INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

REPORT OF THE BOARD OF TRUSTEES MEETING

NOVEMBER 30 - DECEMBER 2, 1983

APPROVAL OF AGENDA

AGENDA

BOARD OF TRUSTEES MEETING, ICDDR,B
DHAKA, NOVEMBER 30 - DECEMBER 2,1983

1.	Approval of Agenda	- 1/BT/DEC.83
2.	Approval of Draft Minutes of Board of Trustees Meeting, June 1983	- 2/BT/DEC.83
3.	Matters Arising	-
4.	Director's Report	- 4/BT/DEC.83
5.	USAID Review	- 5/BT/DEC.83
6.	Programme Coordination Committee	- 6/BT/DEC.83
7.	Vaccine Report	- 7/BT/DEC.83
8.	Resources Development	- 8/BT/DEC.83
9.	Finance Committee	- 9/BT/DEC.83
10.	Presentation of Budget	-10/BT/DEC.83
11.	Report of the Adhoc Search Committee.	-
12.	Report of the Personnel Selection Committee.	-12/BT/DEC.83
13.	Varia.	-

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Schedule of Agenda

30-11-83

Beginning of Meeting - 10 a.m.

1. Approval of Agenda
2. Approval of Draft Minutes of Board Meeting, June 1983
3. Matters Arising
4. Director's Report

   (All members of Management Committee invited for Agenda 4 & 5)
5. USAID Review

Luncheon at IPH Auditorium or Ground Floor (Sandwiches) - 1 p.m.

6. Project Coordination Committee - 2 p.m.
7. Vaccine Report
   - Dr. John Clemens
   - Dr. M.U. Khan/Yunus
   - Dr. T. Butler } invited
   - Dr. K.M.S. Aziz }
8. Resources Development
   - Mr. M.R. Bashir
   - Mr. M. Goon
9. Finance Committee
   - Mr. M.R. Bashir
   - Mr. M. Goon

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Schedule of Agenda
1-12-83

9 a.m.

10. Presentation of Budget
   - Mr. Bashir
   - Mr. Goon
   - Associate Directors for Programmes

11. Report of the Ad hoc Search Committee

12. Report of the Personnel Selection Committee

13. Varia

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2-12-83

9 a.m.

Review and approval of Resolutions

14. Date of Next meeting

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2/BT/DEC.83

APPROVAL OF MINUTES OF THE BOARD OF TRUSTEES MEETING, JUNE 13-15, 1983

MINUTES OF THE MEETING OF THE BOARD OF TRUSTEES, ICDDR,B HELD AT IIE, NEW YORK 13-15 JUNE, 1983.

Members Present:

Mr M.K. Anwar
Prof. D. Bell
Dr D. Bradley - Chairman
Dr W.B. Greenough - Secretary
Maj. Gen. Shamsul Haq
Dr J. Holmgren
Dr G. Jones
Dr J. Kostrzewski
Dr L. Mata
Dr M.A. Matin
Dr V. Ramalingaswami
Dr J. Sulianti Saroso
Dr Y. Takeda
Dr M. Were

Members Absent:

Dr H. Al-Dabbagh, Dr F. Assaad

Agenda 1: Approval of Agenda

The agenda was approved as amended.

Agenda 2: Approval of Draft Minutes of Board Meeting, December 1982

The minutes of the meeting 6-8 December, 1982 were approved with the following further corrections:

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(a) Page 3, Resolution 24/June 82 should be changed to read as follows:

"The Board authorizes the Director to transfer the present Severance Pay Fund held in Taka, to an external Dollar deposit account with a Bangladeshi nationalized bank, pending conversion of the Severance Pay Account into a Staff Pension Scheme.".

(b) Page 7, paragraph 2, line 8 "is willing to treat it as a long term" should be deleted and the words "may be agreeable as an" added in their place.

(c) Page 35, Resolution 23/Dec. 82 should be reworded to read as follows:

"Resolutions 17 through 22/Dec. 82 indicate the completion of transition of the Centre from the former Cholera Research Laboratory to the current International Centre for Diarrhoeal Disease Research, Bangladesh. The provisions of Clause 30(b) of the Ordinance will cease to apply with this transition. The Board asks the Director to ensure that all staff conform to WHO staff rules and pay scales by 1 January, 1983 with a report to the Board.".

(d) Page 36, Resolution 27/Dec. 82. The following sentence should be added after the list of names "Since these are reappointments there will be no special increase in steps or level except by action by the Board for all ranked at these levels.".

It was discussed and agreed that the reports of the Committee to the Board would be in the body of the minutes and the minutes of the Committee meetings would form appendices to the minutes of the Board meeting.

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Agenda 3: Matters Arising

The new programme for the Disease Transmission Programme was presented. After discussion it was decided that the Programme will require the leadership of an experienced senior epidemiologist. The presentation is noted as improved, but cannot be the basis for concluding the review. The recruitment of a new Programme Head for the Disease Transmission Programme remains essential.

Agenda 4: Director's Report

The Director presented the Annual Report for 1982. This was complimented by the Board as a clear improvement over all previous reports. The recent appointment of a consultant skilled in communications has materially assisted the production of the improved annual report. It was, however, mentioned that the very important Programme Coordination Committee had been mislabelled as Project Coordination Committee and not given sufficient coverage. The names and functions of members should appear.

Programme Coordination Committee

Dr Matin reported on this Committee. It was noted that the Standing Committee (SC) was part of the Programme Coordination Committee (PCC). The Committee can play a key role in linking an outstanding international effort to national efforts. The objectives of the Committee should be to build national research capacities by example and supportive actions. The Centre should be a pioneer in this effort. It should be a vehicle for strengthening and coordinating research in Bangladesh. This may provide a useful model for other developing countries. The operating guidelines of the PCC were reviewed. It was noted that the costs of the running inventory of research in diarrhoeal and related subjects will be borne by the Centre through the DISC project.

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Representation of the Centre on the Standing Committee is essential but was not made explicit in the guidelines. It was suggested that an improved draft of these guidelines should be presented to the Board at their next meeting in November 1983.

The following resolution was passed:

RESOLUTION I/JUNE 83

On the basis of the recommendation of the Programme Coordination Committee (PCC) during its meeting of 15 May, 1983, the Standing Committee (SC) of PCC consists of 14 members, as follows:

(a) (i) 7 members to be recommended by the PCC;

(ii) 1 member to be nominated by the BMRC;

(iii) 3 members to be nominated by designation by the Government of Bangladesh;

(iv) 3 members to be nominated by the Board of Trustees of ICDDR,B;

(b) That other members of the SC may either be by name or designation as in case of PCC.

Agenda 5: Resources Development Report

Mr M.R. Bashir presented the report on development of resources as follows:

"The Resources Development Programme of the ICDDR,B has continued to respond positively to the increasing financial needs of the Centre; the budget, which was $3.3 million in 1979 has increased to an income of $7.0 million over a short span of five years. This represents an income of growth of over 100%.

In a world where availability of funds has become highly elastic to political considerations and deteriorating financial conditions, obtaining commitments from donors, both existing and new, has been a very exacting exercise. The world-wide uncertain financial

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conditions are forcing donors not only to tighten their belts but also to scrutinize their aid budgets even more closely and divert their priorities. Coupled with this fact, the competition among the international organizations for the shrinking multilateral funds is becoming more and more intense. ICDDR,B has thus far succeeded in maintaining its lead over others in this race, and we hope will continue to do so in the future.

Success of the Resources Development Programme has been primarily due to our highly aggressive campaign to draw international attention to the ICDDR,B, as a resource that holds the key to the solution of the global scourge of diarrhoeal diseases. During the current reporting period, we have actively followed up with our existing donors and have pursued new sources of funds.

New Commitments

I am pleased to inform you, Mr Chairman, that during the first half of 1983 the Centre received an important new financial commitment in the amount of US $350,000 from the Arab Gulf Fund. Furthermore, ICDDR,B has now become a "listed project" with them and hopefully we will receive further support in 1984 and beyond.

In late 1982 ICDDR,B had applied for the residual funds remaining in the now defunct United Nations Relief Operations in Bangladesh, UNROB. Both UNDP as the executing agency of this fund and the Government of Bangladesh agreed to release this fund to ICDDR,B; then estimated at US $1.0 million. This money was to be made available to the Centre for providing services exclusively in Bangladesh.

Although UNDP insisted that the UNROB fund be treated as an out-right grant, the Government of Bangladesh found it more expedient to treat it as a loan. With the concurrence of the Board, we

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agreed to accept this money as an interest-free loan. Subsequently an agreement was signed with the Government of Bangladesh and an amount of US $1.182 million was released to the Centre in May, 1983.

We would like to extend our gratitude to the Government of Bangladesh for making this money available to us at a time when the Centre was experiencing a rather difficult cash-flow problem. ICDDR,B is a non-profit organization, and the UNROB money is being used exclusively for delivery of health serivces in Bangladesh and for providing treatment to 150,000 patients who visit the ICDDR,B treatment centres every year. Therefcre, we would like to suggest that the Board of Trustees pass a resolution thanking the Government of the People's Republic of Bangladesh and requesting the Honourable Minister of Health and Population Control, Major General M. Shamsul Haq, to kindly take up this matter with the Government for conversion of this loan into an outright grant.

In 1982, the world experienced serious currency fluctuation, with most currencies sliding negatively against the US dollar. Commitments made in currencies other than the US dollars, such as the pound sterling, Swedish Kroner and the Australian dollar, fetched fewer US dollars than originally estimated. However, the fluctuation of the Bangladeshi taka against the US dollar resulted in a net gain for the Centre which amounted to US $0.48 million. This extra budgetary amount is being carried over to 1983.

Mr Chairman, our request for the residual UNROB fund in 1982 was for the purpose of meeting a resource gap in the amount of US $1.0 million. However, the amount disbursed to us in May this year was US $1.182 million. But due to exchange fluctuations, the actual amount received in Bangladesh taka was equivalent to US $1.5 million. This extra budgetary US $0.5 million has also been added to the income of 1983.

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A new source of income for the Centre this year will be the Saudi Arabian project. The project will enable us to cover our overhead costs and also to shift some of the core staff to the project. This will result in the saving of US $150,000 to our core fund.

The Centre began discussions with UNICEF, with whom we share mutual objectives. As a result of these discussions a proposal was submitted to them for their support to our core fund. This proposal was also endorsed by the Government of Bangladesh at the recent meeting of the UNICEF Executive Board. Prior to this meeting, we held detailed discussions with Mr James Grant, Executive Director, for UNICEF support. Mr Chairman, as you are aware, the UN system has again suffered drastic shortfall in their funding for the current fiscal year. In view of this development, we think it would be more prudent and realistic to estimate the support which the UNICEF may provide in 1983 at approximately US $600,000. This represents a reduction of about 50% in the amount originally requested for 1983.

We are also in the final stages of our negotiations with the Ford Foundation and the Government of Bangladesh for the evaluation of the current status of ORS in Bangladesh. This tripartite agreement will generate US $160,000 during 1983.

Renewals

Several existing agreements with our donors came up for renegotiation this year and we have been fortunate to secure their renewals. After expiry of the current agreement in 1983, UNDP will provide a second cycle of funds for clinical research which will begin in 1984 and continue up to 1986. The UNDP contribution will be at a somewhat reduced level compared to the previous grant and will fund the Centre directly rather than through the WHO.

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The Government of Switzerland, which had earlier extended its first cycle of funding, has now agreed to renew its commitment up to 1986. The Swiss Government has also agreed to increase its contribution to S.Fr. 2,458,000 during the next three years.

The Overseas Development Authority of the United Kingdom has also notified us of the renewal of its grant to ICDDR,B. This renewal will include a modest increase over the previous grant.

Australia has also renewed its grant to the ICDDR,B. It is expected that the new grant will make provisions to cover the loss to the Centre due to currency fluctuation.

The Aga Khan Foundation has agreed to extend its support in 1984, but at a very modest level.

The Dhaka USAID Mission has renewed its commitment to the MCH-FP Extension project of the Centre for 1983. The amount committed for this year is US $459,000.

The Centre has requested an increase in the Japanese contribution in 1983. While there was no increase in their grant this year, the Centre achieved the unique distinction of becoming the first institution of its kind to be given a budget line in Japan's national budget after only one year of funding. We may thus expect continued funding from Japan and are hopeful for an increase in 1984.

In addition, Belgium and the World University Service of Canada have agreed to support scientists working at the ICDDR,B. Belgium is interested in supporting two Belgians now working at the Centre. They have also agreed to recruit two more scientists for us in the near future. The World University Service of Canada has also agreed in principle to extend support by providing Canadian mid-level

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scientists in various areas. Obtaining the services of these scientists will result in considerable savings to our core fund. I may mention here, Mr Chairman, that the Centre had received such scientists in the past from the United Kingdom, and we should once again approach the ODA for the revival of these positions.

Collaborations

In the first half of 1983, ICDDR,B has entered into collaboration with some of the major national health institutions of Bangladesh. Collaborative arrangements with Bangladesh Medical Research Council, National Oral Rehydration Project and the Bangladesh Rural Advancement Committee will go a long way in developing a closer and more harmonious relationship with our host country.

Discussions have also been initiated with China and other developing countries, for scientific collaboration and technical assistance. We have already approached some donors for funding such projects under tripartite arrangement so that these projects could be fully funded and our overhead expenditures covered.

Capital Development

The construction of the first floor of the Centre's new treatment centre and clinical research building was completed with the help of two grants from the OPEC Fund, totalling US $1.5 million. This building was formally inaugurated earlier this year by Dr Ibrahim Shihata, Director General of the OPEC Fund. We have already submitted a second proposal to the Fund for the completion of the six remaining floors of this building. I will visit the OPEC Fund headquarters in Vienna in July to discuss our second proposal. Should OPEC make the funds available for the completion of this treatment centre and clinical research building, we suggest that we may name this building the "OPEC Building".

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In addition to the above, we have also approached the Government of Japan for their support to our Capital Development Programme. This proposal includes requests for both construction and equipment.

You may recall, Mr Chairman, that we had submitted a proposal to UNCDF for funding the cost of constructing and equipping the field stations of the Centre. Land for this purpose has been acquired both in Matlab and Teknaf. Our discussions with UNCDF revealed that they can extend their support only if the Government of Bangladesh forwards our case. With your permission, Mr Chairman, I would request the Honorable Health Minister to kindly recommend our proposal to UNCDF. This will enable us to improve services at our rural treatment centres.

1983 Income Status and Forecast

ICDDR,B started the fiscal year 1983 with approximately US $5.0 million in donor commitments. By the middle of this year we have more than US $ 6.0 million already committed (Attachment a). At this point of the year we estimate another US $815,000 in additional donor commitment by the end of 1983, bringing the total income for the year to US $ 7.34 million. Our projection for 1983 was US $ 7.0 million; with hard work and a little bit of good luck, Mr Chairman, we hope to achieve this target.

1984 Income Status and Forecast

The Resources Development Programme since it began in 1979 has been successful in meeting the income forecasts each year. As I have already stated, beginning with a budget of US $3.3 million we hope to achieve an increase in our income by more than 100% to US $7.0 million in 1983. However, it must be recognized that the variables that we have to deal with are extremely unpredictable and all international agencies, except ICDDR,B have suffered major

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cutbacks.

Based on our past experience and taking into account the growing political and economic uncertainties in the world today, I hesitate to make an income projection beyond the US $7.0 million level for 1984 (Attachment b). None the less, we will vigorously continue to pursue our challenge and once again we hope to fulfill our commitment.

Consultative Group

The fourth meeting of the Consultative Group of the ICDDR,B will be held in New York on June 17, 1983. As in the past, the Consultative Group meeting will coincide with the UNDP Governing Council meeting to insure wider participation. At this point, Mr Chairman, I would like to raise some fundamental issues concerning the scope of our Consultative Group. We have by now held three such meetings and time has come for us to assess the results and draw up specific programmes and objectives for the future of this Group.

ICDDR,B currently has the participation of 38 countries and international agencies, 21 of them are donors. The scope of the Centre's activities has increased and the need for wider donor support is also becoming imperative. Side by side with the financial aspects, expansion of the Centre's scientific collaboration with other countries must also increase. This will represent the true manifestation of the Centre's international character. I am afraid operating exclusively out of Dhaka deprives the Centre of the high international visibility it must now have to draw both donors and prospective recipients of our services.

As I have already mentioned earlier, international fund raising

has become highly competitive. An analysis of our sources of income will show that more than 50% of our budget is met by contributions from the North American countries. These sources have to be actively pursued in view of our future interest. Dissemination of the knowledge gained through research at the Centre must be spread beyond Asia to Africa and Latin America in a proper way. Our experience in the recent International Conference on Oral Rehydration Therapy (ICORT) has shown that scientific and financial collaboration are subject to political influence and must be effectively countered, wherever necessary, to insure the stability of an international organization.

In view of the above, I request the Board to give due consideration to the establishment of a permanent Consultative Group of the ICDDR,B under the auspices of the United National Development Programme in New York. I may mention here that such a group already exists for agricultural research centres of the world. A permanent Consultative Group will insure high international visibility for the Cenre, proper dissemination of knowledge among developing countries, increased cooperation and collaboration with various helath research centres, and a sound financial base for the ICDDR,B.

In conclusion, Mr Chairman, I would like to say that the success of Resources Development depends on the continued scientific productivity of the Centre and our ability to disseminate the results. The expectation of the donors and the developing countries is increasing. Political and economic uncertainties of the world are making our efforts increasingly difficult. Time has now come to stabilize our financial commitments. However, as in the past, we will continue our vigorous efforts to meet our annual income projections.".

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Attachment (a)

Donor 1983

(In US $)

	Committed	Prospective
UNRESTRICTED		
Australia	163,000	-
Bangladesh	37,000	-
Japan	200,000	-
SAREC/Sweden	72,000	-
Saudi Arabia	100,000	-
Switzerland	270,000	-
United Kingdom	200,000	-
USAID	1,900,000	-
Sub-total	2,942,000	-
RESTRICTED		
Aga Khan Foundation (ORT)	25,000	-
Arab Gulf Fund (mixed)	350,000	-
Belgium	75,000	-
CIDA/WB(Hand pumps)	179,000	-
Ford Foundation (ORT evaluation)	-	160,000
France	60,000	-
GTZ(Munshiganj)	56,000	-
IDRC (DISC)	66,000	-
IDRC(San Impact phase-I & II)	26,000	30,000
IDRC(Sc. Editor)	-	25,000
Princeton and POCO	25,000	-
SAREC-Immunity/Vaccine	76,000	-
UNDP(Clinical Research)	250,000	-
Sub-total	1,188,000	215,000

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	Committed	Prospective
Restricted contd.		
B.E.	1,188,000	215,000
UNDP/WHO(Reg'l Training)	85,000	-
UNFPA(MCH-FP)	66,000	-
UNFPA (DSS)	426,000	-
UNICEF/IDRC(Water/San Conf)	60,000	-
UNICEF (Global)		600,000
USAID(MCH/FP-Ext.)	595,000	-
USAID/POOO (Ops Res)	83,000	-
Saudi Arabia	100,000	-
UNROB	500,000	-
Sub- Total Restricted	3,103,000	815,000
Sub- Total Un-restricted	2,942,000	-
Total	6,045,000	815,000
FC Tk. Exchange gains for '82 carried over to '83	480,000	
Grand Total		7,340,000

Attachment (b)

Donor 1984

UNRESTRICTED	Committed	Prospective
Australia	200,000	-
Bangladesh	35,000	-
Japan	200,000	200,000
SAREC/Sweden	72,000	-
Saudi Arabia	100,000	-
Switzerland	375,000	-
United Kingdom	200,000	-
USAID	1,900,000	-
Sub-total	3,082,000	200,000

RESTRICTED		
Aga Khan Foundation (ORT)	-	30,000
Arab Gulf Fund (mixed)	-	350,000
Belgium	-	75,000
CIDA (DSS +computer)	1,000,000	-
CIDA (Training)	-	100,000
CIDA/WB (Hand-pumps)	95,000	-
France	60,000	40,000
GTZ(Munshiganj)		30,000
IDRC (DISC)	75,000	-
IDRC (Sah Impact,Phase-II)	-	62,000
IDRC (Sc. Editor)	-	50,000
Princeton & POCO	25,000	-
SAREC- Immunity/Vaccine	76,000	24,000
UNDP Clinical Research	250,000	-
UNDP (DWSS: Women & Water)	-	100,000
Sub-total	1,581,000	861,000

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Restricted contd.	Committed	Prospective
B.F.	1,581,000	861,000
UNDP/WHO (Reg'l Training)	-	30,000
UNFPA (MCH-FP)	66,000	-
UNICEF Global	-	500,000
UNICEF (Country:ORT, Training)	-	50,000
USAID (MCH-FP/Ext)	459,000	-
Ford Foundation (Simmons)	-	50,000
Saudi Arabia/UAE	-	200,000
Sub-total Restricted,	2,106,000	1,691,000
Sub-total Unrestricted,	3,082,000	200,000
Total	5,188,000	1,891,000

Grand Total, 7,079,000

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A discussion on the terms of UNROB[1] Fund followed. In this discussion it was agreed that since it is a loan it will be accounted for as a loan until converted to a grant.

The question of exchange rate gains/losses was also discussed. It was agreed that since all accounts are referred to in U.S. dollars, gains and losses should be viewed from that standard.

The Director and Associate Director, Resources Development, were complimented on their performance in raising funds for the Centre. It was suggested that there should be a wider circulation of materials and information on the activities of the Centre.

There was discussion on the suggestion to establish a more formalized Consultative Group. Several important points for and against such action were made by the members during the discussion. The formulation of aims, justification and cost effectiveness of this must be assessed and presented to the Board before any commitments are made. In addition, exploration of this as a main channel of fund raising shall vigorously be explored and progress reported to the next meeting of the Board.

Agenda 6: Finance Committee Report

The Report of the Finance Committee was presented by Mr Michael Goon as follows:

"Since the December 1982 meeting of the Board, the Finance Committee has met twice, once in Dhaka at the Centre on 3 February, 1983, and

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1. The UNROB fund is a fund established by the UN to assist the people of Bangladesh at a time of hardship after the War of Independence. A residual amount in the fund has been provided to the Centre.

once in New York at IIE on 12 June, 1983. The financial position of the Centre was reviewed. It was noted that in 1982 expenditure was below the budgetted amount of 4.5 million dollars, being 4.3 million dollars. From the first quarter report for 1983 the projected expenditure for 1983 will be 6.2 million dollars, also within the 6.5 million dollar budget.

The cash position and cash flow were reviewed against projections. There is still delay of actual cash receipt against forecast. This requires an even more cautious approach to cash flow projections. It also requires improved follow up by the Centre. The Resources Development Office has noted this as an urgent matter requiring staffing. The Review of Financial Position 1983 is included. A reserve fund has been established as requested by the Board in Resolution 6/Nov. 81, point (d).

A special contribution from UNDP has been received (UNROB Fund). This has been designated as a loan. A letter from the Government of Bangladesh reads as follows:

'Please refer to the Loan Agreement between ERD and ICDDRB for the UNROB funds to be used as interest-free loan by your organisation.

In this connection I would like to refer to Bangladesh Bank's letter No. EDS:226/83 dated 10th May 1983 wherein they informed you and ERD that a sum of Tk.2,89,28,774.88 (Taka two crores eighty nine lacs twenty eight thousand seven hundred seventy four and paisa eighty eitht only) has been deposited on 5th May 1983 to Agrani Bank, Principal Office, Motijheel Commercial Area, Dhaka for credit to Account No. 7697 of ICDDRB with them. The loan become effective from 5th May 1983 per Loan Agreement signed between ERD and ICDDRB and this interest-free loan will run for the period from 5th May 1983 to 4th May 1984.

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In view of the above, I would request that this Agreement may be confirmed in your next Board meeting and an undertaking be given that the amount will be repaid after one year.

Needless to mention that this amount is interest-free and it should be ensured that the fund be used by ICDDRB for its current operations only and not kept as term-deposit in Bank to earn interest.

With regards,

It is suggested that since this fund is designated for service to the people of Bangladesh and is being applied by the Centre for this purpose that the following resolutions be passed by the Board:

RESOLVED:

(a) The Board of Trustees of ICDDR,B accepts an amount of Tk.2,89,28,774.88 from the Government of Bangladesh out of the UNROB Fund and places on record its deep sense of appreciation of the same.

(b) The amount given nominally as a loan for providing services exclusively in Bangladesh has been of immense help in continuing the activities of the Centre. The Centre will face serious financial crisis in case the Centre is called upon to repay this amount. In view of the facts and position stated above, the Board of Trustees unanimously requests the Government of Bangladesh to covert this amount of Tk.2,89,28,774.88 as grant to the Centre in order to enable the Centre to continue its services to the people of Bangladesh.

A report of the progress in Resources Development was made and appears under Agenda 5 of the Board minutes. It was noted that the income of the Centre has nearly doubled in five years. This

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was achieved during a period of severe global economic recession. Although optimistic the level of work needed to sustain such a growth rate is at the limit of the Centre's capacity. As new donors were enlisted the workload of timely follow up reporting and preparation of a new proposal has increased rapidly. Trained staff are lacking to meet further expansion of this requirement. Hence, a forecast of 7.0 million US dollars has been given for 1984. Important new donors have joined and have been committed in 1983. These include the Arab Gulf Fund, UNICEF, Canada and Belgium. Renewals have been associated with increases, as well as changes particularly in the case of Japan which has confirmed a long-term commitment. With completion of the first phase of the building a new approach to the OPEC Fund has been made. It should be noted that the Director General of the OPEC Fund, Mr Ibrahim Shihata, personally visited Dhaka to inaugurate this facility.

In view of the forecast of income for 1984, the Finance Committee suggests that a budget of around 7.3 million US dollars be established, subject to detailed review at the Board meeting in November, 1983. This ceiling would fall short by approximately $500,000 of financing the manpower plan of June 1983. It is hoped that some of the additional personnel can be obtained (as some personnel now are) subsidized by donor agencies, and approaches to certain donors have been already initiated to this end.

The Finance Committee met with the representative of the auditor (Deloitte, Hoskins and Sells) in the absence of the management of the Centre and found the Centre's accounts to be as reported. Suggestions for improvements were received and will be acted upon where possible.".

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FINANCIAL REPORT OF ICDDR,B TO FINANCE COMMITTEE OF BOARD AS OF 20.4.83

1. Operating Expenditure Statement (see attachment)

The first four months adjusted expenditure is approximately $ 1.66 million as against a budget of $ 1.96 million. This reflects that expenditure has been reduced by about $ 300.000 for the first four months which has been largely due to:

a) Savings from the delay in recruitment of "P" level staff.

b) Savings as a result of improved control and timing of purchases.

c) Savings from printing and reproduction, rent communications and utilities, transportation and other contractual services.

By the end of FY 1983 it is expected that most of the savings in personnel costs will be wiped out with the regularisation of project employees salary scales to WHO scales. Subject to the Board's approval the conversion of project employees to WHO scales would mean an additional yearly cost of some $ 150.000 to be funded from the core Budget. The projected expenditure by the end of 1983 is expected to be in the region of $ 6.2 million as shown below:

	4 months Actual	Budget Balance	Projected Actual for Year
Personnel services	1.366,700	3.211.300	5.578.000
Travel	95.720	238.740	334.460
Transportation	4.550	42.900	47.450
Rent,Comm.& Utilities	12.530	66.600	79.130
Printing & Reproduction	4.370	70.000	74.370
Other contractual services	32.810	112.000	144.810
Supplies & Materials	158.640	526.600	685.240
Depreciation/Capital Replacement	90.000	184.900	275.900
Total	1.765.320	4.453.040	6,218.360

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II. CASH POSITION

Although the operating statement indicates a possible reduction in expenditure of approximately $ 300.000 for FY 1983, the cash position as it stands is not very good.
The cash flow statement for 4 months to April 1983 shows as accumulated deficit of cash of some $ 2.0 million. This has been due to projected receipts not being received as were scheduled. Up to end April the bank overdraft position was $ 820.000. There was therefore no way that amount of $ 700.000 could be set aside in the Reserve Fund as planned. Furthermore to help offset the bank overdraft from increasing further $ 400.000 was drawn from USAID two months earlier than scheduled. The main problem in the cash shortfall was the delay in the release of UNROB funds.

However the funds have since been released, but due to the repayment **condition attached to the release of the money, the Centre's cash picture which at the moment is not so bright, is further aggravated by money to be set aside for repayment of this "loan".**

In order to set aside sufficient funds to amortize the loan of $ 1.18 million by May 1984, an amount of some $ 800.000 will be provided this year. The projected income for FY 1983 is expected to reach $ 7.2 million. To set aside $ 800.000 for loan repayment, the net income for FY 1983 would be reduced at $ 6.4 million. This is again based on the assumption that the figures of income predicted for FY 1983 will materialise as forecasted.

Based on this assumption the Centre should by the end of FY 1983 have approximately $ 200.000 in its reserve fund, a far cry from the original provision of $ 1,050.000. It is imperative that the Board now address the issue at hand and that is to instruct the Director to seek immediate steps to convert the UNROB loan to a grant so that

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the Centre's financial position can be restored to the projected levels as originally presented to the Board at the December 1982 meeting.

Otherwise more efforts must be directed at fund raising in order to increase donor support to offset the anticipated shortfall.

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EXPENDITURE STATEMENT

For 4 months to 30 April,1983

	Budget	Actual	Variance + (-)
Personnel Services	1.473.600	976.681	496.919 (1)
Travel	74.560	95.720	(21.160) (2)
Transportation	21.400	4.549	16.851
Rent, Comm.& Utilities	33.200	12.525	20.675
Printing & Reproduction	34.800	4.368	30.432
Other Contract. Services	56.000	32.810	23.190
Supplies & Materials	263.300	158.634	104.666
Total Expenditure	1.956.860	1.285.287	671.573
Adjustments			
(1) Provision for salary increase		390.000	(390.000)
(2) Project travel of Saudi to be reimbursed (extra budgetary)		(20.000)	20.000
Total adjusted expenditure	1.956.860	1.655.287	301.573

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CASH FLOW STATEMENT

At 30,4.83

	Budget	Actual	Variance
Opening Bank Balance	(241.936)	(760.085)	(518.149)
Receipts Brought Over from Previous Year	1.156.000	70.500	(1085.500)
Receipts for the Year	1.850.000	1.403.059	(446.945)
Total Cash Available	2.764.064	713.474	(2.050.590)
Total Operating Exp:	1.956.860	1.285.287	671.573
Advances	-	251.105	(251.105)
Total Cash Expenditures	1.956.860	1.536.392	420.468
Amount to Reserve Fund	700.000	-	700.000
Closing Bank Balance	107.204	(822.918)	(930.122)

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DONOR SUPPORT

Projected Receipts Vs Actual Receipts

Up to April 30,83

Unrestricted	Budget	Actual	Variance
Kingdom of Saudi Arabia	100,000	100,000	-
USAID	500,000	900,000	400,000
UNROB	1,000,000	-	(1,000,000)
JAPAN	200,000	-	(200,000)
SWITZERLAND	270,000	-	(270,000)
Total Unrestricted	2,070,000	1,000,000	(1,070,000)
Restricted			
SHEIKH SALEH AL ABDUL AZIA	-	13,974	13,974
AUSTRALIAN HIGH COMMISSION	-	278	278
AGA KHAN FOUNDATION	25,000	-	(25,000)
CIDA-WB	214,000	-	(214,000)
IDRC	-	21,369	21,369
FRANCE	60,000	-	(60,000)
SAREC	-	38,733	38,733
GTZ MUNSHIGANJ	56,000	50,000	(6,000)
UNDP-WHO REGIONAL	75,000	36,336	(38,664)
UNFPA-DSS	106,500	111,350	4,850
UNFPA-MCH	16,500	20,500	4,000
UNICEF WATER SANITATION	20,000	-	(20,000)
USAID-MCH/FP/EXTENSION	297,500	151,019	(146,481)
USAID-POP COUNCIL	41,500	-	(41,500)
USAID CLINICAL NUTRITION	2,400	-	(24,000)
UNDP WATER EMBANKMENT	-	30,000	30,000
Total Restricted	936,000	473,559	(462,441)
Total Donor Receipts	3,006,000	1,473,559	1,532,441

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There followed a discussion on increase in payment to international level staff of the Centre in response to a pay increase as determined by WHO pay scales. There was agreement that the Centre should meet the new scales but that the implementation date might be allowed to differ on decision by the Board.

The Board approved the following resolution:

RESOLUTION 2/JUNE 83

(a) The Board of Trustees of ICDDR,B accepts an amount of Tk.2,89,28,774.88 from the Government of Bangladesh out of the UNROB Fund and places on record its deep sense of appreciation of the same.

(b) The amount given nominally as a loan for providing services exclusively in Bangladesh has been of immense help in continuing the activities of the Centre. The Centre will face serious financial crisis in case the Centre is called upon to repay this amount. In view of the facts and position stated above, the Board of Trustees unanimously requests the Government of Bangladesh to convert this amount of Tk.2,89,28,774.88 as grant to the Centre in order to enable the Centre to continue its services to the people of Bangladesh.

Agenda 7: Approval of FY1982 Audit Report

The Audit Report was accepted and a letter from the Auditor presented. The comments on the letter 1.1 through 1.3 were rejected as the law is valid and no clause has been violated. The subsequent comments merit inquiry and action especially that the Centre should complete the regulations required by the Ordinance. These may be presented through the Finance Committee. The by laws may be submitted through the Personnel and Selection Committee. The matter of insurance was discussed and will be considered by

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the Management. The suggestion of establishing a fire and ambulance service near the Centre would be advantageous.

Agenda 7a: Selection and Remuneration of Auditor

This matter was discussed by the Board.

The Board passed the following resolutions:

RESOLUTION 3/JUNE 83 The Board examined the report of the Auditor for 1982 and accepted the same as a faithful representation of the accounts of the Centre.

RESOLUTION 4/JUNE 83 The Board appoints M/s Deloitte Haskins & Sells as the Auditor for the Centre for the year 1983 and authorises the management of the Centre to negotiate remuneration of the Auditor.

Agenda 8: Presentation of FY1984 Budget

The budget was presented and thoroughly discussed. The Board decided that in light of current income forecase a budget ceiling of 7.0 million US dollars can be approved. Should the income forecase be revised upward a higher ceiling will be considered by the Board as it is recognized that without increases in pay for international level positions a budget of 7.8 million US dollars will be needed to satisfy the manpower plan presented. The issue of a possible large (30%) increase in international level positions pay was discussed together with its implications for recruiting, programme and budget. In November when revised projections of pay increases/income are available, final decisions can be made. The Director was requested to rank in order of priority all new and vacant positions for the Board. This list is presented in the Report of the Personnel and Selection Committee.

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The Board made the following resolution:

RESOLUTION 5/JUNE 83

A budget for an amount of US$7.0 million is authorised for 1984. In view of the anticipated pay rise by the WHO to international level staff an additional amount of US$400,000 may be required during 1984. The Board will review the budget in its next meeting in November 1983 and take appropriate decision on the basis of more specific facts in respect of the income and expenditure position and also about the anticipated rise in pay by the WHO.

Agenda 9: Programme Review and External Scientific Report

A document summarizing the External and Trustee reviews was presented. It was felt that the more important issue was how the Centre has responded to the areas requiring improvement. It was important to note that improvement in Microbiology is essential as some bacterial strains received from the Centre at another laboratory have not been confirmed as labelled. The question of confidentiality of severe criticism should be considered to allow more freedom in review.

The USAID Review should be circulated to the Board and be an agenda item in the November meeting.

It was suggested that when a review is requested by an interested party, that the summary document with original documents be given to all Trustees. All joining Trustees should receive the original reviews.

Agenda 9a: Vaccine Trial

The issue of development and field trials at the field stations of the ICDDR,B of an oral cholera vaccine developed by the National

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Bacteriologic Laboratory of Sweden, the Merieux Company France, The University of Goteborg and the ICDDR,B. The results of an informal consultation called by WHO and attended by Drs Bradley, Greenough, Holmgren, Kostrzewski and Takeda with others, was discussed in detail by the members of the Board of Trustees. There was general consensus that as ICDDR,B is involved in the effort for control and elimination of cholera it should welcome any effort for development of a vaccine against cholera which promises to be more effective. It was, however, pointed out that the Centre should carefully examine the financial implications of its commitments and the source of meeting the same over a fairly long period of time. The Government of Bangladesh should be effectively involved in deciding to hold trials in Bangladesh in addition to the Bangladesh Medical Research Council and other relevant authorities. The members emphasized the necessity of obtaining clearance from the Government of Bangladesh in the matter of holding trials in Bangladesh. Views were expressed in favour of simultaneous or subsequent trials in some other countries where cholera is endemic in order to assure greater replicability of the results of any single trial. On the basis of the above discussions the Board adopted the following resolution:

RESOLUTION 6/JUNE 83

The Board authorises the Director to initiate steps for field trials of oral cholera vaccine in Bangladesh including examination of its financial aspect, processing it through the Ethical Review Committee and identifying sources of meeting the expenses involved in such an effort. The Board emphasizes the indispensable necessity of obtaining concurrence of the Government of the country where such trials are to be held and requests the Director to maintain close liaison with the Government of Bangladesh in the matter. The Board further requests the Director to inform the Board of the developments in its next meeting in November, 1983.

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Agenda 10: Report of the Ad Hoc Search Committee

All the candidates received through advertisement or mentioned since 1980 were reviewed and a course of action agreed upon.

Agenda 11: Report of the Personnel and Selection Committee

The report was presented by the Chairman of the Committee, Dr M.A. Matin, and reads as follows:

"The Personnel and Selection Committee of the Board has met on two occasions since the full Board Meeting in December 1982. A meeting on 19 March, 1983 was held in Geneva at WHO and a meeting before the Board Meeting was held on 12 June 1983 at IIE in New York.

In the first meeting an organizational diagram was discussed and it was decided that this matter should be left with the management of the Centre with regard to functions and assignment of responsibilities. The number of positions and a manpower plan was requested for the next meeting of the Committee. Staff rules on recruitment, selection, appointment and promotion procedures and geographical quotas reviewed and compared consonant with WHO for P1-3 level positions. Recommendations for new Board members were agreed upon and an overall review of recruitment and appointments was done. The minutes of the 19 March meeting were approved after incorporation of amendments.

In the meeting on 12 June 1983 a report on compliance to WHO staff rules and scales was made. Complete compliance has been achieved except with respect to some project staff. Since their pay scales were fixed in negotiation with donors no budgetary allowance was present to adjust their scales. It was estimated that if conversion were done cost overruns on projects of about $70,000 U.S.

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would occur. The following decisions are recommended:-

1. That all future projects should be budgetted according to WHO scales with contingency for increases.

2. As soon as financially feasible all project staff should go to WHO scales.

3. Staff now designated community workers are neither project nor core staff of the Centre but are related to community or government scales and should remain so linked. WHO does not have such workers or scales for them to the best of the Centre's knowledge.

The Extended Scales were reviewed and recommended for final approval by the Board.

A working paper on the pension fund was discussed. It was noted that the Centre was rejected by the UN pension scheme since it is not a UN agency. It is therefore suggested that maintaining a Provident Fund and Severance Pay, preferably held in U.S. dollars in a nationalized Bangladeshi bank, would be the best interim solution to the need for a pension scheme.

It was agreed that in order to insure a proper geographical balance of core staff thus demonstrating in fact the international character of the Centre that a geographical quota should be established. The WHO has a quote system based on considerations not applicable to the Centre. Since the composition of the Board was carefully worked out it was believed that this should serve as a guideline for geographical distribution of staff.

There was an in depth discussion of staff promotion and surrounding issues especially with respect to the extended scales. It was agreed that WHO policy should be followed. A report was submitted

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to the Committee and the following procedure agreed upon to be recommended to the Board.

'Any staff member whose post is reclassified to a new grade will compete with other applicants for the reclassified post. If the staff member is successful he will be promoted to the new level into which the post has been classified. If unsuccessful and another applicant is appointed to the reclassified post the unsuccessful staff member may as an alternative to termination of his services request the Director to be reassigned.'.

Under this rule any reclassified post would be advertised and if at the international level international advertisement would be mandatory. This avoids the problem of 'creeping' promotion and entry of persons into positions which require function beyond their abilities. The promotion procedures are recommended as presented.

The matter of the process for post classification was taken up, found consistent with WHO, and is recommended for adoption with some amendments which have been incorporated.

It was noted that the Management Committee serves in an advisory capacity to the Director who may form and dissolve ad hoc Ordinance or Trustee mandated committees in the operation of the Centre. No committee supercedes in decision-making power that of the full Board.

The WHO procedures for personnel recruitment and selection as adopted by the Centre were reviewed amended and suggested for approval by the Board. Several policy matters are contained in these procedures:

- The Board would not usually continuously employ staff in P (international) level posts for more than 6-8 years.
- Contracts may ordinarily be for periods of two or three years.

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- All P level positions are considered as 'international level' and as required by the Ordinance of the Centre will be appointed by the Board.

The selection of new staff to vacant posts has not reached the point at which a list of agreed on candidates can be presented to the Board at this June meeting. In order not to delay recruiting vital new staff when the Personnel and Selection Committee has reviewed the many applicants and agreed the concurrence of the Board by mail or telex may be requested. Response to the advertisements has been very good. The closure date for receipt of applications was May 30th due to the slowness of mailings to Dhaka. The closure date in advertisements was 30 April, 1983. The full lists and all applications are in New York available for Trustee review.

A manpower plan was presented and recommended for adoption. In view of financial constraints the Director was asked to make a priority listing for recruitment to vacant posts. This does not include posts already reclassified:

3 scientific positions including one for Library Sciences;

3 administrative positions including those of the Computer Manager, Finance Controller and Supply Officer.

This follows:

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PRIORITY LISTING OF POSITIONS TO BE RECRUITED (VACANT AND NEW)

		Millions Cost	Cumulative UN Budget floor of 6.3 millio
1.	Senior Scientist Disease Transmission (Programme Head)	.083	6.383
2.	Senior Scientist Community Services Research (Programme Head)	.083	6.466
3.	Microbiologist	.083	6.549
4.	Epidemiologist Disease Transmission	.066	6.615
5.	Pediatrician MCH-FP CSR	.049	6.664
6.	Personnel Officer	.058	6.722
7.	Admin. Services Officer	.066	6.788
8.	Programme Coordinator	.076	6.864
9.	Operations Research CSR	.065	6.929
10	Communications Specialist	.053	6.982
11	Nurse Trainer	.035	7.017
12	Pediatrician Pathogenesis & Therapy	.054	7.071
13	Nutritionist	.048	7.119
14	Health Economist	.048	7.167
15	Computer Analyst	.065	7.232
16	Training Materials Development	.053	7.285
17	Trainer Physician .	.048	7.333
18	Extension Coordinator	.038	7.371
19	Immunologist	.065	7.436
20	Clinical Researcher	.065	7.501
21	Head Hospital	.065	7.592

In preparing the above priority listing the following considerations were weighed in order of importance:-

1. Need for Centre.
2. Identification of strong candidates (stage of recruitment).

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A proposed list of reviewers to carry out the Ordinance mandated external review early in 1984 is presented to the Board. It is felt that in each category a minimum of three alternatives be designated who could be contested to insure committing a full term at an early date. The lists follow this report.

The following list of new Trustees is suggested for appointment to the vacancies of those completing their terms. The balance of geography, discipline and developed-developing country categories have been considered and are maintained in these selections.

To be reappointed

Dr J. Sulianti Saroso	-	Research/Administration	- Indonesia

New Appointments

Dr Immita Cornaz	-	Social Sciences	-	Switzerland
Dr Abdul Al-Swailem	-	Pediatrician	-	Kingdom of Saudi Arabia
Dr Derrick Rowley	-	Immunologist	-	Australia

The Government of Bangladesh has sent the following letter nominating a new individual to the seat now held by Mr M.K. Anwar.

'I am directed to say that the Government of the People's Republic of Bangladesh in the Ministry of Health and Population Control has been pleased to nominate Mr A.B.M. Ghulam Mostafa, Secretary, Ministry of Health and Population Control as one of the Directors of the Board in place of Mr M.K. Anwar, the ex-Secretary of this Ministry whose term will expire on 30.6.83.

2. This issues with the approval of the Minister for Health and Population Control.

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The recommendations from the Director in connection with Mr Mark Tucker's retirement are suggested for adoption and implementation.

A request from the Director to extend the contracts of Drs Samadi and D'Souza beyond the period decided in the December 1982 Board Meeting was considered and is not recommended. Any need for out placement may be dealt with for short term action by the Director. Dr Sanyal is on leave from his University which has agreed to allow him to complete his research in Dhaka. He is considered as a Visiting Scientist deputed from a University and extension of his stay is recommended up to 31 January, 1984.

It was agreed that the positions now designated 'Programme Head' would be redesignated as Associate Director in charge of Programmes.

A rewording of Resolution 23/Dec. 82 is recommended as follows:

'Resolutions 17 through 22/Dec. 82 indicate the completion of transition of the Centre from the former Cholera Research Laboratory to the current International Centre for Diarrhoeal Disease Research, Bangladesh. The provisions of Clause 30(b) of the Ordinance will cease to apply with this transition. The Board asks the Director to ensure that all staff conform to WHO staff rules and pay scales by 1 January, 1983 with a report to the Board.

The requirement for a position of Deputy Director was discussed and the establishment of such a position is not recommended.

Contracts for the reappointments of staff to international level positions were reviewed. It was noted that two contracts provided new benefits not given on previous contracts. Since it had been stated in the minutes of this Committee when it met in December 1982 that 'there will be no special increase in steps or level except by

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action by the Board for all ranked at these levels'. It was felt that the matter of the added benefits were beyond the authority of the Director in these cases.".

LIST OF CANDIDATES EXTERNAL REVIEW 1984

MICROBIOLOGY-IMMUNOLOGY

Person	Country
C. Gadjusek	United States
B. Rowe	United Kingdom
J. Craig	United States
P. Orskov	Denmark
H. Mäkälä	Finland
S. Holm	Sweden
H. Smith	United Kingdom
O. Ouchterlony	Sweden
M. Harboe	Norway
G.N. Cooper	Australia
Y. Watanabe	Japan
Y. Takeda	Japan
J. Robbins	United States
M. Richmond	United Kingdom
A. Allison	United Kingdom
D. Westphal	Germany
S. Formal	United States

CLINICAL SCIENCES

Person	Country
Klaus Gyr	Switzerland
Dilip Mahalanabis	India
D. Habte	Ethiopia
A.S. McNeish	United Kingdom
A.H.G. Love	Ireland
Henry Binder	United States
Anne Ferguson	United Kingdom
J. Keusch	United States
Tytgat	Netherlands
I.H. Rosenberg	United States
R. Hornick	United States
H.I. DuPont	United States
D. Powell	United States
R. Zetterström	Sweden
O.R. Kuti	Nigeria
J. Rohde	United States

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IMMUNOLOGY

Person	Country
Pearay Ogra	Sweden
John Robbins	United States
N.F. Pierce	United States
Lars A. Hanson	Sweden

EPIDEMIOLOGY

Person	Country
A. Feinstein	United States
R. Oseasohn	United States
B. Rowe	United Kingdom
G. Gibson (Health Services)	United Kingdom
B. Cjetanovic	Yugoslavia
E. Gangarosa	United States
A.S. Muller	Netherlands
A. Monto	United States
J.M. Boggono	Chile
E. Bermawy	Egypt
R. Brupbacher	Switzerland
Daid Mel	Yugoslavia

BEHAVIOURAL SCIENCES
Health Care and Development

Person	Country
L. Ruzicka	Australia
J. Pierre Habicht (Econ. Nut)	Switzerland
D. Banerjee	India
G. Widstrand	Sweden
Meli Tan	Indonesia
W. Brass	United Kingdom
J. Caldwell	Australia
M. Sringalingbum	Indonesia
R. Nicholas	United States
D.P. Mukherjee	India
K.E. Knutsson (Soc. Anthro)	Sweden
J. Sirajaldin	Egypt
A. Rosenfield	United States

NUTRITION

Person	Country
Vinodini Reddy	India
F. Viteri	Guatemala
J. Cravioto	Mexico
N.S. Scrimshaw	United Kingdom
Kayardi	Indonesia

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NUTRITION (cont'd)

Person	Country
R. Whitehead	United Kingdom
A. Ashworth	United Kingdom
C. Gopalan	India
Lindquist	Sweden
D.B. Jelliffe	United States
Bhumiratna	Thailand
J.C. Waterlow	United Kingdom
A. Lechtig	Peru

SHORT LIST OF EXTERNAL REVIEWERS FOR 1984

Programme Area	Person	Country
Administration/Finance	Dr Omond M. Solandt	Canada
	Mr M.K. Anwar	Bangladesh
Training	Dr William Cutting	U.K.
	Paul Touchetta	U.S.A.
	Ronald Hardin	U.K.
	A. Lechtig	Peru
Pathogenesis & Therapy	G. Keutsch	U.S.A.
	Demise Habte	Ethiopia
	R. Zetterstrom	Sweden
	Klaus Gyr	Switzerland
Disease Transmission	Dr M.H. Wahdan	Egypt
	Dr Kenya	Kenya
	E. Gangarosa	U.S.A.
	Dr Bencic	Yugoslavia
	Dr R. Feldman	U.S.A.
Host Defence	Dr Pornchai Matangkasombut	Thailand
	Dr N.F. Pierce	U.S.A.
Nutrition	Dr Srikantia	India
	Jane Kusin	Netherlands
	L. Chen	U.S.A.
	A. Pradilla	Colombia
	Aleya Hammad	Egypt - WHO
	John Waterlow	U.K.
Community Services Research	Dr Gerhard Pfister	Switzerland

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Programme Area	Person	Country
CSR Demography	Dr J.C. Caldwell	Australia
	Dr Apichat Chamratrithirong	Thailand
	Dr Badrud Duza	Bangladesh
	Dr R. Esquire	
	Dr L. Ruzicka	Australia
Microbiology	Richard Wyatt	United States
	Ms E. Yabuuchi	Japan - Gihu
	Prof. Nzatse	Kenya
Computer Sciences	Peter Smith	United Kingdom
	Walter Willett	United States
	Richard A. Kronmall	United States

A discussion of Board members took place. The conversion of all project staff to WHO scales not later than 1 January, 1984 was agreed. If funds become available before this date this can be accomplished earlier, but all project staff should be transferred effective 1 January, 1984 at the latest.

The implementation of extended scales and progress towards pension schemes were reviewed and felt satisfactory.

The issue of geographical quotas was discussed. It was noted that in an institution with a small staff a rigid formula may introduce problems. Accordingly, no resolution was passed but a policy enunciated as follows:

"The composition of the international level staff should follow the composition of the Board of Trustees with respect to developed-developing countries and numbers of staff from any single country.".

The point that a policy of time-limited appointments to international posts may contribute to a "brains drain" since most Bangladeshis may not be willing to go to a national institution was raised. It was

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noted that this is not always the case and the reverse has been seen in other settings.

The issue of hiring consultants was discussed in relation to recruitment for vacant positions. Concern was expressed that employment of Consultants on anticipation of establishing a position may bias recruitment. If Consultants are selected from the final lists of those under recruitment it serves as an excellent means to judge the quality of the candidates.

In matters of recruitment to international level positions the practice and rules of WHO in respect of place of recruitment was reviewed by the Board. It was pointed out that the WHO rules provide for negotiation on the basis either of the country of citizenship or of the place of recruitment. It was argued that the WHO rules provides enough scope for the Centre to decide on a consistent policy of negotiating on the same basis of either of the country of citizenship or the place of recruitment in all cases as application of discretion in individual cases may create dissatisfaction among the senior members of the staff - particularly among those from Bangladesh. The Board felt that the country of citizenship should be taken as the site of recruitment.

The two contracts which provided additional benefits to the incumbents were examined by the Board and the decision of the Board was to enlist the cooperation of the incumbents on renegotiation of their contracts.

The Board passed the following resolutions:

RESOLUTION 7/JUNE 83 The Board accepts and endorses the content of the Personnel and Selection Committee document no. 11/BT/June 83.

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RESOLUTION 8/JUNE 83 — The conversion of all project staff to WHO scales not later than 1 January, 1984 was recommended. If funds become available before this date this can be accomplished earlier, but all project staff should be transferred effective 1 January, 1984 at the latest.

RESOLUTION 9/JUNE 83 — The tenure of employment in international level positions in the Centre should be on the basis of contracts for periods up to 3 years at a time and ordinarily the total period of tenure of international level positions should not exceed six years.

RESOLUTION 10/JUNE 83 — All P level positions are considered as "international level" and will be appointed by the Board.

RESOLUTION 11/JUNE 83 — In matters of recruitment to all international level positions, the country of citizenship will be the basis for all contracts without any exception. In the event of dual nationality the country of citizenship and domicile irrespective of actual place of origin or actual place of recruitment will be taken into account.

Agenda 12: Selection of Trustees

The terms of Drs Holmgren, Jones and Al-Dabbagh, Sulianti and Mr M.K. Anwar are expiring 30 June, 1983. The proposal for new Trustees is:-

Dr J. Sulianti Saroso	-	Re-appointed
Dr Immita Cornaz	-	New appointment
Dr Abdul Al-Swailem	-	New appointment
Dr Derrick Rowley	-	New appointment
Mr A.B.M. Ghulam Mostafa	-	New appointment nominated by Government of Bangladesh

The Chairman then recognized the special and significant contributions of each of the outgoing members. A vote of thanks

was moved by the Chairman of the Board.

RESOLUTION 12/JUNE 83

It was agreed that Dr J. Sulianti Saroso should be re-apppointed as a member of the Board of Trustees and that Drs Immita Cornaz, Abdul Al-Swailem and Derrick Rowley be appointed as new members, and that the Board welcomes the appointment of Mr A.B.M. Ghulam Mostafa.

Agenda 13: Selection of Chairman, Board of Trustees

Dr David Bradley announced that he was not a candidate and retained the Chair. A single candidate Professor J. Kostrzewski was nominated and appointed by acclaim to a one year term.

A vote of thanks was given Dr Bradley for his service during the past year as Chairman of the Board.

RESOLUTION 13/JUNE 83

The Board unanimously appointed Professor J. Kostrzewski as Chairman of the Board of Trustees for a period of one year from 1 July, 1983 until 30 June, 1984.

Agenda 14: Membership of Committees of the Board

The members of the Board agreed that the Chairman will be an ex officio member of each Committee. The Director is already an ex officio member of all Committees. The Finance Committee will sustain two vacancies due to the departure of Dr Jones and Mr Anwar. Mr Anwar may be replaced by Mr Ghulam Mostafa and Dr David Bradley will replace Dr Jones.

The Ad Hoc Search Committee for the Director is unchanged, consisting of: Dr David Bradley (Chairman), Dr Mata, Dr Matin and Dr Holmgren. It was agreed that the Secretariat will be with Dr Bradley.

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The membership of the Personnel and Selection Committee will remain the same.

Agenda 15: Date of Next Meeting

The dates of the next formal meeting will be 30 November and 1 and 2 December, 1983. Members of the Finance and Personnel and Selection Committees should meet on 27 and 28 November, 1983.

MINUTES OF FINANCE COMMITTEE MEETING

OF BOARD OF TRUSTEES, ICDDR,B

The meeting was convened at 11.45 a.m. at ICDDR,B in the Director's Conference Room on Thursday, 3 February, 1983.

Members Present : Mr M.K. Anwar, Prof. David Bell, Dr W.B. Greenough.

Member Absent : Dr Gavin Jones.

Invited Staff : Mr M.R. Bashir, Mr Michael Goon.

The Agenda was agreed upon.

1. The minutes of the meeting of 3 December, 1982 were approved without change.

2. There were no matters arising.

3. Mr Michael Goon, Associate Director for Administration and Finance reviewed the financial position of the Centre noting that the increased overdraft position was due to delays in receipt of the UNROB fund and the USAID contribution. He also noted that the new contract with USAID for the current year was from January 1, 1983 thru December 31, 1983 instead of from November 1, 1982 thru October 31, 1983. It should be clarified by appropriate documentation that the Centre would still receive the full amount despite shift of the contract dates from October to January. It was reported that the severance pay account was being shifted to a U.S.

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dollar account with the local Agrani Bank. Discussion of the possibility of achieving higher interest rates by moving this finally to an account outside of Bangladesh still in a nationalized bank ended with a request that a working paper be prepared on this subject. The Committee was satisfied that the financial position did not reflect any substantial change from that presented in December but noted that the overdraft was draining valuable programme funds. One function of a reserve fund could be to avoid such expense based on delayed cash flow.

Although there is an understanding that the UNROB funds may eventually be converted into a grant, the initial agreement for prompt disbursement is in the form of an interest free loan. Accordingly, it was agreed to be prudent to set aside an amount each month, from July 1983, for repayment over a two year period. When the UNROB loan is converted to a grant this money could then be added to the reserve fund.

4. Mr M.R. Bashir, Associate Director for Resources Development, reviewed the progress on fund raising. It is possible that our proposal for core contribution of one million dollars per year over three years, which was submitted through UNICEF, may be funded directly by UNICEF using Italian funds rather than being forwarded by UNICEF to the Arab Gulf Fund. Notification of a new contribution of $350,000 from Arab Gulf Fund through UNDP has been received. An excess from UNROB that was not planned one third will be credited to 1983 income, and the originally expected two thirds will be credited in 1982. The

target figure of 7.0 million dollars income for 1983 seems well within reach.

5. There was a discussion of the reasons for a Reserve Fund and the nature of its operation. It was felt that this fund should be tailored to best suit the needs of the Centre. Some of the reasons mentioned for such a fund were -

(1) To provide in case of emergency stability to the Centre and ensure continuity of its essential activities in time of unforeseen financial shortfalls.

(2) "Insurance" to guarantee being able to recruit international level leadership without risk to programme or the individual under recruitment.

(3) To prevent fluctuations in programmes and logistics due to cash flow consideration.

(4) To avoid the necessity of paying interest on overdrafts and loans due to cash flow problems.

(5) To provide initiative funds for development of future research directions.

The desirable initial size of this Reserve Fund was felt to be about one years operating budget and expecting that it will take several years to build to this level a figure of 10 million U.S. dollars was felt reasonable and was the figure agreed upon previously by the Board. The relevant resolutions by the Board for the creation of the Reserve Fund are listed below:-

Resolution 6/June 81

"The Finance Subcommittee is requested to examine the desirability/possibility and mechanism of creating a 'Reserve

Fund' to enable the Centre to attain better financial stability and also to enable it to retain a satisfactory level of work in case of uneven flow of resources for reasons beyond its control.".

and

Resolution 6/Nov. 81

"(a) There shall be a fund designated as 'Reserve Fund' of the Centre in which specified amount shall be credited every year.

(b) The target shall be to create a Reserve Fund of the order of $US 10 million.

(c) In case total receipts for the year 1982 is less than $US 6.5 million an amount of $US 100,000 is to be set apart and deposited to Reserve Fund.

(d) If the total receipts is equal to or more than $US 6.5 million the entire amount above 6.5 million not exceeding 10% of the total receipts will be set apart as Reserve Fund in addition to the amount of $US 100,000 mentioned in (c) above.

(e) In case receipts exceed $US 7.25 million, the Director will come up to the Board with appropriate recommendations for utilizing the amount in excess of the budgetary commitments including Reserve Fund.

(f) The Finance Subcommittee will work out the necessary details in respect of operation of the Reserve Fund, maintaining its account and other issues relating to its handling and utilization and will report to the Board.".

There was a consensus that the Fund should not be as rigidly defined as a liquidation or endowment but might function with temporary withdrawal over fixed time period with mandatory replacement.

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The interest could initially accumulate until the target figure is reached then might be utilized as initiative funds for programme development. The Committee asked the Management of the Centre to develop a working paper to circulate and form the basis of a presentation to the Board Meeting in June 1983.

6. The history of Ford Foundation support of the internationalization process was reviewed. It was noted by Professor Bell that contribution to reserve or endowment funds was within the scope and previous actions by the Ford Foundation. The working paper to be developed would form the basis for further discussion with Ford and other potential donors. The best idea seems to proceed with the currently developing Reserve Fund to seek matching funds on a one to one basis from Ford to establish it. Once established added gifts can be sought.

7. Plans for the June Board Meeting involve principally presentation of the 1984 budget and the material discussed in detail on the Reserve Fund.

8. Varia - None.

WBG:jc

MINUTES OF THE FINANCE COMMITTEE MEETING OF BOARD OF TRUSTEES, ICDDR,B

The meeting was convened at 4 p.m. at the Institute of International Education (IIE) on the 12th floor on Sunday, 12 June, 1983.

Members Present : Mr M.K. Anwar, Professor David Bell, Dr G. Jones and Dr W.B. Greenough.

Invited Staff : Mr M.R. Bashir, Mr Michael Goon, Mrs J. Chowdhury.

The agenda was agreed upon.

1. Minutes of meeting of 3 February, 1983.

The minutes were approved with the following changes:-

(a) Delete "between ICDDR,B and the External Resources Division of the Government of Bangladesh" from the first sentence of paragraph 2 of page 2.

(b) Paragraph 4, page 2, line 8 should read "An excess from UNROB that was not planned one third will be credited to 1983 income, and the originally expected two thirds will be credited in 1982.".

(c) Paragraph 5, page 3, delete "rather than prepared from the point of view of any donor agency in particular" from the second sentence.

(d) Paragraph 5, page 3, point 5 should be point 1 and changed to read "To provide in case of emergency stability to the Centre and ensure continuity of its

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essential activities in time of unforeseen financial shortfalls.". Points 1, 2, 3 and 4 would then become points 2, 3, 4 and 5.

2. Matters Arising.

(a) It was reported that point (d) of Resolution 6/Nov. '81 on page 4 of these minutes has been achieved i.e. an amount of $US 100,000 has been set aside as Reserve Fund.

(b) The Working Paper for Reserve Fund requested for presentation to the Board in the June meeting (page 5) will not be submitted. A progress report will be given and the papers circulated to the Finance Committee before the November 1983 Board Meeting.

3. Review of Financial Position 1983.

A financial report was presented. It was agreed that the mechanism of setting aside sufficient funds to amortize the loan of $1.18 million by May 1984 was good and that this should be done. A strong resolution is needed from the Board to address the letter from the Government of Bangladesh. No resolution should be made re repayment of the loan.

The cash flow position is much improved now as some of what was predicted to be received in April has arrived in May. It was reported that it is difficult to forecast accurately what cash will be available and there was discussion. One solution would be that letters pledging funds could be used to discount

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the payment i.e. underwrite promises of all donors provided an intended date of provision of funds is given. No interest would be charged, only a one percent service charge. This has to go to the Consultative Group and be discussed with the World Bank or Asian Development Bank.

4. Resources Development Review for 1983.

The Resources Development report was presented and further explained to the Committee. It was explained that certain donors/agencies will fund staff. This would release funds from the core budget if essential positions were filled in this manner. The expected funds for 1984 is US$ 7 million and at this time commitment above this level would be unwise. It was emphasized that increased fund raising each year cannot be assured at present without further development of the Consultative Group.

It was reported that securing cash flow of committed funds is also a problem. The Centre should try to develop the Consultative Group under the auspicies of the UN into a body that could guarantee the approved budget. The UNDP might approach the World Bank to ensure timely payment and disbursement for such a group. The Committee discussed and updated the forecast for predicted funds.

In discussing cash flow problems it was agreed that in future there is a need to be more conservative when projecting receipt of funds. A coordinated follow-up for funds is necessary and will require staff in the Development Office to accomplish this adequately.

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5. Budget Review 1984-85.

The review of the 1984 budget was presented. US$ 7.3 million is required without additional recruitment. There is a commitment to recruit 8 new international positions this year and these have been taken into account for the 1983 and 1984 budget. This is in addition to existing positions now vacant or that will become vacant in 1983-84.

Other comments made on presentation of the review were:-

(a) In the past the Centre has not replaced equipment in favour of sustaining operations. In 1984 an investment has to be made on equipment and physical plant. There is also a need to invest in capital development for which funds must be raised.

(b) In the new building US$ 100,000 per year is estimated for utilities. This has not been budgeted. This is presently being billed directly to ICDDR,B. There is a need to make a special arrangement with the Government of Bangladesh for relief from this expenditure. In the facilities at the Institute of Public Health utilities have been provided at no cost.

(c) It was explained why there is no space for the new computer. The Supply Section will be brought from a rented premises to the space vacated by the hospital and the remianing free space will be taken up by other sections to reduce serious congestion. The maintenance and warehouse have been returned to the Mohakhali campus from Tejgoan in 1982 which has required significant space and has achieved major cost savings.

(d) It is expected that World University Service (Canada) will

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fund 5 or 6 positions (mid-level Scientists) in 1984 and this will off-set some of the recruitment funds required.

It was agreed that the requirement is for a budget of at least US$ 7 million with extra budgetary provision for recruitment. Core funds must be committed to recruit the highest priority positions as funds become available. The Director explained why various positions were required and agreed to rank persons/positions for recruitment in order of priority.

The Board can review the 1984 budget again in November 1983 and the Committee in October 1983. At this stage it was felt that the only way the budget can be kept within its limit is to cut down on recruitment of senior staff from core funds and seek from participating countries and agencies secondment of staff as has been achieved with France, U.K., U.S.A., Belgium and several others.

6. Review Reserve Fund Status.

It was reported that the document would not be presented as the Centre did not wish to submit it until a full developed document was available. However, the reserve fund has been started and priority will be given to producing the supporting document which could serve to raise matching support from interested parties.

The management of the Centre left the meeting at 7.15 p.m. so that the Board members could meet with the Auditor.

Encl. List of suggested resolutions

LIST OF SUGGESTED RESOLUTIONS

(a) The Board of Trustees of ICDDR,B accepts an amount of US$ 1,181,731 from the Government of Bangladesh out of the UNROB Fund and places on record its deep sense of appreciation of the same.

(b) The amount given nominally as a loan for providing services exclusively in Bangladesh has been of immense help in continuing the activities of the Centre. The Centre will face serious adverse financial crisis in case the Centre is called upon to repay this amount.

(c) In view of the facts and position stated above, the Board of Trustees unanimously requests the Government of Bangladesh to convert this amount of US$ 1,181,731 as grant to the Centre in order to enable the Centre to continue its activities in Bangladesh.

MINUTES OF MEETING OF PERSONNEL AND SELECTION COMMITTEE OF BOARD OF TRUSTEES, ICDDR,B HELD MARCH 19, 1983 IN GENEVA

Present : Dr M.A. Matin (Chairman), Dr F. Assaad, Dr J. Sulianti Saroso, Dr Greenough.

Observers: Dr D.J. Bradley, Mr M. Goon

Absent : None

The meeting was convened at 9 a.m. in OMS, Dr Fakri Assaad's office.

1. Agenda - Approved.

2. Minutes of Committee meeting held in Dhaka 5 December, 1982 were approved.

3. Matters Arising. It was noted that a portion of the Committee report had been omitted from the Minutes of the Board meeting. This will be corrected.

4. Consideration of the organizational diagram was deferred to the end of the meeting.

5. a.b.c.

The implications of the draft rules were considered taking into account the specific requirement that appointments to all international level positions are to be approved by

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the Board. It was decided that the P1-3 positions are "interntional" and must be approved by the Board. The mechanism for this will be introduced in correcting the draft procedures provided. The corrected draft will be circulated. It was noted that section 230 be redrafted to be clarified.

The issue of a departure from WHO by establishment of a ceiling on the number of years a contract can be renewed was discussed. The benefit of insuring sufficient staff turnover to infuse fresh expertise was noted. It was felt that a convention which is also present in WHO that after a five year period reassignment is encouraged should be noted and followed by the Board when approving contract renewals for international level positions. It was also noted that certain benefits are withdrawn after five years. "The assignment allowance shall cease when a staff member has been in receipt of it for five consecutive years at the same official station. However, if he has been serving at an official station outside Europe and North America (but including those in Turkey situated south of the Bosphorus) and if he is maintained at the same official station at the initiative of the Centre beyond that five-year period, the Centre may authorize extension of the period of entitlement of the allowance for a single finite period not exceeding two years. No further extension shall be granted."
It was noted that full implementation of WHO staff rules at ICDDR,B took place on 1 January, 1983.

Geographical Quotas. The implications of establishing

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geographical quotas was carefully considered. It was agreed that quotas should be established following the Ordinance. As at 31.12.82 there were 34 P-level positions approved. This figure excludes 3 Executive Secretary positions, and 3 specially funded positions of demographer, endocrinologist and clinical research physician. Since these are dollar paid positions and are included in the overall Centre's budget, the total approved positions should therefore be 40. This would apply only to established positions approved by the Board in the manpower plan for the Centre for international level positions (P1 and above).

The Board will appoint international level staff positions accordingly.

7. The matter of recommendation of new members for the Board of Trustees was discussed from the list of nominees. Four names were decided upon for suggestion to the Board.

8-9. The report on recruitment of new staff and promotions to Extended level were taken as one agenda. It was decided that the Selection Committee did not need to be involved in decisions other than at the P or international level. Therefore the report given was acknowledged for promotion of staff into Extended levels but no discussion or action occurred.

The appointments of Drs Bodgan Wojtyniak and Ivan Ciznar were acknowledged.

There was comment on the appointment of Michael Bennish.

First, it was felt that a final offer should await closure of the advertisements on 30 April. Second, he should be regarded as a general Pediatric research worker not only as a person to assist with the Chlamydia protocol. The Board had clearly indicated that the expenditure and effort on Chlamydia should be modest until pilot work showed it to be an important cause of illness in Bangladesh. The Committee were assured by the Director that these views would be taken into account and communicated to the Programme Head.

The advertisement for a position of Scientific Programme Coordinator before its establishment by the Board was criticized. However, the advertisement allows recruitment to proceed short of commitment and this requires at least 3-6 months. Should the Board decide not to establish this position at their June meeting the respondants would be informed and no action taken.

10. Report on Compliance to WHO rules and scales. The report was accepted as presented. There was discussion on staff which had not opted for the WHO rules and scales. Some leniency would be agreeable for the Director if he believed termination of an employee who had not opted was not in the best interest of the Centre. This might be that that employee could be admitted to the WHO scales in the next budgetary cycle beginning 1 January, 1984 thus forfeiting all benefits which would accrue in 1983. Other options may also be considered.

The one P level staff member who was not willing to accept

a contract consonant with WHO rules may have his contract honoured as it stands but shall be informed that when it is over any new agreement will be according to WHO rules and scales.

11. Miscellaneous. The need of a selection process for External Reviewers was discussed. It was decided that the Director should write to all participating countries and agencies to solicit their suggestions for reviewers. The selection committee could then prepare a suggested list to be invited at the June meeting.

WBG:jc

MINUTES OF THE PERSONNEL & SELECTION COMMITTEE MEETING OF THE BOARD OF TRUSTEES, HELD IN NEW YORK CITY AT IIE ON 12 JUNE, 1983 AT 10.00 A.M.

Members Present : Dr M.A. Matin (Chairman), Dr David Bradley, Dr W.B. Greenough and Dr J. Sulianti Saroso.

Members Absent : Dr F. Assaad

Invited Staff : Mr M. Goon, Mrs J. Mecartney

The draft Agenda was agreed upon as follows:-

1. Minutes of last meeting held on 19 March, 1983.
2. Matters Arising.
3. Report on Compliance to WHO.
4. Extended Scales review and approval.
5. Working Paper on Pension Fund.
6. Geographical Distribution.
7. Procedures on Staff Promotion.
8. Post Classification.
9. Personnel Recruitment and Selection Procedures.
10. Appointment Procedures
11. Selection of New Personnel 1983.
12. Manpower Plan 1984.
13. Selection of External Reviewers.
14. Selection of New Trustees.
15. Miscellaneous.

Agenda 1 : Minutes of last meeting held 19.3.83

The minutes of the meeting held on 19 March, 1983 were approved with the following changes:-

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(a) Re Agenda 6, Geographical Quotas. It was felt that percentage figures were too precise and could cause difficulty. Therefore, from "Using the composition ... shall have a total range of 12.50% to 37.50%" should be deleted and replaced by "It was agreed that quotas should be established following the Ordinance.". "(f)" would be deleted and that point would be a new sentence in the same paragraph.

(b) Re Agenda 8-9. The acceptance by Drs Bogdan Wojtyniak and Ivan Ciznar of appointments was reported. The last sentence of the last paragraph on page 6 beginning with "The recruitment of Drs Marge Koblinsky and ..." should be deleted.

(c) Re Agenda 10, Report on Compliance to WHO rules and scales. It was decided that everyone must give their final option by 1 July, 1983. New wording was introduced in the second paragraph on page 7 so it now reads as follows: "The one P level staff member who was not willing to accept consonant with WHO rules may have his contract honoured as it stands but shall be informed that when it is over any new agreement will be according to WHO rules and scales.".

Agenda 2 : Matters Arising

(a) Re Agenda 5 a.b.c. The suggested five-year period assignment was discussed. Its virtue is that it provides for the revitalization of ideas and prevents entrenched interests. People should

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be encouraged to work for a period of five years - 2-3 years being seen as a time period to settle into a project and the next 2-3 years as maximum productivity. In some cases this will not be long enough but some time ceiling seems desirable. Unfortunately, the best scientists tend to leave early and those who want to stay on may have no other choices. It was discussed whether to use the words "usually" or "ordinarily" after "the Board" in the sentence "... the Board when approving contract renewals for international level positions." but it was felt to weaken the statement and should not be used here.

(b) Re Agenda 11, External Reviewers. Dr Greenough expressed that he was not fully satisfied about the list of External Reviewers. He requested that this item be left to the regular agenda.

(c) The minutes of Committee meetings are separate reports and should not be read into the full minutes of the Board meeting. A report will be prepared for the body of the Board minutes.

Agenda 3 : Report on Compliance to WHO

Full compliance to the WHO rules and pay scales was reported excepting some project staff which were on projects budgetted to donors before the transition to WHO scales occurred. All new projects will be budgeted on the WHO scales with contingency for increases. How to reconcile project scales is now a budgetary problem. Before any renewal the donors should be asked to meet

WHO scales. Partial corrections of selected staff may cause problems but may be needed. Conversion of all project staff would cost $75,000 - $150,000 annually. For 1983 approximately $70,000 would be required that is not budgeted. Community Health Workers pay scales are related to Government rules and require correction only when Government scales change.

Agenda 4 : Extended Scales for review and approval

Extended level scale was discussed and reviewed as compared with the bottom of the Professional level scale. The difference is very large. Extended level three will be useful to hold staff before they achieve P or international levels.

For Extended level positions action by the Personnel and Selection Committee of the Board is not necessary.

Agenda 5 : Working Paper on Pension Fund

The UN has rejected the request for ICDDR,B to join the UN pension fund because ICDDR,B is not an international agency, according to their definition. It was felt that continuing the Provident Fund was currently the best course. If offers flexibility such as early withdrawals, loan privileges, etc. and may be held in US dollars to protect against inflationary erosion. This was recommended. The disposition of the Severance Pay and Provident Fund accounts will be decided when the Pension Scheme has been developed.

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Agenda 6 : Geographical Distribution

The question of exact percentage quotas was discussed. It was felt that rigid quotas could raise unnecessary problems. Some flexibility is required but clearly no one country should predominate over others. The Charter provides adequate guidelines in the rules concerning composition of the Board of Trustees. The following wording is to be suggested to the Board for adoption:-

"The Board laid down the following guidelines for the geographical origins of staff of the Centre at international (P) level, based upon the rules for distribution of Trustees. Among the international level staff paid from the core funds of the Centre, so far as feasible, half shall be from developing countries and up to one-third shall be nationals of Bangladesh; not more than one fifth shall be from any other one country so far as feasible; unless the Board shall determine otherwise in the interest of the scientific work of the Centre.".

Agenda 7 : Procedures on Staff Promotion

The importance of consistency and fairness in promotion was discussed. All promotions must be advertised internally and if excellent candidates are not available externally. Such a procedure should avoid the problem of "creeping promotions" which occur when an individual is upgraded with his/her position. There was discussion of what would happen to the people who applied for a position which they already held and failed. It was felt that there must be alternatives

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for these persons should they fail. It was agreed that they could request transfer to another post at their original level. It was emphasized that hiring should not be a lengthy process. Steps should be taken to speed this up.

Agenda 8 : Post Classification

The procedures presented were agreed upon with minor changes. Since committees, including the Management Committee, play a role in this process, the powers of the Management were discussed and agreed to be advisory to the Director. The Director has the power to form committees. None supercede the Board in any matter nor relieve the Director of his full accountability to the Board.

Points 30.3 and 30.4 were reworded to read as follows:-

"30.3 Upon clearance by the Chief of Personnel the reclassified post description is circulated to relevant staff.

30.4 The post classification accompanied by the comments of senior staff members and Chief of Personnel is forwarded to the Director for his final decision on whether it is to be presented to the Personnel and Selection Committee for their review and acceptance.

Agenda 9 : Personnel Recruitment and Selection Procedures

There was extensive revision of the Working Paper presented. The revised version was agreed upon.

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Changes made were as follows:-

(a) On page 4, Selection International Level Staff, point 280 should read as follows - "Authority for the selection of international level staff is undertaken by the Board through the Personnel and Selection Committee. The Director shall prepare a short list of suitable candidates for the consideration of the Personnel and Selection Committee of the Board.". This replaces points 280, 290 and 300 on page 4.

(b) On page 5, Search for Director, point 310, should read as follows - "For the Director's position the Board may create a Search Committee to submit a list of suitable candidates to the Board for final approval and appointment.". This replaces point 310 on page 5.

(c) Points 370, 380, 390, 400, 410 and 450 on page 5 should be deleted.

The Committee was not able to go through the applications provided and make a short list. The Director was instructed to prepare a short list for presentation to the Committee for the vacant positions which have been advertised.

Agenda 10 : Appointment Procedures

The draft procedures for appointing personnel were reviewed and revised. The document reflects these revisions. Changes made were as follows:-

(a) Point 20, the following sentence was added after "candidate" on line 4 "For international level positions the Chairman of the Board or his/her nominee will

review the final offer.".

(b) Also under point 20, "- for posts at Grade P1 ..." should be deleted and the line above should be changed to read "- for posts at Grade P1 to D2 by the Director".

(c) Point 60, second line after "two" and before "years" the words "or three" should be added.

(d) Point 60.1 should be deleted and replaced by the following "60.1 The Board would not usually employ continuously international level staff for more than a period of 6-8 years.".

(e) Point 60.2 should be deleted.

Rewording of the Professional (P) Level Rules was also discussed and agreed upon as follows:-

(f) Point 1.1 there should be a comma after "Board" and the following words added "and appointment to them made by the Board.".

(g) Point 1.3 should read "All appointments are made for a contract period of 2 or 3 years. Contract renewals are made on a 2 or 3 year basis.". The rest of this point should be deleted.

(h) Point 1.4 the words "to the Board" should be added after "recommended" and before "by" in the first line.

(i) Point 1.5 should be deleted and replaced by old point 1.6 which should read as follows "1.5 All

international positions (except the Director's position) are to be selected by the Personnel & Selection Committee together with the Director. The Board is then requested by mail or formally at the next Board meeting for their approval on the appointments.".

(j) Point 1.7 should be 1.6 and read as follows - "Appointment of the Director can only be made by the Board. A special Search Committee is appointed by the Board who will review all applicants and make recommendations to the Board for appointment.".

(k) Point 1.8 should be 1.7 and the words "from unrestricted core funds" added after "appointments" and before "are" on the first line. "Selection Sub-Committee" should read "Personnel & Selection Committee".

Agenda 11 : Selection of New Personnel 1983

The Committee was informed that there were a large number of applications for each post which was advertised. These applications were available in the meeting room for review. Due to recent closure of the advertisements and time constraints placed on the Director with the first Board Meeting away from Dhaka a short list was not ready. The Board members were asked to assist the Director in reviewing applications and preparing a short list.

Agenda 12 : Manpower Plan 1984

The Manpower Plan was presented. In view of the planned use of consultants it was suggested that there be a

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budget for consultants. The point was made that consultants were used against positions and functions which were unfilled. The budget was that of the position under recruitment but not yet filled. The use of the word "Fellows" was discussed; WHO has a strict definition for this word which differs from ICDDR,B use of it. The Centre will adopt the WHO definition. Those individuals formerly termed fellows not satisfying the WHO definition have been given other designations.

Agenda 13 : Selection of External Reviewers

The selection of names was discussed. The Director expressed the need for expansion of the list. The names of three or more reviewers for each area are needed in order to insure a full panel at an early time. This was agreed and a list prepared which would be presented to the Board.

Agenda 14 : Selection of New Trustees

Nominations for new Trustees were agreed to as follows:-

Dr J. Sulianti Saroso - Indonesia - Reappointed
Dr Immita Cornaz - Switzerland - New Trustee
Dr A.R. Al-Swailem - Saudi Arabia - New Trustee
Dr D. Rowley - Australia - New Trustee
Mr A.B.M. Ghulam Mostafa - Bangladesh - Appointed by the Government of the People's Republic of Bangladesh.

Agenda 15 : Miscellaneous

(a) In view of the long service of Mr Mark Tucker and the failure of CRL to provide a retirement plan, it

was agreed to provide the equivalent benefit, to be set by the Management to be equivalent, to a pension benefit for his service time.

(b) The extension of contracts was discussed. It was agreed that Dr Sanyal was a Visiting Scientist on leave from his University and could continue up to the leave granted him.

It was agreed that Dr Samadi's and Dr D'Souza's contracts would not be extended. Leave time and funds to complete work and explore possibilities for a new position were at the discretion of the Director.

(c) It was agreed to redesignate as "Associate Director" the positions of the Scientific Programme Heads.

(d) The rewording of Resolution 23/Dec. 82 to address Clause 30(b) of the Ordinance was agreed upon as follows: "Resolutions 17 through 22/Dec. 82 indicate the completion of transition of the Centre from the former Cholera Research Laboratory to the current International Centre for Diarrhoeal Disease Research, Bangladesh. The provisions of Clause 30(b) of the Ordinance will cease to apply with this transition. The Board asks the Director to ensure that all staff conform to WHO staff rules and pay scales by 1 January, 1983 with a report to the Board.".

(e) It was agreed that a position of "Deputy Director" had not been established and was not recommended.

(f) It was agreed that under the prior wording of this Committee that the contracts which provided added benefits must be revised.

WBG:jc

2/BT/DEC. 83 (a)

RESOLUTIONS OF BOARD OF TRUSTEES MEETING

13-15 JUNE 1983

RESOLUTIONS

BOARD OF TRUSTEES MEETING

13-15 JUNE 1983

RESOLUTION 1/JUNE 83

RESOLVED : On the basis of the recommendation of the Programme Coordination Committee (PCC) during its meeting of 15 May, 1983, the Standing Committee (SC) of PCC consists of 14 members, as follows:

(a) (i) 7 members to be recommended by the PCC;

(ii) 1 member to be nominated by the BMRC;

(iii) 3 members to be nominated by designation by the Government of Bangladesh;

(iv) 3 members to be nominated by the Board of Trustees of ICDDR,B;

(b) That other members of the SC may either be by name or designation as in case of PCC.

RESOLUTION 2/JUNE 83

RESOLVED : (a) The Board of Trustees of ICDDR,B accepts an amount of Tk.2,89,28,774.88 from the Government of Bangladesh out of the UNROB Fund and places on record its deep sense of appreciation of the same.

(b) The amount given nominally as a loan for providing services exclusively in Bangladesh has been of immense help in continuing the activities of the Centre. The Centre will face serious financial crisis in case the Centre is called upon to repay

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this amount. In view of the facts and position stated above, the Board of Trustees unanimously requests the Government of Bangladesh to convert this amount of Tk.2,89,28,774.88 as grant to the Centre in order to enable the Centre to continue its services to the people of Bangladesh.

RESOLUTION 3/JUNE 83

RESOLVED : The Board examined the report of the Auditor for 1982 and accepted the same as a faithful representation of the accounts of the Centre.

RESOLUTION 4/JUNE 83

RESOLVED : The Board appoints M/s Deloitte Haskins & Sells as the Auditor for the Centre for the year 1983 and authorises the management of the Centre to negotiate remuneration of the Auditor.

RESOLUTION 5/JUNE 83

RESOLVED : A budget for an amount of US$7.0 million is authorised for 1984. In view of the anticipated pay rise by the WHO to international level staff an additional amount of US$400,000 may be required during 1984. The Board will review the budget in its next meeting in November 1983 and take appropriate decision on the basis of

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more specific facts in respect of the income and expenditure position and also about the anticipated rise in pay by the WHO.

RESOLUTION 6/JUNE 83

RESOLVED : The Board authorises the Director to initiate steps for field trials of oral cholera vaccine in Bangladesh including examination of its financial aspect, processing it through the Ethical Review Committee and identifying sources of meeting the expenses involved in such an effort. The Board emphasizes the indispensable necessity of obtaining concurrence of the Government of the country where such trials are to be held and requests the Director to maintain close liaison with the Government of Bangladesh in the matter. The Board further requests the Director to inform the Board of the developments in its next meeting in November, 1983.

RESOLUTION 7/JUNE 83

RESOLVED : The Board accepts and endorses the content of the Personnel and Selection Committee document no. 11/BT/June 83.

RESOLUTION 8/JUNE 83

RESOLVED : The conversion of all project staff to WHO scales not later than 1 January, 1984 was recommended. If funds become available before this date this can be accomplished earlier, but all project staff should be transferred effective 1 January, 1984 at the latest.

RESOLUTION 9/JUNE 83

RESOLVED : The tenure of employment in international level positions in the Centre should be on the basis of contracts for periods up to 3 years at a time and ordinarily the total period of tenure of international level positions should not exceed six years.

RESOLUTION 10/JUNE 83

RESOLVED : All P level positions are considered as "international level" and will be appointed by the Board.

RESOLUTION 11/JUNE 83

RESOLVED : In matters of recruitment to all international level positions, the country of citizenship will be the basis for all contracts without any exception. In the event of dual nationality the country of citizenship and domicile irrespective of actual place of origin or place of recruitment will be taken into account.

RESOLUTION 12/JUNE 83

RESOLVED : It was agreed that Dr J. Sulianti Saroso should be re-appointed as a member of the Board of Trustees and that Drs Immita Cornaz, Abdul Al-Swailem and Derrick Rowley be appointed as new members, and that the Board welcomes the appointment of Mr A.B.M. Ghulam Mostafa.

RESOLUTION 13/JUNE 83

RESOLVED : The Board unanimously appointed Professor J. Kostrzewski as Chairman of the Board of Trustees for a period of one year from 1 July, 1983 until 30 June, 1984.

4/BT/DEC. 83

DIRECTOR'S REPORT

DIRECTOR'S REPORT

Since the meeting of the Board of Trustees in New York, June 1983, there have been several notable events and accomplishments. In the research programmes a list of publications up to November 1983 reflects finished and reported work. Beyond this are a series of documentation reports on the work of the MCH-FP projects with the Government of Bangladesh in Sirajganj and Noapara and a collaborative project with the German Technical Assistance Programme and the Government of Bangladesh in Munshiganj. Work currently in progress can be quickly appraised from the attached list of ongoing protocols. All this indicates sustained high productivity.

The Training Programme has been very full as the attached schedule of their 1983 activities indicates. This included two major workshops on water and sanitation and one on clinical trials. Of particular importance has been the successful cholera surveillance and control programme based on training the responsible Thana officers of the Government, and establishing both Government and ICDDR,B staffed "flying" field teams. Reports of this effort are available with the Training Branch.

Outside of Bangladesh, the Centre has begun a project jointly with the Government of the Kingdom of Saudi Arabia in the Eastern Region of that country to establish diagnostic capabilities, treatment facilities and surveillance capacities. Two ICDDR,B teams have visited Indonesia, and we

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have been asked to assist in the control of diarrhoeal diseases on a long term basis. At the request of UNICEF we have paid initial visits to Tanzania and Colombia to assess the possibilities of the Centre's assisting efforts in those countries. The increasing demands on the Centre indicate that many countries and agencies are recognizing the success of our initiatives in the field. The Trustees and Centre's management must address how best to respond. The Centre's efforts have always been at a practical field and bedside level not at a national planning level which is the responsibility of CDD/WHO. We see our initiatives as an essential component to which WHO/CDD will link its national plans as these are developed. However, some of our efforts needed are likely to grow to a considerable size eventually and will raise the questions of whether other centre similar to ICDDR,B may be needed in other geographic areas. Another issue that will need to be addressed is whether if such initiatives are developed, they should be entirely restricted to diarrhoea. In addition to those interventions now used by the Centre in its field areas acute respiratory illness is clearly the next most major accessible cause of death in many countries. It has been little studied to date. When an approach is made using general demographic data with cause of death information it tends to focus priorities for interventions based on the field realities. I think this is appropriate.

In your folders are briefing papers on the proposed field trial of oral cholera vaccine. It is expected that WHO, ICDDR,B and the Government of Bangladesh will jointly sponsor this trial, which is scheduled to begin in 1984. The Centre

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feels strongly that a well focused, two cell trial to test efficacy of the best available vaccine is the first step.

In the area of Resources Development and financial control we have had successes which complement each other in that the larger amount of resources available is being utilized with much greater efficiency.

There are physical changes at the Centre such as the fully occupied new Hospital, return of Maintenance from Tejgoan to our own campus in Mohakhali, shifting of Training and Supply to the vacated ground floor, formerly occupied by the Hospital, and expansion of the Library and Computer facilities. We hope to receive a new computer in 1984 from Canadian CIDA in connection with the new DSS project grant. We are recommending that at low cost a floor be added at the level of the Director's office immediately to accommodate Host Defence and other laboratories

We have had important international staff and long term consultants changes since June with the departure of the following valuable members:-

Dr Stan D'Souza
Dr Roger Glass
Dr A.R. Samadi
Dr P. Satterthwaite
Dr Barbara Stoll

and have welcomed consultants and employees as follows:-

Dr Michael Bennish
Dr John Clemens
Ms Wendy French

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Dr Fitzroy Henry
Mrs Wendy Hussain
Dr M. Koblinsky
Ms Naomi Novak
Dr Bonita Stanton
Mrs Sonja Waara-Conway
Dr Bogdan Wojtyniak

The importance of developing effective ways by which the Centre can facilitate research in the National institutions of Bangladesh cannot be over stressed. The main vehicle for this effort is the Programme Coordination Committee. This Committee and its Standing Committee have met on several occasions and are rapidly developing plans which should lead to a good cooperative relation of the Centre to the National research process. Ways are now being sought to stimulate research projects and facilitate their support. As requested by the Board improved guidelines for these Committees have been prepared and appear as Agenda 6.

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A ORIGINAL SCIENTIFIC PAPERS, BOOK CHAPTERS AND REVIEW ARTICLES:

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ICDDR,B ONGOING RESEARCH PROTOCOLS:

Position as of 31st October, 1983

Sl.No.	Working Group	Protocol number	Title	Principal Investigator(s)	Starting date	Completion date	Remarks
1	2	3	4	5	6	7	8
1.	CSRWG	78-001	Demographic Surveillance System, Teknaf and Matlab	Dr.Stan D'Souza Dr.M.M.Rahaman	4.1.78	31.12.83	
2.	NWG	78-012	Detection of Antitrypsin in studying the Gastrointestinal Protein Loss	Mr.M.A.Wahed	4.4.78	31.3.84	
3.	CSRWG	78-025	Oral Therapy Field Trial	Dr.M.Yunus Mr.J.Chakraborty	7.11.78	31.12.83	
4.	NWG	78-026	Absorption of Foods during attack of diarrhoea in Children	Dr.A.M.Molla	7.11.78	28.2.84	
5.	CSRWG	79-014	Effects of Reporting Errors in retrospective Survey Data on Indirect Estimates of Fertility & Mortality using vital Registration Data from Matlab, Bangladesh	Dr.Stan Becker	6.12.79	28.2.84	
6.	CSRWG	80-004	Interactions between maternal nutrition, morbidity and reproductive process	Dr.A.K.M.A. Chowdhury	5.2.80	30.6.84	
7.	CSRWG	80-022	Water and Sanitation Intervention: Teknaf	Dr.M.M.Rahaman	10.6.80	31.5.85	
8.	CSRWG	80-035	Demographic Surveillance System Matlab	Dr.Stan D'Souza	26.8.80	30.9.84	
9.	CSRWG	80-042	The Community Health Services Project, Matlab	Dr.J.Phillips Mr.M.Rahman	16.2.81	31.12.83	
10.	PTWG	81-019	Gastric Emptying Time in children with acute diarrhoea due to different	Dr.P.K.Bardhan Dr.A.M.Molla	1.10.83	31.3.84	

1	2	3	4	5	6	7	8
11.	HDWG	81-033	Further identification of colonization factors (CFA) in E.coli and Assays of Antibodies to these factors as well as to enterotoxins	Dr. L.Gothefors	9.9.81	30.11.83	
12.	PDC	81-034	Studies on Rotavirus Serotypes in Bangladesh and Kenya	Dr.G.H.Rabbani	1.9.81	28.2.84	
13	CSRWG	81-037	Antenatal and Postnatal Care-Socio-cultural aspects	Mr.M.Shafiqul Islam	6.10.81	31.12.83	
14.	HDWG	81-038	Respiratory infections as complications to Diarrhoea in Hospital patients	Dr.L.Gothefors Dr.Nigar S.Shahid	6.10.81	30.11.83	
15.	PTWG	81-042	The role of prostacycline in the development of Haemolytic-Uremic syndrome in acute shigellosis	Dr.A.N.Alam	7.1.82	31.13.83	
16.	NWG	81-044	Protein losing enteropathy in post measles diarrhoea	Dr.Shafiqul Alam Sarker	8.2.82	31.10.83	
17.	DTWG	81-045	Studies on the clinical manifestations and toxicity by Aeromonas Hydrophila strains isolated from cases of diarrhoea and other serological responses	Dr.S.C.Sanyal	12.2.82	30.11.83	
18.	DTWG	81-046	Studies on the pathogenic mechanisms of Campylobacter fetus ssp.jejuni isolated in Bangladesh and their role in the aetiology of diarrhoea	Dr.S.C.Samual	12.2.82	30.11.83	
19.	DTWG	81-048	Development of potential live oral vaccine strains of vibrio cholera	Dr.M.I.Huq	11.2.82	30.11.83	
20.	CSRWG	81-050	Study on Socio-Economic and Mortality Differentials	Dr.Stan D'Souza	5.1.82	30.4.84	

1	2	3	4	5	6	7	8
21.	CSRWG	81-052	The Community Health Services Project, Matlab (MCH component)	Dr.J.Phillips	5.1.82	31.12.83	
22.	CSRWG	81-054(P)	Determinants of Areal Variation in Contraceptive Practices in Bangladesh	Mr.Makhlisur Rahman	11.3.82	30.4.84	
23.	CSRWG	82-002(P)	Lay reporting and DSS "Cause of Death Forms"	Dr.Stan D'Souza	8.7.82	31.12.83	
24.	PTWG	82-006	Pathological Studies of Fatal Complications of Invasive Diarrhoeal Diseases	Dr.T.C.Butler	11.2.82	31.3.84	
25.	PTWG	82-014	Characteristics of Diarrhoea in Typhoid Fever	Dr.S.K.Roy	18.6.82	31.12.83	
26.	DTWG	82-017	Investigations of the Extent of Fecal Pollution by Enumeration of Fecal Coliforms and Fecal Streptococci	Mr.Zeaur Rahim	4.5.82	31.12.83	
27.	CSRWG	82-018(P)	Dynamics of Nutrition, Diarrhoeal Diseases and Mortality of Children in Rural Bangladesh	Dr.R.Bairagi	4.5.82	31.12.83	
28.	NWG	82-025	Intake and Utilization of Calories from Rice Strach Electrolyte Therapy in Acute Diarrhoea due to Cholerae, etc., Rotavirus and Shigella	Dr.A.M.Molla	1.6.82	30.11.83	
29.	NWG	82-029	Nutrient Intake and Utilization during diarrhoea with Giardiasis in children	Dr.Ayesha Molla Dr.A.M.Molla	3.7.82	31.1.84	
30.	PTWG	82-030	Epidemiological Studies on Diarrhoea Associated with Measles	Dr.Asma Khanam	7.9.82	31.3.84	

1	2	3	4	5	6	7	8
31.	DTWG	82-031	ICDDR,B Surveillance Programme-Dhaka Hospital	Dr.Nigar S. Shahid	7.9.82		Ongoing activity protocol
32.	DTWG	82-032	ICDDR,B Surveillance Programme-Matlab Hospital	Dr.A.H.Baqui	7.8.82		Ongoing activity protocol
33.	PTWG	82-035	Role of colonic disfunction in Shigella Diarrhoea	Dr.T.C.Butler	5.12.82	31.12.83	
34.	CSRWG	82-036	The MCH-FP Extension Research Project: An Experiment in the Transfer of some MCH-FP Strategies from Special Non-Governmental projects to the Government Health, Population Control and Family Planning Services in two Thanas of Bangladesh	Dr.J.Phillips	14.10.82	31.12.84	
35.	NWG	82-037	A culturally based nutrition,education action-cum-research project to improve the feeding of young children in Bangladesh	Dr.Najma Rizvi	7.9.82	30.9.84	
36.	PTWG	82-038	Comparative efficacies of ceftriaxone and ampicilin given as single dose for the treatment of acute Shigellosis	Dr.I.Kabir	4.11.82	30.11.83	
37.	NWG	82-039(P)	Behavioral aspects in determining nutritional status of children	Dr.N.Rizvi	11.10.82	30.11.83	
38.	PDC	82-040	Feasibility of rice based ORS in field condition including the training to mothers and family members in its preparation and use	Dr.ASMM.Rahman	23.9.82	30.11.83	

1	2	3	4	5	6	7	8
39.	HDWG	82-041	Septicemia during Shigellosis;clinical features and pathogenic role of bacterial virulence related to serum iron availability & complementy activity	Dr.M.J.Struelens	17.10.82	31.12.83	
40.	PDC	82-042(P)	Assessment and surveillance of cropping patterns,land use,and rural employment before, during and after the Matlab Embankment Construction	Mr.Nazir K.Ahmad			Not yet started
41.	DTWG	82-043(P)	Boric acid tolerant Vibrio cholerae: Possible live oral vaccine	Dr.M.Ola Ojo	2.10.83	31.12.83	
42.	DTWG	82-044	Does handwashing prevent the spread of rotavirus infection ?	Dr.A.R.Samadi	2.10.82	31.10.83	
43.	DTWG	82-047	Ecology & Survival of Vibrio cholerae and related pathogenic vibrios in the aquatic environment of Bangladesh during cholera epidemic and inter-epidemic periods	Dr.M.I.Huq	2.10.82	30.11.83	
44.	PTWG	82-049	Trial of Cereal based (Rice powder) Oral Rehydration solution in the treatment of Diarrhoea in a Out-patient centre	Dr.A.M.Molla	2.10.82	30.11.83	
45.	CSRWG	82-053	Health Education Phase II:Sanitation addendum to Water and Sanitation Intervention - Tekn[illegible]	Dr.K.M.A.Aziz	4.11.82	30.11.83	
46.	DTWG	82-055(P)	Cellulose GM$_1$ binding of cholera toxin in family contacts of cholera patients	Dr.M.M.Hossain Dr.Roger I.Glass	2.12.82	31.12.83	
47.	PTWG	82-056	Indigenous plants in the treatment of acute diarrhoeal diseases	Dr.A.K.Azad Khan	1.8.83	1.5.84	

1	2	3	4	5	6	7	8
48.	NWG	83-002	Nutritional Anaemia in Matlab DSS area	Dr.A.N.Alam	2.2.83	30.6.84	
49.	DTWG	83-006	Detection Enterotoxigenic *E.coli* from stool culture and environmental samples by hybridization with specific $^{32}_{p}$ labelled DNA probe	Dr. M. I. Huq	7.2.83	31.12.83	
50.	PTWG	83-007	Loperamide in Travellers' Diarrhoea	Dr.P.Speelman	2.3.83	28.2.84	
51.	DTWG	83-011	Isolation of *E.coli* phages for their epidemiological and diagnostic use including identification/typing of *E.coli* strains	Dr.K.A.Monsur	6.4.83	31.3.84	
52.	DTWG	83-012	Intervention of Transmission of cholera in family contacts by hand washing/chlorination	Dr. M. U. Khan	4.5.83	30.4.84	
53.	PTWG	83-014(P)	Efficacy of Sodium Citrate to replace Sodium Bicarbonate in oral Rehydration solution (Limited study)	Dr.M.R.Islam	4.5.83	31.12.83	
54.	PTWG	83-015(P)	Trial of Berberine as an Anti-Secretory Drug in Human Cholera	Dr.J.Knight & Dr.G.H.Rabbani	4.5.83	31.12.83	
55.	PTWG	83-017(P)	Presence and Biochemical basis of an increased serum anion gap in the metabolic acidosis of cholera	Dr.J.Khight & Dr.T.C.Butler	1.6.83	31.12.83	
56.	HDWG	83-018	Modulation of murine antibody responses to V.cholerae by enteric immunization	Dr.Ansaruddin Ahmed	1.6.83	30.9.84	
57.	NWG	83-019(P)	Serum Transferrin and Iron status in malnourished children	Dr.N.M.Abdal	1.10.83	31.3.84	

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58.	CSRWG	83-022	Child Mortality: Social and Biological Determinants	Dr.Anne R.Pebley	6.7.83	31.5.85	
59.	CSRWG	83-023(P)	The Community Health Services Project, Matlab (Morbidity Surveillance)	Dr.Md.Giasuddin Dr.Nasreen Jahan	6.7.83	30.11.83	
60.	PDC	83-024	Field comparison between WHO-ORS and Rice-Salt ORS	Dr. Abdul Bari	6.7.83	30.6.85	
61.	PTWG	83-025(P)	Amebic Antigen detection in stool specimens (Pilot study)	Dr.P.Speelman	6.7.83	31.12.83	
62.	HD	83-026	An animal model for the study of invasive colitis	Dr.K.A.Al-Mahmud	6.7.83	30.6.84	
63.	NWG	83-027(P)	A study on the vitamin A content of vegetable based cooked food ingested by people of different socio-economic groups in Bangladesh	Mr.M.Mujibur Rahman	3.8.83	31.12.83	
64.	CSRWG	83-028(P)	Nandipara Census 1983	Dr.Sama Khanam	3.8.83	30.11.83	
65.	CSRWG	83-029	Socio-economic,health and family planning KAP baseline survey for the Teknak MCH-FP Extension project	Dr.J.Phillips Mr.Mizanur Rahman	3.8.83	30.6.84	
66.	DTWG	83-031(P)	"A study of the prevalence of rotavirus infection in Calves in the selected areas of Bangladesh	Dr. S. A. Selim	1.9.83	28.2.84	
67.	DTWG	83-033(P)	Detection of Shigella-like toxin in E.coli isolates from diarrhoeal patients in Bangladesh	Dr.T.C. Butler	7.9.83	30.11.83	
68.	CSRWG	83-034(P)	Geo-Coding the Matlab Map to locate Cholera by household	Ms.Marian Craig	7.9.83	30.11.83	

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69	DTWG	83-035(P)	Antibody responses to different formulations of oral B-subunit + Whole Cell cholera vaccine.	Dr.John Clemens.	1.11.83	31.3.84	
70	DTWG	83-036(P)	Investigation of simultaneous outbreak of classical Inaba & El Tor Ogawa cholera.	Dr.Nigar.S.Shahid	1.11.83	31.3.84	
71	DTWG	83-037(P)	Cryptosporidium as a pathogen for diarrhoea in Bangladesh.	Dr.Nigar.S.Shahid	1.11.83	31.3.84	
72	DTWG	83-038(P)	Study of Temporal Trends in Post-Monsoon El Tor & Classical Biotype cholera in Bangladesh.	Drs.Riley & Stephen H.Waterman	1.11.83	31.3.84	
73	DTWG	83-039(P)	Acceptability of Alkalinizing solutions in Children.	Drs.Bonita Stanton & John Clemens	1.11.83	31.3.84	

ICDDR,B

TENTATIVE TRAINING SCHEDULE FOR 1983

1.	January 2 - 6	: Orientation Course for Post Graduate Medical Students.
2.	January 16-20	: Trainer's Training Course for the Medical Assistants Training Programme.
3.	February 21-24	: Asian Conference on Diarrhoeal Disease (NICED/ICDDR,B) in Calcutta,
4.	March 20-31	: Inter-Regional Course on Diarrhoeal Disease: Clinical Aspects (WHO/UNDP).
5.	May 15-19	: Trainers' Training Course for Trainers of FWVTI.
6.	June 12-16	: Course on Diarrhoeal Disease Clinical Practice for B.Sc.(PHN) Nurse Students from College of Nursing,Dhaka.
7.	June 26-30	: -do- -do-
8.	Aug. 10	: Workshop on Informed Consent.
9.	Aug. 8-12	: Training of Army Medical Officers.
10.	Aug. 14-18	: Training Course on Diarrhoeal Diseases: Epidemic Control. (1)
11.	Aug. 21-25	: Trainers' Training Course for Trainers of FWVTI.
12.	Aug. 28- Sept. 1	: Training Course on Diarrhoeal Diseases: Epidemic Control. (2)
13.	Sept. 4-8	: -do- -do- (3)
14.	Sept. 11-15	: -do- -do- (4)
15.	Oct. 02-13	: Inter-Regional Training Course on Diarrhoeal Diseases: Clinical Aspects (UNDP/WHO)
16.	Oct.	: Training Course on Diarrhoeal Diseases: Epidemic Control. (5)
17.	Nov. 6-7	: -do- -do- (6) for Civil Surgeons, Addl.Civil Surgeon and Deputy Directors.
18.	Nov. 8-11	: Workshop on National Diarrhoeal Disease Control Programme (NDDCP). (NORP/WHO/UNICEF & ICDDR,B)
19.	Nov. 11-	: Workshop on Clinical Trials in Acute Diarrhoea (WHO)
20.	Nov. 21-25	: International Workshop on Measuring Health Impacts of Water Supply and Sanitation Programmes.

21. Dec. 4-8 : Workshop on Effects of Large Scale Water Control Project in Bangladesh.

22. Dec. 4-8 : Course on Diarrhoeal Diseases: Epidemic Control. (7)

23. Dec. 11-15 : Workshop on Manual for Teachers of Medical Colleges

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5/BT/DEC. 83

USAID REVIEW

AN ASSESSMENT OF THE SCIENTIFIC ACHIEVEMENTS OF THE INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH AND THEIR RELEVANCE TO AID HEALTH SECTOR PRIORITIES

A Report Prepared By:
ALFRED BUCK, M.D.
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MYRON LEVINE, M.D.

During The Period:
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I. INTRODUCTION

EXECUTIVE SUMMARY

This document reports the findings of an AID assessment of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) which examined the scientific work of the Center in relation to AID's health sector priorities. AID's Bureau of Science and Technology/Health has been providing core support to ICDDR,B but this grant terminates during F.Y. 1983. The multi-disciplinary assessment team was charged with making recommendations about the continuation of these funds and about any ways in which the ICDDR,B program might be modified to more closely respond to AID's concerns.

ICDDR,B's scientific research is of excellent quality and of great significance to the acquisition and spread of new knowledge about diarrheal diseases. There is every reason to believe that the work of scientists at ICDDR,B, which has in the past revolutionized thinking about these diseases, will continue to contribute to the search for ways to address this critical public health problem. AID should, therefore, continue to provide generous core support to ICDDR,B.

The nature and diversity of the global diarrheal disease problem, and the ecologically determined differences in the requirements of implementation of control programs, make it impossible for ICDDR,B to carry the burden of scientific investigation alone. While the Center should continue to play a focal role, AID is encouraged to identify and support institutions in other developing countries which could undertake scientific and operational research of diarrheal diseases. ICDDR,B could assist this global effort by providing guidance and specialized technical consultation and training as new research programs are being developed elsewhere.

The program of ICDDR,B is generally balanced and appropriate. However, the assessment team was concerned about the lack of expertise in epidemiology and immunology at the Center. This deficiency has been recognized by the Board of Trustees and the Director. Remedial action is likely to happen soon. There was concern also about the use of core funds to support operational research and health service provision, but bi-lateral and other categorical funding is expected to provide most of this support. ICDDR,B's role as a training institution is unique but the Center agrees with the AID team's view that practical, field-based and laboratory bench training should take precedence over more structured learning experiences. The contributions of ICDDR,B in the areas of disease surveillance and health services research have been significant but are constrained by computer hardware limitations and the lack of a senior epidemiologist. While not wanting to see the Center place too much emphasis on these activities, the assessment team agrees that the contraints should be removed.

I. INTRODUCTION

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) was established in December 1978 by an ordinance of the Government of People's Republic of Bangladesh. The ordinance was subsequently ratified in February 1979 at an Interim Internationalization Committee meeting held in Geneva and chaired by the United Nations Development Program. Thirty-four countries and international agencies are currently participating in the work of the Center.

The Center succeeds the former Cholera Research Laboratory which was established in 1961 by the Governments of the United States of America and Pakistan. The United Kingdom and Australia also participated. The scientific achievements of the former Cholera Research Laboratory are well recognized internationally. Significant scientific advances included pioneering breakthroughs in understanding the pathophysiology of cholera and closely related enterotoxigenic E. coli and the development of efficacious treatment of cholera and other diarrheas first with an intravenous replacement mixture, "Dhaka Solution", and later with an oral rehydration preparation. Five major vaccine field trials, undertaken at the Matlab field station, have demonstrated that the current cholera vaccine provides only limited protection of brief duration. Other epidemiologic field studies have delineated the transmission patterns of cholera and other diarrheal diseases and have highlighted the importance of asymptomatic infections. These field studies have resulted in major policy decisions by international organizations and national governments.

The aims and objectives of this Center are:

1. To undertake and promote study, research, and dissemination of knowledge of diarrheal diseases and directly related subjects of nutrition and fertility with a view to developing improved methods of health care and for the prevention and control of diarrheal diseases and improvement of public health programs with special relevance to developing countries.

2. To provide facilities for training Bangladeshi and other nationals in areas of the Center's competence in collaboration with national and international institutions.

Central funds of the Agency for International Development (AID) provide core support to ICDDR,B. When ICDDR,B succeeded the Cholera Research Laboratory a grant of $10 million was made by what is now AID's Bureau of Science and Technology/Health, but this annual commitment of $1.9 million will terminate in F.Y. 1983. This AID grant to ICDDR,B accounts for approximately 40 percent of the Center's core budget, or 27 percent of the total budget.

AID also funds specific projects of the ICDDR,B, but this support derives from the USAID mission in Bangladesh and is not the subject of this assessment.

The purpose of the assessment reported on in this document was to consider the past, future and potential contributions of the ICDDR,B to areas of relevance to AID's own objectives and strategy. The assessment was conducted in Bangladesh between November 29 and December 10, 1982 by a multi-disciplinary team of four people. The visit to Dhaka coincided with a program review by ICDDR,B's Board of Trustees. The AID team members participated in most aspects of the Board's review but were not invited to attend the formal Board meeting which followed. Members of the AID team, either during this assessment or previously, visited each of ICDDR,B's field stations in Bangladesh.

The charge to the assessment team was to make recommendations about what changes, if any, may be needed for the future program and plan of action of ICDDR,B as they relate to the aims and health policy of AID. The recommendations were also to address the global significance of the Center. Questions were posed by AID about the actual and potential contributions of ICDDR,B in assisting other countries to develop national programs, in disseminating new knowledge, advising on national demographic and disease surveillance systems, and building effective training programs. These questions and related issues are addressed in Chapter IV of this report.

The report is presented in four chapters. Following this introduction, Chapter II provides an overview of ICDDR,B and documents the resources and organization of the Center. Chapter III describes the achievements of ICDDR,B and its plans for the future and is organized into sections which address each of the Center's program areas. The relevance of these achievements and plans to AID is pointed out in this discussion. The final chapter, Chapter IV, documents the conclusions and recommendations of the assessment team.

II. OVERVIEW OF ICDDR,B

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The Dhaka headquarters of ICDDR,B contains a clinical research ward and laboratories in microbiology, immunology and biochemistry. In addition, the Dhaka station contains a treatment facility which serves over 100,000 patients, as well as a library and publications unit, animal facilities, statistical and data management resources, and administrative, logistical, and maintenance support systems.

In Matlab a study population of 160,000 has been under longitudinal demographic surveillance for 15 years and in Teknaf a study population of 40,000 has been under intensive observation for 6 years. These field stations include both an independent longitudinal data collection capacity as well as selective health services for diarrhea-related illnesses. Recently research activities have been extended to Nosapara and Sirajgang at the request of the Government of Bangladesh. Figure 1 shows the location of these ICDDR,B activities.

ICDDR,B Staff

The total number of people employed by ICDDR,B is at present 1,060. This staff complement is lower than last year and it is planned to reduce it further over the next 12 to 18 months. The distribution of these employees across locations and functional categories is shown in Table 1. Only three percent of Center employees earn an international salary (34 people) and more than half of these are scientists. Eighteen of the employees on local salaries are classified as scientists (2 percent).

The range of salaries is, of course, very great with the 34 international scale employees consuming a major proportion of the personnel budget and the lowest paid worker earning only $640 a year. The personnel costs of the research program account for 49 percent of the total personnel costs, reflecting the concentration of people on international salaries in this budget category.

The organizational structure of ICDDR,B is currently undergoing revision. The main feature at present is that the Director is the focal point and is reported to by the Deputy Director, three Associate Directors, (Resources Development, Administration and Finance, and Training, Extension and Communications) and the Program Head of each of the five research programs.

Budget

The operating budget for 1983 and the estimated budget for 1984 are shown in Table 2. The following table, Table 3, presents the distribution of the estimated budget for the years 1980 through 1983 across budget categories. Changes in accounting and budgeting procedures, and in the fiscal year make this comparison of limited value but the table does point out some trends.

Table 4 presents the ICDDR,B estimate of donor support for 1983. About one-third of the anticipated resources derive from contributions which are to be used for specific project activities as distinct from core budget support.

Physical Facilities and Scientific Equipment

The laboratory facilities in Dhaka are presently crowded and in need of repair and updating. The microbiology facilities are particularly weak. During the next few months some re-organization will occur as clinical facilities are transferred to a new building and space becomes available in the main structure.

Scientific equipment at Dhaka is generally adequate though the scientists would welcome an amino acid analyser to accurately appraise intake and absorptive function in nutrition studies, and an election microscope for morphological studies of Reyes Syndrome and other uses, including virologic studies. Other equipment items, such as refrigerators, freezers and centrifuges are in short supply and disposable items are often difficult to get promptly and in sufficient quantity.

The animal facility is an excellent resource. The physical plant of the facility is spacious and includes an ample operating theater and cages, pens and enclosed spaces for both small and large animals. Perhaps the most notable attraction of this facility is the relatively large numbers of trained assistants available to the investigator. With proper instructions beforehand and sufficient advance notice, these assistants prepare everything before the investigator arrives and investigative work in the animal facility proceeds in an admirably efficient way.

In Matlab, excellent basic facilities for simple clinical microbiology exist but are poorly and only sporadically utilized because of the lack of an M.D. epidemiologist. Routine cultures are conducted for Salmonella, Shigella, Vibrio and Campylobacter, and E. coli and stools are saved for further enterotoxin, virologic or parasitologic studies. The Matlab laboratories could usefully be upgraded and more effectively used once senior and junior epidemiologists team up with the able hospital and field staff there to expedite imaginative new protocols.

FIGURE 1

MAP OF BANGLADESH SHOWING ICDDR,B STUDY AREAS

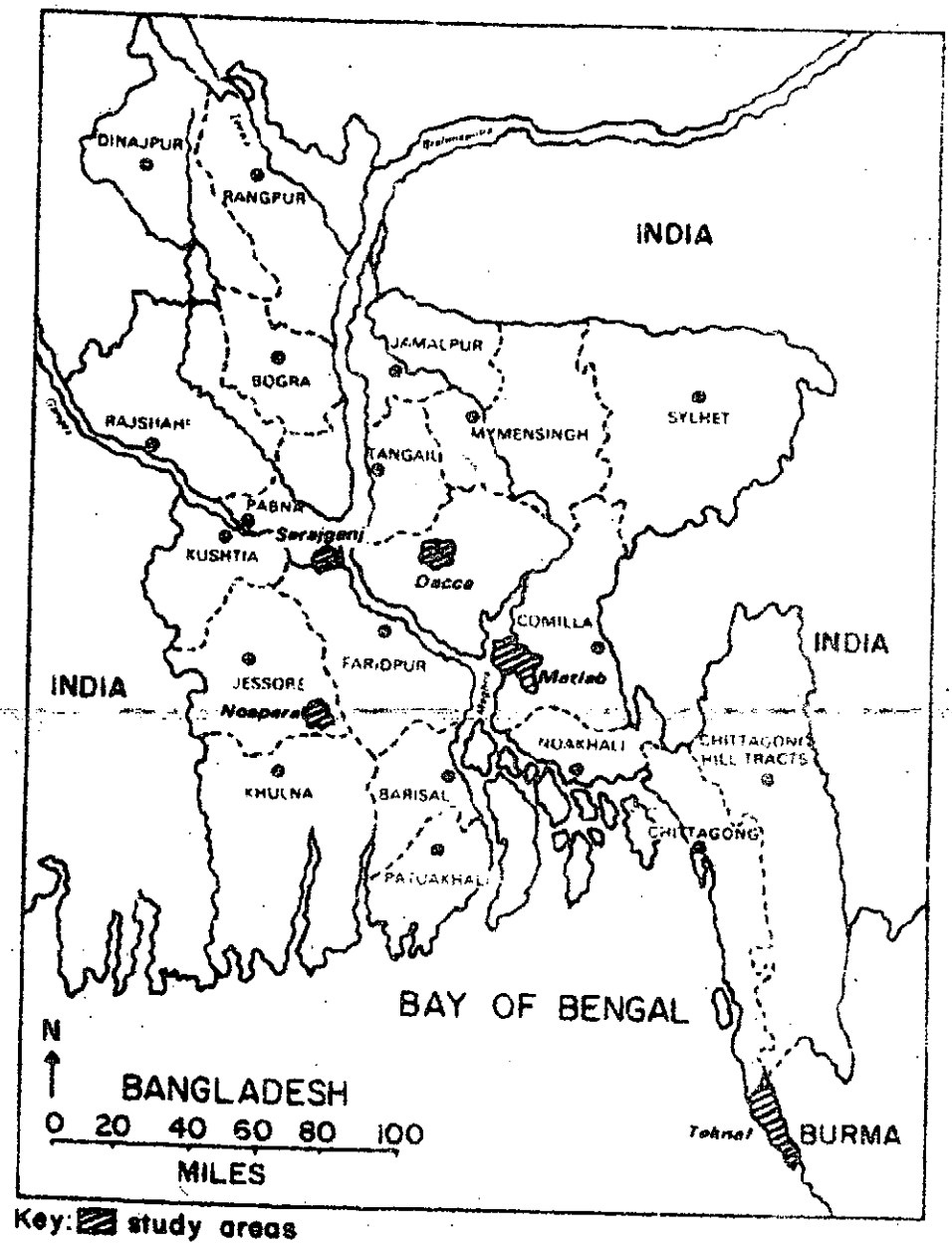

TABLE 1

ICDDR,B STAFF AS OF DECEMBER 1, 1982

a) Location of Local Pay Scale Employees:

	Core*	Project*	Total	Percent of All Local Staff
Dhaka	522	64	586	57
Matlab	152	137	289	28
Teknaf	42	14	56	5
Other Areas	7	88	95	9
	723	303	1026	

b) Categories of Local Pay Employees:

	No.	Percent of All Local Staff
Scientific	18	2
Scientific Support*	607	59
Administrative	401	39
	1026	

c) International Pay Employees:

	No.	Percent of All International Staff
Scientific	19	56
Administrative	6	18
Consultant	9	26
	34	

*Definitions: Core staff are not on limited term contracts.
Project staff are on 3 year contracts with every expectation of renewal.
Scientific support staff is a catch-all category for everyone except scientists and administrative personnel.

TABLE 2

1983 OPERATING BUDGET AND ESTIMATED BUDGET FOR 1984

(In US $)

	Personnel Services	Travel & Transp. of Persons	Transp. of Things	Rent, Comm. & Utilities	Printing and Reproduction	Other Cont. Servs.	Supplies and Material	Depreciation	1983 Total	1983	1984 Total	Percent Distribution
A. RESEARCH PROGRAM	2,273,900	43,500	1,600	23,000	17,800	31,800	248,200	25,300	2,665,200	41.0	3,280,000	41.0
1. Disease Transmission	586,500	6,200	500	6,400	2,600	5,900	68,700	6,500	663,300		816,300	
2. Pathogenesis & Therapy	349,700	7,100	200	4,900	1,400	4,200	55,400	3,200	426,300		524,600	
3. Host Defense	165,300	5,000	200	1,000	1,000	1,200	20,000	8,800	202,500		249,300	
4. Nutrition	403,000	8,200	200	3,700	2,200	7,000	34,100	1,200	459,600		565,600	
5. Community Services Research	769,400	16,800	500	7,000	10,600	13,500	90,000	5,600	913,400		124,200	(34.3)
B. TRAINING PROGRAM	209,800	26,600	500	3,300	8,300	9,000	38,800	9,100	305,400	4.7	377,400	4.7
C. PROJECT DEVELOPMENT	363,100	38,500	100	1,300	37,900	30,200	34,500	1,500	505,100	7.8	621,500	7.8
D. STAFF DEVELOPMENT	45,000	6,000		500	500	20,000	8,000		80,000	1.2	98,400	1.2
E. RESEARCH & TRAINING SUPPORT FACILITY	537,300	4,100	19,300	17,700	27,100	600	296,100	163,200	1,065,800	16.4	1,311,600	16.4
F. MAINTENANCE & LOGISTICS	283,700	7,300	40,200	21,500	800	1,700	30,800	60,650	446,200	6.9	551,400	6.9
G. MANAGEMENT	784,800	54,300	1,400	28,400	8,900	49,700	100,300	12,000	1,039,800	16.0	1,279,600	16.0
H. RESOURCES DEVELOPMENT	137,900	45,300	400	3,200	2,300	3,900	5,800	2,500	201,200	3.1	247,600	3.1
I. MANDATORY COMMITTEE	30,000	89,600	600	600	500	900	1,000		123,200	1.9	151,600	1.9
J. EMPLOYEE BENEFIT	19,400	200	200	300	700	18,300	26,400	700	66,200	1.0	81,300	1.0
TOTAL	4,684,900	313,300	64,300	99,800	104,900	168,100	789,900	274,900	6,500,000		8,000,000	100.0
PERCENT	72.1	4.8	1.0	1.5	1.6	2.6	12.2	4.2	=100	100		

TABLE 3

DISTRIBUTION OF ICDDR,B BUDGET 1980-1983

	1983	1982	1981	1980
TOTAL	$6,500,000 Percent	$6,500,000 Percent	$4,065,300 Percent	$4,216,250 Percent
A. RESEARCH PROGRAM	41	35	37	34
1. Disease Transmission	10	7	9	7
2. Pathogenesis & Therapy	7	6	5	4
3. Host Defense	3	4	-	-
4. Nutrition	7	6	6	4
5. Community Services Research	14	12	13	15
B. TRAINING PROGRAM	5	15	9	6
C. PROJECT DEVELOPMENT	8	NA	NA	NA
D. STAFF DEVELOPMENT	1	NA	NA	NA
E. RESEARCH AND TRAINING SUPPORT FACILITY	16	18	25	19
F. MAINTENANCE AND LOGISTICS	7	7	10	19
G. MANAGEMENT	16	10	16	22
H. RESOURCES DEVELOPMENT	3	5	2	NA
I. MANDATORY COMMITTEE	2	2	2	NA
J. EMPLOYEE BENEFIT	1	4	NA	NA

Notes:
1) The 1983 budget figures are those presented at the meeting of the Board of Trustees in December 1982.
2) The amount spent in 1982 was approximately $4.5 million, rather than the estimated $6.5 million.
3) During 1982 accounting and budgeting procedures underwent major modifications.
4) The fiscal year was changed from July-June to the calendar year as of January 1, 1981. Figures for 1980 are approximate, being derived from the July 79-June 80 and the July 80-June 81 budgets.

TABLE 4

STATEMENT OF ESTIMATED DONOR SUPPORT - 1983
(In U.S. Dollars)

A. CORE BUDGET

		PERCENT (A. Subtotal)	(Total)
Australia/ADAB	225,000	4.8	3.2
Bangladesh	37,000	.8	0.5
Ford Foundation	200,000	4.3	2.8
France	80,000	1.7	1.2
Japan	625,000	13.3	8.8
Saudi Arabia	100,000	2.1	1.4
Sweden/SAREC	72,000	1.5	1.0
Switzerland	270,000	5.7	3.8
United Kingdom	200,000	4.3	2.8
USA/USAID	1,900,000	40.3	26.8
UNICEF/AGFUND	1,000,000	21.2	14.2
	4,709,000	100.0	66.5

B. EARMARKED CONTRIBUTIONS

		(B. Subtotal)	
Aga Khan Foundation	25,000	1.1	0.4
Belgium	75,000	3.2	1.1
GTZ-Munshiganj	56,000	2.4	0.8
IDRC - DISC	66,000	2.8	0.9
IDRC - Sanitation Impact	26,000	1.1	0.4
IDRC/UNICEF - Water Sanitation Conference	60,000	2.5	0.8
Kuwait	100,000	4.2	1.4
SAREC - Immunity & Vaccine.	76,000	3.2	1.1
Saudia Arabia	250,000	10.5	3.5
UNDP/WHO - Clinical Research	350,000	14.7	4.9
UNDP/WHO - Regional Training	75,000	3.2	1.1
UNFPA - DSS	426,000	18.0	6.0
UNFPA - MCH	66,000	2.8	0.9
UNICEF - Water & Sanitation	20,000	.8	0.3
USAID - MCH-FP Extension	595,000	25.1	8.4
USAID - Population Council	83,000	3.5	1.2
USAID - Clinical Nutrition	24,000	1.0	0.3
	2,373,000	100.1	33.5
TOTAL	7,082,000		100.0

C. EARMARKED CONTRIBUTIONS

As Percent of the Total 1983 Budget: 33.5 percent

Data Processing Facilities

Until recently data processing was being carried on by using computer facilities at the Bureau of Statistics (Dhaka), Engineering University (Dhaka), Johns Hopkins University (Baltimore), and the Asian Institute of Technology (Bangkok). The Center installed its own computer, an IBM System/34, in mid 1980. Soon after its installation, several scientific projects and administrative and financial management systems of the Center were computerized. By mid-1982 the System/34 has reached almost its saturation point and it has become more difficult to take on any further computer applications. Sophisticated analytical work is being impaired owing to the limitations of the System/34 for analytical computing.

A serious problem of computerization in Bangladesh is the lack of trained personnel. Initially, the position of Computer Manager had to be filled by several acting computer managers who were only partially conversant with computer management in a Third World setting. In 1981 they were replaced by the present Computer Manager, who returned home to Bangladesh after training and working abroad. ICDDR,B has also been fortunate to attract computer science graduates who returned home after their studies. However, their stay was brief due to higher paying jobs in the Middle East. The branch then introduced its own in-house training program and, today, the computer at ICDDR,B is fully run by Bangladesh nationals and is one of the best utilized System/34 installations in the developing countries.

The data processing staff have overcome many of the problems of capacity and personnel training as well as the constraints of the S/34 in terms of computer language and consequent unsuitability of standard statistical packages. During 1982 some 72 million characters were entered for punching, verification and updating, but more hardware will be needed within the near future if ICDDR,B is to remain self-sufficient in data processing.

Organizational Units Within ICDDR,B

The scientific research of ICDDR,B is organized into five areas, each of which is addressed by a working group. In addition, the organizational structure identifies a division with responsibility for training and activities concerned with extending the Center's work to other areas of Bangladesh. The following chapter discusses the achievements and plans of these organizational units in detail. An overview of the purpose and scope of each scientific working group is presented in the paragraphs below.

The Disease Transmission program has three goals: to identify causative agents of diarrhea and to define and identify their cycles of occurrence and

modes of transmission; to delineate how these agents interact with human beings and how they are transmitted in different communities; and to develop effective means to interrupt the spread of causative agents.

The Pathogenesis and Therapy program seeks to understand the causes and mechanisms by which micro-organisms and parasites produce diarrhea, and to develop simple, effective and inexpensive methods for treating and preventing diarrheal diseases. The Pathogenesis and Therapy program is responsible for the Dhaka hospital and out-patient treatment center, where in 1981 it treated 96,586 patients; 66,016 of these were treated as outpatients with oral rehydration solution.

The broad goals of the Host Defense program are to determine how the body defends itself against infecting agents which produce diarrhea and to develop interventions by strengthening these immune mechanisms.

The Nutrition group is working to discover ways to interrupt the diarrhea-malnutrition cycle effectively and appropriately, including the study of nutrient loss during diarrhea, the effect of diarrheal control on nutrition status, traditional feeding practices which may contribute to the cycle, and the nutrititional/disease impact of such interventions as hand pumps and water-sealed latrines. Teknaf field station is under the administrative control of this program.

The Community Services Research program carries out and evaluates interventions and large-scale field studies directed at preventing or treating diarrhea and related health problems in the context of overall community health. This program oversees the Matlab field station and its longitudinal demographic surveillance system. The data system has provided a unique resource for study of the efficacy of maternal-child health and family planning interventions in rural Bangladesh.

The primary objective of ICDDR,B's Training Division is to help Bangladesh and other developing countries to improve the planning and delivery of diarrheal and related health services and to develop their research capacity. Technical and applied training is given for health workers from Bangladesh and other countries in the region, ranging from short formal courses to individually-designed fellowships.

III. THE ACHIEVEMENTS AND PLANS OF ICDDR,B

III. THE ACHIEVEMENT AND PLANS OF ICDDR,B

The AID assessment of ICDDR,B took place at the same time as the Board of Trustees of the Center were undertaking a major program review for their own purposes. In preparing for the Board's review, the staff of ICDDR,B had documented their plans for the future and, during the review process, staff members presented these plans along with summaries of recent achievements. The AID assessment team members were invited to participate in these discussions but did not attend the formal Board meeting which followed. This chapter presents the findings of the AID team and is based on their participation in the Board's review and on discussions with ICDDR,B staff members which took place outside the Center's own review process. It should be pointed out that the minutes of the Board's deliberations are not yet available and, although some decisions of the Board were communicated informally to the AID team, the team's findings do not take into account all aspects of the Board's review and subsequent deliberations.

This chapter is organized into eight sections. These describe the work of each of ICDDR,B's scientific working groups, the division responsible for training and communications and the activities of the Project Development Committee. Within each section the presentation highlights achievements and plans of particular relevance to AID's health sectors priorities. The chapter which follows synthesizes the assessment team's conclusions and recommendations to AID.

Disease Transmission Working Group

The Disease Transmission Working Group has made many important contributions to scientific understanding of diarrheal diseases. Among the most important are those listed below:

1) Identification of the etiology of diarrheal disease in 70-80 percent of the patients treated at Matlab over a two-year period.

2) The demonstration that two agents, enterotoxigenic Escherichia coli and rotavirus, account for approximately two-thirds of the cases of dehydrating diarrhea in infants in Matlab. This finding reinforces the importance of developing vaccines against these agents.

3) A village-based longitudinal study of infants in Matlab which showed that in the first two years of life each Bangladeshi infant suffers an average of seven distinct episodes of diarrhea per year. This finding is similar to those from Guatemala and Gambia.

Enterotoxigenic E. coli were the most frequent pathogens identified in Matlab, accounting for two episodes per child per year. These findings provide guidance as to the magnitude and nature of the diarrheal disease problem.

4) Epidemiologic studies in Matlab which showed that Enterotoxigenic E. coli infections had a striking age-specific incidence with peak infection occurring in the first few years of life and with low incidence rates in older children and adults. These observations lend strong credence to the notion that acquired immunity is responsible for the decreased incidence rate for E. coli diarrhea found in adults.

5) Environmental bacteriologic studies of infant weaning foods showing heavy contamination with coliform bacteria. Levels of contamination are worst in the hot season and increase with hours of storage after preparation of the food. These studies incriminate weaning foods as an important vehicle of transmission of enteric pathogens and thus reinforce the importance of breast-feeding.

6) The demonstration in a longitudinal village-based study that diarrhea due to enterotoxigenic E. coli is significantly correlated with subsequent development of malnutrition. This fact reinforces the need to address the problems of diarrheal diseases and malnutrition in a concerted fashion.

7) Identification of Campylobacter jejuni as a common enteric pathogen in Bangladesh and also recognition of a high rate of asymptomatic infection.

8) Recognition of shigellosis and other dysenteric invasive bacterial enteric infections as significant causes of mortality in areas (Matlab) where deaths from diarrheal dehydration are controlled, thus supporting the desirability of developing a vaccine against Shigella.

9) Demonstration of the efficacy of hand washing as a means of significantly diminishing the transmission of Shigella infections, suggesting that a relatively simple behavior change could have major impact.

10) Identification of the transient appearance of multiple antibiotic resistant V. cholerae in Bangladesh.

11) The first studies in man of the safety, immunogenicity and efficacy of purified cholera B subunit vaccine.

12) Establishment of a model hospital-based diarrheal disease surveillance system which can be used to monitor etiology in relation to patient load and seasonality.

The future plans of the Disease Transmission scientific working group emphasize the following:

- Development of techniques for studies of the invasiveness of Shigella and the pathogenic mechanism of Campylobacter.
- Studies on the epidemiology and transmission of rotavirus infections including identification of serotypes.
- Epidemiological, immunological and bacteriological studies on classical and El Tor biotypes V. cholerae infection.
- Collaborative studies toward development of an oral vaccine against cholera.

The first of these priorities would appear to fall more logically within the parameters of the Pathogenesis working group, reflecting the somewhat confused allocation of investigations among the working groups. However, the development of a method to screen large numbers of strains is certainly an important area of study, allowing comparisons of the relative virulence of Shigella strains and perhaps explaining differences in rates of infection and clinical characteristics.

Rotavirus is the single most important cause of dehydrating diarrhea in children less than two years old in Matlab. Information about the relative importance of the various serotypes of rotavirus is critical for field trials of the new vaccines being developed in several laboratories.

Studies on cholera are also urgent and important, especially since large-scale epidemic due to classical type V. cholerae occurred in Bangladesh during October-December 1982. It is encouraging that this working group includes these studies among their priorities, although the present exceptional circumstances suggest that intensive epidemiological studies of cholera might well be accorded overriding priority. Collaboration with Dr. John Murphy of Harvard on a vaccine against cholera is placed fourth among the Disease Transmission Working Group priorities. While this is valuable, other investigators in the U.S. and the U.K. are undertaking similar work and two groups have vaccine candidate strains.

The lack of an experienced epidemiologist is a serious constraint of ICDDR,B's Disease Transmission Working Group. In particular the statistics

from the Matlab Demographic Surveillance System, which are a unique and valuable data base, could be improved and better used if an epidemiologist were a member of the team.

Pathogenesis and Therapy Working Group

The recent achievements of the Pathogenesis and Therapy Working Group include the discovery that citrate and acetate are effective substitutes for bicarbonate in the ORS formula in order to correct the acidosis with diarrhea. These non-reactive bases considerably improve the shelf life of packaged ORS salts. Recent work with rice powder and labon gur formulations of ORS is demonstrating that such preparations provide an excellent (perhaps even better) oral therapy solution. This work has great potential impact as it suggests that a culturally adapted formulation using ingredients already in village households might be an alternative to pre-packaged ORS.

Work on the pharmacologic reversal of the intestinal secretory processes has been led by studies involving chlorpromazine, which has been tested in clinical cholera at the Center and found to significantly reduce stool volume, intravenous fluid requirements, vomiting and the duration of diarrhea in clinical cholera. However, one side effect is sedation, which may interfere with oral rehydration. Studies of other agents, such as nicotinic acid, indomethacin, salicylates, and chloroquine are currently underway or planned.

Studies of travelers' diarrhea in Dhaka reveal that 25 percent are dysenteric - have blood and mucus in their diarrheal stools - of which 26 percent have Shigella, 18 percent Campylobacter, and 6 percent amebic infections. However, an important finding that 50 percent remain unknown has led to additional interest in exploring invasive diarrheas.

Current activities on pathogenesis and therapy are now being extended in several areas. In investigating the pathogenesis of invasive diarrhea, colonoscopic findings in several patients with shigellosis, amebiasis, and Vibrio parahemolyticus infections have been examined. In acute shigellosis, pathological findings range from 100 percent in the recto-sigmoid area to 13 percent in the ascending proximal colon. Of considerable interest is the description of "aphthous" ulcers in a number of patients with Shigella infections that have extended beyond ten days. Studies of amebiasis shows the smaller, deeper ulcers more confined in the recto-sigmoid area. In contrast, the V. parahemolyticus infections result in no colonic lesions but a terminal ileitis. Other-hospital based studies of severe shigellosis and its complications are currently underway. In another study, the investigators have addressed the kidney lesions in a hemolytic-uremic syndrome that complicates Shigella infections and the work now includes the demonstration of an animal model with which to study this complication.

From a series of autopsy studies, members of the Pathogenesis and Therapy Working Group are describing several newly recognized syndromes for Bangladesh. These include severe Yersinia infections, necrotizing enterocolitis, as well as the pneumonic complications of diarrhea. Some very interesting theories on the possible pathogenesis of rotavirus diarrhea have been developed by an investigator who is finding elevated stool cyclic-AMP concentrations in patients with rotaviral diarrhea. These studies lead to new and important hypotheses that require further study.

These scientific findings are highly relevant contributions to increased knowledge of how diarrheal illnesses occur and have potential application to the development of improved management of these illnesses both in the hospital and in the field. They also identify several areas where further work is needed. Confirmation and extension of such concepts as the rice powder ORS preparations and their field testing in village households has great relevance to improved primary health care for diarrheal diseases and for preventing the severe dehydration which requires hospitalization.

Several new, innovative studies are planned by this working group. Regarding the pathogenesis of invasive diarrheal diseases, studies are already underway of the colonic function of shigellosis. Whole bowel and total colon perfusion studies have been started using the colonoscope to define the site and extent of interference with absorptive function.

Extension of autopsy studies will include electron microscopic studies if new facilities are donated, as hoped in 1983. Further studies of the hemolytic-uremic syndrome following shigellosis are planned, using the experimental rabbit model. Also studies are planned to examine the mechanism of diarrhea seen in the few cases of typhoid fever admitted to the Center's hospital with diarrhea each month.

The roles of new etiologic agents and newly recognized syndromes will be studied with measles diarrhea, with possible synergistic measles virus and other enteric infections. Studies are also planned of Chlamydia and Yersinia as agents of acute diarrhea, as are studies of possible causes and mechanisms of chronic diarrhea.

Metobolic studies to be undertaken include those of the anion gap in cholera, intracellular pH and potassium concentrations in acute cholera, and potential renal effects of prolonged acidosis. Planned studies of the treatment of diarrheal diseases include investigations of rice powder ORS to determine the optimal concentration of rice powder for rehydration and nutritional benefit. Further studies will investigate citrate salt substitutes for bicarbonate and newer antibiotics, as well as single dose sulfa-trimethoprim, in the antibotic of management of shigellosis. Other issues to be studies include antisecretory drug treatment including nicotinic acid, new calcium blockers, and loperamide.

As discussed under the Disease Transmission Working Group, there are some overlaps and inconsistencies in the allocation of research protocols among the ICDDR,B scientific departments. Better communication among scientists and stronger scientific leadership would encourage closer coordination and foster synergy. The Center hopes to recruit a senior immunologist and it can be hoped that this person will assist in resolving these problems, as well as contributing to the scientific work.

Host Defense Working Group

Work on host defenses has been somewhat limited by the need for a permanent program head. However, new scientific findings in this area have included the demonstration of a slight effect of a ganglioside-charcoal preparation on diminishing the volume of diarrhea if given early in the course of clinical cholera. Other work has involved the study of a major outer membrane protein that is common in both El Tor and classical biotypes of Vibrio cholerae; this protein has potential significant implications for vaccine development.

Considerable work with the cholera toxin B subunit has been done with Swedish collaborators. This includes the demonstration of both secretory and serum antibody responses to oral B subunit administration. In family studies in which B subunit was given to contacts of documented cholera cases, a slight decrease in attack rates among contacts appeared to be present, but no change in the severity of clinical cholera was noted. Measurement of local antibody responses in breast milk, saliva, and intestinal secretions has been done, and a correlation has been found between intestinal secretory antibody and salivary antibody responses to the B subunit.

Studies of Giardia lamblia infections have been initiated. To date, findings suggest that breast milk is protective against symptomatic Giardia infections and that mothers of young infants excrete Giardia cysts in over 50 percent of instances.

The future plans of the Host Defense Working Group include studies of specific antibodies that are responsible for the natural termination of cholera diarrhea and infection. The specificities of these antibodies have important implications for effective vaccine development.

Similar studies of local, intestinal immunity in acute shigellosis are planned. The site of Shigella antibody protection will also be studied. Regarding vaccine development, atoxigenic transductants of V. cholerae and other potential vaccine strains will be studied in animal models, volunteers, and it is hoped in patients.

A newly developed magnesium-breath hydrogen test for gastric acidity is expected to facilitate possible field studies of achlorhydria as a predisposing factor to sporadic cholera and other enteric infections. Studies of passively given antitoxic antibodies in bovine colostrum will also be conducted by giving this material to cholera patients in an attempt to inactivate the toxin. The success of this work will determine its relevance to future developments for treatment and prevention of infectious diarrhea. Because of the known effect of endotoxin to stimulate leukocyte mediators of inflammation, the Host Defense Working Group will examine the endotoxin of Shigella with human leukocytes for the production of possible mediators of diarrhea or fever in experimental animals.

Nutrition Working Group

The objectives and research priorities of the Nutrition Working Group have focused on three major questions:

- How does diarrhea lead to malnutrition?
- How does undernutrition influence the course, severity, and outcome of diarrhea?
- How can the diarrhea - undernutrition cycle be interrupted?

The significant investigations of this group include the following - studies dealing with the complex interaction of diarrhea, undernutrition, Vitamin A deficiency and eye lesions (xerophthalmia, keratomalacia, night blindness, etc.); investigations of serum and liver Vitamin A levels following oral application of retinol in children with acute diarrhea; protein losses in measles diarrhea, shigellosis, ETEC,; and a longitudinal study of the growth and weight of children between birth to age 10 in relation to common childhood diseases, diarrheal episodes, seasonal undernutrition, breast-feeding, teething and intercurrent diseases. A significant, on-going study has examined the intake and utilization of calories from rice starch electrolyte therapy in acute diarrhea due to cholera, ETEC, Rotavirus and Shigella. The Nutrition Working Group is also concerned with studies of culturally-rooted behavioral aspects of child nutrition, disease concepts, sanitation and health education.

The Nutrition Working Group differs from the three working groups discussed previously in that about one-half of its operating research budget comes from contributions which are restricted for certain investigations only. The largest of the bi-lateral projects with restricted funds is a new study on the impact of safe water and sanitation in the Teknaf field station. This important investigation is being carried out jointly with the Community

Services Research Working Group and is discussed further in the following section.

Anemia of undetermined etiology is one of the most frequently made diagnoses in the primary health care services of Bangladesh. Little is known as yet about its prevalence, distribution, severity and causes. It is assumed that iron deficiency and undernutrition (folic acid) are the major determinants in a complex picture. The Nutrition Working Group in cooperation with the Institute of Public Health and Nutrition and assisted by Dr. Paul Goff, a hematologist of the U.S. Embassy, has written two research protocols for epidemiologic investigations of anemia and its causes in Bangladesh. These studies will use on-going demographic population studies in Matlab, Teknaf, peri-urban Dhaka, and in the new extension areas to obtain results from ecologically different parts of Bangladesh.

Almost all of the ongoing and new studies being undertaken by the Nutrition Working Group are concerned with MCH and especially with child nutrition and health at the primary health care level. The relationships among health education, water and sanitation, and nutrition are given emphasis in the approach of ICDDR,B's Nutrition Working Group in order to fill gaps in knowledge and to develop new methods for improved diarrheal disease control and prevention at the community level through focused research.

Community Services Research Working Group (CSRWG)

The CSRWG is the largest of the five research programs of the ICDDR,B, its budget representing 34.3 percent of the Center's total research budget ($769,000 in 1982 and a projected budget of $913,000 in 1983).

CSRWG undertakes two major types of studies:

1) Population based investigations of behavioral and environmental aspects of diarrhea, including demographic and social determinants of morbidity, mortality and fertility; and

2) field trials of new methods for diseases control and prevention in rural communities.

The important scientific contributions of the CSRWG include the following: Evaluation of ORS packages prepared from locally available, cheap ingredients against the WHO standard; evaluation of the impact of tetanus immunization of pregnant women on the incidence of tetanus neonatorum; studies of the effects of systematic, service-intensive family planning on fertility and infant mortality; and measurements of time trends of morbidity and mortality in longitunidal observations.

In addition to the research into diarrheal diseases, the working group has been responsible for the establishment and maintenance of a demographic surveillance system (DSS) in the river delta area of Matlab. This system was begun in 1963 when it included about 280,000 rural people. In 1978, after refinement of the procedures and methods needed for longitudinal follow-up of a large population using multiple parameters, the number under surveillance was reduced to 160,000.

The DSS is the largest component of the CSRWG. Over the years, it has become a major source of demographic information and research and is probably the largest continuous system of accurate vital registration for any sizeable population in a developing country. Vital records are now updated routinely by regular household visits and all of the information is computerized. The system permits the creation of printouts for different types of sample populations, such as field trials, epidemiologic inquiries and health service research.

The DSS has been used in family planning and health intervention experiments which investigate relationships between mortality, primary health care and family planning acceptance. It has also been used to evaluate tetanus immunization of pregnant mothers as a means of reducing neonatal tetanus. Further a major field trial has been carried out with locally prepared ORS as compared with ORS packages supplied by WHO, which noted that there was no difference between the two treatment groups. Updating of this large demographic surveillance system has continued and offers unique opportunities for conducting scientifically sound field trials of new vaccines, treatment schedules and of alternative methods of diarrheal disease control and other major public health problems.

A second major area for population studies was initiated in 1974 in the Teknaf area after a serious outbreak of dysentery. Because of the close association between diarrheal disease and nutrition in children, the Teknaf project has been carried out jointly with the Nutrition Working Group. The Teknaf area is also the site for a major investigation of the impact of water and sanitation on the incidence of diarrhea and on morbidity in general. This bilateral project between the People's Republic of Bangladesh and Canada is funded by IDRC. The study was started in July 1980 and has involved the installation of hand pumps (tubewells), water-sealed latrines for each family in the sample, combined with systematic health education. The population selected for this type of intervention is approximatley 2,000 comprising 300 families. This population sample has been compared for nutritional parameters and diarrhea frequency with ten control villages in which no intervention projects have been carried out.

After a review of the Matlab project in 1981, the UNFPA requested ICDDR,B to extend Matlab-like services to three other areas of Bangladesh. In response, plans were made to conduct MCH-FP extension projects in Sirajgang,

Noapara, and Teknaf. These studies have started or are in the implementation stage but so far, no results have become available. The new extension projects will study the tranferability of the experiences in Matlab to the health services provided by the Ministry of Health and Population Control (MOHPC). Technical components to be studied will include oral rehydration therapy, tetanus immunization and comprehensive family planning. For evaluation and training, three research teams were created, one for a sample registration system of vital event assessment, another survey team for special studies of simple population sampling methods, and functional analysis team for operational research of health services.

The CSRWG suffers from two major problems. Data collected through the DSS and from other survey populations are not processed and analyzed in a timely fashion, leading to long delays in generating the results which are needed in Bangladesh and elsewhere. This problem stems from limitations of ICDDR,B's computer facilities which, although efficiently run and operating on a 24-hour schedule, are not able to keep up with the various demands. The second problem centers around the lack of epidemiological and clinical expertise in the planning, execution, analysis and evaluation of the population data. The addition of one or more epidemiologists would bring focus to the currently fragmented and somewhat duplicative CSRWG program and would also identify further ways in which the existing data collection system could contribute to scientific knowledge.

Training

Under Title 5(1)(b) of the ICDDR,B ordinance, the Center is required to: "Provide facilities for the training of Bangladeshi and other nationals in areas of the Center's competence in collaboration with national and international institutions, but not to include the conferring of academic degrees." In responding to this requirement, the Center has developed a training program staffed by an Associate Director and a technical staff of three.

The training program undertakes a variety of formal and informal training activities. For Bangladeshi scientists and students, ICDDR,B provides an exceptional opportunity to learn scientific and medical techniques through observation and individual instruction on an unstructured basis. In a more structured way, ICDDR,B assists in the development of Bangladesh's scientists by offering six research fellowships each year and by organizing a three-week course in research methodology.

Bangladeshi health care workers of all kinds participate in orientation tours and brief courses describing diarrheal diseases management, and several hundred health care workers and medical students visit ICDDR,B each year for

this purpose. To assist in the national oral rehydration therapy effort, ICDDR,B, has developed a manual on the treatment and prevention of diarrheal diseases and complementary flip-chart and trainer's guide. These draft materials have been used to train trainers and are now undergoing evaluation. ICDDR,B is also taking a leading role in the development of course materials on diarrheal diseases management to be used in Bangladesh's medical colleges. This activity follows coordinating workshops with broad participation, and a further workshop will be held next year to introduce the materials to medical college teachers in Bangladesh.

The ICDDR,B training program also includes an international component. Fellowships, usually sponsored by other organizations, provide the opportunity for pre- and post-doctoral students from other countries to learn from ICDDR,B scientists for periods ranging from a few days to several months. The Center has also served as the site for several international workshops and conferences concerned with topics relevant to the work of ICDDR,B.

During the past two years, ICDDR,B has become increasingly involved in offering inter-regional training courses in collaboration with WHO. Three two-week courses - one each on laboratory, clinical and epidemiological aspects of diarrheal diseases - are now developed. Participants have come mainly from developing countries in Asia and the Middle East and faculty have been recruited from among the Center's staff and from outside consultants.

Continuing education for the Center's own staff also falls within the scope of the training division and ICDDR,B encourages staff members to take advantage of training opportunities, both within Bangladesh and overseas. While most long-term international training is sponsored by external funds, the Center does have some fellowships available for this purpose.

The facilities for training at ICDDR,B are somewhat limited. One room is designated the lecture room, but it is also needed for other purposes. Similarly, one laboratory with limited bench space can be used for training but must also serve other needs. Audio-visual equipment includes a slide projector and an overhead projector. Further space for training may become available shortly as a result of reorganization.

The staff of the training program consist of four professionals, none of whom has had any formal training in training methodologies or techniques. The Associate Director in charge of training has a number of other major responsibilities within the Center. The Training Coordinator was a senior official in the Ministry of Health but is new to the field of training. The Training Physician conducts most of the routine training with little back up or assistance, while the Senior Research Officer coordinates the practical experience in the laboratory. Other staff members at ICDDR,B, as well as other resource persons in Bangladesh and abroad, participate in the training activities on an as-needed basis.

The shortage of staff time and experience has limited ICDDR,B's ability to develop training materials. Assistance from outside consultants has been needed to develop the Trainer's Guide, and will be needed in developing the teaching materials for the medical schools as well as any other lengthy materials. The Center does, however, have an excellent graphics department that could probably support such activities if given sufficient guidance.

Issues of concern to AID include the actual and potential role of ICDDR,B in the transfer of knowledge through training at the Center and through the development of training materials which could be used elsewhere. This concern stems from a recognition of the urgent need to diffuse information about the recent innovations in diarrheal disease control to as broad an audience as possible, and particularly to decision-makers, administrators and health workers in the developing countries.

A wide range of training activities are taking place at the Center and it is important to recognize that ICDDR,B must provide training to Bangladeshis as part of its overall commitment to the Government and its people. While this aspect of the training program may at times be burdensome and distracting to the research responsibilities of the Center, every attempt is made to keep this to a minimum. The present staff of the training program are adequate to provide this service, especially since, over time, more and more Bangladeshi trainers will be trained in diarrheal diseases management.

The ICDDR,B is a unique site for training in certain aspects of diarrheal diseases and provides a valuable opportunity for exposure to realities in the hospital and the field. The inter-regional courses in collaboration with WHO are a reflection of this opportunity. However, this kind of training challenges the capacity of the Center's facilities and any increase in the number or scope of these courses is probably unwise without a significant expansion of the training program. Adding staff or facilities in training to respond to what may well be a short-term demand for international training is a lower priority than meeting the needs of ICDDR,B in other areas. Similarly, the Center can serve as a site for international conferences and workshops but these kinds of activities could consume a considerable amount of staff time and energy and should be kept to a minimum.

The one area where training activities could usefully be increased is at the field stations. The work underway at Matlab and the other newer stations is directly relevant to the design and implementation of surveillance systems in other developing countries, as well as to many aspects of the health services research which is so urgently needed. The opportunity to spend time learning about the methodologies and techniques being used at these field stations would be very useful to technicians charged with such responsibilities in other developing countries. To facilitate coordination between the central training program and those responsible for the work in the field, consideration might be given to designating an existing field-based

staff member as the person responsible for this kind of training and assigning this person to the training program.

As experience is gained in training of various kinds, ICDDR,B could develop training materials for use in other places. To date, Bangladeshi materials for primary health care workers have been developed and medical college modules are underway. However, these materials are less than useful in other settings without adaptation. Given the limited expertise and resources at the Center it seems inappropriate for ICDDR,B to become actively involved in developing materials other than those it needs for its own purposes. Rather, the ICDDR,B materials should be widely available to others and, along with other efforts, can form the basis of materials developed for a specific purpose by country-specific or international organizations.

Publications

ICDDR,B publishes Annual Reports, Working Papers, Scientific Reports, Monographs, and occasionally, conference reports and books. The Center also publishes the newsletter Glimpse which is now bi-monthly. Up to now these publications have been available without charge and they are distributed to a mailing list, visitors to ICDDR,B and upon written request. In the future, it is planned that charges will be made for the publications other than the newsletter.

During 1981, 32 new publications became available and a total of 11,766 ICDDR,B publications were mailed out and a further 2,222 were distributed by hand. A total of 43,521 copies of the newsletter were either mailed or distributed in 1981. Between January and October 1982 ten papers were added to the list of publications. Altogether 4,102 copies of ICDDR,B's publications were distributed by mail, and a further 7,136 by hand. A total of 38,454 copies of the newsletter were also distributed during this period.

A list of ICDDR,B publications to date and a copy of the newsletter, Glimpse, may be found in Appendix A.

Project Development Committee Activities

In April 1982, ICDDR,B established a Project Development Committee (PDC) to coordinate the development of proposals and the early stages of projects, especially those which do not clearly fall within the areas of responsibility of an existing working group. The Director of ICDDR,B was given full executive authority over PDC projects and the Center's Management Committee was to be kept informed and given the opportunity to comment on PDC's

recommendations. The PDC was established as a result of the need to proceed quickly and efficiently once a project suitable for external funding had been identified and approved.

As of December 1982, PDC is responsible for 11 projects within Bangladesh. Seven of these projects are funded by donors, one by ICDDR,B and three are not yet funded. The projects with funds include the major research activities in MCH-FP at Sirajgang, Noapara, Matlab and Teknaf, the diarrheal diseases interventions at Chandpur and other urban and rural treatment centers, assistance to the BRAC oral rehydration therapy program, an investigation into cereal-based oral rehydration solution, a monograph on growth in relation to diarrhea, and an evaluation of ICDDR,B's training in diarrheal diseases treatment and prevention. The PDC projects in Bangladesh for which funds are being sought are concerned with the embankment at Matlab, the uses of duckweed and collaboration with the Medical Research Council.

The responsibilities of PDC include the development of relationships with other countries interested in collaboration. To this end exploratory discussions have been held with Saudi Arabia, Kuwait, N. Yemen, Egypt and China. These discussions have been concerned with training and technical consultation in diarrheal diseases research and training. No commitments have been made as of November 1982.

IV. CONCLUSIONS AND RECOMMENDATIONS

IV. CONCLUSIONS AND RECOMMENDATIONS

In assessing ICDDR,B in relation to AID's health sector priorities, it was concluded that the Center undertakes excellent scientific investigations which provide new and important knowledge. This knowledge has revolutionized the understanding of diarrheal diseases and led to much improved techniques to prevent, control and manage these diseases. There is every reason to believe that the future work of ICDDR,B will be of equal or even greater importance to the fight against this enormous public health problem. It is recommended, therefore, that AID continue to provide generous core support to ICDDR,B.

It must be recognized that ICDDR,B cannot address all the issues of diarrheal diseases in each country where the problems exist. The Center can, and should, continue to serve as a global focal point but some needed scientific research can be better done elsewhere, and problems of national program implementation should be tackled in the geographic regions where they occur. Training, also, is often more effective if conducted on a regional or country-specific basis. Therefore, AID should <u>also</u> support other organizations which are engaged in activities relevant to diarrheal diseases.

The scope of work for the assessment included six specific questions which were to be answered. These questions and the team's responses are presented below. Following this, some recommendations are made about ways in which the ICDDR,B might be improved.

How successful has ICDDR,B been in rapidly and effectively disseminating the research findings through scientific publications, scientific meetings, the mass media and training courses?

1) Scientists at ICDDR,B place very high value on scientific publications, and the list of publications in Appendix A attests to their productivity. However, the increasing proportion of scientists whose native language is not English has led to some problems in generating well-written, scientifically sound articles which pass the scrutiny of peer review and appear in high quality international journals. These problems could be redressed through improved scientific and editorial review within the Center. The alternative approach of dissemination through publications produced by ICDDR,B might be reviewed in light of their cost and limited usefulness as reference materials.

2) Dissemination through scientific meetings has been successful, on the whole, but could be improved if more travel funding were available. The Center has also served as host to several important scientific meetings.

3) Mass media could be better and more carefully used to promote the Center and to disseminate research findings which have important implications for all developing countries.

4) Training courses at ICDDR,B are a useful and well-run means of disseminating research findings but training resources are limited and any expansion of the program would be difficult.

Utilizing their research findings, to what extent has ICDDR,B been able to develop new, simple and economic tools for routine-use at peripheral hospitals and health centers? Are there shelf items from which new tools for disease control could be developed through extended field research?

1) The safe and effective use of household items to make oral rehydration solution has been an outstanding contribution of ICDDR,B.

2) Findings about the proven importance of handwashing in relation to transmission of shigella in a rural, endemic area have shown that this simple intervention is valuable in reducing disease.

3) The development of diagnostic tools for diarrheal diseases for use at the periphery has been largely unproductive so far and therefore should be a priority for future research.

4) Shelf items include the use of ORS packages, soap, Vitamin A additives and appropriate tubewell maintenance systems.

How successfully has the Center "exported" its research findings to other LDCs? How could the methods developed in Bangladesh be adapted to meet the conditions in different ecological settings?

1) ICDDR,B's role is to undertake research and to publish high quality research findings and scientific information. The application of these findings and their dissemination to others is the responsibility of other, more appropriate, organizations. Close collaboration exists between ICDDR,B and WHO, as well as with other organizations, and such organizations are better suited than the Center to "export" findings.

2) ICDDR,B is a valuable resource for other countries and the Center's senior staff have a potential role to play as consultants to governments wanting to establish diarrheal disease research centers.

3) However, the adaptation of methods developed at ICDDR,B must be done within the context of the different cultural, ecological and physiological environments around the world. The magnitude of the diarrheal diseases problem and the extent of diversity are beyond the scope of ICDDR,B and require investigations in other regions. Other Centers are needed and existing institutes should be funded to strengthen their work in diarrheal diseases. In addition, protocols to compare findings from the different regions should be developed and supported. ICDDR,B is an appropriate institution to serve Asia and to play an important role in the guiding and coordinating of such efforts.

To what extent has the Center's training programs, training facilities, audio visual aids, research protocols and demographic surveillance systems been used for: the development of training courses in primary health care; the development of training manuals aimed at different levels of health workers; inclusion in the curricula of medical and nursing schools; the continuing education of AID's own staff?

1) The training program at ICDDR,B meets many needs in Bangladesh and internationally, both in training of trainers and in training scientists. The unique opportunity to learn from seeing and doing at the various Center facilities is of great value, but any major increase in more structured training activities is beyond the existing resources.

2) Training materials developed at ICDDR,B require adaptation if they are to be used outside Bangladesh. This work is better done by the country wishing to develop materials or by another international organization.

3) ICDDR,B is currently developing teaching modules on diarrheal diseases for use in medical colleges in Bangladesh. These are likely to be adaptable to other country situations.

4) The Center provides the opportunity for AID's staff to observe the work of the Center and to read about it in the newsletter, Glimpse. Apart from this, no special attempts have been made to meet the continuing education needs of AID.

Many research projects in Bangladesh have included the rendering of medical services to patients and to the general population. Are there service activities that should become part of the general health service of Bangladesh? Could these services be better supported under a bilateral agreement between the U.S. and the Bangladesh government?

1) The provision of medical services is a necessary and integral part of

ICDDR,B's work and the Center has to meet the demands for service which result from the needs of Bangladeshis.

2) The volume of medical services provided exceeds that needed for research alone. It would benefit the research program if separate provision could be made for the capital and recurrent costs of this service delivery component over and above those directly related to research.

How effectively have new scientific findings in the different areas of diarrheal disease, nutrition and fertility and family planning been applied to a comprehensive analysis of all available data to identify major determinants of health and disease in the community?

1) Better coordination among scientists at ICDDR,B and closer cooperation with other research institutions in Bangladesh would go far towards answering important questions about aspects of community health.

2) The addition to the staff of a senior epidemiologist would greatly strengthen this area of applied research.

3) The Center should be cautious about diverting too many resources into such investigations without support for this kind of activity. However, relevant data have been collected by ICDDR,B in different parts of Bangladesh and a critical analysis of these data under the direction of an epidemiologist might yield useful conclusions without incurring the costs of additional surveys.

Recommendations

The following recommendations result from the assessment of ICDDR,B made by the team and are included here as guidance to ICDDR,B and to AID. It should be stated again here that the assessment team was very much impressed by the work being done at ICDDR,B and by the dedication of its staff. The recommendations for change should be considered in this context.

A. Staffing

1) The ICDDR,B would benefit greatly from the rapid recruitment of the following staff members:

One senior and one or two more junior epidemiologists

- One senior immunologist to head the Host Defenses Working Group

- One microbiologist trained in the most modern techniques.

The suggestions of adding a health economist and a training specialist are seen as lower priorities.

2) In addition to permanent staff members, the Center should have funding to support senior scientists in related fields who could visit Bangladesh for periods of a few weeks to several months. This would not only provide special technical expertise when needed, but would also increase the potential for collaboration with other research institutions.

B. Organization

1) The Director of ICDDR,B should be relieved of many of the administrative tasks that might better be performed by a trained administrator. The present Director is particularly suitable to provide the scientific leadership and direction of ICDDR,B and to inspire the highest standards in research and he should be encouraged to make this his primary activity.

2) Consideration should be given to reorganizing the scientific staff in order to avoid the overlaps and gaps which now occur, and to foster closer coordination and collaboration.

3) The exchange of ideas among ICDDR,B's scientists is inadequate. Open discussions should take place on a regular, structured basis.

4) The Director and senior staff of ICDDR,B should develop a long-term overall strategy for scientific investigation which relates their present and future work to the efforts of other scientists at the Center and to clearly stated goals and areas of concern. This should be submitted for approval by the Board and should become an important criterion against which funding decisions are made about proposed protocols.

C. Program Priorities

1) ICDDR,B should give priority to epidemiological studies supported by, and in conjunction with, research in the laboratory. Of particular importance are longitudinal studies of the etiology and transmission of diarrheal diseases, the relationships between diarrheal diseases and nutrition, investigation into the most fruitful points of intervention, and intervention trials.

2) Emphasis should be placed on research into diarrheal diseases which are major problems in Bangladesh (cholera) and those which do occur in Bangladesh and are also of great importance to other developing countries (Enterotoxigenic E. coli, rotavirus and Shigella).

3) Epidemiological and etiological studies of diarrheal disease and their control should be encouraged as a research emphasis of the Center.

4) Because of limited funds, studies of viral diarrheal disease should at present be limited to epidemiology and control, rather than basic studies of virology for which additional facilities and scientists would be needed. Rather, the present close collaboration with international institutes specializing in basic research of rotavirus and other enteric viral pathogens should be encouraged.

5) Health services research should not be emphasized at ICDDR,B, but rather the Center should encourage donors wishing to support such research to collaborate with other organizations in Bangladesh. ICDDR,B should assist in the conduct of health services research by other organizations by providing limited guidance when requested and by making data available, but this should not be to the detriment of other Center activities.

6) Better use should be made of the field and animal facilities at ICDDR,B so that they may more fully support the Center's research priorities, expecially in studies in pathogenesis and pathology.

7) The emphasis of the training program should be on participation in the various specific on-going laboratory and field activities of ICDDR,B. Training activities should not distract from research activities and therefore probably should not be expanded beyond their present level.

APPENDIX A

LIST OF PERSONS CONTACTED

APPENDIX A

LIST OF PERSONS CONTACTED

ICDDR,B Staff Members

Dr. W. B. Greenough III. Director
Ms. R. L. Akbar
Dr. K. M. S. Aziz
Mr. M. R. Bashir
Dr. T. Butler
Mr. Chakraborty
Ms. M. K. Chowdhury
Dr. S. D'Souza
Dr. R. Glass
Mr. M. Goon
Dr. M. I. Huq
Dr. A. Molla
Dr. A. M. Molla
Dr. J. Phillips
Dr. M. M. Rahaman
Dr. A. R. Samadi
Dr. S. Sanjal
Ms. S. Smith
Dr. P. Speelman
Dr. B. Stoll
Ms. S. Zimick

ICDDR,B Board of Trustees

Dr. D. J. Bradley, Chairman
Dr. H. S. Al-Dabbagh
Mr. M. K. Anwar
Dr. A. Q. M. Chowdhury
Dr. J. Holmgren
Dr. G. W. Jones
Prof. J. Kostrzewski
Dr. L. Nata
Prof. M. A. Matin
Dr. J. S. Saroso
Dr. M. K. Were

USAID, Bangladesh

Ms. C. Carpenter
Mr. C. Guerney
Ms. S. Olds

6/BT/DEC.83

PROGRAMME COORDINATION COMMITTEE

DRAFT PROPOSAL ON OPERATIONAL GUIDELINES FOR
PROGRAMME COORDINATION COMMITTEE(PCC) OF ICDDR,B(THE CENTRE).

In accordance with the decision of the Board of Trustees of ICDDR,B vide its resolution No.12 of December 1982, constituted a Committee, named Programme Coordination Committee(PCC) of ICDDR,B. The Programme Coordination Committee(PCC) shall act as per the guidelines laid down below:-

2: OBJECTIVES OF PROGRAMME COORDINATION COMMITTEE:

The Programme Coordination Committee(PCC) shall act as an advisory committee to the management of the Centre and its Board of Trustees with regard to research on diarrhoeal diseases and the related subjects of nutrition and fertility and ensure the following:-

(a) To establish a linkage between international efforts and national efforts.

(b) To recommend measures for and assist in building up national research capacities.

(c) To make constant endeavour to strengthen and coordinate research in these fields, in Bangladesh.

(d) To identify any undesirrable overlaps between the work of the Centre and other organizations involved in research in the aforesaid fields.

(e) To mediate any inter-institutional controversies regarding undesirable overlaps and competition in diarrhoeal diseases research and directly related subjects.

(f) To maintain a running inventory of the work done in the field of diarrhoeal diseases and related subjects, both by ICDDR,B and other institutions in Bangladesh. Similarly, inventory of the relevant scientific personnel working in Bangladesh, should also be maintained.

(g) To train qualified staff of the national institutions in preparing research protocols and, where appropriate, assist them in obtaining funds for the approved research protocols for collaborative projects. Provide the Centre's facilities, where appropriate, for carrying out such research works.

(h) To consider - any other related subjects/responsibilities assigned by the Board of Trustees of ICDDR,B.

3. COMPOSITION OF THE COMMITTEE:

Membership of the Committee shall consist of:-

(a) Ex-officio members from different research institutions as listed by the Board of Trustees;

(b) All Standing Committee(SC) members;

(c) ICDDR,B internal members:

(i) 3 representatives from the Board of Trustees, representing Bangladesh;

(ii) Director (Ex-officio)

(iii) Associate Director, Training,Extension & Communication(Ex-officio)

(iv) All Associate Directors in charge of the Programmes(Ex-officio).

(d) Further individuals may be co-opted at the discretion of the Programme Coordination Committee(PCC), subject to the condition that the non-ICDDR,B members should not normally exceed 35(thirtyfive).

(e) The membership of this Committee may be on individual basis or by designation, as indicated.

4. DURATION OF MEMBERSHIP:

(a) Ex-officio members will remain so long as the institution is represented in the Programme Coordination Committee(PCC). A head of an organization can nominate a suitable senior person from his institution to act as a member of the PCC, in case of his inability to act as member of the PCC. Such membership shall remain valid so long the nominated person remain with that institution. However, the Head of the Organization reserves the right to revoke his nomination at any time and make fresh nomination. In case, a head of the organization cannot attend a particular meeting of the PCC due to official preoccupation, he may nominate a senior person of his institution for that particular meeting. For this purpose prior official intimation will be required.

(b) Individual members shall be appointed for a period of 3(three) years by the Board of Trustees of ICDDR,B and they shall hold office from January following the decision by the Board meeting in June, when the Board reconstitutes the PCC.

(c) ICDDR,B internal members shall be by designation.

(d) Membership of organizations shall be decided by the Board of Trustees of ICDDR,B as required.

4. MEETINGS OF THE COMMITTEE:

(a) The Programme Coordination Committee(PCC) shall meet at least twice in a year. The meetings will be convened by the Member-Secretary of the Committee in consultation with the President of the Committee, with at least 15(fifteen) days notice.

(b) The notice for the meeting should indicate the items of agenda, time, date and venue of the meeting and sent to the members through Peon Book or by registered post to the last known address of the members.

(c) The Member-Secretary shall invite items of agenda from the members of the Committee at least 4(four) weeks prior to the scheduled date of meeting.

(d) The quoram of the meeting shall require presence of 1/3rd members of the Committee.

5. OFFICIALS OF THE COMMITTEE:

The President, Vice President and Member-Secretary of the Committee shall be nominated by the Board of Trustees of ICDDR,B from time to time.

DRAFT PROPOSAL ON OPERATIONAL GUIDELINES FOR STANDING COMMITTEE(SC) OF PROGRAMME COORDINATION COMMITTEE(PCC) OF ICDDR,B(THE CENTRE).

In accordance with the decision of the Board of Trustees of ICDDR,B vide its resolution No.12 of December 1982, as reproduced below:-

"RESOLUTION 12/DEC. 82

RESOLVED: The Programme Coordination Committee of the following composition be established:

Ex-officio members-

1. Vice Chancellor, Bangladesh Agricultural University
2. President, BIRDEM
3. Director, Institute of Nutrition and Food Science
4. Chairman, BARC
5. Director, NIPSOM
6. Director, BFRP
7. Executive Director, Bangladesh Rural Advancement Committee
8. Chairman, BCSIR
9. Director, Institute of Public Health
10. Vice Chancellor, Dhaka University
11. Director, NIPORT
12. Director, MIS
13. Director, IPGM&R
14. Director, Shishu Hospital
15. Director, Children's Nutrition Unit (Save the Children Fund)
16. Director, IPHN
17. Principal, Paramedical Institute
18. Chairman, BIDS
19. Project Director, National Oral Rehydration Project
20. Director, IBS, Rajshahi
21. Director, BMRC
22. Representatives from the Board of Trustees and Director, Program Heads, including Associate Director, Training and Extension of ICDDR,B.

Individual Members-

1. Dr. (Brig) M. R. Chowdhury
2. Dr. Hajera Mahtab, BIRDEM

3. Dr. Radida Huq, IPH
4. Dr. Ghyasuddin Ahmed, NIPSOM
5. Dr. Anwarul Azim Chowdhury, Microbiology Dept., Dhaka Universit

Further individuals may be co-opted at the discretion of the Programm Coordination Committee.

All 11-member Standing Committee is recommended as follows:-

1. Dr. Kamaluddin Ahmed, INFS
2. Mrs. Gole Afroz Mahbub, MIS
3. Dr. A. K. Khan, BMRC
4. Director, NORP
5. Dr. A.K.M. Aminul Haque, BAU, Mymensingh
6. Dr. (Brig) M. R. Chowdhury, AFIP&T
7. Director, ICDDR,B
8. Dr. M. A. Matin (Trustee member)
9. Dr. K.M.S. Aziz, ICDDR,B (Chairman, RRC)

10&11 Government Nominations

RESOLUTION 13/DEC. 82

RESOLVED: The Board approves the following By-laws of the Programme Coordination Committee (PCC):

(1) There would be a bigger body to be named as a PCC to meet at least twice a year and a smaller body, a Standing Committee which shall meet at least once a quarter of the year.

(2) The heads of organizations engaged in research in the relevant fields would be members of the PCC. Membership of the Committee may be in the individual capacity or ex-officio. A head of an organization can permanently nominate a suitable senior person from that institution to become a memebr of PCC. Individual members shall be appointed for three years.

(3) The Standing Committee with representatives of Government would be formed by the Board of

Trustees on recommendation of the PCC. There would be 11 members in the Standing Committee inclusive of 2 representative of the Government.

(4) A running inventory of the work done in this field (diarrhoeal diseases and related subjects) and of workers in Bangladesh would be prepared by the Standing Committee and presented to the PCC.

(5) The PCC shall identify overlaps between the work of the Centre and other organizations in the field of diarrhoeal diseases and related subjects.

(6) The PCC shall discuss and offer to mediate any inter-institutional controversy regarding undesirable overlaps and competition in diarrhoeal diseases and related subjects.

(7) The PCC shall be supportive on request of national institutions in preparation of research protocols, training and in securing funds for approved research protocols, in addition to providing Centre's facilities for carrying out research as feasible. (Protocols approved by PCC or its Standing Committee.) The Standing Committee will be responsible for scrutinizing such protocols either by itself or by any other suitable committee(s).

(8) The Research Review Committee of ICDDR,B on approval of ICDDR,B protocols shall forward the approved protocol to PCC, so that the Committee can identify and report to the Board actions prejudicial to the interest of research in similar fields carried out by other organizations in Bangladesh.

(9) The nominated members from the Government to the Standing Committee will also be members of the PCC.

(10) At least 1/3 members of the Committee(Standing and PCC) will form a quorum for the meeting. There would be 15

days notice for PCC and 7 days notice for Standing Committee.

(11) The Standing Committee will nominate one of its members to ICDDR,B , namely Research Review Committee and Ethical Review Committee, for better coordination between these 3 Committees."

and further resolution of the Board of Trustees in its June 1983 meeting as reproduced below :-

"Programme Coordination Committee

Dr. Matin reported on this Committee. It was noted that the Standing Committee(SC) was part of the Programme Coordination Committee(PCC). The Committee can play a key role in linking an outstanding international effort to national efforts. The objectives of the Committee should be to build national research capacities by example and supportive actions. The Centre should be a pioneer in this effort. It should be a vehicle for strengthening and coordinating research in Bangladesh. This may provide a useful model for other developing countries. The operating guidelines of the PCC were reviewed. It was noted that the costs of the running inventory of research in diarrhoeal and related subjects will be borne by the Centre through the DISC project. Representation of the Centre on the Standing Committee is essential but was not made explicit in the guidelines. It was suggested that an improved draft of these guidelines should be presented to the Board at their next meeting in November 1983.

The following resolution was passed:

RESOLUTION 1/JUNE 83 On the basis of the recommendation of the Programme Coordination Committee(PCC) during its meeting of 15 May, 1983, the Standing Committee(SC) of PCC consists of 14 members, as follows:

(a) (i) 7 members to be recommended by the PCC;

(ii) 1 member to be nominated by the BMRC;

(iii) 3 members to be nominated by designation by the Government of Bangladesh;

(iv) 3 members to be nominated by the Board of Trustees of ICDDR,B;

(b) That other members of the SC may either be by name or designation as in case of PCC."

and constituted a Committee, named Standing Committee(SC) of Programme Coordination Committee(PCC) of ICDDR,B. The Standing Committee shall act as per the guidelines laid down below:-

2. OBJECTIVES OF STANDING COMMITTEE(SC):

The Standing Committee(SC) shall have the following objectives:-

(a) To receive reports/comments from the Director of ICDDR,B with regard to both ongoing protocols and new protocols for diarrhoeal diseases and related subjects.

(b) Scrutinize and compile reports/comments in respect of (a) aboveand submit the same to PCC for consideration.

(c) To receive research protocols from national organizations/ individuals (other than ICDDR,B) and submit the same to the PCC with recommendations including possible sources of funding, where such protocols have been approved by the Ethical Review Committee/Research Review Committee, but have not received funding.

(d) To prepare and update, from time to time, a running inventory of the work done in the field of diarrhoeal diseases and related subjects, both by ICDDR,B and other research organizations in Bangladesh. Similarly, inventory of scientific personnel working in those research institutions should be maintained.

(e) To review and encourage collaborative research, training and service activities within the country.

(f) To discuss agenda items accepted by Standing Committee(SC).

(g) Any other responsibilities assigned by the Programme Coordination Committee(PCC), from time to time.

3. COMPOSITION OF THE COMMITTEE:

The Standing Committee(SC) of Programme Coordination Committee(PCC) of ICDDR,B shall consist of 14 members, as follows:-

(a) (i) 7 members to be recommended by the PCC;
(ii) 1 member to be nominated by the BMRC;
(iii) 3 members to be nominated by designation by the Government of Bangladesh; and

(iv) 3 members to be nominated by the Board of Trustees of ICDDR,B.

(b) The members of the Standing Committee(SC) selected by the Board of Trustees of ICDDR,B will serve a term of 3 years and accordingly, the present members of the SC shall continue in office for a period of 3 years beginning January 1983. The membership will be on an individual basis (by name), or by designation as indicated.

The Board will reconstitute the SC every 3 years during its June meeting and start functioning with effect from the 1st of January next year. The old SC will continue to function until the new SC is constituted by the Board.

(c) Any casual vacancy will be notified to the Board and the Board will take appropriate steps.

4. MEETINGS OF THE COMMITTEE:

(a) The Standing Committee(SC) shall meet at least once in a quarter of the year and meetings of the Committee may be convened by the Member-Secretary of the Committee in consultation with the President, SC, with at least 7(seven) days notice.

(b) The Member-Secretary shall invite items of agenda from the members of the Committee at least 3(three) weeks prior to the scheduled date of meeting.

(c) The notice for the meeting shall indicate the items of agenda, time, date and venue of the meeting and be sent to the members of the Committee through Peon Book or by registered post, to the last known address of the members.

The members may however propose for inclusion of any important issue, as additional agenda item, in the beginning of the meeting.

(d) The quorum of the meeting shall require presence of at least 1/3rd members of the Committee.

5. OFFICIALS OF THE COMMITTEE:

The President, Vice President and Member-Secretary of the Committee shall be nominated by the Board of Trustees, from time to time.

7/BT/DEC. 83

VACCINE REPORT

NOTE FOR THE RECORD

Participants:

Dr M.H. Merson, CDD/WHO
Dr J. Holmgren, University of Goteborg
Dr M. Jertborn, University of Goteborg
Dr Cadoz, Institut Merieux
Mr Nojd, National Bacteriology Laboratory, Sweden
Dr W.B. Greenough, ICDDR,B
Dr M.U. Khan, ICDDR,B
Dr K.M.S. Aziz, ICDDR,B
Dr B. Stanton, ICDDR,B
Dr J.D. Clemens, ICDDR,B

The above met at ICDDR,B Dhaka on 14 November, 1983, to discuss the planned oral cholera vaccine trial at ICDDR,B, scheduled for July, 1984. Specific items discussed were as follows:

1. Vaccine Pre-test:

It was agreed that the vaccine pre-test proposed on the rough draft of the field trial was acceptable if carried out according to schedule (beginning March 4). The schedule of vaccination for the pre-test will replicate the vaccination for the trial. Because a decision about vaccine immunogenicity can be made on the basis of responses to the first and second doses of the vaccine, serum antibody responses to these doses can be evaluated by early May, 1984. All records of adverse reactions, including those after the third dose, will be taken into account

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in evaluating vaccine safety. If production of the vaccine is delayed, the vaccine could be given at 3-week intervals during the pre test and this would necessitate a similar dosing schedule in the field trial. If the vaccine is not ready by June 1, the field trial will be postponed until after the fall cholera epidemic.

2. Production, formulation and Dosage of the Vaccine:

The production time for the B-subunit/whole-cell vaccine will be approximately 3 months. Institut Merieux will produce both the B-subunit and whole cell components of the vaccine and the vaccine lot will be ready no later than July 1, 1984. It was emphasized that a decision to begin production is needed immediately if the vaccine lot is to be available by March 1, 1984.

It was agreed that a liquid formulation for the vaccine is most appropriate for the trial. It was also agreed that ICDDR,B will assist in testing alternate formulations, such as an enteric-coated tablet, for future field evaluations.

Single unit dosing of the vaccine was accepted as most desirable for the trial, and the regimen proposed in Geneva in October, 1983, was considered suitable. This regimen will be as follows: Dose 1 (2mg B-subunit and $2x10^{11}$ killed whole cells), Dose 2 (1mg B-subunit and $1x10^{11}$ killed whole cell), Dose 3 (1mg B-subunit and $1x10^{11}$ killed whole cells).

3. Acid-Neutralization Studies:

Investigations into acid-neutralization solutions to be given with the vaccine will commence at ICDDR,B in December, 1983.

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Neutralization will be accomplished with flavoured citric acid buffered sodium bicarbonate tablets which can be dissolved rapidly in water. In these studies the 2-dose neutralizing regimen used in earlier studies will be compared with two solutions with different bicarbonate concentrations when administered as a single dose with the B-subunit/whole cell vaccine. In this study, the vaccine will be given in 2 doses separated by a 3-week intervals. Primary serum antibody responses will be measured and will form the basis for evaluating the different neutralizing regimens. It was also agreed that Vitamin C should be incorporated into these tablets so that some benefit may be conferred to all participants in the trial.

4. Formulation of the Placebo:

A solution which is as identical as possible with the vaccine in appearance, taste, and smell will be developed at Institut Merieux. The vehicle for the vaccine will be one component of the placebo. The placebo and vaccine will be distributed in identical ampules, distinguishable only by letter markings. It was agreed that letters, not colours, should serve to identify the vaccine and placebo agents.

5. Safety and Immunogenicity Testing of the Vaccine Lot:

Before going into the field all safety and immunogenicity tests that are required by the Government of France and the Government of Bangladesh will be conducted. Such testing will be completed by Institut Merieux and the vaccine lot will be made available for testing in Bangladesh. Protocols for tests required in France

will be sent as soon as possible to ICDDR,B for incorporation into the field trial protocol.

6. Trial Design:

Unpublished results of the volunteer trial of oral whole cell cholera vaccine vs. placebo conducted recently at the University of Maryland are now available. Of the 9 subjects receiving the vaccine, 3 developed diarrhoea after a cholera challenge dose, as opposed to 6 of 8 subjects receiving the placebo. Accordingly, the protective efficacy for the vaccine was found to be 56%, though this result did not attain statistical significance ($P<.10$). Mean purging rates and numbers of stools were significantly ($P<.05$) lower among diarrhoea cases in the vaccine group than among cases in the placebo group, but severe diarrhoea was uncommon in the placebo group.

It was the opinion of the Bacterial-Enteric Infections Steering Committee, CDD/WHO, that a separate whole cell alone vs. placebo comparison should be added to the existing B-subunit/whole cell vs. placebo trial. Institut Merieux also supported a 3-cell trial, but was not opposed to a 2-cell trial if a consensus was obtained from all concerned.

All in attendance agreed that the ultimate evaluation of the whole-cell vaccine vs. the B-subunit+whole-cell vaccine is of great importance. Several options were considered:

(i) A Large 3-cell Trial Permitting Direct Comparison of B-subunit+Whole Cell vs Whole-Cell Vaccines:

One suggestion was that a 3-cell trial be mounted in 1984. The cells would consist of placebo, liquid B-subunit+whole cell vaccine, and liquid whole-cell vaccine. A major

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problem with this approach is that it would require a minimum sample size of approximately 600,000 subjects, even without increasing the sample size to account for multiple vaccine comparisons, to detect meaningful differences in efficacy (e.g., 80% vs 60%) between the two vaccines. This sample would correspond to an area with a population of over 1 million persons.

(ii) A Preliminary 3-cell Trial in 1984 Before Undertaking a Large 3-cell Trial Directly Comparing B-subunit+Whole-Cell vs. Whole-Cell Vaccines:

It was suggested that a smaller 3-cell trial with the two liquid vaccines be undertaken initially in the Matlab population and that it later be expanded if necessary. One strategy would be to take a population in which the initial index of interest would be "vaccine effect" (where a "vaccine effect" would consist of the comparison of cholera incidence in the pool of all vaccinees vs. all placebo recipients). If this pooled effect at 1 year after vaccination were so low (e.g., <20%) as to make it unlikely that either vaccine were effective, the trial would be terminated. Similarly if the effect were so high (e.g., >95%) that it would be unlikely that the vaccines differed substantially in their individual effects, the trial could also be terminated and the simple (whole-cell) vaccine would be accepted as superior. To make these distinctions with acceptable precision a sample of 153,000 controls and 153,000 vaccinees, corresponding to an area with a population of 588,000 would be required. This calculation does not take into account multiple vaccine comparisons, whose consideration would raise the total sample to an even higher level (406,000). Since a vaccine effect in the above high or low ranges is unlikely, the population

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probably would have to be expanded the following year to attain the ~600,000 subjects described in (i) to make the necessary inter-vaccine discrimination. If the whole-cell vaccine were found most acceptable by virtue of a very high overall vaccine effect, a subsequent field trial of whole-cell vaccine vs. placebo in a more convenient formulation (e.g., pill) would be necessary. Similarly whatever vaccine was found superior in a ~600,000 subject 3-cell trial would still require a subsequent 2-cell trial using a more convenient formulation before a decision about the best vaccine for general use could be made. Thus, this strategy would probably entail a large-scale 3-cell trial, after which a 2-cell trial would still be necessary.

An analagous alternative would be to conduct a 3-cell trial with the 2 liquid vaccines during the first year, but to interpret the results differently. It was suggested that any efficacy result for whole-cell vs. placebo exceeding 80% would indicate that this preparation would be practically superior, regardless of the efficacy found for B-subunit+whole cell vaccine. Other results would require special decisions. One possible scheme would be:

Efficacy of WC Vaccine in 1984-85	Efficacy of BS+WC Vaccine in 1984-85	Decision for 1985-86
50-80%	>80%	Expand to large 3-cell trial*
<50%	>80%	New 2-cell trial: BS+WC vs. placebo+
50-80%	50-80%	Possibly expand to large 3-cell trial*
<50%	50-80%	Possible 2-cell trial: BS+WC vs. Placebo+
<50%	<50%	Reject both vaccines
50-80%	<50%	New 2-cell trial: WC vs. Placebo+

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* 3-cell trial requiring 600,000 subjects, as described in (i)

+ 2-cell trial using more convenient formulation of BS+WC vaccine or WC vaccine.

Thus, if efficacy rates for both the whole-cell and the B-subunit+whole-cell vaccines were <50% the trial would stop after one year and both vaccines would be rejected. For any other result, either an expansion during the second year to a ~600,000 subject 3-cell trial would be required (with a subsequent 2-cell trial assessing a more practical formulation of the superior vaccine in the 3-cell trial), or a 2-cell trial evaluating more practical B-subunit+whole cell or whole-cell alone formulations would be necessary before any judgement about a superior vaccine for general use could be made. Without making adjustments for multiple comparisons and demanding 0.8 power, the sample size required for this strategy for 1984 would be 204,177, which would require an area with a total population of approximately 400,000 persons. If more statistical power (.9) were desired and P value corrections were made for the fact that two vaccines were to be evaluated, 309,975 persons would be needed and an area with a population of 596,000 would be necessary for the first year of the trial. The less extreme criteria for vaccine efficacy used to make decisions about a choice of 1985 studies and the smaller minimum sample size are advantages of this strategy over the first strategy mentioned in this section, although it still would seem probable that a ~600,000 subject 3-cell trial would be required, and the initial phases of both strategies would demand inclusion of an area outside of Matlab (pop. 180,000).

(iii) <u>A 2-cell Efficacy Trial Before Undertaking a Large 3-cell Trial Directly Comparing B-subunit+Whole-Cell vs. Whole-Cell Vaccines</u>:

Another suggestion was that the originally proposed 2-cell

efficacy trial comparing B-subunit+whole-cell vaccine vs. placebo with a total sample of 70,000 be undertaken in 1984. If substantial efficacy (e.g., >70-80%) were found, a 3-cell effectiveness trial would be undertaken the next year. If lower values for efficacy were obtained, both oral vaccines would be regarded an unattractive candidates, and no further studies would be undertaken. If a 3-cell trial were warranted by these criteria, the trial would compare conveniently formulated B-subunit+whole and whole-cell vaccines, obviating the need for further 2-cell studies of vaccines with revised formulations. The 3-cell trial would also use a sample size of about 600,000 subjects necessary to directly compare the two vaccines. This strategy would enhance the efficiency of evaluating the vaccines by signaling the necessity for a 3-cell trial on the basis of conclusive results after one year and by enabling the conduct of the 3-cell trial with vaccines having convenient formulations. The design would not, however, permit a relative comparison of the 2 vaccines after the first year.

(iv) Trials That Would Not Permit Definitive Comparison of the B-subunit+Whole Cell and Whole-Cell Vaccines:

Two strategies were discussed for studying the vaccines in a way that would not permit statistically meaningful comparisons of the two vaccines with one another, but would allow estimates of the individual vaccine efficacy rates. The first proposal would be to conduct a 3-cell trial designed only to conduct comparisons of B-subunit+whole-cell vs. placebo and whole-cell vs. placebo. This study could be accomplished either with a single vaccination campaign, or with two years of vaccinations. Without correcting P values for multiple vaccine comparisons and assuming .8 statistical

power, a sample of 132,049, corresponding to a population of 253,940 persons, would be required for this study. If more stringent P values than P<.05 were required because of the two vaccines under simultaneous consideration, and if .9 statistical power were desired, a sample of 200,105, corresponding to a population of 384,817, would be needed.

As an alternative, the originally proposed 2-cell trial with B-subunit+whole-cell vaccine vs. placebo could be done in 1984, and, if substantial efficacy were shown, a 2-cell whole-cell vs. placebo trial could be done in 1985. The samples for these trials combined would be 167,308, corresponding to a population of 321,746. Neither of these options was attractive to all members of the group since neither strategy would permit statistically meaningful differentiation of the two vaccines and since the second strategy would involve non-concurrent comparisons of the vaccines.

7. The ICDDR,B Position on Trial Design:

Representatives of ICDDR,B favoured strategy (iii) for several reasons. First, this appeared to be the most efficient strategy for arriving at a firm conclusion at the earliest date about the public health usefulness of B-subunit+whole-cell vs. whole-cell oral cholera vaccines. Second, it was felt important to test the best possible vaccine in the field in 1984 and to be able to provide conclusive results about this vaccine within one year of initiating the trial, since many past trials of cholera vaccine at ICDDR,B have not yielded impressive levels of efficacy. Third, in contrast to strategies noted in (i) and (ii), the first year of plan (iii) could be accomplished in

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1984-85 without the need for expanding the study area outside of Matlab, which would create substantial logistical difficulties. In this regard, it is worth noting that no past trial of cholera vaccines at ICDDR,B has employed a sample size >93,000 subjects, and most trials have studied fewer than 40,000 subjects. At the same time, additional resources necessary for an expanded 3-cell trial would be sought, so that if a definitive 3-cell trial were warranted by the results of the 2-cell trial, such a trial could be initiated swiftly. Fourth, it was felt that it was important to initiate the trial as soon as possible since it is expected that such a trial would be well received in Bangladesh in 1984.

Dr Merson reported that WHO will consider this position in making a final decision about sponsorship of the trial. It is hoped that this decision will be made within two weeks. If WHO sponsors the trial, a protocol will be sent to WHO within the next few weeks.

8. Sample Size Assumptions:

The assumptions for sample size calculations were discussed It was agreed that the outcome used for estimates of cholera incidence -- cases of cholera seeking outpatient or inpatient care -- was appropriate since a meaningful trial of cholera vaccines should be designed to evaluate adequately the vaccine protection against this outcome. A value of 1 case/1000-person years was generally felt suitable for sample size calculations, although various members of the group suggested slightly higher or slightly lower values. It was recognized that statisticians

differ in their views on the correction of P values for the analysis of multiple vaccine comparisons. Several published works by eminent biostatisticians strongly advocate such corrections in sample size calculations, but other eminent biostatisticians that were personally consulted by the WHO Steering Committee did not regard such corrections as necessary. Some in the group felt that since none of the statisticians consulted regarded such corrections as incorrect and since other equally eminent statisticians strongly advocate such corrections, the safest strategy would be to perform the sample size calculations with the corrections. Others in the group felt that this approach was too conservative. Since no consensus was reached on this topic, sample size figures have been presented above both with and without corrections for multiple comparisons.

9. Miscellaneous Issues:

Two points were raised about other aspects of the field trial protocol. First, it was pointed out that "sentinel care" surveillance could be accomplished with 5-6 days rather than 10 days of cultures of family members. Second, it was suggested that maternal breast milk antibodies could not be taken as reflections of antecendent immunity at the time that nursing children are treated for infections, and that the breast milk studies be reformulated accordingly.

8/BT/DEC. 83

RESOURCES DEVELOPMENT

RESOURCES DEVELOPMENT REPORT

The international aid situation continues to be rather complex as 1983 draws to a close. On one hand, 1983 has seen a great leap in international awareness of diarrhoeal disease. Health policy-makers around the world are beginning to include diarrhoea in their health care programs; in particular, developing countries are seeking assistance to strengthen the diarrhoea component of their national health programmes. An increasing number of these countries are looking to ICDDR,B for assistance.

On the other hand, major aid-givers have slashed their aid budgets to serve other priorities in a very uncertain economic and political climate. The available aid money is increasingly going to support either bilateral funding arrangements or regional groupings, thereby causing difficulty for ICDDR,B which depends on multilateral support. While the major victim of this shift in priorities has been the United Nations and its various agencies,

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ICDDR,B has suffered both indirectly -- losing UN funding -- and directly, as some donors' financial priorities move away from international health and health research. Consequently competition for the donor dollar is more intense today than before.

The report below summarizes how ICDDR,B in particular the Resources Development Office, is handling these simultaneous opportunities and constraints in 1983. In 1982, projections for 1983 donor-related income were made based on commitments and expectations from donors. However, delays and other factors resulted in variation from the original projections. Revised projections were made in June 1983 and were approved by the Board of Trustees. Appendix A lists these projections and compares them with donor commitments, estimates and actual cash receipt of contributions as of October 31, 1983. 1983 has been a year of mixed success in fund-raising. Agreements with some of our major donors have expire-, but some important new donors have announced their contributions. One-time contributions were provided by the Arab Gulf Fund, Belgium, UNDP for the Embankment Workshop, and the UNROB fund. Donors whose multi-year agreements have expired this year include the Aga Khan Foundation, GTZ, IDRC (infant mortality), IDRC (sanitation impact), the Population Council, SAREC/Sweden (both core funding and support of immunity studies), UNDP (regional training) and UNFPA (global support for the DSS). The Aga Khan Foundation has provided some additional support in 1983 and is considering a related project in 1984, while GTZ may request a further survey round in 1984. IDRC is interested in supporting a second-phase sanitation impact study in Teknaf, and our agreement with the Population Council will now extend through 1984.

An amount of $47,000 remains in the UNROB funds, which should

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be released to us in early 1984. The External Resources Division of the Bangladesh Ministry of Finance has suggested that we apply for conversion of the full amount from a loan to a grant after receiving the $47,000.

Donor governments and agencies often are wary of making the continuing commitment of core support. They prefer to support a project, which has a time frame within which definite results are expected, and after which funding ceases. The general donor trend is toward specific project support or yearly core support. However, Resources Development has been able to maintain continuity of support to our projects, including recovery of overhead costs.

With regard to obtaining new commitments from donors, both existing and new, we have successfully negotiated with the following donors: Belgium, CIDA, the Ford Foundation, IDRC, the Federal Republic of Germany, the United Kingdom, the OPEC Fund, the Sasagawa Foundation, UNICEF and USAID/Indonesia.

The most important new donor to ICDDR,B is the Canadian International Development Agency (CIDA). CIDA has agreed to support the Centre's Demographic Surveillance System from 1984 through 1987, following the conclusion of UNFPA funding at the end of 1983. CIDA support not only includes a substantial increase in Matlab funding, but will include the Tekraf DSS and will provide for purchase of an appropriate scientific computer, which will greatly enhance the potential applicability of the DSS and other scientific projects.

A second major achievement in 1983 has been securing the support of the Federal Republic of Germany. After more than three years of hard work and continuous effort, the FRG has agreed in principle to extend support to the Centre.

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A third major breakthrough this year has been the establishment of a close relationship with UNICEF. In the long term this may prove to be one of the most important collaborations, both technically and financially. ICDDR,B's goals fit closely with the UNICEF objective of promoting GOBI; this has led UNICEF to cooperate and extend support to our activities. UNICER is now supporting ICDDR,B and has requested our assistance in strengthening their programs in Tanzania and Colombia. We can now visualize a long term partnership implementation of the Centre's research results in developing countries. These activities will be fully funded by UNICEF which will also support our core programs. The Centre's resources and mandate are limited; this partnership with UNICEF could enable us to make more effective use of our own strengths and resources.

In 1983 we have also established very close contacts with both the Government and private foundations of Japan, building on the Japanese Government's contribution to ICDDR,B. Recently two high-level delegations have visited the Centre, one from the Ministry of Foreign Affairs and one representing the national legislature. We have submitted proposals for increased Japanese core support and for other project and capital areas. We look forward to this increased support.

Other new contributions include CIDA/World Bank support for a three-year sanitation package study; three separate grants from the Ford Foundation for training of a Government epidemic preparedness team, an evaluation of the Government's National Oral Rehydration Programme, and support for operations research and training (1984); and expanded IDRC support for the Diarrhoeal Information Service Centre.

COLLABORATION

The growing awareness around the world of the threat of diarrhoea

and the possibilities for solving it has let to increasing interest in ICDDR,B and its activities on the part of donor and developing countries alike. The Ministry of Health of Indonesia has requested the Centre to organize training of its health personnel in microbiology and epidemiology, and to assist in the clinical aspects of diarrhoea management as a follow-up to the cholera intervention and epidemiological survey carried out by ICDDR,B in 1982. A two-member team from the Centre has already visited Indonesia for the initial survey and study, and a final proposal will be submitted based on the team's findings. This project will be fully funded by USAID/Indonesia.

As mentioned above, first steps have been initiated for collaboration in diarrhoeal disease with the Governments of Tanzania and Colombia, at the request of UNICEF/New York. Feasibility reports on these projects will be finalized in early 1984.

Recently Belgium requested assistance in organizing a diarrhoeal disease workshop for Africa in Rwanda. CIDA/Canada made a similar request for Central Africa and offered funding. We have suggested that these two interests be combined into one workshop for Central Africa. This workshop would be organized by ICDDR,B and jointly funded by Belgium and CIDA.

One of the most important of the possible collaborations has been proposed by the People's Republic of China. Sixteen Chinese scientists have received training at the Centre, and the Director and Associate Director for Training, Extension and Communication have visited China to explore areas of possible collaboration. ICDDR,B has now received a formal request from the Chinese Ministry of Health to provide training and technical assistance, particularly training in ORS, clinical management of

diarrhoea and microbiology. We are expecting the visit of a delegation from China to discuss and finalize this project. CIDA has shown keen interest in supporting this project.

ICDDR,B has also received requests from eight member countries of the South EAst Asia Region of WHO to train their health personnel in various aspects of diarrhoeal disease management, at the Centre and through in-country training. This request has been routed through WHO and the Government of Bangladesh.

An International Conference on Oral Rehydration Therapy was held just before the June Board of Trustees Meeting. Co-sponsored by USAID, UNICEF and ICDDR,B it focused world attention on diarrhoea and ORT, and gave very high visibility to the Cenre. Among those governments responding to the ORT message was the US administration, which has already allocated US$12,000,000 fcr ORS and primary health care programs.

To implement any collaborative activities, two crucial needs are funding and expertise. The Board has stipulated that projects should not be undertaken without donor support; most of the prospective projects described above have been assured funding by donors, generally under tripartite arrangements. The second need, for experienced personnel, is equally complex as the Centre faces continuing personnel constraints. We are moving cautiously and taking advantage of outside expertise, particularly ICDDR,B alumni and others who are familiar with the Centre's objectives and activities. These collaborations provide essential technical assistance to developing countries.

1984

The many changes in the world situation in 1982 and 1983 have required ICDDR,B to consider carefully its fund-raising strategies. As currency rates continued to fluctuate and

political and economic uncertainties influenced a diversion of interest from health to other more politically important sectors, some countries turned to more centralized aid giving, such as through the EEC or ASEAN. This trend tends to work against globally-focused agencies like ICDDR,B and we cannot hope to have any control over these factors.

Therefore we have revised our fund-raising strategies in some areas. A major focus in 1983 has been to insure continuity of funding in 1984 and beyond, particularly trying to obtain longer-term commitments. We have also worked to broaden the base of donors to ICDDR,B's activities; in 1984 we project 24 donor countries and agencies.

Finally we have increased the visibility of ICDDR,B in the world community. The Centre has enjoyed awareness among the scientific community for many years, and this should continue. But we are aiming at the policy-makers, lay people who must make health and aid-giving decisions for their nations. Both ICORT and our Consultative Group at the UN in June enabled us to focus media attention on ICDDR,B. As a result of these, a number of articles on diarrhoeal disease and ICDDR,B have appeared in newspapers around the world; the examples in *Appendices C and D ran in the New York Times, International Herald Tribune, Bangkok Post, and other papers in Asia, Europe and Africa.

All of these factors have had an effect on the ICDDR,B income forecast for 1984, which is provided in Appendix B. The Board will note that the Centre moves into 1984 with more firm commitments than in previous years.

In 1984, the agreement with USAID, the Centre's largest single donor, will come up for renewal. We are negotiating with them for the next funding cycle, which will be on a year-to-year

*C and D not in these minutes

basis rather than a five-year commitment. The agreement expires in June 1984, but a three-month extension to September has been negotiated to bring the grant period into line with the U.S. fiscal year without any funding gap. We hope to be able to finalize the agreement during a forthcoming visit to Washington.

Two developments regarding USAID funding to diarrhoeal disease work should be mentioned here. First is that for the first time USAID has agreed to contribute to the CDD Program of WHO. We hope that this funding will be over and above financial support provided to ICDDR,B. The second is that a doctor at the State University of New York (Buffalo) has submitted a proposal to USAID for research and training in chronic diarrhoea for US$ 11 million over five years. Despite our growing visibility in the US, this does place us in an uncertain position.

CAPITAL DEVELOPMENT

Efforts to raise funds for the Centre's Capital Development Program have continued in 1983, with the first priority being the further six stories on the new building. We have submitted a proposal to the OPEC Fund for support to complete construction of the new building at the Dhaka Centre. During discussions with the Acting Director of the OPEC Fund, he informed us that the Fund has US$ 50 million of counterpart funding held in Bangladesh. He suggested that we approach the Government of Bangladesh for release to ICDDR,B of US$ 6 million of this amount, which the OPEC Fund would approve. However, we anticipate that will be very difficult to achieve, as the counterpart funds are essentially bilateral rather than multilateral.

For needed construction in ICDDR,B field stations we have approached the United Nations Capital Development Fund. This project proposal must be forwarded to UNCDF by the Government

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of Bangladesh. We request the assistance of the Honorable Board members from Bangladesh in this regard.

We have approached the Government of Japan and various Japanese foundations to support our capital development program, both for construction and for equipment. We are actively pursuing this matter.

IN-KIND SUPPORT

The Board has recommended that the Centre should seek in-kind support wherever possible. The Centre has sucdessfully negotiated such support from several sources. The French scientist who is already working at the Centre will continue through 1984. Belgium has agreed to support the two Belgian staff members already working at the Centre as well as a microbiologist who will be recruited in early 1984. Belgium will also support training in Belgium of two ICDDR,B microbiology staff members.

We have approached the United Kingdom to provide an expert under the ODA Technical Assistance Programme. They have suggested that we develop a protocol which would include the services of a British scientist, which they will consider funding.

An agreement for technical cooperation has been signed with ORSTOM, a French institute focusing on demography under which they will depute a scientist to the Centre on a long term basis. This agreement also provides for exchange of scientists and information between the two organizations.

We also expect to receive some mid-level scientists and technical personnel from Canada, under an agreement now being negotiated with the World University Service of Canada.

RESERVE FUND

We are now finalizing our proposal for the Reserve Fund, whose

establishment has been approved by the Board. We have already had discussions with the Ford Foundation in this regard and their reaction was very favourable. We will take this proposal to the donors in early 1984.

CONSULTATIVE GROUP

This year the Consultative Group meeting was attended by participants from 25 countries and international agencies. This year's meeting was the most successful of the four held so far, and provided an excellent forum with lively discussion where both donors and beneficiaries could participate. Several major new donors, including UNICEF and the Federal Republic of Germany expressed their interest in funding the Centre's activities. We would like to extend our thanks and gratitude tc Mr William Mashler of UNDP for chairing this meeting, and to Dr J. Sulianti Saroso, who very ably represented the ICDDR,B Board of Trustees. We request the Board's authorization to hold the next meeting of the Consultative Group in Geneva on June 6, 1984, to coincide with the UNDP Governing Council meeting. UNDP has offered tc chair the meeting.

In the past, flow of funds into the Centre has been delayed because donors had required the concurrence of their parliament. In 1984 also, parliamentary approval will be needed by some donors before money can be released. The multilateral funding mechanism, through which the Centre receives its funds, is itself a complex mechanism which often causes delays that are difficult to predict. We also face difficulty in providing suitable unfunded projects to donors. However, with the Board's advice we hope to be able to meet the Centre's funding needs for 1984 and beyond."

7/BT/Dec.83 Resources Development Report

Appendices A and B : Projected, Committed and Estimated Donor Income 1983 and 1984

The attached appendices detail donor commitments and estimated commitments; 1983 statements also include actual receipts against those commitments as of October 31, 1983. Both 1983 and 1984 figures are compared with income projections submitted to and approved by the Board of Trustees in June 1983.

In 1983 the total committed and estimated income is $6,547,000, including $3,475,000 unrestricted and $3,072,000 restricted. Of this total $3,856,000 had been received by October 31st. An additional $1,945,000 has been or should be received by the end of December, with the remaining $494,000 expected in early 1984. $324,000 represents estimated income for 1983 from SAREC and UNICEF; proposals have been submitted to these donors and are under positive consideration. Disbursements are expected in early 1984.

For 1984 the Centre's projected income is $7,159,000, including $3,033,000 unrestricted and $4,126,000 restricted. Of the total, $5,153,000 has been committed by donors, and $ 2,006,000 is the estimated further contribution.

A significant difficulty faced by the Resources Development Office which should be addressed by the Finance Committee is the need to establish an information-flow system between Resources Development and the Finance Office. There is a major information gap in two areas: current status of grant disbursements, and status of donor reporting, particularly financial. The Centre's cash-flow position and its ongoing good relations with donors depend heavily on these two areas. Resources Development can facilitate timely processing in both areas, but only with up-to-date, accurate information.

Projected, Committed and Estimated Income 1983

November 1983
Resources Development Office

Donor	Projected June'83	Committed	Estimated	Recd. up to 31 Oct. 1983	
UNRESTRICTED					
Arab Gulf Fund	350,000	350,000	-	-	*
Australia	163,000	163,000	-	-	*
Bangladesh	37,000	35,000	-	35,000	
Japan	200,000	200,000	-	200,000	
Saudi Arabia	100,000	100,000	-	-	*
Sweden/SAREC	72,000	-	72,000	-	
Switzerland	270,000	230,000	-	230,000	
U.K.	200,000	178,000	-	178,000	
U.S.A.	1,900,000	1,900,000	-	1,583,000	*
UNROB	500,000	233,000	-	186,000	*
Other	-	14,000	-	14,000	
TOTAL	3,792,000	3,403,000	72,000	2,426,000	

Notes:

1. AG Fund: The AG Fund's disbursement has been much delayed. Therefore we have requested payment of the full grant amount. We have received information that a disbursement order has been issued.
2. Australia : Funds are expected to be released in the first week of December 1983.
3. Saudi Arabia : We have been informed that they are processing disbursement. Due to variance in the Saudi calendar, disbursement is usually delayed. However, payment is expected by December 1983.
4. SAREC : This grant expired in June 1983 and is expected to be renewed in December with retroactive effect. Dr. Jan Holmgren, former ICDDR,B Trustee, is actively pursuing this matter in Sweden.
5. USAID : The balance is due by the year's end.
6. UNROB : The June '83 projection of US$ 500,000 included an exchange gain of $ 314,000 on the total UNROB fund of $ 1,186,000, which was disbursed in Taka. However, the Board subsequently decided to credit the dollar amount only. The final figure now stands at $ 233,000 which includes an additional $ 47,000 which should be disbursed by end December, 1983.
7. Total amount committed $ 3,403,000
   Amount received up to 31st Oct. 1983 $ 2,426,000
   Outstanding balance $ 977,000
   * Disbursement expected by end Dec. $ 977,000

Estimated additional contribution of $72,000 from SAREC for 1983 is expected to be disbursed in early 1984.

Projected, Committed and Estimated Income 1983

Donor	Projected June '83	Committed	Estimated	Recd. up to 31st Oct. 1983	
RESTRICTED					
Aga Khan Fdn.	25,000	40,000	-	25,000	*
Belgium	75,000	75,000	-	75,000	
CIDA/WB(hand-pumps)	179,000	132,000	-	-	*
Ford Fd.(Epid.)	-	50,000	-	50,000	
Ford Fdn.(NORP)	160,000	100,000	-	-	**
France	60,000	60,000	-	20,000	**
GTZ	56,000	50,000	-	50,000	
IDRC(DISC)	91,000	87,000	-	58,000	*
IDRC(Inf.Mort.)	-	8,000	-	8,000	
IDRC(San.Imp.)	56,000	26,000	-	26,000	
Princeton/JHU	25,000	23,000	-	14,000	*
Pop Council (Opn. Res.)	83,000	62,000	-	37,000	*
SAREC (Imm.)	76,000	39,000	-	39,000	
Saudi Arabia	100,000	275,000	-	-	*
UNDP (Emb.)	-	30,000	-	30,000	
UNDP(Reg. Tr.)	85,000	86,000	-	36,000	*
UNDP(Cl. Res.)	250,000	250,000	-	250,000	
UNFPA(DSS)	426,000	426,000	-	311,000	*
UNFPA(MCH-FP)	66,000	66,000	-	66,000	
UNICEF	660,000	302,000	252,000**	-	*
USAID(MCH-Ext.)	595,000	608,000	-	326,000	**
USAID(Indonesia)	-	13,000	-	-	*
USAID(Nutrition)	-	12,000	-	9,000	*
RESTRICTED	3,068,000	2,820,000	252,000	1,430,000	
UNRESTRICTED	3,792,000	3,403,000	72,000	2,426,000	
GRAND TOTAL	6,860,000	6,223,000	324,000	3,856,000	
# Less	314,000				
Total	6,546,000	Total Cols. 2 and 3 = $ 6,547,000			

Notes:# The total 1983 income projected in June was $ 6,860,000, which included a calculated exchange gain of $ 314,000 from the UNROB total grant of $1,186,000. However, the Board subsequently decided to credit the dollar amount only. Accordingly the final projected 1983 income for the Centre is $ 6,547,000.

*Further notes on next page.

Notes :

RESTRICTED

1. Aga Khan Foundation: is providing an additional $15,000 for 1983, which should be received in December 1983.

2. CIDA/WB: Delay in project approval by CIDA resulted in a later project and funding start date. The first payment was made in November 1983.

3. Ford Foundation(Epidemic): This grant was negotiated after the June 1983 Board meeting.

4. Ford Foundation(NORP): The revised project, for $100,000 has been approved. Disbursement should be made in January 1984.

5. France: Funds against this grant have been placed but reimbursement has been claimed to date for $20,000 only.

6. IDRC(DISC): The next grant instalment is due in December.

7. IDRC(San. Impact): The first phase ended in June 1983, and second phase funding was expected to begin from July. However, the project proposal for the second phase has not been finalized.

8. Population Council: The starting date was delayed; therefore the total disbursement has been reduced. The balance $25,000 is expected in early December 1983.

9. SAREC(Immunity): Expected new collaborative proposals did not materialize. The present agreement expired in June 1983; new funding depends on progress of the trial for the B-subunit vaccine

10. Saudi Arabia: This amount includes $230,000 for project and $45,000 for pre-project activities. Disbursement is being processed.

11. UNDP(Regional Training): The balance $50,000 is expected in early December 1983.

12. UNFPA (DSS): The final quarterly payment will be made in December 1983.

13. UNICEF: Disbursement of $302,000 is expected in December 1983; the remaining $252,000 is under positive consideration and should be disbursed in early 1984.

14. USAID(MCH-FP Ext.): The original agreement has been revised; the new 1983 grant amount is for $608,000. The balance should be received in January 1984. This amount includes an advance for 1984.

15.

Total amount committed	$ 2,820,000
Amount recd. to 31 Oct '83	$ 1,430,000
Outstanding balance	$ 1,390,000

* Disbursement expected by end Dec. 1983 $ 968,000

** Payment expected by early 1984 $ 422,000

The estimated additional contribution of $252,000 from UNICEF for 1983 activities is expected to be disbursed in early 1984.

Projected, Committed and Estimated Income 1984

Donor	Projected	Committed	Estimated
RESTRICTED			
Aga Khan Fdn.	30,000	-	30,000
Belgium	75,000	-	100,000
CIDA(DSS)	1,000,000	1,700,000	-
CIDA(Tr./Wshop)	100,000	-	50,000
CIDA/WB(H.pump)	95,000	94,000	-
FRG	-	-	300,000
Ford Fdn. (Opn. Res./Tr.)	50,000	-	50,000
France	100,000	-	40,000
GTZ	30,000	-	30,000
IDRC(DISC)	125,000	125,000	-
IDRC(San Imp.)	62,000	-	30,000
Princeton/JHU	25,000	21,000	-
OPEC Fund(proj.)	-	-	97,000
Pop.Council/ USAID	-	-	85,000
Sasagawa Fdn.	-	-	45,000
Saudi Arabia	200,000	195,000	150,000
UNDP(Cl. Res.)	250,000	225,000	-
UNDP(DWS Decade)	100,000	-	50,000
UNDP(Reg.Tr.)	30,000	-	-
UNFPA(MCH-FP)	66,000	66,000	-
UNICEF	550,000	278,000	-
USAID/Indo	-	-	100,000
USAID(MCH-FP Ext.)	459,000	-	265,000
TOTAL	3,347,000	2,704,000	1,422,000
UNRESTRICTED	3,632,000	2,449,000	584,000
GRAND TOTAL	6,979,000	5,153,000	2,006,000

Total Cols. 2 and 3 = $ 7,159,000

In-kind Estimated 1984 support

Belgium	-	$ 100,000
WUSC	-	175,000
France	-	40,000
U.K.	-	50,000

Projected, Committed and Estimated Income 1984

November 1983
Resources Development Office

Donor	Projected	Committed	Estimated
UNRESTRICTED			
AG Fund	350,000	-	-
Australia	200,000	163,000	37,000
Bangladesh	35,000	35,000	-
Japan	400,000	200,000	-
SAREC/Sweden	72,000	-	72,000
Saudi Arabia	100,000	100,000	-
Switzerland	375,000	350,000	-
U.K.	200,000	176,000	-
USAID	1,900,000	1,425,000	475,000
TOTAL	3,632,000	2,449,000	584,000

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INSIGHT INSIGHT INSIGHT

Extra punch for Dhaka cocktail

UNITED NATIONS, New York

A HOME-MADE, lifesaving gruel is being brewed for the pharmacopoeia of the United Nations Children's Fund in its campaign against diarrhoeal dehydration, the greatest single cause of death among the Third World's young.

The formula is the second-generation development in a piece of health engineering hailed in its original form by the British medical journal *Lancet* as "potentially the most important medical advance this century."

The restructured remedy is a simplified, less costly, more effective version of one developed earlier in the same Bangladesh laboratory: the International Centre for Diarrhoeal Disease Research in Dhaka.

Chemically, the essential difference is that the original oral rehydration solution, or ORS, uses glucose (sugar) as its principal ingredient. The improved formula substitutes starch (grain) for sugar and optionally adds peptides (proteins).

Explaining the advantages of the cereal-based ORS, the Dhaka Centre director, Dr W.B. Greenough, reported during a recent UNICEF session here:

"If a treatment is needed most by the poorest, every simplification counts, especially if effectiveness is increased in the process. The substitution for glucose of the starches found in foodgrains replaces a chemical (sugar) requiring a factory for its production with natural, unprocessed foods (grains)."

Greenough told me that the Dhaka centre, which used rice to develop the starch-based formula, is focusing on potatoes and wheat "almost any starchy plant will do."

The key to simplification, cost reduction and popular acceptance is an ORS formula based on familiar and readily available ingredients.

Most of the five million children who die every year of dehydration caused by diarrhoeal infection could be saved by a mixture of salt, sugar and water developed in Bangladesh — "potentially the most important medical advance this century." Now, TED MORELLO reports, a further advance has been made.

Thus, as a substitute for the gruel of rice common to the diets of Bangladesh, Southeast Asia and southern India, one of wheat would be more acceptable in northern Pakistan and India's Punjab, of maize or millet (sorghum) in many African countries, of manioc (cassava) in Brazil and of "Irish" potatoes where they originated — in South America's Andean countries.

Another advantage of the starch gruel is that since antiquity, some such grain-and-protein dish — from fish broths to chicken soup — has been regarded in nearly every culture as a folk remedy for stomach and intestinal disorders.

Home-made

Greenough said that the domestic preparation of such home-made ORS soups "may be entirely satisfactory and thus immediately acceptable" throughout the Third World as a therapeutic measure against dehydration.

However, he made clear that at least for the time being, the distribution of glucose ORS packets, which cost scarcely US 10 cents each, should continue in parallel with the spread of the grain-based rehydration technique.

UNICEF and the World Health Organisation estimate that five million to six million children die annually of diarrhoeal dehydration. Greenough said: "With the knowledge we now have for treating this silent killer, almost none of these children needs to die."

The enthusiasm exhibited by Greenough, a former staff member at the Division of Geographic medicine at America's Johns Hopkins University, was echoed in interviews and statements here by the Dhaka Centre's deputy administrator, M.K. Bashir, and by UNICEF executive director, James Grant.

Bashir pointed out that the centre, whose 1984 budget is a modest $7 million, provides dehydration-related training and research opportunities for public health and medical staff from throughout the Third World.

And in its first major outreach programme, it is getting involved in projects in other countries. For example, a centre team helped Indonesian government health workers establish a system for identifying and controlling cholera epidemics.

In Saudi Arabia, the Dhaka institute will help set up facilities for diagnosing and treating diarrhoeal diseases.

In Kenya, a Dhaka team cooperated with the Nairobi government in comparing types of cholera virus there with those in Bangladesh.

Diarrhoea, rampant in the Third World, causes sudden severe dehydration that drains up to 15 per cent of a child's body weight. At that point, UNICEF says, "death is only hours away."

The classic treatment, basically unchanged since it was first used in 1832, consists of intravenous injection of a saline solution.

But as Greenough pointed out, the technique requires special hospital equipment and trained medical staff available to only a minuscule portion of the world's poor.

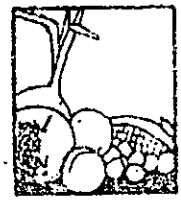
Through experiments begun some 15 years ago at the Dhaka Centre, oral rehydration therapy, or ORT, was developed, field-tested and put into general use.

The breakthrough was based on

life-saving

The life-savers

40,000 children die every day from malnutrition and infection

Mother's health	Oral rehydration	Immunization	Breast-feeding
			
2m. children a year would be saved if their mothers had extra food during pregnancy	A mixture of salt, sugar and water could save 5m. diarrhoea deaths	Vaccines could save 5m. (measles alone kills 1.5m.a year)	1m. lives could be saved by elimination of unsuitable bottle feeding

the discovery that a solution of sugar and salt dissolved in water and administered orally accelerates the body's fluid absorption rate 2,500 per cent, or 25-fold.

The first-generation formula called for eight teaspoons of sugar and one teaspoon of salt dissolved in a litre of water, preferably but — in an emergency — not necessarily sterilised by boiling.

With UNICEF's encouragement, this "Dhaka cocktail" was quickly adopted as the standard diarrhoeal rehydration remedy in many African, Asian and Latin American countries.

Programmes

More than 40 countries are formulating ORT programmes, and UNICEF reports "particularly encouraging results" from Thailand, the Philippines, Indonesia, Tunisia and Honduras.

UNICEF itself supplies some 25 million sugar-based ORS packets a year to more than 80 countries. In addition, more than 20 countries are undertaking large-scale ORS production, among them Argentina, Colombia, Pakistan, Syria, India, China, Nepal, South Korea and Malaysia.

One UNICEF focal point in Latin America is Nicaragua, where diarrhoeal infections have traditionally killed 10 per cent of the nation's infants. There, the UN agency has helped to equip almost 300 oral rehydration units serving more than 155,000 children, to train more than 1,400 people to teach the use of ORS and to produce more than a quarter of a million leaflets explaining the treatment to mothers.

In Haiti, where diarrhoeal diseases kill 130 out of every 1,000 children born in the shanty towns that have mushroomed in the capital, Port-au-Prince, an ORT campaign aims at saving the lives of 10,000 otherwise dehydration-doomed children a year by 1987.

In Narangwal, India, the death rate among children between eight days and three years of age has already been halved by community development workers using nothing but ORT and penicillin.

WHO estimates the worldwide need at 750 million ORS packets a year — a difficult target.

However, the spread of starch-based rehydration can be expected to help fill the gap and, Greenough predicts, replace sugar-based ORS altogether over the next five to 10 years. — Gemini.

Diarr

Hope in ug me eatment be pioneered in

By WILLIAM

DH

THE man st walked in and lapsed on ti friend not bo up. Soon he was stret in a long, spotless, wa held perhaps 125 si people, more than h dren who appeared t years old.

Pale and sunken-e children whimpered mothers, wrapped i Bengali saris, minist most were silent.

No cyclone or war All were victims of a of gigantic proport powers. It is not the or yellow fever. It i able, inelegant dia widespread and p problem in underde and the biggest kill the earth.

"Delhi belly" is a travelers, although those who have had rica and Latin Amer capable fact of ex those under 5 a very

Four million to fiv die each year from caused by severe d studies indicate the to two billion cases nually. Virtually ev third world will have than once in his or h some common diar child or even an adul so severe and rapid tion.

Yet, experts in the diseases say that such diseases has b that prevention an grams have been h and nonexistent at vances in both under trolling the diseases many of them here world's only intern sored center for the ment of diarrhea.

"Ten years ago, we

9/BT/DEC. 83

REPORT OF FINANCE COMMITTEE

December 1, 1983

Report of the Finance Committee

The Committee conducted a review of the financial position and prospects for the Center, and has arrived at a number of recommendations for consideration by the Board. Before reporting them, the Committee wishes first to commend the Center's management and staff for the improved documentation prepared for this meeting. The information put before the Committee, both from the financial management office and from the resource development office, is substantially better, in the Committees view, than ever before - it is clearer, more carefully analyzed, and based on more realistic assumptions. We congratulate those responsible.

1. Expenditures in 1983

The Committee first reviewed the estimated expenditures for the present year as projected to the end of December, 1983. The most important point to be noted is that total expenditures for the year are now estimated at $5.4 million, as contrasted to an approved budget of $6.5 million. Since the estimated income for the year will be approximately $5.4 million, this means that savings achieved by economise and by not filling approved positions have kept expenditures within the limit set by income. The Committee warmly commends this record of prudent management.

Three additional points are worth bringing to the Board's attention

First, while total expenditures were reduced substantially below the budget, management plans to spend the full amount budgeted for Depreciation/Capital Replacement ($275,000). The Committee fully supports this action and the high priority being given to the purchase of new equipment, in accordance with earlier recommendations of the Board and external reviewers.

Second, actual expenditures for international travel are expected to be substantially in excess of the original budget, not because of a deliberate policy decision but because controls were inadequate. The Committee considers that tighter controls are needed, and the Director concurs. Among the steps that will be taken will be (1) to seek to maximize the amount of travel for Center staff that is funded by other organizations, and (2) to conduct regular reviews, at three or four month intervals during the year, of actual as against budgeted travel.

Third, the Committee inquired into the sharp reduction shown in expenditures for supplies and materials below the amount originally budgeted. The Committee was assured that the reduction reflects the elimination of unnecessary stocks and the rationalization of items on hand, and has not significantly hampered the conduct of the Center's research or services.

2. Income for 1983

The Center entered the fiscal year on January 1, 1983, with an overdraft of $760,000. Receipts in the form of contributions and project grants for 1983 seem likely to total about $5.4 million by the end of December. In addition, funds promised to the Center for 1982, but actually received in 1983 totalled $490,000, and a loan to the Center of $1.2 million was made by the Government of Bangladesh from UNROB funds.

On the surface, this combination of income sources will not only cover the expenditures for 1983 ($5,4 million), but alsow allow (1) repayment of the January 1983 overdratf, (2) payment of $200,000 needed to meet the Center's responsibilities for a severance pay account; (3) payment of $300,000 (much less than had been hoped for at the beginning of the year), into the Center's much-needed Reserve Fund; and (4) ending the year with a cash balance of $350,000 - the first time for several years that the Center will have ended a year in the black.

This favorable result, however, is entirely due to the Government of Bangladesh loan of UNROB funds. Without that, 1983 would again end with an overdraft, quite possibly larger than the one a year ago. The Government of Bangladesh loan is at present a one-year, interest-free obligation, repayable in May, 1984.

The first major recommendation of the Committee to the Board, therefore, is that the Center approach the Government of Bangladesh, explain the critical importance of the UNROB funds being available to the Center on a longer-term basis, and request that the Government convert the loan into a grant.

3. Cash Flow

Achieving a steady and reliable cash flow for the Center, once funds have been pledged, has been very difficult - a problem the Center shares with other international organizations such as the international agricultural research centers. There are several reasons. Some donors are simply dilatory (although some, fortunately, are very prompt). Some funds are released to the Center as unrestricted contributions, while others are limited to restricted purposes. Some are paid as advances against which the Center files certificates of expenditure, while others will be paid only as reimbursements after the Center has filed proof of expenditures. These and other differences are made enormously more complex by the great variations among donors in fiscal years and financial procedures.

All this did not make much difference to the Center when it was principally supported by two or three donors. But as the number of separate contributions and grants has grown to over two dozen the problems have become more and more serious, and the Director stated frankly that the staff and procedures of the Center have not, as yet, been sufficiently adapted to the new situation.

The Committee has made no thorough study of the problem, and does not wish to prescribe the necessary steps to meet it. It does to emphasize the seriousness of the matter, and to urge the Director to give high priority to finding solutions.

Among the steps suggested by the Committee, for the consideration of the Director and his colleagues, are the following:

(1) Careful forward monthly projections might be made of the anticipated arrival of funds from each donor/project for an eighteen-month period into the future. Such projections might be updated each six months, and used as the basis of internal planning. As the mores, habits, and idiosyncracies of each donor become better understood, these projections should become more accurate.

(2) Better coordination is needed between the Financial Management office and the Resource Development office. Some of the improvements needed are relatively simple, such as more prompt and assured communication between the two offices, and can be achieved by the proposed assignment of an accountant from the Finance office to the Resource Development office. Other needed improvements will not be achieved so easily, such as the preparation of reports to donors in which scientific and financial data need to be integrated. But, easy or hard, the improvements are essential, because the effectiveness of the Center's continued fund-raising effort is absolutely dependent on a businesslike, up-to-date, accurate reporting system to donors on the use of their funds.

(3) One of the principal uses to which the proposed Reserve Fund would be put would be to bridge over the unevenness of cash receipts. The management of the Fund will be challenged to

find forecasting and control systems that will permit the Fund to be borrowed against during a year, but ensure that the Fund will be fully restored at the end of each year.

(4) A similar stricture applies against the possible use of overdrafts. If essential to maintain staff and services, and if funds are clearly in sight to restore the overdraft before the end of the year, a temporary overdraft may be appropriate. But the resort to overdrafts, because of their high cost, should be extremely limited.

(5) The Board in its December 1982 meeting resolved that new projects should not be started until donors have started the flow of funds to finance them. The resolution may have been worded in an unrealistically sweeping fashion, but the problem it was meant to address is unhappily illustrated by the Saudi Arabian field project, in which the Center has placed in the field a full team of scientists, paid by the Center, before the funds promised by Saudi Arabia to support the project have begun to flow.

(6) Finally, the Committee suggests that the basis for planning the Center's budget be changed, from estimating income on the basis of the fiscal year in which the donor makes a pledge, to estimating income on the basis of when the funds are likely to arrive. This recommendation, if feasible, would mean using for budgeting purposes, the results of the eighteen-month projections of receipts that were suggested above under (1).

4. Income for 1984

The available data from the Center has been used in an attempt to prepare such an eighteen-month projection, donor by donor and project by project, for operating funds exclusive of donor funds earmarked for new capital equipment.

Summary figures are as follows, (beginning with 1983 since estimates of receipts in the remainder of 1983 are a necessary underpinning for forward estimates):

	(in millions of dollars)
Receipts to November	3.8
Expected receipts, December 1983	1.5
1982 funds received in 1983	.5
UNROB loan	1.2
Bank overdraft, January 1, 1983	(.8)
Severance and reserve funds	(.5)
Expenditures in 1983	(5.4)
Estimated year-end balance	.3
Estimated income to be received in 1984	7.1
Total funds available, 1984	7.4
Less: UNROB funds repayable in 1984	(1.2)
Funds available for operations, 1984	6.2

5. Budget for 1984

The Committee was presented with a budget of $7.1 million for 1984. The Committee does not think it prudent to plan such a large budget total. Instead, the Committee recommends a budget limited to $6.2 million, at least until the question of the UNROB loan funds is settled. Even then, if the Government of Bangladesh agrees to convert the loan to a grant, or to extend the loan for a further period on an interest-free basis, the Committee believes that the situation is too precarious to permit substantial expansion of expenditure.

It is also essential to continue the regular seeting aside of funds in the Reserve Fund.

On the expenditure side, to the 1983 level of expenditures ($5.4 million) must be added the normal increments (cost of living plus merit) for existing staff as required under WHO rules. This amount is currently estimated at $617,000. If the budget for 1984 were restricted to $6.2 million, this would clearly leave little room for additional staff. Three important qualification must be added:

(1) The anticipated receipt of $700,000 from CIDA for the new computer has been removed from the income side of the calculations, since this is a capital rather than an operating cost.

(2) No allowance is made in the figures put before us by the Center for personnel deputed to the Center at the expense of others, (the Belgian and French governments, for example, or the CDC).

(3) Finally, it may be possible to raise project (or unrestricted) funds in larger amounts than the estimates shown above.

6. Other Items

a) Overdraft facilities - Management proposes to negotiate an increase in its overdraft limit in Taka to the equivalent of $1,000,000; to negotiate for the elimination of certain conditions AEIBC proposes to attach to the increase; and to require that any use of this increased overdraft limit beyond Taka 10,000,000 be subject to the approval of the Chairman of the Board. The Committee recommends approval of these changes.

b) Tightening of internal credit procedures - Management proposes to reduce the number of authorised signatories for the Center, and to permit only the Director; the Associate Director, Administration and Finance; and the Controller to deal with all bank matters and transactions. The Committee recommends approval of these changes.

c) Staff loan for purchase of household appliance and motor vehicles - In order to correct an error in the Center's application of tax exemption to local international staff, certain household appliances and motor vehicles have to be withdrawn from them. To mitigate the hardship, the Center proposes to establish a staff loan fund of $100,000 to permit importation of appliances and vehicles for affected staff. Loans will bear interest at 12% per annum (the Center's overdraft rate in New York) and total loans plus interest will be repayable over two years. The Committee recommends approval of these arrangements.

d) Formation of a Credit Union - With the establishment of the Center's Staff Retirement Plan from January 1, 1984, the existing Provident Fund will be closed. Management proposes to offer employees the option of converting the balance in the Provident Fund into the capital of a Credit Union. The Committee recommends approval.

10/BT/DEC. 83

PRESENTATION OF BUDGET

BUDGET FOR FY 1984

(Board of Trustees Meeting December 1983)

Enclosed are financial statements for the December 1983 Board meeting.

I. A summary of Operating Budget for FY 1984

II. A summary of Operating Budget for FY 1985

III. A Comparative Statement of 1983 budget and Expenditure and yearwise expenditure

IV. A Manpower Planning of International level positions for FY 1984 (two pages).

V. FY 1984 International Personnel Budget (levelwise) (three pages).

VI. Personnel Services Budget for 1984.
This includes all employees for 1984 in filled, vacant and new positions Due to fund constraint three vacant and all new international positions are deleted.

VII. Position status in FY 1984.

VIII. Programwise allocation of personnel cost and manpower after attribution of Research and Training Support Facilities (RTSF) personnel cost.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

PROPOSED FY 1985 OPERATING BUDGET

(IN US DOLLAR)

Program Code	Description	Person Year	Personnel Services & Benefits 11	Travel & Transportation of persons 21	Transportation of Things 22	Rent, Communication & Utilities 23	Printing & Reproduction 24	Other Contractual Services 25	Supplies & Materials 26	Equipment 40	Total
	RESEARCH PROGRAM	402	2,890,700	111,000	4,100	14,300	14,700	38,600	278,100	32,100	3,383,600
01	Disease Transmission	62	534,100	22,200	600	6,300	3,300	5,500	81,100	8,300	661,400
02	Pathogenesis & Therapy	47	580,800	22,200	600	2,000	900	5,800	46,600	4,000	662,900
03	Host Defense	27	324,300	22,200	1,700	1,700	900	4,600	39,100	11,200	405,700
04	Nutrition	91	507,300	22,200	600	1,400	3,300	11,200	53,800	1,500	601,300
05	Community Services Research	175	944,200	22,200	600	2,900	6,300	11,500	57,500	7,100	1,052,300
06	RESEARCH & TRAINING SUPPORT FACILITIES	241	857,300	10,200	9,400	15,200	10,900	17,300	299,000	199,100	1,418,400
07	TRAINING, EXTENSION & COMMUNICATION	30	250,600	33,700	300	1,700	2,300	13,800	40,100	11,500	354,000
08	MAINTENANCE & LOGISTICS	105	370,800	10,200	7,800	5,800	1,200	8,100	103,400	76,700	584,000
09	MANAGEMENT	123	895,200	76,700	1,300	18,300	600	82,800	61,000	32,400	1,168,300
10	RESOURCES DEVELOPMENT	7	171,500	20,500	2,600	1,700	300	4,000	8,100	3,100	211,800
11	MANDATORY COMMITTEE	-	29,300	97,200	7,600	900	600	5,700	900	-	143,800
12	EMPLOYEE BENEFIT	7	29,800	1,000	600	100	600	13,800	25,900	23,900	95,700
13	PROJECT DEVELOPMENT	223	570,500	66,500	1,400	6,700	17,300	10,400	36,600	5,100	714,500
14	STAFF DEVELOPMENT	-	48,300	14,400	600	600	600	24,100	2,300	-	90,900
	TOTAL:	1,138	6,114,600	441,400	35,700	65,300	49,100	219,600	855,400	383,900	8,165,000

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

OPERATING BUDGET FOR FY 1984

(IN US DOLLAR)

Program Code	Description	Person year	Personnel Services & Benefits 11	Travel & Transp.of persons 21	Transp. of Things 22	Rent Comm.& Util. 23	Printing & Reproduc. 24	Other Cont. Services 25	Supplies & Materials 26	Equipment 40	1984 Total	1983 Projected Expenditure	1985 Projection
	RESEARCH PROGRAM	402	2,513,500	95,500	3,500	12,400	12,900	33,600	241,900	27,900	2,942,200	1,934,340	3,383,600
01	Disease Transmission	62	464,400	19,300	500	5,500	2,900	4,800	70,500	7,200	575,100	487,000	661,400
02	Pathogenesis & Therapy	47	505,000	19,300	500	1,700	800	5,000	40,600	3,500	576,400	384,810	662,900
03	Host Defense	27	282,000	19,300	1,500	1,500	800	4,000	34,000	9,700	352,800	86,500	405,700
04	Nutrition	91	441,100	19,300	500	1,200	2,900	9,800	46,800	1,300	522,900	374,280	601,300
05	Community Services Research	175	821,000	19,300	500	2,500	5,500	10,000	50,000	6,200	915,000	601,750	1,052,300
06	RESEARCH & TRAINING SUPPORT FACILITIES	241	745,500	8,900	8,200	13,200	9,500	15,000	260,000	173,100	1,233,400	1,289,030	1,418,400
07	TRAINING, EXTENSION & COMMUNICATION	30	217,900	29,300	300	1,500	2,000	12,000	35,000	10,000	308,000	264,090	354,000
08	MAINTENANCE & LOGISTICS	105	322,400	8,900	6,800	5,000	1,000	7,000	90,000	66,700	507,800	374,210	584,000
09	MANAGEMENT	123	778,400	66,700	1,100	16,000	500	72,000	53,000	28,200	1,015,900	744,150	1,168,300
10	RESOURCES DEVELOPMENT	7	149,100	17,800	2,200	1,500	300	3,500	7,000	2,800	184,200	153,600	211,800
11	MANDATORY COMMITTEE	-	26,000	84,500	6,600	800	500	5,800	800	-	125,000	118,230	143,800
12	EMPLOYEE BENEFIT	7	29,900	900	500	100	500	12,000	22,500	20,800	83,200	55,740	95,700
13	PROJECT DEVELOPMENT	223	496,100	57,800	1,200	5,800	15,000	9,000	32,000	4,400	621,300	444,620	714,500
14	STAFF DEVELOPMENT	-	42,000	12,500	500	500	500	21,000	2,000	-	79,000	53,990	90,900
	TOTAL 1984	1,138	5,316,800	383,800	30,900	56,800	42,700	190,900	744,200	333,900	7,100,000	-	-
	TOTAL 1983	-	3,833,000	440,000	44,000	62,000	52,000	146,000	580,000	275,000	-	5,432,000	-
	TOTAL 1985	-	6,114,600	441,400	35,700	65,300	49,100	219,600	855,400	383,900	-	-	8,165,000

Amendment - 1

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

COMPARISON OF EXPENDITURE

Program Code	Description	1983 Budget	1983 10 mths Actual + 2 mths Est.	1983 Variance	YEAR WISE FY 80 Jul.1,'79 to June 30,'80	1980 July-Dec.	1981	1982	1983
	PROGRAMME								
01	Disease Transmission	663,300	487,000	176,300	276,934	197,618	423,045	363,927	487,000
02	Pathogenesis & Therapy	426,300	384,810	41,490	122,038	100,221	250,088	354,440	384,810
03	Host Defense	202,500	86,500	116,000	168,976	124,217	283,978	99,206	86,500
04	Nutrition	459,600	374,280	85,320	184,338	111,513	298,586	299,519	374,280
05	Community Services Research	913,400	601,750	311,650	558,561	345,832	822,718	514,880	601,750
06	Research & Training Support Facilities	1,065,800	1,289,030	(223,230)	1,202,465	875,166	1,208,367	892,389	1,289,030
07	Training, Extension & Communication	305,400	264,090	41,310	153,188	132,122	672,139	559,361	264,090
08	Maintenance & Logistics	448,200	374,210	73,990	775,329	329,740	569,709	355,797	374,210
09	Management	1,008,100	744,150	263,950	778,316	512,395	778,894	701,168	744,150
10	Resources Development	201,200	153,600	47,600	46,943	94,292	217,950	150,639	153,600
11	Mandatory Committee	123,200	118,230	4,970	-	-	170,036	100,027	118,230
12	Employee Benefit	66,200	55,740	10,460	-	-	67,781	71,242	55,740
13	Project Development	536,800	444,620	92,180	-	-	-	-	444,620
14	Staff Development	80,000	53,990	26,010	-	-	79,876	40,812	53,990
	TOTAL:	6,500,000	5,432,000	1,068,000	4,267,088	2,823,116	5,843,167	4,503,407	5,432,000
	HEADS OF ACCOUNT								
11	Personnel Services & Benefits	4,684,900	3,833,000	851,900	1,913,786	1,350,770	3,102,688	2,913,339	3,833,000
21	Travel & Transportation of persons	313,300	440,000	(126,700)	281,124	208,286	610,627	275,780	440,000
22	Transportation of Things	64,300	44,000	20,300	131,973	110,796	219,653	149,224	44,000
23	Rent, Communication & Utilities	99,800	62,000	37,800	173,724	125,154	127,190	86,369	62,000
24	Printing & Reproduction	104,800	52,000	52,800	34,306	41,737	53,716	40,373	52,000
25	Other Contractual Services	168,100	146,000	22,100	253,298	200,511	398,375	129,031	146,000
26	Supplies & Materials	789,900	580,000	209,900	467,163	497,868	909,098	754,468	580,000
40	Equipment	374,900	275,000	(100)	1,011,712	287,994	421,820	154,623	275,000
	TOTAL:	6,500,000	5,432,000	1,068,000	4,267,088	2,823,116	5,843,167	4,503,407	5,432,000
	PROJECTED INCOME				3,300,100	3,010,800	4,068,700	6,377,600	7,882,000
	ACTUAL RECEIPTS				4,836,570 1/	1,423,224	4,315,488	4,712,879	9,191,000 2/
	SURPLUS/DEFICIT OF RECEIPTS OVER EXP.				569,482	(1,399,892)	(1,527,679)	209,472	1,759,000

1/ Plus Equipment worth $ 651,752 donated by the NIH

2/ Includes $ 1,673,[illegible] FY 1982 Funds received in 1983 which includes $ 1,186,000 received from UNROB.

MANPOWER PLANNING FOR FY 1984

(Figures in thousand US Dollar)

Job Title/ Position	Person	Lv/ St	Approved Filled	Position Vacant	Others	Forecast of New Positions	Total Cost 1984	MANPOWER DISTRIBUTION: DT	P&T	HD	N	CSR	RTSE	T	DO	A&F	RD
01 DISEASE TRANSMISSION																	
Associate Director		P5/10	-	83.0	-	-	83.0	83.0									
Microbiologist/ Visiting Scientist		P5/10	-	83.0[c]	-	-	83.0	83.0									
Epidemiologist	MU Khan	P4/8	71.0	-	-	-	71.0	71.0									
Microbiologist	MI Huq	P4/5	67.6	-	-	-	67.6	67.6									
Epidemiologist	Clemens	P3/10	-	65.6[a]	-	-	65.6	65.6									
Research Associate		P2/1	-	-	-	48.0	48.0	48.0									
02 PATHOGENESIS & THERAPY																	
Associate Director	Butler		94.0	-	-	-	94.0	-	94.0								
Gastro-Enterologist/ Pediatrician	Molla	p4/7	66.4	-	-	-	66.4	-	66.4								
Clinical Research Physician	Patto	P4/1	64.7[b]	-	-	-	64.7	-	64.7								
Gastro-Enterologist	Speelman	P3/13	73.6	-	-	-	73.6	-	73.6								
Pediatrician	Bennish	P3/1	-	53.8[a]	-	-	53.8	-	53.8								
Pediatrician		P3/1	-	58.0[c]	-	-	58.0	-	58.0								
Research Associate		P2/1	-	-	-	48.0	48.0	-	48.0								
03 HOST DEFENSE																	
Associate Director	Cisnar	P5/1	84.3[c]	-	-	-	84.3	-	-	84.3							
Immunologist		P4/1	-	66.0	-	-	66.0	-	-	66.0							
Clinical Research Physician	Struelens	P1/2	30.2	-	-	-	30.2	-	-	30.2							
Research Associate		P2/1	-	-	-	48.0	48.0	-	-	48.0							
04 NUTRITION																	
Associate Director	Rahaman	P5/10	84.9	-	-	-	84.9	-	-	-	84.9						
Biochemist/ Nutritionist		P1/1	-	34.8	-	-	34.8	-	-	-	34.8						
Nutritionist/ Anthropologist	Rizvi	P3/4	63.2	-	-	-	63.2	-	-	-	63.2						
Research Associate		P2/1	-	-	-	48.0	48.0	-	-	-	48.0						
05 COMMUNITY SERVICES RESEARCH																	
Associate Director		P5/10	-	82.5	-	-	82.5	-	-	-	-	82.5					
Biostatistician	Jojtynia	P4	70.6	-	-	-	70.6	-	-	-	-	70.6					
Epidemiologist	Zielcki	P2	43.2[d]	-	-	-	43.2	-	-	-	-	43.2					
Demographer/ Scientist	Phillips	P4/	64.7	-	-	-	64.7	-	-	-	-	64.7					
Demographer	Choudhury	P4/5	67.7	-	-	-	67.7	-	-	-	-	67.7					
Physician Trainer/ Pediatrician	Stanton	P3/10	-	49.1[a]	-	-	49.1	-	-	-	-	49.1					
Anthropologist		P1/1	-	34.8	-	-	34.8	-	-	-	-	34.8					
Operations Research		P4/1	-	64.8	-	-	64.8	-	-	-	-	64.8					
Health Economist		P3/1	-	-	-	48.0	48.0	-	-	-	-	48.0					
Trainer Physician (Extension)		P3/10	-	-	-	65.6	65.6	-	-	-	-	65.6					
Extension Coordinator		P1/1	-	-	-	37.8	37.8	-	-	-	-	37.8					
Executive Secretary	Saldanha	-	-		14.2	-	14.2	-	-	-	-	14.2					

Cont'd.

Job Title/ Position	Person	Lv/ Stp	Approved Filled	Position Vacant	Others	Forecast of New Positions	Total Cost 1984	MANPOWER DISTRIBUTION DT	P&T	HD	N	CSR	RTSF	T	DO	A&F	RD
06 RESEARCH & TRAINING SUPPORT FACILITIES																	
Computer Analyst		P4/1	-	66.0	-	-	66.0	-	-	-	-	-	66.0				
Computer Manager		P1/1	-	34.8	-	-	34.8	-	-	-	-	-	34.8				
Head, Hospital		P5/1	-	-	-	91.3	91.3	-	-	-	-	-	91.3				
Nurse-Trainer		P1/1	-	-	-	34.8	34.8	-	-	-	-	-	34.8				
Librarian		P1/1	-	34.8	-	-	34.8	-	-	-	-	-	34.8				
Associate Scientist - (Matlab)		P1/1	-	-	-	34.8	34.8	-	-	-	-	-	34.8				
Associate Scientist - Dhaka		P1/1	-	-	-	34.8	34.8	-	-	-	-	-	34.8				
Associate Scientist - Biochemistry		P1/1	-	-	-	34.8	34.8	-	-	-	-	-	34.8				
Associate Scientist - Microbiology		P1/1	-	-	-	34.8	34.8	-	-	-	-	-	34.8				
Associate Scientist - ARB		P1/1	-	-	-	34.8	34.8	-	-	-	-	-	34.8				
07 TRAINING PROGRAM																	
Associate Director	Aziz	P5/10	83.5	-	-	-	83.5	-	-	-	-	-	-	83.5			
Executive Secretary	Tawassa	-	-	-	14.6	-	14.6	-	-	-	-	-	-	14.6			
Training Materials Dev		P3/5	-	-	-	52.6	52.6	-	-	-	-	-	-	52.6			
Research Associate		P2/1	-	-	-	48.0	48.0	-	-	-	-	-	-	48.0			
08-09 ADMINISTRATION & FINANCE																	
Director's Office																	
Director	Greenough	-	150.0	-	-	-	150.0	-	-	-	-	-	-	-	150.0	-	-
Executive Secretary	Chowdhury	-	-	-	18.7	-	18.7	-	-	-	-	-	-	-	18.7	-	-
Internal Auditor		P1/1	-	-	-	34.8	34.8	-	-	-	-	-	-	-	34.8	-	-
Program Coordinator	Koblinsky	P4/1	-	70.6a/	-	-	70.6	-	-	-	-	-	-	-	70.6	-	-
Communications Specialist		P1/1	-	-	-	34.8	34.8	-	-	-	-	-	-	-	34.8	-	-
Associate Director-AF	Goon	D1/7	91.2	-	-	-	91.2	-	-	-	-	-	-	-	-	91.2	-
Admin. Services Officer		P4/1	-	66.0	-	-	66.0	-	-	-	-	-	-	-	-	66.0	-
Personnel Officer		P3/1	-	58.0a/	-	-	58.0	-	-	-	-	-	-	-	-	58.0	-
Controller		P4/1	-	37.8	-	-	37.8	-	-	-	-	-	-	-	-	37.8	-
Supply Officer		P1/1	-	34.8	-	-	34.8	-	-	-	-	-	-	-	-	34.8	-
10 RESOURCES DEVELOPMENT																	
Associate Director	Bashir	D1/6	85.9	-	-	-	85.9	-	-	-	-	-	-	-	-	-	85.9
Development Officer	Smith	P1/3	32.0	-	-	-	32.0	-	-	-	-	-	-	-	-	-	32.0
Total Cost (1984)		$	1,388.7	1,078.2	47.5	813.7f/	3,328.1	418.2	450.5	228.5	230.9	643.0	455.7	198.7	388.9	287.8	117.9
Total Number (1984)		No.	19	19	3	18	59	6	7	4	4	12	10	4	5	3	2
Total Cost (1983)							1,453.6	313.7	265.8	24.3	174.8	264.0	-	91.2	126.7	77.7	115.4
Total Number(1983)							24	4	4	1	2	6	-	2	2	1	2

a/ Incumbents are on board but the positions need approval. b/ In-kind support by French Govt. c/ Will be on board in December 1983
d/ Presently on study leave without pay e/ Approved positions deleted due to fund constraint ($ 70.6). f/ $ 813.7 deleted due to fund constraint.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

1984 INTERNATIONAL PERSONNEL BUDGET

Program Code	Program	Filled		Vacant		New		Total	
		No.	$	No.	$	No.	$	No.	$
01	Disease Transmission	2	138,600	3	231,600	1	48,000	6	418,200
	P6 - P4	2	138,600	2	166,000	-		4	304,600
	P3 - P1		-	1	65,600	1	48,000	2	113,600
	Other		-		-	-			-
02	Pathogenesis & Therapy	4	298,700	2	111,900	1	48,000	7	458,600
	P6 - P4	3	225,100		-	-		3	225,100
	P3 - P1	1	73,600	2	111,900	1	48,000	4	233,500
	Other								
03	Host Defense	2	114,500	1	66,000	1	48,000	4	228,500
	P6 - P4	1	84,300	1	66,000	-		2	150,300
	P3 - P1	1	30,200		-	1	48,000	2	78,200
	Other		-		-	-			-
04	Nutrition	2	148,100	1	34,800	1	48,000	4	230,900
	P6 - P4	1	84,900		-	-		1	84,900
	P3 - P1	1	63,200	1	34,800	1	48,000	3	146,000
	Other		-		-	-			-
05	Community Services Research	5	260,400	3	166,400	3	151,400	11	578,200
	P6 - P4	3	203,000	1	82,500	-		4	285,500
	P3 - P1	1	43,200	2	83,900	3	151,400	6	278,500
	Other	1	14,200		-	-		1	14,200
06	Research & Training Support Facilities		-	3	135,600	8	334,900	11	470,500
	P6 - P4		-	1	66,000	1	91,300	2	157,300
	P3 - P1		-	2	69,000	7	243,600	9	313,200
	Other		-		-	-			-

Program Code	Program	Filled		Vacant		New		Total	
		No.	$	No.	$	No.	$	No.	$
07	**Training**	2	98,100	-		2	100,500	4	198,600
	P6 - P4	1	83,500	-		2	100,500	1	83,500
	P3 - P1	-		-		-		2	100,500
	Other	1	14,600	-		-		1	14,600
08	**Maintenance & Logistics**	-		1	34,800	-		1	34,800
	P6 - P4	-		-		-		-	
	P3 - P1	-		1	34,800	-		1	34,800
	Other	-		-		-		-	
09	Management	3	259,900	4	232,400	1	34,800	8	527,100
	P6 - P4	2	241,200	2	136,600	-		4	377,800
	P3 - P1	-		2	95,800	1	34,800	3	130,600
	Other	1	18,700	-		-		1	18,700
10	Resources Development	2	117,900	-		-		2	117,900
	P6 - P4	1	85,900	-		-		1	85,900
	P3 - P1	1	32,000	-		-		1	32,000
	Other								
11	Mandatory Committee	-		-		-		-	
	P6 - P4	-		-		-		-	
	P3 - P1	-		-		-		-	
	Other	-		-		-		-	
12	Employees Benefit	-		-		-		-	
	P6 - P4	-		-		-		-	
	P3 - P1	-		-		-		-	
	Other	-		-		-		-	

Program Code	Program	Filled		Vacant		New		Total	
		No.	$	No.	$	No.	$	No.	$
13	Project Development	-		1	64,800	-		1	64,800
	P6 - P4	-		1	64,800	-		1	64,800
	P3 - P1	-		-		-		-	
	Other	-		-		-		-	
14	Staff Development	-		-		-		-	
	P6 - P4	-		-		-		-	
	P3 - P1	-		-		-		-	
	Other	-		-		-		-	
	Total	22	1,436,200	19	1,078,300	18	813,600	59	3,328,100
	P6 - P4	14	1,146,500	8	581,900	1	91,300	23	1,819,700
	P3 - P1	5	242,200	11	496,400	17	722,300	33	1,460,900
	Other	3	47,500	-		-		3	47,500
-	Deleted due to fund constraint	-		3	211,600	18	813,600	21	1,025,200
-	P6 - P4	-		2	153,600	1	91,300	3	244,900
	P3 - P1	-		1	58,000	17	722,300	18	780,300
	Other	-		-		-		-	
-	Total (after deletion)	22	1,436,200	16	866,700	-		38	2,302,900
	P6 - P4	14	1,146,500	6	428,300	-		20	1,574,800
	P3 - P1	5	242,200	10	438,400	-		15	680,600
	Other	3	47,500	-		-		3	47,500

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

PERSONNEL SERVICES BUDGET FOR 1984

(IN US DOLLAR)

Prog # Code #	Particulars	INTERNATIONAL				LOCAL				TOTAL					
		Filled	Vacant	New	Total	Filled	Vacant	New	Total	Filled	Vacant	New	Total	Overtime & Others	Grand Total
	RESEARCH PROGRAM	960,300	610,700	343,400	1,914,400	295,100	18,000	50,800	363,900	1,255,400	628,700	294,200	2,278,300	12,400	2,290,700
01	Disease Transmission	138,600	231,600	48,000	418,200	28,000	-	16,300	44,300	166,600	231,600	64,300	462,500	5,100	467,600
02	Pathogenesis & Therapy	298,700	111,900	48,000	458,600	31,500	7,200	4,800	43,300	330,200	119,100	52,800	502,100	1,200	503,300
03	Host Defense	114,500	66,000	48,000	228,500	33,400	2,900	8,600	44,900	147,900	68,900	56,600	273,400	1,000	274,400
04	Nutrition	148,100	34,800	48,000	230,900	151,300	5,500	10,500	167,300	299,400	40,300	58,500	398,200	2,000	400,200
05	Community Services Research	260,400	166,400	151,400	578,200	50,900	2,400	10,600	63,900	311,300	168,800	162,000	642,100	3,100	645,200
06	Research & Training Support Facilities	-	135,600	334,900	470,500	1,276,900	25,800	82,000	1,384,700	1,276,900	161,400	416,900	1,855,200	32,200	1,887,400
07	Training, Extension & Communication	98,100	-	100,500	198,600	89,100	13,400	14,800	117,300	187,200	13,400	115,300	315,900	2,500	318,400
08	Maintenance & Logistics	-	34,800	-	34,800	235,100	5,100	26,600	266,800	235,100	39,900	26,600	301,600	20,800	322,400
09	Management	259,900	232,400	34,800	527,100	252,100	14,700	71,100	337,900	512,000	247,100	105,900	865,000	18,800	883,800
10	Resources Development	117,900	-	-	117,900	23,400	-	7,600	31,000	141,300	-	7,600	148,900	200	149,100
11	Mandatory Committee	-	-	-	-	-	-	-	-	-	-	-	-	26,000 1/	26,000
12	Employee Benefit	-	-	-	-	17,400	2,200	5,700	25,300	17,400	2,200	5,700	25,300	600	25,900
13	Project Development	-	64,800	-	64,800	289,400	40,700	-	330,100	289,400	105,500	-	394,900	1,400	396,300
14	Staff Development	-	-	-	-	-	-	-	-	-	-	-	-	42,000 2/	42,000
	SUB-TOTAL:	1,436,200	1,078,300	813,600	3,328,100	2,478,500	119,900	258,600	2,857,000	3,914,700	1,198,200	1,072,200	6,185,100	156,900	6,342,000
	Deleted due to Fund Constraint	-	211,600	813,600	1,025,200	-	-	-	-	-	211,600	813,600	1,025,200	-	1,025,200
	TOTAL:	1,436,200	866,700	-	2,302,900	2,478,500	119,900	258,600	2,857,000	3,914,700	986,600	258,600	5,159,900	156,900	5,316,800

1/ $26,000 for payment of Honorarium to the Members of the Mandatory Committees, $42,000 for temporary replacement of employees on training abroad and the remaining amount will be used for payment of overtime compensation to the General Services Category employees.

2/ Replacement cost of staff on training.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

POSITION STATUS IN 1984

Program Code	Program	International				Local				Total				Total after deletion
		Filled	Vacant	New	Total	Filled	Vacant	New	Total	Filled	Vacant	New	G. Total	
01	Disease Transmission Program	2	3[c]	1	6	6	-	3	9	8	3	4	15	13
02	Pathogenesis & Therapy Program	4	2[c]	1	7	7	2	1	10	11	4	2	17	15
03	Host Defense Program	2	1	1	4	4	2	1	7	6	3	2	11	10
04	Nutrition Program	2	1	1	4	67	2	2	71	69	3	3	75	74
05	Community Services Research Program	4+1[a]	3	3	10+1	10	1	2	13	14+1	4	5	23+1	21
	Research Program Total	14+1	10	7	31+1	94	7	9	110	108+1	17	16	141+1	133
06	Research & Training Support Facilities	-	3	8	11	541	9	10+5[b]	560+5	541	12	18+5	571+5	568
07	Training, Extension & Communication	1+1[a]	-	2	3+1	21	5	1+1[b]	27+1	22+1	5	3+1	30+2	30
08	Maintenance & Logistics	-	1	-	1	96	2	6	104	96	3	6	105	105
09	Management	2+1[a]	4[c]	1	7+1	98	5	14	117	100+1	9	15	124+1	123
10	Resources Development	2	-		2	3		2	5	5		2	7	7
11	Mandatory Committee	-	-	-	-	-	-	-	-	-	-	-	-	-
12	Employees Benefit	-	-	-	-	5	1	1	7	5	1	1	7	7
13	Project Development	-	1	-	1	145	19	-	164	145	20	-	165	165
14	Staff Development	-	-	-	-	-	-	-	-	-	-	-	-	
	GRAND TOTAL	19+3[b]	19	18	56+3	1003	48	43+6	1094+6	1022+3	67	61+6	1150+9	1138
	Deleted due to fund constraint	-	3	18	21	-	-	-	-	-	3	18	21	-
	Total	19+3	16	-	53+3	1003	48	43+6	1094+6	1022+3	64	43+6	1129+9	1138

a. Secretarial (3) position at International level.
b. Deputed (6) to Saudi Arabia Project.
c. Deleted one position each from three Programmes.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

PROGRAMWISE ATTRIBUTION OF PERSON YEAR FOR 1984

Description	Person year	DT 01	PT 02	HD 03	N 04	CSR 05	PD 13	Sub Total	RTSF 06
International	24	4	5	3	3	8	[illegible]	24	-
Local	274	9	10	7	71	13	164	274	-
	298	13	15	10	74	21	165	298	
Research & Training Support Facility	568	49	32	17	17	154	58	327	241
Total:	866	62	47	27	91	175	223	625	241

PROGRAMWISE PERSONNEL COST FOR 1984

After Attribution of Research & Training Support Facility Personnel Cost

Description	Person year	DT 01	PT 02	HD 03	N 04	CSR 05	PD 13	Sub Total	RTSF 06	Total
		$	$	$	$	$	$	$		$
International	24	287,200	352,600	180,500	182,900	426,800	64,800	1,494,800	-	1,494,800
Local	274	44,300	43,500	44,900	167,300	63,900	330,100	694,000	-	694,000
Sub-Total:	298	331,500	396,100	225,400	350,200	490,700	394,900	2,188,000	-	2,188,000
Research & Training Support Facility	568	132,900	108,900	56,600	90,900	330,300	101,200	820,800	745,500	1,566,300
Total:	866	$ 464,400	505,000	282,000	441,100	821,000	496,100	3,009,600	745,500	3,755,100

12/BT/DEC. 83

REPORT OF THE PERSONNEL SELECTION COMMITTEE

REPORT OF THE PERSONNEL & SELECTION COMMITTEE TO THE BOARD MEETING OF NOVEMBER 30 TO DECEMBER 2, 1983

The Personnel and Selection Committee of the Board of Trustees, ICDDR,B has met twice since the full Board Meeting of 13-15 June, 1983, in New York. There was a meeting in Geneva on 13-14 October, 1983, and one in Dhaka on 29 November, 1983. In the October meeting the progress on a pension plan was reviewed with the Associate Director, Administration and Finance, Mr Michael Goon. The decision was taken that a final report would be submitted to the Board in December. All candidates for advertised positions were reviewed and a short list prepared. It was requested that in presentation to the Board parameters of geography, expertise, age, sex, qualifications and all necessary information to be presented. It was requested that the Director also solicit from all Board members nomination for candidates for the Board of Trustees. The meeting on 29 November reviewed matters raised in October and completed work leading to the recommendations in this report.

I. Recommendation to convert the Severance Pay and Provident Fund into a Pension Plan and a Credit Union.

A retirement or pension plan study has been made and is incorporated into this report as it was presented. The members of the Committee endorse the plan and forward it to the Board for implementation. The Retirement Plan study is as follows:-

../2.

"RETIREMENT PLAN STUDY

1. BACKGROUND INFORMATION

The ICDDR,B adopted WHO pay scales and benefits scheme from January 1, 1983. The WHO has a pension fund for its staff. Staff members contribute 7% of their salary to the fund and WHO contributes 14%. All WHO staff members are eligible to join the United Nations Joint Staff Pension Fund (UNJSPF).

Prior to the date of the conversion to WHO pay scale and benefits scheme, ICDDR,B staff were eligible for terminal payments consisting of severance pay and a provident fund.

1.1 Severance Pay Account

The main feature of this plan is that for each completed year of service, a staff member earns one month's salary. The formula for calculation of separation payments is:

Number of years service x last earned monthly salary

1.2 Provident Fund

Staff members and the Centre each contribute 8.33% to the fund. This fund is allowed to grow in a time deposit and interest earned is credited to each staff member's account. The fund also provides loan facilities to staff members who can borrow money against their own contributions.

1.3 Major Inadequacies in Existing Plans

1.3.1 Severance Pay

- It is difficult to predict ICDDR,B's cost liability. This is so because the Centre is unable to forecast

final salary payments of staff and thus run the risk of not being able to meet the full burden of payments. As a matter of fact the Centre's severance pay account at December 31, 1982 had a deficit of $ 200,000/-

- ICDDR,B does not have capable and qualified investment managers who can examine various portfolio mixes to enable them to earn sufficient income to cover current and projected severance pay liabilities. This investment exercise has never been done at all.

- The severance pay account is not protected. Often times when ICDDR,B experiences cash flow problems, "loans" have been made from this fund in order to provide temporary bridging finance to cover income shortfalls to carry on the Centre's activities. In the event that the Centre should cease operations entirely due to financial or other reasons, then whatever "loans" made from this account would have to be written off at the expense of staff member entitlements.

- Since the account is kept and payable in local currency the net worth of the fund is not protected against inflation and currency devaluations.

1.3.2 Provident Fund

- This fund acts as a credit union by providing loan facilities to staff members. Like the severance pay account the net worth of the fund is not protected from erosion resultant from inflation and currency devaluation.

- Should a staff member leave the Centre with prejudice then he does not receive the Centre's contribution to his account. He is only entitled to his own contribution plus accumulated interest.

2. PLAN PROPOSALS

Basically there are two general types of retirement plans. They are:

(a) a defined benefit plan, whereby the employee's retirement benefit is known precisely, and

(b) a defined contribution plan whereby the employee's retirement benefit amount is uncertain.

The key difference between these two plans is that under a defined benefit plan the employer comits himself to providing a specific benefit, but cannot precisely predict the cost. He has to rely on actuarial estimates. Under this plan he must also assume responsibility for the results of plan asset investments and to make up any inadequacy of assets to pay plan benefits.

Under a defined contribution plan, the ultimate benefit amount is not specified, whereas the employer's cost is defined precisely. The employer's plan liabilities are fully funded at all times.

2.1 The Defined Benefit Plan

As explained above, this type of plan usually refers to a situation where the employer undertakes to provide a certain level of benefit for each staff member. Generally the aim is to link this benefit to salary at retirement or

withdrawal, according to the number of years service the employee has completed. Although employees may well contribute to the Plan the employer remains ultimately responsible for the excess cost as determined by the actuaries from time to time. In reality it is impossible to predict the future and consequently the employer will not be able to fully cover the cash deficits of the fund on a current basis.

2.2 The Defined Contribution Plan

This type of plan would operate as a savings scheme with the employee's and employer's contributions being invested in a fund which accumulates for the benefit of the members. An individual account would be incorporated for each member, his share of the fund being in direct proportion to the contributions made in his name.

The size of each employee's account at retirement is not known and depends upon amounts contributed and the investment performance. The reasons employers select defined contribution plan are:

a) to avoid unknown longterm funding and liability commitments and requirements,

b) to avoid exposure to contingent liability should plan terminate, and

c) that it is simple to administer as no complex actuarial techniques are required.

3. SURVEY CONDUCTED BY THE INSTITUTE OF INTERNATIONAL EDUCATION

When ICDDR,B was unable to gain membership into the UNJSPF, various pension insurance companies were approached to come up with proposals comparable to WHO benefits. The IIE was also requested to seek professional assistance in this matter. Using the services of a consultant, the IIE was able to come up with recommendations after reviewing the various benefits attached to popular Pension Plans currently in existence .. Pension Plans compared were namely:

Defined Benefit Plans	Defined Contribution Plan
UNJSPF	AIRCO
US Plan	TIAA-CRSF
World Bank	
UK Plan	
Dutch Plan	

Comparisons of these plans were made based on the following assumptions that:

a) the final 3 years' salary (in US Dollars) equals 38,095; 40,000 and 42,000. For purposes of comparison on a one-to-one basis, it can be changed to the local taka or any type of currency, and

b) yearly salary progressions were at 5% and investment return at 7% per annum.

For comparative figures please refer to the table attached overleaf.

3.1 Recommendations

From the table of comparisons it will be noted that a defined contribution plan with benefits calculated on a total

accumulation of contribution plus interest would provide an employee with a much higher retirement benefit amount at the time of his retirement than those provided by a defined benefit plan.

Based on a salary progression of 5% per year and a minimal 7% investment return, the final benefits accruing from the AIRCO and the TIAA-CREF are far more superior than that provided by the UN Joint Staff Pension Fund.

For ease of reference, the comparisons are tabulated as follows:

	BENEFIT AMOUNTS PER YEAR			
	10 YEARS SERVICE	15 YEARS SERVICE	25 YEARS SERVICE	35 YEARS SERVICE
UNJSPF	8,006	12,009	20,015	26,020
AIRCO	16,751	26,388	46,289	59,008
TIAA-CREF	17,671	27,839	48,834	62,252

Although TIAA-CREF provides better returns than AIRCO the plan is only available to US citizens and US immigrants. However, the AIRCO plan is available to non-US staff members.

4. PROPOSED PLAN FOR ICDDR,B

In order to provide maximum flexibility to staff members the proposed retirement plan must incorporate the following features:

a) security of the plan,

b) non-forfeitable benefit in the event of termination or cessation of contribution by ICDDR,B,

c) full and immediate vesting, i.e non-forfeitable benefit in the event of termination or resignation from employment,

d) provide protection of benefits from eroding due to inflation or currency devaluation,

e) provide flexibility of benefit payment options, like lump-sum cash settlement, monthly retirement income, part cash and part monthly retirement income and so on,

f) early retirement option.

The study made by the IIE has shown that the defined contribution plan has more to offer in terms of terminal benefit and flexibility than the defined benefit plan. Especially in ICDDR,B the past experience of funds deficit in the severance pay account and the uncertainty of yearly income will rule out any possibility of the ICDDR,B in adopting a defined benefit plan. Moreover the Centre does not have the financial resources nor the expertise to manage such a plan. Fortunately, from the study conducted by IIE the defined contribution plan has been recommended as being much more superior than the defined benefit plan. Having this in mind ICDDR,B started looking for an investment vehicle which could best handle the defined contribution plan.

4.1 Choice of Investment Vehicle

Considerable discussion was made with a number of insurance companies and Banks in the USA, Europe and UK. Proposals were submitted by AIRCO, Van Breda, AEIBC, and Barclays Bank. Based on various proposals and the Centre's association with IIE, American International was recommended as the most appropriate group to meet the requirement for the ICDDR,B staff members. Barclays Bank in UK, although they have their own insurance company also recommended selection of the American International Group as the most appropriate to handle ICDDR,B's flexible pension/features. The American International Group has been recommended for the following important reasons:

a) They have a significant world wide operation with office coverage in Bangladesh itself. This is important because on the spot local representation can be made available at any particular time.

b) To provide protection against benefits erosion, a US dollar contract is available. This is not only a strong currency but also one that is most convenient to ICDDR,B. Contribution's can be made directly from New York in US Dollars, and upon withdrawal by policy holders, the Taka equivalent will be paid to them.

c) Premiums are invested in a tax efficient portfolio. Investment would take place in an off-shore location to take advantage of tax laws. Benefits are normally available tax free in a lump-sum.

d) Contracts enjoy the security of the American Life fund and its guarantees.

e) Present international staff members are also contributing to a retirement plan administered by the American International Group, and

f) They have a better overall investment performance compared to other interested groups.

4.2 Reasons for Choosing an Off Shore Fund

Criteria affecting the choice of a location for an offshore fund are many. Important criteria influencing location selection are:

a) political and economic stability,

b) availability of the desired currency,
c) access to investment media and insurance contracts,
d) freedom for oppressive taxation,
e) reliable communications,
f) good support services

The most popular locations tend to be Bermuda, Jersey, Guernsey or Hongkong and the tax laws of many of these locations enable insurance companies to enjoy a tax status which is more favourable than can be achieved by other investment media.

The IIE and Barclays Bank have both selected Bermuda as an ideal offshore location because of:

a) POLITICAL AND ECONOMIC STABILITY

Bermuda is a self-governing British colony. Its government is democratically elected and is responsible for all relevant business matters. Only defense remains with the power of the Governor. There have been political riots in the past but basically the country is politically and economically stable. The economy is based largely on tourism and international finance. It is particularly a centre for insurance and shipping operations; and has a good reputation for controlling offshore operations. The legal system is based on English common law, with locally enacted legislation.

b) FINANCE AND CURRENCY

An offshore fund in Bermuda can operate and maintain local bank accounts in any currency with virtual freedom from local exchange control. In Bermuda, there is therefore considerable freedom to invest both externally and internally.

c) TAXATION

There is no income tax, corporation tax, capital gain's tax, estate duty or withholding tax in Bermuda. Contributions from staff members and the Centre participating in an offshore fund with dividends received or paid locally and benefit payments do not need therefore to escape local tax.

d) RELIABLE COMMUNICATION

The language is English and both travel and telecommunication facilities are good, particularly to North America and the UK.

e) SUPPORT SERVICES

There are well established legal, accountancy and banking services and a wide variety of investment managers in Bermuda.

The American International Group have their own company in Bermuda.

5. PLAN SELECTION

The present trend of most organizations is to spread their retirement contributions in a mixed portfolio like equity, mutual funds, capital growth funds, income plans etc. Except for fixed or guaranteed income plans, most of these investments are purely speculative in nature and are therefore risky. A pension fund must not have too much exposure to such risks. The most important criteria of a retirement plan is that the income is guaranteed and secure.

This being the main criteria, the AIRCO (American International Group) in USA, American Express International Banking Corporation in New York and UK, Barclays Insurance in UK, and Van Breda in Belgium were approached to present proposals for a retirement fund, based on a defined

contribution plan, and with guarantees of principal and interest. A table of comparisons summarizing various proposals is attached as Annex A.

The Plan which offers the most favourable terms is that of the AIRCO Plan handled through IIE. It offers a higher guaranteed interest rate and lower asset charge although administrative charges is $5/higher per policy holder as compared with Barclays or AIRCO direct. Based on computations for 700 staff members and $1,000,000 initial investment in the fund, the following calculations compares net returns between plan policies held direct with AIRCO and through IIE.

	IIE	DIRECT
Admin. charges/year	$ 14,000	$ 10,500
Asset Charges	$ 3,750	$ 5,000
Initial Charge	-	$ 1,000
Total Cost	$ 17,750	$ 16,500
Guaranteed Interest	$107,500	$105,000
Net Return	$ 89,750	$ 88,500
Net %	8.975%	8.850%

The average guaranteed interest of AIRCO over the 3 years of 1980, 1981 and 1982 has averaged 11.167%. Moreover, the final declared interest over this period has been 13.731% or a net increase of 2.564% over and above the guaranteed interest minimum. Using this average net increase as a guide, the effective interest guaranteed at 10.75% and 10.5% should correspond to 13.314% and 13.064% respectively. The effective yield is therefore 11.537% for plans administered through IIE and 11.414% for plans direct to ICDDR,B. This can be seen as follows:

	IIE	DIRECT
Total interest earnings (13.314%)	$133,140(13.064%)	$130,640
Less Charges	$ 17,750	$ 16,500
Net Earnings after charges	$115,370	$114,140
% Yield	$ 11.537%	11.414%

6. HOW THE DEFINED CONTRIBUTIONS PLAN WORKS

1. An amount of money is set aside every year for each employee participating in the plan. This allocation will consist of a combination of contributions from the ICDDR,B and the staff members. The present contribution rate is 14% by ICDDR,B and 7% by staff members.

2. An account is maintained for each staff member in which is allocation will accumulate until death, termination or retirement.

3. The amount of benefit available to a staff member will depend on the length of time he has been under the Plan, the level of net contribution paid and the investment performance of the fund.

4. Upon retirement, a staff member is entitled to take the accumulated value of his account in the form of cash, convert it to an annuity, or take a combination of part cash and part annuity.

5. All final payments are subject to currency conversion laws of the country and for this particular purpose, payments from the fund will be made in Bangladesh Taka.

6. The Insurance Company guarantees a minimum rate of interest on deposits in the Fund each year, and as the Insurers earns excess interest, such interest will be credited to the fund. In no event, will the accumulated value of the fund be less than that guaranteed on each deposit received.

7. PROPOSED PLAN SPECIFICATIONS

1. **Eligibility:** All full-time staff members with a minimum of one year's contract are eligible for entry into the plan

2. **Exclusions:** The plan is not extended to the following categories of employees:
   a) Community Health Workers.
   b) Temporary part time or casual workers.
   c) Staff members who are not governed under rules for the GS, STM or P-level scales.

3. **Normal Retirement Age:** The normal retirement age will be the 60th birthday.

4. **Early Retirement Age:** With the consent of the ICDDR,B, a participant may advance the retirement date.

5. **Contribution:** Participants will be required to continue 7% of their salary to the Plan. The ICDDR,B will contribute on behalf of each participant at the rate of 14% of each participant's salary.

6. **Benefits:** At retirement, or upon leaving the service at ICDDR,B a participant will receive the full sum of his contributions, the Centre's contribution plus accumulations of all interests and earnings to his individual account.

   A participant is entitled to take the accumulated value of his account in the form of cash, convert it to an annuity or take a combination of part cash and part annuity. All benefits at retirement are paid in the equivalent of the Bangladesh Taka.

7. Operational Retirements Benefit Forms:

Participants will also be entitled to elect one of the following optional forms of retirement benefits, provided that such election is made at least 2 years prior to retirement date.

a) Life Annuity with Ten Year Certain Period

This form of annuity provides for monthly payments to be made to an annuitant during his lifetime and in the event of his death before 120 monthly payments have been made for him, payments shall continue to the designated beneficiary until such 120 payments have been made.

b) Contingent Annuitant

This form of annuity provides for monthly payments to be made to an annuitant during his lifetime. After the death of the Annuitant, 1/2, 2/3 or any portion agreed upon shall continue to the designated contingent annuitant, if surviving, who shall receive monthly payments commencing one month after the date of the last payment to the annuitant and continuing during the contingent annuitant's further lifetime."

Annexe A

SUMMARY OF VARIOUS PROPOSALS OFFERED AND THEIR FEATURES

	VAN BREDA	BARCLAYS	AEIBC	AIRCO Direct / Separate Plan	AIRCO Via IIE Plan
1. Guaranteed Principal	N/A	Yes	Yes	Yes	Yes
2. Guaranteed Interest	Yes	Yes	Yes	Yes	Yes
3. Guaranteed Annuity Purchase Rates	Yes	During 1st 5 yrs of policy.	N/A	During 1st 5 yrs of policy.	During 1st 5 yrs of policy.
4. Guaranteed Reitrement Income	N/A	After purchase of annuity.	N/A	After purchase of annuity.	After purchase of annuity.
5. Annual Financial Statements	Yes	Yes	Thru' a hired insurance company.	Yes	Yes
6. Complete Recording and Administration	Yes	Yes	-do-	Yes	Yes
7. Employee Benefit Certificate	Yes	Yes	-do-	Yes	Yes
8. Administration Charges					
First Year	$ 750	$ 1,000	0.5%	$ 1,000	Nil
Renewal	-	$ 500	0.5%	$ 500	Nil
Per Employee	$ 17.50	$ 15	N/A	$ 15	$ 20
9. Asset Charges	0.3%	0.5%	Nil	0.5%	0.375%
10. Plan Termination Charges					
1 year or less	4%	5%	Nil	N/A	N/A
2	4%	4%	Nil	N/A	N/A
3	4%	3%	Nil	N/A	N/A
4	4%	2%	Nil	N/A	N/A
5	4%	1%	Nil	N/A	N/A
6	0	0	Nil	N/A	N/A
11. Guarantee Charge	-	-	0.25%	-	-
12. Interest Guaranteed	4%	10.5%	10%	10.5%	10.75%
13. Minimum Interest kept by Insurers	$ 2,500	Nil	Nil	Nil	Nil

MFLC:

PROJECTED NORMAL RETIREMENT BENEFITS WITH VARYING YEARS OF SERVICE

TYPES OF PLAN	NORMAL BENEFIT FORMULA	NUMBER OF YEARS SERVICE							
		10 YEARS SERVICE		15 YEARS SERVICE		25 YEARS SERVICE		35 YEARS SERVICE	
		Benefit Amount Per Year	% of Final Pay	Benefit Amount Per Year	% of Final Pay	Benefit Amount Per Year	% of Final Pay	Benefit Amount Per Year	% of Final Pay
UN Plan	2% x 40,031 x No of yrs service	8,006	19.0%	12,009	28.6%	20,015	47.6%	26,020	61.9%
US Plan	2% x 40,031 x No of yrs service	8,006	19.0%	12,009	28.6%	20,015	47.6%	28,022	66.7%
World Bank	2% x 40,031 x No of yrs service	8,006	19.0%	12,009	28.6%	20,015	47.6%	28,022	66.7%
UK Plan	1.25% x 42,000 x No of yrs service	(15,750 one time payment) 5,250	16.2%	(23,625 one time payment) 7,875	24.4%	(39,375 one time payment) 13,125	40.6%	(55,125 one time payment) 18,375	56.9%
Dutch Plan	1.75% x 41,000 x yrs service 2% x 4,741 x yrs service	6,227	14.8%	9,340	22.2%	15,567	37.1%	21,793	51.9%
TIAA-CREF*	Total accumualtion of contribution plus interest	10,561	25.1%	16,637	39.6%	29,184	69.5%	37,203	88.6%
AIRCO*	Total accumulation of contribution plus interest	10,561	25.1%	16,637	39.6%	29,184	69.5%	37,203	88.6%
TIAA-CREF**	Total accumulation of contribution plus interest	17,672	42.1%	27,839	66.3%	48,834	116.3%	62,252	148.2%
AIRCO**	Total accumulation of contribution plus interests	16,751	39.9%	26,388	62.8%	46,289	110.2%	59,008	140.5%

* Based on total contributions of 12.55% of payroll for TIAA-CREF and 13.24% for AIRCO.

** Based on total contributions of 21% (7% from employee and 14% from employer)

ASSUMPTIONS:

1) Final 3 years salary equals 38,095; 40,000; 42,000

2) 5% salary progression and 7% investment return.

MFLC:lfb

Since the Provident Fund has provided valuable loan facilities it is recommended that this be modified to form a credit union. The recommendations in this regard are as follows:

"FORMATION OF A CREDIT UNION

Staff members had previously been enjoying loan facilities from their deposits in the Provident Fund Account. With the establishment of the Retirement Plan on January 1, 1984, the Provident Fund will cease to operate. Present deposits are being held in a local bank in Takas. It is recommended that the following actions be taken:

1) The provident fund deposits be converted to a time deposit in US Dollars, to prevent erosion in real terms and this deposit be made to earn the highest interest rates.

2) Against this deposit to be used as collateral, the bank be asked to extend an overdraft facility up to 1/3 the value of the deposits in Taka.

3) The overdraft facility be used as a "credit/loan facility for participants of the previous Provident Fund" and the Centre will administer loan facilities from this account.

4) Payments to the loans will be deducted from salary payments and repaid into the overdraft facility.

5) The terms and conditions for administration of loan facilities will be the same as presently provided in the rules governing loans in the Provident Fund Account.

II. Administrative Manual for Implementing the new ICDDR,B Staff Regulations and Staff Rules.

A full ICDDR,B Administrative Manual has been completed and covers the entire operational needs of the Centre and the relationships to WHO staff rules. Salient points are:

1. The proposed ICDDR,B Manual relating to personnel matters which has been prepared to the extent applicable to ICDDR,B on the basis of the WHO Manual is available to all Board Members at this time to review.

2. This Manual elaborates on the provisions of the ICDDR,B Staff Regulations and Staff Rules adopted by the Board of Trustees.

3. This manual is presented as follows:
   - an introduction;
   - a General Index; and
   - 17 sections covering the various fields of Personnel Management.

4. This Manual is intended to be a single unified source of information and gives the principles of application and implementation of the Regulations and Rules. As and when required changes can periodically be introduced in the Manual in order to keep it up-to-date as a practical tool for the management of all fields of ICDDR,B personnel policies.

5. It is submitted to the Board for its consideration and possible adoption. Its adoption is recommended by this Committee.

Two important areas of the Manual are called to the attention of the Board. One in respect to salaries of Extended Level staff as follows:

"EVOLUTION OF SALARIES IN THE SCIENTIFIC, TRAINING AND MANAGEMENT CATEGORY LEVEL STAFF (STM GRADES I, II, & III)

1. Since the Board approved the establishment of the locally recruited Scientific, Training, and Management category of Staff, the locally recruited staff in the various United Nations Agencies, including WHO has been granted a salary increase.

2. This increase was approved by the Board in June 1983 meeting to be implemented retroactively on 1 January 1983.

3. The salary scale of the STM category staff being higher than any of the National officers or the extended level category salaries in the UN agencies in Dhaka, was granted

   A lower percentage increase as the General Service level category (35%-38%).

   Plus a non-pensionable across the board additional allowance of Takas 13,500 per year (Board of Trustees' General Resolution 7 June 1983) as per Resolution 22 December 1982.

4. After the increase on 1 January 1983 the salary scale of the STM level category is still higher than the salaries of the National officers level or extended levels in the UN salary system.

5. As a general principle the salary received by a staff member is, except in case of down-grading, considered as an acquired right of staff members.

6. Therefore, it is considered that in order to progressively bring the STM category level into line with the United Nations salary system, in accordance with the wish expressed repeatedly by the Board of Trustees and also not to penalize unduly the STM staff, the following principles would help to reach this goal. They have been embodied in the ICDDR,B Manual (Section 10 paragraph 100). They are submitted to the Board of Trustees under this item in view of their importance.

7. Paragraph 100 of Section 10 ("General Service and Scientific, Training and Management Staff") reads as follows:

   "The STM category of staff salary schedule is not yet part of the United Nations Agency salary schedule and has been initially established by a decision of the Board of Trustees. When salary scheduled for locally recruited GS staff are reviewed, (see paragraph 80 above), the actual salary scale of the STM staff is also increased by an ad hoc percentage decided upon by the Board of Trustees. Such adhoc increases will necessarily continue until

such time as the STM category scale will eventually be equal to or lower than the U.N. National Officers scale at which time, in accordance with previous directives of the Board of Trustees, the STM category staff shall have the same salary scale, benefits, and the conditions as established for National Officers, (see also Staff Rule 330.2)."

(Staff Rule 330.2 mentioned in paragraph 100 above gives the STM level category salary scale.)

(ICDDR,B Manual Section 10 paragraph 80 mentioned in paragraph 100 above reads as follows: "Salary schedules for GS staff are amended from time to time following a survey of local conditions of employment, made in Dhaka by Unicef, acting as the "designated agency" for all United Nations' GS staff. Amendments result mainly from the change in prevailing local wage levels. Where such changes in the salary schedule are approved by the United Nations system and the date of its implementation fixed, the change becomes also applicable to the Centre's staff concerned as from the same date, subject however, to the approval of the Board of Trustees."

8. It is thought that this devise will eventually bring forth a satisfactory solution for all concerned and therefore, the above is submitted to the Board of Trustees for their consideration and possible approval."

And one concerning Contractual Service Agreements as follows:

"CONTRACTUAL SERVICE AGREEMENT

1. The attention of the Board of Trustees is drawn to Section 12 (Consultants) paragraph 430 to 500 of the ICDDR,B Manual (separately submitted to the Board of Trustees' consideration).

2. Paragraphs 430 to 500 examines the provision of a special type of contract which is utilized inter alia by WHO and which has appreciable advantages for certain specific types of assignments.

3. This advantages are the following:

   3.1 The work can be performed by one or several persons as a team and still require one contract only;

   3.2 the time limits are clearly defined in the contract;

   3.3 there is normally no need for the "contractual expert" to be present at the ICDDR,B (at least permanently); and

3.4 therefore there is no per diem to be paid (and if "contractual expert" does not need to come to ICDDR,B, no travel cost is to be paid);

3.5 the ICDDR,B has no civil responsibility for illness, accident, etc., and premimums to pay;

3.6 the "contractual expert" is in no way a staff member and can claim in no circumstance to be ruled by the ICDDR,B Rules and Regulations;

3.7 there is no need forsupervision but only for evaluation (possibly periodic evaluation as the work advances);

3.8 in all cases the frame prepared by ICDDR,B shall allow a clear-cut, well defined delivery of the work required, thus simplifying the task of the "contractual expert" and well as, on receipt of the work, of the ICDDR,B.

3.9 The cost of the entire work will be clearly defined, as should be, in two types of contractual service agreements:

3.9.1 Those costing less than $10,000 for which as in WHO, the Director would have the authority to approve;

3.9.2 those costing more than $10,000 for which the approval of the Board of Trustees is required.

Thus any contractual service agreements will guarantee that the overall cost will at all times remain at the originally budgeted level.

The above item is submitted to the Board of Trustees for its consideration and possible approval.

Changes in ICDDR,B Staff Regulations are called to the attention of the Board and are listed and charted.

No. of Regulation or Rule	Title of Regulation and Rule
Staff Rule 310.5	Definitions (International level staff)
" " 330.2	Salaries (Scientific, Training and Management level staff)
" " 330.3	Salaries (General Service level staff)
" " 340.1	Dependents Allowance
" " 350.3.1	Education Grant
" " 360.2	Assignment Allowance
" " 365.3	Installation Allowance (Lump-sum element)
" " 373	Severance Payment and Provident Fund Payment
Staff Regulation 4.5	Appointments and Promotion
Staff Rule 470.1	Re-employment
" " 610.2	Working Hours and Attendance
" " 610.5	Working Hours and Attendance
" " 625	Overtime and Compensatory Leave
" " 630.4	Annual Leave
" " 640.2.2	Home Leave
" " 640.5	Home Leave
" " 645	Leave Abroad
" " 660	Approval and Reporting of Leave
" " 710	Pension Fund
" " 740.1.3	Sick Leave
" " 810.2.3.2	Travel of Staff Members
" " 820.2.4.3	Travel of spouse and children
" " 1010.3	Resignation
" " 1030.3.4	Termination of Reasons of Health
" " 1010.4	Staff in Posts Subject to Local Recruitment
" " 1030.2.3	Termination for Reasons of Health
" " 1030.3.2	Termination for Reasons of Health

CHANGES IN THE ICDDR,B STAFF REGULATIONS AND STAFF RULES SUBMITTED FOR CONSIDERATION TO THE BOARD OF TRUSTEES

Regulation or Rule No.	Regulation or Rule Title	Present text	Proposed text	Justification of the change
S.R. 310.5	Definitions	"International level staff"	"International level staff", for determining entitlements under the Rules, are all professional staff appointed by the ICDDR,B	Introduction of definition as approved by the Board.
S.R. 330.2	Salaries		Insertion of salary scale for "Scientific, Training and Management level staff."	As per Board of Trustees Resolution 22/Dec. 82 and General Resolution 7/June 83.
S.R. 330.3	Salaries		Insertion of salary scale for "General Service level staff."	As the Board of Trustees Resolution 22/Dec. 82.
S.R. 340.1	Dependants Allowance	US$450 per annum for a child..	US$700 per annum for a child..	This figure has been changed in the WHO Staff Rule of 1983 and should be authorized by Board of Trustees to keep in line with WHO Rules.
S.R. 350.3.1	Education Grant	The education grant shall not be paid 350.3.1 when the staff member is assigned to the country of his recognized place of residence;	Deleted	As per Board of Trustees Resolution 21/Dec. 82. - Following this deletion SR350.3.2 becomes 350.3.1 SR350.3.3 " 350.3.2 SR350.3.4 " 350.3.3

Regulation or Rule No.	Regulation or Rule Title	Present text	Proposed text	Justification of the change
S.R. 360.2	Assignment allowance	The annual rates of this allowance are: Grade: Staff without dependants as defined in Rule 310.6.1 & 310.6.2 / Staff with dependants as defined Rule 310.6.1 & 310.6.2 P4 & below: US$1600 / US$2000 US$1900 / US$2400	The annual rates of this allowance are: Grade: Staff without dependants as defined in Rule 310.6.1 & 310.6.2 / Staff with dependants as defined Rule 310.6.1 & 310.6.2 P4 & below: US$2400 / US$3000 US$2850 / US$3600	These figures have been changed in the WHO Staff Rules of 1983 and should be authorized by the Board of Trustees to keep in line with WHO Rules.
S.R. 365.3 (3rd & 4th lines)	Installation payment (lump sum element)	...The amount of the lump-sum is US$300 for a staff member and US$300 for each family member...	..The amount of the lump-sum is US$600 for a staff member and US$600 for each family member...	These figures have been changed in the WHO Staff Rules of 1983 and should be authorized by the Board of Trustees to keep in line with WHO Rules.
S.R. 373	Severance payment and Provident Fund payment	373. SEVERANCE PAYMENT AND PROVIDENT FUND PAYMENT 373.1 A staff member in the scientific or administrative officers or in the general staff category, who on leaving the service of the ICDDR,B other than by summary dismissal under Rule 1075, has performed at least one year of continuous service shall be entitled to: 373.1.1 a severance payment corresponding to one monthly last net base salary for each year's of service in the ICDDR,B and 2½ days for each additional month service.	Deleted	This Staff Rule is to be deleted because of the replacement of Severance Pay and Provident Fund. Staff Rule 710 providing that staff member appointed for one year or more are participants in the Staff Pension Plan takes full effect.

Regulation or Rule No	Regulation or Rule Title	Present text	Proposed text	Justification of the change
S.R 373 (contd.)		373.1.2 a provident fund payment to which both the staff member and the ICDDR,B contribute equally, corresponding to his and the ICDDR,B's contribution to the Fund including interest earned.		
S.R. 4.5	Appointment and Promotion	Appointment of the Director of the ICDDR,B and of Programmes Directors shall be for a period not to exceed five years, subject to renewal. Other staff members shall be granted either permanent or temporary appointments, under such terms and conditions consistent with these regulations as the Board of Trustees may prescribe.	Appointments of the Director of ICDDR,B is governed by the Ordinance of the Centre. Appointment of Associate Director are an administrative assignment of existing staff under the authority of the Director. All professional staff except the Director shall be eligible for contracts of a duration of two to three years, subject to the approval of the Board of Trustees. Other staff members shall be granted either temporary or permanent contracts under such terms and conditions consistent with these regulations as the Board of Trustees may prescribe.	As per Board of Turstees' Resolution 9/June '83.
S.R 470.1 (1st sentence)	Re-employment	A staff member other than one referred to in Rules 1320 and 1330, who is re-employed within one year of the termination of his appointment may at the option of the ICDDR,B be reinstated.	A staff member other than one referred to in Rules 1320 and 1330, who is re-employed within 3 years of the termination of his appointment may at the option of the ICDDR,B be reinstated.	When a staff member leaves the ICDDR,B he receives his final emoluments. At the time he is at the option of the ICDDR,B re-employment he must reimburse his final emoluments (which is an asset for the pension plan and for the re-instated staff member himself), until now this was limited to 1 year.

Regulation or Rule No.	Regulation or Rule Title	Present text	Proposed text	Justification of the change
S.R. 470.1 (continued)				To extend it to 3 years is in the interest of both the ICDDR,B and the re-employed staff member.
S.R. 610.2	Working hours and attendance	Saturday and Sunday shall not normally be a work day.	Friday and Saturday shall not normally be a work day.	Non-working days both generally been changed in Bangladesh.
S.R. 610.5	Working Hours and attendance	Not existing	No salary shall be paid to staff members in respect of periods of unauthorized absence from work unless such absence was due to reasons beyond their control.	New Staff Rules introduced by WHO in 1983 in order to fight Absenteeism.
S.R. 625	Overtime and compensatory leave	When authorized by the appropriate supervisor non-supervisory staff below general service grade IV may be receiving, subject to procedures established by the Director monetary compensation or compensatory leave.	When authorized by the appropriate Programme Head general service staff may be receiving, subject to procedures established by the Director and subject to availability of funds, monetary compensation or compensatory leave.	When the Staff Rules of ICDDR,B were established the provisions of this Rule had been made very restrictive in order to save funds. At present it is possible to relax the Rule and fall in line with the WHO Rules.
S.R. 630.4	Annual leave	Annual leave shall be completed in units of hours	Annual leave shall be completed in units of days and half days.	To fall in line with WHO Rules and simplify the computation of annual leave.

Regulation or Rule No.	Regulation or Rule Title	Present text	Proposed text	Justification of the change
S.R. 640.2.2	Home leave	A staff member is eligible for home leave when: His service is expected to continue at least six months beyond the date of return from home leave or six months beyond the date of eligibility...	A staff member is eligible for home leave when: His service is expected to continue at least 4½ months beyond the date of return from home leave or 4½ months beyond the date of eligibility..	A period of 24 months of service was previously required by the WHO Rules for eligibility for Home leave. Home leave could be taken in exceptional cases after 12 months and normally six months earlier or 6 months later than the date of eligibility. At present for "difficult" duty stations eligibility for home leave is 18 months. Therefore the different provisions indicated above are to be reduced by ¼ i.e., 18 months, 9 months, 4½ months respectively.
S.R. 640.5	Home leave	Home leave may be granted at any time during the six months prior to, or following, the date of eligibility.	Home leave may be granted at any time during the 4½ months prior to, or following, the date of eligibility.	Same reasons and same comments as under 640.2.2.
S.R. 645	Leave Abroad	Staff members of international level category, with place of residence in Bangladesh, presently employed by the ICDDR,B will be entitled during the period of their stay in the ICDDR,B for themselves, their spouse, and their eligible dependents, to leave abroad at periods fixed by the Director. The ICDDR,B shall pay the return travel expneses to a place designated by the Director. The staff member may go to any other place provided the cost to ICDDR,B does not exceed that for the (continued)	Deleted	This was a provisional Rule. It is not existing in WHO and is not justified anymore, especially because of the full implementation of WHO Rules.

Regulation or Rule No.	Regulation or Rule Title	Present text	Proposed text	Justification of the change
S.R. 645 (continued)		return travel to the place designated by the Director. Rule 640.2.2, 640.5, 640.6, 640.7 and 640.8 for home leave will apply. Staff members in this situation appointed in the future shall not be entitled to payments under this Rule which will be cancelled whenever the last staff member benefiting from it shall leave the ICDDR,B.		
S.R. 660 (3rd line)	Approval and Reporting of Leave	The granting of leave under Rules 625, 630, 640, 650 abd 655 is subject to the exigencies of the service and must be approved in advance by authorized officials.	The granting of leave under Rules 625, 630, 640, 650 and 655 is subject to the exigencies of the service and must be approved in advance by authorized officials as provided under Staff Rule 610.5.	Added to complete this Staff Rule in the light of the provisions of new Staff Rule 610.5 (see above).
S.R. 710	Staff Pension Plan	710. STAFF PENSION PLAN, SEVERANCE PAY AND PROVIDENT FUND Staff members of the professional level category upon appointment for one year or more, shall be participants in the Staff Pension Plan subject to the provisions of this plan. Staff members of the general service and the scientific or administrative officers categories upon appointment for one year or more shall be entitled to severance pay and provident fund benefits in conformity with the provisions established by the Director.	710. STAFF PENSION PLAN All staff members appointed for one year or more shall be participants in the Staff Pension Plan subject to the provision of this plan.	The title of Staff Rule 710 has been shortened as Severance Pay and Provident Fund are replaced by Pension Plan for All staff of ICDDR,B.

Regulation or Rule No.	Regulation or Rule Title	Present text	Proposed text	Justification of the change
S.R. 740.1.3 (3rd line)	Sick leave	...under the organizations' disability policy...	...under the ICDDR,B's disability policy...	Editorial change, the word "Organization" had been inadvertently left in.
S.R. 810.2.3.2	Travel of staff members	(The ICDDR,B shall pay the travel expenses..for internationally recruited staff...on an assignment of at least two years duration...provided that:) 810.2.3.2 his assignment is to continue for at least six months after his return.	(The ICDDR,B shall pay the travel expenses...for internationally recruited staff... on an assignment of at least two years duration...provided that:) 810.2.3.2 his assignment is to continue for at least 4½ months after his return.	Change for same reasons and with same comments as under 640.2.2.
S.R. 820.2.4.2	Travel of spouse and children	...the ICDDR,B shall pay the travel of an internationally recruited staff members.. dependant children..under the following circumstances: ..for a child for whom there is an entitlement to an education grant under Rule 350 provided Rule 655.2.4 does not apply. 820.2.4.3 return travel on home leave between the place of study and the staff member's recognized place of residence.	...the ICDDR,B shall pay the travel of an internationally recruited staff members.. dependant children..under the following circumstances: ..for a child for whom there is an entitlement to an education grant under Rule 350 provided Rule 655.2.4 does not apply. 820.2.4.3 return travel on home leave between the place of study and the place to which the staff member is authorized to travel under Staff Rule 640.3...	Based on Staff Rules 640.3 where the staff member has the option for home leave to travel to his "recognized place of residence, or elsewhere provided there is no greater expense to the ICDDR,B." This choice was already being implemented. Additionally, this brings the ICDDR,B's Rule in line with WHO's.
S.R. 1010.3	Resignation	An internationally recruited staff member resigning within six months from the date of return from home leave....	An internationally recruited staff member resigning within 4½ months from the date of return from home leave.....	Change for same reasons and with same comments as per Staff Rule 640.2.2.

Regulation or Rule No.	Regulation or Rule Title	Present text	Proposed text	Justification of the change
S.R. 1030.3.4	Termination for Reasons of Health.	A staff member whose appointment is terminated under this Rule (Termination for Reasons of Health) shall receive a termination payment at the rates set out in Rule 1050.4 (indemnity payable in case of Abolition of Post) provided that the total payment in Rules 1030.33 (disability payment) and 1050.4 due in the 12 months following termination are not more than one year's salary.	A staff member whose appointment is terminated under this Rule (Termination for Reasons of Health) shall receive a termination payment at the rates set out in Rule 1050.4 (indemnity payable in case of Abolition of Post) provided that the total amount due under this Rule together with any periodic diability benefits due in the 12 months following termination and payable by virtue of the provisions of Section 7 of these Rules shall not exceed one years' salary.	Change introduced in order to elaborate the Rule and give a more complete definition. This will avoid future possible complications in case of termination for Reasons of Health.
S.R. 1310.4	Staff in Posts Subject to Local Recruitment	Not included	Persons whom it is necessary to recruit outside the local area for such posts because qualified candidates are not available locally, shall be appointed under the conditions of employment established for persons locally recruited. In addition, any such staff member whose recognized place of residence is determined to be outside the country of duty station may be granted an annual non-resident's allowance and any such other entitlements as required to meet extra costs of non-resident status.	This Rule is introduced to bring the Rule into line with WHO's Staff Rules. It is well understood to be utilized only in absolutely exceptional cases.
S.R. 1310.4 S.R. 1310.5		No editorial change	No editorial change	Change in numbering: S.R.1310.4 to become 1310.5 S.R.1310.5 " " 1310.6

Regulation or Rule No.	Regulation or Rule Title	Present text	Proposed text	Justification of the change
S.R. 1030.2.3	Termination for Reasons of Health	Prior to such termination the following conditions must be fulfilled: 1030.2.3 participants of professional level category in the pension plan shall have their pension rights determined.	Prior to such termination the following conditions must be fulfilled: 1030.2.3 participants <u>of all level categories</u> in the pension plan shall have their pension rights determined.	Changes result from the fact that the provisions made for all staff to benefit from a Pension Plan.
S.R. 1030.3.2	Termination of Reasons of Health	A staff member whose appointment is terminated under this Rule: 1030.3.2. professional category staff may be entitled to a disability benefit under insurance cover.	A staff member whose appointment is terminated under this Rule: 1030.3.2 <u>all categories of of staff</u> may be entitled to a disability benefit under insurance cover.	Same as under Staff Rule 1030.2.3 above.

III. Manpower Plan and Selection of New Staff

The manpower plan as presented in the new budget and the prioritization of vacant new positions was reviewed. The priority listing presented at the June meeting remains unchanged except for the deletion of a position entitled "Programme Coordinator". The Director was requested to prioritize all vacant positions for the information of the Board (priority list on next page).

There was a discussion on the request of the Director to be given authority to interchange vacant positions according to recruiting needs. This was agreed. The Director should inform the Board of any shifts in the priority listing.

The Personnel and Selection Committee also requested to be informed of any consultants extended beyond six months. In respect of Consultants, WHO staff rules will be strictly followed as per the Administrative Manual.

Priority	Job Title/ Position / Person	Lv/Stp	Approved Filled	Position Vacant	Others	Forecast of new position	Total cost 1984	MANPOWER DISTRIBUTION									
								DT	P&T	HD	N	CSR	RTSF	T	DO	A&P	RD
	DISEASE TRANSMISSION																
1	Senior Scientist	P5/10	-	83.0	-	-	83.0	83.0									
	COMMUNITY SERVICES RESEARCH																
2	Senior Scientist	P5/10	-	82.5			82.5	-	-	-	-	82.5					
	DISEASE TRANSMISSION																
3	Microbiologist/ Visiting Scientist	P5/10	-	83.0 [c/]	-	-	83.0	83.0									
4	Epidemiologist	P3/10	-	65.6 [a/]	-	-	65.6	65.6									
	COMMUNITY SERVICES RESEARCH																
5	Physician Trainer/ Pediatrician	P3/10	-	49.1 [a/]		-	49.1	-	-	-	-	49.1					
	ADMINISTRATION & FINANCE																
6	Personnel Officer	P3/1	-	58.0 [a/]	-	-	58.0		-	-	-	-	-	-	-	58.0	
7	Controller	P1/1	-	37.8	-	-	37.8	-	-	-	-	-	-	-	-	37.8	
8	Supply Officer	P1/1	-	34.8	-	-	34.8	-	-	-	-	-	-	-	-	34.8	
	RESOURCES DEVELOPMENT																
9	Development Officer	P1/3	32.0	-	-	-	32.0	-	-	-	-	-	-	-	-	-	32.0
	ADMINISTRATION & FINANCE																
10	Admin. Services Officer	P4/1	-	66.0	-	-	66.0	-	-	-	-	-	-	-	-	66.0	
	COMMUNITY SERVICES RESEARCH																
11	Operations Research	P4/1	-	64.8	-	-	64.8	-	-	-	-	64.8					
12	Communications Specialist	P1/1	-	-	-	34.8	34.8	-	-	-	-	-	-	-	-	34.8	
	RESEARCH & TRAINING SUPPORT FACILITIES																
13	Nurse-Trainer	P1/1	-	-	-	34.8	34.8	-	-	-	-	-	34.8				

Priority	Job Title/ Position	Person	Lv/Stp	Approved Filled	Position Vacant	Others	Forecast of new position	Total cost 1984	MANPOWER DT	P&T	HD	N	DISTRIBUTION CSR	RTSF	T	DO	A&F	RD
PATHOGENESIS & THERAPY																		
14	Pediatrician		P3/1	-	53.8[a/]	-	-	53.8	-	53.8								
NUTRITION																		
15	Nutritionist		P1/1	-	34.8	-	-	34.8	-	-	-	34.8						
COMMUNITY SERVICES RESEARCH																		
16	Health Economist		P3/1	-	-	-	48.0	48.0	-	-	-	-	48.0					
RESEARCH & TRAINING SUPPORT FACILITIES																		
17	Computer Analyst		P4/1	-	66.0	-	-	66.0	-	-	—	-	-	66.0				
TRAINING PROGRAM																		
18	Training Materials Dev		P3/5	-	-	-	52,6	52,6	-	-	-	-	-	-	52.6			
19	Research Associate		P2/1	-	-	-	48,0	48,0	-	-	-	-	-	-	48.0			
COMMUNITY SERVICES RESEARCH																		
20	Trainer Physician (Extension)		P3/1	-	-	-	48,0	48,0	-	-	-	-	48,0					
21	Extension Coordinator		P1/1	-	-	-	37,8	37,8	-	-	-	-	37,8					
HOST DEFENCE																		
22	Immunologist		P4/1	-	66,0	-	-	66,0	-	-	66,0							
PATHOGENESIS & THERAPY																		
23	Podiatrician		P3/1	-	58.0[c/]	-	-	58,0	-	58.0								
RESEARCH & TRAINING SUPPORT FACILITIES																		
24	Head, Hospital		P5/1	-	-	-	91,3	91,3	-	-	-	-	-	91,3				
PATHENESIS & THERAPY																		
25	Research Associate		P2/1	-	-	-	48,0	48,0	-	48,0								
HOST DEFENCE																		
26	Research Associate		P2/1	-	-	-	48,0	48,0	-	-	48,0							
NUTRITION																		
27	Research Associate		P2/1	-	-	-	48,0	48,0	-	-	-	48,0						

Priority	Job Title/ Position	Person	Lv/Stp	Approved Filled	Position Vacant	Others	Forecast of new position	Total cost 1984	MANPOWER DISTRIBUTION									
									DT	P&T	HD	N	CSR	RTSP	T	DO	A&F	RD
COMMUNITY SERVICE RESEARCH																		
28	Anthropologist		P1/1	-	34.8	-	-	34.8	-	-	-	-	34.8					
RESEARCH & TRAINING SUPPORT FACILITIES																		
29	Librarian		P1/1	-	34.8	-	-	34.8	-	-	-	-	-	34.8				
ADMINISTRATION & FINANCE																		
30	Internal Auditor		P1/1	-	-	-	34,8	34,8	-	-	-	-	-	-	-	-	34.8	
RESEARCH & TRAINING SUPPORT FACILITIES																		
31	Research Associate (Matlab)		P1/1	-	-	-	34,8	34,8	-	-	-	-	-	34.8				
32	Research Associate (Dhaka)		P1/1	-	-	-	34,8	34,8	-	-	-	-	-	34.8				
33	Research Associate (Biochemistry)		P1/1	-	-	-	34,8	34,8	-	-	-	-	-	34.8				
RESOURCES DEVELOPMENT																		
34	Research Associate		P1/1	-	-	-	34,8	34,8	-	-	-	-	-	-	-	-	-	34.8
RESEARCH & TRAINING SUPPORT FACILITIES																		
35	Research Associate (ARB)		P1/1	-	-	-	34,8	34,8	-	-	-	-	-	34.8				

It was agreed that the following candidates could be recruited:

1. Dr. R. Eekels - Belgium
   Pediatrics MCH/CSR

2. Dr. Shushum Bhatia - India
   MCH/CSR

3. Dr. M. Badrud Duza - Bangladesh
   Demography/CSR

4. Dr. David Sack - USA
   Immunology/Host Defence

5. Dr. Marjorie Koblinsky - USA
   Operations Research/CSR

6. Dr. M.G.M. Rowland - U.K.
   Epidemiology/Nutrition/DT

7. Dr. Monowar Hossain - Bangladesh
   Demography/Statistics/CSR

8. Dr. Aime De Muynk - Belgium
   Epidemiology/DT

9. Dr. Rene Germanier - Swiss
   Microbiologist/Immunologist

10. Dr. Bonita Stanton - USA
    MCH/CSR

11. Dr. John D. Clemens - USA
    Epidemiology/DT

12. Dr. Michael Bennish - USA
    Clinical Research/PT

13. Dr. F.C. Patra - India
    Clinical Research/Nut.

14. Dr. Fitzroy Henry - Guyana
    Epidemiology/Nut.

15. Ms. Sonja L. Waara-Conway - Sweden
    Personnel

Numbers 3 and 7 are both demographers only one may be recruited. It was agreed that number 7 may be offered a position first and if not taken then number 3 can be recruited.

Were these recruited and inclusive of seconded staff at the Professional level the grographic distribution would be as follows:

Country	No. of Persons	% of total
Afghanistan	1	2.38
Bangladesh	8	19.05
Belgium	3	7.14
Canada	4	9.52
Czechoslavakia	1	2.38
England	1	2.38
France	3	7.14
Guyana	1	2.38
India	2	4.76
Malaysia	1	2.38
Netherlands	1	2.38
Poland	1	2.38
Sweden	1	2.38
Switzerland	1	2.38
U.S.A.	13	30.95

100% = 42 persons

There was an agreement that the international level positions just advertised should be processed as soon as possible for appointment. The following resolution should be passed to cover the period between December 31, 1983 and the completion of this recruitment:-

In view of the time lag required to finalize the recruitment of staff to the reclassified positions of:

Controller, Supply Officer, Computer Manager, Librarian, Bio-chemist/Nutritionist and Anthropologist,

as an exception to the rules, the Board extends the maximum period of 12 months as provided by Staff Rule 320.4 by an additional 6 months. During the time the staff members are assuming the responsibilities of these positions they shall receive the additional payments as provided by the said rule.

A listing of contract expiry dates of all incumbent staff was requested and follows:-

Name	Expiry Date of Contract
Dr A.R. Samadi	31 December, 1983
Dr K.M.S. Aziz	30 June, 1985
Mr M.R. Bashir	30 June, 1986
Dr A.K.M.A. Chowdhury	30 June, 1985
Dr M.I. Huq	30 June, 1986
Dr M.U. Khan	30 June, 1986
Dr A.M. Molla	30 June, 1986
Dr M.M. Rahaman	30 June, 1986
Dr M. Struelens	31 December, 1985
Dr I. Ciznar	December, 1984
Dr D. Patte	
Dr F.J. Henry	1 August, 1984

Name	Expiry Date of Contrac
Dr S.C. Sanyal	31 January, 1984
Mr M.F.L. Goon	28 February, 1984
Dr P. Speelman	31 August, 1984
Dr B. Wojtyniak	31 July, 1985
Mrs S. Waara-Conway	23 September, 1984
Dr M.L. Bennish	30 June, 1984
Dr T.C. Butler	31 October, 1984
Dr J.D. Clemens	30 August, 1985
Dr W.B. Greenough	30 June, 1985
Dr M. Koblinsky	31 March, 1984
Mr D. Leon	31 October, 1983
Ms N. Novak	30 June, 1984
Dr J.F. Phillips	28 February, 1984
Dr N. Rizvi	31 October, 1984
Dr B. Stanton	30 August, 1985
Ms S. Smith	31 December, 1984

It was emphasized that for all incumbents notification of extension or termination by the Board should be in so far as possible one year in advance of the expiry date of their contract. This would require presentation of evaluation materials gathered to the Board in time for such decision.

../41.

IV. External Review Selection

The status of acceptance by nominee as external reviers was presented as follows:-

1.	Admin. & Finance	Omond Solandt (Canada)	Not available at all.
2.	Training	*William Cutting (UK)	Available between 17 Feb. and 8 March.
3.	Path. & Therapy	*Demise Habte (Ethiopia)	Prefers 2nd week of March.
4.	Disease Trans.	*M.H. Wahdan (Egypt)	No word.**
5.	Host Defence	*P. Matangkasombut (Thailand)	Prefers as early as possible before mid-March.
6.	Nutrition	*A. Pradilla (Colombia)	No word.
7.	CSRWG	G. Pfister (Switzerland)	Not available at all.
8.	Demography	*J.C. Caldwell	Available 1st or 2nd week of April.
9.	Microbiology	*Mrs E. Yabuuchi (Japan)	Not available 1-5 March.
10	Computer Science	Walter Willett (USA)	Unable to contact - no address.

* On 23 November, 1983 a telex was sent to these persons enquiring whether they would be available for the External Review to be held 5-8 March, 1984.

** Received word 26.11.83 - In principle Dr Wahdan is available but prefers to start 19 March, 1984.

There was agreement to proceed with invitations to the following additional reviewers:

1.	Jane Kusin	Royal Tropical Institute Netherlands	Nutrition
2.	Aleya Hammad	WHO, Geneva	CSR
3.	Dr Badrud Duza	Egypt	Demography
4.	Richard A. Kromnell	USA	Computer
5.	Mr M.K. Anwar	Bangladesh	Admin./Finance