of the Government of Bangladesh. It had to do with the write-off of the UNROB loan. In the middle of 1980s and in early 1990s the Centre had been in a critical financial situation and was just about to close, when the Government came out with the loan of over a million dollars for the Centre. That loan saved the Centre and in many ways was responsible for its presence here today. After a series of negotiations in which Mr. Majid and his colleagues actively participated, the Government had now written off that loan as a grant and all legal issues that had been raised in regard to that loan had now been settled.

As had been mentioned a number of times, the Centre had been very busy during the last year trying to meet its obligations to research, service and training, and the Director was proud to say that by and large the Centre had achieved most of the targets that it had set. In the area of research activity, if research could be measured by the number of publications that came out of the Centre, then the Centre was proud to have had over 200 publications and many more briefing papers during this year since the last Donors' Support Group meeting. While Dr. Habte was not in a position to give an accurate quantification of the impact of these, he could say that many of these publications would have potential impact on policy and action and that a few such as the Centre's work on vitamin A had already had a direct impact on both the global and national community. A lot of research activities in 1994 were preoccupied with further studies on the new 0139 strain of *Vibrio cholerae,* and he was happy to announce that in collaboration with colleagues and institutions abroad in the next year there would be a trial of the vaccine that combines the cholera 0139 Bengal strain with the 01 El Tor strain, and that perhaps by the next year, some preliminary results might be forthcoming.

The Centre continued to build its institutional capacity and during 1994 had succeeded in attracting a number of senior staff. To mention a few: in the area of social environmental sciences Dr. Jim Ross had joined from the Ford Foundation; others who joined recently include: Dr. George Fuchs who is a senior scientist in the Clinical Science Division, Dr. Khaled who is a clinical biochemist, Professor Barkat-e-Khuda who heads the MCH-FP project, Dr. Shameem Ahmed and Dr. Sarah Hawkes. He felt great danger of leaving out names, but noted that the Centre had several important staff joining in and that this would be reflected in increased productivity and better quality of research activities. A research institution like ICDDR,B was dynamic and this year, after long periods of service, Dr. Dilip Mahalanabis, who had been at the Centre for 7 years, and Dr. Brad Sack, who had been with us for 4 years, were leaving. Now, in itself this was a very sad affair, but fortunately the prospects of replacing these two individuals had brightened considerably. Professor Patrick Vaughan would come and join as the head of the Community Health Division. Professor Vaughan was one of the most distinguished public health authorities coming from the London School of Hygiene and Tropical Medicine. The Centre hoped to attract Professor G. Riethmuller from Germany to come and head the Laboratory Sciences Division.

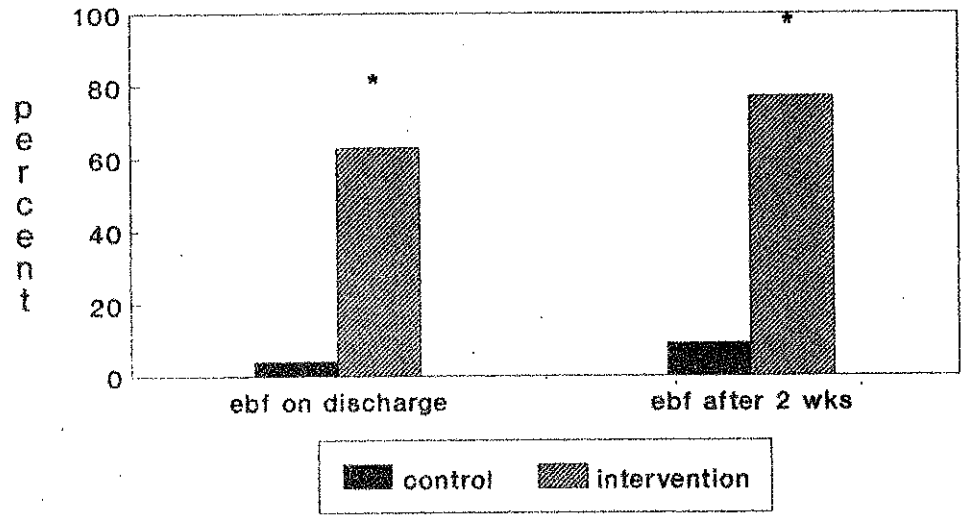
Institutional capacity is also a function of the tools that the scientists use and in this instance the issue of Laboratory Science Division was a case in point. Thanks to a large grant from the Sasakawa Foundation, the laboratories in the Centre, both research and service laboratories, had undergone considerable refurbishing and now had the latest state of the art equipment and technology to pursue their activities. Another area of capacity building relates to the Centre's plan for staff development. Dr. Habte personally believed that the Centre had one of the most productive staff development programmes. A large number of staff went out annually and also throughout the year for training in relevant fields to the point where the Centre was now proud to say that a large number of its mid level and senior staff has as a minimum the Ph.D. research degree.

In the area of training and dissemination, again the Centre had a few hundred participants from over 20 countries in short and long courses and in fellowship programmes. The Training Coordination Bureau had had a major resuscitative injection of talent in the guise of Dr. A.N. Alam who now heads the considerably strengthened programme. The training programme now increasingly places emphasis on development of skills for programme managers whether on diarrhoeal disease activities or on family planning activities. As had been mentioned in the past, health research training was the great comparative advantage of the Centre. Although this was a very difficult undertaking and one where large numbers may be difficult to achieve, the Centre's venture into the field of health research manpower development continued to grow. However, he noted that the training activities would have gone even further had the Centre had adequate funds available.

In the area of dissemination, the Centre was increasingly made aware by its donor community, the international community and by governments, that it was not enough to come out with a lot of research findings if it did not take active interest in seeing that these research findings were translated into policy and action. One essential component of the dissemination activities which the Centre had done more in 1994 than at any other time in the past, was its efforts to disseminate its findings through seminars, workshops, conferences and so on, both at the national and at the international level. For example, in the area of family planning, the Centre took active steps to disseminate its findings to colleagues in the Government of Bangladesh as well as in the NGO community. Another example was the vitamin A symposium held in last October. The Centre was able to bring together both national experts and policy makers as well as those from outside. They came out with conclusions and recommendations that those results were very likely to have an impact. So the Centre's dissemination efforts continued and in 1995 the Centre's involvement in dissemination would continue to grow.

Many publications came out of the Centre as part of that effort and before the end of this session, the Centre would present the new Matlab book. A lot had been said of the Centre's involvement in the cholera epidemic amongst the Rwandan refugees, of the ORS 25th anniversary, and many more, and he had no intention to repeat that. To conclude, Dr. Habte said he believed that the Centre remained a vibrant dynamic institution ever growing in strength and in capacity.

Comparison of ebf between control and intervension group



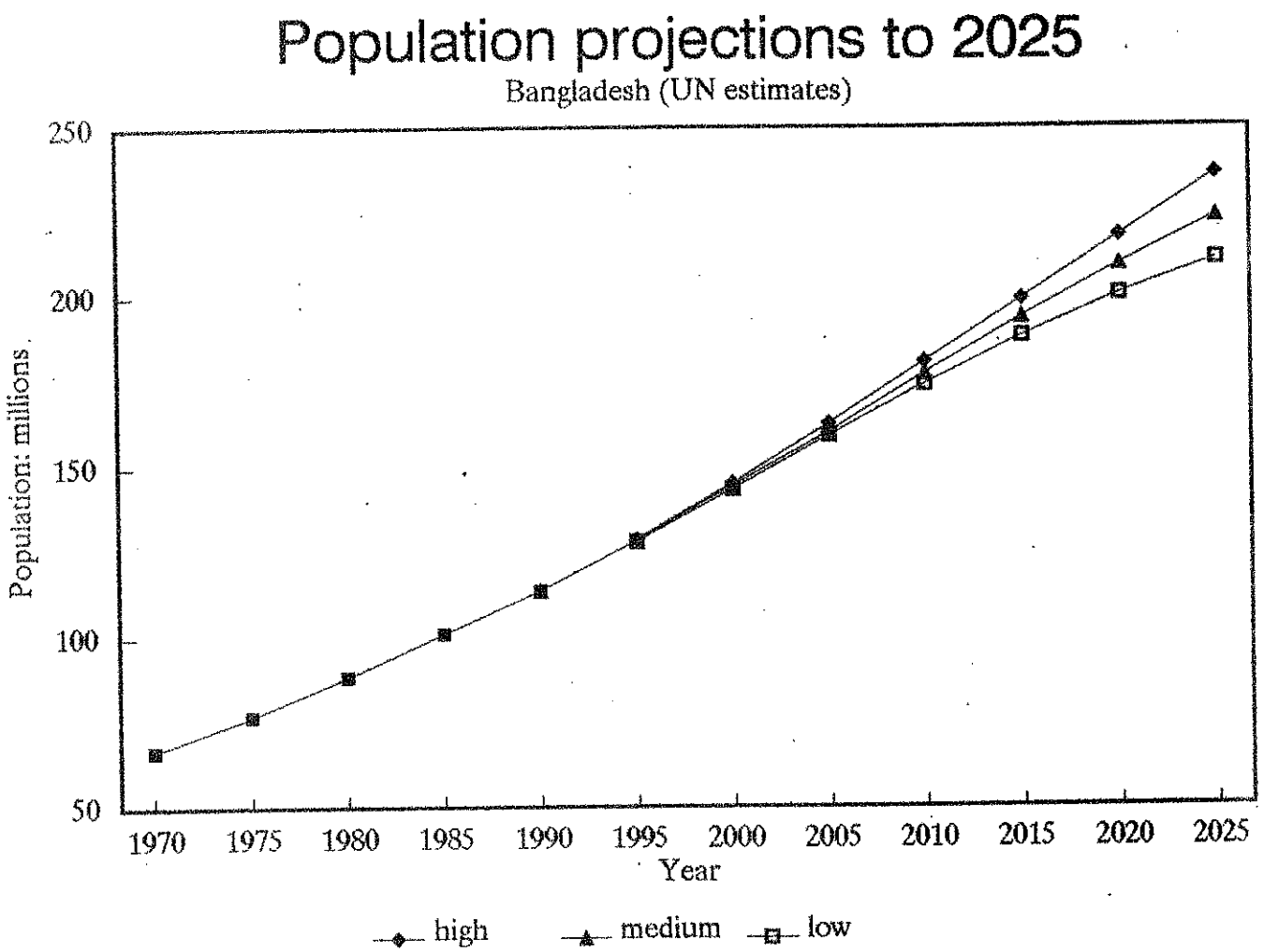
* p<0.001

- Appropriate breastfeeding counselling and support **can help** mothers of partially breastfed infants to breastfeed exclusively in a hospital setting.

- Breastfeeding counselling encourages mothers to **continue** exclusive breastfeeding at home and prevents bottle feeding.

Policy Implications

Counselling of mothers at health facilities can contribute significantly in improving breastfeeding practices.


Population projections to 2025
Bangladesh (UN estimates)
250
200
150
100
50
Population: millions
1970
1975
1980
1985
1990
1995
2000
2005
2010
2015
2020
2025
Year
high
medium
low

Primary concerns regarding rapid population growth

- land resources; • exhaustible resources; • physical capital; • human capital;
- environment

Concerns of individuals and families

The right of individuals and couples "freely and responsibly to decide the number and spacing of their children and to have the information, education, and means to do so".

The Cholera Research Laboratory and Matlab

- sole initial concern was to find a cholera vaccine
- data collected in Matlab made it a population lab as well

Background basic research for national and international family planning programmes

- measurement of vital rates in Bangladesh; • age at marriage; • breast feeding and post partum amenorrhoea; • levels of abortion; • existing fertility regulation; • qualitative research on sexuality and attitudes; • validation of international survey methods.

Contraceptive Distribution Project

(First fully measured saturation project in the provision of contraceptives)

Testing: House-to-house delivery of oral contraceptives starts October 1975, condoms added in 1976.
By: "Lady Village Workers" who had worked with the CRL
Result: CPR rose from 1% to 17%, then fell to "only" 11%

Conclusions

- couples wanted to limit family size; • availability of contraceptives not the problem;
- need client-oriented programme with supportive family planning workers.

BUT: 6-village injectable (DMPA) study; by male worker and village assistant; achieved 15% CPR, good continuation.

MCH-FP Project

Testing: Home delivery of a wide range of FP services in a programme emphasizing frequent worker visits, quality of care, good MIS, supervision, and feedback, and increasing provision of MCH services.
By: Educated local women who were themselves contraceptive users with paramedic backup
Result: CPR rose to 62% by 1994

Conclusions

- a wide range of contraception is important; • client-oriented and culturally appropriate
- adequate visitation frequency (i.e., worker density); • training, supervision, and management are critical.

BUT: Supply side important, but demand context is, too:
• contraceptive methods must meet demand; • legitimation of FP at local and national levels.

Policy impact

- in Bangladesh, largely through the MCH-FP Extension Project
- elsewhere through literature, exchange visits, etc.

Towards Cairo - UNFPA interests

• population growth; • balance with environment; • population programmes; • family planning as a human right; • support for population policy; • valuing women equally; • migration and urbanization; • information, education, and communication; • overcoming the population data barrier.

Towards Cairo

- population growth
- population programmes
- family planning as a human right
- valuing women equally
- migration and urbanization
- information, education, and communication
- overcoming the population data barrier

With echos from Matlab

- averaged 2.6 1966-1974
- Matlab is cost effective
- couples do want to limit family size
- studies on mortality, desired fertility
- 10,000 left Matlab, 1/3 to Dhaka (1992)
- importance of cultural sensitivity
- DSS and RKS: providing data and methodologies

Cairo International Conference on Population and Development

Programme of Action

I. Preamble

II. Principles

III. Interrelationships between population, sustained economic growth and sustainable development
BRAC-ICDDR,B (Ford) , environmental sanitation initiative (UNICEF)

IV. Gender equality, equity, and empowerment of women
discrimination against female children (UNICEF, UNFPA), BRAC-ICDDR,B (Ford)

V. The family, its roles, rights, composition, and structure
adult health study (NIH), data on family composition

VI. Population growth and structure
data and studies on fertility, mortality, children and youth, the elderly (ODA, core)

VII. Reproductive rights and reproductive health
family planning (Japan),
reproductive health (Ford), contraceptive use dynamics (ADB), STD/HIV (ODA)

VIII. Health, morbidity, and mortality
MCH-FP Project (EEC)

IX. Population distribution, urbanization, and internal migration
data available on migration (ODA, core)

X. International migration
data available on migration (ODA, core)

XI. Population, development, and education
BRAC-ICDDR,B (Ford), MCH-FP (Japan, EEC)

XII. Technology, research, and development
basic data collection (core), research (various)

XIII. National action
through MCH-FP Extension Projects (USAID)

XIV. International cooperation

XV. Partnership with the non-governmental sector

XVI. Follow-up to the conference

Continued importance of Matlab to Bangladesh

a) Matlab's success as an applied operations research project
b) Continuing importance of lessons learned
c) Matlab is a cost-effective demonstration project
d) Matlab can test the next phase of GoB programmes
e) Matlab continues to make other contributions to Bangladesh.

Presentation on the New Matlab Book: 'Women, Children and Health'

Dr. Vincent Fauveau expressed his sorrow to say that he was not prepared to speak in this meeting and so he had no slides. But actually he thought the book itself would present the slides and everything the participants needed to know about Matlab. So he just wanted to say that he was very very pleased to be back again in Dhaka and in ICDDR,B. He had always felt that he was still a member of ICDDR,B and he thought that had happened with most of them who had worked for a long time here. They felt that they were still active staff of the Centre and they met people in the corridors, in the parking lots, in every office. They still felt friends and they had lots of exchange of good news. So he thanked the Director for allowing him to be here for this event.

The book on Matlab, as Dr. Habte said, had a long gestation. Dr. Fauveau thought it was much longer than even an elephant, but it was there now and he would very much like to pass this message that this was not his book, although he had edited it. It was the book of the people of Matlab, it was the book of the people who had worked in Matlab: the researchers, the scientists, and the field workers. It was not a book on achievement, but was a book about lessons learnt, so it was just a milestone. At some point everyone felt that they needed to go back to the 15 years before 1990 and look into what they had learnt. This was hoped to be a stimulus for further strategy for thinking and research in the future and for the future of Matlab. As Mike Strong said, lots of lessons learnt in the ICPD would now be addressed and studied in Matlab; so it was very much a continuous process. Dr. Fauveau thanked the donors and the people with whom they conceived the project of the book but were no longer here. NORAD was very instrumental and had participated very nicely in the book, along with the Norwegian Government, BADC and the Belgium Government, the Ford Foundation and WHO. These were the 4 donors. He would very much like to thank them again for their support and patience. Finally, he specially thanked those who had done the incredibly difficult job of producing the book. It was much more difficult than to write or to edit and Albert and Iqbal did that job and he really thought they must be praised. He then thanked everyone for the support of ICDDR,B all along, and for all the support to Matlab and he hoped everyone would enjoy reading the book, despite the few mistakes that were still in it.

ADVANCES IN DIAGNOSTIC TESTS AND VACCINOLOGY

Presented by Dr. R. Bradley Sack

VACCINE DEVELOPMENT

Decision based on public health indices (incidence and mortality)

↓

Identify appropriate antigens to develop (living or non-living)

↓

Animal tests (antibody production/protection)

↓

Human tests (adults; then children) (Safety, antibody production/protection)

↓

Field trials (Safety, antibody production/protection)

↓

Public Health Use

Vaccines for prevention of diarrhoeal diseases

Rotavirus, Cholera*, *Shigella,* Enterotoxigenic *E. coli** *(Presently being studied at ICDDR,B)

***V. cholerae* 01 Vaccine**

Oldest Enteric Vaccine: 5 field trials in Bangladesh had shown Injectable Vaccine not useful.
Oral Killed Vaccine: tested by ICDDR,B provided protection of 50% for 3 years.
Field trials being done in Peru (licensed in Sweden, Vietnam).
Live Attenuated Vaccine: Field trial being done in Indonesia (licensed in Switzerland).

***V. cholerae* 01 and 0139 Vaccine**

3 candidate vaccine (2 living, 1 killed). Oral (one or two doses). 01 and 0139 strains plus B-subunit of cholera toxin. Being tested in volunteers in developed countries. To be tested in volunteers at ICDDR,B. Field trial in Matlab likely.

***Enterotoxigenic E. coli* vaccines**

One candidate vaccine (killed). Oral (two doses). Many antigens, including B subunit of enterotoxin. Being tested in volunteers in developed countries. Being tested in volunteers at ICDDR,B. Field test at ICDDR,B likely; will be tested at multiple sites.

***Shigella* Vaccines**

Several candidate vaccines (live). Oral (single dose). Different species (*S. sonnei; S. flexneri*). Being tested in volunteers in developed countries. Being given small field trial.

Rotavirus Vaccine

One major vaccine candidate (live). Oral (2 doses). 4 serotypes of rotaviruses. Has been tested in volunteers in developed and developing countries. To be licensed soon. Mostly for use in developed countries.

Possible future vaccine studies at ICDDR,B

Pneumococcal vaccines (mothers/infants). Measles vaccines (<9 months of age). *Shigella* vaccines. Respiratory syncytial virus vaccines.

Saving Cholera Victims' Lives - Easy When You Know How
Presented by Dr. A.K.M. Siddique

On July 23rd in Mugunga camp, just outside Goma, the relief operation's medical teams were overwhelmed, and fast losing the battle. Their adversary, cholera, was killing nearly one in two of the refugees admitted to the make-shift treatment centre, and the epidemic showed no sign of relenting. Throughout the surrounding countryside, the bodies lay dehydrated, dead or dying. The medical teams, generally staffed by doctors with little or no experience of treating cholera patients, struggled to control the epidemic. With the mass exodus, and the high levels of contamination, there was little potable water to make the life-saving Oral Rehydration Solution (ORS) for those who so desperately needed it.

Recognizing the critical nature of the situation, and the need to bring the epidemic under control before it claimed hundreds of thousands of lives, Brian Atwood, Administrator of USAID, called on "the most prestigious and knowledgeable organization in the world". ICDDR,B, the Centre for Health and Population Research, where ORS was developed in the late 1960s, responded to the call and sent a group of eight experts to Rwanda. Specialists in clinical management and laboratory analysis of diarrhoeal disease joined epidemic control and logistics experts to form a team that was able to provide technical assistance to the emergency relief teams coping with the Rwandan refugees.

Upon arrival, the team visited several camps, and evaluated the situation in Goma, and the surrounding areas where millions of refugees had fled from neighbouring Rwanda. The team then provided briefings and technical assistance to the international relief agencies operating treatment centres to deal with the cholera epidemic. This resulted in substantial changes being made in treatment regimes and the management of the treatment centres in and around the camps. Large gauge IV needles and a faster rate of initial rehydration were introduced, increased emphasis was placed on the maintenance of rehydration through effective use of ORS, and more appropriate forms of IV fluid were recommended.

The ICDDR,B laboratory specialist was able to identify the pathogens causing the cholera, and the dysentery that was also developing in all the camps. He was also able to identify and alert the relief agencies to the drug-resistance patterns of these pathogens. The dysentery was caused by *Shigella* type 1 and was resistant to almost all antibiotics, with the exception of Mecillinam. This information prevented millions of dollars being wasted on procuring and transporting ineffective drugs. The clinical management experts also made recommendations on how best to treat and manage this form of shigella.

The ICDDR,B team stayed for 15 days, and made many important contributions to the relief and epidemic efforts. They had arrived to see the carnage of a raging cholera epidemic, with average case fatality rates of around 20% in the treatment centres scattered through the camps. The most rewarding indication of the team's success was that these case fatality rates had been cut to less than by the time they left to return to Bangladesh.

"This is a great example of how the international community can collaborate together for the greater good, the importance of an international centre like ICDDR,B, and how Bangladesh can make many vital contributions to the world," said Dr. Demissie Habte, Director of ICDDR,B.

FINANCIAL STATEMENT 1994 AND BUDGET 1995
Presented by Dr. Jon Rohde

Table 1: 1994 Budget/Forecast (All amounts in $000)

Income		$000	From	To
Central	Down	16	4,578	4,562
Project	Down	940	6,041	5,101
Overhead	Down	210	966	756
Other	Up	64	650	714
Total	**Down**	**1,102**	**12,235**	**11,133**
Expenditure				
Operating	Down	1,005	12,126	11,121
Depreciation	Up	42	668	710
Total	**Down**	**963**	**12,794**	**11,831**
Operating deficit	Up	139	559	698
Cash surplus	Down	97	109	12

Table 2: 1995 Budget/Forecast (All amounts in $000)

Income				
Central	Up	41	4,562	4,603
Project	Up	2,014	5,101	7,115
Overhead	Up	456	756	1,212
Other	Up	16	714	730
Total	**Up**	**2,527**	**11,133**	**13,660**
Expenditure				
Operating	Up	2,437	11,121	13,558
Depreciation	Up	36	710	746
Total	**Up**	**2,473**	**11,831**	**14,304**
Operating deficit	Down	54	698	644
Cash surplus	Up	90	12	102

Dr. Jon Rohde said the summary of the budget that the Board documents contained had far greater details and breakdown, and he would be glad to answer questions. He noted that the Board in November looked at where the Centre was in the present year's budget and received revisions based on more up to date information than was available at the June meeting of the Board when it was last discussed.

In table 1, the income was divided into two major categories: "central support" to the central functions of the Centre and "project" which was for the implementation of projects. The major change this year was a decrease of roughly 1 million dollars in project. This was not due to the lack of interest and

support of donors, but rather due to changes in the implementation of projects and savings therefrom. So, the money did not come because it was not drawn forward. Some of this amount related to personnel and some related to specific projects which were delayed in agreement with the donor. Concomitant with that, of course, overhead went down by a proportion which was roughly reflective of the overhead for the Centre's institutional operating costs derived from the projects. So, the overall income was down by 1.1 million dollars. The expenditure, at the same time, showed a comparable change that is the operating expenditure was down by the same 1 million dollars. The depreciation changed slightly based upon the amount for equipment and capital in the organisation which was a little higher due to equipment purchases. The operating deficit of 700,000 dollars appeared alarming at first view. One needed to fully understand that this figure coincided with the depreciation figure. A properly balanced operating company in the world of free market economies would be expected to fund its own depreciation from its sales and profits. If it failed to do that then essentially the capital value of the organisation would diminish. However, in fact the capital valuation of the Centre continued to be enhanced through the accumulation of capital from donors either in the form of equipment or hardware which was put in through projects, which became capital, or from a Foundation grant, specifically to increase equipment or buildings. So while the Centre would like to fund depreciation to the extent that was possible, an inability to fully fund depreciation did not represent the kind of disaster that it were a private sector profit making organisation. Thus the cash status was the real question. At the end of the year, it appeared that the Centre would have 12,000 dollars surplus, which was pretty close management of a twelve million dollar budget.

Mr. Brian Proskurniak, First Secretary of the Canadian High Commission, Dhaka, enquired about the decrease of approximately one million dollars relating more to changes in implementation.

Dr. Habte noted that the lack of utilisation of this fund was due to the fact that three large projects could not be implemented and the money remained unutilised. This related to the rural and urban MCH-FP extension projects supported by USAID, the BRAC/ICDDR,B joint venture supported by Ford Foundation, and the Swiss Red Cross-supported projects on community study at Chakoria in Chittagong. Most of this amount of money would have been used on salaries of international level staff had the Centre been able to recruit these individuals in time. So a large section of this related to the inability to recruit people in time, but also in the case of both urban and rural MCH-FP extension projects, this related to major changes taking place in the two projects. The rural extension project was moving over into a new area in Chittagong and the launching preparation of that took considerable time, and similarly in the case of the urban project organisation to mobilise NGO and other communities in urban health activities was a bit slow. The Centre was very confident that in 1995 the stage was all set to move full steam ahead.

Dr. Rohde continued to present the budget for 1995 and noted that in table 2, the "from" was a realistic estimate of 1994, and the "to" was the 1995 projection. The major changes were clear in project income, and this was the flip side of the story of those project costs which did not get expended in 1994. They would be expended in 1995 and therefore project income appeared to go up dramatically, in part as a reflection of the delays and the catch up expenditure. Similarly overhead would rise for the same reason. This gave quite a substantial increase in the budget of about two and a half million dollars. While looking at expenditure, the picture reflects the availability of that income and the operating expenditures very closely matched the available funds. Once again the amount for depreciation falls short of the full level of depreciation giving a predicted cash surplus of $100,000. The Board had generally asked that a cash surplus of at least $100,000 be budgeted as the absolute minimum that needed to be in the budget to give some slack and replenish the fixed asset replacement fund that was maintained to invest in new capital.

Dr. Rohde concluded the presentation by saying that the Finance Committee received extensive information from the management in the form of detailed tables and reports throughout the year. It showed how the Centre managed its resources very carefully and adjusted to the exigencies of an organisation which received its income not in a totally predictable fashion. It was remarkable that the Centre was able to meet all its bills and yet was not having money unexpended. The Centre also faced the difficult problem of trying to compete with its Ordinance-suggested comparability of staff salaries to

the United Nations. Dr. Rohde noted that those who worked in the United Nations were always way out in front in at least one thing and that was staff salaries. It was very difficult for the Centre to keep up with these and it faced a constant difficulty in trying to adjust. The Centre was trying to keep at least the salaries so they are not going backwards against local inflation and that was about as good a news as it could offer the staff. Any adjustments to staff salaries were recommended usually at this meeting but not implemented until the next year in order to be sure that the resources necessary for those adjustments were in hand.

RESOURCE DEVELOPMENT STRATEGY

Mr. G. Wright presented the Resource Development Strategy noting that in 1992 the Board approved a new Resource Development Strategy with 5 key objectives. He outlined the sort of progress that had been made on those objectives. The Resource Development Strategy was put together in 1992 after extensive work going round North America, Europe and Australia discussing issues with both public and private sectors and he thanked USAID Washington for funding the initiative. The first objective of the strategy was to increase annual income by 10% per annum. Progress in 1993 was absolutely on target but in 1994 as had been described in the presentation of Dr. Rohde, the Centre was lagging behind in project spending. The cycle of identifying and recruiting international staff took longer than would be optimal so that when a project started on January 1, quite often it was 6 months or more before the Centre started spending those international salaries. In 1995, the current projected budget was above the 10% annual growth so the Centre was on or even above target on that.

Now, how was this achieved? Well, through a mixture of activities. The completion of the strategic planning process and the strengthening of competitive grant activities had given the Centre additional leverage. The Centre was moving into the competitive grant area more and more. It was clearly an important area and source of funds, but there was more work needed in terms of training the staff. Many had already gone through the Epidemiological Methods and the Research Methodology workshops which gave them the ability to write competitive grant project proposals but the Centre still had more work to do.

Mr. Wright cautioned at this stage that competitive grants or, indeed, endowments were never going to replace the Centre's need to call on its traditional donors. In the case of competitive grants, many grant organisations had geographical stipulations that precluded the Centre from receiving funds from them. For example, the Wellcome Trust in the UK gave largely to UK based institutions only. This was a very common pattern for many of the Foundations as well as the competitive grant sources that the Centre would like to be accessing.

The Centre had done a lot of work to try and raise the profile of the Centre through PR activities and in the donor packs there were brochures. The Centre also produced slide packs for all the Trustees and Directors, and had just completed 2 videos, one 13-minute - giving an overview of the Centre, and another one, 20-minute - giving an introduction to Matlab. One of the objectives was to broaden the donor base so that the Centre did not have to keep coming back to exactly the same Governments and multi-lateral agencies all the time and it had achieved quite a lot in that respect: from China, small grant from the European Union for a specific lab science protocol, and Sri Lanka had also committed to give. The Centre was particularly encouraged when developing countries gave money because it believed that this underscored their recognition of the importance and appreciation of the work that ICDDR,B did. In 1993 South Korea and Germany gave in kind in response to the 0139 epidemic and the Centre was working hard to translate those into cash and regular contributions. In addition, the Centre had been going to the private sector, and had had success with the Swiss Red Cross, CARE, the Dutch and Save the Children, and so on. This was an ongoing process which would be continuing.

The second major objective was to maintain long term core funding and under multi-year agreements. One of the major problems that the Centre faced was that time and time again by November of the year it still did not know what the final budget would be. That made planning terribly difficult. New multi-year agreements had been signed with Bangladesh as was noted this morning by the Secretaries. This demonstrated a great support from the Government, which had made significant increases in donations over the past few years, and the Centre was very grateful for that. The Centre had also recently signed with BADC, was about to sign with the Netherlands, had signed with NORAD that was funding the Epidemic Control Preparedness Programme, from SAREC and was in the process of finalising negotiations with the Swiss Development Cooperation. Mr. Wright could not overstate the importance of these multi-year core agreements for the Centre. This was what allows the Centre to really do effective, planned research and he encouraged participants to do their best to try and encourage their organisations to understand that need. If they believed in the management, they should try to assist it in the planning process, which was difficult without multi-year core-based agreements.

The Secretaries had talked about the use of bilateral funds for health care services etc. Some were being used already particularly with regard to the family planning programmes and the Centre's technical assistance to these. The Centre of course would like to see more bilateral funds freed up, particularly in the area of health care provision and for the hospitals in particular, and was working on that with the Government.

The Centre set a target of developing a hospital endowment fund of 10 million dollars in two 5-million dollar phases. Under the stewardship of Dr. Dilip Mahalanabis, significant and extensive contacts and goodwill had been developed and already 150,000 dollars had been raised for the hospital endowment fund. There was great potential in Bangladesh for increasing this fund. There was one obstacle that the Centre was currently discussing with the Government of Bangladesh. The Centre did not have tax exempt status for the hospital endowment fund, and in fact the Government withdrew tax exempt status under the instructions of the World Bank/ IMF recently. This had caused a great deal of problems, as the Centre had several corporate donors who were interested in giving but would use the tax exempt issue as a reason for not giving.

And finally, the institutional reserve fund: Initially the Centre dreamt of establishing a fund of 30-million over two 15-million dollar phases. Feasibility studies suggested that this was a trifle too ambitious and the Centre had reduced that down now to two targets. By 1996 it hoped to have raised US$10 million and by the year 2000 US$20 million. The Centre had revised the name from Institution Reserve Fund to "The Centre Fund". This was for various marketing activities. With a grant from the Ford Foundation the Centre had completed the preparatory planning, drafted a "case statement" which was the sort of non technical document for engaging people's thoughts and interest in the campaign. Feasibility studies had been completed and the Centre had many important initial contacts including very high up within USAID, which had just issued a new Policy Determination number 21 on endowments, recognising the value and importance of endowed funds. Again this reflected the issues that Mr. Wright had stressed when talking about the need for multi-year core donations. If the Centre was going to plan the research properly and the world was to use this unique institution properly, it needed to have that sort of financial stability and predictability.

A very successful alumni meeting was held when Dr. Habte was in the USA in October, and this would provide the basis for really strengthening the powerful group of alumni that the Centre has in North America. Later, the Centre would move the effort across slowly into Europe and Japan and later perhaps to the Middle East. In addition, the Centre had hired a new full time desk officer who was based in the United States. The Board was then presented with an action plan for the future to move this beyond just planning and into actual raising of the Centre Fund. The Centre had committed 230,000 dollars from its own resources for this initiative and that underscored the importance that the Board attached to this initiative. Over the next year, the Centre would be recruiting a senior development officer to work with its colleagues at the Child Health Foundation and its excellent consultant, Mr. Robert Smith, in the US,

and Dr. Habte and Mr. Wright would be working very closely with them to drive this initiative forward. He thought that the prospects for reaching all the targets were very good, but the Centre needed all the support that it could get not only from its trustees and its own staff but also from the traditional donors, to say to potential donors for these endowment funds that this was a worthwhile investment.

In that context it was necessary to bear in mind that the Centre Fund was not going to be able to replace traditional donor support for the Centre. A 20-million dollar fund would provide "the edge of excellence". This would mean that the Centre would be able to respond more quickly to new opportunities and needs. For example, when 0139 cholera arrived the ability to access flexible funds meant that the Centre could get on with the work immediately without spending 6 months to-ing and fro-ing to donor organisations trying to find the money. In addition, it would allow the Centre to smooth out some of the problems with project-based cycles so that, for example, when a project was coming to the end and a follow-up project was being designed rather than letting all the staff go and then having to rehire another set of field staff, 3 or 6 months later, the Centre would hope to be able to smooth that across and thus reduce the problems between the project cycles. And finally, the small-scale seed money would be used in situations where the Centre could see a piece of research work that could usefully be done but needed a little more information on it before presenting a full fledged proposal for consideration by a donor agency. The money from the Centre Fund would allow the Centre to initiate those very important small-scale activities that would then hopefully lead to a larger-scale full blown projects.

Mr. Raymond Offenheiser, Country Representative, Ford Foundation, Dhaka, made some comments on the Centre Fund exercise to which the Ford Foundation had been a party since its beginning. Some 14 years ago his predecessors in Dhaka made a contribution of about half a million dollars to the Centre at the time it was being internationalised. At that time the hope was that there would be a similar kind of effort made to develop a fund of this sort but it never really materialised. If they look at the particular fund that Ford donated at that time, it had now increased to about 2.3 million dollars. Mr. Offenheiser thought the use the Centre had put it to had been important in terms of resolving a variety of disbursement problems, transitions between projects, etc., and demonstrated many of the points that Graham Wright had been making about the usefulness of this kind of discretionary money. Moving to the present and commenting perhaps briefly on the exercise that was under way, Ford had been very pleased with the work that had been done in the United States. They were particularly pleased that Robert Smith had joined the team. He was someone known to the Foundation, known to the philanthropic community in the United States, and brought a lot of wisdom, experience and just the right touch to the entire exercise. It was Ford's sense that the exercise in the United States at least was on the move and that a strong case study had been prepared, and many of the important institutions in the United States had been contacted. If he was not mistaken the Rockefeller Foundation had agreed to take on a leadership role among foundations in the United States in attempting to raise money for the fund. The Ford Foundation, for its part, feels that it would be a part of whatever exercise was developed and that it perhaps was not in the best interests of the Centre for Ford to be the lead agency in this because they had been seen as associated with the Centre for a long time and a strong supporter of it. Ford thought it was perhaps time to bring in some other donors on board.

Mr. Offenheiser hoped that donor agencies represented at the meeting would take the time to think about how this campaign might be developed in their particular country or regions. The funding that Ford had provided to develop the strategy had been US-centric, but there could be ways to internationalise the overall exercise and bring others in. Whatever counsel could be provided to the Centre's leadership in Bangladesh or to the group in the United States that is working on this exercise would be most welcomed.

Dr. Habte wanted to reemphasize some of the things that Graham Wright had said. One was that the major source of funds for the Centre's activities would remain the traditional source of income that it had and this was likely to continue for decades. He knew of no institution in the world that was entirely dependant (100%) on endowments. Secondly, the interest from endowments would be used to give the Centre the flexibility to embark on and undertake research initiatives. This was very important. A number

of times researchers came up with bright ideas they wanted to try, but could not do it for lack of funds. This project development initiative is critical to the Centre remaining at the cutting edge of science. Thirdly, the Centre would use such funds to nurture the very many institutional linkages that it had. This was again another critical undertaking for any centre of excellence. Fourthly, the Centre needed to recruit talent very quickly for short varying periods of time, sometimes for one to three months, and the Centre needed the flexibility to be able to do that. Budgeted activities rarely allowed it to do so. And finally, of course there were peaks and valleys in the Centre's budgetary allocations dependent on factors that cannot be predicted, like donors cutting down their contribution for good reasons of their own. The Centre would be better able to plan, maintain and optimize its activities if it had this flexibility. This institutional endowment fund was critical for the Centre.

Ms. Fabia Shah of AIDAB made a brief comment on Resource Development Strategy presentation. Speaking from the Australian side, she commended the Centre's efforts to set up innovative fund raising activities like the endowment funds for example. However, at the same time she also commended the Centre's efforts to recruit developing country members to be donors to the Centre. This was something that she would particularly like to encourage, and would not like them to be forgotten with the concentration on raising funds in the US, Europe and Australia. So she encouraged ICDDR,B to keep on with its efforts to raise funds from developing country members as well.

STRATEGIC PLAN "TO THE YEAR 2000" - NEW STRUCTURE AND CURRENT CONSTRAINTS.

Dr. Habte presented the "Strategic Plan To The Year 2000 - New Structure and Current Constraints". Exactly one year ago the Centre presented the draft Strategic Plan. At that time many donors gave very valuable comments which were incorporated along with the comments of members of the Board of Trustees and many others. In July the Centre finally came out with the document which he was sure all of the participants had since received. The major thrust of the Strategic Plan the Centre had decided was to address a critical core of interacting health problems which together accounted for over two thirds of third world disease morbidity and mortality, and which impacted very greatly on economic development. This critical core of interacting health problems was an issue related to child survival and to population and reproductive health. Even within these two areas of child survival and population and reproductive health the Centre had again tried to identify the key components which would have critical importance. It had selected this critical core of interacting health problems because it believed that the solution to these problems were likely to have a synergestic effect and maximise the reduction of morbidity and mortality. Regarding the selection of these two key areas, the Centre also decided that it had to redouble its efforts to ensure that all steps were taken to translate research findings into policy and action. And in this regard, the Centre's involvement in training and in dissemination would be very much expanded.

Dr. Habte went on to highlight the new emphasis in activities that the Centre was undertaking. The first thing was that it was clear that the Centre was not for only diarrhoeal disease research but it was indeed a Centre for health and population research. For now ICDDR,B would remain the name of the Centre, but the sub title "Centre for Health and Population Research" better reflected the activities of the Centre. There had been extensive discussion of this in the Board and it had come to this resolution. Now, the fundamental mission of this Centre for Health and Population Research was **"to develop and disseminate solutions to some of the major health problems facing the developing world, with an emphasis on simple and cost effective modes of therapy".**

In the next set of slides he demonstrated that already in 1994 and certainly in 1995 the Centre was moving into new areas of emphasis. A colour slide showed the disciplines in which the Centre was involved. Noteworthy was the emphasis that the Centre gave to social and behavioural sciences, and to health services research and health policy research. Together these constituted a third of the Centre's activities. This was a major move from the past. Training and dissemination and preoccupation with

environmental health would increase over the next few years. Even, 1995 amounted to a significant increase. The participants would notice that the role that the laboratory sciences and clinical sciences played had, therefore, diminished as the Centre emphasised the other disciplines. They had to add up to 100. He reiterated because this issue had been raised by some, that the Centre would remain a Centre of excellence for research into diarrhoeal diseases and would like to be considered as the foremost Centre of Excellence in cholera research in the world and to be able to maintain that reputation the Centre would do everything necessary.

Looking at the research activities, there was again the shift in emphasis: diarrhoea accounted for 31% of the research activities, family planning 26%; together these two constituted nearly 60% of the Centre's activities. Population and reproductive health, population studies and issues related to maternal mortality together accounted for another 27% and so on. The next transparency showed the 2 main areas: child survival and population & reproductive health in detail. Within child survival which accounted for a little less than 50% of the Centre's activities, 64% is on diarrhoeal disease, 15% on acute respiratory infections, 17% on nutrition, and the rest on EPI preventable diseases. Within the area of reproductive health and population, family planning programmes accounted for nearly 50% of the Centre's activities, reproductive health for no less than 30% and issues of demography and population studies another 20%. In order to be able to implement the Strategic Plan, the Centre would continue to maintain its unique infrastructure that had been developed over the last 34 years. Both the facilities in Dhaka and out in the field would continue to have a central role to play in the interdisciplinary approach in the solution of these health problems.

Finally, having given a few glimpses on the issues of the Strategic Plan, it was appropriate to underline the fact that for the Centre to be able to carry out and implement this Strategic Plan it had to overcome constraints. Dr. Habte mentioned only 3 examples of these constraints. Number one is space. He had to make regular rounds of the staff in the area in the Community Health Division in order to prevent major civil disobedience ! Actually it was not a joke because in some departments individuals were allocated a seat every so many hours and they had to get up so others can sit down. The Centre had very severe problems of space particularly in the Community Health Division. In the long term if the Centre was going to embark on more activities which would even require more space, and this was beside the fact that a number of offices were now moving into the field where research activities were being carried out. The second major constraint the Centre faces was the difficulty in meeting the remunerative package in recruiting individuals with talent. This had become a major issue. If the Centre wanted to have people who were going to lead in an area of research, not only were they difficult to identify but it was difficult to attract them with the remunerative package that the Centre would offer. Thirdly, and finally, one major area in which the Centre should not wait to launch itself was the area of training and dissemination, and particularly with the emphasis on population and family planning. The Centre had been pushed from several quarters to exploit the unique state of the family planning that the Centre had and to share it with the rest of the world. To be able to do that, the Centre required manpower and again required space.

Ms. Hellen Ohlin representing SAREC, the Research Council in Sweden, which had been associated with the Centre for a long time, said that SAREC was very happy to note the great improvements during the time of the present director. She had had the chance for the first time to attend the Board meeting and that puts her in a difficult situation as she had already voiced some of her comments. She had been able to walk around and interview staff to get their reaction, so that in a way she found herself in the situation that she had got such wonderful answers to all her queries that she had no questions left.

She had voiced some concern from medical scientists in Sweden, who collaborate with the Centre, about the changing emphasis in relation to the new Strategic Plan and the Director of course had replied to that already a few minutes ago by saying that the Centre was certainly not going to change its emphasis but was going to continue to be a Centre of Excellence in the field of diarrhoeal diseases. SAREC welcomed the new broadening of the mandate and thought that it was a good development. She asked about the possibility of increasing the emphasis on nutrition, but however, noted that there was to be an inter-

divisional interest group looking into this field. She suggested that the Centre may have a greater comparative advantage in nutrition than in reproductive health. After the Cairo conference, everyone wanted to stress the field of reproductive health, but she thought the Centre was still in the same position as UNFPA involved in a process of trying to define what really the priorities for UNFPA were in this field. One aspect that she had not heard any discussion about, which she was sure the Board had pondered about many times was the question, "what is the role of international centres today", as the Centre had existed for many years and now it was after all a different world in relation to research capacity in developing and developed countries? So how big should international research centres really be and how broad a mandate should they have? Another issue which she had not heard so much about was the replicability in other countries of the models developed in Matlab. She had asked questions about this and had got some answers. She thought that it was unclear as to how the Matlab experience was replicable in Bangladesh and replicable models in other countries. One reply she had received was that what was replicable was the model to approach the problems, maybe not the exact situation or the design of health services delivered but the mechanism of how to attack different types of health problems.

Ms. Watanabe then asked for comments or questions on the Strategic Plan, if there were any.

Dr. Caryn Miller of USAID/Washington, made a short comment that in the Strategic Plan she did not think that it was obvious that the Centre was doing a lot more multi-disciplinary work and a lot more integrated work because things were presented in a sort of vertical fashion. But in reality, there was much more of an emphasis on multi-disciplinary work in the sense that the Centre was bringing together work from the different divisions. Even within the divisions, the Centre was bringing together anthropologists and biomedical scientists. This really was a change from the past and was something positive and very practical. This did not come out in the Strategic Plan and the next time the Centre writes the Strategic Plan, it might want to emphasize some of the cross cutting themes a little more.

Ms. Gabrielle Ross of the Ford Foundation commended the Centre for its leadership role in the population sector over the last 30 years. The Ford Foundation had supported and commended the work of the Centre in integrating the social sciences across the different divisions and in placing the issue of population in the broader context of development by looking closely at the impact of integrated rural development on health and well being including fertility. She also said that Ford supported the work in integrating some research on selected reproductive health interventions including RTIs and was happy to hear that research would be of a practical nature and the data would be designed to inform interventions. The Ford Foundation felt that it followed along with the Centre's work in policy and application. Ford believed that the Cairo Conference represented a major paradigm shift from population policies which were based on a demographic objective to policies and programmes that are based on health and human rights. She underlined what Caryn Miller had said regarding designing of programmes that reflected that new paradigm shift which would look at integration and at how women's needs at the field level and broader reproductive health needs of both women and men at the field level were met. She concluded by encouraging the Centre to look at this question of integration.

Dr. Mehtabunisa Currey of the ODA was very happy to see the mission statement of ICDDR,B came out very clearly, particularly the emphasis on the development and application of various methods. That particular statement came out very clearly in the population and reproductive health care and in the application and policy area. She saw the same in the work of the MCH-FP extension project particularly and perhaps in the urban health project as well. When it came to child survival, where ICDDR,B had the cutting edge, the longest experience, particularly in terms of preventing deaths from cholera and diarrhoeal diseases, she would have expected more of that to come into the statement; also particularly within Bangladesh where the Centre saw the annual phenomenon of the hospital being flooded with patients. One and all came in to see what a great job ICDDR,B was doing but she would have expected that if that was really applied to diarrhoeal diseases it would not be the Centre's hospital that would be flooded but the Centre would actually be creating mini centres. She knew that there was a lot of talk

about ORT centres but those really had not taken off and she imagined that national capacity would have been expanded by now so that people did not have to travel to this extent, that more deaths would have been prevented because they would have had them accessible closer to home.

Dr. Habte responded and noted that indeed the Centre had made efforts to try and export health care delivery models for child survival and had tried to get involved in the urban MCH services. All he could say was that so far the Centre had not been very successful, as the problems were too big. Of late, the urban extension project had succeeded to mobilise Government and NGOs and formed a national task force for strengthening MCH services in urban sector, particularly in Dhaka. The Centre hoped that the committee would address the issues that Dr. Currey had raised. Many of the research findings that had come out of child survival were indeed exportable. In the area of the epidemic response, the Centre had succeeded and hoped to be able to transfer capabilities from its team to that of the Government.

Dr. Strong noted that with regard to Matlab, the replicability issue had two aspects; one was transferring the specific lessons learned in Matlab or the extension project areas, rural or urban, to other parts of Bangladesh where they are perhaps most directly applicable, so looking at rickshaw travel for rural field workers to get out was pretty specific to Bangladesh. On the other hand, the operational research methods of studying how to get services from a centre out to a people, how to run an intervention area, perhaps a comparison area, were replicable, exportable to other countries. The Centre had a very successful workshop last year where groups from 3 countries in Africa came and looked at the Matlab and extension project areas, and got very good feedback from the group in Ghana who were doing just this. Working with the Ghanian Government in a rural intervention area to try out new service delivery methods using some of the Centre's MIS techniques, some of the Centre's interventions but more importantly the methodology of studying in this case how to get contraceptives out to people in rural areas in Ghana.

With regard to some of the other issues like increasing emphasis on nutrition related research, Dr. Habte said that everyone must remember that the consequences of infection by the childhood diseases contributed significantly to prevailing nutritional deficiency states. Beyond that, however, other than the sort of research presented today which was even so built on diarrhoea, and promotion of breastfeeding, development of weaning foods and so on, the Centre had not really undertaken much work on nutrition. One of the reasons for this was the belief that if the Centre was to undertake any such measures, it needed to be a Centre of excellence and to develop the capability to do that. The Centre would look into this and if indeed ICDDR,B can be a Centre of excellence in nutrition. Dr. Habte personally had doubts on this. The issues were extremely complex. With regard to the role of an international health research centre, Dr. Habte was going to a meeting in California this week, and one of the issues was exactly this. There was fortunately, an increasing interest in the development of a network of international health research centres. At the Board meeting, the Board had welcomed the creation of an International Vaccine Institute in Seoul, which would become the first sister institution established after ICDDR,B. Dr. Habte thought that there would be more and more talks about these international health research centres.

Ms. Watanabe asked if Dr. Habte would like to comment on the point made by Ford Foundation about the paradigm shift made in Cairo on looking at population issues more as the issues on women's rights and reproductive rights.

Dr. Habte said that he was not an expert and asked some of his family planning colleagues to elaborate. He noted that one of the most important lessons that was learnt in Matlab which was replicated throughout Bangladesh was that the provision of family planning services with an MCH component went a long way to reducing population growth and to spur economic development. He did not think that this necessarily contradicts the paradigm that Gabrielle Ross was talking about. In principle, the Centre was committed to the type of policy set out at the ICPD in Cairo.

Dr. Strong added it was an interesting point that this paradigm shift had taken place, and that the Centre was in the middle somewhere between the problems that the community had, the nation had, in worrying about population size, population pressures, at that level, and the problem the individual or the couple had in deciding their own reproductive decisions. These were not necessarily in conflict but there was no necessary harmony between the individual and the community. The world would be shifting a bit from the supply side (which probably favoured the community aspect more) to the demand and the health side. He felt that the Cairo Conference was broadly saying: "Having met many of the objectives on the supply side, many of the family planning targets are on course, let us shift and make this a more human programme that better meets the needs of individuals". So the Centre's emphasis is on reproductive health, on demand, on the BRAC-ICDDR,B project looking at women's empowerment, helping them to realise their own goals, and meet those kinds of objectives also.

Ms. Watanabe thanked the participants and moved on to the final item on the agenda: discussion of donor representatives.

DISCUSSION OF DONOR REPRESENTATIVES

Ms. Fabia Shah noted that this was her first donor support meeting and she was very grateful for having the opportunity to participate. To begin with, she noted that the morning's discussions were very interesting. She was struck by the commitment of the staff and the Director in particular, the commitment of the staff to the Director, the obvious respect of the Government for the Centre's work, the Secretary's personal respect for the Director, and thought that these were all important ingredients for a successful research centre in a country like Bangladesh. At the same time from Australia's point of view, AIDAB found the Centre's transparency in terms of the work that it does, in terms of its expenditures, in terms of any request AIDAB made, to be somewhat unusual for an international organisation and it was something that AIDAB was very grateful for.

Australia had a long relationship with ICDDR,B since 1978 and since then it had committed about four and a half million Australian dollars to the Centre. So it was a quite significant commitment for AIDAB and it was a Centre AIDAB had paid very special attention to. Last year AIDAB were fortunate to be able to actually increase its contributions to the Centre by about 30% and Ms. Shah was happy to say that this year that would be maintained or slightly increased. So that was also a reflection of AIDAB's continuing commitment to the Centre. She knew that the Director would be happy after mentioning that he was trying to stop a revolution happening at ICDDR,B because of lack of space, and was happy to announce a contribution of Aus$40,000 to the building work on top of the library building which should open up some space for the Community Health Division.

AIDAB had also been working with ICDDR,B on a very interesting project this year. ICDDR,B was very open to the suggestion which came from AIDAB to trial a new ORS application called the "infuso-feed balloon pump" which was an Australian invention and the protocol had now been approved and the trials were going to start in December which AIDAB was quite excited about. AIDAB thought it had enormous potential and the Centre was very quick in responding to their request to see if they could trial it here. AIDAB looked forward to seeing the results which would be ready by about January or February. She made a quick mention of the other contributions which were not as transparent as AIDAB's normal core contributions. This was the contribution that Australia had made for quite some time since the late 1970s in terms of training. Every year the Government of Bangladesh actually kindly allocated part of AIDAB's training scholarships to enable officers or staff of the Centre to go to Australia to undertake Masters and Ph.D. programmes. A lot of those Ph.D. programmes had been undertaken in Queensland at the Queensland Institute of Technology, Queensland University, and the Australian National University (ANU). This year there were three ICDDR,B staff currently studying at ANU in Ph.D. and Masters programmes. So, this was another small way in which AIDAB contributed and also the Government of

Bangladesh contributed because they actually lost scholarships by allocating them to ICDDR,B. This was an indication of the Government's continuing support as well. She noted that whilst AIDAB was increasing its funding and would continue to increase funding for the population sector and also to ICDDR,B's programme, AIDAB was now in a position where they were having to be much more accountable in terms of how they spend those population funds. Just last year, there was a population enquiry in Australia looking into AIDAB's population programmes and issues of human rights, gender issues; and the outcome of it had produced quite a momentous checklist which now had to be gone through by all the agencies which received funding. So while AIDAB was going to give the Centre increased money, the old adage of "no pain no gain" would hold true because it was going to require more and more paperwork.

In closing, Ms. Shah commended the Centre for some remarkable achievements in the last year. The 25th anniversary of ORS, the development of the Strategic Plan which was excellent, and also the Centre's response to the situation in Rwanda was commendable. It was widely publicised in Australia and was really remarkable. She also commended the Centre for its input into the ICPD: AIDAB's delegates to the ICPD met with delegates from ICDDR,B and were very impressed.

Dr. D. Ceuninck from BADC noted that it was his first time coming to the Centre but he knew the Centre for some time by documentation. Now that he had the opportunity to come himself, it was very different than seeing it in only through reading reports, etc. He had had the opportunity to go to Matlab and was very impressed and was very pleased also to visit the hospital. He had one remark that it would be interesting if the hospital services could be more decentralised but this was an observation of a person who had come here for the first time. On the other side, BADC was very happy and very proud to have the opportunity to collaborate with the Centre. BADC had an agreement and would be meeting with the Centre management at the beginning of next year. BADC made a financial contribution and also a contribution with 5 experts involved in the research programmes and he thought that the discussions about the BADC contribution up to 1997 would be the second part of the contribution of those experts here. Belgium had a lot of interest in this region and that was the reason why he was at present resident in Bangkok, responsible for the medical cooperation in the countries of the region. And without forgetting BADC's former activities in other parts of the world, he was very interested in the activities developed in Goma for the Rwandan refugees because for historical reasons and for many other reasons, BADC were very concerned about the drama that was unfolding there.

H.E. Mr. Jon J. Scott, the Canadian High Commissioner said how pleased he was to be here once again for the annual donor support group meeting. For the second year it was his privilege to acknowledge Dr. Maureen Law as a member of the Board of Trustees. It was a pity that she could not attend but he was also pleased to welcome back Professor Richard Hamilton, another Canadian board member, who had taken leave from his teaching duties at McGill University in Montreal to spend his sabbatical year at the Centre. He was sure that both Professor Hamilton and the Centre would benefit by his decision to come to Bangladesh.

He was also happy to see Dr. Brad Sack again, who was missed by many here and in Dhaka musical circles. One of the advantages of participating in functions such as the present one at intervals of the year is one could observe longer term trends in play and certainly this was true in Canada. Just last week the Canadian special joint committee on parliament reviewing foreign policy tabled its report. This was the result of six months of cross country consultations with the Canadian public and one whole chapter was devoted to official development assistance and significantly particularly for Canadians, it was entitled "reforming international assistance."

Now what did the Canadian parliamentarians think required reform? Well, it was hard at first to determine the major recommendations which were not inconsistent with what had been going on already in CIDA and with what other donors were doing particularly emphasising basic human needs, human rights, democratic development and good Government, participation of women in the development

process, environmental sustainability, private sector development and public participation. On closer reading however, there were some recommendations which implied a strengthening or reform of how Canada supports development cooperation. At the micro level it was suggested that Canada broadened the conditionalities of its development contributions to include reduced military expenditures and increased transparency of Government operations. This was in line with what a number of countries particularly in Europe had been doing recently. In Bangladesh terms he had heard this latter issue, that was transparency of Government operations, referred to as "democratic accountability". Interestingly, the Canadian parliamentarians noted that in their past rhetoric emerging nations had tended to blame domestic economic problems on an inequitable international order. While acknowledging the partial validity of this viewpoint the report noted that developing countries now recognise that no amount of external assistance can ever substitute for the fundamental reforms needed in their domestic economies. This reform had many dimensions of course. It must start and be pursued most vigorously by Governments. But it cannot be undertaken without cooperation of non governmental institutions and private sector bodies. Perhaps of equal and more immediate interest to this group was the recommendation on results achieved by development assistance. While congratulating the rich diversity and vibrancy of the NGO community, the report suggested that there was scope for significant improvement in NGO abilities to deliver the goods. Most significantly the report recommended that Canadian partnership mechanisms which have in the past funded initiatives such as ICDDR,B, allocate ODA resources on the basis of clearly demonstrated records of effectiveness and efficiency of NGO partners. Their emphasis was very clear in establishing a link between the investment made and the results achieved. While this would not be a challenge to groups such as ICDDR,B, the application of accountability not only to Governments but also to elements of civil society engaged in development, would be an increasingly important matter for development cooperation in the future.

On a more personal note, Mr. Scott was happy to have had the opportunity to become better acquainted with ICDDR,B's activities since he arrived. This had led him to believe that this institution had not only strong historical roots but did indeed possess a strong vision of its own future. The Centre's original mandate was to research diarrhoeal diseases and its associated problems and the result was now the famous breakthrough with ORT. Since its discovery and propagation more than 25 years ago hundreds of thousands of lives had been spared and not only in the South Asian region but also around the world. As with all such ventures the Centre's period of growth and change had not been without challenges.

An external review in the late 1980s made some critical recommendations to which the Centre had since responded most positively. This was evident in the continuing evolution of its management style, which had seen greater bottom-up participation in setting priorities, goals and objectives, and the result was an increasingly "team ICDDR,B" feeling that now pervaded the Centre from top to bottom. The Centre's finances reflect a more realistic balance between the institution's desires and donor fund availability. This positive evolution was also evident in the manner in which ICDDR,B had been increasingly outward looking in its orientation. From its pioneer work on the diagnosis of the cholera strain 0139 last year, to the team of doctors and support staff the Centre provided to the distressed in Rwanda this past summer, the international relevance of ICDDR,B continued to be demonstrated. The Centre's partners were particularly proud of its role in Rwanda and the positive image enhancing visibility it gave to Bangladesh.

Perhaps the Centre might care to reflect on potential areas of priority and growth. Mr. Scott alluded earlier to Canada's parliamentary concerns with aid accountability and management for results. He knew also that a recent UNICEF State of the World's Children report focused on the need to continue efforts to improve the welfare of the world's children. In this respect CIDA would support the Centre's wish to further focus on issues related to family planning and mother and child health care. The most important of all the Centre's work should continue to demonstrate relevance and be disseminable.

The worldwide health benefits which resulted from the Centre's development of ORT doubtless served as a model for all its present and future work. It was particularly pleasing to note that the Canadian International Development Agency had had a long history of involvement with ICDDR,B. In the 1980s this included supporting the Centre in the creation of its world renowned baseline demographic surveillance system at Matlab. In the early 1980s CIDA provided three technical advisors with a view to improving the integrated health care system of the Centre and of the country. More recently CIDA'S focus of support had moved from project to core funding and in this respect we have disbursed 3.0 million Canadian dollars over a 4-year period for activities that the Centre deemed appropriate. This demonstrated CIDA's faith in ICDDR,B's Board of Trustees and in its senior management in setting priorities for the Centre. He wished to state that it was his Government's intention to continue along this path. CIDA was currently in the process of approving continued financial support to the Centre and this had not been without difficulty. While the international perspective of ICDDR,B was one of its strengths, it also made it more problematic from the administrative point of view within a system of national ODA accounting. However, he was assured that the process of establishing a firm allocation for continued support from CIDA was well in hand. CIDA's intention was to continue support at a level comparable to previous years that was at the same level as last year. It was clearly the desire of all concerned that Canada would continue to contribute to ICDDR,B's funding needs.

Mr. Raymond Offenheiser of Ford Foundation thought that Ms. Gabrielle Ross had very succinctly stated the Ford Foundation's appreciation for the principles and the new Strategic Plan that identify very much with the Cairo agenda. Ford had stated that they very much want to help the Centre support that agenda, particularly in the social sciences that would help deepen the understanding of the demand side of the family planning equation. At present the Ford Foundation was supporting two projects that actually predate the Cairo meeting and very much embodied Ford's commitment to support for an integrated approach to women's reproductive health as well as women's rights. One was the BRAC-Matlab initiative which Ford had been supporting over the last two years or so. This unique joint venture between BRAC and ICDDR,B was an extraordinary opportunity to really explore the relationships between health behaviours and other sectoral development interventions. The baseline survey was now out, and there was a research agenda that was beginning to take shape. There was a lot of excitement generated in various other research centres around the world which were beginning to want to partner with other research teams on aspects of this particular project. So the Ford Foundation was very pleased with the progress made, and wanted to continue to be associated with this effort. Ford saw this as a project that was taking best advantage of the long history of the demographic survey system that the Centre had set up and would bring new dimensions to that exercise. This point was mid way through a grant made to both institutions to initiate this (that is to say to BRAC as well as to ICDDR,B) and Ford expected as the project proceeded to begin negotiations for further funding of that into a second phase.

The other project which was in line with this, and complemented nicely the work in the BRAC-Matlab programme, was the newly established social science programme within ICDDR,B. This was an initiative that the Ford Foundation had been encouraging the Centre to take on for quite some time and they were quite pleased that now the department was a reality, staff were being hired. There had been interest he understood from ODA to bring in a health economist, and the London School of Hygiene and Tropical Medicine again was partnering with the Centre on a variety of different kinds of research programmes. This again Ford saw as a long term initiative. They wanted to stand by that programme as it developed and welcomed other partners; but it was an area where Ford would have its feet firmly planted for some time to come. At present, Ford was one year into the establishment of that programme and had funded it to the tune of 750,000 dollars and would expect again towards the end of that programme to begin negotiations for a next round of funding. Going back to the earlier comments on Ford's broad concern with reproductive health issues, Ford, as an institution, would also be open to other proposals from the Centre in the area of sexually transmitted diseases, reproductive tract infections, a variety of other related issues in the reproductive health area. The Ford Foundation had had conversations with the Centre staff on these issues and had been supportive of the initiation of the Centre's work in the HIV/AIDS area and

again would continue to be available to the Centre for conversations on perhaps further support to initiatives in that particular area. He made one final comment on the Centre Fund.

The Ford Foundation felt that it had been a very bold step on the part of the Centre to try to come up with an innovative plan for achieving long term financial sustainability and setting up a fund that would enable the Centre to, as it had been put earlier by the Director, remain on the edge of excellence. Ford hoped that the Centre would be able to achieve its goal of 20 million dollars, and would continue to be available to the Centre as a possible funder of the fund raising effort itself, although he was pleased to hear that the Board of Trustees had approved use of the Centre's funds to underwrite some of that new effort. Many of those involved in international public health knew the Centre and its programmes very well but there was also a very difficult public education exercise that the Centre would now be embarking on to reach out to new private sector donors in the United States as well as foundations that had not hitherto had contact with the Centre, and a whole range of even potentially new individual donors. This was a time consuming labour intensive job. The Ford Foundation stood behind it, wished the Centre the best and hoped that it can, in fact, achieve that 20-million dollar goal in as short a time as possible.

Mr. T. Uesawa from the Government of Japan noted that his Government was happy with the work that the Centre was doing on family planning, *Vibrio cholerae* and so forth. Japan was also paying attention to the uniqueness of this Centre, which was not only an international research centre but also ran the hospital where it saved a lot of lives of the poor people. The Government of Japan was very interested in it and appreciated this noble performance. The other characteristic of the Centre he was interested in, was the very positive involvement of the Centre in activities and research in the population sector. Mr. Uesawa had just 4 points to raise in order to express the Japanese position on the future cooperation to the Centre. Number one was relating to the population cooperation, before touching upon the very specific topic about cooperation with the Centre. He wanted to introduce one new Japanese plan in the population sector. The Government of Japan had been keenly interested in steady development in the population sector, particularly in the developing countries. Japan regarded the population programme as a global issue and on the occasion of the meeting between the then Japanese Prime Minister and the President of the United States, Mr. Clinton, Japan announced its new plan for population, which they called, Global Issue Initiative (GII), that it would expand bilateral and multilateral Japanese ODA in the field of population and AIDS in developing countries up to and around US$ 3 billion in the next 7 years from fiscal year 1994 to 2000. Under this plan collaboration with the United States was one of the very important parts of this plan. In line with this policy the Government of Japan had decided to make funds (three hundred thousand US dollars) available to the population project in Matlab from this fiscal year and this 300,000 was in addition to the existing Japanese contribution to the core fund of US$380,00 so the total of the Japanese contribution would be US$680,000. Therefore, the Matlab project had become more important for Japan, and he wanted to have some report, some progress on that as Tokyo was very interested in that project. He also hoped the results and achievements of the Matlab project could be shared with other international organisations.

Regarding the second point, that was just on the Centre's brochure in Japanese, he was very happy to see the conclusion and publication of that and hoped that by using this sort of brochure, the Centre would make more effort to attract more Japanese public and private sectors as potential donors to the Centre. And third point, how properly the Centre used the funds donated by the donors and also it was about the resource mobilisation strategy. The most important thing was not to need a strategy but how to implement this strategy. So he wanted to take this opportunity to request the Centre to make more effort to use donor funds as properly as possible by restructuring or by keeping the number of staff that it really needed. And also he wanted to request the Centre to make more efforts to develop other potential donors and to get more funds for the Centre. The last point was that for the smooth operation of the Centre, multi-year pledges were very important. He was sorry to say that because of the Japanese budget system, it was not possible for Japan to commit on a multi-year basis. However, on this occasion, he wanted to express the Japanese intention to cooperate with this Centre. The Japanese Government would like to continue to keep its donation at least at this year's level of $680,000.

Ms. Rita Imanuel-Rahman from the Royal Netherlands Embassy noted that this was her first time here in the Donors' Support Group meeting, but it was not the first time that the Netherlands was present. However, she was somewhat illegally here, perhaps as some sort of candidate member, since the Netherlands had not approved till now, two projects of ICDDR,B funding support which had been pending for almost two years. She was very sorry for that but had to say at the same time that the Centre would understand as a research institution because what happened was that these two proposals both became part of the sample and this was a sample to test the Netherland's new funding criteria especially on research institutions and NGOs. It was not a joke. It was the truth. That was why she had to come over and over again to the Centre to raise a lot of tricky questions the last month. She was then about 80% to 99% sure that by the end of this year she could bring the good news. And by then the Netherlands would be a definite member. She wanted to stress or to emphasise what Ford Foundation said, that the Netherlands were also very much interested in research on STD, on reproductive tract infections and on HIV/AIDS. They wanted to add to that, but that was a concern from the Netherlands. They had noticed last year perhaps that there were twice the number of research efforts in these specific fields, but they had the feeling that there was huge lack of coordination. Of course they would not put this question as such on the table of ICDDR,B but felt that there should be some more coordination especially in this field. Finally she had to say that there was also great interest from all sides in what was mentioned this morning by Dr. Michael Strong.

She added that there was still enough need and space in Bangladesh for a supply driven approach but in terms of sustainability and in terms also of implementing the action plan of Cairo she noted that it was necessary to develop the demand driven approach. This was not only for ICDDR,B's activities but since the Netherlands participated in the fourth population and health programme also, there they felt that perhaps historically by starting first on family planning then adding to that mother and child health and then adding to that health concerns, that this had perhaps also shaped the way of approaching the issue of health and population in Bangladesh. She had a meeting with women in Bangladesh some weeks ago, and they said if she would freely interpret the outcome of Cairo then one of the ideas of demand was that women in a village should go to the village leader or the thana leadership and tell them about their willingness to join the family planning programmes, but on this and that conditions. These conditions would be the needs they felt in terms of access to education, access to employment, access to better health facilities and access to good service.

Mr. Nick Roberts from the European Union (EU) said that it was nice to follow a donor who had been talking for two years, as the EU had only been talking for one year about funding ICDDR,B. He was pleased also to hear from Mr. Graham Wright that the EU had actually funded something. He thought this was something very small from the EU's research division and that the Centre was looking for a lot more than that from the EU. However, the talks continued and a number of positive developments had taken place over the past year. They had managed to get Dr. Habte to Brussels where he discovered some of the realities of the EU bureaucracy, and they have had a series of meetings and visits with ICDDR,B and to their programmes.

Mr. Roberts personally had visited the Matlab programme and was struck by the fact that there was a model of quality delivery of both health and family planning services which should be replicated throughout Bangladesh. He noted the need to find the mechanism to disseminate this model as soon as possible. In this connection, the EU had a project as part of the population and health project with the Government, in another 2 districts shortly to help the Government improve the quality of their health and family planning service delivery at thana level and below. There was already a link between the project and the Centre but if it was possible to create a closer link with ICDDR,B, it would help the Centre in its dissemination activities and it could also feed back into the research agenda which needed to be carried out for the future. As regards the question of formal funding, the EU had held a meeting with the Government recently and had been approached in writing by the Government with a request to fund ICDDR,B. This facilitates very much the possibility of funding, and in the working group meeting the

EU had in November, 1994, it was agreed that they should proceed to the next stage of making a commitment.

The EU had a project proposal from ICDDR;B for supporting the MCH-FP Matlab programme over a 4- or 5-year period and this would be the basis on which the EU would finance. It was likely that the EU would need some sort of review mission from commission officials or consultants early next year which he hoped would firm up a proposal for formal commitment. He also thanked the Centre for the quality of the presentations in the morning. He had actually brought some materials to read but since the lights were turned off he had to listen and was rewarded with some very good presentations which demonstrated the outward looking approach of the Centre.

Ms. Hellen Ohlin from Sweden noted that she had already expressed several times SAREC's great satisfaction at the development of the Centre as it had had a long history of contacts. These contacts were both with SAREC as an agency and with scientific collaboration of scientists in Sweden, for instance, Jan Holmgren for the cholera vaccine. Right now there were a couple of female scientists working for their Ph.D. programmes in one institution in Sweden, the Karolinska Institute and they were doing extremely well in relation to getting the papers accepted for publication. So, SAREC was very happy to know that the Centre's problems with its mandate and its financing, seemed to be under control now. So, SAREC wanted to compliment the Director for the work and also the work that had been presented about the funding strategy and additional efforts in fund raising. SAREC had contributed a 3-year grant consisting of 2.5 million Swedish krona each year for core funds as well as for collaboration with 3 scientific institutions in Sweden. SAREC was now in the second year of this obligation and so there was still one more year to go. In this context, she mentioned the Swedish aid policy and financial situation as prevailing now after the election in September.

Sweden had a socialist Government and the economic situation in Sweden was quite unsatisfactory. Sweden had been so good in its public relations that often it was not known that it actually had the fastest growing national debt in Europe comparatively. Only Italy was worse and this was really quite a problematic situation so the new socialist Government would have to continue the policy of the previous non-socialist Government by making cuts in the budget. This was in a way a new situation but if these cuts were also going to affect the aid budget which was likely, this would be presented in January. Also another issue was that a decision about a big reorganisation of the Swedish aid administration under which SAREC as a research council would be abolished together with a couple of other aid agencies. She hoped that SAREC would be allowed to continue as a department for the support of research in the big new organisation. She hoped that SAREC would continue to have good and interesting collaboration with the Centre and looked forward very much to the developments of the policy in accordance with the Strategic Plan.

Dr. Mehtabunisa Currey from ODA thanked the chair very much for breaking the alphabetic order and allowing her to go. First of all, she thanked the Australian delegate for living up to the tradition. AIDAB had always done the compliments so well that she had always generally followed and said that she would just echo the same. She hoped that these sentiments would be recorded again which would allow her to be even more brief. She gave the message from headquarters' health and population division first. Their core funding had really allowed the updating of demographic surveillance data, and they were very happy to see the regular productions of the demographic surveillance reports. ODA was very happy to receive them. The other message from them, however, was that they were eagerly waiting to hear from the Centre regarding the two conditions they had in the agreement which she thought would make the export of the Matlab model even more practicable for other countries. One was the cutting down of the costs by reducing the visits by the FWAs or the home visitors from the fortnightly visits to a monthly visit. The other was in relation to being able to price the demographic surveillance data which was very valuable. This would encourage more research by selling the available data production, so that more people were able to access the product. The other message was that ODA was really seriously considering further funding requested by the Centre and there would be a visit in December to take that forward; so

she hoped that by the end of the year there would be good news. Particularly because most of the ODA's research funds really come from headquarters rather than from its office here.

With regard to the office in Dhaka, they were very happy to know that the reproductive tract infections project that they had supported had taken off. She had been discussing with Dr. Sarah Hawkes who was present at the particular meeting where the Netherlands raised the issue of coordination because there were a few other initiatives that ODA were funding in Bangladesh. ODA was already funding a Government initiative on STD projects, and had several NGO initiatives actually providing services for STDs and ODA wanted to see these tie in and had already been having discussions to see how these initiatives could be tied in. In terms of the future rather than new areas she would have really liked to see an expansion in the area of STD; the reproductive tract infections really taking off in collaboration with the other organisations into community-based services.

Dr. Peter Arnold of SDC noted that SDC had supported ICDDR,B for a number of years, precisely since 1980 and he was happy to announce that SDC would remain a partner for at least another three years. Indeed the present funding agreement was coming to an end at the end of this year but SDC was about to sign a new agreement covering the next 3 years (1995-97). Once the proposal had taken the final approval hurdle - it was unfortunately still not signed by the minister - the green light would be given by SDC headquarters. The agreement would include yearly contributions for core and project funding on the 50% share basis recommended by the Board of Trustees and as the meeting heard in the morning, a substantial amount of about three million US dollars would go into the investment in the hospital endowment fund. SDC hoped of course that its contribution to the endowment sent a positive signal for other donors.

He admitted that the present situation with the tax exemption was not a satisfactory one, and it acted as a disincentive but he hoped that in one or another way it would be overcomed. For example, the Government of Bangladesh would continue to increase their annual contribution accordingly. SDC believed that endowment funds were valuable appropriate instruments to provide long term stable funding to central components of ICDDR,B's institutional set up and to protect scarce resources from the financial strain caused, for instance, by a sudden massive influx of patients or a temporary breakdown in funding flows thus safeguarding research from short term financial problems. SDC also believed that it was one of the measures the Centre needed to get a certain kind of financial autonomy to become less dependent on donor funding. He noted that taking into account the very limited experience with financial endowments of this size in Bangladesh, ICDDR,B had agreed to jointly review the fund's performance after five years. He confessed another reason for SDC contribution to the hospital endowment was that SDC would have to live in the coming years with a reduced budget due to financial difficulties faced by the Swiss Central Government. He had heard that public debt in Sweden was growing very fast, in Switzerland this was also true, and in addition, it was forbidden by the constitution. So the Swiss Government was continuously acting against the constitution. It was likely that the absolute priority given to preventive health during the last years (in the last four years SDC had allocated around 50% of its disbursements in Bangladesh to sanitation, water supply, and health), will be largely de-emphasized in the near future in favour of other sectors of intervention. With this input, SDC therefore, wanted to make a contribution towards a stable future of ICDDR,B while foreseeing its own incapacity to sustain SDC assistance at the same level as in the past.

SDC's continued support essentially expressed its agreement with ICDDR,B's mission, perspectives and approach. SDC was very happy about the formulation of the mission in the Strategic Plan, "ICDDR,B's fundamental mission is to develop and disseminate solutions for major health and population problems facing the world with emphasis on simple and inexpensive methods of prevention and management". SDC could add that in this way ICDDR,B would work towards the final goal of increasing the capacity of poor countries and poor individuals to protect themselves efficiently against major causes of illness. SDC also believed that ICDDR,B had become an outstanding international reference Centre for diarrhoeal diseases and population issues with interesting perspectives for promoting Third World centred health research

capabilities. He supported what Australia had said about being happy to see more Third World countries coming and joining the donor community. The holistic approach adopted by the new Strategic Plan especially the particular emphasis placed on community-based approaches to health on prevention in preference to care and on translating research into action through operations and policy related research was very much in line with SDC's own thinking. SDC had always tried to balance the Centre's activities away from a focus on individual diseases, on technology and qualitative health, more towards the field of social, cultural, and behavioural aspects of health, and more towards how to implement existing technological knowledge. But despite SDC's basic belief in the fundamental soundness of what ICDDR,B was doing, it would remain what it had always been, a critical though constructive partner. SDC would, in particular, observe with utmost interest how ICDDR,B practically translated into action the adopted holistic approach to health. The Centre recognised itself that it had an important backlog in not directly technology-oriented research expertise especially in the field of human behaviour and health delivery systems research, and he was happy to learn that the first important steps had been taken. Build up of the missing capabilities should therefore be given first priority to be able to translate the holistic approach into practice. In this respect it should never be forgotten and SDC would always continue to repeat it, that in spite of increased clinical successes the epidemiological impact of the diarrhoeal disease technology development at the Centre remained doubtful so long as there were no substantial changes in certain behaviours of the population. Only more knowledge on how to change attitudes and how to implement the acquired knowledge properly could bring about a real breakthrough. Another important question that SDC asked and would continue to ask was who sets the research priorities and how were they set. SDC adhered to the principle that setting of health priorities should never be left to the scientific community alone. Others (policy makers, health practitioners, health programme planners and implementers and user communities) should have an equal or even more important say. This, however, required expertise and skills in participatory methods and action research approaches which would allow the Centre to look at communities not merely as objects of investigation but as recognised partners in priority setting, and would help to learn from experience. In this respect, he wanted to illustrate it shortly.

Looking at the figure of priorities in the Strategic Plan there were these two important fields of activities which converged to policy and application but there should be another arrow that was going from policy and application to the research priorities. How, indeed, could we expect research findings to be successfully and quickly transformed into action when they did not reflect the concerns of policy makers of health practitioners and of communities. SDC had reasons to believe that in this respect there was still a certain lack to be overcome within ICDDR,B although there were first steps that had been taken. SDC was prepared to provide assistance in this field to the Centre if requested within the framework of its project funding.

Mr. Richard Greene of USAID/Dhaka supported the Centre by two means: one was from missions in countries such as Bangladesh, and the other one was direct support from USAID Washington, which Dr. Caryn Miller would discuss. He had a few points for the bilateral side, which was presently supporting the urban and rural MCH family planning extension projects including technical assistance through the Population Council and Johns Hopkins University. These initiatives would continue until 1997 and the life of project funding since the beginning and through 1997 would be about 15-16 million dollars. This was an ongoing programme. Due to USAID's programming process, he was not in a position to announce any new contributions at this time. However, he wanted to say a few things one of which was that USAID was very pleased with the leadership and the results of the programme and in particular the MCH family planning and extension projects; and the USAID wanted to emphasise this point. USAID hoped that the results of these programmes could be widely disseminated and replicated and believed that in the future USAID's expanded support for research as a mission would probably be linked to the evidence that the research programmes had been shown to have concrete application in the field. So this was very important to demonstrate and important to document. USAID also encouraged the development of new initiatives such as the endowment fund and the new initiative to develop a family planning and maternal and child health training programme. USAID felt that these were worthwhile initiatives and were naturally pleased to consider for possible future support all such new initiatives.

Mr. Greene announced that in March 1995, USAID planned to do a population and health sector assessment in Bangladesh which would take a look at USAID's large family planning and health programme in the context of the entire sector and during this assessment USAID would also look at its research programmes at ICDDR,B. Following that in September 1995 USAID would be designing a new global family planning and health services project to replace the ten-year effort under which the present cooperative agreement with ICDDR,B was funded and during this time this would probably programme USAID's funds for the next 7-10 years on the mission's bilateral side. USAID would be working very closely with ICDDR,B during both of those programming exercises. USAID also wanted to make a point that when it made a commitment, a planned contribution to a project or a cooperative agreement, it was very important to be able to demonstrate the timely expenditures of committed funds in order to justify continued increments and this was something that was a concern to USAID in all of their programmes. Finally, he wanted to repeat USAID's congratulations to the Centre for its achievements and to strongly pledge USAID's support for the organisation in the future.

Dr. Caryn Miller from USAID/Washington noted that USAID Dhaka played very complementary roles, vis-a-vis the contributions to the Centre. Participants had just heard a few more details about what the bilateral programme was planning and had been doing. USAID Washington focused rather differently on child health and nutrition research now that USAID had been combined as a single unit together with population. USAID/Washington was particularly interested not just in biomedical research even though she was presenting it disease-wise, but also in the behavioural aspects. So USAID/Washington had been very interested in the ICDDR,B-BRAC collaboration that was started by Ford. USAID/Washington had funded one portion or module of that and was interested in continuing that particular application.

From USAID Washington, priorities were mainly related to diarrhoeal and respiratory diseases, nutrition deficiencies and integrating research on these particular conditions. As the research which was funded by Washington was important in that it had global as well as national implications. USAID/Washington was pleased that the ICDDR,B had contributed to such a great extent to these global efforts including their technical assistance for cholera and shigella in the refugee camps in Goma as well as in Latin America and hoped that the Centre would continue its contributions on a global as well as on a national scale. In particular, USAID/ Washington looked forward to future efforts in the Asia region particularly related to the vaccine development centre in Asia, a network which it hoped would develop soon, and in particular, also related to the International Vaccine Institute in Korea, and global efforts were underway to develop methodologies to cost-effectively monitor the emerging and re-emerging diseases including antimicrobial resistance.

USAID/ Washington commended the efforts of the Centre to develop a coherent Strategic Plan and particularly the progress on resource development not only in the sense of the endowment fund but also the expanded donor base. USAID/Washington had been funding ICDDR,B and its predecessor since 1960, and had established the original Cholera Research Lab so to see the transition from a single US funded institution into this multi donor institution which had broadened its mandate well beyond biomedical research, and cholera was a real reward, especially the progress that had taken place in the last 5 years. USAID/Washington had also been extremely pleased that the Government of Bangladesh had increased its contribution as was announced this morning. They had also increased their contribution but also the human resource contribution during the Board Meeting was quite rewarding and very constructive on the part of Bangladesh. As to future funding and future agreements, USAID/Washington continued to want to see the Centre take on a more integrated multi-disciplinary approach which she had already commented on. USAID/Washington currently had a five-year cooperative agreement with ICDDR,B which had one more year to go. So, over the next year they would be formulating the parameters of that particular agreement and hoped to have a 5-year agreement in place before the end of 1995. She gave some special thanks to the Goma team. During that time she was at the other end in Washington trying to find places to send money when she got desperate messages that they had no tent, no supplies and no money. While she was frantically running around, it was very sobering to think that there they were stuck

in the middle of nowhere without anything. So, she really wanted to give a special thanks on behalf of USAID Washington.

Dr. Seung-Il Shin of UNDP, New York, was very glad to be representing UNDP which had been a very strong, consistent and long time supporter of this programme. He noted that Tim Rothermel who generally came here, and had the honour of chairing the Donors' Support Group meeting, particularly asked him to give the meeting his regrets that because of some family matters he could not be here today. On the other hand that gave Dr. Shin a chance to come here and see many friends. On a personal note, he added that he had been tremendously impressed with what goes on in the Centre scientifically as well as in terms of patient care, as well as in Matlab. UNDP had been very pleased over the years especially during the last 5-6 years at the very substantial improvement in management, the research output as well as its contribution to many of the acute problems in the world. He had noted with great appreciation the comments from delegates from Australia, Bangladesh, Japan, and Switzerland. He wished that he could add something to that but the best he could do was to say that UNDP intended to continue its present level of support at least for the time being, as always of course being a UN agency, subject to availability of funds.

Finally, he added one special note: Dr. Habte and just now USAID delegate, Dr. Caryn Miller mentioned the emergence of what was called the International Vaccine Institute. UNDP looked at ICDDR,B as a prime successful example of capacity building in the developing world, that contributed not only to the solving of immediate problems but a long term building up of human and institutional capacity. The International Vaccine Institute was another effort by UNDP to respond to a recent global initiative called the International Vaccine Initiative, the former name was actually Children's Vaccine Initiative. After a long feasibility study a committee had selected the Republic of Korea as the site for this new initiative. Simply put, they were trying to create another international institution which they hoped would, in time, be as successful as ICDDR,B. And here the emphasis would be in building capacity in science and technology that was relevant to vaccine development, vaccine testing, and vaccine production especially for the vaccines that were relevant to the developing countries. The prime goals of this new international vaccine institute was to be quite complementary to the activities at ICDDR,B. And so UNDP was really very gratified that the Board of ICDDR,B had formally welcomed the new institute as a sister institute because it believed there would be great need as well as opportunity for these institutes to grow together and reinforce the strength of each other. UNDP hoped to see very active exchange of ideas, personnel, and also scientific talent in the years to come.

Dr. Jon Rohde speaking on behalf of UNICEF, started out by saying that the Centre's agenda in research focusing as it did on women and children made it almost precisely UNICEF's research institute and the Centre had a tremendous influence on UNICEF policies. UNICEF looked to the Centre a great deal to answer practical questions that they hoped to put into the field worldwide very quickly, so in a way UNICEF was an implementer of the Centre's products, a consumer, and perhaps one of the extensions of the Centre out into the world at large. Those who knew Mr. James P. Grant well recognised that every day for the past probably ten and maybe more years when he got dressed he put his ORT packet in his top packet before he put on his tie. He carried it in his pocket all day until he gave it away to somebody like Bill Clinton or some other person who then asked what this was anyhow? And Jim told them the story of the whys and wherefores of this remarkable technology. A number of the participants had shown some interest and so Dr. Rohde noted that Mr. Grant was asked, ten days ago, by the Secretary General to extend his term as Executive Director of UNICEF for another year and Mr. Grant was very pleased to accept that invitation. Back to the issues of the Centre, UNICEF was particularly pleased with a number of the areas that the Centre has moved into from diarrhoeal disease. Most notably the efforts in safe motherhood had helped UNICEF to guide strategies not only in Bangladesh and nearby India but would be very formative in setting out policies for the major thrust UNICEF was in the process of mounting and would be pushing throughout the rest of this decade to try and deliver on the promise not only to children but the promise to halve maternal mortality throughout the world by the year 2000. He added that the complexity and the profundity of the nutrition problem was no reason that this Centre

should back away from it. He feared in fact that the very underlying nature of high infant mortality and morbidity, and high childhood morbidity, was indeed related to those unanswered questions of malnutrition.

Like Dr. Habte, Dr. Rohde had started his career largely in paediatric nutrition and many had run away from it frightened because there was no magic bullet. There was probably no problem less likely to be solved by a magic bullet approach, and therefore, it was only a Centre such as ICDDR,B with the broad abilities especially those that were being developed today in social sciences, behavioural sciences interacting with environmental science studies. With everything from the engineering to the behaviour to the microbiology and indeed with the excellent laboratory facilities that were available - the Centre was unique and he was hopeful that the Centre would indeed take on even more of the challenge even though he recognised the Centre's honest humility in dealing with the nutrition problem. There was probably no better institute to do it however. He would try and encourage that move although he could not make any promises, he had some schemes as to how he might try and grease the skids a bit with some money to make it more interesting to get started in that direction. He was pleased to hear from Dr. Siddique that UNICEF was helpful but was also embarrassed to say that with all of the indoctrination that UNICEF had in proper management of diarrhoea the world should not have even needed Dr. Siddique and his team in Goma. And so he would be talking with UNICEF to see if they could not help catalyse an inter-donor effort to try and do more on disaster preparedness so that when that inevitable next emergency would come that NGOs and Government relief organisations would be better prepared to do the right things from the very onset. He expected that if it was done in an inter-agency fashion, it would be all the more popular with the donors' country NGOs as well as with United Nations organisations and all those who were interested in responding to these terrible challenges.

Like UNDP, not only did UNICEF fund others but they themselves were recipients of donor funding and while their contributions to this Centre came from two sources of money, one from UNDP's central budget which was small and shrinking, many of the countries represented around this table were asking UNICEF to keep less of its money in its core budget and put more of it into country budgets which put real pressure on support to the Centre which came from UNICEF global funds. The only exception to that was, of course, the projects and there had been really excellent collaboration between the local UNICEF office and programme with the Centre in cases of having a research question to which UNICEF needed an answer immediately and got it literally within weeks. This was usually in the form of small problem solving projects or analyses and the Centre had always come very quickly, and had been very practical in their help and UNICEF appreciated that. He closed by saying that UNICEF looked at the efforts of the Centre to establish its endowment fund as a very worthwhile effort and while it was unlikely that UNICEF would contribute money to the endowment, he had received the agreement of various people in UNICEF to join in this effort and to use UNICEF's name to the extent that they were good offices and encouragement to donors of all kinds not only Governments, but foundations, corporations; and others, to join in this effort of the Centre. He was hoping that perhaps he could even get UNICEF committees in some of the countries in Europe, in the developed countries, to get behind this and encourage it since UNICEF really did see the Centre as its R&D wing. On behalf of UNICEF, it would only leave it for him to thank all of the donors also for funding the Centre which means so much to UNICEF in its programmes around the world.

Dr. Habte concluded and on behalf of the staff of ICDDR,B and on his own behalf, he thanked the donor community assembled here today for their words of appreciation. Like a little child, the Centre grew almost in direct proportion to the appreciation it received from its donors. The Centre was also very grateful for the participants' critical inputs, and would take them up very seriously and continue to use advice and criticism to continue to improve what the Centre was doing. He added that he could not help but note that what had happened at this institution over the last few years was a remarkable example, an example where donors played a very critical role to shape the institution and prevent its demise. He thought this was a very critical and important event, particularly so because largely as a result of the experience of ICDDR,B the international community was getting disenchanted about the role of

international health research centres. For the first time now in the last two years, the pendulum had swung to the other direction and people had realised that given the goodwill on all sides international health research institutions had a definite and important role to improve the health of people in the developing as well as in the developed world. It was a credit to people like those sitting around this desk that they had made that possible and thus knowingly or unknowingly made a very important contribution. He thanked them all for this. He took the opportunity also to thank Eimi Watanabe for agreeing to chair this session, being at the Centre for the whole day. She was a very busy person for whom time was a precious commodity and the fact that she had spent the whole day and did so at fairly short notice was a testament to the friendship that existed with UNDP.

Ms. Watanabe, Chair of the meeting thought that all the positive comments she had heard around the table from the donor community was the testament and tribute to the work being done at the Centre by all its staff, and Dr. Habte's very dynamic and substantive leadership. What they had been hearing today and what she had been observing since coming to Dhaka was that indeed there had been a remarkable change at ICDDR,B and what the meeting had been hearing was an expression of appreciation as to the role that Dr. Habte had been playing and the very very hard work being put in by all his staff. Having said that, however, she thought the Centre had also been given challenges by the donor community, and what it had before it was a tough balancing act, balancing between the expanded mandate of health and population, meeting the challenge of nutrition as Jon Rohde so eloquently put it, and yet maintaining the Centre's focus on the excellence of its research and pre-eminence in the field of diarrhoeal disease.

So how to balance that larger mandate and the Centre's focus on diarrhoeal disease; how to balance the multi-sectoral, multi-disciplinary approach into the Centre's work, which was so essential to understanding the issues of child survival, and health and population research with again the pre-eminence in the biomedical research particularly in the field of cholera research which was the origin of the Centre. Both were necessary and what the Centre had before it and what had been so eloquently expressed in the Centre's Strategic Plan was how it balanced these needs and challenges. Well, the Centre had the support of the donor community and it was indeed quite exceptional that it was receiving this level of support in an environment, the financial environment of today which was not very conducive as far as development assistance goes. So, it was indeed quite exceptional and a very very significant tribute to what the Centre was doing. She wished the Centre further growth in meeting the challenges before it and thanked everybody who had made excellent presentations, the quality of which had been noted by several donors. She too had gained a lot from the presentations and thanked Dr. Habte and other staff who had made excellent arrangements for today's meeting and also thanked everybody who were present for their active participation.

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

- MISSION STATEMENT -

"The mission of the Centre is to develop and disseminate solutions to major health and population problems facing the world, with emphasis on simple and cost-effective methods of prevention and management."

International Centre for Diarrhoeal Disease Research, Bangladesh

• Produced by Sirajul I. Molla, Julie Banfield and ERID Office