INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

REPORT OF THE BOARD OF TRUSTEES MEETING

24-25 NOVEMBER, 1986

AGENDA

BOARD OF TRUSTEES MEETING

24-25 NOVEMBER, 1986

1.	Approval of Agenda	- 1/BT/NOV.86
2.	Approval of Draft Minutes of June 1986 meeting.	- 2/BT/NOV.86
3.	Director's Report.	- 3/BT/NOV.86
4.	Summary Reports on Resources Development and Financial Situation.	- 4/BT/NOV.86
5.	Programme Committee Report includes: (a) Update on priority Programme and organizational structure. (b) ERC Panel report. (c) Relationship with industry. (d) External Scientific Review report. (e) Programme Coordination Committee-Terms of References.	- 5/BT/NOV.86
6.	Personnel & Selection Committee Report includes: (a) Secondment (b) New appointments.	- 6/BT/NOV.86
7.	Task Force Report.	- 7/BT/NOV.86
8.	Resources Development Report includes: (a) Donor consortium document.	- 8/BT/NOV.86
9.	Finance Committee Report includes: (a) UNROB Loan (b) Salaries 1987 (c) Interest free or soft loan. (d) Budget for 1987	- 9/BT/NOV.86
10.	Date of next Board Meeting. (a) Discussion on number of Board Meetings per year.	-10/BT/NOV.86
11.	Miscellaneous.	-11/BT/NOV.86

DRAFT PROGRAMME FOR BOARD OF TRUSTEES
MEETING NOVEMBER 1986

Tuesday, 18 November

Personnel & Selection Committee Members Arrive

Wednesday, 19 November

Remaining Board Members Arrive

9.00 am	Meeting of the Personnel & Selection Committee

Thursday, 20 November

9.00 am	Continuation of the meeting of the P&S Cttee
11.00 am	Programme Coordination Committee Meeting
4.00 pm	Meeting with reviewers of Community Medicine Division and Population Science & Extension Division

Friday, 21 November

9.00 am	Programme Committee Meeting

Saturday, 22 November

9.00 am	Finance Committee Meeting

Sunday, 23 November

Full day free for Report Writing/Reviewing Board Papers

Monday, 24 November	-	Board Meeting
8.30 am - 9.00 am		Welcome to new Members; Approval of Agenda; Approval of Draft Minutes of Board Meeting
9.00 am - 9.45 am		Presentation of Director's Report
9.45 am - 10.30 am		Discussion of Director's Report
10.30 am - 10.45 am		Tea
10.45 am - 11.30 am		Presentation of Summary reports on Resources Development and Financial Situation
11.30 am - 12.30 pm		Presentation of Programme Committee Report
12.30 am - 2.00 pm		Lunch
2.00 pm - 3.30 pm		Discussion/Resolutions of Programme Committee Report
3.30 pm - 3.45 pm		Tea
3.45 pm - 5.00 pm		Presentation and Discussion of Personnel & Selection Committee Report (except items connected to Task Force Report)

Tuesday, 25 November

8.30 am - 10.15 am	Presentation and discussion of Task Force Report
10.15 am - 10.30 am	Tea

10.30 am - 11.30 am	Recommendations/Resolutions from Task Force Report
11.30 am - 12.30 pm	Recommendations/Resolutions from Personnel & Selection Cttee Report
12.30 pm - 2.00 pm	**Lunch**
2.00 pm - 2.30 pm	Meet with representatives of the Staff Welfare Association
2.30 pm - 3.30 pm	Presentation, Discussion and Resolutions, Resources Development Report
3.30 pm - 3.45 pm	**Tea**
3.45 pm - 5.00 pm	Presentation, Discussion and Resolutions, Report of Finance Committee

Wednesday, 26 November

8.30 am - 10.15 am	Dates of Next Meeting (includes discussion on number of Board Meetings per year)
10.15 am - 10.30 am	**Tea**
10.30 am - 12.30 pm	Open for unfinished business
12.30 pm - 2.00 pm	**Lunch**
2.00 pm - 4.00 pm	Passage of all Resolutions
4.00 pm	Closure of Meeting

Note: The Programme Committee Meeting and Full Board Meeting will be held in the Training Lecture Room

The Finance and Personnel & Selection Committee meetings will be held in the Director's Office

20.11.86

APPROVAL OF
THE MINUTES OF BOARD OF TRUSTEES
MEETING, JUNE 1986

DRAFT

Minutes of the Meeting of the Board of Trustees, ICDDR,B held at Dhaka, June 17-19, 1986.

Members Present

Dr A.R. Al-Sweilem
Mr M.K. Anwar
Professor D. Bell - Chairman
Dr I.Cornaz
Professor R. Beckels - Secretary
Dr R. Feachem
Mr Manzoor ul Karim
Professor J. Kostrzewski
Professor L. Mata
Professor M.A. Matin
Dr M. Merson
Dr Nyi Nyi
Professor D. Rowley
Dr J. Sulianti Saroso

Members Absent

Professor V. Ramalingaswami
Dr D. Sebina
Professor Y. Takeda

Invited Staff

Mrs J. Chowdhury, Executive Assistant to the Director

For the Opening Session Only

Dr K.M.S. Aziz, Associate Director, Training, Extension & Communication Programme
Dr Badrud Duza, Project Director, MCH-FP Programme
Dr M. Bennish
Dr I. Ciznar, Associate Director, Host Defence Programme
Dr K.A. Monsur

For the Opening Session and Agenda 4

Dr M.G.M. Rowland, Associate Director, Community Services Research Programme
Dr D. Sack, Associate Director, Disease Transmission Programme

For the Opening Session and Agendas 5 & 7

Mr M.R. Bashir, Associate Director, Resources Development
Mr H.A.N. Janssen, Chief Finance Officer

Observers

Representatives from:-
The Australian High Commission,
Government of Bangladesh, Dept. of Health Services
The French Embassy
The Japanese Embassy
The Norwegian Embassy
The Swedish Embassy
The Swiss Embassy
UNDP
UNFPA
UNICEF
USAID
WHO

For Agendas 3, 4, 5 & 7 on 18 June

Dr Ken Bart, USAID, Washington

Professor Bell, Chairman of the Board, opened the meeting at 8.30 a.m. on Tuesday, 17 June, 1986. He welcomed the donors and encouraged them to participate in the discussions. Professor Bell also welcomed Prof. M.A. Matin, Honourable Minister for Health and Family Planning back on the Board explaining that Prof. Matin had previously been a Chairman of the Board and Chairman of the Personnel & Selection Committee. He also welcomed the other representatives of the Bangladesh Government, namely Messrs M.K. Anwar, Secretary, External Resources Division and Manzoor ul Karim, Secretary, Health and Family Planning. Dr Nyi Nyi was welcomed as a new member of the Board, from UNICEF headquarters and replacing Dr S. Joseph. Professor Bell said how pleased the Board was to have someone of Dr Nyi Nyi's background and experience on the Board.

After outlining the morning's programme, Professor Bell introduced Professor Matin and requested that

Professor Matin commence the morning's proceedings by giving an address . The address by the Honourable Minister for Health and Family Planning, Government of the People's Republic of Bangladesh, Professor M.A. Matin, is as follows:-

"Mr Chairman, Distinguished Board Members, the Representatives of Donor Agencies and the Gentlemen present.

Aassala-mu-alikum.

I welcome you all to this very important meeting cordially. It is indeed a proud privilege to be able to be in your midst once again, a privilege which offers me the opportunity of looking into the present state of the ICDDR,B with a renewed interest.

The ICDDR,B was created through an Ordinance promulgated by the Government of Bangladesh in December, 1978 by converting the erstwhile Cholera Research Laboratory and Hospital set up in 1962 under an Agreement with SEARO. It will not be out of place to mention here that since the time of its inception the Centre has been carrying our laudable activities towards achievement of its aims and objectives. We are really very happy that this important international organization was located in Dhaka and its being run with the kind help and assistance of about fifty friendly countries and donor agencies most of whom are signatories of the 'Memorandum of Understanding'. It is needless to mention here that because of its constitution and location, we have a singificant role to play in the continued and smooth running of the Organization with all the objectives of the Organization in view. One such stated objective of the organization is to ensure the rights and opportunities of Bangladeshi scientific personnel to participate in the programmes and activities of the Centre; to provide proper facilities for training to Bangaldesh nationals in the the areas of Centre's competence and to conduct such activities with the concurrence of our Government whenever necessary.

Apart from imparting training to Bangladesh and other nationals, the Centre has done some wonderful work in the field of diarrhoeal disease, the most important of which is Oral Rehydration Therapy (ORT) which has been accepted universally as a break-through in the field of diarrhoeal disease. There are also other important areas of achievement of the Organization. Like many other countries, from these, the benefits derived have not been limited to

Bangladesh only -- even those countries who are not involved in the affairs of ICDDR,B have also been benefitted. In 1984-85 alone, about 2,000 professional personnel, of which a large part is from outside Bangladesh, were trained by this Organization. The Centre today is also at a stage of finally inventing new type of Oral Saline and Cholera Vaccine.

In fine, because of the achievements so far made, the ICDDR,B has established a name for itself which is internationally acknowledged. But these achievement have not come very cheap.. While we gratefully acknowledge the contributions of the various countries and donor agencies, we must also not lose sight of the significant contribution made and required by Bangladesh and Bangladeshi scientists. Apart from the land and building now being used by the Centre and the annual contribution of the Government of Bangladesh, Bangladesh also contributes in other direct and indirect ways which include relief in terms of Custom Duty, Sales Tax, Income Tax, Rentals and various other facilities given to the Organization and its personnel. The contribution made by Bangladesh in terms of research facilities provided to the Centre and its Satellite Stations at MATLAB and TEKNAF are also significant as the hospital and field stations have been maintained not primarily for treatment purpose but to facilitate research. As we learn from Newspapers, there has been serious complaints about unethical practices in matters of conducting research on human beings -- the situation which invited a criticism of the Government for providing easy access to our nationals for being used as guineapigs.

Inspite of this useful work of the Centre in the matter of diarrhoeal disease, the criticism to the effect that a considerable fund of the Organization were wasted without achieving concommitant benefit are not totally invalid. The result of such expenditure combined with unimaginative personnel policy and financial prudence has placed the Centre in a situation in which it is finding difficulties to meet its expenditure which has gradually risen sharply over the past years and the Centre has run into an overdraft of about 3 million dollars on which yearly interest of about five hundred thousand dollars are to be paid by the Centre. The Organization has also shown little regard for adhering to rules and sound practices. As of today, the Centre has more than forty employees who draw salary at the International level although many of these were avoidable. Similarly, areas of wastage and unnecessary expenditure in the Centre are also

considerable.

In view of the difficult financial position the Board of the Centre has proposed certain actions on grounds of economy. These actions include termination of contracts and abolition of international posts occupied by five Bangladeshi's after expiry of their existing contracts and also creation of posts in National Officers level to absorb some of these Bangladeshis.

Initiatives taken by the Board for affecting economy are welcome but many other areas remain where money can be saved. The question of purchase, employment as secretaries and nurses at international level, employment of spouses of expatriate serving elsewhere in Dhaka have already been mentioned. If training of Bangladeshis by way of serving in the Centre is one of the important objectives of the Centre then that will require rotation of persons after a specified period of time. The period of six years appears to be a reasonable cycle for such rotation. But what is important is that in the name of rotation, the percentage of Bangladeshi's in the international level positions, both in research and support services, should not be allowed to drop. If the services of the outgoing incumbents are replaced by newcomers at equivalent levels, there may not be much objection to this from the national point of view.

In short, what has happened due to the very unusual administrative steps taken by the Centre is a feeling of frustration amongst the Bangladeshi scientists and staff. In the Bangladesh circle, there is a feeling of discrimination by the Centre's management.

I wonder whether the management at all appreciates the demoralizing effects its decisions had on the Centre's staff as well as on the Government and social implications thereof, not to speak of the sufferings and agony of the families!

This and other instances, only make many people believe that there has been a serious lack of perception by the management of the socio-cultural context in which the Centre is located.

Bangladesh is a poor country making its both ends meet with great difficulty. The contribution Bangladesh has been making for ICDDR,B directly and indirectly is quite significant and disproportionately high compared to our abilities. A piece of land costing several crores is only one instance of our contribution. For Bangladesh to take up responsibility of funding an international

institution like ICDDR,B may not be consistent with the established principles of funding such an institution and may lead us to financial commitments beyond our means. ICDDR,B has all along been pressing us to directly involve Government of Bangladesh mobilising funds for them. Though we have full sympathy for the cause, we cannot directly involve ourselves in such fund mobilisation without adversely affecting our interest in respect of mobilisation of funds for our domestic requirements. Besides, to make liberal funding from public exchequer of Govt. of Bangladesh to pay salaries of the order of $7000 a month and mostly to expatriates and to buy stationaries through an agent in a far off country for airlifting may not be consistent with our scheme of things. Funding responsibility of an International Centre should be on the international community who are its sponsors and beneficiaries.

In view of the financial difficulties of the Centre and in view of the need for affecting economy, we would request this meeting that a Committee be appointed for the purpose which should go into the detail of the financial and administrative matters and make recommendations. As it is, it will be very difficult for this meeting to decide on actions suggested in the working papers of the Centre circulated only recently. I am sure, very few of those who are attending this meeting, have had the chance to go through the whole working paper and obtain the replies on their queries as these were circulated only recently - a practice which should be avoided in future.

I shall request this meeting not to miscontrue my intentions in this deliberation. My whole purpose is limited to Centre's well-being and continued success so that its reputation already established remain untarnished. While we are trying our utmost to make as much contributions as possible as the host country of the Centre of international magnitude, we would request others to join their hands in an effort to bring the Centre out of its present difficulties and also to ensure smooth running of the Organization, free from the financial worries in the years to come.

We would also request all concerned to take steps for bringing the required administrative and financial discipline in the Centre so that all expenditures become cost-effective.

We wish the Centre to continue to be a success story on international scale and we would like to leave no stone unturned for achieving this.

Thank you all."

Professor Bell thanked Professor Matin saying that he recalls vividly Professor Matin's participation in prior Board discussions and that he will be a most valuable Board Member. He went on to say that, for the information of the various guests, it is important to note that the issues raised by Professor Matin will be addressed fully in this meeting of the Board. The Finance and Personnel and Selection Committees have been discussing and trying to learn about and understand the issues addressed by Professor Matin. He said the the Board faces many extremely difficult decisions and that he welcomes Professor Matin and his Bangladeshi colleagues as a distinguished group of Trustees and hopes that by the end of the meeting we will have a firmer and clearer idea of how to go forward.

Agenda 1: Approval of Agenda

The agenda was accepted with the following change:-

Under Agenda 7 part (b), "Approval of 1987 Budget", should be deleted.

Agenda 2: Approval of Draft Minutes of Board Meeting November, 1986

The draft minutes of the meeting held 26-28 November, 1985 were confirmed without objection.

Later, in the afternoon session of the Board on November 17th, in response to a member's request, Professor Eeckels went through the November 1985 draft resolutions, one by one, updating the Board on the status of each and indicating action taken. Queries raised by Board Members were answered. These included confirmation that the Centre is no longer advancing money to the International Child Health and Diarrhoeal Disease Foundation (ICHDDF) and assurance that the Centre will insist on speedy repayment of moneys advanced; an update on scientific travel; and discussion on deadlines set by the Board and the fact

that consultants could be hired to assist in meeting these deadlines. Professor Eeckels commented that he has followed a policy of hiring consultants only when funds were provided from outside and that this has limited his flexibility.

In the morning session on June 17th, the Board next took up:

Agenda 3: Director's Report - Presentation of Annual Report

Professor Eeckels presented his report which is attached (annex 1) and the 1985 Annual Report which is also attached (annex 2). Professor Bell thanked Professor Eeckels for his report and invited comments and questions from donors or other observers advising that Board Members would have the opportunity later to question the Director.

During the open session several issues were raised, concerning whether the Centre should be using the WHO salary scale; whether the Centre ensured that the rules regarding tax exemption status for its employees are followed and appropriate evidence provided to the proper authorities; the desirability of the six-year rule for scientific staff at the international level; and ethical matters including the composition of the Ethical Review Committee. Professor Bell stated that all these matters will be addressed in detail later in the meeting. He emphasized that the Board in its meeting last November addressed itself to the serious financial difficulties of the Centre and will again this meeting set up policies for a stronger Centre both scientifically and financially. The Board must also consider whether we should aim for a different pay scale and seek scientific staff in other ways. He said that the ethical question is a wider and more complex one than one protocol - some protocols, for example, have been approved by the Ethical Review Committee which some Board members feel should not have been approved.

It was pointed out by a Board Member that the Centre is going through a growing process which is normal for all research institutions and that the research activities of the Centre are still very much alive.

Mr Anwar said that should there be a necessity to make changes in the Ordinance regarding international level salaries, etc. then the Bangladeshi Board Members would be only too eager to support these changes when presented to the Government.

One donor praised the activities in Matlab and the spirit in which the workers carry out their work there. Another donor said it believes that the Centre has done useful work in the past and will do so in the future and on the basis of this has doubled its contribution to the core this year. The donor said that problems are inevitable in all organizations but they should be solved fairly and it is with this belief that it feels the Centre will grow into a vibrant organization in which everyone will do their share.

Mr Karim, as Secretary, Ministry of Health and Family Planning, conveyed his gratitude to the Centre for giving its support whenever requested to help with an epidemic of diarrhoea. He said that the achievements of the Centre are not only known in Bangladesh but outside the country too. Professor Eeckels said that thanks to the devotion of Dr Aziz, the training activities of the Centre not only mean that many Bangladeshi doctors and other health workers from outside the Centre are being trained to better respond to the needs of the country but also that several Bangladeshis on the staff of the Centre are being trained abroad or will be going shortly on training to Australia, England, France and the United States.

Later in the Board meeting (on June 18th morning), the Board discussed the Director's Report. These discussions are summarized as follows:-

Professor Eeckels was praised for the annual report, several Board Members stating their appreciation that it was more of a scientific report than past versions. Several Trustees suggested further improvements before it was finally printed, and Professor Eeckels thanked them saying that their comments were duly noted.

In reply to a query as to why the cholera vaccine has not been more widely publicised, Prof. Eeckels said that he and his colleagues were afraid that if, e.g., a press conference had been given, it would have raised false hopes and a general belief by the people than they could now be immunized. To date, the information has been circulated to Trustees and a scientific paper has been accepted for publication in The Lancet.* It was expected that more publicity would be given to the "success" of the trial at the Donors Meeting, by which time more results would be known. The Trustees agreed with this policy: there should be a message for the donors to encourage further support, but not, at this point, a public message.

Professor Eeckels was asked about the upgrading of the biochemistry laboratory. In response, Professor Eeckels agreed that the laboratory needs upgrading urgently but said this is dependent on funds being available. Two sources of funding may be forthcoming and, in the meantime, an informal committee has been set up to look into the upgrading.

Professor Bell congratulated Professor Eeckels on the greatly improved quality of the Annual Report and for his Director's Report.

The next agenda on Tuesday morning, June 17th, was:

Agenda 4: Programme Committee Report

Professor Bell introduced Professor Rowley, Chairman of the Programme Committee, who presented his report which is attached (annex 3). Professor Bell thanked Professor Rowley for his lucid, clear and stimulating report and asked donors for their questions and comments.

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*Published in The Lancet July 19, 1986

Donors and observers asked questions about the role of the Centre's training programme; the possibilities of advancement for Bangladeshi scientists and how the Centre can encourage the best persons from Bangladesh to join the Centre; and whether the changing etiology of diarrhoeal diseases, vaccines for rotavirus, the resistance of shigella to conventional antibiotics, and research on environmental factors were part of the Centre's programme.

Various Board Members and staff spoke in response to these queries. It was pointed out that training is explicitly mentioned in the Ordinance as one of the Centre's objectives and that it will certainly continue, in close collaboration with WHO and the Government of Bangladesh. It will, however, be re-evaluated. Recently there has been increased collaboration between the Centre and National institutions and the French representative said how much they appreciate the Centre's links with foreign organizations and institutions. He said these are essential and full of promise for the future.

With reference to the opportunities for Bangladeshi scientists, it was noted that the Board has agreed to expand the NO scale which will help to bridge the gap between the national and international pay scales.

With regard to the specific questions about what is in the Centre's programme, Professor Rowley apologised that he did not go into details in his report, but said that all the points mentioned are part of the Centre's programme.

Later in the Board meeting (on June 18th morning), Dr Feachem opened the discussion of the Programme Committee report by highlighting the main points of the report. Professor Rowley advised that the topics listed for the priority programme are tentative suggestions only for the Director to consider. He said too that the organizational structure is tentative and should be modified by the Director according to circumstances. However, the Committee agrees that it is a framework on which to work and requests the Director to provide a more detailed proposal for discussion in the next meeting (November 1986).

Professor Eeckels welcomed the concept of bringing more post-doctoral fellows and said that he is looking forward to young scientists coming to the Centre from Bangladesh, the region and abroad under this scheme. The support of donors will, of course, be needed to finance strong institutional linkages. Professor Eeckels went on to say that he hopes the Centre is able to obtain donor support for its service activities in the near future. He said it is unacceptable not to give service but that this is presently a heavy drain on the core budget - the expanded service activities are one of the reasons why the Centre is facing financial problems.

The forming of a scientific consultancy group was welcomed by the Trustees. Professor Eeckels said he sees this international "group" working more as 2 or 3 persons coming for 10 to 14 days at a time to interact with the Centre's scientists, look at protocols, give lectures, foster institutional linkages and help in finding the best possible candidates for recruitment. The group would include distinguished scientists from Bangladesh and the region. It was suggested and agreed that it is highly appropriate that scientific Board Members could be on the list of consultants for this group. Professor Eeckels said he concurs with these suggestions and that when the body is built up, members of the Programme Committee will be kept fully informed of who would be coming when.

Concern was expressed that a strong paper on the scientific priorities of the Centre and plans regarding research, service and training should be ready for the donors meeting in September. The Programme Committee report should be used as a basis for the report to the donors. The report needs to be sent to the donors by 1 August and be approved by Professors Rowley and Bell beforehand. The organizational structure of the Centre is important to donors and the report should show that the Centre is aiming for a leaner, tighter arrangement with a suggestion of 3 or 4 scientific divisions rather than 5. Details of the divisions etc. should not be specified to the donors (these should be prepared for November). It was pointed out that donors are also interested in epidemic control; projects such as this and the Urban Volunteers project should be spelled out in more detail than they are in the draft.

Next, the Ethical Review Committee was discussed. The Board agreed that Drs K.A. Monsur and A.N. Alam should replace Drs K.M.S. Aziz and M.M. Rahaman as ICDDR,B members of the Committee. With respect to the Chairman of the Committee various options were considered. It was decided that with respect to the existing Committee, so long as it is active and provided it does not change, the Board proposes to nominate Brigadier Hedayetullah as Acting Chairman. Again, after considering several alternatives, the Board decided to accept the Programme Committee's suggestion that a panel be constituted to develop a comprehensive statement on the ideal composition, method of work, duties, powers and functions of the ERC. It is in this context that the present ERC is considered an interim committee and it is for this reason that an Acting Chairman has been appointed.

Dr Merson pointed out that, in view of the discussions of this agenda item, the Director may need a sum of money for 1, 2 or 3 consultants to help draft documents requested by the Board. These could be drafted by an outside consultant and left with the Director to finalize. He said that WHO may be able to help to defray some of these costs.

The Board accepted the report of the Programme Committee, recognizing that it should be understood as a serious and important contribution to the Director as he prepares his reports for the meetings in September and November. The report does not explicitly establish a new organizational or staffing pattern but it is there for the Director's discretion to adjust as needed for his report in November.

The next agenda item on Tuesday morning, June 17th was:

Agenda 5: Finance and Resources Development Report

In introducing this item, Professor Bell explained that in previous meetings only an income statement had been given but this time he is requesting Mr Janssen, Chief Finance Officer, to give a short statement about the financial status of the Centre. Mr Janssen gave his presentation which included the Centre's status now and the future outlook. He

mentioned additional measures which are being taken to reduce the overdraft: a cut in capital expenses by 50%, departments using core funds being requested to contain level of discretionary expenditure by 25%, and a reduction of core funded administration, logistics and scientific management by a little over three-quarters of a million dollars. The Centre is now operating on a basis of covering its current expenditures but needs to deal with the deficit accumulated in the past.

Mr Janssen answered an earlier query re taxation. He said that the Centre has been acting in the spirit of the law and will now comply with the terms fully and request expatriate employees to produce evidence of home country tax exemption. The Centre currently pays taxes for Bangladeshi nationals at local and international level and these will amount to approx. $300,000 in 1986.

Professor Bell next introduced Mr M.R. Bashir, Associate Director for Resources Development, and Mr Bashir presented his report which is attached (annex 4).

Professor Bell pointed out that the outlook for 1987 will be better if support is found for the clinical services which have to date been funded out of unrestricted core funds. It is hoped that these funds will be forthcoming. He said it will be useful to discuss the longer term plans for the Centre's funding at the donors meeting. It is difficult for the Centre to run smoothly on solely project funds. The Centre needs sure funding to do good science and faces serious difficulties because donors have been lowering their core support.

Professor Beckels expressed his gratitude to Messrs Bashir and Janssen for their collaboration and mutual understanding. He stessed that they have been most helpful.

Professor Bell thanked the donors for attending the opening session and for the useful, lively and important discussions. He said the Board Meeting has started well.

The discussions on the Resources Development report on June 18 combined with the discussion of the

Finance Committee report and are incorporated into the minutes at that point.

After lunch on June 17th, the Board moved to:

Agenda 6: Executive Committee Report

Professor Bell advised that the minutes of the Executive Committee meeting form the report to the Board and that apart from one or two minor changes, the report is as was circulated. Professor Bell pointed out that the Executive Committee had limited authority only, and it limited itself to action outlined in Resolution 24/Nov. 85. It did discuss two matters informally, i.e., the ethical review question and nominations of Trustees, but no decisions were involved. Trustees were requested to limit questions to those subjects which will not come up later in the meeting.

A question was raised why the activities in Teknaf are continuing when they were expected by the Board to have been stopped. Professor Eeckels replied that unfunded research at Teknaf had been stopped. Funded research had been expected to end from 1 July, 1986. This was the position when the Executive Committee met in March. The donor (CIDA) and a consultant they had employed to review the DSS activities in Matlab, have now advised that they do not wish to stop their activities in Teknaf until 1987. It was agreed that the Centre should not simply do whatever the donor wants, but in this case the continuation of activities in Teknaf is desirable from the Centre's viewpoint.

Professor Bell asked the Trustees whether they felt the experience of an Executive Committee meeting was a happy one or not. Trustees felt it was and queried whether in future there could be one Board Meeting per year with one or two Executive Committee meetings as required. This should be discussed next Board Meeting (November 1986) and, in the meantime, Trustees were requested to give their views on this subject to Professors Bell or Eeckels or to Mr Karim. As such a decision would require a change in the Ordinance, its full implications need to be discussed.

Agenda 7: Finance Committee Report

Professor Bell, as Acting Chairman of the Finance Committee opened discussion of this agenda item on Wednesday, June 18, by summarizing the Finance Committee's Report. The Report of the Finance Committee is attached (annex 5).

The issues discussed under this agenda item were:-

(1) Cost containment;
(2) Additional measures needed to cut costs;
(3) How to reduce the overdraft;
(4) UNROB loan;
(5) Possibility of new salary scales; and
(6) Matlab building.

Dr Nyi Nyi summarized the options for improving the Centre's financial situation:

(a) Convert the Reserve Fund for repaying the UNROB loan to a partial payment of short term debts.
(b) Obtain a soft loan.
(c) Change payment pattern of project funds - get donors to pay in advance.
(d) Centre should be leaner - reduction of staff - leave in hands of Director how to reduce e.g. $500,000.
(e) Review the salary structure - could Governments subsidize salaries of their nationals who work at the Centre?
(f) Could all expatriates be seconded from technical assistance funds?
(g) Raise special contributions from donors.
(h) Transfer core persons to projects funding.
(i) Obtain bilateral funds for Centre's service activities.
(j) Raise endowment funds.

He suggested that if the Centre had (b) and (i) and if the UNROB loan could be converted to a gift then point (a) could be implemented.

(1) Cost containment

Professor Eeckels said that the Centre must go on

with strict cost containment measures for at least the next 2 to 3 years, and this includes the cost of staff, otherwise we will again find ourselves in a similar situation, as we found ourselves in last November. He added that institutions all over the world are facing the problem of staff cuts, as we have been forced to implement. Professor Bell said that it is in realization of this that the Finance Committee recommended that the severe emergency restraints (10% cut and holding back of rises) continue until the end of the year.

(2) Additional measures needed to cut costs

There was a lengthy discussion on what further measures should be taken in order to cut the costs of the Centre. It was finally decided that rather than instruct the Director to take certain action, as was done in November 1985, the Board would set a reduction target for the Director, and how the Director reached this target was up to him. A target of reducing the anticipated budget, as presented by Mr Janssen, by $200,000 between 1 July, 1986, and 30 June, 1987, was set and the Director was requested to give a progress report at the November 1986 meeting of the Board, when an adjustment could be made if necessary. Resolution 1/June 86 refers.

(3) How to reduce the overdraft

Mr Janssen pointed out that the Centre is carrying the overdraft problem into 1986, and that in order to get the Centre on a sound footing the overdraft needs to be cancelled. Professor Bell noted that based on present outlook the overdraft won't be added to this year but that it won't be lessened either unless special measures are taken.

Professor Beckels said that the Centre should never have gone into a commercial bank loan. This, added to the fact that the Centre started without any reserve fund or endowment was bound to cause cash flow problems as some donors don't pay until the work has been completed. He said that the Centre must get rid of the commercial loan and that we should approach the Government of Bangladesh to assist in obtaining an interest-free or soft loan from, e.g., the Asian Development Bank. Secondly, we should try to convince the donor community that we need a

reserve fund. Another avenue would be to try and obtain the approval of the Ministry of Finance to seek bilateral funds for the service activities. It was agreed that the Centre should seek the help of the Government of Bangladesh to obtain a soft loan, and that the Centre should try to reduce its overdraft (hopefully converted to a soft loan) by planning for a surplus of $500,000 per year.

(4) UNROB Loan

The Board agreed that the Centre should request the Government of Bangladesh to allow a further extension of repayment of the UNROB loan, and the use of the present reserve for repayment of the loan to reduce the overdraft. Resolution no. 2/June 86 refers.

(5) Possibility of new salary scales

It was pointed out that a thorough review of the salary scales would take two years at least. For the time being, the NO scale has been extended.

(6) Matlab building

It was proposed that the decision on whether or not to go ahead with the building of the new Matlab Treatment Centre should be deferred until the November 1986 Board Meeting. This proposition was made in view of the grave financial situation. Mr Bashir advised that the agreement has already been signed by the Government of Bangladesh and UNCDF and that the building has been announced publicly by the former Health Minister while in Matlab. Professor Eeckels said that Mr Morse also announced that UNCDF would be giving these funds to the Centre at the ICORT II meeting in December 1985.

There was considerable discussion of the pros and cons of continuing with the Matlab building. Professor Kostrzewski said "As I mentioned at the Programme Committee meeting three days ago, the Board of Trustees should make its decision on the basis of adequate information presented to the Board concerning the subject of the decision. The information concerning the construction of the Matlab

treatment centre presented to the Board is not adequate. The Board has not been informed of the financial consequences of building the new Matlab centre. For example, we have not received information on the equipment for the centre, how much this will cost and who will cover these expenses. It is also not clear how much the operating costs of the new centre will increase. In view of the difficult financial situation and in light of the overdraft foreseen at the end of 1986 and at the beginning of 1987, we should postpone the decision until November 1986, in order to receive from the management of the ICDDR,B adequate information with regard to the new Matlab centre.". Other members noted that the Board had permitted the building to go forward to the point of agreement on funding between the Government of Bangladesh and the UNCDF, and that there was no doubt of the need for better facilities at Matlab.

Professor Bell summarized by saying that the Board is not happy with the documentation presented but, at the same time, the Board has approved this project in principle and had only instructed that the plans be submitted to the Board before construction commenced. This has been done as per the Board's request. In the end, the Board agreed that construction should proceed. Dr Feachem requested that his vote against this proposal be recorded.

In addition to discussing the six items mentioned above, the Board noted that the Finance Committee had discussed the questions of depreciation and the auditor's report. Mr Bart said that their consultant, Peter Rouselle, had questioned the appropriateness of depreciation for this institution. He said, however, that USAID would respect that approach if the Board feels comfortable with it. Dr Cornaz said other donors feel that it is important to keep depreciation in the accounts. Mr Bart said USAID would accept whatever decision the Board made on this matter.

The following resolutions were passed:-

RESOLUTION 1/June 86 The Board recognizes that the stringent measures that have been implemented since July 1985 have already achieved reductions in unrestricted core funded expenditure equivalent to $596,000 per year, and that actions already taken will result in a further core funded expenditure reduction of about $460,000 from July 1 to December 31, 1986. Nevertheless, the Board considers that the financial position remains

extremely grave and the future availability of funds is uncertain and, therefore, requests the Director to take measures that will achieve a further reduction in expenditure from the unrestricted core budget of $200,000 during the period July 1, 1986 to June 30, 1987.

RESOLUTION 2/June 86 — The Board resolves that the Government of Bangladesh be requested to allow a further extension of one year of the UNROB loan and, if the request is granted, allows the Centre to reduce the bank overdraft by appropriating the reserve that has been kept for repayment of the loan.

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Indian Airlines	US$ 129
SYD Travels	US$ 1,287

RESOLUTION 8/June 86 — The Board approves a revised 1986 budget expenditure of $9.5 million as follows ($ thousand):

Funded Research (Direct Cost) $6.656

Core Costs (Indirect Cost) $2.893

Funded research may be expanded as additional sources of income are identified so long as this will not result in any additional core costs. Any additional core income is to be used to generate an operating surplus.

RESOLUTION 9/June 86 The Board authorizes the Director to appoint an individual to act temporarily as a Group I signatory when all Group I signatories are expected to be outside Bangladesh.

Agenda 8: Personnel & Selection Committee Report

Professor Bell requested Dr Cornaz, Chairman of the Personnel & Selection Committee, to give the Committee's report. Board Members read the report and then Dr Cornaz led them through the report discussing each item point by point.

International contracts and reintegration at NO level

Before the discussion on this subject commenced Dr Cornaz pointed out that one person affected by the reintegration at NO level was Mrs Wendy Hussain and that Mrs Hussain died during the Spring. Dr Cornaz said that Wendy was a very good Head Nurse and expressed the regret of the Committee and Board.

There was a lengthy discussion on the above subject, both in the meeting on Tuesday afternoon, June 17, and again on Thursday, June 19. The discussion revolved around (a) a proposal that there should be a small task force formed to review certain of the decisions made last November, and, in the meantime, these particular decisions should be held in abeyance; (b) the six-year rule for scientific staff; (c) the desirability of maintaining a geographic balance of staff at the international leve; (d) the fact that the Centre is still in a precarious financial situation and hence the need to reduce the number of international level positions; and (e) the need to demonstrate to donors and others that the Centre is continuing to strive for a leaner and more efficient Centre. Professor Bell summarized these

discussions saying that, on the one hand, it is realised that the Board actions taken in November were severe, but that they must basically go into effect due to the finances of the Centre, the need for the Board to be consistent with its own decisions, and the need not to lose donors' confidence, but that, on the other hand, it is argued that the decisions made in November can be challenged and may have done some injustice/inequity and so a number of decisions taken should be held in abeyance.

It was finally agreed that a Task Force should be set up and its Terms of Reference are set out in Resolution 10/June 86. It was agreed that the Task Force should be chaired by Mr Manzoor ul Karim as he is Chairman of the Personnel & Selection Committee, that members of the Task Force should include one other Board Member, 2 Bangladeshis not working in the Centre (one would be Brigadier Heyadetullah), and the Director. Dr Feachem agreed to serve as the other Board Member on the Task Force. Dr Merson said that WHO may be able to pay one fare of the Board Member. The Task Force should meet several times but it was realised that the Board Member may not be able to attend all meetings. The bulk of the work will need to be prepared by staff and maybe one staff member should be assigned to the task for 3 or 4 months. The Task Force should give a report to the Board in November 1986 and it is realised that this may be an interim report.

Acquired Rights

There was a lengthy discussion also on this subject. In response to Professor Eeckels query of how to accommodate a younger person and an older person, both of whom would be able to carry out an advertised position (but at different levels), he was advised that the UN system requires first that the level of the position be decided. Once the level is decided then if a younger less experienced person was the best candidate then he could offer the position to that person at a lower level. After say, one contract, that person could then request a promotion, in view of increased experience, to the level at which the position was advertised. He would not have to go through another competition for the position. It is possible to employ at a level lower than the position is advertised but it is not possible to

employ at a higher level than advertised without changing the job description and going through the advertising process again.

Resolution 11/June 86 was agreed to. This resolution takes into account that in November 1985 the Board asked the Director to renegotiate contracts with "undue" acquired rights, and a WHO senior personnel officer later advised that the Centre should let current contracts with "acquired rights" run their terms. The word "undue" was deleted by the Board as it caused confusion. Some Board Members registered dissatisfaction that the "acquired rights" have not already been eliminated. It was pointed out that the Director reported the WHO personnel officer's advice to the Executive Committee in March and the Executive Committee felt that the advice should be followed. The Director said that the Board should be aware of the risk, to the Centre, of disallowing contractual rights to persons currently in the Centre before the end of their present contracts.

Salary Cut for International Level staff

The Director was requested to write to staff members who accepted the cut advising them of the Board's gratitude and to those who did not accept the cut referring to the Board's dissatisfaction.

Husband and Wife Teams

It was reported that Dr Stanton will be, from 1 July, 1986, an employee of The Johns Hopkins University and not the Centre. Professor Eeckels said that he is not happy with the way the secondment was arranged but that the donor (USAID) had its own legal constraints. Dr Bart has agreed that in future, if in any way possible, the Centre shouldn't be involved financially and that secondments should be done directly.

It was pointed out that the present arrangement is in fact a reimbursable secondment and under these terms Dr Stanton would be considered a spouse as per WHO rules.

The Board recorded its uneasiness at the above solution and accepts that the problem is awkwardly, but satisfactorily, resolved. Professor Beckels agreed to make one more attempt to get USAID to pay Dr Stanton directly. The question of different types of secondment should be considered at the next meeting.

Education Grant

A request has been forwarded by the Ministry of Health to the Ministry of Law seeking clarification as to whether or not Bangladeshi nationals at the international level should receive the Education Grant while posted in Bangladesh. It is hoped that this clarification will be received before the beginning of the new school year. This is one case where the Ordinance and the UN rules may be in conflict.

Anomalies in P level scales

In response to a query as to whether or not any progress had been made in new hiring, the Director informed the Board that Dr V. Fauveau was hired at the step below the ceiling given by the Board and that one P1 consultant was replaced by another consultant at P1 Step 1.

Staff Reduction

Professor Bell advised that savings in staff at the NO and GS levels have been made (66 positions so far and 33 more to be reduced) but not as much as envisaged by the Board, as the majority of staff are supported by projects or are assigned to service activities. The Director has been requested to reach a target for reduction in expenditure and it is up to him as to what extent staff reductions at the NO and GS levels are required.

Appointments

Applications for the position of Head, Dhaka Hospital have been reviewed and short-listed by two eminent physicians from outside the Centre, in addition to the usual Centre procedures for a P3 level position. It was agreed that Dr A.N. Alam should be appointed (Resolution 12/June 86 refers).

Contract Renewals (Scientific)

The Board was advised of the persons willing to be considered for extension and each case was discussed. Resolutions 13/June 86 and 14/June 86 outline the decisions taken. Dr Merson requested that his vote against Resolution 14/June 86 be recorded.

It was noted that Dr Brad Kay wishes to extend for one year only, i.e. to 31 July, 1987 and that Dr D. Sack does not wish to extend beyond the present expiry date of his contract which is 30 June, 1987.

New Positions (Scientific)

The Board approved the advertisement, subject to availability of funds, of three positions (see Resolution 15/June 86) and noted that the Director is attempting to fill the following positions by secondment:- Epidemiologist (CDC), Pathologist (DANIDA), Nurse Matron (DANIDA), and Nurse Health Educator (WUSC).

Administrative Positions

Mr M.R. Bashir - Resolution 16/June 86 details the decision made re Mr Bashir and the position of Resources Development Officer P5.

The Board discussed the future organization and staffing of the Centre for managing its finance, personnel, and general support services activities. Officers responsible for these three sets of activities currently all report separately to the Director. The Board agreed with the Director that it would be simpler and more efficient to have, as in the past, a single senior officer reporting to him,

to whom the chief officers concerned with finance, personnel, and general support services would report. The senior officer might be called Associate Director, Finance and Administration.

The Board also concluded that it should be feasible to find well-qualified Bangladeshis to staff the positions of the chief officers concerned with budget and personnel at the NO level. The Board noted that Mr H. Janssen, Chief Finance Officer, does not wish to extend his contract beyond its present expiry date (June 30, 1987). WUSC have been requested to find his replacement.

The contracts of persons currently filling other international positions on the administrative and financial side, Mr R. Dery, Administrative Services Officer (currently Acting Chief Personnel Officer) and Mr L. Chang, Budget and Finance Officer, expire on June 30, 1987. Accordingly, the Board decided to collapse these three international positions on the administration and finance side of the Centre as of June 30, 1987, and authorized the Director immediately to begin recruiting an Associate Director, Finance and Administration. Resolution 17/June 86 refers.

Post Adjustment Multiplier

After discussion, it was agreed that the -10 multiplier should be applied to all international level staff. For those persons who agreed to the 10% cut in salary, the 10% cut will be reduced by the amount of the -10 multiplier thus ensuring that there is no reduction in take home pay while the 10% cut is in force.

The following resolutions were passed:-

RESOLUTION 10/June 86 The financial problems of the Centre have necessitated the implementation of a comprehensive package of measures to reduce expenditure. These measures were proposed at the November 1985 meeting of the Board and the current meeting has reviewed, modified and strengthened them in the light of new information available. These measures, although essential for the survival of the Centre, have created a radical and abrupt change in the staffing pattern of the Centre at the international level. Some of the features of the new staffing pattern may

not be desirable in the longer term. In addition, considerable progress has been made in defining the research priorities of the Centre and in evolving a new structure for scientific management, leadership and coordination. In view of the above, the Board resolves to appoint a Task Force with the following terms of reference:

1. In light of the research priorities, overall objectives and new management structure of the Centre to determine the needs of the Centre for international posts and to propose guidelines on their number, roles and balance of nationalities.

2. To compare the current staffing pattern at the international level with the result of item (1) and to propose a detailed plan for achieving the desired pattern by the end of 1987.

3. To consider and make recommendation on whether, and in what way, the "six-year rule" should be applied after the new staffing pattern defined under item (1) has been implemented.

4. To identify appropriate policies for the Centre to foster the careers of its Bangladeshi scientists, including international scientists, attached senior scientists, and (post) doctoral research fellows.

5. To examine the pay structures of the Centre, particularly at the international level, and make recommendations about the appropriateness of the current application of WHO pay scales to international posts at the Centre in the light of the difficult financial position of the Centre and the cost of living in Bangladesh.

6. To recommend appropriate measures as may be justified to meet the long term objectives of the Centre. Within this item the Task Force may also examine the cases of the persons who have been affected by the resolutions of the Board in November, 1985 and may make appropriate recommendations.

RESOLUTION 11/June 86

The Board reaffirms its resolution of November 1985 that all contracts with Centre staff that do not fully conform to the ICDDR,B staff rules should be renegotiated and instructs the Director to complete these renegotiations by December 31, 1986, at the latest. Further, the Board resolves that all new contracts, whether they be with existing or new members of staff, shall contain no provisions, payments or allowances (in money or in kind) that do not conform with ICDDR,B staff rules.

RESOLUTION 12/June 86 — The Board authorizes the Director to appoint Dr A.N. Alam as Head, Dhaka Hospital at P3 level.

RESOLUTION 13/June 86 — The Board authorizes the Director to extend the contracts, on a proper basis, for a period up to three years of –

Dr M.G.M. Rowland, Senior Scientist;
Dr B. Wojtyniak, Scientist;
Dr J. Clemens, Scientist;
Dr F. Henry, International Research Associate; and
Dr I. Ciznar, Senior Scientist.

RESOLUTION 14/June 86 — The Board authorizes the Director to negotiate a new contract with Dr M. Bennish if funds are available provided they do not come from pharmaceutical firms.

RESOLUTION 15/June 86 — The Board authorises the Director to advertise, subject to the availability of funds, for the posts of

- Senior Scientist, Clinical Services, P6
- Environmental Microbiologist, level to be determined
- Paediatric Gastroenterologist, level to be determined

RESOLUTION 16/June 86 — The Board resolves to abolish the post of Resource Development Officer at P5 as of 1 July, 1987 and to authorize the Director to extend for 1 year on a proper basis Mr M.R. Bashir's contract.

RESOLUTION 17/June 86 — The Board decides to collapse the postions of Chief Personnel Officer P3, Budget and Finance Officer P2, and Administrative Services Officer P4, as of June 30, 1987. From July 1, 1987 there should be a position of Associate Director, Finance and Administration, at the international level (P4-P6), the person holding this position being supported by Budget, Personnel and Administrative Officers at the National Officer level.

Agenda 9: Nominations of Trustees

Drs A.R. Al-Sweilem, I. Cornaz and Prof. D. Rowley were unanimously re-elected for second terms of 3 years each.

Professor Bell advised that two new Board Members needed to be chosen to replace Dr J. Sulianti Saroso and Dr D. Sebina. Dr Sulianti has reached the end of her statutory period as a Trustee and Professor Bell said that the Board feels regret at her having to leave as she has served the Board brilliantly, faithfully and energetically. She was the first Chairman of the Board and she was a wise participant in the recent Executive Committee meeting. Professor Bell advised the Board that Dr D. Sebina, a very valued member of the Board, had to resign as he has joined the World Bank and under their rules must resign from the Board. A replacement needs to be found to complete Dr Sebina's term, i.e. to 30 June, 1987. On completion of one year the new Trustee would be eligible to be considered for re-election to one full three-year term as a Trustee.

After discussion, the Board agreed on a priority listing of individuals and alternates for the two vacant seats on the Board, and authorized the Chairman to issue invitations accordingly.

The following resolutions were passed:-

RESOLUTION 18/June 86 — The Board reappoints Dr A.R. Al-Sweilem, Dr I. Cornaz, and Prof. D. Rowley as Members of the Board for three years each. The Board authorizes the Chairman to invite two individuals to serve as new Members of the Board, in accordance with the priority listing of individuals and alternates agreed by the Board at this meeting.

RESOLUTION 19/June 86 — The Board expresses its deep appreciation to Dr J. Sulianti and to Dr D. Sebina for their excellent contributions to the Centre. In her long service to ICDDR,B, beginning as first Chairman of the Board, subsequently as Chairman of the Personnel and Selection Committee, and as Member of Committees and of the full Board, Dr Sulianti has been a faithful, energetic, and wise participant in Board deliberations, bringing to bear her broad experience in national and international health and her great store of human warmth and sensitivity. Dr Sebina served more briefly, but contributed strongly to the Centre; as Member and Acting Chairman of the Finance Committee, and participant in full Board discussions,

Dr Sebina benefitted us by his able and balanced judgment. We wish Dr Sulianti and Dr Sebina long life and happiness.

Agenda 10: Election of Chairman of the Board - Membership of Committees of the Board

Professor David Bell accepted to be Chairman for a further year and expressed his deep appreciation for the cooperation he has received from the Board.

The following resolutions were passed:-

RESOLUTION 20/June 86 The Board elects Professor David Bell as Chairman of the Board for a further year from July 1, 1986 by acclamation. The Board thanks Professor Bell sincerely for the services he rendered as Chairman during the past year.

The formation of the various Committees was then discussed and resolutions passed as follows:-

RESOLUTION 21/June 86 The Board appoints to the Personnel and Selection Committee:
Mr Manzoor ul Karim, Chairman of the Committee
Dr I. Cornaz
Dr M. Merson
Dr V. Ramalingaswami
Prof. D. Rowley
Prof. D. Bell, Ex Officio (Chairman of the Board)
Prof. R. Eeckels, Ex Officio (Director)
for one year effective 1 July, 1986.

RESOLUTION 22/June 86 The Board appoints to the Finance Committee:
Dr R. Feachem, Chairman of the Committee
Mr M.K. Anwar
Dr Nyi Nyi
Prof. D. Bell, Ex Officio (Chairman of the Board)
Prof. R. Eeckels, Ex Officio (Director)
for one year effective 1 July, 1986.

RESOLUTION 23/June 86 The Board appoints to the Programme Committee:
Prof. D. Rowley, Chairman of the Committee
Dr L. Mata, Vice-Chairman of the Committee
Dr A.R. Al-Sweilem
Prof. J. Kostrzewski
Prof. M.A. Matin

Dr Y. Takeda
Prof. D. Bell, Ex Officio (Chairman of the Board)
Prof. R. Eeckels, Ex Officio (Director)
for one year effective 1 July, 1986.

Agenda 11: Dates of Next Board Meeting

It was agreed that in future the Board Meetings should not be so long. Two days should be set aside for Committee Meetings, 1 day for report writing and 3 days for the full Board Meeting (the second night to be kept free in case a night session needed). The members of the Programme Committee would come a little earlier whenever possible.

The November 1986 meeting will be held from Thursday, 20 November to Wednesday, 26 November, 1986 inclusive.

Tentative dates for the June 1987 meeting are Sunday, 14 June to Friday, 19 June, 1987 inclusive.

Agenda 12: Miscellaneous

Donors' Meeting

It was agreed that the timing of the Donors' Meeting should be left to the Director. Should he wish to continue with the meeting in September 1986, invitations would need to go out by the end of June and the documents sent by the end of July. The document presented to the Board needs redrafting and a research plan included.

Professor Bell closed the meeting by wishing Dr Sulianti a long life and happiness.

4.9.86

2/BT/NOV.87
Appendix.

RESOLUTIONS OF THE
BOARD OF TRUSTEES MEETING
17-19 JUNE,1986

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RESOLUTIONS

BOARD OF TRUSTEES MEETING

17-19 JUNE 1986

RESOLUTION 1/JUNE 86

RESOLVED : The Board recognizes that the stringent measures that have been implemented since July 1985 have already achieved reductions in unrestricted core funded expenditures equivalent to $596,000 per year, and that actions already taken will result in a further core funded expenditure reduction of about $460,000 from July 1 to December 31, 1986. Nevertheless, the Board considers that the financial position remains extremely grave and the future availability of funds is uncertain and, therefore, requests the Director to take measures that will achieve a further reduction in expenditure from the unrestricted core budget of $200,000 during the period July 1, 1986 to June 30, 1987.

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RESOLVED : The Board resolves that the Government of Bangladesh be requested to allow a further extension of one year of the UNROB loan and, if the request is granted, allow the Centre to reduce the bank overdraft by appropriating the reserve that has been kept for repayment of the loan.

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RESOLVED : The Board accepts that for the time being the Centre's Reserve Fund assets be invested in U.S. dollar term deposits with the Centre's principal banker, American Express, for terms to maturity not to exceed one year with early encashment options.

RESOLUTION 4/JUNE 86

RESOLVED : The Board approves a change in depreciation rates effective from January 1, 1987 as follows: buildings 5 percent; vehicles 25 percent; furniture and equipment 20 percent; and other assets 20 percent.

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RESOLVED : The Board reaffirms its resolution of November 1985 that all contracts with Centre staff that do not fully conform to the ICDDR,B staff rules should be renegotiated and instructs the Director to complete these renegotiations by December 31, 1986, at the latest. Further, the Board resolves that all new contracts, whether they be with existing or new members of staff, shall contain no provisions, payments or allowances (in money or in kind) that do not conform with ICDDR,B staff rules.

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RESOLVED : The Board authorizes the Director to extend the contracts, on a proper basis for a period up to three years, of:-
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RESOLVED : The Board decides to collapse the positions of Chief Personnel Officer P3, Budget and Finance Officer P2, and Administrative Services Officer P4, as of June 30, 1987. From July 1, 1987 there should be a position of Associate Director, Finance and Administration, at the international level (P4-P6), the person holding this position being supported by Budget, Personnel and Administrative Officers at the National Officer level.

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RESOLVED : The Board elects Professor David Bell as Chairman of the Board for a further year from July 1, 1986 by acclamation. The Board thanks Professor Bell sincerely for the services he rendered as Chairman during the past year.

RESOLUTION 21/JUNE 86

RESOLVED : The Board appoints to the Personnel and Selection Committee:

Mr Manzoor ul Karim, Chairman of the Committee

Dr I. Cornaz

Dr M. Merson

Dr V. Ramalingaswami

Prof. D. Rowley

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Prof. D. Bell, Ex Officio (Chairman of the Board)
Prof. R. Eeckels, Ex Officio (Director)
for one year effective 1 July, 1986.

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Mr M.K. Anwar
Dr Nyi Nyi
Prof. D. Bell, Ex Officio (Chairman of the Board)
Prof. R. Eeckels, Ex Officio (Director)
for one year effective 1 July, 1986.

RESOLUTION 23/JUNE 86

RESOLVED : The Board appoints to the Programme Committee:
Prof. D. Rowley, Chairman of the Committee
Dr L. Mata, Vice-Chairman of the Committee
Dr A.R. Al-Sweilem
Prof. J. Kostrzewski
Prof. M.A. Matin
Dr Y. Takeda
Prof. D. Bell, Ex Officio (Chairman of the Board)
Prof. R. Eeckels, Ex Officio (Director)
for one year effective 1 July, 1986.

3/BT/NOV.86

DIRECTOR'S REPORT

4/BT/NOV. 86

SUMMARY REPORT ON
RESOURCES DEVELOPMENT AND FINANCIAL SITUATION.

SUMMARY REPORT ON RESOURCES DEVELOPMENT

The Centre's income for 1986 was projected at US $ 10,088,000 by Resources Development at the June 1986 meeting of the Finance Committee. Actual commitments now stand at $9,303,000 with another commitment of $200,000 from NORAD, expected to be finalised by December 1986, as advised by their local office. This brings the total income for 1986 to $9,503,000.

There is a difference of US $585,000 between the June 1986 projections and commitments received to date. One of the major factors responsible for this shortfall in income is that the Centre had expected US $580,000 from USAID for the UVP for 1986. According to a draft agreement, the effective date for the start of the grant was to have been June 1. Subsequently however, due to technical difficulties and problems of identifying an appropriate funding mechanism, there was a delay in finalising the agreement. The effective starting date for the grant as signed in Washington is October 1 and the amount made available to the Centre for UVP for 1986 is $175,000.

Regarding the Centre's cash flow situation, we draw the Committee's attention to our June statement where we had mentioned that it would be possible to remain within the bank overdraft limit for the rest of 1986. We are pleased to inform the Committee that the Centre has been able to reduce its bank overdraft substantially and we now expect it to remain below US $2,000,000 till the end of this year.

1987

The Centre's income projection for 1987 made in June 1986 was US $10,912,000. Our revised estimate for 1987 is now $10,065,000. The reduction in income forecast by $847,000 was caused by the following:

a) We had anticipated UNICEF contribution to the Centre's core fund at an amount of US $ 500,000. This figure now stands reduced at $250,000.

b) USAID contribution to the Centre's core fund was also estimated at US $500,000. This figure has also been reduced to US $250,000.

(c) DANIDA contribution to the Centre's restricted core fund was estimated at US $1,000,000. This figure now stands reduced at $700,000.

(d) USAID contribution to UVP which was estimated at US $1,000,000 has now been finalised at US $ 750,000 for 1987.

Firm donor commitments for 1987 received to-date now stand at US $ 7,915,000 and we expect to raise another US $2,150,000 during the course of 1987.

5/BT/NOV. 86

PROGRAMM COMMITTEE REPORT.

5/BT/Nov. 86

REPORT OF THE MEETING OF THE PROGRAMME COMMITTEE

The Programme Committee to the Board of Trustees, ICDDR,B met on November 21, 1986 from 9 am to 1:15, and from 2:15 to 6:15

Members present:	D.E. Bell (Acting Chairman)
	D. Habte
	R. Eeckels
Co-opted Members:	I. Cornaz
	K.A. Monsur
	P. Sumbung
Members absent:	D. Rowley (Chairman)
	A.R. Al-Swailem
	J. Kostrzewski
	L. Mata (Vice-Chairman)
Staff:	D. Sack
	M. Rowland
	M. Badrud Duza
	I. Ciznar

Report on Organizational Structure and Progress of Programme

The Director described the structure of four research divisions through which the Centre's research programme is managed. These are shown on the Organogram which has been provided to Board members. Their titles and the units within them are rather different from the organizational structure of the last several years. The Director expressed the view that by and large these divisions are beginning to shake down as effective working units and seem in general to be satisfactory from his point of view and that of the research staff. (The remaining two major units shown on the Organogram - the Resources Development Office and the Support Services Division - in contrast are still quite far from final in the Director's view.)

The Director considers that there are some anomalies and uncertainties remaining regarding these four divisions. For example, he thinks that in due course the Epidemiology Department should be shifted from the Laboratory and

Epidemiology Science Division to the Community Medicine Division. For another example, he notes that the training function is temporarily lodged with the Resources Development Office pending review of the recently completed report of the training task force. But in general he thinks there has been important progress toward order and clarity.

The Committee agrees with this view, and considers that the present organizational structure represents a major step in the right direction, although there are clearly additional changes to be made. At the same time, the Committee registered several comments and questions for consideration by the Director as the organizational structure evolves further.

1. The Committee understands that the program of the Centre is giving greater emphasis to disease prevention and health promotion, which the Committee is very glad to see. It would be helpful if ways could be found to make that emphasis plainer in the titles of divisions and units, especially in the Community Medicine Division and the Population Science and Extension Division. ("Extension", in particular, is not a word that will convey much to the donor community.)

2. The Committee also applauds the greater emphasis the Centre is giving to the social sciences such as anthropology, and hopes that also might be reflected more clearly in organizational structure and titles.

3. The Committee looks forward with keen anticipation to the further development of the Centre's training program, which is a central part of the Centre's responsibilities.

The Committee then reviewed briefly the status of work in each of the four divisions. The prepared statements of each division are clear and relatively brief, and the Committee recommends that each Member read them. Only a few highlights are included here especially those that raise issues for Board action.

Community Medicine Division

The Committee was informed that Dr. M. Rowland, the head of the Division, has decided to leave the Centre at the end of his present contract in September 1987. Dr. Stanton, the head of

the Urban Volunteer Project, left in September, and a replacement is being urgently sought.

Most of the work of the Division has just been reviewed by Drs. John Ross and Shanti Ghosh with strongly favourable results.

The program in the Matlab area is changing substantially and rapidly, with much more emphasis on MCH interventions and research underway or planned on maternal mortality, acute respiratory infections, prevention of diarrhoea, and nutritional improvement based on locally available foods.

An important question relates to the future of Teknaf. the CIDA funding for the Teknaf DSS (including the health centre) runs to the end of 1987. Many reasons of managerial efficiency argue for planning to close Centre activities there at that time, after careful advance and planning with the people of the area, the donors, and the Government of Bangladesh. The only question which has arisen is that the Centre is about to expand its work on shigellosis, and there is in the Teknaf area an unusually high incidence of resistance to the latest antibiotics used againat the disease. The question identified by the Committee was whether the opportunity to conduct research under these circumstances is sufficiently unique to warrant continuing to use Teknaf as a research area, assuming project funding could be found to cover the costs. The Director and his colleagues require more time and thought before they can answer this question.

Laboratory and Epidemiology Sciences Division

As has been known for some time, Dr.David Sack, the head of the Division, is leaving the Centre in June 1987. No replacement has been found as yet. On the other hand, Dr. Kay, the head of the Laboratory Services Department, has indicated his willingness to stay on for an extra year, until the end of 1988. (This is discussed further in the Report of the Personnel and Selection Committee, since the post has already been advertised.) Moreover, Dr. Clemens, the head of the Vaccine Trial, and Dr. Ciznar, the head of the Immunology and Bacterial genetics Unit, have extended their contracts for three years, to December 31, 1989.

With respect to the cholera vaccine, the Committee was disappointed to learn that there are no further findings as yet on the length of effectiveness of the test vaccines. Data through June, 1986, however, are almost fully entered into the computer, and new results are hoped for in a few weeks. Further analysis of the data from the first six months of the trial in 1985 has added the important information that two doses of the vaccine are almost as effective as three.

The laboratories continue to improve in modernization and efficiency. New equipment has been ordered for the biochemistry lab (using USAID Director's discretion funds), and the Clinical Laboratory Branch at long last is moving into the hospital (a move planned since 1978).

Population Science and Extension Division

This Division, under the direction of Dr. Badrud Duza, has just been reviewed by Drs. John Ross and Shanti Ghosh, also with strongly favourable results.

The two largest projects in the Division, the DSS (funded by CIDA), and the MCH-FP Extension (funded by AID), will need an extension of funding following the end of 1987, hopefully for five years in each case. Negotiations will commence soon.

Clinical Sciences Division

This Division has no full-time head, with Dr. Eeckels acting part time in that capacity. The Committee was favourably impressed by how much Dr. Eeckels has managed to accomplish in a short time to introduce a much stronger spirit of research into the Dhaka Treatment centre, by establishing research "firms" and clarifying the organizational responsibilities for research work. Dr. Eeckels informed the Committee that work on improved types of ORS continues in this Division. Dr. Eeckels also informed the Committee that there are possibilities, at early stages of negotiation, for collaborative relationships on shigellosis with Dr. Keusch of Tufts University, USA, and on chronic diarrhoea with Dr. Guerrant of the University of Virginia, USA.

All in all, the Committee can report to the Board that it was favourably impressed by the progress being made toward more orderly, sustained, and high-quality programmes in these four divisions. There are many important issues ahead, prominently including the need to recruit for several crucial

positions of scientific leadership, and the need to develop a fuller and stronger statement of research objective and priorities. Nevertheless, the Committee wishes to record its pleasant surprise at the rapid gains in recent months.

Recommendations on the Composition, Method of Work, Duties, Powers and Functions of the Ethical Review Committee of ICDDRB

In June the Board approved the establishment of a joint committee of ERC and ICDDR,B to prepare a statement of duties, powers, and functions of the Centre's Ethical Review Committee. That Committee functioned under the chairmanship of our new Board colleague, Dr. K.A. Monsur, and produced a major document for consideration at the present Board meeting.

The Committee has discussed thoroughly the Recommendations presented by the joint committee, and with a few minor caveats finds that they constitute an admirably complete, coherent, and clearly stated charter for the ERC. Two or three minor editorial changes in the recommendations were agreed. The Committee recommends that the Board adopt the Recommendations to take immediate effect, with a few specified exceptions on which further drafting is desirable, and request the joint committee, continuing under Dr. Monsur's chairmanship, to complete the further drafting and bring it back to the Board for final action in June.

The exceptions on which the Committee recommends that the Board request further drafting work are as follows:

1. Paragraphs 4.3 and 4.4 on page six describe the processes to be followed if the ERC has reason to feel that the ethical requirements of a protocol are not being properly met.

The committee felt that these two paragraphs should probably be reversed in order, and that the procedures regarding suspension should be revised to make it clear, that a suspension should be temporary pending an enquiry that includes giving the investigator(s) an opportunity to defend. Dr. Monsur stated that he thought these changes would be entirely in accord with the intentions of the joint committee.

2. Paragraph 4.6 on page 7 needs review with respect to the narrow point whether the ERC need approve the first one-year extension of time for an approved protocol.

3. With respect to Annexure II,

a) The question was raised whether the adjective "new" should be dropped from the title, from para 1(d), from para 2, from para 2a, and from para 2e;.

b) Para 2(a) needs to be clarified;

c) Para 2(e) needs to be clarified;

d) In para 2(g), line 6, the words "and the sponsor" should be added after "ICDDR,B".

The Committee reommends a vote of thanks by the Board for the splendid work of the joint committee under Dr. Monsur's hard-driving leadership, and is most pleased to have the serious problem of unclear guidelines for the ERC almost completely solved, with the few remaining issues in sight of solution by June.

Ethical Problems Related to Particular Protocols

In the past year, individual Board members have raised questions about the ethics of two protocols. With respect to one, (a protocol on measles vaccination), on which a question was raised in November, 1985, the Director asked the ERC to review the protocol again. The ERC did so, and confirmed its positive finding. In June, 1986, the Director was instructed to ask for another opinion. The Director felt that he should do this via the ERC, which he has done. Thus far, the ERC has not responded.

With respect to the other case, (a protocol on Ciprofloxacin), a question was raised at the June, 1986, Board meeting. The Director has asked the ERC to review the protocol again; thus far, the ERC has not responded.

In the light of the new ERC guidelines, the Committee reached the following conclusions with respect to questions by Board members about the ethics of protocols that have been approved by the ERC.

1. It is entirely appropriate for Board members to raise such questions. Board members should state their questions in writing, and the Board after due notice should discuss them. If the Board agrees there is weight to the questions, they may be referred to the ERC in writing, with a request for reconsideration. The ERC will be expected promptly to reconsider the protocol, and to reply to the Board in writing.

2. If the ERC confirms its prior judgement, and the Board continues to believe there are significant questions of ethics involved, the Board may request the ERC, in writing, to seek expert consulting advice, as is provided for in the ERC

guidelines. The ERC's decision, after seeking such advice, will be final, as the guidelines state.

In the case of the two protocols that have been questioned during the past year, the Committee recommends to the Board that the Board members who raised the questions be asked to put them in writing, and the above procedures be followed. The informal referrals the Director has made, that are currently pending with the ERC, should be withdrawn.

Contacts Between the ICDDR,B and Industry

As requested by the Board, the Director has provided a position paper on the guidelines that should be followed with respect to relations between pharmaceutical companies and the Centre. This paper most usefully summarizes the numerous past cases in which pharmaceutical companies provided all or part of the funding for research protocols carried out by the Centre. The paper concluded by recommending certain guidelines for the Centre to follow with respect to future protocols and other activities (e.g. research seminars, conferences) in which funding from pharmaceutical countries may be involved.

The Committee discussed the Director's findings and recommendations at length, and made several suggestions for modifications that the Director accepted. In its revised form, the Committee fully endorses the Director's paper and recommends that the Board adopt as Board policy the guidelines proposed by the Director. In addition, it should be noted that the guidelines for the ERC contain, as Annexure II, a set of "Review Procedures for Protocols Involving Use of New Drugs in Human Subjects". The Director proposed, and the Committee recommends, that the Board adopt these procedures for use throughout the Centre and for the guidance of all investigators.

External review by John Ross and Shanti Ghosh

It was noted earlier that two external reviewers, Drs. Ross and Ghosh, have recently completed an examination of the work of the Population Sciences and Extension Division, and of most of the work of the Community Medicine Division. (Certain units recently added to the latter Division were omitted from the review).

The report submitted by the reviewers, dated November 18 1986, is being made available to every Board member. It is a careful and expert report which in the Committe's view is of very high value to the Centre. It is reassuring to the Board in its general findings about the quality and value of the Centre's work in the areas reviewed. At the same time, as it should, it raises numerous important questions about improvements that could be made in the Centre's work, directions for future research, etc.

The Committee recommends:

1. That the Board express' its thanks to the reviewers for their excellent and very useful report.

2. That the Centre's management be asked to review the report with care, and to report to the Board at its next meeting its responses to the principal points made by the reviewers. The Director and the heads of the two Divisions involved may wish to make a few preliminary comments at the present meeting but clearly need more time to prepare a considered response.

3. That members of the Board be invited at the present meeting to raise any specific comments or questions they may have after reading the report, which they would like the Centre's management to consider in preparing its response.

4. That copies of the reviewer's report, together with a brief initial response by the Director, be included in the set of documents circulated for the donors meeting.

Fellowships for Scientists from Developing Countries

The Director informed the Committee that during 1986, apart from the international training courses offered, a long term fellowship has been offered to a Chinese scientist for one year, according to the terms of the collaborative agreement between the Centre and the Chinese Ministry of Public Health. The Centre has also announced a total of 14 fellowships to the 7 SAARC countries with two nominations from each country. The fellowships are for 3 months each and carry a monthly allowance of $1000 plus travel. All these fellowships are supported by funds made available by CIDA. The Centre has also provided the Project Coordination Committee with $10,000 for research and training activities during 1986-87. This would help strengthen the research potential of national scientists from Bangladesh.

Powers, Functions and Duties of Programme Coordination Committee

Board members will recall that, as required by the Ordinance, the Board has created a Programme Coordination Committee (PCC), and a Standing Committee (SC) which acts as the Executive Committee of the PCC. The general purpose of these Committees is to coordinate research by the Centre with that of other organizations in Bangladesh in the fields of the Centre's mandate, and ensure that the Centre shall be supportive of, and avoid actions prejudicial to, the interest of research carried out by other organizations in Bangladesh.

The PCC has now prepared a formal document stating the powers, functions, and duties of the PCC and SC, and has requested that the Board approve this document. Members of the Board who were in Dhaka (Bell, Eeckels, Cornaz, Monsur, and Sumbung) attended the PCC meeting on 20 November, 1986 at which the PCC approved this document and requested the Board to approve it.

The PCC document was subsequently reviewed by the Programme Committee at its meeting on 21 November, 1986 and the Committee recommends its approval by the Board. The principal obligations that will be undertaken by the Board, if it approves the PCC document, include the following:

1. Abstracts of all Centre research proposals, after they have been approved by Working Groups/Divisions, will be forwarded for information to the Standing Committee.

2. The Programme Committee of the Board will meet with the SC during each Board meeting, to discuss collaborative projects and other PCC/SC matters. This will begin with the June 1987 Board meeting.

3. Collaborative proposals betwen scientists in ICDDR,B and in Bangladeshi institutions may be presented to a joint Scientific Review Committee (SRC) including representatives of the Bangladesh Medical Research Committee and the Centre's Research Review Committee. If a proposal is approved by the SRC, and by the Centre's Ethical Review Committee, "it will be called a protocol and it will be funded from the PCC/BMRC fund or any other source".

The Committee noted that Dr. K.M.S. Aziz has been serving as Member-Secretary of the PCC/SC, and requested that the Director arrange with Dr. Aziz to serve as a consultant to the Centre for the time devoted to this post.

Report on Training in the ICDDR,B

A report has just been completed on training in the Centre. It was prepared by an internal committee chaired by Richard Wroot, Acting Head, Training, Library and Publications. The report was given to the Committee on the day of its meeting, so there was no time to read it or discuss it.

The Committee considers that training in the Centre is a very important subject, and regards the Wroot report as a valuable first step in establishing a strong training programme. At this meeting, the Committee simply calls the attention of Board members to the Wroot report, and recommends that the Board ask the Director for a report on training in the Centre for consideration by the Board at its June meeting. Among the subjects that should be covered are:

- the nature and scale of training activities that should be undertaken by the Centre;

- the organization and staffing of training activities, including the mix of centralized and decentralized activities; and

- the type and extent of equipment that should be available in the centre.

The Committee suggests that, having in hand the internal Wroot report, the Director shold seek the advice of external consultants, perhaps funded by one of the donor agencies with much experience in training, in the course of preparing his report to the Board.

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ATTACHMENT TO:

5a/BT/NOV.86

UPDATE ON PRIORITY PROGRAMME.

ATTACHMENT TO

5a/BT/NOV.86

DIVISION HEADS REPORTS

Community Medicine Division

Community Medicine is concerned with the promotion of health and the prevention of disease, with the assessment of a community's health needs, and with the provision of services to communities in general and to special groups within them. It complements the concerns of Clinical Medicine with the health of individual patients. The Community Medicine Division carries out its activities in both rural and urban areas.

Rural Community Studies

The main rural commitment is in Matlab where health services are delivered in an integrated Maternal and Child Health, Family Planning (MCH-FP) Programme with special emphasis on the treatment of diarrhoeal diseases. The main goal of the Matlab MCH-FP Programme is a substantial reduction in maternal and childhood mortality, particularly with reference to diarrhoeal diseases and the immunisable diseases. A number of steps have already been taken to help achieve this goal. First has been to improve our knowledge of the contribution of the various diseases to the bulk of morbidity and mortality in the population. Cause of death reporting has been improved and an internationally recognized classification has been adopted. Anthropometric and disease factors associated with risk of imminent death have been identified. Under-fives children with a mid-upper arm circumference of <110 mm and dysenteric symptoms, diarrhoea exceeding 1 week, or a lower respiratory tract infection are at substantial risk of death within 1 month of such events. Despite domiciliary and treatment centre facilities watery diarrhoea still appears to contribute to childhood deaths. A regular diarrhoea surveillance system is now in place based on the monthly reporting of childhood diarrhoea (simple, watery, dysenteric), as is a record of the use of oral rehydration solution provided through the bari-mother (household cluster) depot system. This information will be supplemented by a study of behavioural practices adopted by mothers in response to diarrhoea of various kinds. There are already indications from neighbouring Chandpur that ORS is not as widely used when dysenteric symptoms predominate. The implications of such practices for prevention of diarrhoeal deaths will be evaluated.

A major priority of this programme is the prevention of dysenteric deaths in childhood. Conventionally the mainstay of treatment has been the use of antibiotics bringing with it problems in the community of cost, distribution, possible complications and the rapid emergence of multiple resistant strains. Yet results in Matlab suggest that a substantial improvement in nutritional status in the community could be equally effective in reducing the number of deaths. The feasibility of this approach is given support by the much more favourable outcome of dysentery in boys, the difference apparently being related to their better nutritional status as compared with girls. As a matter of short term expediency the aim will be to reduce dysenteric deaths by the effective treatment of severe concommittant malnutrition in the Matlab

Nutrition Rehabilitation Centre. This activity will be disseminated in 1987 to the Subcentres also. The ultimate aim will be to improve the nutritional management of diarrhoea and the recovery phase.

The full range of immunisations is being introduced as an integral part of the EPI component of the MCH-FP Programme, as is the bi-annual community distribution of Vitamin A supplements. The latter is being phased in such a way as to permit evaluation of its impact on childhood mortality and even on diarrhoeal morbidity. The effect of Vitamin A on the course of a diarrhoeal episode will be investigated in patients attending the Treatment Centre.

In neighbouring Chandpur the community comparison of WHO and rice-based ORS is nearing completion with a study of relative costs involved particularly in the household. Amongst the insights afforded by available data are the effects of different treatment regimes on the outcome of diarrhoeal attacks including the incidence of persistent diarrhoea. This latter is another priority area of research justified by its excessive impact on health (growth) and mortality. The effect of ORS on persistent and dysenteric diarrhoea will be determined from current analyses. Both Matlab and Chandpur will yield data on the natural history and evolution of persistent diarrhoea.

In Mirzapur a preventive programme is in place specifically aimed at reducing diarrhoeal incidence rates with particular reference to shigellosis, through a combined water, sanitation and health education programme. The water intervention is based on provision of the Tara pump, one of whose virtues is the local manufacture of component parts and easy maintenance by community mothers with minimal training. Various design improvements have been made in the light of experience to date. Water use patterns are being monitored and related to changing morbidity levels. Acceptance rates are high. The latrine used is a ventilated twin-pit design which will hopefully obviate the need for periodic emptying. Acceptance and use of these latrines has been gradual and is still the subject of an intensive education programme. Currently diarrhoea rates are declining steadily in parallel in both intervention and comparison areas, though more so in the former. Studies are continuing in both areas to determine the reasons for this. An attempt will be made to assess the possible economic impact of improved water availability and reduced diarrhoeal morbidity.

Another study in the Mirzapur area is aimed at comparing nutritional status of the population with that of an urban population on the outskirts of Dhaka and to determine to what extent the differences may be due to varying exposure to diarrhoeal diseases rather than to primary dietary differences.

The Diarrhoea Treatment Centres and outreach services at Teknaf will be maintained at least until the end of 1987. Despite a substantial water sanitation programme in the recent

past the area continues to encounter very high rates of shigellosis (both in relative and absolute terms) and the occurrence of multiple resistant organisms. This remains an obvious candidate population if the ICDDR,B is to evaluate any large scale shigella intervention.

Urban Community Studies

The mainstay of the urban studies continues to be the Urban Volunteer Programme which offers a service in the majority of Dhaka's 18 districts. The main component of the primary health care service is still the provision of ORS and treatment of diarrhoea in the home and a number of community-orientated treatment centres. Other components have been nutritional, including the distribution of Vitamin A and the provision of nutrition rehabilitation facilities in the community.

A subsection of this programme has dealt with documenting environmental determinants of diarrhoeal morbidity with the aim of identifying specific behavioural risk factors. These in turn have been the subject of a specific preventive programme aimed at modifying selected patterns of behaviour and lowering the diarrhoeal incidence rates. In the process of doing this, a useful diarrhoea recall instrument has been developed which can be used to monitor diarrhoeal prevalence rates on a regular basis in the home. In the future emphasis will be of the follow up of diarrhoea cases discharged from the ICDDR,B Dhaka Treatment Centre, as currently most of these subjects are lost and the long term outcome of their treatment is not known.

PSED

Note for the Programme Committee,

Board of Trustees

November 1986

The new Division of Population Science and Extension (PSED) emerged in July 1986, following the decisions of the June 1986 Board meeting. Population related activities were carried out earlier under the former Community Services Research (CSR) Working Group. The present arrangement provides for more extensive opportunities for consolidating pertinent programmes under a distinct Division, addressing various methodological, substantive, and extension activities.

As presently conceived, the PSED comprises of the following major units:

I. Population Science Department

(i) Matlab DSS Branch

(ii) Teknaf DSS Branch

(iii) Matlab MCH-FP Population Section

(iv) Data Management Branch

II. Population Extension Department

(i) Abhoynagar MCH-FP Extension Branch

(ii) Sirajganj MCH-FP Extension Branch

III. Computer Information Services (CIS) Department

(i) System Development Branch

(ii) Technical Services Branch

(iii) Operations Branch

While exploring future programmatic directions for PSED, several points are to be kept in view:

(i) The transition from the earlier set-up, where Population was a part of another Working Group, to its present form is just beginning to crystalise, and we should allow ourselves a few additional months to make definitive plans for future.

(ii) This year population activities have been due for the usual four-yearly review, the last review having taken place in 1982. Starting early this month, two reviewers — Dr. John Allen Ross, a demographer from the Centre for Population and Family Health, Columbia University, and Dr. Shanti Ghosh, a Community Paediatrician from India - have been undertaking a three-week review of the Division (concurrently with a review of the Community Medicine Division, the second component of the erstwhile CSR). It is envisaged that the future programme of the PSED would be guided in light of the reviewers' comments as moderated by the Programme Committee of the Board of Trustees.

(iii) The agreement of both DSS and MCH-FP Extension Projects with the donors (CIDA and US AID respectively) is due for renewal next year (end of 1987). Pending such renewal and broad donor concurrence to our operations, it is somewhat premature to make specific and definite plans for future.

(iv) In light of ongoing structural changes in the Centre, directives of the Programme Committee of the Board also would prove most valuable in formulating PSED proposals for the donors as well as in working out the specifics of our research and related activities.

The brief observations noted below about PSED work plan are thus to be treated as tentative and contingent on inputs from various sources noted above. The following comments appear worthwhile:

(i) Population as a substative field should continue to play a pivotal role in the ICDDR,B framework. For, the investigation and understanding of diarrhoeal diseases in particular, and morbidity and mortality in general, in the context of the developing world can hardly be approached except in light of the syndrome of poverty, under-development, and high fertility, apart from the dynamics of population in broad terms.

(ii) Besides, and equally important, population studies — specifically, demographic surveillance — should continue to provide an indispensible element of monitoring and evaluation of diarrhoeal and other health interventions of the Centre. It is inconceivable that such interventions could ever be attempted by the health scientists of the Centre in the absence of high quality and precise socio-economic and demographic data on the population concerned, collected and presented on a longitudinal basis. Indeed, attempt should be made to progressively develop and link health surveillance with the existing demographic surveillance system.

(iii) Researchers in both health and population should be encouraged to engage in collaborative investigations which would provide for better utilization of existing data, and should generate new insight into the underlying dynamics.

(iv) As for DSS operations:

a) The main focus in the coming months should be on fulfilling existing commitments to the donor (CIDA) by way of completing research set forth in the existing work plan, and wrap up the current four year phase in a meaningful way.

b) The present work on preparation of the DSS data base development should proceed on schedule so as to complete the work by around the middle of 1987. Once completed, this would open-up considerable further opportunities for new research by way of linking up the entire set of DSS data collected over the years with all other socio-economic, demographic, and health data sets of the Centre created from time to time.

c) The DSS Workshop for in-house staff development, with technical support from Princeton University, should be held in February-March 1987, as planned.

d) Steps should be undertaken to initiate communications with CIDA for extension of DSS for the next five years (1988 to 1992) and finalize proposals towards that end. Apart from streamlining existing operations, specific attention should be devoted to:

- Linkage between population and health data.
- Extensive research utilizing the new DSS data base.
- Carrying out a Census early in 1988, the last Census having been conducted in 1982.
- Conduct a Socio-ecnomic Survey early in 1988, the last one (1982) proving to be dated by now.

- Development of a Sample Registration System (SRS) hand in hand with the existing DSS, which would prove valuable methodologically, substantively, as well as from the point of view of practical application nationwide in Bangladesh and other parts of the developing world.
- Develop systematic institutional linkage with universities, research organizations, and government agencies in Bangladesh, and various conutries in the developing and developed worlds.
- Dissemination to, and sharing and proper utilization of DSS data on the part of, collaborating institutions — efforts that should prove of enormous scientific and policy significance in light of extensive DSS data sets, which are virtually without parallel in the third world.
- Continuation of research on population and related areas in morbidity, nutrition, MCH-FP, infant and child mortality, and the like.

(v) As for the MCH-FP Extension Project:

a) The main emphasis for the immediate months should be to wrap-up the current phase by answering existing commitments to the donor (US AID) and the Government of Bangladesh — with respect to both research and various extension efforts in MCH-FP. Among others,

this would call for: completion of studies based on the operations of the Extension Project in Abhoynagar and Sirajganj as well as those on the Record Keeping System in Matlab, utilizing relevant materials from the Treatment and Comparison areas.

b) New operational issues should be explored in conjunction with the Government of Bangladesh, and attempt should be made to answer practical field problems that impede the Government's goals in the area of MCH-FP. Involvement in the Bangaldesh Third Five Year Plan implementation effort should also be considerated in a selective way.

c) Considerations should be made as to whether and how we should move Beyond the Extension Project so as transfer the fruits of the Project's research to the government programme nationally.

d) More active and systematic dissemination should be undertaken with a view to acquainting various national and international agencies of the Project's findings.

e) Within the Division, there should be an active collaboration of research utilizing the Project's data sets, along with those generated by the DSS. In addition, collaborative studies should be undertaken

in conjunction with investigators in other scientific Divisions of the Centre, engaged in various morbidity and related studies and interventions.

f) Steps should be initiated to formulate and finalize work plans for the next phase of the Project for submission to the donor (US AID). As an Extension Project involved in national operations, it would be essential to have the Government's approval on the proposed plans; and indeed, seek the Government's advice while formulation the proposals.

vi) As for CIS:

a) Built with CIDA grant, essentially as part of efforts to computerise huge data sets generated by the DSS, CIS would continue to provide assistance to projects in PSED other than DSS; and in addition, should continue to serve other Divisions of the Centre.

b) Optimal utilization of the facilities should be ensured, thus cutting down costs and attracting clients both from within and outside the Centre.

c) Judicious expansion of CIS should be planned, keeping in view the need for developing a self-sustaining capability both in terms of financial and technical management.

DIVISION OF LABORATORY SCIENCES AND EPIDEMIOLOGY

The Division of Laboratory Sciences and Epidemiology has been formed by combining activities of the Disease Transmission and Host Defense Working Groups. Work of the Division is carried out by the Departments of 1) Laboratory Services, 2) Immunology and Bacterial Genetics, 3) Epidemiology, and a major project, the Vaccine Trial Project. A separate report was prepared re: the activities of the Laboratory Services Department by Brad Kay. Likewise a detailed report of the protocols of the Division (as well as additional protocols funded by UNDP through the Clinical Division) has been prepared for Board members. Finally a project proposal on shigellosis was prepared and this has received support from USAID. This rather long document is available on request.

Within the priorities of the Centre established by the Board at its June meeting, this Division is cencentrating primarily in three areas: 1. Vaccine Development, 2. Shigellosis and 3. Environmental Microbiology. In addition we have made substantial progress in the related area of rapid diagnosis of diarrhea pathogens. A brief report on these areas follows:

As already reported, the B subunit-whole cell vaccine has proved to provide high level short term protection from cholera. Thus we have continued the surveillance for cholera to determine the duration of the protection. Since the rate of cholera was unusually high in 1985-1986, we will be able to determine efficacy with considerable precision. Active surveillance (i.e. family studies) are now complete and have been discontinued though passive surveillance (i.e. patients with cholera sufficiently severe to bring them to hospital) will continue as long as necessary to determine duration of protection, or until a practical, heat stable vaccine is available for mass distribution in Matlab.

Data from the vaccine trial is now being processed in the Computer. With more than 25 data forms, and several hundred thousand records; plus the prospect of many types of analysis the creation of a computerized master file with all relevant data has been necessary. From this file the investigators will be able to carry out the needed analysis. We expect that analysis of protection for the year following vaccination will be available within a few months.

Funding for continuation of the vaccine trial activities has been proposed to USAID and prospects are good for this continued funding. Likewise WHO has continued its contribution to the trial, both financially and in terms of scientific oversight.

We have had preliminary discussions with the manufacturers of the vaccine and our collaborators, Jan Holmgren and Ann Marie Svennerholm about future developments of the vaccine to make it more practical for public health use. In this regard several developments are important.

a. Formulation of the vaccine has been developed incorporating lyophilized antigen into an antacid tablet similar to "Alka Selzer". Analysis of the tabletted formulation shows that the B subunit and the LPS is preserved in the tablet and that the same antigenic bands appear a Western Blot with the tabletted vaccine. We expect, but need to validate, that the new formulation will be stable to room temperature.

b. New culture conditions have been developed which will substantially increase the yield of B subunit. This will decrease the cost of the vaccine.

c. Bacterial genetic methods hold promise for a vaccine strain which would obviate the need for high technology purifications since the B subunit could be produced in the absence of A subunit.

To validate a new formulation, we are currently exploring the possibility of a second field trial in an area outside Matlab. Such a trial would be carefully coordinated with the Government of Bangladesh and would hopefully involve the Ministry of Health in its preparation and activities.

Other Cholera Vaccines

We are aware of the development of live oral cholera vaccines, especially those fom Adelaide and the University of Maryland. The vaccine from Maryland appears to be associated with an unacceptably high rate of side effects (diarrhea) so that we have not pursued studies with this vaccine. We understand tht the Australian vaccine will be tested in volunteers for efficacy soon and we await those results eagerly. The ability of the ICDDR,B to use areas outside Matlab for evaluation of cholera vaccines will be important to the future development of these and other promising vaccines.

Rotavirus Vaccine

Though we have continued to be in communication with relevant vaccine developers, neither the RIT nor the NIH rotavirus vaccines have been suitable for Bangladesh so we have not pursued testing either of these. A new vaccine from Wistar Institute appears promising and we are exploring the possibility of an evaluation of this vaccine.

Measles Vaccine

Though not a "diarrhea vaccine", measles could plausibly have a protective effect against diarrhea associated with measles. To test this hypothesis and to evaluate the overall impact of measles in the Matlab area Dr Clemens carried out a case control analysis of mortality and its relation to measles immunization. This analysis estimated that measles vaccine reduced overall childhood mortality by 36% ($p < .0001$) and that the protective effect was primarily in deaths associated with diarrhea,respiratory infection,or malnutrition.

Shigellosis

A shigellosis project document was prepared which outlines a range of studies to be undertaken. The proposed studies were selected because they appeared to lead to potential interventions in the control of shigellosis, and include clinical, laboratory and epidemiological studies.

Clinical studies will include some treatment studies, especially aimed at illnesses due to antibiotic resistant bacteria, as well as treatment of patients with severe complications (HUS, toxic colitis, sepsis). Epidemiological studies are being designed to evaluate risk factors for severe shigellosis and to evaluate case detection methods in preparation for a shigellosis vaccine trial. (Handwashing studies were not proposed because we feel that, from a research standpoint, the beneficial effect is established). Laboratory studies in shigellosis are describing the antigens of the bacteria, and in collaboration with the University of Adelaide, we are developing mutant strains which will lead towards a live oral vaccine. A rabbit model is being used to evaluate the immunogenicity of these strains.

Environmental Microbiology

We are now developing a program in environmental microbiology with the first objective to search for environmental factors which prolong survival of *V. cholerae* and enhance its transmission. This hopefully will lead to the explanation of cholera's seasonality and the possibility of predicting cholera epidemics. The University of Maryland is collaborating with us in this work.

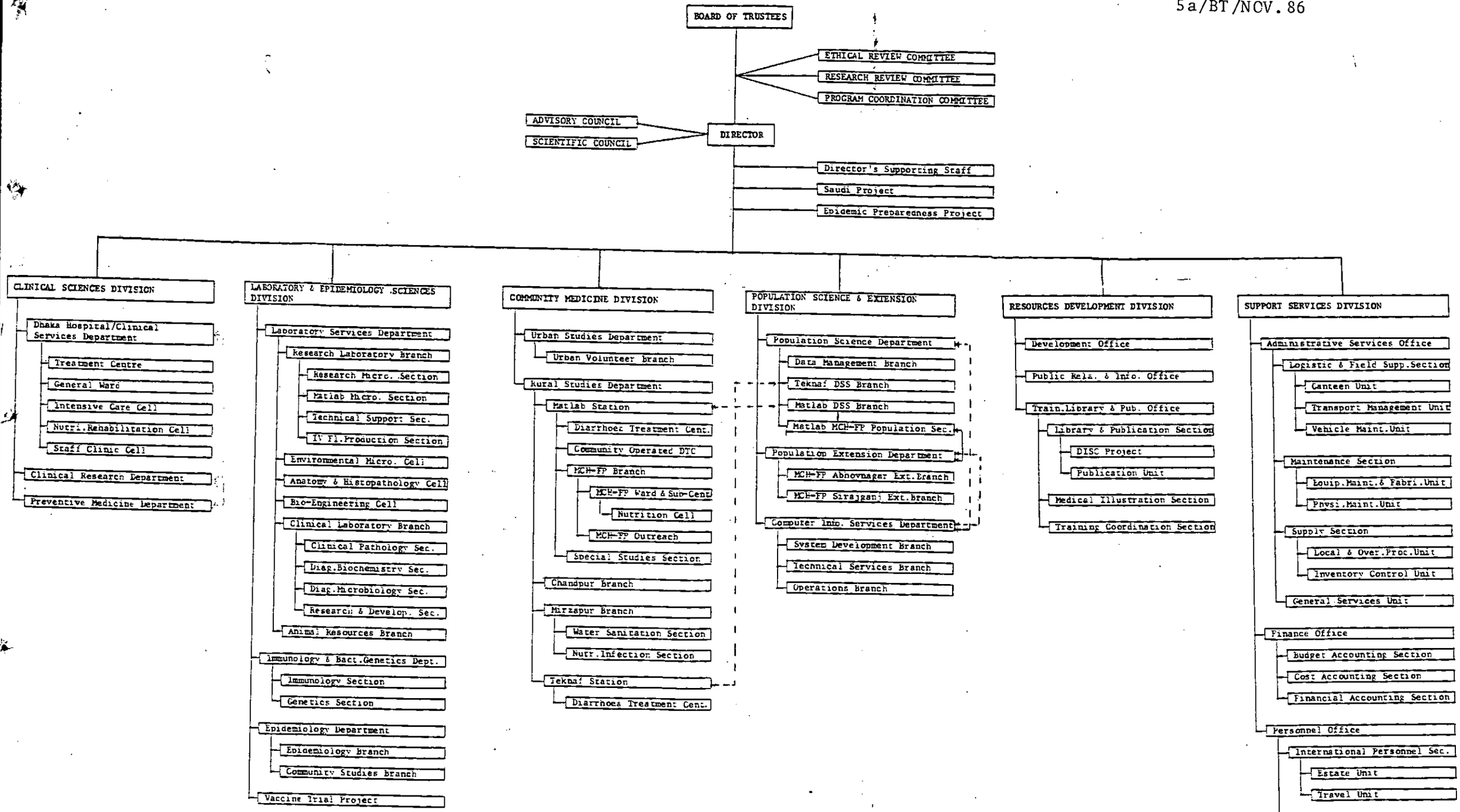
Rapid Diagnostic Tests

During the cholera vaccine trial we developed an ELISA test for *E. coli* LT which provided results within 18 hours of stool collection. Results were needed quickly in order that family studies of LT-ETEC diarrhea could be started within 24 hours of index case arrival. Though specific, (>95%) this overnight test lacked sensitivity (~70%). Subsequently we have refined the assay so that we can now detect both LT and ST and provide definitive results within 48 hours of stool collection. We anticipate that this test can be provided routinely (for protocol patients) by Jan 1, 1987.

Rapid progress is also being made in regard to rapid diagnosis of shigellosis. Using coagglutination techniques and an enrichment broth culture. Dr Mahbubur Rahman has developed reagents for diagnosing shgiella infection to the species level within 5 hours. Since antibiotic resistance correlates with the species, this will have a practical impact on therapy. Also important is the decreased cost of the new test relation to standard methods and the possibillity of the new test's use in minimally equipped laboratories.

Recently a similar test has been developed for 01 V. cholerae infection. Though of similar sensitivity and specificity with a dark field exam, the coagglutination test requires no microscope and can be done in field conditions.

The summary of protocols provides a more detailed status report of the ongoing work of the Division.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RESEARCH REVIEW COMMITTEE
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ADVISORY COUNCIL
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Preventive Medicine Department
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COMMUNITY MEDICINE DIVISION
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Urban Volunteer Branch
Rural Studies Department
Matlab Station
Diarrhoea Treatment Cent.
Community Operated DTC
MCH-FP Branch
MCH-FP Ward & Sub-Cent
Nutrition Cell
MCH-FP Outreach
Special Studies Section
Chandpur Branch
Mirzapur Branch
Water Sanitation Section
Nutr.Infection Section
Tekhal Station
Diarrhoea Treatment Cent.
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Population Science Department
Data Management Branch
Teknaf DSS Branch
Matlab DSS Branch
Matlab MCH-FP Population Sec.
Population Extension Department
MCH-FP Abhoynagar Ext.Branch
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Public Rela. & Info. Office
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Vehicle Maint.Unit
Maintenance Section
Equip.Maint.& Fabri.Unit
Physl.Maint.Unit
Supply Section
Local & Over.Proc.Unit
Inventory Control Unit
General Services Unit
Finance Office
Budget Accounting Section
Cost Accounting Section
Financial Accounting Section
Personnel Office
International Personnel Sec.
Estate Unit
Travel Unit
Local Personnel Section

ATTACHEMENT TO
5b/BT/NOV. 86

ERC PANEL REPORT

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

RECOMMENDATIONS ON THE COMPOSITION, METHOD OF WORK, DUTIES, POWERS AND FUNCTIONS OF THE ETHICAL REVIEW COMMITTEE (ERC) OF ICDDR,B.

1.0 STATEMENT OF PRINCIPLES:

1.1 The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) attaches great importance to the ethical and scientific acceptability of all its research and related activities which involves human subjects. It is a fundamental responsibility of the ICDDR,B to ensure that while conducting any such research:

(a) the rights, dignity and welfare of the subjects involved are adequately protected;

(b) there has been a careful assessment of inherent risks compared to foreseeable benefits to the subjects or to their safety;

(c) the subjects have been appropriately informed of the purpose and nature of the research activity;

(d) voluntary informed consent has been obtained by a method which is appropriate and acceptable;

(e) the subject be in such a mental and physical state as to be able to exercise fully the power of choice to participate, and if the subjects are unable to give consent it be obtained from their legal guardian;

(f) adequate measures have been taken to safeguard the confidentiality of information;

(g) children be excluded in research that could appropriately be undertaken in adults; similarly, pregnant and breast-feeding women be excluded whenever the study can be carried out on others;

(h) special precautions be taken in case of clinical trials with new drugs;

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(i) the subjects are apprised of their right to withdraw from their participation in research at any time; and

(j) the research is scientifically sound as unsound research is intrinsically unethical.

1.2 When externally sponsored research is undertaken, it shall be ensured that in addition to such research being ethical, whenever appropriate and feasible, there is a tangible commitment for the benefit of the Centre.

1.3 The ICDDR,B shall not approve publication of the results of studies which do not have ethical approval.

1.4 The ICDDR,B shall, through the Ethical Review Committee (ERC), follow the above principles in defining its procedures and will not approve research unless the proposal is in accordance with the foregoing principles. In implementing these, the ERC shall take into account the regulations of the Bangladesh Medical Research Council (BMRC), the proposed international guidelines for biomedical research as laid down by the Council of International Organization of Medical Sciences (CIOMS) and the Declaration of Helsinki in relation to biomedical research involving human subjects as revised by the 29th World Medical Assembly, Tokyo, Japan, 1975. It shall also take into account the established laws and policies of the concerned government(s).

2.0 RELATIONSHIP OF ERC WITH THE ICDDR,B:

2.1 The ERC is the sole independent body concerned with granting ethical clearance for scientific research

2.2 The Director of the ICDDR,B (The Director) as the Chief Executive of the ICDDR,B shall ensure that the decision of the Committee is implemented.

2.3 If there be any disagreement between the Director or the Board of Trustees and the ERC, in respect of any opinion expressed or decision given by ERC on any protocol, the matter may be referred back to the ERC for its consideration, giving reasons therefor and the ERC shall examine the reasons given, but the decision of the ERC shall be final in all ethical matters.

2.4 The ERC is accountable to the Board of Trustees and any communication or files required by the Board from the ERC may be obtained by request made through its Chairman. The Committee will provide all necessary information but may, at its discretion, withhold information leading to the identification of specific person(s) to prevent possible victimization of the concerned individual(s).

2.5 If in the opinion of the Board, it is felt that the ERC needs to be reconstituted, the Board has the authority to do so.

3.0 CONSTITUTION, SIZE AND COMPOSITION OF THE ERC:

3.1 The ERC shall comprise of Bangladeshi and expatriate members from different backgrounds. The Committee must command technical competence and be able to safeguard the physical, mental and social well-being of the subjects, and the reputation of the Centre.

3.2 Competence is specifically required in the field of biomedical and social sciences as well as in law and religion. An authoritative knowledge and awareness of public opinion and possible areas of sensitivity will also be embodied in the Committee so that it may judge the risks and consequences of the proposed projects and ensure adequate protection of the rights and welfare of the subjects.

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3.3 The Committee may seek expert opinion from within or outside ICDDR,B as and when necessary.

3.4 The number of members of the ERC should be sufficient to represent the following:-

(i) A representative of the Bangladesh Medical Research Council (BMRC);

(ii) A representative of the Programme Coordination Committee (PCC) of the ICDDR,B;

(iii) WHO Country Representative or his nominee;

(iv) Four representatives of the ICDDR,B including at least one expatriate and one member from the Nursing profession.

(v) The remaining members will be chosen to ensure that the Committee as a whole embodies each of the following disciplines:

a) Physician
b) Basic Science
c) Epidemiology/Community medicine
d) Pharmacology
e) Nutrition
f) Paediatrics
g) Religion/Theology
h) Law
i) Women affairs
j) Psychology/Philosophy/Behavioural Science
k) Social Science/Population Science.

After taking into consideration Ex-officio scientists representing BMRC(i), PCC(ii), WHO(iii) and the ICDDR,B(iv), the rest of unrepresented disciplines will be filled by nomination by the ERC. It is expected that these requirements will be met by a Committee not exceeding 15 members.

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3.5 A member will serve the ERC for a three-year term and will not ordinarily serve for more than six consecutive years. The mechanism for such reconstitution will be developed by the ERC keeping in mind the continuity of the Committee.

3.6 The present Committee, with addition of representatives from the Nursing profession and Epidemiology/Community Medicine may continue to operate in accordance with these guidelines for three years. Occasional vacancy, except for ex-officio positions under serial numbers 3.4(i) to (iii), shall be filled by the ERC and the Director will be informed. As regards the representation of ICDDR,B, the Director will nominate them.

3.7 The ERC shall elect from amongst its members a Chairman and one or more Co-Chairman, as and when necessary.

3.8 The members shall serve on the Committee in their individual capacities and not as representatives taking instruction from other bodies.

3.9 Presence of two-thirds of the members of the Committee shall form a quorum.

3.10 The Director of the Centre will provide the necessary secretarial support and budgetary provision for smooth functioning of the ERC.

4.0 POWERS OF THE ERC:

4.1 The ERC will have the power for initial and continuing review of protocols concerning research activities involving the ICDDR,B and

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to approve, reject or require amendment of protocols submitted for its review. In case of rejection or amendment of the protocol, the Chairman will communicate the reasons for such decisions.

4.2 Once the protocol has been approved it will be the responsibility of the principal investigator and his supervisor to ensure that the ethical requirements are fully met. The ERC may, at its discretion, make physical inspection of any protocol to satisfy that the ethical requirements are met.

4.3 The ERC shall have the authority to suspend or terminate approval of research under a protocol that is not being conducted in accordance with the ERC's requirements, or that has been associated with unexpected harm to human subjects. Any suspension or termination of approval shall include a statement of reasons for the decision and shall be reported promptly to the Director and to the investigator.

4.4 At any stage, if the ERC has reasons to feel that the ethical requirements in respect of a protocol have not been properly met, the ERC may make an enquiry giving the investigator(s) an opportunity to defend. Following this, if the ERC is satisfied that a particular investigator has wilfully ignored the ethical requirements or has shown negligence or incompetence in fulfilling these requirements, the ERC may, at its discretion, withdraw the ethical clearance and recommend to the Director to take such action as the ERC may consider appropriate and the Director will inform the Committee of the action taken.

4.5 Where a breach of ethics has been identified, but ethical clearance has not been withdrawn, the ERC may require that all manuscripts emanating from such studies be submitted to ERC for clearance prior to submission

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for publication.

4.6 Any proposed amendment to an approved protocol, including its extension of time, can be implemented only with the approval of the ERC.

4.7 The ERC may constitute a Sub-Committee for carrying out a specified function.

4.8 The ERC may, in consultation with the Director, organize workshops, or seminars on ethical procedures in research and may circulate ethical guidelines to be followed for such research.

5.0 FUNCTIONS AND DUTIES OF THE ERC:

5.1 The ERC is responsible for reviewing all research and research related service protocols which must include details of activities such as training, demonstration and support, carried out by the investigators, trainees and staff of ICDDR,B. The primary function of the ERC is to assess whether any particular activity involves an unacceptable physical, social or psychological risk to human subjects or there is any other ethical objection.

5.2 The mere statement in the protocol that there is no human involvement does not preclude it from the review process of the Committee. For every protocol it is for the Committee to decide whether there is any element in the protocol which requires ethical consideration. This includes research projects in which there is direct ICDDR,B input in the research in the form of either financial, or personal commitment and where an investigator participates as a consultant or co-investigator officially representing the ICDDR,B.

5.3 The ERC shall consider whether the investigator is appropriately qualified and experienced and commands facilities to ensure that all ethical requirements are fulfilled.

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5.4 The ERC shall satisfy itself that there is a mechanism to ensure that subjects are not deprived of reasonable compensation for any incidental harm or injury. This will be considered particularly carefully in the case of externally sponsored research.

5.5 The ERC will give its decision on research protocol as expeditiously as possible. Where the Committee rejects a protocol or suggests an amendment to the same or recommends any specific measures not included in the protocol, it will give reasons for its decision.

5.6 The ERC will be solely responsible for reviewing ethical issues in relation to research which has already been completed, should such queries be raised. Such a review will be carried out within the frame-work of the ethical guide-lines at the time the research was undertaken.

5.7 Each year the ERC will give a brief account of its activities to the Director.

6.0 MODE OF OPERATION OF THE ERC:

6.1 The proposed mode of operations of the ERC is set out in the "Committee Procedures" in Annexure-I. Special procedures to be followed in case of research involving new drugs are laid down in Annexure-II. These are operational guidelines to be followed by the ERC. In special circums-tances which are not appropriately covered by these guidelines, the ERC shall follow, or adopt additional guidelines for its operation. These guidelines may be reviewed or revised from time to time, if necessary. Any major change will be discussed with the Director and the Board of Trustees will be notified.

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7.0 PROCEDURE FOR SEEKING EXPERT ADVICE:

7.1 The ERC will make use of consultants from within or outside ICDDR,B when this is felt to be necessary or desirable. Such consultants will be provided with an honorarium, as may be determined by the Director, ICDDR,B. The consultant will normally be selected from the country, where the research will be carried out. Such consultant(s) will function in an advisory capacity.

8.0 REFERENCES:

8.1 While formulating the above recommendations, the following documents have been taken into consideration:

1. Proposed International Guidelines for Biomedical Research Involving Human Subjects incorporating the declaration of Helsinki, 1975, Council for International Organizations of Medical Sciences (CIOMS), 1982.
2. OPRR Reports : (Office for Protection from Research Risks) (National Institute of Health, Department of Health & Human Services, USA). March 8, 1983.
3. Responsibility in Investigations on Human Subjects, reprint from the Report of the Medical Research Council for 1962-63 (Cmnd. 2382), pages 21-25, (U.K.).
4. Guidelines on the Practice of Ethics Committees in Medical Research, July, 1984, Royal College of Physicians of London.
5. Guidelines for Evolution of Drug for Use in Man, WHO, Technical Report series 563, 1975.
6. Guidelines followed by the Bangladesh Medical Research Council(BMRC).
7. Dr. W.H. Mosley's memo. dated 17.5.77 to all CRL Investigators on Principles, Practices & Procedures for the Protection of Human Subjects.

ANNEXURE-I

COMMITTEE PROCEDURES - MODE OF OPERATION

Introduction:

While examining a protocol, the ERC will ensure that its principles are implemented in letter and spirit as fully as possible.

The ERC in deciding its mode of operation shall keep in view that in research on humans the interest of science should never take precedence over consideration related to the well-being of the subject.

The primary concern and interest of the Ethical Review Committee is to protect the welfare and rights of subjects participating in research projects. These review procedures also serve to protect the principal investigator in giving assurance that the appropriate requirements have been fulfilled. However, the primary responsibility for the project proposals and their implementation and surveillance must remain with the Principal investigator. It should also be a responsibility of the immediate supervisor to monitor that the ethical requirements are being followed.

Information required of the Investigators:

It is desired that ERC should have brief biodata of the principal and the co-investigators stating their research background specially in relation to studies involving human subjects.

It would normally be sufficient if a statement from the Director giving the necessary information is communicated to ERC at the time any new scientist, who is likely to participate in research activity of the Centre, joins the ICDDR,B. Such information may be provided in the Curriculum Vitae Form (Attachment-A).

Division Heads and principal investigators of the studies are required to submit the following information:

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(a) Research Information Forms (i.e. Face Sheet) supplied by the Ethical Review Committee (Attachment-B).

(b) Required number of copies of protocol for each research or training project which involves use of human volunteers. In addition to the protocol, the Committee should be furnished with an abstract, summarizing the purpose of the study and the methods and procedures to be used which should:

1. Describe the requirements for a subject population and explain the rationale for using in this population special groups such as children, or groups whose ability to give voluntary informed consent may be in question.

2. Describe and assess any potential risks - physical, psychological, social, legal or other - and assess the likelihood and seriousness of such risks. If methods of research create potential risks, describe other methods, if any, that were considered and why they will not be used.

3. Describe procedures for protecting against or minimizing potential risks and an assessment of their likely effectiveness.

(c) Copies of survey forms and questionnaires, along with a Bengali translation of the questionnaires, where necessary.

(d) A copy of an Informed Consent Statement or an explanation justifying the use of an alternate method of obtaining informed consent, describing procedures to be followed including how and where informed consent will be obtained.

Informed consent of subjects must be obtained by methods that are adequate and appropriate. When subjects include individuals who are

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ANNEXURE-I

not legally or physically capable of giving informed consent, because of age, mental incapacity or inability to communicate, the Committee will consider the validity of the consent by next of kin, legal guardians or by other qualified third parties representing the subjects' interest. The Committee will consider whether these third parties can be presumed to have the necessary depth of interest and concern for the subjects' rights and welfare and whether they are legally authorized to expose the subjects to the risks involved.

The Consent Form should be signed by the volunteer and by the principal investigator when this procedure is feasible and does not jeopardize the interest of the study. When the principal investigator feels that the use of such a consent form would be impracticable or would jeopardize the purpose of the study, he should provide the Committee with a statement to this effect and describe an alternate procedure explaining why this requirement should be waived. If information is to be withheld from a subject, this course of action must be justified to the Committee.

Whenever possible, the consent should be obtained in presence of the nurse-in-charge of the patient. This fact should be recorded in the history sheet.

Basic Elements of Informed Consent include:-

(a) a clear explanation of procedures including an identification of those which are experimental;

(b) a description of risks and discomforts;

(c) an assessment of the potential benefits to be gained by the individual

subjects as well as the benefits which may accrue to society in general as a result of the planned work;

(d) disclosure of alternative procedures that are available that would be advantageous for subject;

(e) an offer to answer any inquiries;

(f) information that subject can refuse to participate and is free to withdraw participation at any time without prejudice to the subject;

(g) statement in the consent form stating whether or not compensation and/or treatment will be available, if there is a potential risk to the subject or privacy of the individual is involved in any particular procedure.

Committee Determination:

The Committee is responsible, on the basis of the information furnished, to make an independent determination of possible risks; to assure itself that the study or activity does not include unacceptable hazards and that adequate safeguards are provided to protect the rights and welfare of the subject.

The Committee must decide if the information to be given to the subject or to qualified third parties in writing or orally, is a fair explanation of the project, of its possible benefits, and of its attendant hazards.

The Committee is also responsible for determining if the consent required, whether written or oral, is appropriate in the light of the risks to the subject, and the circumstances of the project. If a prior written consent is not to be obtained the Committee must approve the specific alternate procedure and the justification for the alternate procedure must be recorded in its minutes.

The agreement, written or oral, entered into by the subject should include no exculpatory language through which the subject is made to waive, or to appear to waive, any of his legal rights.

In general, the Committee is concerned with the quality of the research protocol only insofar as is related to its consideration of whether risks to human subjects are outweighed by the potential benefits of the research. Therefore, when submitting proposals which do involve risks, investigators are encouraged to incorporate into the protocol a description of any potential benefits the subject may derive from the study either directly or indirectly and assess the risk-benefit ratio.

It is recognised that application for the support of certain studies involving the use of a questionnaire or interview schedule may have to be submitted for clearance prior to the time of completion of the final instrument. Under these circumstances the Committee should be provided with the following:

(a) A description of the areas to be covered in the questionnaire or interview which could be considered either sensitive or which would constitute an invasion of privacy.

(b) Examples of the type of specific questions to be asked in the sensitive areas.

(c) An indication as to when the questionnaire will be presented to the Committee for review.

The data collection instruments have to be seen and approved by the Committee before the investigator begins the field work.

ANNEXURE-I

Method of Committee Operation:

The Ethical Review Committee will convene regularly each month. A quorum must be present before the Committee will transact any business. All applications for Committee consideration should be submitted at least ten days prior to the monthly meeting in which the study is to be reviewed and should include full documentation.

An application for approval, with attached documentation, will be referred by the Chairman to one or more members of the Committee for preliminary consideration. The Committee member will write a brief comment recommending approval, disapproval, or other disposition and include any pertinent comments. This note is made part of the record.

In the Committee meeting, each document will be presented by the Committee member who reviewed it and it will then be discussed by the entire Committee. The principal investigator may be asked to meet with the Committee in order to furnish further information or to clarify the document. Final action of the Committee will require the general consensus of the members.

If Committee approval is conditional, the condition(s) may, where necessary, be discussed with the principal investigator by the Chairman of the Committee, or the Committee member who made the preliminary review, or the Committee as a whole. It is anticipated that the principal investigator will modify the proposal or other document or agree to comply with the procedures consistent with the Committee's recommendation, and will provide the Committee with a written statement accepting the modification agreed upon. An investigator always has the privilege to appeal in respect of a Committee decision and may request a special hearing before the Committee.

Under special circumstances, when there is a bona-fide need for action between regular meetings of the Committee, the application with attached

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documentation will be circulated to the entire Committee for consideration. If this elicits no questions or reservations, and is approved by a majority of the Committee, the investigator will be informed promptly of this action.

No member of the Committee will be involved in the review of a study or activity in which the member has a professional responsibility except to provide information requested by the Committee.

A statement of Committee approval/modification/rejection is provided in the attached form (Attachment-C) with comments or recommendations, if these are indicated. This form will be addressed to the principal investigator with a copy to the Director and the Division Head and a copy to the Committee file.

Continuing Review by Ethical Review Committee:

Changes after Initial Approval

Each investigator or director of a programme is responsible for informing the Committee of any proposed change in his research or programme involving human subjects and for submitting formal request for approval for such change. Proposed changes are reviewed by the Committee in the same manner as initial applications for approval.

At the time of initial approval by the Committee of a project or training grant which may encompass a future activity involving human subjects, the principal investigator and Division Head are informed of their responsibilities to submit each such activity for approval prior to its implementation. To avoid inadvertant oversights the Committee will send notices to this effect to all such Principal investigators and Division Heads.

The Committee may constitute a Sub-Committee for the purpose of auditing ethical compliance on any research protocol.

Contd..... P/8

Annual Review:

All research projects and other activities involving human subjects are reviewed annually by the Committee. To initiate the review, the Committee at yearly intervals after the date of initial approval sends a request for a status report to each principal investigator or Division Head (Attachment-D and Attachment-E). If the status report indicates no change in the protocol or programme affecting human subjects, the Chairman of the Committee reviews the project file to determine whether anything is to be brought to the attention of the Committee. If the status report indicates a change affecting human subjects which had not previously been brought to the attention of the Committee, the protocol is reappraised by the Committee.

Interval Reports

Primary responsibility for bringing to the Committee new information pertaining to possible risks to human subjects or to a change in procedures which merits interval review rests with the investigator. However, the Committee may request interval reports on a more frequent basis than the annual report whenever this is indicated by the nature and degree of apparant risk to human subjects. Interval reports are reviewed by the Committee to determine whether any action is necessary. To avoid inadvertant oversights, the Committee will maintain a schedule of the interval reports.

Committee Records

The Committee will maintain complete minutes of its meeting. The following documents regarding each application are kept on file by the Committee:-

(a) A copy of the protocol and other information furnished by the principal investigator.

(b) Bio-data of the investigator (Attachment-A).

) Research Information Form regarding the use of Human volunteers

filled out by the principal investigator (Attachment-B).

(d) A copy of Informed Consent Statement for human volunteers, where appropriate.

(e) Recommendation of the Committee member who made the original review and any other comments which are relevant.

(f) Statement of action of the Committee (Attachment-C).

(g) Annual Review Notices (Attachments D & E).

ANNEXURE-II

REVIEW PROCEDURES FOR PROTOCOLS INVOLVING USE OF NEW DRUGS IN HUMAN SUBJECTS

1. The following definitions are adopted:

(a) An "adverse reaction" to a drug means one which is noxious or unintended and which occurs at doses at which it has been used in man for the diagnosis, prophylaxis or therapy of disease or for the modification of physiological functions.

(b) "Licensing authority" of drugs means such authority appointed by the Government of Bangladesh, and presently, the Director of Drug Administration of Bangladesh.

(c) A "new drug" means a drug which has not been previously registered for general use or marketing for medicinal purposes in Bangladesh, United States of America or United Kingdom, and shall also include any new salt or ester or any other derivative of an active substance, new fixed combination of substances or of drugs previously registered or marketed or any drug previously marketed if its indication, mode of administration or formulation is changed, or any drug substance which is not recognized by qualified experts as safe or effective for the purpose for which the drug or substance is intended to be used.

(d) "Phase 1 clinical trial" means clinical pharmacology trial which starts when a new drug is first introduced into man on the basis of only animal or in vitro data, with the purpose of determining human toxicity, metabolism, absorption, elimination, and other pharmacological action, preferred route of administration, and safe dosage range; phase 1 clinical trial is normally confined to healthy adult voluntee-.

.../2.

(e) "Phase 2 clinical trial" covers the initial trials on a limited number of patients for specific disease control or prophylaxis purposes; it is also a clinical pharmacology trial.

(f) "Phase 3 clinical trial" provides the assessment of a drug's safety and optimum dosage schedules in the diagnosis, treatment or prophylaxis of groups of subjects involving a given disease or condition; this phase may be conducted by separate groups with reasonable variations to produce well-controlled clinical trial.

(g) The term "registration" in respect of a drug means its release, compliance or approval for marketing after the drug has undergone a process of evaluation by the competent health authority.

(h) The term "sponsor" in respect of a new drug means, the person or agency who assumes in a written statement full responsibility and liability for any harm or damage that may be caused by the new drug to any person who has been given the new drug in the course of an experiment or clinical trial. The "sponsor" may be the manufacturer of the new drug or a scientific institution lawfully engaged and authorized for the investigation of new drugs involving human subjects.

2. A protocol involving the use of a new drug in human subjects may not be approved by the ERC unless the following conditions are fulfilled:

(a) The new drug has been shown to be safe and effective for its intended use(s) in man and detailed results of phase 1 and phase 2 clinical trials are available.

(b) The Committee may exercise its discretion in waiving the requirements of phase 1 and phase 2 trials where there are adequate clinical

and scientific justification as well as adequate facilities for clinical pharmacological studies.

(c) Only in case of a new drug developed in the ICDDR,B or in Bangladesh, a phase 1 or phase 2 clinical trial may be allowed, provided all other conditions are fulfilled.

(d) Details of preclinical studies in suitable animals, acute, sub-acute and chronic toxicity studies including LD_{50} and histopathological studies in more than one species are available in fully documented form, unless there are sound scientific reasons to consider that such studies are not necessary.

(e) Full composition and chemical identification of the new drug and its relationship to other chemically related substances are known.

(f) The identity of the name and place of the manufacturer, the nature of the manufacturing process and tests undertaken to establish and control the quality of the drug are known.

(g) A written statement of the sponsor is available, assuming the full responsibility and liability for any harm or damage that may be caused to the subjects. Such responsibility will depend on an association of cause and effect. Whether there has been such association and the nature and amount of the compensation will be decided by a body constituted by the ICDDR,B,and approved by the ERC. The sponsor must give in writing that it shall abide by the decision given by the said body.

(h) Written permission will be obtained from the licensing authority of drugs, authorising the import and/or use of the new drug for experiment in human subjects, as provided under Rule 33 of the Drugs Rules, 1945.

(i) A commitment from the P.I. that all adverse reactions to the new drug will be individually recorded and immediately reported to the ERC for each subject. Such records, including all records of laboratory investigations, shall be preserved intact for at least three years from the time of completion of the research.

(j) Ethical standards shall be applied as they would be for similar research work involving a new drug in the country of its origin.

3. Subjects shall not, in giving their consent to participation in a clinical trial of a new drug, be required to waive their rights to compensation in the case of harm or injury; nor shall they be required to alleged negligence or lack of skill on the part of the investigator(s) in claiming compensation for any possible injury, damage or accidental death.

4. An investigator shall not accept from a sponsor any monetary gift or loan or any expensive item for his/her personal use. The ERC should be informed of the conditions under which grants of money or equipment is made to the ICDDR,B by the sponsor.

5. Children and women of the child bearing age shall not be involved as subjects in clinical trial of a new drug whenever such research can be appropriately undertaken in adult male subjects.

6. Unless specifically waived by the ERC, clinical trial or research of a new drug involving human subjects shall not be allowed without written informed consent of all the subjects.

7. Investigators who are involved in studies of new drugs in human subjects shall report all adverse reactions to the new drug to the ERC and Director of ICDDR,B. Since the ICDDR,B participates in the US FDA Voluntary Reporting System, the Director shall promptly inform the US FDA of any adverse reaction that may be reported to him by an investigator. Criteria which may be useful

Contd..... P/5

in deciding which adverse reactions are significant and which should be reported are :-

(a) Serious, life-threatening or fatal reactions.

(b) Unusual increases in numbers or severity of reactions in clusters.

(c) Reactions not listed in the labelling or not recorded in the reports of earlier studies.

(d) Potential association with carcinogenicity or congenital anomalies.

All adverse drug reactions will also be reported to the Bangladesh Medical Research Council.

CURRICULA VITAE

PRINCIPAL/CO-INVESTIGATOR

1. Surname/Family Name:

   First name/other names

2. Date of birth:

   Place of Birth:

   Nationality:

3. Degrees

Degree	Year	Institution	Desciplines

4. Academic Distinctions:

	Degree	Year

5. Present post (Title, Institution, Dates)

   Title:

   Institution:

   Dates:

CURRICULA VITAE

6. Previous posts (Title, Institution Dates)

Title: a.

b.

c.

Institution:

a.

b.

c.

Dates:

a.

b.

c.

7. Academic & Research Awards, Consultant & other posts

8. Other University & Institutional Posts

9. Current Research Interests including details of Projects of which Applicant is Principal Investigator.

10. Publications & Communications

ATTACHMENT-B (OF ANNEX. I)

THE ETHICAL REVIEW COMMITTEE OF ICDDR,B

APPLICATION DATE: _____

Principal Investigator _____ Trainee Investigator (if any) _____

Application No. _____ Supporting Agency (if Non-ICDDR,B) _____

Title of Study _____

_____

_____

Project status:
( ) New Study
( ) Continuation with change
( ) No change (do not fill out rest of form)

Circle the appropriate answer to each of the following (If Not Applicable write NA).

1. Source of Population:
   (a) Ill subjects Yes No
   (b) Non-ill subjects Yes No
   (c) Minors or persons under guardianship Yes No
2. Does the study involve:
   (a) Physical risks to the subjects Yes No
   (b) Social Risks Yes No
   (c) Psychological risks to subjects Yes No
   (d) Discomfort to subjects Yes No
   (e) Invasion of privacy Yes No
   (f) Disclosure of information damaging to subject or others Yes No
3. Does the study involve:
   (a) Use of records, (hospital, medical, death, birth or other) Yes No
   (b) Use of fetal tissue or abortus Yes No
   (c) Use of organs or body fluids Yes No
4. Are subjects clearly informed about:
   (a) Nature and purposes of study Yes No
   (b) Procedures to be followed including alternatives used Yes No
   (c) Physical risks Yes No
   (d) Sensitive questions Yes No
   (e) Benefits to be derived Yes No
   (f) Right to refuse to participate or to withdraw from study Yes No
   (g) Confidential handling of data Yes No
   (h) Compensation &/or treatment where there are risks or privacy is involved in any particular procedure Yes No
5. Will signed consent form be required:
   (a) From subjects Yes No
   (b) From parent or guardian (if subjects are minors) Yes No
6. Will precautions be taken to protect anonymity of subjects Yes No
7. Check documents being submitted herewith to Committee:
   ___ Umbrella proposal - Initially submit an overview (all other requirements will be submitted with individual studies).
   ___ Protocol (Required)
   ___ Abstract Summary (Required)
   ___ Statement given or read to subjects on nature of study, risks, types of questions to be asked, and right to refuse to participate or withdraw (Required)
   ___ Informed consent form for subjects
   ___ Informed consent form for parent or guardian
   ___ Procedure for maintaining confidentiality
   ___ Questionnaire or interview schedule *

* If the final instrument is not completed prior to review, the following information should be included in the abstract summary:
1. A description of the areas to be covered in the questionnaire or interview which could be considered either sensitive or which would constitute an invasion of privacy.
2. Examples of the type of specific questions to be asked in the sensitive areas.
3. An indication as to when the questionnaire will be presented to the Cttee. for review.

(PTO)

We agree to obtain approval of the Ethical Review Committee for any changes involving the rights and welfare of subjects before making such change.

_____ Principal Investigator

_____ Trainee

ATTACHMENT-B (OF ANNEX. I)

INFORMATION TO INCLUDE IN ABSTRACT SUMMARY

The Committee will not consider any application which does not include an abstract summary. The abstract should summarize the purpose of the study, the methods and procedures to be used, by addressing each of the following items. If an item is not applicable, please note accordingly:

1. Describe the requirements for a subject population and explain the rationale for using in this population special groups such as children, or groups whose ability to give voluntary informed consent may be in question.

2. Describe and assess any potential risks - physical, psychological, social, legal or other - and assess the likelihood and seriousness of such risks. If methods of research create potential risks, describe other methods, if any, that were considered and why they will not be used.

3. Describe procedures for protecting against or minimizing potential risks and an assessment of their likely effectiveness.

4. Include a description of the methods for safeguarding confidentiality or protecting anonymity.

5. When there are potential risks to the subject, or the privacy of the individual may be involved, the investigator is required to obtain a signed informed consent statement from the subject. For minors, informed consent must be obtained from the authorized legal guardian or parent of the subject. Describe consent procedures to be followed including how and where informed consent will be obtained.

   (a) If signed consent will not be obtained, explain why this requirement should be waived and provide an alternative procedure.

   (b) If information is to be withheld from a subject, justify this course of action.

   (c) If there is a potential risk to the subject or privacy of the individual is involved in any particular procedure include a statement in the consent form stating whether or not compensation and/or treatment will be available.

6. If study involves an interview, describe where and in what context the interview will take place. State approximate length of time required for the interview.

7. Assess the potential benefits to be gained by the individual subject as well as the benefits which may accrue to society in general as a result of the planned work. Indicate how the benefits outweigh the risks.

8. State if the activity requires the use of records (hospital, medical, birth, death or other), organs, tissues, body fluids, the fetus or the abortus.

The statement to the subject should include information specified in items 2, 3, 4, 5(c) and 7, as well as indicating the approximate time required for participation in the activity.

ATTACHMENT-C (OF ANNEXURE-I)

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

Memorandum

TO : _____
Principal Investigator

FROM : Chairman, Ethical Review Committee **DATE:**

SUBJECT : Research Proposal No._____, entitled,

"_____

_____

_____"

COMMENTS OF ERC

1. The Ethical Review Committee is pleased to inform you that the above-noted proposal has been approved/approved subject to the following conditions:

   a.

   b.

   c.

   d.

2. The Ethical Review Committee regrets to inform you that it is unable to approve the above-noted proposal for reasons mentioned below:

   a.

   b.

   c.

   d.

3. In case of an approved protocol the P.I. is requested to please note the following ethical guidelines as mentioned at page-2 (overleaf) of this memo.

Thank you.

THE ETHICAL GUIDELINES TO BE FOLLOWED BY THE PI/CO-PI/INVESTIGATORS

1. The rights and welfare of individual volunteers are adequately protected.

2. The methods to secure informed consent are fully appropriate and adequately safeguard the rights of the subjects (in the case of minors, consent is obtained from parents or guardians).

3. The Investigator(s) assume the responsibility of notifying the Ethical Review Committee if there is any change in the methodology of the protocol involving a risk to the individual volunteers.

4. To immediately report to the ERC if any evidence of unexpected or adverse reaction is noted in the subjects under study.

5. This approval is subject to PI's reading and accepting the ICDDR,B eithical principles and guidelines currently in operation.

-0-

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

ATTACHMENT-D (OF ANNEX. I)

Memorandum

TO : _____

DATE : _____

FROM : Chairman: _____
Ethical/Research Review Committee

SUBJECT : ANNUAL REVIEW - Your Protocol No. _____
Title: _____
_____

Your protocol, noted above, was approved on _____ by the Research Review Committee. Your protocol indicates that you will be working beyond _____

In order to be in compliance with the policy and procedure of the International Centre for Diarrhoeal Disease Research, Bangladesh, all protocols are subject to no less than annual review.

In order that your above-mentioned investigation will not be at risk, please submit 15(fifteen) copies of your progress report, in the attached form, to this office by _____.

If changes from the experimental approach described are to be made in the future, the Investigator will obtain prior approval from the Committee.

The Investigator agrees to:

(1) Report any adverse effects or death associated with the study immediately.

(2) Notify the Committee of any title changes.

Note: Attached is a Progress Report form for your convenience.

c.c: Head, _____ Division
Director, ICDDR,B
File : ERC/RRC

ATTACHMENT-E (OF ANNEX.I)

ETHICAL REVIEW COMMITTEE - PROGRESS REPORT FORM FOR ON-GOING PROTOCOLS

Protocol No. Investigator:

Title:

(a) Activity in the preceding 12 months:

(b) Results achieved:

(c) Direction of the study in the next months:

(d) Any modification in the protocol:

(e) Any other remarks:

I agree to:

(1) Report any adverse effects or death associated with the study immediately.

(2) Notify the Committee of any title changes.

Signature:-

Date:-

ATTACHMENT TO

5c/BT/NOV. 86

RELATIONSHIP WITH INDUSTRY.

Contacts between the ICDDR,B and Industry

In November 1985, the Board of Trustees requested from the Director a position paper on the possible ethical problems arising from contacts between the ICDDR,B and industrial or commercial firms. I regret not having been able to submit the present document at the June 1986 meeting. The Board was especially concerned about contacts involving drug trials funded by pharmaceutical companies. This particular problem is dealt with in great detail in the report of the subcommittee of the Ethical Review Committee (ERC) created to propose to the Board the powers, functions and duties of the ERC. The ERC subcommittee's report has been written with great care and I submit that the problem at hand be dealt with when considering this report. In the present document and its attachment, I will only try to give some background material and present a few options.

1. Definitions

1.1 "Drug" is understood here in its broadest sense, viz., any agent, irrespective of its route of administration, that has, or is claimed to have, preventive, curative or other health-promoting activities. The definition thus includes, e.g., zinc and ORS. It is considered as an axiom that no drug can or should be considered as completely free of side-effects.

1.2 "Pharmaceutical company": any company, or organization, or its agent that for commercial reasons produces, advocates, sells, or distributes a "drug". (It should be taken into account that at least one pharmaceutical company (Burroughs-Wellcome) has no avowed commercial aims, and that many prestigious non-commercial organizations or scientific bodies advocate the use of "drugs", and even distribute them free of cost. Gratuity, and non(commercial)-profit motives are not necessarily a seal of quality or safety.)

1.3 "Drug-trial": Any study involving humans used as experimental subjects to study whatever action of

a "drug". Careful monitoring of persons receiving a drug as part of a well-established treatment schedule would not be considered a drug-trial. At ICDDR,B it still might be considered a protocol, subject to all usual review processes.

2. Drug-trials at ICDDR,B

The Research Review Committee (RRC) secretariat has, with the help of the Finance Office, listed all protocols involving drugs on record since 1980. The list is attached. The roman figures (from I to IV) in the left-hand margin represent a tentative classification of the protocols, all being considered as drug-trials, according to their "phase".

2.1 Agents studied

The agents studied can be classified in several groups.

2.1.1 Antimicrobials (total = 9) : ampicillin, ceftriaxone, chloramphemicol, ciprofloxacin, doxycycline, furazolidone, menicilliwam, nalidixic acid, tetracycline.

2.1.2 Antisecretory agents and related compounds (total = 11): acetylsalicylic acid, berberine, chloroquine, chlorpromazine, clonidine, digoxin, indomethacine, loperamide, nicotinic acid, somatostatin, verapamil.

2.1.3 Bacterial preparations and related compounds (total = 5): cholera toxin B-subunit, colostral anti-cholera toxin antibodies, GM_1 ganglioside, V. cholerae whole cell killed vaccine (WCV), WCV + B-subunit.

2.1.4 Rehydration solutions *oral (total 9): maize, millet, plantain, rice, sorghum ORS alanine, base precursors, citrate, potassium.

*I.V.: Dhaka solution with added glucose.

2.1.5 Contraceptives: medoprogesterone acetate.

2.1.6 Indigenous plants: (unknown).

2.1.7 Nutrients and vitamins (total = 4): copper, zinc, Vit. A, wheat.

2.1.8 Others: alkalizing solution.

Of all these studies, only those mentioned under 2.1.3 and 2.1.4 have led to significant though not yet fully established scientific progress.

2.2 Funding

Of the 53 studies for which the funding is known, 14 (26%) were financed by a donor or with ICDDR,B core money, with variable input from a pharmaceutical company. It is not fully clear whether the donor was, in each case, informed about the contribution made by the company. At least in one case (oral vaccine trial) the amount of money involved is completely unknown. An overview of the funding according to its origin is given below.

	Funding	
	Without input from drug companies	with input from drug companies
	In absolute numbers (and percentage of the total [53])	
ICDDR,B	12 (23%)	6 (11%)
International agencies (AKF, UNICEF, UNDP, WHO)	21 (40%)	3 (6%)
Donor countries	2 (4%)	5 (9%)
Drug Companies		4 (8%)
Unknown	5	

2.3 Protocols exclusively funded by drug companies

I could identify 4 such trials (see numbers on attached list).

2.3.1 III No. 20. Ciba-Geigy - ORS effervescent tablets, 1982.

2.3.2 IV No. 33. Norwich-Eaton - Single-dose furazolidone, 1983.

2.3.3 I No. 40. Roche - Ceftriaxone in typhoid fever, 1984.

2.3.4 III No. 55. Miles - Ciprofloxacin in Shigellosis, 1983.

Only the ethical propriety of 2.3.4 was challenged during the June 1986 Board Meeting. I checked the questions I received in writing (upon my request) with the protocol and could not find anything wrong. The Board Member who raised the questions is not able to attend and might have another opinion.

3. Other Aspects of the Question

3.1 There are obviously many other ethical problems related to contacts between ICDDR,B and the industrial and commercial world. The procurement of goods and services--a daily occurrence--is inevitably a potential source of unethical or frankly dishonest practices. ICDDR,B has a complete set of rules and regulations intended to prevent such practices, but no more ingenuity is required to outwit rules and regulations than to make them.....

3.2 It should also be obvious that ethical issues pervade all human activities, and thus all activities being conducted at ICDDR,B and that contacts with industry are only a relatively small part of them. Yet, to stay within the limits of the Board's questions, and to try and answer to its preoccupations, some other specific points should be mentioned.

3.2.1 Support from drug companies can take other forms than financing drug trials or possibly other protocols. It includes:

* straight or restricted core funding to ICDDR,B;
* financing scientific travel of ICDDR,B staff members;
* financing scientific publications of ICDDR,B staff members;
* contributes to the scientific activities through e.g. specialized laboratory examinations, literature searches, editing

of papers, etc.

3.2.2 Contacts with industry, as understood in this document, should include, besides drug companies, manufacturers of scientific equipment and of diagnostics. In theory, now - purely commercial relations can include all those mentioned under 3.2.1 and, in addition

* gifts of diagnostics or equipment, either free or with the purpose of testing or validation.

3.2.3 Finally, it must be realized that ICDDR,B, though a non-profit agency, is, in many ways, behaving like a commercial organization. It does so by being an employer, by borrowing money, by developing or producing diagnostic methods and IV fluids and especially by selling its know-how or, in other words, accepting money for its programmes and projects. Whether, in all these activities, ICDDR,B has always been able to adhere to strict commercial and professional ethics might be a matter for reflection.

4. Proposals

The Board might consider the following guidelines

4.1 As a non-profit, humanitarian organization, ICDDR,B must exercise great care and prudence in all its dealings with commercial firms or their agents ("the industry").

4.2 No contacts between ICDDR,B and the industry should result in personal profits or benefits to any of ICDDR,B's staff members or their relatives.

4.3 No staff member of ICDDR,B is allowed to make any private dealings with the industry in any matter related to his or her work at ICDDR,B.

4.4 ICDDR,B is allowed to ask for, and accept, support in kind or in money from industry. This support can only be accepted by the Director who must let himself be guided by the principles mentioned under para 4.1.

4.5 Regarding more particularly drug trials or other scientific protocols partly or totally funded by industry the following is required:

4.5.1 As in all protocols, scrupulous adherence to ethical standards must be maintained.

4.5.2 Only those drugs can be tested that are of potential value to alleviate medical problems in third-world countries within the mandate of ICDDR,B.

4.5.3 Whenever the involvement of industry exceeds providing a well-known and registered drug, or diagnostics and laboratory equipment, a written contract shall detail and stipulate the relationship between ICDDR,B and the company.

This contract shall be scrutinized by the Chief Finance Officer and the Chief Resources Development Officer. The contract shall be signed by an authorized representative of industry and the Director ICDDR,B.

The contract shall be communicated to the Chairman of the ICDDR,B Board of Trustees, the Chairman of the Finance Committee of the Board and to the Chairman of the Ethical Review Committee.

4.5.4 In no case shall the full scientific freedom of ICDDR,B be waived.

RE
22-11-86
Encl.

THERAPEUTIC AND VACCINE TRIALS CONDUCTED AT ICDDR,B

JANUARY 1980 - JUNE 1986

IV 1. Evaluation of tetracycline therapy in patients with cholera due to tetracycline resistant cholera. (80-008) Funding not known

IV 2. Treatment of travellers diarrhoea with chlorpromazine. (80-023) ICDDR,B

IV 3. Aspirin as an antisecretory agent. (80-027) ICDDR,B

I-II 4. B subunit blocking of cholera toxin in family contacts of cholera patients. (80-028) Japan*

I-II 5. Local & systemic immune responses to cholera B subunit and whole cell vaccine in persons with different immune preparedness. (80-029) SAREC*

IV 6. Effect of mecillinam in the treatment of shigellosis. (81-002) ICDDR,B*

IV 7. Use of base-precursors as a substitute of bicarbonate in the oral rehydration solution. (81-005) ICDDR,B

I-II 8. Influence of WCV on the immunogenicity of B-subunit given by the oral route. (81-014P) ICDDR,B*

IV 9. The effect of somatostatin on intestinal fluid loss in cholera. (81-031P) ICDDR,B*

III 10. The efficacy of ORS in correcting hypokalaemia due to acute dehydrating diarrhoea in children under 5 years of age. (81-040) ICDDR,B

III 11. Effect of nutritional status on the pharmacokinetics of depomedroxyprogesterone-acetate. (82-004) ICDDR,B

III 12. Acceptability and digestibility of wheat syrup. (82-011P) ICDDR,B

III 13. Intake and utilisation of calories from rice starch electrolyte therapy in acute diarrhoea due to cholera, ETEC, rotavirus and shigella. (82-025) UNICEF/AKF

III 14. Comparative studies of oral rehydration solutions in childhood diarrhoea - potassium 30 mmols vs. 20 mmols, and base 30 mmols. vs. no base. (82-007) ICDDR,B

IV 15. Antisecretory drug trial (indomethacin, chloroquine and nicotinic acid). (82-008P) UNDP/WHO

III 16. Evaluation of antisecretory effects of verapamil. (82-033P) Funding source not known

III 17. Comparative efficacies of ceftriaxone and ampicillin given as single doses for the treatment of acute shigellosis. (82-038) WHO/UNDP/Roche*

I 18. Trial of orally-administered bovine colostral anti-cholera toxin in cholera patients. (82-046) ICDDR,B*

III 19. Trial of a cereal based (rice powder) oral rehydration solution in the treatment of diarrhoea in a outpatient centre. (82-049) AKF/UNICEF

III 20. A comparative trial of WHO recommended ORS with ORS effervescent tablets. (82-054P) Ciba Geigy

I 21. Indigenous plants in the treatment of acute diarrhoeal diseases. (82-056) WHO

IV 22. Single dose tetracycline therapy in cholera.(82-057) ICDDR,B*

I 23. Cellulose GM1 binding of cholera toxin in family contacts of cholera patients. (82-055) Japan

24. Clinical studies of shigellosis. (Budget No.02 42 00) Roche Pharmaceutical**(?)

III 25. Wheat syrup as a caloric supplement for improving the rate of weight gain in children. (83-003) ICDDR,B

I 26. Digoxin absorption and metabolism in patients with acute diarrhoea. (83-004) ICDDR,B

IV 27. Loperamide in travellers diarrhoea. (83-007) WHO/UNDP*

III 28. Efficacy of sodium citrate to replace sodium bicarbonate in oral rehydration solution. (83-014) WHO

III 29. Trial of berberine as an anti-secretory drug in human cholera. (83-015) UNDP/WHO

III/ IV 30. Field comparison between WHO-ORS and rice-salt ORS. (83-024) UNICEF

I 31. Antibody responses to different formulation or oral B-subunit + whole-cell cholera vaccine. (83-035) SAREC*

IV 32. Acceptability of alkalinizing solutions in children. (83-039) Arab G/F

IV 33. Single dose furazolidone in cholera. (83-042) Norwitch Eaton Pharmaceuticals**

IV 34. Antisecretory drug trial: clonidine hydrochloride. (83-043) ICDDR,B*

IV 35. Nutritional impact of periodic deworming of young children in Bangladesh. (83-045) Study deferred

I 36. Antibody responses to different formulations of oral B-subunit + whole-cell cholera vaccine. (83-046) SAREC*

III 37. Trial of a wheat-based ORS in the treatment of acute diarrhoea. (83-048) UNICEF

III 38. Field trial of oral B-subunit/whole-cell cholera vaccine. (84-001) SAREC/UNDP/WHO/USAID/Japan*

IV 39. Effect of zinc and copper supplementation on the dietary intake of weight-gain in Bangladeshi children recovering from severe malnutrition. (84-012) ICDDR,B

I 40. Typhoid fever: determination of C-AMP and prostaglandin production during diarrhoea and comparative therapeutic trial with the chloramphenicol and ceftriaxone. (84-013) Roche Pharmaceutical**

III 41. Digestibility and efficacy of different cereal based ORS (potato, wheat, maize, sorghum & millet) in the treatment of acute diarrhea. (84-014) UNDP/WHO

I 42. Safety of killed K12 E.coli strains as placebo for oral cholera vaccine trial. (84-019) ICDDR,B*

IV 43. Effect of zinc supplementation on the utilization of macro-nutrients in children of Bangladesh. (84-024) ICDDR,B

II 44. Double-blind controlled clinical trial with bioflorin (streptococcus faecium) in management of acute diarrhoea in Bangladesh. (84-030) WHO

II 45. Trial of orally administered bovine colostrum anti-cholera toxin in cholera patients. (84-040) ICDDR,B

III 46. Randomized, controlled trial of berberine to inhibit fluid loss in non-cholera diarrhoea. (84-041) WHO

III 47. Efficacy of different cereals (maize, millet, sorghum) based oral rehydration solution in the management of acute diarrhoea in children. (84-048) AKF

III 48. Field comparison between glucose-ORS and maize-ORS. (84-049) AKF

IV 49. Double blind randomized trial of nalidixic acid and ampicillin in the treatment of childhood shigellosis. (85-002) UNICEF*

III 50. Clinical trial of plantain (green banana) salt solution and maize based ORS in the treatment of acute diarrhoea in children. (85-016) Funding source not known

III 51. Comparison of efficacy, digestibility of plantain-salt and rice-salt as home made fluid with standard glucose ORS in the management of dehydration in acute diarrhoea in children. (85-019) UNDP/WHO

III 52. A double blind randomized study to evaluate intravenous "Dhaka solution" with and without 25 gms/litre of dextrose. (85-021P) UNDP/WHO

IV 53. Effect of zinc supplementation on pregnancy, infant growth and infant mortality. (85-030) External funding - not known

IV 54. Single-dose doxycycline in the treatment of cholera. (85-031) WHO*

III 55. Double blind randomized trial of ciprofloxacin and ampicillin in the treatment of shigellosis. (85-034) Miles Pharmaceuticals**

I 56. Gastric emptying of rice-powder electrolyte solution and a sucrose electrolyte solution in adult patients with acute cholera. (85-037P) UNICEF/UNDP

I 57. Oral rehydration therapy with alanine-glucose ORS: a controlled clinical trial. (85-038) WHO

III 58. Comparison of efficacy of bicarbonate versus citrate based glucose ORS in acute diarrhea. (85-041) WHO

I 59. Vitamin A levels in breast milk following supplementation after delivery (A prospective cohort study). (86-007) UNDP/WHO

I 60. A study of the impact of zinc therapy on intestinal permeability in malnourished Bangladeshi children with acute and persistent diarrhoea. (86-009) Not known

III 61. Double blind controlled trial of berberine sulphate in treating childhood diarrhoea. (86-016) Not yet approved by ERC

I 62. The antisecretory role of 5-Ht antagonist (Ketanserin) in patients with diarrhoea due to Vibrio cholerae. (86-017)

III 63. Does food potentiate the efficacy of ORS? (86-018) UNICEF

* Denotes a study that was supported by industry to a limited degree such as producing or supplying drug used in the study.

** Fully funded by industry

ATTACHMENT TO

5d/BT/NOV.86

EXTERNAL SCIENTIFIC REVIEW REPORT.

5d/BT/Nov. 86

EXTERNAL REVIEW

By

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and
Dr. Shanti Ghosh

18 November 1986

This external review of the Population Science and Extension Division and of the Community Medicine Division has benefitted from full cooperation and excellent briefings from the Center's administrative and scientific staff. We base the following report upon these and upon a variety of written materials as well as observations and discussions here and in field visits to Matlab, Jessore, and Teknaf, and to the Urban Volunteers Program and the Mirzapur Handpump Project in Dhaka. The report is in two parts, the first drafted principally by Dr. Ross and the second by Dr. Ghosh, reflecting their complementary specializations.

PART I

MATLAB

Matlab continues to be a vital experimental area for studies that can hardly be done anywhere else in the developing world. Preston's assessment of four years ago remains current:

> "The ICDDR,B has been an enormously important source of demographic information and research in the past two decades. In Matlab, it maintains the largest continuous system of accurate vital registration for any sizeable population in a developing country. This data base has served to document long-term trends in vital rates; the demographic and epidemiologic consequences of natural experiments such as the 1974 famine;... and the levels and trends in the biological intervening variables that determine fertility levels. The data base has also served as a sampling frame for more intensive investigations and as the basis for evaluating a variety of experimental health interventions. ICDDR,B's contribution to improved understanding of the determinants of population change in developing countries probably exceeds that of any other single locale.... There are few demographic issues that research based upon ICDDR,B data has not served to clarify... (including) the clear documentation of a major fertility decline induced by an expanded family planning program..."

To this demographic assessment can be added other positive ones for the epidemiological and medical sides. Matlab is in fact the subject of continuing research under all three headings with such examples as the present oral vaccine trial, the continuing demonstration of high contraceptive prevalence (including the innovative use of domiciliary injections), and the MCH programs.

Matlab's promise for the future is enlarged through the creation in 1986-1987 of the linked DSS data base from the 1982 Census onward, and, later, for 1982 backwards. The essence of this work is to enable the computer to access scattered information for the same mother, or household, etc. and to follow changes through time. The new data base will permit a series of important secondary analyses not previously feasible, at low cost.

One issue concerning the data base is whether simplifications are possible in the elaborate 1987 work program designed to create the data base, with the accompanying staff drain and probable delay to completion. It is easy to under estimate the true elapsed time to completion of this work. For both Matlab and Teknaf the errors and inconsistences discovered

are computer-classified by type, and the degree of data cleaning should be balanced against costs and delay. " Ninety-five percent cleanliness" may be by far the best solution. The actual workload both in Dhaka and in Matlab needed to clean the data can be estimated by early January.

The workload concern relates also to a large increase in Matlab in the information collected on services rendered. This appears to require closer coordination between the various personnel involved.

We recommend that the routine Matlab publications not wait upon the six-month lag to determine the true residential status of each temporary migrant. Most rates will be very little different without this check (comparisons can easily be made to confirm this). Moreover, many rates use denominators that are largely free of persons who move in and out frequently (e.g. the general fertility rate or the total fertility rate). No research program looks as good, or contributes as much, with lagged reports as with prompt ones, and this half-year delay in publication should be corrected.

(We note however that considerable field checking is needed to learn the present location of persons dislocated by the floods, including three whole villages that were permanently lost to river erosion).

A clarification is perhaps needed as to the current research objectives in Matlab. Originally the aim was to test cholera vaccines, and in 1975 a second objective was added, to test a new way of raising contraceptive prevalence. In 1977 a second and much more successful stage began, which demonstrated that the right kind of delivery system could raise prevalence to a very significant level under the most forbidding of subcontinent conditions. In 1982 a further phase began, to examine the much argued issue of whether the addition of MCH inputs to family planning ones would increase prevalence further -- a question that is not yet decided as the MCH inputs are not fully implemented. There also remains the important question as to <u>which</u> MCH inputs will have the most telling effect, either on prevalence or on infant/child mortality, the presumed precursor to further change in childbearing practice.

Now with the dual lines of interest and authority that issue from the two concerned Divisions at the Center it is vital to maintain close agreement on the objectives in Matlab. It is agreed in principle that the primary aim is not mere service, i.e. not a sheer drive to reduce mortality, since it is the knowledge output that is wanted to guide national programs. It is not clear that each MCH input can be researched closely enough to say what its effect is; rather a <u>bundle</u> of MCH services, not any one in particular, may be needed to (a) reduce infant/child mortality, and (b) reduce it enough to modify childbearing practice. However, useful knowledge will not emerge for either purpose unless the new inputs are introduced in such a

way as to permit an empirical statement on their effects. A rare opportunity unquestionably exists in Matlab to learn what MCH interventions, if vigorously implemented, will reduce mortality and, perhaps, also reduce fertility, a combination universally sought, and one that can be well researched in only a few places in the developing world.

One possibility for future work in Matlab deserves particular consideration. Although Matlab has served well as a site for vaccine tests and diarrheal treatment, it has never shown the way to diarrheal prevention. Diarrheal incidence rates remain high and, compounded with malnutrition, continue to support a high infant/child mortality rate. It seems overdue for the Center to undertake a major investigation into diarrhea prevention, with accompanying surveillance of appropriate health indicators. We fully recognize that prevention of diarrheal, or of the diarrheal/malnutrition syndrome, must involve a combination of difficult interventions, at the community level, and the protocol would have to be somewhat selective to be manageable. The particular interventions should be chosen through a careful analysis, considering priority ordering of the underlying problems, allocation of scarce resources, cost-effectiveness, and replicability elsewhere. By focusing on morbidity the project would provide a corrective to the usual preoccupation with mortality. Such action components as involvement of community leadership, and the establishment of a rural volunteer program, based probably upon the Bari Mother, would seem important. Our recommendation is that appropriate staff members be assigned to develop a workable plan, and that supplementary donor funding be sought.

The basic Matlab design, of one large area for the experimental work and another area for comparison, serves nicely for such a protocol. Especially for this trial of a "bundle" of inputs, as with the present MCH interventions, no scientific conclusion as to net effect can be drawn without a comparison. In some experiments it suffices to watch the outcome indicators before, during, and after the interventions in the action area alone, but the Matlab data show wide seasonal and annual swings in diarrheal incidence as well as changes in diarrheal types through time. Thus it would be impossible to judge the success of the proposed intervention without the comparison area.

A parallel case is the past course of fertility in the two areas. Both areas show considerable fluctuations, but they are very closely similar in pattern, and the fertility line for the experimental area is consistently below that for the comparison area, with a widening gap through time. Were there only the experimental line, with its large swings, the evidence of program effect would not be at all convincing. It is the contrast of the two that makes up the evidence, and this is exactly what would be hypothesized for a reduction in diarrhoeal incidence under the proposed experiment.

A further suggestion regarding Matlab is that continuation

and failure rates for the oral pill, the Copper T, and the injectable be determined. Staff impressions are disturbing regarding pill and IUD failures, and a recent Copper T study shows high removal rates. The failure rates and discontinuation rates, besides their intrinsic significance for service quality, may help explain a possible elevation of fertility relative to what the contraceptive prevalence level implies.

Finally, we suggest that the unusual competence and project experience of Dr. Yunus, Mr. Chakraborty, and Mr. Sardar be used more fully, not only in evolving future Matlab protocols but more generally in the Center's work. They are clearly exceptional, and both will grow further and contribute more by enlarged roles.

JESSORE

The Extension Project in Jessore has established once again that contraceptive prevalence can rise to a high level in very unfavorable circumstances even without the intensive inputs of Matlab. This is a most significant finding internationally. The experience here is still registering outside Bangladesh, and as with Matlab, the work should most certainly continue.

Additional outcomes: Throughout the last twenty years, pilot projects in this field (and others) have suffered from poor transfer of results to national programs. The Extension Project was deliberately designed to test ways to achieve transfer, and much has been learned that relates to both local and national levels. These lessons very much need to be widely disseminated -- the necessity of government's enlarged involvement and its sense of joint "ownership" of the work; the avoidance of rich inputs; the identification of manipulable factors (e.g. worker density and training, vs. more intractable ones, e.g. supervisory quality); and documentation of the true difficulties of establishing new insights and new practices in bureaucracies.

At the national level additional lessons have emerged, which very much need recognition -- that a good working relationship between researchers and officials is the best guarantee of transfer, that the research should be ready with articulated findings at the teachable moment, i.e. when officials face a problem, or must develop a plan, or must respond to a donor offer. The presence of interface persons is vital -- individuals who are known and trusted by the officials, who in turn know the research findings -- this channel of transfer works far better than reliance upon thick written reports issued on the researcher's own timetable.

Many of these points apply also to transfer of research results to major donors as well.

All these lessons are still taking shape, and are still being disseminated. The Extension Project should be continued by ICDDR,B, not only for the new findings yet to emerge but also to

keep alive these extremely important results for their further absorption by the field. Jessore and Sirajganj are a nearly unique trial calculated specifically to explore transfer issues, and the results should be communicated energetically as a Centre contribution.

The foremost example of impact from the Extension Project is the Ministry's decision to add 10,000 FWAs to the national program, recruited and trained along the lines developed by the Project. This will raise front-line worker density in Bangladesh by about 80% over 4-5 years, which stands as one of the most significant contributions of any pilot project ever done, and it should be recognized as such.

TEKNAF

Whether to close the Teknaf station needs a decision as the season for renewal of its funding approaches. Demographic reasons alone appear not to provide convincing justification for continuing the DSS there, as the potential of the ten years of data already gathered has yet to be realized.

The health interventions that have been tried have foundered for various reasons, and none are now seriously proposed nor seem very feasible. A good deal of medical data have been gathered that have never been analyzed. There may be Shigella research opportunities; Dr. Sack's December 12 memo makes the case for these, but the funding assurances (including capital inmprovements) are incomplete and there is the question of his successor's concurrence on work there.

One gets the impression that the Teknaf Center would already have been closed except for the difficulty of releasing the very dedicated staff there, and the clear need for the treatment center to continue. The latter appears to be solved now by Danida at least for the near term.

The basic problems with Teknaf need to be briefly mentioned: its inaccessibility, requiring a three day trip to do one day's work, and virtually no outside supervision of the field activities during the four month rainy season; its large geographic area, low density, and difficult terrain; the easy migration flows across the river to the ethnic Bangladeshis in Burma, with many families having members on both sides; the atypicality of the area culturally and demographically; the absence of reliable electricity and water supplies; and the isolation from Dhaka communications, without telephone contact, and even telegrams taking several days. There is also considerable cost to the Teknaf project (apparently $150,000 to $200,000 per year).

Were the project to be closed the preferred timing would be when the current funding stops at the end of 1987, and to be sure to complete the data base work before then. That will create an extensive resource for secondary analyses, which can be exploited by a doctoral or post-doctoral person for much less than the present cost. Gathering an 11th or 12th year of additional data has no apparent scientific justification, and the load on managerial time and donor funding hardly seems justified. Moreover, if the Center as a whole must realize cost savings, reductions in Teknaf are preferable to those in more vital activities.

If the Bio-medical possibilities develop especially regarding Shigella a reduced DSS might be needed for them and should probably be funded through them. The remote "Coastal Villages" could be dropped and selective data collection continued in the Teknaf and Shahpuridwip areas.

THE CIS UNIT

The CIS Unit is most impressive, with good leadership and excellent equipment. At present it stands at a major juncture that will bear heavily upon future staff and funding questions. This is considered in depth by Alan Sunter, but these brief comments are included here as the decision is important for funding pressures on substantive research activities.

The immediate issue is a further expansion of CIS capacity--hardware and some accompanying software -- through a gift from IBM. This appears inadvisable (except perhaps for two tape drives) in the light of the likely net drain on the Center's funding and the expected trend in micro-computer technology. Notwithstanding that the hardware/software for the proposed expansion is a gift, it will immediately involve ICDDR,B in installation and maintenance costs and will create pressures for increases in the management infrastructure. Over the next 3-5 years the capacity/cost ratio of the micro is bound to attain further breakthroughs, radically improving its competitive position against mainframes. Staff (and some donor) sentiment already runs to micros, partly to escape charges for mainframe use but also for personal convenience, and both staff and donors will be increasingly so inclined as micro technology jumps ahead. There is probably no stopping this staff/donor trend.

That being so, it appears best for longer term financial planning to hedge now against an enlargement of the funding burden of the CIS Unit, particularly as one expansion tends to engender yet another (as is now being observed).

Were there large profit potential for CIS in outside jobs from a hardware expansion, <u>that cannot be realized from current equipment</u>, the arguments might run differently, but I believe that no-one anticipates that, no market assessment supports it,

and no donor encourages it. It would also tend to distract managerial attention from the Center's own projects.

To repeat, it is not in the best interests of the CIS unit to charge the present high rates, as it undercuts patronage of the facility. A price elasticity curve is involved here, and CIS should try to move to the "lower charge/higher volume" portion of that curve. CIS operates now at only partial capacity, and volume could easily increase.

This would occur within the Center by lowering rates. It might also occur by inviting use of the facility by those local institutions with which the Center wishes to establish collaborative relationships. This will require the CIS leadership to devote time to such users, but this would be preferable to assisting outside commercial concerns, whose work would be substantively irrelevant.

Provision should be made to give access to CIS services to staff who have no grant from which to pay charges. Their needs may be modest but still critical to their research. Another category is outside scientists, whether local or foreign, who are able to come here for collaborative work but who lack funds to cover computing costs. In fact a variety of issues surround the operation of any CIS-type of facility, and we commend the plan of monthly computer users meetings with participation of all concerned parties.

RESEARCH PRODUCTIVITY

Several points of concern are organized here under "research productivity." Although this puts the focus on the immediate needs of the research staff, it also applies to their superiors and to the Center's support arms.

1. Staff Capacity. We understand that the freezes on hiring and on promotion are being eased a little, and the Board is considering a full plan to create national positions at levels C-F, with effective tenure from D-F. Something like this is much needed, as good mid-level national staff lack a career ladder and now tend to be lost and can hardly be replaced. National salaries have also become much less competitive locally. Clearances for international hiring are also a concern. These problems have mounted; for example, the large Extension Project currently has only one full-time senior person.

We have discussed the following ways to augment the slender professional staff, some of which also give the Center good tie-ins to the best scientific work elsewhere:

- Use already available funds to bring in international consultants (especially in DSS, following the Extension example), trying to establish enduring relationships rather than ad hoc

visits.

- Use local consultants, and establish ongoing linkages with local institutions (needed also for good relations).

- Attract international staff on sabbatical, or seconded at low cost from other institutions, perhaps through a three-way arrangement with a donor. Attention should go to possibilities from institutions in this region as well as elsewhere.

- Invite carefully selected interns and post-doctoral fellows, again at low cost.

- Create a permanent relationship with a very small number of first-rate institutions where there is a senior investigator of the highest caliber who will reside at the Center for a few weeks annually, and will arrange for his advanced students or junior colleagues to work here. Center staff will pay return visits for further training and exchange. Significant funding for this and for the collaborative research involved may be obtained partly by the cooperating institution.

2. Manuscript Reviews. Many manuscripts are now inordinately delayed, due partly to reviewers' overload and partly to the multi-step procedure. We strongly recommend simplification along the following lines. Instead of a set procedure we would let each Division Head (Associate Director) decide what review is needed for each manuscript. The first decision would be whether it is sensitive or has political ramifications, in which case the Director's review would be included. Short of that it would (a) go directly to the journal when the journal is peer reviewed and the manuscript is clearly of good quality; or (b) go to one or two colleagues for critical comment; or (c) simply be distributed as an internal working paper. All internal reviews would be time-bound, carrying a date after which the author may assume concurrence.

It is not expected that the Division Head need himself undertake a painstaking review, only that he peruse the manuscript sufficiently to decide its disposition.

3 Protocol Reviews. Here the issues are complex, but the current procedure is excessively lengthy and rigid for some cases. We recommend that the full procedure be retained for certain protocols that are quite technical or that involve ethical issues. At the other end of the range however the Division Head (Associate Director) should be able to decide whether a "pilot review" (under $5000, less than 6 months) is needed if the new work is modest in extent and raises no ethical question, or is a minor secondary data analysis. Large project agreements signed with donors will already have gone through scientific and administrative reviews, and activity under them should start promptly without being delayed by a subsequent protocol review that appears to pre-empt the agreement. Thus

there are now various cases not all of which fit very well under the Center's traditional model of laboratory and clinical investigations. We recommend that each Division Director be authorized to decide what kind of protocol review is appropriate in each case -- in the simplest instance whether any is needed, whether one or two colleagues should comment, or whether it should go the Research Review Committee and/or the Ethical Review Committee. If a protocol originates in one Division but also involves the work of another one, the Division Head is of course expected to request a review from the other concerned Division.

4. Access to data. Some worthwhile analyses are hampered by lack of access to data held by other research units or individuals. While some "ownership" of data is natural, especially when it is newly collected, the Center's management should develop satisfactory guidelines that will clarify ambiguous situations and encourage full exploitation of data sets.

5. Administrative Problems. Research staff are unanimous in their dissatisfaction with the present personnel system and administrative support. Much time, and much creative energy, are dissipated in delays and inaction, and also in exceedingly complex procedures (as with the numerous steps needed for hiring). Present feeling clearly goes beyond the usual complaints found in most bureaucratic environments -- it is a deeply held assessment that these drains are a principal drag on research output. We recommend that the Center's senior managers address this problem head-on, with a set timetable for corrective measures. (One helpful step may be to reassign one or two staff from the Administrative Unit to each Division who will become conversant with the work there and will also understand the administrative procedures).

SAMPLE REGISTRATION SYSTEM (SRS)

The SRS is a multi-round survey that covers the same 7500 households every three months, in each of the two Extension Areas. At great effort, a remarkable computer program has been developed that performs extensive edits and consistency checks as data are entered from each new round, and directly produces finished output of rates and tables. The program yields vital rates, contraceptive prevalence figures, proportions pregnant, and other results quarterly, and can generate a "census" covering numerous variables for any past point in time. A nice feature is that after each round it is only changes of status in each household that the interviewers send to be entered into the computer, and it takes only two hours of running time to process each round's data and produce the finished results. Error messages go back to the field and are resolved by revisits in a two-week period of each quarter. (Additional contraceptive prevalence rates should be added that use the denominator of all currently married women aged 15-44, also 15-49.)

A brief module of questions on a special topic can be added to any round of interviewing, and as these accumulate they enrich the variable set, both for cross-correlations and for determining whether responses at one time agree with behavior later (e.g. do family size preferences stated in 1983 match behavior over the ensuing three years).

When a household splits, as by marriage of one member, the new household is added to the file. Households out-migrating are no longer followed, and we understand that households in-migrating are ignored so the sample is essentially a slowly shrinking cohort of households selected in early 1982. (By modification, in-migrating households could be added to maintain representativeness of the community, and this should be discussed as to feasibility and cost.)

The SRS program can become a major international contribution of ICDDR,B. It represents much skilled labor and over four years of field use, and it is unlikely to be created elsewhere. It can be applied in a variety of situations, probably at modest cost (its cost is presently being assessed). When micro adaptation is completed and documentation is finished it should be made widely available as a most notable ICDDR,B product.

The first test of its transferability will come through the Indonesian trial expected soon. This may do much to confirm that the SRS software is amenable to minor adaptation and can indeed served as a powerful tool for multi-round surveys of this approximate size.

Part II

In Matlab, in the intervention area there is evidence of better fertility regulation and some reduction in infant and childhood mortality, which however still remains very high. The same applies to maternal mortality. The various MCH components are being gradually introduced one by one, (ORS and T.T. for pregnant women) but the package was until recently very limited and hence the impact on maternal and child health is not substantial. Immunisations for children against the 6 diseases included in EPI has recently been introduced as well as increased measures for safe birth practices. These steps accord with current priorities of the Government of Bangladesh, Ministry of Health and Family Planning in a major drive towards reducing childhood and maternal morbidity and mortality.

With the Matlab treatment centre catering largely for diarrhoeal diseases, and the four sub-centres serving around per 20-25,000 population, service facilities for treating illness in community are seriously constrained. The Community Health Workers are well trained, and do not seem to have too heavy a work load. Making a simple drug kit available to them after relevant training should be considered seriously. This could cater for upper respiratory infections, pyrexias, eye infections, skin infections etc. These though not critical during an individual episode, do take a heavy toll because of their prolonged course and repeated episodes.

Acute lower respiratory disease has emerged as a major cause of mortality among young children. Community level management with appropriate training and skills should be a priority area of research and intervention.

The reports indicate that deaths due to diarrhoeal diseases are increasing and ORS alone obviously is not the answer as shigella has emerged as a major causative factor. Again the Community management of this disease seems to be the only way of saving lives and research and action needs to be focussed in that direction.

Prolonged diarrhoea as a cause of death and malnutrition does not seem to have received the attention it deserves, and only recently has emphasis been given to diet during diarrhoea and nutrition rehabilitation after the episode. New regimes are still not adequately implemented. This aspect did not emerge as a clear concern or an area of follow up and research during our discussions with the field staff. KAP studies regarding the community attitudes and beliefs regarding food during and after an episode of diarrhoea would be crucial to appropriate nutrition education advice and rehabilitation.

ORS packets are available with the health workers and Bari mothers. It does'nt seem possible to take the packets to the remote rural areas of Bangladesh in the foreseeable future and so the home made fluids should not be given a backseat as seems to be happening at present. Earlier reports from the Centre (Snyder 1982, Zimicki) have testified to their safety and effectiveness.

Maternal mortality continues to remain very high in the study area and at least some break up of the numbers in the prenatal, natal and postnatal periods is available. The interventions to reduce maternal mortality are difficult but the Centre should not postpone the problem any further. The studies on maternal mortality should now be translated into relevant interventions.

The time lag between collection of data and its analysis needs to be reduced. It seems that the data on causes of neonatal and postneonatal morbidity collected in 1982-83 is still being analysed.

Another area of concern is the total reliance on home based service which is not replicable. Nor does it seem a wise strategy to make a community so completely dependent on a home based service. With appropriate motivation and social mobilisation it should be possible to render equally satisfactory service from a nearby field location, which should be well within easy reach of the community. At least this strategy should be tried in a part of the study area.

Nutrition Rehabilitation Centre Matlab

This centre has been started recently but the facilities and the staff do not seem geared for running the facility adequately where only critically malnourished children, who in all probability will have one or more infections (including possibly tuberculosis), would be admitted. The management of such Centres is always very expensive and not very rewarding as to the effect on mortality in general and to case fatality on follow up. The Matlab Project is in an ideal situation to demonstrate whether suitable and precise nutrition education (this is one thing that is best done at the family level) and detection of early growth faltering would not be the answer to the problem of malnutrition and its contributory effect on the young child mortality. That severe malnutrition contributes to death is well known. The incline, however, is gradual, and goes on rising with increasing malnutrition and early interventions can prevent children from reaching that critical stage. Poverty and non-availability of food in the household is too often cited as a cause of the inevitable malnutrition when several studies have shown that almost half the malnutrition is in the households where there is no absolute shortage of food. There is need for a few anthropological and sociological studies on infant feeding practices including introduction of semi solids and transition to the regular family diet, mother's conception of child's

food requirements etc. This would be vital for developing nutrition messages and for obtaining optimum compliance.

The MCH-FP Extension Project Abhoynagar

The training of FWA seems to be good and the one worker we met was certainly a good example. Again the emphasis seems to be only on family planning and ORS and does not include any other MCH component at all. The worker is now going to be involved with the EPI campaign which may take her away for a day or two per week from her own job responsibilities. It is always difficult to decide how much a field worker can be loaded with skills before he/she becomes ineffective. Gradual inclusion of new skills has usually shown better results than everything being introduced simultaneously. But the crucial MCH inputs have to be clearly identified and introduced as soon as possible along with FP. inputs. The extension project is meant to serve as a replicable model for government. Home delivery of services will have to be assessed critically keeping this in view.

The Urban Volunteer Programme in Dhaka

This is an exciting programme which was established in 1981 in response to a recognition that existing health facilities could not adequately reach the poorer section of Dhaka city. Urban volunteers are illiterate women recruited and working in 16 of Dhaka's 18 districts. About 1200 volunteers are involved in the delivery of primary health care services. The service component includes household and clinic based work. The 1200 volunteers have treated approximately 92,000 patients for dehydration. Children with Vitamin A deficiency were treated and health education regarding Vitamin A was augmented. Seeds were distributed to encourage the community to grow vegetables.

A community based day care institution education and rehabilitation centre staffed by volunteers has been started. Mothers actively participate in comprehensive nutrition education and demonstration of food preparation.

Research activities included use of a case-control study to identify hygiene practices associated with reduced rates of childhood diarrhoea. Three practices -- washing hands before eating and handling food, and excluding faeces and garbage from the family living area -- were the basis of a subsequent education intervention. Soap was provided to support the messages of hygiene and cleanliness. The impact of this intervention was evaluated. Diarrhoeal rates were reduced by 20%. An interesting observation was that unhygienic use of sari was correlated with higher rates of diarrhoea.

These are very exciting studies carried out under very difficult conditions, using the community based volunteers and with active participation of the community itself.

The Mirzapur Handpump Project, besides providing hand pumps and latrines, involves the community in maintaining hand pumps and carrying the health messages to the community. It is perhaps to early too evaluate its full impact, but the trend is very promising. To pursuade the community to use latrines is a real achievement

Cause of Death Study

This has been done using the WHO lay reporting system with considerable rechecking. Because of the inherent problems in this kind of reporting a simpler system is being devised using trained Health Assistants and Supervisors. A physician analyses the more complicated cases. The classification focuses mainly on disease categories which is often the main requirement for policy makers. Diarrhoeal diseases, severe malnutrition, measles and lower respiratory illnesses account for most of the deaths between 1-4 years. Problems related to birth are responsible for almost 40% of infant deaths.

Detection of children with a high rate of death by monthly measurements of arm circumference.

This study has tried to identify the critical levels of arm circumference measurement which are associated with a high risk of death, so that interventions can be targeted to that group. Presence of tibial oedema and an arm circumference of less than 100 mm seems to carry the maximum risk. While this may be important and relevant when a new population is surveyed, in an ongoing MCH programme, this level of severe malnutrition should become a rare event, most of the children having been identified when growth faltering occurs or when arm circumference goes into the border line range of 13.5-12.5 cms.

The success of any programme has so far been mainly judged by the family planning achievements, and management of diarrhoeal diseases, but there is clear evidence now that other aspects of MCH and child survival are beginning to receive attention. Studies on the evaluation of morbidity and mortality following measles immunisation and vitamin A administration and some other studies are evidence of this and no doubt will result in appropriate interventions.

Training of TBAs

Some thought needs to be given to the content and duration of TBA training, since such a training has not provided sufficient dividends anywhere. TBA's role in providing prenatal care should be considered. While traditionally their role is

only to conduct delivery and to offer some postnatal service, several NGOs have involved them in prenatal care with excellent results.

The safe delivery kit in its present form also needs to be evaluated as it is rather expensive at the moment and not likely to be used on an extensive scale in the country.

Finally it is rather disappointing to note the lack of collaboration of ICDDR,B with other Centres carrying out research in similar problems within the region. A great deal could be gained by exchange of ideas, exchange visits by scientists etc. Similarly there needs to be more collaboration with other institutions within the country itself for research, even though there is now increasing collaboration with government and some other agencies at grass root level.

ATTACHMENT TO:

5e/BT/NOV.86

PROGRAMME COORDINATION COMMITTEE-
TERMS OF REFERENCES.

POWERS, FUNCTIONS AND DUTIES OF
PROGRAMME COORDINATION COMMITTEE (PCC/SC) 5e /BT/Nov.86

INTRODUCTION:

1.0. Creation of PCC/SC:

1.1. The Board of Trustees of ICDDR,B (The Board) has created a Programme Coordination Committee(PCC) for the purpose of coordination of research in Bangladesh and to oversee that the Centre shall be supportive of, and avoid actions prejudicial to, the interest of research in similar fields carried out by other organizations in Bangladesh.

1.2. The Board has also created a Standing Committee(SC) to coordinate research by the Centre with that of other organizations in the field of diarrhoeal disease and directly related subjects of nutrition, fertility and related fields in Bangladesh. This SC will also act as the Executive Committee of PCC.

1.3. The Board subsequently decided that "There was agreement that the PCC is a valid body and can appoint its own members without the Board intervening".

1.4. As per 1.3 above, the PCC and the SC were reconstituted for a period of 3 years. Each of the Committees will have powers for co-options as necessary. The present members of the Committees, from July 1,1986 will be as follows:-

1.4.1. Members of the PCC

1.	Prof. M. A. Matin	- Chairman
2.	Prof. Kamaluddin Ahmad	- Vice Chairman
3.	Dr.K.M.S.Aziz	- Member-Secretary
4.	Hon'ble Minister of Health & Family Planning	- Board's Representative
5.	Secretary, Ministry of Health & Family Planning	- Board's Representative
6.	Secretary, External Resources Division	- Board's Representative
7.	Vice Chancellor, Bangladesh Agricultural University	- Ex-officio
8.	Vice Chancellor, Dhaka University	- Ex-officio
9.	Vice Chancellor, Bangladesh University of Engineering and Technology	- Ex-officio
10.	Vice Chancellor, Chittagong University	- Ex-officio
11.	Vice Chancellor, Rajshahi University	- Ex-officio
12.	Vice Chancellor, Jahangir Nagar University	- Ex-officio
13.	Chairman, Bangladesh Agricultural Research Council(BARC)	- Ex-officio
14.	Chairman, BCSIR Laboratories	- Ex-officio
15.	Chairman, Bangladesh Institute of Development Studies(BIDS)	- Ex-officio(represented by Research Director)

16. Prof. Nurul Islam - Individual capacity
17. Maj.Gen.M.R.Chowdhury - Individual capacity
18. President, BIRDEM - Ex-officio(Represented by Medical Director)
19. Director General, Health Services, GOB - Nominated by the Government
20. Prof. T. A. Chowdhury - Nominated by the Government
21. Dr. K. A. Monsur - Nominated by the Government
22. Director General, Family Planning Implementation, GOB - Ex-officio
23. Director General, NIPORT - Ex-officio
24. Director, IPGM&R - Ex-officio
25. Director, Institute of Nutrition & Food Science(INFS), D.U. - Ex-officio
26. Director, NIPSOM - Ex-officio
27. Director, IPH - Ex-officio
28. Director, IPHN - Ex-officio
29. Director, Bangladesh Fertility Research Programme(BFRP) - Ex-officio
30. Executive Director, BRAC - Ex-officio(Represented by the Programme Coordinator)
31. Director, MIS Unit, Directorate of Family Planning - Ex-officio
32. Director, Dhaka Shishu Hospital - Ex-officio(Represented by the Paediatric Consultant)
33. Director, Institute of Bangladesh Studies(IBS), Rajshahi University - Ex-officio
34. Director, Bangladesh Medical Research Council (BMRC) - Ex-officio
35. Director/Manager, CDD Programme, GOB - Ex-officio
36. Project Director, NORP, GOB - Ex-officio
37. Dr. Zafrullah Choudhury - Individual capacity
38. Brig. M.Hedayetullah - Individual capacity
39. Dr.Humayun K.M.A. Hye - Individual capacity
40. Dr. A. K. Khan - Individual capacity
41. Dr. Mobarak Hossain - Individual capacity
42. Dr. Sultana Khanum - Individual capacity
43. Director, ICDDR,B - Ex-officio
44. Associate Director, Resources Development, ICDDR,B - Ex-officio
45. Associate Director, DTWG,ICDDR,B - Ex-officio
46. Associate Director, CSRWG, ICDDR,B - Ex-officio
47. Associate Director, HDWG,ICDDR,B - Ex-officio
48. Associate Director, Population Science & Extension, ICDDR,B - Ex-officio
49. Associate Director, PTWG, ICDDR,B - Ex-officio
50. Associate Director, NWG, ICDDR,B - Ex-officio
51. Associate Director, TE&C, ICDDR,B - Ex-officio
52. Chairman, Research Review Committee, ICDDR,B - Ex-officio

Contd..... P/3

1.4.2. Members of Standing Committee(SC)

1.	Prof. M. A. Matin	- Chairman
2.	Prof. Kamaluddin Ahmad	- Vice Chairman
3.	Dr.K.M.S.Aziz	- Member-Secretary
4.	Prof. Nurul Islam	- Individual capacity
5.	Dr.Humayun K.M.A. Hye	- Individual capacity
6.	Dr. Zafrullah Choudhury	- Individual capacity
7.	Maj.Gen.M.R.Choudhury	- Individual capacity
8.	Dr. Sultana Khanum	- Individual capacity
9.	Director General, Health Services	- Nominated by the Government
10.	Dr. T. A. Choudhury	- Nominated by the Government
11.	Dr. K.A. Monsur	- Nominated by the Government
12.	Director General, Family Planning Implementation, GOB	- Ex-officio
13.	Director General, NIPORT	- Ex-officio
14.	Director, BMRC	- Ex-officio
15.	Research Director, BIDS	- Ex-officio
16.	Vice Chancellor, BAU	- Ex-officio
17.	Vice Chancellor, Dhaka University	- Ex-officio
18.	Director, ICDDR,B	- Ex-officio
19.	Associate Director, Resources Development, ICDDR,B	- Ex-officio
20.	Chairman, Research Review Committee, ICDDR,B	- Ex-officio
21.	Director, IPH	- Ex-officio.

2.0. The powers, functions and duties of the PCC/SC :

2.1. While considering the powers, functions and duties of the PCC and SC, Articles 12(4), 5(1)(b), 5(2)(f) and other relevant Articles of the ICDDR,B Ordinance were noted.

2.2. The powers, responsibilities and duties of the PCC/SC shall be as stated in the ICDDR,B Ordinance, 1978 (Ordinance No.LI of 1978).

2.3. In compliance to the guidelines/prescribed under 2.1 and 2.2 above, the powers, functions and duties of the PCC/SC shall be as follows :-

2.3.1 To reconstitute itself every three years and to fill up any vacancy as and when it occurs.

2.3.2 To ensure that the Centre offers facilities for training and research to Bangladeshis in areas of the Centre's competence in collaboration with national and/or international institutions, but not to confer academic degrees.

2.3.3 To ensure that the Centre establishes and maintains contact with Bangladeshi institutions through collaborative "studies", seminars, exchange of visits or otherwise.

2.3.4 To offer fellowships for different categories of scientists and health personnel.

2.3.5 To ensure that the Centre shall be supportive of, and avoid actions prejudicial to, the interest of research in similar fields carried out by other organizations in Bangladesh.

2.3.6 To assist in solving any controversy in relation to the involvement of ICDDR,B in research and training in Bangladesh.

2.3.7 To assist in securing funds for approved research protocols of scieintists belonging to national intitituion in Bangladesh in collaboration with ICDDR,B and BMRC.

3.0 For collaborative protocols or protocols to be pursued /by ICDDR,B /with national institutions, the procedure of collaboration with Bangladesh Medical Research Council is appended herewith (See Appendix-A-I).

4.0 PCC and SC will, from time to time, formulate necessary rules for their operation within the framework of ICDDR,B Ordinance and commonly understood procedures followed in Bangladesh for calling of meetings, quorum and conduct of the meeting. PCC should meet preferably four times a year, but not less than twice a year. The Standing Committee will meet as and when required, but not less than four times a year.

5.0 There shall be a Secretariat of PCC.

5.1 A formal PCC Secretariat shall be established as soon as possible. Till such time, the routine Secretariat and budgetary procedures as currently being followed, will continue.

6.0 All ICDDR,B research proposals, immediately after the approval of the Working Group/Division of ICDDR,B i.e., at the pre-RRC stage, should be brought to the attention of SC in the form of abstract.

7.0 The other terms of reference of the PCC/SC will be as already approved by the Board in its previous meetings, excepting as they are made more functional by the above powers, functions and duties of the PCC/SC.

8.0 Interaction of the PCC/SC and the Board:

8.1 During the Board meeting, the SC will meet with the Programme Committee of the Board, for which a specific programme is to be drawn up to discuss the collaborative projects and other PCC/SC matters. This should be effective from May/June 1987 Board meeting.

Contd..... P/5

9.0 PCC/SC will create a Scientific Review Committee(SRC), including representatives from BMRC and RRC of ICDDR,B, which will scrutinize collaborative proposals and interact with BMRC and ERC of ICDDR,B, after the clearance of the institution concerned.

9.1 When the proposal will receive approval from the SRC of PCC and ERC of ICDDR,B, it will be called a protocol and it will be funded from the PCC/BMRC fund or any other sources.

Approved.

(Prof.M.A. Matin)
Chairman, SC & PCC

Dated: Dhaka: Aug.5, 1986.

PROPOSED PLAN OF ACTION ON THE COLLABORATIVE RESEARCH PROGRAMMES BETWEEN PCC INSTITUTIONS AND ICDDR,B.

OBJECTIVES:

The programme aims at promoting medical research in Bangladesh through active participation of Bangladesh scientists in research. With this objective in view, in addition to a PCC Secretariat, it is proposed to set up a Research Coordinating Cell at BMRC, situated at Institute of Public Health Building (IPH), Dhaka, where Bangladesh scientists sponsored by Bangladesh Medical Research Council (BMRC) will participate in medical research along with scientists from the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B). Based on the experience gained from this initial project, similar cells may be set up in other institutions as appropriate. Later on the programme will also aim at setting up an organized research oriented training programme for Bangladesh scientists with a view to developing high technology competence, to meet, as far as possible, the national need of Bangladesh.

CONTROL AND MANAGEMENT OF THE PROGRAMME:

Routine administration of the programme, management and financial control will remain with a Committee consisting of 2 representatives from BMRC and 2 representatives from PCC, and will be exercised in accordance with policies agreed upon between BMRC and ICDDR,B. ICDDR,B will nominate 2 representatives, who will, from time to time, consult with representative(s) of BMRC and, subject to the overriding control of the parent bodies, decide on these issues.

The role of ICDDR,B will be mainly to provide technical support, assistance and guidance. This will normally be done by active participation of ICDDR,B scientists in collaborative research projects along with scientists from National Institutions. ICDDR,B will be responsible for all payments of ICDDR,B consultants and participants.

BMRC will undertake an active search for promising research talents in the country and those interested should be encouraged and helped to participate in the programme.

BMRC scientists participating under this programme will be compensated from the programme funds, for their time spent, or in any other way, as may be considered appropriate, according to a system mutually agreed upon by BMRC and ICDDR,B.

BMRC will arrange the necessary space for the Research Coordinating Cell in addition to a PCC Secretariat. The investigator will be based at their own

Contd..... P/2

institution or at ICDDR,B, by a collaborative agreement.

DURATION:

The programme will initially be for a two-year period and may commence as early as possible. Discussion on the extension of the programme, beyond two years, will start at least six months before the end of the second year.

FUNDING:

ICDDR,B will donate a sum of US$10,000 (US Dollars ten thousand only) to meet, as far as possible, the initial expenses for the collaborative Protocols.

ICDDR,B may also support specific collaborative studies, in which BMRC and ICDDR,B scientists may jointly participate in the priority areas of ICDDR,B reviewed and approved by the process followed by ICDDR,B.

Subsequently, efforts will be made to procure the necessary fund from external donors. ICDDR,B with as far as possible full participation of BMRC, will take the initiative for the purpose.

The Committee will maintain an up-to-date running account of the expenditure according to the system agreed upon by BMRC and ICDDR,B. This account along with audited report will be available for scrutiny.

REVIEW, APPROVAL AND ACKNOWLEDGEMENT:

PCC/SC will create a Scientific Review Committee(SRC), incorporating representatives from BMRC and RRC of ICDDR,B, which will scrutinize collaborative proposals and interact with BMRC and ERC of ICDDR,B, after the clearance of the institution concerned.

The Principal Investigator of a study will be the main author for publication(s) based on the finding of the study. The Co-Investigators will be the other authors.

Due recognition of the BMRC and ICDDR,B support will be acknowledged in all publications.

Approved.

(Prof. M. A. Matin)
Chairman, SC/PCC

Dated: Dhaka, Aug.5, 1986

APPENDIX-A-II

EXTRACTS FROM THE ICDDR,B ORDINANCE
(Relevant Articles)

*** *** *** ***

5(1)(b) : "To provide facilities for training to Bangladeshi and other nationals in areas of the Centre's competence in collaboration with national and international institutions, but not to include conferring of academic degrees."

5(2)(f) : "To ensure the rights and opportunities of Bangladesh scientific personnel to participate in the programme and activities of the Centre."

12(4) : "The Board shall create a Programme Co-ordination Committee for the purpose of co-ordination of research in Bangladesh and may create such other standing committees or ad hoc committees as may be deemed necessary for carrying out the responsibilities of the Centre. The Centre shall be supportive of, and avoid actions, prejudical to, the interest of research in similar fields carried out by other organizations in Bangladesh. A standing committee with representatives from the Government shall be set up for the purpose of co-ordinating research by the Centre with that of other organizations specifically in fertility and related fields in Bangladesh."

*** *** *** ***

6/BT/NOV.86

PERSONNEL & SELECTION COMMITTEE REPORT.

Personnel & Selection Committee Report to the Board

The Committee convened on Wednesday, 19 November and Thursday, 20 November under the Chairmanship of Mr Manzoor ul Karim. Members present were Prof. D. Bell (Chairman of the Board), Dr I. Cornaz, Prof. R.E. Eeckels (Director), Dr K.A. Monsur (invited Member), Dr P. Sumbung (invited Member, for 20 November).

1. Implementation of Board Resolutions & Decisions

1.1 Task Force

The Committee has met under the Chairmanship of Mr Manzoor ul Karim with Brig. M. Hedayetullah, Prof. Ali Ashraf, Prof. R. Feachem and Prof. R. Eeckels as Members. Dr Feachem was unable to attend any session and Professor Eeckels attended one session only. The Chairman of the Board pointed out that in his understanding only an interim report was expected at this stage. It was understood that the report should be discussed by the Full Board as it was asked for and addressed to the Board. The report was informally discussed by the Committee in order to clarify some points and to get a better mutual understanding; no decisions were taken by the Committee.

1.2 Acquired Rights

Acquired rights issues have been settled in all cases except with Dr M. Bennish and Mr M.R. Bashir.

1.3 Husband-Wife Cases

None remaining.

1.4 Education Grant

No response received as yet from Ministry of Law and Justice. The Centre's legal adviser has stated that the Ordinance allows for the change proposed by the Board.

1.5 Staff Reduction and Contract Extensions, etc.

See chapter 2 hereafter.

1.6 Post adjustment multiplier

Action has been taken as decided.

* * * *

2. Manpower Staffing

2.1 Development in Manpower Staffing

The table in Annex 1 shows the development from May 1985 to October 1986.

2.2 Contract Extensions

- Dr M. Rowland (Head of Community Medicine Division) intends to leave the Centre at the expiry of his present contract (16 September 1987); the Management as yet has received no notification in writing. The Committee recommends that the Board authorize the advertisement for the replacement of Dr Rowland. The post description should also indicate that the Epidemiology Department would also come under the functions of this Division (see Report of Programme Committee). It was stressed that the Division Head should also be a good leader for the research team.

- Dr Bradford Kay (Head Laboratory Department) recently informed the Management that although he had indicated in June 1986 that he would not be able to extend his stay, he was now able to accept such an extension until mid 1988. Since the post has already been advertised, he was requested to apply. The Committee recommends to extend his contract until mid 1988, and in addition that his successor be selected from the present roster of candidates if a suitable candidate is found.

- Mr M.R. Bashir (Resources Development) has been offered a short term contract of 11 months, with a remuneration equivalent to that which he would receive on a consultancy (which would have been offered to him according to the Board decision), the reason for this change, was that a staff position could not be held by a consultant. The Committee took note of this short

term contract. The discussion on the future contract of Mr Bashir was delayed until after the discussion of the Task Force report (see also 2.4 hereafter).

The dates of the contracts of those international positon staff members who have been offered a contract extension are as follows:-

Dr B. Wojtyniak (Population Science & Extension Division)	Dec. 31 1987
Dr J. Clemens (Laboratory Science & Epidemiology Division)	Dec. 31 1989
Dr I. Ciznar (Laboratory Science & Epidemiology Division)	Dec. 31 1989
Dr F. Henry (Community Medicine Division)	Dec. 31 1989
Mr M.R. Bashir (Resources Development)	June 30 1987

2.3 Staff Recruitment

(a) Recruitment by the Centre

Announcements for the following positions have been published nationally and internationally, applications have been received and screened for the minimum requirements.

	Positions	No. of applcns. received	No. of applcns mtg. min. req.
1.	Head, Laboratory Services Dept. (up to P4)	15	9
2.	Senior Scientist & Head Clinical Sciences Divsn. (up to P6)	4	2
3.	Senior Scientist & Head Laboratory & Epid. Divsn. (up to P6)	1	1
4.	Senior Administrator & Finance Officer (up to P6)*	136	31

* (see 2.4 hereafter)

Search Committees have also been formed, including national members from outside the Centre, for each of the above positons. Their function is to look for potential other national and international candidates and to contact them as appropriate to encourage their

applications. The Management proposes that an Executive Committee convene in February-March 1987 to finalize the appointments by the Board. The Committee reached no conclusion on this proposal.

The Committee noted with regret the very small number of receivable applications for posts nos. 2 and 3 above, welcomed the setting up of the Search Committees and stressed the importance if their complementary search, regretted that the short listing had not yet been done for posts 1 and 4, especially since the Board had stressed the urgency of filling the post no. 4 (Administrator and Finance).

As for post no. 1 (Laboratory Services Department, succession of Dr B. Kay) it was decided to go on with the search and recruitment process, inspite of the extension of Dr B. Kay's contract; (see 2.2) recognizing that the appointment will be made after the initally foreseen date of July 1987 and an overlapping between Dr Kay and his successor would be advisable.

Due to the non-extension of Dr Rowland's contract (see 2.2 above) a fifth post should be advertised:

5. Head of Community Medicine and Epidemiology Division (up to P6)

and a Search Committee should be set up for this post.

(b) Recruitment in collaboration with funding agencies

(i) Funded Projects

	Grade
Shigella Project (Laboratory Science & Epidemiology Division) USAID	
Director *1	Up to P6
Epidemiologist*1	P4
Extension Project (Population Science & Extension Division) Population Council (recruited by Population Council)	
Cost Benefit Scientist*3	P5
Operation System Scientist*3	P5
Demographer*3	P3
Scientist for FWA Density Study*3	P3

Epidemiologist (to be recruited by CDC*2)	P3
Urban Volunteers Project (Community Medicine Division) recruited through Johns Hopkins	
Project Director (Pediatrician/Epidemiologist)	Up to P4

(ii) Fellows

Vaccine Trial (Laboratory Science & Epidemiology Division)	1
Shigella Project (Laboratory Science & Epidemiology Division)	2

(iii) Seconded Posts

Chief Finance Officer (WUSC)

Grants Administrator (WUSC)

Health Trainer (WUSC)

Medical Doctors, 2 (Belgium)

Clinical Pathologist (Belgium)

Footnotes

1. Advertisement by the Centre and normal recruitment procedure.

2. The Committee requested the Director to inform CDC that good Epidemiologists available locally.

3. The Committee felt it lacked information on these posts.

2.4 Positions for Review

Administrative Posts

	Date of Departure of incumbent	Proposed level (Board decsn. June 1986)
Chief Finance Officer (Mr H. Janssen)	July 1987	Up to P5 Secondment offered by WUSC
Senior Finance & Administration Officer	New post decided by Board June 1986	Up to P6
Chief Personnel Officer (Mr R. Dery)	June 1987	N.O.
Budget & Finance Officer (Mr L. Chang)	June 1987	N.O.
Resources Development Officer (Mr M.R. Bashir) see 2.2 above	End of short term contract June 1987	P5 Step 10

The Committee felt that its proposals to the Board concerning the Senior Administrator and Finance Officer and concerning the Resources Development Officer, would depend on the discussion of the Task Force Report. It, however, felt that the Chief Finance Officer should hold a senior position up to P5 level.

* * * *

3. Local Staff Insurance Plan

The Management reported that after inquiry (i.e. also contact with ILCA, Africa) it felt the financial risks were too high for an insurance scheme comparable to the WHO (UN) system. The Committee decided that the Centre should continue to self

insure, although this is a deviation from the WHO rules. The question would be reconsidered after a suitable plan had been introduced in Bangladesh in another institution and had been operating successfully for some time.

* * * *

4. Rahn and Hiscock's Review

The Committee discussed the implication of the implementation of the recommendations.

- Recommendation 1 & 2 (Application of Master Standard System): The system should be applied to GS level too from 1987. The Committee recommends the training of a staff member (funding from UNDP should be sought for this training) for the application of the system and for the training of other staff of ICDDR,B; such a training is presently being arranged by Mr. Eggleston (WHO) in WHO Regional Office. A regular visit (annual) of an expert would be helpful.

- Recommendation 8 (the Centre should consider itself as a Headquarter concerning salary scales): The Committee feels that a certain independence would be beneficial, following also the example of the Agricultural Research Centres. The Centre should avoid retroactive salary adjustments.

- Recommendation 10 - is being implemented.

- Recommendation 11 - the possibilities are being investigated.

- Recommendation 12 (use the expertise of UN Volunteer Programme): the proposal is not workable as the potential candidates would not have the requested qualifications.

- Recommendation 13 (to rely more on the administrative and personnel practices of the CGIAR): contacts have been made (ILCA) and further contacts should be undertaken (ICRISAT, IRRI).

- Recommendation 14 (regarding 6-year rule): This question has to be dealt with in conjunction with the Task Force Report.

* * * *

5. Computerization of Personnel and Management System

The Committee took note of the development of the introduction of the new system.

* * * *

6. Staff Ranking Policy

The Committee was informed of the work done by the Committee set up to prepare the policy. The document, which needs still further definition, should be finalized for consideration in the next Board meeting. Several aspects were stressed by the Committee: overlapping of scientific and medical ladders; recognition of work done in other institutions e.g. Shishu Hospital; recognition of training responsibilities; goal oriented appraisal system. For the ranking of administrative staff the master standard system is needed. No direct action is reuired from the Board as the proposed system concerns N.O. level.

* * * *

7. Staff Promotion and Reclassification Policy

The Committee agreed that up to GS4 level "a staff member may be promoted to the reclassified post he is currently holding if he is judged capable of performing the higher level duties by his immmediate supervisor, the concerned Asssociate Director and Chief Personnel Officer".

For GS5 level and above, the present system of advertisement and open competition will continue to apply.

* * * *

8. Secondment Policy

Currently there are three types of secondment: fully funded by other than Centre sources; partially funded; and unfunded (the seconded person is directly paid by his or her organization/institution under a project or contract paid by the Centre). Except for the salary, for the period of secondment, seconded staff are governed by the administrative rules and procedures of the Centre. A statement should be added to secondment agreements to the effect that any research funding that arrives at the Centre in support of that seconded person will be controlled by the Centre.

The Committee felt strongly that the Centre should be involved in the procedure of choosing seconded personnel and that this should be stipulated in any such new agreements. Organizations/institutions should be made aware that the final decision whether a person is accepted for seconment or not has to be with the Centre.

The Board should be kept informed of possibilities of secondment and should give final approval, if possible, before formalities are completed. An example of when this would not be possible is the resignation of Dr Stanton and the need to replace her midway through a project. In cases such as the offer of an organization to second a certain number of persons the organization will select, the Board should approve the framework - e.g. the profile of the type of the posts among which the seconded posts will be - within which the Director can act. In the case of a secondment for a fully-funded project position, the Board only needs to be informed (e.g. Professor Guerrant has proposed an institutional collaboration in chronic diarrhoea and suggested that Dr Wanke be seconded to the Centre under this agreement). For core positions the secondment should go through the normal recruitment procedures i.e. revision and approval by the Board.

It was also suggested that the Centre would make interested people/institutions aware of the openings it has. A narrative could be circulated which outlines what the Centre is doing, its interests for the future, and stating that the Centre would accept a limited number of persons on secondment in given fields who could augment its research activites provided they are fully funded. The Centre is presently doing this through its alumni, visitors, etc.; it could possibly be done more systematically, also with institions the Centre is in contact with.

* * * *

9. Proposed New Organogram

See Report of the Programme Committee.

The Committee also stressed that the Training should not be neglected as it forms an integral and important part of the Centre's functions.

* * * *

As the Chairman of the Committee, Mr Karim, outgoing member, would not be able to attend the full Board Meeting, Dr I. Cornaz was appointed interim Chairman and Rapporteur.

Report on Centre's Manpower Staffing

By Type of Contract

PAID AT NATIONAL STAFF LEVEL	CORE	PROJECT	SPECIAL SERVICE	TOTAL
May 31, 1985	763	517	275	1555
Oct 31, 1985	813 1/	318 2/	270	1401
May 31, 1986	786	319	253	1358
Oct 31, 1986	780	311	233	1324

FUNDING STATUS

Restricted	Unrestricted
831	724
769	632
814	544
811	513

INTERNATIONAL STAFF	FIXED TERM	SHORT TERM	SECONDED 3/ (Centre Cost)	SECONDED 4/ (No Cost)	TOTAL
May 31, 1985	32	12	2	7	53
Oct 31, 1985	35	7	3	8	53
May 31, 1986	32	10	2	13	57
Nov 18, 1986	19	5	2	9	35

Restricted	Partially Restricted	Unrestricted
19	10	24
20	11	22
25	8	24
21	2	12

	NATIONAL (% Change)	INTERNATIONAL (% Change)	TOTAL (% Change)
May 31, 1985	1555 (100.0%)	53 (100.0%)	1608 (100.0%)
Oct 31, 1985	1401 (91.9%)	53 (100%)	1454 (90.42%)
May 31, 1986	1358 (87.0%)	57 (107.55%)	1415 (97.32%)
Nov 18, 1986	1324 (85.1%) (Oct 31, 1986)	35 (61.4%) (Nov 18, 1986)	1359 (86.04%)

1/ Increased due to the recruitment against vacant/new core positions.

2/ Decreased due to release of staff hired for the different projects, such as Vaccine Trial, Measles Studies, NORP, etc.

3/ Centre funded.

4/ Fully funded.

TASK FORCE REPORT.

OBSERVATIONS AND RECOMMENDATIONS OF THE TASK FORCE SET UP U/RESOLUTION 10/JUNE 86 OF THE MEETING OF THE BOARD OF TRUSTEES, ICDDR,B

INTRODUCTION

1. The Task Force set up under Resolution 10/June '86 of the meeting of the the ICDDR,B Board of Trustees, 17-19 June 1986, comprised of the following members :

(1)	Mr. Manzoor ul Karim	-	Chairman
(2)	Brig. M. Hedayetullah	-	Member
(3)	Prof. Ali Ashraf	-	Member
(4)	Dr. Richard Feachem	-	Member
(5)	Director, ICDDR,B	-	Member

2. The following are the Terms of Reference of the Task Force :

i) In the light of the research priorities, overall objectives and new management structure of the Centre, to determine the needs of the Centre for international posts and to propose guidelines on their number, roles and balance of nationalities.

ii) To compare the current staffing pattern at the international level with the result of item (i) and to propose a detailed plan for achieving the desired pattern by the end of 1987.

iii) To consider and make recommendation on whether, and in what way, the 'six-year rule' should be applied after the new staffing pattern defined under item (i) has been implemented.

iv) To identify appropriate policies for the Centre to foster the careers of the Bangladeshi scientists, including international scientists, attached senior scientists, and (post) doctoral research fellows.

v) To examine the pay structures of the Centre, particularly at the international level and make recommendations about the appropriateness of the current application of WHO pay scales to international posts at the Centre in the light of the difficult financial position of the Centre and the cost of living in Bangladesh.

vi) To recommend appropriate measures as may be justified to meet the long term objectives of the Centre. Within this item the Task Force may also examine the cases of the persons who have been affected by the resolutions of the Board in November, 1985 and may make appropriate recommendations.

The Terms of Reference were received by the Task Force on 21 September 1986 and the first meeting was held on 1 October, 1986. The Task Force held several subsequent meetings among its members. Dr. Feachem was not available for any of the meetings; the Director was present in meetings. The Task Force met the management as well as senior scientific and administative staff of the Centre and discussed in detail various matters relating to its terms of reference. Relevant written information was also sought from the Centre in several important areas. Following were the observations and recommendations on the terms of reference given by the Board of Trustees :

Term 1 : In order to understand the perspective of our terms of reference, we need to appreciate the objectives for the creation of the Centre. The ICDDR,B came into being by incorporating the Cholera Research Laboratory (CRL) which was created by an agreement, signed on 15.5.1974 between the Governments of Bangladesh and U.S.A. The multinational character of the Centre was built

in this agreement, which was based on the understanding that Bangladesh would have a major role, both in scientific and administrative affairs, of the Centre. Since this agreement had expired in 1977, it was necessary that a mechanism be created by which the institution could function on a permanent basis.

The ICDDR,B Ordinance was promulgated on 9.12.1978 in order to provide this mechanism. A close study of the Ordinance would reveal that the original spirit of the CRL agreement has not only been maintained but underscored by way of focussing on the developing countries with emphasis on Bangladesh (See Article 5(1)5(2)(1)(a), 8(3), 11(4) etc). The above facts must be taken into account in deciding the needs of the Centre for international posts and in proposing guidelines on their numbers, roles and balance of nationalities. Several comments appear imperative :

(i) The Centre does not seem to have a coherent policy of scientific programme and staff career development with the objective of developing high level Technical competence of Bangladesh. On request a draft organogram was produced, which has obvious deficiencies with the requirements of the Centre.

(ii) The question of balance of nationalities of the personnel holding international posts is extremely crucial in this context. Since the Primary objectives of the Centre relate to research and programmes relevant to the developing countries in general and Bangladesh in particular, the international staffing pattern must particularly draw upon talents from these areas. This would make the experience and investment of the Centre more relevant and fruitful in practical terms.

(iii) Most of the field studies and human experimentations are carried out in Bangladesh. Some of these can be of a sensitive nature and elicit ethical questions involving public opinion, government and the press. It is thus absolutely imperative that there are sufficient numbers of qualified Bangladeshi professionals in senior positions to create the confidence that not only the scientific aspects of the programmes but also the national interest and the acceptability for the community have been ensured.

(iv) In the past the Centre has made important contributions by way of developing treatment and management of diarrhoeal diseases. Novertheless, the Centre has still a long way to go to develop "improved methods of health care" and "prevention and control of diarrhoeal diseases and improvement of public health programmes with special reference to developing countries", as sought by the Ordinance (Article 5.1.a.) It is generally accepted that chronic diarrhoea and malnutrition syndrome are the most common cause of death among those who attend the Centre's treatment facilities, often patients attend the Centre; improve slightly on treatment; come back again with another attack and further deterioration; and after a number of such episodes, ultimately succumb to death. Even in the experimental areas of Matlab, after years of field studies, prevalence of diarrhoeal diseases is massive and endemic, and in fact, child, as well as general mortality levels still among the highest in the world. These are the biggest challenges not only for the Centre but also for the entire third world. Massive multidisciplinary input specially involving biochemistry, clinical microbiology, clinical epidemiology and community medicine are essential to get an answer to the proper solution. There is a poor representation of all these disciplines in the

Centre. Clearly much more has to be done and appropriate initiatives, backed by experience in local conditions must be taken. The need for an adequate number of skilled Bangladeshis in international position is thus obvious.

(v) In the above context it would be unrealistic to expect consistent input from expatriate scientists who usually come to the Centre for an average of some two-year duration. This is normally the minimal time required by an outside scientist to understand the possibilities, drawbacks, limitations, and potentials of a place entirely unknown to him/her, and then to formulate a plan for development. If one looks for understanding and using the local language and dialect - not to speak of subtleties of cultural practices relating to diseases and their handling - the difficulty would appear to be truly formidable. Hence, even under best expectable circumstances, by the time an expatriate starts becoming useful, it is time for him/her to leave. Moreover, the successor expatriate is bound to have views, ideas and lines of action different from his/her predecessor. This situation could upset the continuity of programmes or activities of the Centre. Thus, the core activities of the Centre must be vested in the hands of persons who are likely to continue here for a sufficiently long time. Obviously, scientists from Bangladesh and from the region, can more satisfactorily fulfil this requirement. Continuity of the programme through such core staff members serving over a long range time frame would also cut down the possibility - as is faced now - that some specific high level skills are lost to the Centre and the country with the departure of an expatriate specialist in a particular field, working without the simultaneous involvement of a senior national scientist.

(vi) It would thus appear most logical that, as far as available, qualified Bangladeshi scientists should be placed in core positions of a "tenure" type. They would be in charge of sections in a scientific Division, and would be assisted by counterpart expatriate scientists/consultants, if necessary. They would hold if necessary, ranks of a minimum of NOD (National Officers level D) level and would have a career ladder through NOE and NOF, and then to international positions as branch heads at the P-level - perhaps limited to two or three in each Division. In view of the present financial constraints the international core positions may not be graded beyond P3.

(vii) A limited number of Programme Heads (heading scientific Divisions) and senior management staff (heading administrative Division) - perhaps ranging up to ten - will hold purely contract positions at the international level for a term of three years, renewable for a further term. The position will then be advertised and incumbent will be eligible to apply. Apart from these senior international staff, there would be a few other contractual fully funded positions at the international level, needed for different projects of varying duration from time to time. Recruitment to these positions would be done through international competition, and Bangladeshi - including those in "core" positions mentioned above would be entitled to fill these positions but on a purely contractual basis. Those coming to international posts from "core" positions would get back to their original posts at the end of such contracts, which would allow them greater career opportunities, coupled with job security. This also would help the Centre to attract highly qualified Bangladeshi professionals, which is currently a problem in view of the prevailing insecurity of job in the senior positions and of lack of attraction by rather low NO level positions currently offered to national scientists and administrative staff.

Term 2. The overall structure of scientific and administrative activities of the Centre - as operational unit June 1986 and since July 1986 - has been studied by the Task Force. Several comments are called for:

(i) As of June 1986, apart from the Director (an expatriate), there were six Associate Directors - three expatriates and three Bangladeshi. All these are senior programme head/management positions at the international level. Presently (October 1986) there are four expatriates (Director and three Associate Directors) and two Bangladeshi (Associate Directors) at the Centre in such senior positions.

(ii) As of June 1986, there were 35 personnel in the Centre, including the above mentioned ones, at the international level 22 expatriates and 13 Bangladeshis. Presently (October 1986), there are 23 persons in the Centre holding regular international positions, of whom 20 are expatriates and 3 Bangladeshis. Two more Bangladeshis are on international level: one has special contract and one on fixed term consultancy. It may be noted that these international positions include those of two expatriate executive secretaries - one to the Director and the other to one of the expatriate Associate Directors. This latter Secretary has been given seven short term appointments since 1981, without going through open competition for regularisation. Apart from international personnel directing on Centre's pay role, there are presently scientists and management staff on secondment, holding various key positions in the Centre. This brings the total Bangladeshi international level staff to an insignificant level compared to expatriate scientists and management staff.

(iii) A number of Bangladeshi scientists whose international contracts were terminated in the process had been of high international standing in their relevant fields and were associated with the Centre since its inception. Two of them indeed were in top management positions, holding ranks of Associate Directors. Their departure has created a destablilising vacuum in certain areas of the Centre's scientific and management fields, a scare among the Bangladeshi scientists and deep concern in the community. There is thus a critical need for their replacement by an adequate number of highly qualified senior Bangladeshis.

(iv) In short, the above profile depicts a serious imbalance in the nationality composition of international staff of the Centre. The problem of manning important decision making positions, scientific and administrative, as well as continuity and stability of the programmes has thus become acute.

(v) The senior Bangladeshi professionals and two expatriate scientists of Bangladesh origin had to leave their international positions at the Centre following termination of their jobs as a result of November 1985 Board decisions. Some of them were constrained to accept much lower NO level positions at the Centre. However, all the expatriate scientists whose contracts had been terminated at the same time, were absorbed by some projects at the Centre.

(vi) These happenings, apart from upsetting the balance necessary for viable operations at the Centre, created widespread frustration, low morale and alienation in the local staff and community concern, with adverse implications for quality and productivity of work.

(vii) Questions of injustice, discrimination, and inconsistency in personnel policies have been raised not only by the Centre's staff but by the Government of Bangladesh, the media, intellectuals, and the medical community. Charges have been hurled at ICDDR,B in terms of unethical research with Bangladeshi humans and collaboration with questionable foreign agencies. Appropriate steps must be taken to rectify the pertinent problems and remove misgivings about the Centre's operations. Involvement of senior Bangladeshi scientist in the implementation and decision making process is essential to protect the image of the Centre.

(viii) It is thus essential that starting from now, the Centre should work out a viable staffing pattern along lines suggested above. If taken up on an urgency basis, by the end of 1987, a new organogram - with qualified nationals in key"core" positions (tenure position for continuing actions of the Centre) and others in senior contract positions - can certainly be a fruitful and achievable goal. Appropriate measures should "ensure the rights and opportunities of Bangladeshi scientific personnel to participate in the programme and activities of the Centre", one of the aims and objectives laid out in the Ordinance (see Article 5.1.f.); and would strengthen its scientific operation.

(ix) One important step toward bringing harmony and balance in the ICDDR,B administration internally as well as in relation to the host Government and various national institutions would be activating the post of the Deputy Director. The Ordinance provides for the post of a "Deputy Director, who shall be selected and appointed by the Board" who would assist the Director "in all matters assigned to him by the Director and shall act as the Director during the Director's absence serving as a member of the Executive Committee but not assuming the seat of the Director on the Board" (Article 12.4). In the light

of recent happenings leading to the formation of the present Task Force, it would appear most pertinent that this position be activated, and the Director be assisted by a Deputy Director. One of these two should be a Bangladeshi. The Deputy Director would also be responsible for overall supervision of administrative, financial and resources development activities. Such a distribution of functions will enable the Director to devote more time to research and scientific leadership which at present he finds difficult to carry out. Under this arrangement, there will be no necessity for the position of Associate Director, Administration and Finance and in reality no additional expenditure will be involved. Since the post of Associate Director, Resources Development will also be abolished there will in fact be considerable savings.

Term 3. This has been addressed under discussions on Term 1. To recapitulate, all "contract" positions could be for a maximum period of six years; while "core" positions would be of a tenure nature. It is to be noted in this context that the Ordinance provides for a "six-year rule" only for the Director (Article 13-1). Application of this rule to the "core" staff would be against the interest of the Centre as it would discourage qualified scientists both Bangladeshi and expatriates who would, obviously, be reluctant to join such a position leaving a secure job elsewhere. However, the "six-year rule" could be applied to all "contract" positions, with a provision that persons affected could internationally compete for recruitment against the vacancies created at the expiry of their own contract, without any break of service.

Term 4. This has been largely answered under comments on Terms 1, 2 & 3. In addition, more openings should be explored for collaboration with national institutions - perhaps through PCC as well as directly - by way of establishing

positions of national consultants, attached senior scientists, master's,doctoral fellows from universities, and post doctoral research fellows. It is essential that studies undertaken at the ICDDR,B should have a reasonable number of projects where scientists from Bangladesh and the developing countries will be the Principal Investigators.

For international positions the utter imbalance of scientific leadership in the Centre, nationality wise, is reflected in the allocation of 83% of the total budget for research protocols to expatriate scientists, as compared to merely 17% for Bangladeshi scientists working as Principal Investigators. This is contrary to the spirit of the Ordinance which calls for ensuring "the rights and opportunities of Bangladeshi scientific personnel" (Article 5.1.f.). This kind of practice, magnifies the problem of retention of the acquired skills and scientific knowledge in the Centre in particular and Bangladesh in general.

Proper assessment of the financial status of the Centre is essential since recruitment of international level staff is dependent on the availability of resources. A mechanism has to be developed whereby the correct financial status of the Centre is reported. The current situation could have been avoided if proper budgetary and financial controls had been exercised in the past. Proper procedures for recruitment of international level staff should be strictly followed and no unfunded recruitments should be made, except for core positions.

Term 5. This item has been dealt with under Term 1. The "Core" positions should range from high NO level to pertinent P level as provided under WHO scales, thus cutting overall costs substantially. International positions at

programme / Division Head levels and fully funded international positions under different projects would be "contract" positions as provided under the WHO scale. Since these would be "contract" positions, their number could be easily regulated in terms of funds available. As provided for in the Ordinance, persons including Bangladeshi nationals appointed to the international level positions of the Centre by the Board shall receive the same privileges and salaries for equivalent positions (Article 14.1). No discrimination, based on nationality, should be made in this regard. Cost of living in Bangladesh should be strictly reflected by way of positive or negative "post adjustment" to the basic salary, as done in the UN.System. As emphasized earlier there should be a reasonable representation of Bangladeshis in these positions. For a small Centre like this, full WHO scale may be too-high. But by limiting the salary scales upto branch heads at P3 or less, this cost would be reduced substantially. However, considerable savings can be achieved if the usual international benefits attached to WHO positions are reduced to a level which the Centre can comfortably afford.

Term 6. Several observations are called for:

(i) Those who have been affected by the resolutions of the Board in November, 1985 should be free to apply for any new vacancy. The restriction imposed by the Board in this respect should be waived. Selection should be made on open competition based on qualification and background of the candidate.

(ii) The Board of Trustees shall designate an Executive Committee which shall, from time to time, act for the Board on all matters requiring Board's decision. This E.C. should meet as often as is necessary, but not less than

twice a year. It will be composed of (1) Chairman, Board of Trustees, (2) two Bangladeshi members of the Board of Trustees, (3) the Director-ICDDR,B and (4) Deputy Director. The decisions of the E.C. shall be treated as decisions of the Board of Trustees, unless they are changed by a two-thirds majority of the members of the Board of Trustees.

(iii) If this is done, it may no longer be necessary to have personnel and selection committee and for the full Board to meet twice a year. A meeting once a year will then normally be adequate and there will be considerable financial saving.

(iv) In the light of usual international convention all new members of the Board should require prior clearance of the Government of Bangladesh and for this purpose the names and curriculum vitae of concerned persons shall be presented to the Government of Bangladesh for its review and concurrence.

(v) To ensure that all actions taken are in accordance with the provisions of the Ordinance, the Government of Bangladesh may review the decisions of the Board from time to time as necessary especially in the context of sensitive problems and policy decisions reflected earlier.

(vi) Objectives of the ICDDR,B Ordinance stipulate the dissemination of knowledge in diarrhoeal diseases and directly related subjects of nutrition and fertility with a view to developing improved methods of health care and improvement of public health programmes with special relevance to developing countries (Article 5.1.a.). Achievement of this objective requires close cooperation and collaboration with countries and institutions of this region. ICDDR,B has been able to achieve only limited success in this regard as close

collaboration and cooperation could not yet be fully established with countries and institutions of the region. This constraint can be mitigated by the active participation of the WHO Regional office as well as that by the UNICEF Regional office. It is therefore recommended that representatives of their Regional offices be nominated as members of the ICDDR,B Board of Trustees. Additional possibilities of regional level collaboration should be explored in the forthcoming years by way of expanded exchange of scientific personnel between the ICDDR,B and various participating institutions from the developing countries of the region.

(MANZOOR UL KARIM)
CHAIRMAN

(DR. M. HEDAYETULLAH)
MEMBER

(DR. ALI ASHRAF)
MEMBER

(DR. ROGER EECKELS)
MEMBER

* Dr. Richard Feachem was not able to attend any meeting of the Task Force.

8/BT/NOV.86

RESOURCES DEVELOPMENT REPORT.

RESOURCES DEVELOPMENT REPORT FOR BOARD OF TRUSTEES MEETING, NOVEMBER 1986

At the June 1986 meeting of the Board of Trustees, firm donor commitments to the Centre totalled US $8,523,000 and an estimated US $1,565,000 was due for finalisation during the year. In November 1986 Resources Development is pleased to report that the Centre's total committed income is US $9,303,000 which is the result of a shift of US $780,000 from estimated to committed income. The only outstanding estimated amount is US $200,000 which represents NORAD's 1986 contribution which, according to the local NORAD office, is expected to be signed by mid December 1986. The total income of the Centre for 1986 is therefore US $9,503,000 which is US $585,000 less than the amount projected in June 1986 (US $10,088,000) This shortfall can be explained by the following major factors:

First, although the Centre had expected US $ 580,000 from USAID for the UVP in 1986 it received only $175,000, which is US $ 405,000 less than the expected amount. This is principally because the negotiations which started in Dhaka had to be finalised in Washington due to technical difficulties and problems of identifying an appropriate funding mechanism. There was a resultant delay in the starting date of the grant from June 1, as mentioned in draft agreement to October 1.

Second, the support of the Government of Australia to the Centre's unrestricted core fund projected at US $ 200,000 in June stands at US $130,0 : November, US $70,000 less than the expected amount. Due to a sharp reduction in the Australian aid budget in the current financial year ADAB has regretted that the secondary payment it had earlier forecast for the Centre by the end of 1986, would not be forthcoming.

Finally, Ford Foundation's additional support for Epidemic Control in the amount of US $60,000 as envisaged in June has not materialised as the project had sufficient funds for extension up to the end of December 1986.

Since we reported in last June, there have been the following major developements in the resources development activities of the Centre:

1) SAREC's (Sweden) contribution to the Centre's unrestricted core fund for the first half of 1986 has been US $ 120,000. Additionally, SAREC had indicated its desire to finalise a longer term, multi year grant at the Donors' Meeting which had been scheduled for September 1986. However with the postponement of the

meeting SAREC's announcement of the additional contribution has also been delayed. Negotiations are underway for at least a one year grant for ensuring continuity in the Swedish aid until a longer term agreement is signed.

(2) As part of its four year cooperative agreement with the Centre USAID/Washington has made a total commitment of US $3.1 million in 1986 to the Centre's unrestricted and restricted core funds. This includes
USAID/W the unrestricted core contribution of US $500,000 which had been indicated in the June report, and an additional grant of US $920,000 to cover administrative and financial costs, support for project development and for research on shigella, the latter to be carried on for a period of two years.

(3) USAID/Dhaka has signed an agreement for a grant of US $4 million
USAID/D for the Centre's Urban Community Volunteer Programme. The grant will be for the 1986-1991 period, effective October 1, 1986.

(4) The renewal proposal of NORAD's grant of US $200,000 for the Centre's MCH-FP programme has already been submitted and a final decision
NORAD is expected in early December as indicated by its local office. NORAD has agreed to consider the Centre's proposal for funding for 1987-88.

(5) As the Centre's present agreement with the Swiss Development Cooperation terminates in December, a proposal for grant renewal has already been submitted. However the final decision on Swiss contribution
SDC to the Centre which was expected at the Donors' Meeting scheduled for September 1986 was delayed due to the postponement of the meeting. Until this decision is taken at the Donors' Meeting rescheduled for early 1987 an interim one year agreement is expected.

(6) The UNDP Clinical Research grant to ICDDR,B ends in December 1986. Negotiations have been initiated for a three year agreement to be signed in
UNDP early 1987 which would preclude the necessity of arranging for any bridge financing as had been forecast in June. The fresh grant is to be in the same amount as the previous and expected to be directly funded to ICDDR,B instead of being routed through WHO.

The Centre's income projection for 1987 made in June 1986 was US $10,912,000. Our revised estimate for 1987 is now $10,065,000. The reduction in income forecast by $847,000 was caused by a 50% reduction in the contributions of UNICEF and USAID to the Centre's core fund; reduction in the estimated contribution of DANIDA to the Centre's unrestricted core fund and finally a reduction in USAID contribution to UVP. Firm donor commitments for 1987 received to-date now stand at US $7,915,000 and we expect to raise another US $2,150,000 during the course of 1987.

At the June 1986 meeting of the Board of Trustees, a request was made for a further extension, by one year, of the UNROB loan from the Government of Bangladesh to the Centre. This request has been turned down.

The Donors' Meeting of ICDDR,B was originally scheduled for Sept., 1986. It has been postponed to early 1987 due to a delay in processing documents. Dates for the meeting are to be finalised by the Board of Trustees. It is expected that the meeting being held in Dhaka for the first time, would enable donors to acquaint themselves with the facilities of ICDDR,B, assess its research requirements and pledge further support for the Centre's various research and training activities.

RESOURCES DEVELOPMENT REPORT FOR FINANCE COMMITTEE, NOVEMBER 1986

The Centre's income for 1986 was projected at US $ 10,088,000 by Resources Development at the June 1986 meeting of the Finance Committee. Actual commitments now stand at $9,303,000 with another commitment of $200,000 from NORAD, expected to be finalised by December 1986, as advised by their local office. This brings the total income for 1986 to $9,503,000.

There is a difference of US $585,000 between the June 1986 projections and commitments received to date. One of the major factors responsible for this shortfall in income is that the Centre had expected US $580,000 from USAID for the UVP for 1986. According to a draft agreement, the effective date for the start of the grant was to have been June 1. Subsequently however, due to technical difficulties and problems of identifying an appropriate funding mechanism, there was a delay in finalising the agreement. The effective starting date for the grant as signed in Washington is October 1 and the amount made available to the Centre for UVP for 1986 is $175,000.

Regarding the Centre's cash flow situation, we draw the Committee's attention to our June statement where we had mentioned that it would be possible to remain within the bank overdraft limit for the rest of 1986. We are pleased to inform the Committee that the Centre has been able to reduce its bank overdraft substantially and we now expect it to remain below US $2,000,000 till the end of this year.

1987

The Centre's income projection for 1987 made in June 1986 was US $10,912,000. Our revised estimate for 1987 is now $10,065,000. The reduction in income forecast by $847,000 was caused by the following:

a) We had anticipated UNICEF contribution to the Centre's core fund at an amount of US $ 500,000. This figure now stands reduced at $250,000.

b) USAID contribution to the Centre's core fund was also estimated at US $500,000. This figure has also been reduced to US $250,000.

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(c) DANIDA contribution to the Centre's restricted core fund was estimated at US $1,000,000. This figure now stands reduced at $700,000.

(d) USAID contribution to UVP which was estimated at US $1,000,000 has now been finalised at US $ 750,000 for 1987.

Firm donor commitments for 1987 received to-date now stand at US $ 7,915,000 and we expect to raise another US $2,150,000 during the course of 1987.

ICDDR,B DONORS 1986 PROJECTIONS

(In US Dollars)

A. Unrestricted-Core

	Donor	Committed	Estimated	Total
1.	Australia/ADAB	130,000	-	130,000
2.	Bangladesh	34,000	-	34,000
3.	Saudi Arabia	70,000	-	70,000
4.	Switzerland	442,000	-	442,000
5.	UK/ODA	200,000	-	200,000
6.	UNICEF	500,000	-	500,000
7.	USAID	500,000	-	500,000
	Sub-Total :	1,876,000	-	1,876,000

B. Restricted-Core

	Donor	Committed	Estimated	Total
1.	AG Fund	250,000	-	250,000
2.	CIDA/DSS	860,000	-	860,000
3.	Japan (Training Research)	340,000	-	340,000
4.	USA/AID(W)	2,180,000	-	2,180,000
5.	Sweden/SAREC/SIDA	120,000	-	120,000
	Sub-Total :	3,750,000	-	3,750,000

1986 PROJECTIONS

C. Restricted-Projects

	Donors	Committed	Estimated	Total
1.	Belgium	100,000	-	100,000
2.	CIDA/Training	301,000		301,000
3.	Ford Foundation (ECPP)	60,000	-	60,000
4.	Ford Foundation/Morbid Study	80,000	-	80,000
5.	IDRC/DISC	55,000	-	55,000
6.	NORAD/MCH	-	200,000	200,000
7.	NORWICH Eaton	30,000	-	30,000
8.	BOSTID/NAS	28,000	-	28,000
9.	Saudi Arabia (Dammam)	560,000	-	560,000
10.	UNDP/WHO Clin Research	300,000	-	300,000
11.	UNDP/UCVP	50,000	-	50,000
12.	UNICEF/ORT/Training	300,000	-	300,000
13.	USAID/MCH-FP Ext	1,300,000	-	1,300,000
14.	USAID/Phil-Nep-Indon Trg	100,000	-	100,000
15.	USAID/UCVP	175,000	-	175,000
16.	WHO Project Support	61,000	-	61,000
17.	WHO/Vaccine Trial	50,000	-	50,000
18.	WB/Sanitation Intervention	127,000	-	127,000
	Sub-Total :	3,677,000	200,000	3,877,000
	Total :	9,303,000	200,000	9,503,000

A	-	1,876,000
B	-	3,750,000
C	-	3,877,000
		9,503,000

Oct/86

ICDDR,B DONORS 1987 PROJECTIONS

(In US Dollars)

A. Unrestricted-Core

	Donors	Committed	Estimated	Total
1.	Australia/ADAB	200,000	-	200,000
2.	Bangladesh	34,000	-	34,000
3.	Saudi Arabia	70,000	-	70,000
4.	Switzerland	450,000	-	450,000
5.	UK/ODA	165,000	-	165,000
6.	UNICEF	250,000	-	250,000
7.	USAID	250,000	-	250,000
	Sub-Total :	1,419,000	-	1,419,000

B. Restricted-Core

	Donors	Committed	Estimated	Total
1.	AG Fund	250,000	-	250,000
2.	CIDA/DSS	803,000	-	803,000
3.	Japan	340,000	-	340,000
4.	USAID(W)	2,370,000	-	2,370,000
5.	Sweden/SAREC/SIDA	-	200,000	200,000
6.	DANIDA	-	700,000	700,000
	Sub-Total :	3,763,000	900,000	4,663,000

1987 PROJECTIONS

C. Restricted-Projects

	Donors	Committed	Estimated	Total
1.	Belgium	100,000		100,000
2.	CIDA/Training	100,000	250,000	350,000
3.	Ford Foundation/ECPP		100,000	100,000
4.	IDRC/DISC	55,000		55,000
5.	NORAD/MCH		200,000	200,000
6.	NAS/BOSTID	28,000		28,000
7.	Saudi Arabia/Dammam-Riyadh	400,000		400,000
8.	UNDP Clinical Research		300,000	300,000
9.	World Bank/Mirzapur		200,000	200,000
10.	USAID/MCH-FP Ext	1,300,000		1,300,000
11.	USAID/UVP	750,000		750,000
12.	WUSC/MCH		200,000	200,000
	Sub-Total :	2,733,000	1,250,000	3,983,000
	Total :	7,915,000	2,150,000	10,065,000

A	-	1,419,000
B	-	4,663,000
C	-	3,983,000
Total :		10,065,000

Oct/86

ATTACHMENT TO:

8a/BT/NOV. 86

DONOR CONSORTIUM DOCUMENT.

8a/BT/NOV.86

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

PLANS AND PROSPECTS

A DOCUMENT PREPARED FOR THE INFORMATION OF DONORS, GOVERNMENTS AND AGENCIES

SEPTEMBER 1986

Introduction

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), was established to conduct research, training, and service in the field of diarrheal diseases and directly related problems of nutrition and fertility. The Centre is the successor organization to the Cholera Research Laboratory, first established in 1960 by the Governments of the then Pakistan, of Australia, the United Kingdom, and the United States. It was established in its present form as an independent, non-profit, international organization under an Ordinance of the Government of Bangladesh, dated December, 1978. The Ordinance was drafted, under the chairmanship of a UNDP representative, by an international committee convened by the Government of Bangladesh and comprising of delegates from the host country and from a number of interested governments and organizations.

After the promulgation of the Ordinance, a meeting was held at the Headquarters of WHO. This resulted in 16

developed and developing countries, international agencies and foundations agreeing to support or to participate in the activities of the Centre. A list of donors for 1985 is attached (see Appendix 1).

The headquarters of the ICDDR,B are in Dhaka, where it has offices, laboratories, and a major treatment centre serving free of cost some 70,000 patients per year. The Centre also has a field station at Matlab, some 45 miles from Dhaka and in Teknaf at the South-Eastern tip of Bangladesh. In Matlab, continuous demographic data have been maintained since 1960 concerning a population of around 200,000. Both Matlab and Teknaf have treatment centres jointly serving some 15,000 patients per year. The Centre conducts laboratory and field research and training in Dhaka, Matlab, Teknaf and other locations within Bangladesh and in other countries. In addition to its own research, training and service activities, the Centre collaborates in a variety of ways with the Ministry of Health and other health organizations in Bangladesh, and with ministries, universities and other institutions concerned with health in both developing and industrialized countries.

The Centre is governed by an international Board of Trustees with a majority membership from developing countries. Its activities are carried out by an international staff originating from 17 countries;

its financing comes from more than 20 public and private sources in many parts of the world including governments, international agencies, and foundations. All of its research, training, and service activities are reported publicly, and all its income and expenditures are reviewed by independent auditors whose reports are published annually.

Background and current situation of the Centre

The Cholera Research Laboratory was an early example of a research organization dedicated to health problems of the developing world. It was originally established to conduct research on the causes and control of cholera and to disseminate its findings widely through training and publication. During its eighteen-year life, the Cholera Research Laboratory made a number of significant scientific contributions, including:

- pioneering in the use of oral rehydration therapy as a successful treatment for cholera, and for other watery diarrheas;
- demonstrating the ineffectiveness of the standard injectable cholera vaccine;
- demonstrating that with paramedical staff trained in intravenous and oral rehydration, the fatality rate of cholera can be drastically reduced to

below 1% and that antibiotics shorten the course of the illness;

- developing of the Matlab Demographic Surveillance System (DSS) as a large-scale, long-continuing record of major demographic events in a rural community.

The ICDDR,B was given a broader mandate, viz. to work on diarrheal diseases and related problems of nutrition and fertility, in contrast to the earlier concentration on cholera. It was given a more appropriate structure, as a full-fledged international organization rather than being essentially a foreign-aid project. And through a variety of elements in the charter, the new Centre was given a clearer and stronger relationship with the scientific community of Bangladesh.

Since the establishment of ICDDR,B in 1979, it has undergone a considerable expansion, with the budget rising from about 3.3 million in 1979 to 9.6 million in 1986. Further important scientific contributions have been made, including:

- demonstrating the rising importance of bacterial dysentery (shigellosis) in Bangladesh, identifying the importance of malnutrition as a negative prognostic factor in this disease, of handwashing with soap as a measure to control

the spread of the infection, and describing some of its major complications (hemolytic-uremic syndrome, hypoglycemia and possibly chronic diarrhea in the young child);

- demonstrating the equal if not superior effectiveness of a cereal-based oral re-hydration solutions, as compared with the glucose-based one, where the cereal-based solutions can feasibly be used;
- demonstrating the effectiveness of a combined maternal and child health/family planning intervention in the Matlab area in increasing contraceptive use and lowering infant and child mortality;
- successfully conducting a large-scale field trial on the first oral vaccine against cholera which shows highly encouraging early results (covering the first six months after vaccination - see Appendix 2);
- sponsoring a promising health extension effort training illiterate women in the urban communities within the Dhaka metropolitan area to promote primary health care activities.

The Centre has been very active as a <u>training institution</u>. To date ICDDR,B has trained 10,185 health personnel, 9,019 of whom are from Bangladesh and 1,166

came from 63 countries representing all continents of the world. The Centre also organises, or participates in, conferences, seminars and workshops both in Bangladesh and abroad on diarrheal diseases to provide scientists and researchers with a forum to share their experience and exchange information.

ICDDR,B has another programme under which it helps its staff members to further develop their professional skills and obtain higher degrees. To date 62 Bangladeshi staff members of the Centre have received overseas training. Five have received doctoral degrees, 17 a master's degree, and 40 short term training or diplomas. In addition to this, 11 staff members are currently receiving training abroad (5 doctoral, 3 master's and 3 others).

The ICDDR,B also runs three extension projects at the request of, and in collaboration with, the Governments of the People's Republic of Bangladesh and of the Kingdom of Saudi Arabia. The two Bangladeshi projects are financed by external donors. The Maternal and Child Health/Family Planning (MCH-FP) Extension Project attempts to transfer the success of MCH-FP strategies developed in Matlab to the Ministry of Health and Family Planning activities in Sirajganj and Noapara. The Epidemic Control Preparedness Programme, working in close collaboration with the Ministry of Health and

Family Planning, trains Upazilla officials and health workers in coping with epidemics of diarrhea occurring in the aftermath of natural disasters. At the request of the Government, the programme has also sent out its medical teams for intervention, in and epidemiological surveillance of more than 200 diarrheal epidemics in Bangladesh. Recently the combined efforts of Government officials and ICDDR,B experts have quickly controlled an outbreak of diarrhea, bringing the case fatality rate from 16% before the intervention could be started to 1.06%. The Kingdom of Saudi Arabia finances the establishement by Bangladeshi scientists and technicians of regional diarrhea treatment centres in Riyadh and Dammam. The three extension projects, especially the Bangladeshi ones, combine service, research and training activities.

The health care activities in Dhaka, Matlab and Teknaf have already been mentioned (p2). They are one of the backbones of the activities of ICDDR,B. The important service component of the Urban Volunteer Programme (UVP) should not be forgotten. This until now well endowed projects bases its interventions on thoroughly studied health problems in the urban slums of Dhaka. It concentrates on providing diarrhea treatment and nutritional education. This is accomplished by recruiting a cadre of women volunteers and training them

in the prevention and treatment of diarrhea patients in their homes. Training provided also includes lessons on hygiene and health education. UVP has grown tremendously in scope and size since its inception in 1981 and has 1,200 women in the training network today. In 1985 alone this programme has distributed 215,000 packets of ORS and treated 88,000 diarrhea patients in their homes, many of whom would otherwise have presented themselves at one of the city hospitals.

Along with its expanding scientific, training and service activities, the ICDDR,B has encountered serious problems in its first few years, as could be expected from any institution having to face so many pressing obligations.

On the scientific side, the Centre is defining further its scientific priorities, taking into account the significant expansion in recent years in research, both in industrialized and less-developed countries, concerned with infectious diseases in developing countries. It is clear that ICDDR,B has very important assets to contribute - among them its location in an area where diarrheal and other infectious diseases are prevalent; its experience in developing and applying effective interventions in both rural and urban areas; the steady flow of patients through its treatment centres; its unrivalled demographic data base. Making

optimal use of these assets, and linking them most effectively with scientific groups around the world that are addressing diarrheal diseases needs to be an ongoing and carefully monitored process but is not an easy task.

Moreover, while the Centre inherited able scientists from the CRL, and has attracted others in the early ICDDR,B years, there are many problems not yet resolved in how to recruit and maintain a first-class scientific staff, Bangladeshi and foreign, capable of sustained research, training, and service at international standards.

On the financial side, it is clear in retrospect that during the period of expansion after the establishment of ICDDR,B expenditures were allowed to run ahead of income, leading to a cumulative deficit by December 31, 1984 of $2.2 million. Even though $0.6 million of this deficit was accounted for by accumulated depreciation (a non-cash expenditure) and another $0.8 million by the establishment of a reserve for potential repayment of an interest-free loan from the Government of Bangladesh, the cumulative operating deficit of $0.8 million was plainly not a satisfactory record (Table 1).

An unsatisfactory financial situation became a financial crisis during 1985 as a result of two factors: a shortfall of $0.2 million in estimated income, and, much more important, a reduction from $2.9 million of core funding in 1984 to less than $1 million in 1985 (Figure 2). This sudden and radical drop in core funding left numerous ongoing research, training, and service activities without financial support. The organizational response to this shift in funding was clearly beyond the Centre's capacity to achieve in the short run. Two apparently easy solutions were deliberately rejected: drastically curtailing the service activities, and massive laying off of staff, considered as ethically and socially unacceptable.

Beginning in the latter half of 1985, a series of measures was undertaken to respond to the financial crisis, culminating in an emergency action plan mandated by the Board of Trustees at its November 1985 meeting. This action plan was undertaken to cut back sharply on the Centre's costs and to modify its staffing pattern and methods of work to make them more appropriate for an organization that will have to find a much larger share of its financing from project grants and a much smaller share from core financing than was the case prior to 1985. The adjustments required by the Centre's new financial situation are well along in execution but by

no means completed.

The following pages discuss first, the Centre's scientific opportunities and plans, and second, the Centre's financial problems and how they are expected to be dealt with.

The Centre's Scientific Opportunities and Plans

- The scientific activities of the Centre will continue to focus on diarrheal diseases and their complex interrelationships with maternal and child health, nutrition, fertility and other aspects of family and community health in low-income nations.
- Being located in Bangladesh and dependent on political, economic, and scientific support from the Government and people of Bangladesh, the Centre recognizes its obligation to give high priority to meeting the health needs of this country. At the same time, being an international organization, the Centre recognizes its obligation to collaborate with other countries and organizations in the international effort to attack diarrheal diseases.
- The choice of the Centre's research priorities is based on the guiding principle that all research at ICDDR,B must have direct

relevance for the health problems of developing countries. Two main orientations will be followed:

* applied research into life-threatening conditions and appropriate measures to prevent or treat them;
* fundamental research into selected basic mechanisms of health and disease in developing countries.

The major effort will be devoted to the former. Still, if one accepts that ICDDR,B has to contribute to research strengthening of its host country and the developing world, basic research must be a part of its activities: applied and fundamental research must foster and nurture each other.

Discussions between the Scientific Programme Committee of the Board of Trustees, visiting scientists, some major donors, and the ICDDR,B staff has led to selecting the following priority areas:

* risk factors and interventions: being the identification and quantification of nutritional, behavioural and environmental risk factor for diarrhea morbidity and mortality and the design and field trial of preventive interventions intended to reduce the

magnitude and/or prevalence of these risk factors:

* rehydration and feeding: concentrating on super-ORS and cereal-based ORT and feeding during diarrheal illness and convalesence; including studies of home-based therapy and on the delivery of services at the community health level:
* shigellosis: including laboratory, clinical and community studies:
* chronic diarrheas: including laboratory, clinical and community studies:
* vaccine studies: initally focusing on cholera and shigella vaccines:
* demographic studies: concentrating on the interactions between maternal-child health activities, diarrhea control and demographic variables, and on the impact of demographic variables (e.g. birth interval and birth order) on risk of diarrhea illness and death:
* environmental microbiology: concentrating especially on the study of putative aquatic reservoirs for Vibrionaceae and especially V. cholerae.

In this respect, the Centre recognizes that it is to some extent subject to the wishes of its host country and its donors, and the actual priorities

of its research agenda will inevitably reflect the judgements of the different parties involved. One donor has made it possible to start with what we believe is a most important initiative: creating a group of scientific advisors. On its own, ICDDR,B cannot remain on the forefront of the many scientific disciplines it has to practice. Neither can it fully make use of its own research potential. On the other hand, the Centre has much to offer to many scientists from both developed and developing countries. Many of them are interested or participate already in the Centre's activities. Therefore, a continued effort will be made to attract scientific advisors from Bangladesh, South-East Asia and further abroad. These leading scientists will be asked to fulfill four essential tasks: (1) to come once or twice per year to the Centre, to guide and advise its scientists, and participate in its training activities; (2) to help set up institutional relationships and collaborative research; (3) to help identify the best possible candidates for research positions and (4) to help audit the Centre's scientific activities and productivity. ICDDR,B appeals to its donors to help it fully realize this plan. To help setting up a research environment where scientists from

rich and poor countries can meet and work together in a congenial and productive atmosphere is certainly worthwhile.

The Centre's training programs are regarded by the Board and the management as of major importance. A review is underway of the Centre's training activities to date, and some modifications are likely. The international courses will be continued, especially in the fields of laboratory methodology, and of clinical diagnosis and treatment of diarrheal diseases, two areas in which the Centre has much to offer. Requests for training of health professionals and paramedics by the Government of Bangladesh and by NGO's will be met on a priority basis. Efforts to establish closer contacts with national and foreign institutions and with international organizations will be maintained and intensified. ICDDR,B is most pleased to have been recognized as a training institution (medicine and clinical laboratory sciences) by the Bangladesh College of Physicians and Surgeons. It is hoped that the existing common clinical training sessions with the Institute of Post-Graduate Medicine and Research and with Shishu Hospital will be expanded, and that the planned exchange of junior staff members can be started soon. Offering bench space and tutorship to Bangladeshi graduate (MSc) and post-

graduate (Ph.D) students is an important task which will be vigorously pursued. Close collaboration with WHO will be fostered. Last but not least, a specially earmarked fund will make it possible to offer fellowships to scientists from Bangladesh and other SAARC countries in the very near future. These and similar medium-and longer term individual training and research opportunities deserve special attention. These changes are expected to make better use of the Centre's comparative advantage, to increase the long-run impact of Centre training, and to result in a better division of work with the training programs on diarrheal diseases organized by the World Health Organization.

- The Centre's service activities, while on a scale far larger than would be needed simply to support the Centre's research and training activities, have developed historically as a substantial element of the health services available in Bangladesh to deal with diarrheal diseases. As such, they are considered by the Board and the management of the Centre to constitute activities central to the Centre's responsibilities. While it may be possible in the longer run to find more appropriate arrangements to accommodate both the

health needs of Bangladesh and the limited operational capacity of the Centre, over the next few years the Centre's purpose is to maintain the services especially in Dhaka and Matlab, and to steadily improve both their quality for patients and their value in supporting research, training, and extension activities for the Centre.

The Centre's Financial Problems and How it Expects to Meet Them

The essential causes of the financial difficulties of the Centre are four. They stem from the history and basic characteristics of the institution, and they are not easy to overcome in a short time period. They are:

1. The Centre was initially supported and was sustained for many years largely by core funds; it must now organize and plan its work to win financial support for research projects (including both the direct and indirect costs of such projects) from international funding agencies on a competitive basis. There is nothing untoward or unfair about this, but it does require major adjustments in the attitudes and behavior of the scientific staff of the Centre.
2. When core funding was slashed sharply in 1985 (Figure 2), this left the service functions of the Centre without financial support, and a major

cause of the Centre's ensuing and current financial problems is the necessity to continue the service activities although only a very small part of them can properly be charged to research or training projects. In the long run, the Centre's treatment centres should probably become part of the normal functioning of the health facilities of Bangladesh. But there is no way to accomplish that in a brief period of years, and in the next years, therefore, special funding must be sought to support the Centre's service activities.

3. The Centre has at present no sustaining assurance of basic funding under its own control - no endowment, no continuing, assured governmental grants. The international agricultural research centres can count on large, continuing core support grants from the donors belonging to the Consultative Group on International Agricultural Research. Major private universities and research centres in the United States plan for at least one-third of their funds to come from endowments; governmentally supported universities and research institutions, in the United States and in Europe, have even larger shares of their income assured by continuing governmental funding. The Centre is not so favored.

4. During the rapid expansion of the Centre from 1979 to 1984, a cumulative deficit was allowed to develop. This cumulative deficit rose sharply during 1985, primarily as a result of the reduction in core funding (see page 10). At present, therefore, it is necessary for the Centre not simply to achieve a balance between income and expenditure, but to eliminate the accumulated deficit as soon as possible.

The Centre's response to those financial problems has two aspects: an immediate, short-run response to financial crisis, and a longer-term financial plan for operating successfully on a sustained basis. In many ways, of course, the two responses are interrelated.

The immediate, short-run response includes the series of changes included in the Board's emergency action plan (November, 1985), other steps instituted by management before and since that date, and additional measures decided by the Board at its June, 1986 meeting.

Major action taken include:

- Stopping, as of January 1, 1986, all research (and all related activities) supported by core funds;
- Sharply reducing the number of international-level positions on the Centre's payroll, to achieve

- a smaller central staff and a leaner, more economical organization;
- Asking international-level and national-level staff to accept 10 percent salary reductions and limitations for the year 1986;
- Adopting a series of severe economy measures, such as eliminating all core-funded international travel except for fund-raising purposes.

The economy measures taken in 1985 reduced core funded expenditures in that year by $300,000 and for 1986 the estimated expenditure reductions total $858,000. These measures, along with a favorable response by some donors to the Centre's emergency requests for additional funding, have resulted in a substantially improved financial outlook. Reflecting reductions in core funded international level staff costs undertaken in 1986, expenditures in 1987 are expected to be about $705,000 lower than they would otherwise have been. Nevertheless, the Centre's financial problems are far from solved: there is as yet no assured financing in hand for the Centre's service activities (the Dhaka, Matlab and Teknaf treatment centres), and there is no assurance that the Centre's outstanding overdraft can be significantly reduced in 1986 (1).

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(1) See Tables 1 and 2 and Figure 1 in Appendix.

Consequently, the Board at its June, 1986, meeting directed that further economy measures be taken, including further reductions in core-funded expenditures, negotiating with donors to increase the coverage of indirect costs in project budgets, and, if possible, using the current $900,000 balance in the reserve for potential repayment of a loan from the Government of Bangladesh to reduce the Centre's overdraft and thus reduce net interest costs.

At the same time, the Board established the essential guidelines of the longer-term financial plan, under which it expects the Centre to operate in the future on a basis of covering all costs and eliminating the accumulated deficit. These essential guidelines are:

1. The Centre expects in the future to obtain the funding for the great bulk of its research and training activities from grants and contracts for programs and projects mutually agreed upon between donors and the Centre. The Centre recognizes the risks in this approach - principally the risk that its research and training activities will be pulled this way and that way by the varied preferences of different donors. The Centre expects to respond to this risk by establishing a much stonger system of internal quality control, aided by the scientific advisors (see p 14).

Another risk of having to rely on program and project funds to support research support is that third-world scientists, from Bangladesh and other countries, who are working at the Centre, may have more difficulty in obtaining research funds than scientists at the Centre who are from industrialized countries and may be better known to donor agencies. The Centre expects to take special steps to overcome this risk, including providing expert help to its staff scientists in drafting proposals, and ensuring, through the quality-control system, that all research proposals emanating from the Centre meet very high standards.

2. The Centre expects to obtain funding for the general administrative services (accounting, personnel services, supply, management, etc.) that are needed to support its research and training activities by including indirect as well as direct costs in the budgets for such activities financed by donors. In recent years, the Centre has developed a reliable system of cost accounting, enabling it to identify clearly the costs of general administrative services and their relationship to the direct costs of projects and programs. It appears that the indirect costs on

average constitute about 31 percent of the direct costs, and the Board has instructed the management to seek this percentage of indirect costs from all donors, subject to annual reviews of the appropriate amount. The Board realizes that some donors are not accustomed to including indirect costs in the budgets they fund, but appeals to those donors to recognize that, unlike other organizations to which they make grants, ICDDR,B has no other source from which to finance these elements of its necessary costs.

3. As noted earlier, the great bulk of the costs of the Dhaka, Matlab and Teknaf treatment centre, including the indirect costs attributable to those activities, could not be appropriately financed by research grants. This is a major financial problem for the Centre, since the annual cost of these services is of the order of $1.5 million. The present intention of the Centre is to seek special funding for these service functions, including their interconnection with urban and rural primary health care programs, from donors willing to finance them. In the longer run other solutions will be explored.

4. In addition to grants and contracts specially

intended to finance the direct and indirect costs of training, and service projects and programs, the Centre must have some core funding as long as it has no signficant endowment or other source of funds under its own control. Contributions to core funds are necessary:

- to provide an assured source of funding for the senior leadership of the Centre, who are responsible for designing and managing the Centre's program; there will only be a few of these senior leaders, but they require the assurance of independence and continuity that core funding brings;
- to permit the Centre to exercise initiative in developing ideas, working up new proposals, and conducting small scale, early-stage testing of new lines of research; otherwise the Centre would be wholly dependent on donors to develop new program ideas; and
- to specifically support expanding of relationships with collaborating scientists and institutions; these are essential both for quality control and for keeping the Centre in touch with the research frontiers of its subject.

To accomplish similar purposes, well-known

research organizations such as the Brookings Institution in Washington, D.C., that depend primarily on research and training grants for their funding, try very hard to find through endowment and otherwise about one-third of their annual budgets in the form of core funds. ICDDR,B is not likely to be able to achieve such a high percentage. It appeals to donors, however, to recognize the continuing validity of the need for significant amounts of core funds. In 1986, as matters appear at present, the Centre will be receiving about 20 percent of its budget in the form of core funds. The Board believes this percentage should if possible be bettered, especially in view of the likelihood that not all donors will at once be willing to pay the full amount of indirect costs, thus creating additional demands, temporarily it is to be hoped, that can only be met through core funds. The Board therefore has asked management to try to raise the contributions to institutional support in future funding above 20 percent, and ideally to 31 percent.

5. An organization like ICDDR,B will inevitably face an uneven flow of funds over time, since many donors pay slowly and some pay only after work on

a project has been completed. Consequently, ICDDR,B needs working capital with which to even out the flow of funds during a year; ideally, such working capital would show positive balances in some parts of the year and negative balances in other parts. The net amount of working capital needed on average will vary with circumstances and are currently estimated to be between 1 and 2 months' expenditures. The international agricultural research centres follow a similar rule and their donors have recognized the propriety of funding such amounts.

In the case of ICDDR,B, the task of building working capital requires the simultaneous elimination of the accumulated deficit, which at present takes the form of a bank overdraft. The Centre's financial plan includes two simultaneous approaches to this problem. The first is to budget for modest surpluses, say $500,000 per year, or 5 percent on a $10 million budget. If such surpluses are achieved, the accumulated deficit could be progressively eliminated over several years, and a positive working capital balance built up. The second approach, complementary with the first, is to seek a long-term, low-interest loan to replace the present high-interest, short-term bank overdraft. It is

conceivable that, with the help of interested Governments and Agencies such a loan might be obtained. If it were, the current interest cost of carrying the accumulated deficit would be greatly reduced, although the necessity of repaying the loan would of course remain.

6. In the longer run, it would be highly advantageous if the Centre were able to build an endowment. Income from such an endowment could provide needed assured funding for the Centre's senior leadership, to permit some degree of program initiative and independence, and to support some minimum of continuing collaboration with scientific leaders and institutions working on diarrheal diseases. If an endowment were large enough, it could reduce the need for contributions to core funds. The Ford Foundation has contributed $500,000 as a starter fund, and the Centre is seeking other contributions. Adding substantially to the endowment in the near future must be considered a priority.

7. This, then, is the present financial plan for the Centre. It is based on accepting as irreversible a major shift from core financing to project and program financing. In future, the expectation is

to finance research and training activities by grants that will cover their direct and indirect costs, and to seek special donors to finance the direct and indirect costs of the Dhaka and Matlab treatment centres. Core funds will still be needed to provide the essential minimum of scientific leadership, funds for program initiatives, and scientific collaboration. In addition, the plan includes the gradual elimination of the accumulated deficit and meanwhile, if possible, refinancing the overdraft with a low-interest loan.

Such a plan is necessarily uncertain and subject to the inherent ups and downs of project and program funding. It will be very important for donors, where possible, to provide forward assurances of funding for some years ahead to minimize disruptive fluctuations in staffing and planning for the Centre.

8. None of this financial plan will work without a highly disciplined set of procedures that will permit the Centre to function effectively. A series of changes is underway toward this end:

- The number of internationally-recruited staff positions on the Centre's payroll is being sharply reduced; it is down between

July 1985 and July 1986 from 48 to 27 and will be reduced further. The object is to have a small cadre of internationally-recruited senior leaders, who will be supplemented, as project and program funds permit, by junior research staff, both from developing and industrialized countries, and by occasional more senior researchers seconded from collaborating scientific institutions. This should result in a much smaller core staff, with capacity for flexible enlargement and contraction with the number and scale of research projects.

- The nationally-recruited staff is also being more closely related to the ups and downs of project requirements. The implication - not easy to accomplish in a country where employment opportunities are so scarce and highly valued - is that part of the staff will be employed for the duration of particular projects and then let go. The Centre has already begun to carry out such arrangements, and in the future it is expected that they will become routine.

In these various ways, the Centre's Board believes that a leaner, more economical organization and a more

effective system of scientific management are being established which, with the cooperation of donors, will permit the Centre in the future to operate in the black while continuing to make significant contributions to overcoming the major health problems caused by diarrhea diseases for millions of persons, especialy children, throughout the developing world.

DONORS LIST

1. AGA KHAN FOUNDATION
2. ARAB GULF FUND
3. AUSTRALIA
4. BANGLADESH
5. BELGIUM
6. CANADIAN INTERNATIONAL DEVELOPMENT AGENCY (CIDA)
7. DANIDA (DENMARK)
8. FOOD AND AGRICULTURE ORGANISATION (FAO)
9. FORD FOUNDATION
10. INTERNATIONAL DEVELOPMENT RESEARCH CENTER (IDRC)
11. JAPAN
12. MANAGEMENT SCIENCE FOR HEALTH, USA
13. NAS/BOSTID, USA
14. NORAD (NORWAY)
15. NORWICH EATON PHARMACEUTICALS, USA
16. ORSTORM (FRANCE)
17. POPULATION COUNCIL
18. SAREC (SWEDEN)
19. SAUDI ARABIA
20. SWITZERLAND
21. UNITED KINGDOM
22. UNITED NATIONS CAPITAL DEVELOPMENT FUND (UNCDF)
23. UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP)
24. UNITED NATIONS CHILDREN FUND (UNICEF)
25. UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)
26. WORLD BANK

Aug 1986

DATES OF NEXT MEETING

In June 1986 it was decided that the tentative dates for the June 1987 meeting would be Sunday, 14 June, to Friday, 19 June, 1987 inclusive. It was also decided that two days be set aside for Committee Meetings, 1 day for report writing and 3 days for the full Board Meeting. The June 1987 dates would be as follows:

Sunday, 14 June & Monday, 15 June	-	Committee meetings
Tuesday, 16 June	-	Free for report writing
Wednesday, 17 June	-	Full Board Meeting commences
Thursday, 18 June	-	Full Board Meeting continues
Friday, 19 June	-	Full Board Meeting concludes

Tentative dates for November are 1987 are:

Sunday, 22 November to Friday, 27 November, 1987 inclusive.

TABLE 1

OPERATING FUND RESULTS 1981 TO 1985
(Thousands of U.S. dollars)

	1981	1982	1983	1984	1985
REVENUE	5,406	4,574	5,375	6,864	7,455
EXPENDITURE	5,843	4,349	5,364	6,694	8,678
OPERATING SURPLUS (DEFICIT)	(437)	226	11	170	(1,223)
LESS: DEPRECIATION	-	-	277	334	416
TRANSFER TO RESERVE FUND		100	300	442	-
TOTAL SURPLUS (DEFICIT)	(437)	126	(566)	(606)	(1,639)

FIGURE 1

COMPARISON OF INCOME AND EXPENDITURE 1985 (ACTUAL) AND 1986 (ESTIMATED) EXCLUDING DEPRECIATION

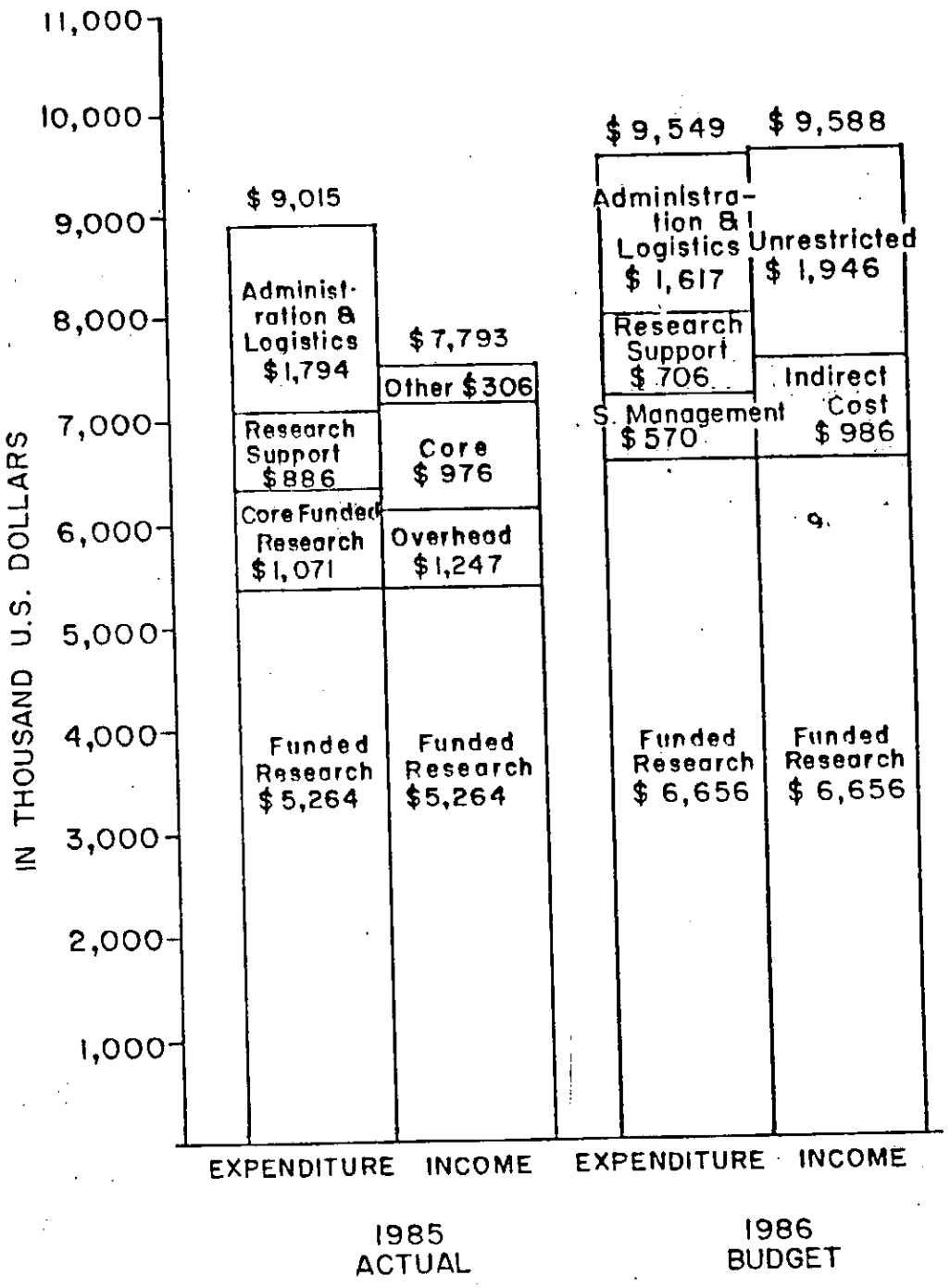
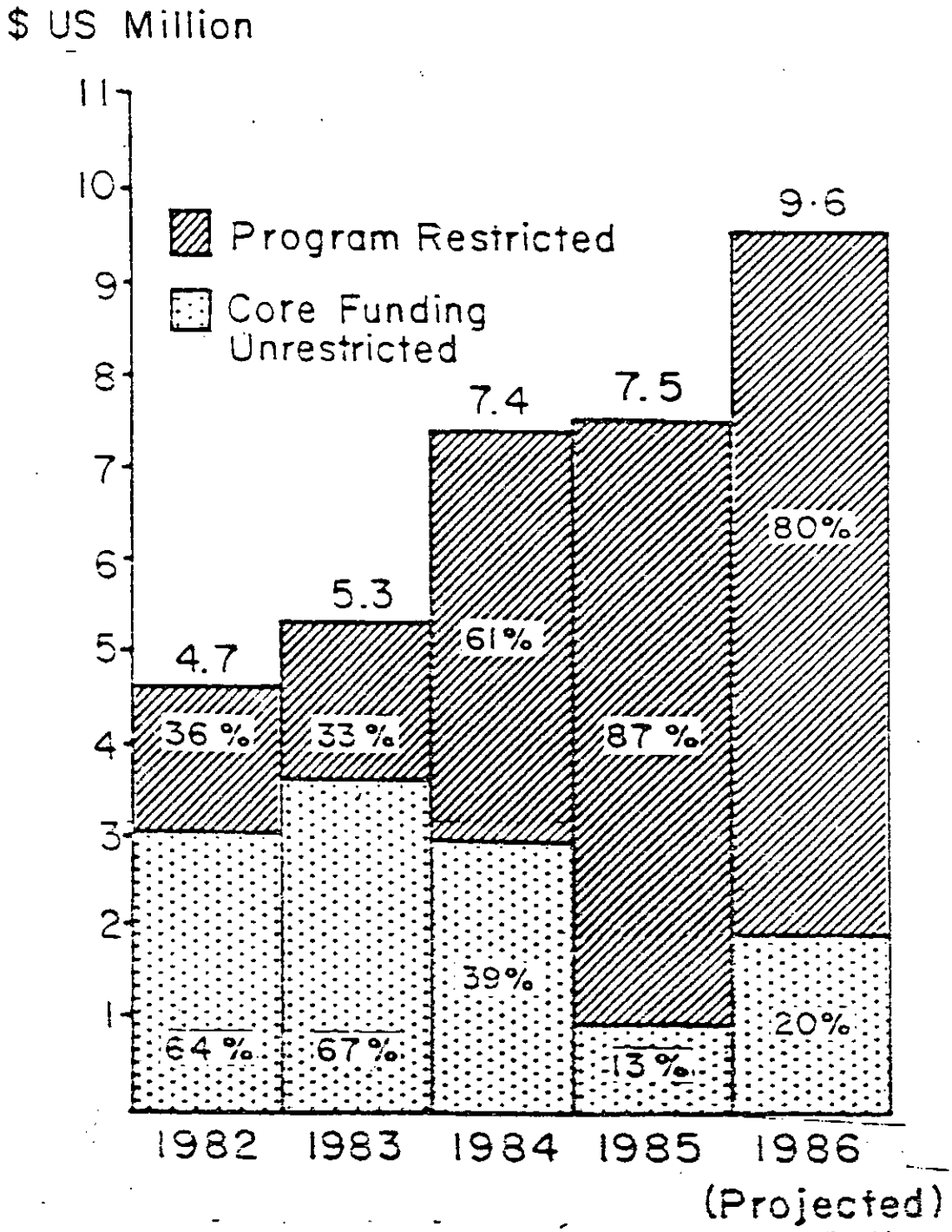


FIGURE 2

ICDDR,B DONOR CONTRIBUTIONS, OPERATING FUND



NOTE TO THE BOARD OF TRUSTEES

Some elements for the discussion on the Donor's Meeting - Agenda 8a

1. Aim and Objectives of the Meeting

- To get the donor's support for the Centre
  - financial support
  - moral support: donors agree that the existence of the Centre is justified/necessary/important.

  and to ensure their commitment for the Centre.

- To strengthen and clarify the relationship between the donors and the Centre, while

  * preserving/strengthening the autonomy of the Centre: it is not (anymore) a little orphan which has to obey the will of its well meaning/generous/strong-headed aunts and uncles, it is a responsible adult who has an agreement with several partners who make it possible for him to reach the aim;

  * Defining/clarifying the aims it should reach and agreeing on the justification of these aims;

  * Clarifying the respective roles:

    Without the partners the Centre cannot reach its aim, but the responsibility of delivering the goods it has been created for lies with the Centre, and there must be a common understanding/agreemen on what is expected from both sides, what is needed and what is to be avoided.

- To promote exchange of opinion/negotiation/consensus between donor's:

  * On the role and aim of the Centre;

  * On the policy to be followed by the donors in dealing with the Centre.

..2..

NB: The donors are of various types and follow various policies!

- If possible to promote a common approach and a commitment by the donors.

- To give the donors a good and correct view of the Centre:

  * What it does: type of research/service/training - programmes.

  * How it functions.

  * What it intends to do in the future: priorities.

- To clarify the key issues and to allow for an exchange of views among the partners (donors, Centre's management and senior staff, Board of Trustees, Government of Bangladesh) e.g.:

  * aim and role of the Centre
  * its priorities
  * personnel policy
  * international character of the Centre
  * earmarked contributions/non-earmarked contributions

2. Points which should be examined at the Donors Meeting

- Budget of the Centre, estimated income, measures to reduce expenses and increase cost-effectiveness;

  Budget levels and their implications:

  * what can be done with a minimum budget
  * what more can be done (more activities, better quality) with next levels.

- Balance between earmarked and non-earmarked contributions:

  * overall percentage of non-earmarked contributions (implications of earmarking for the policy of the Centre, minimum core necessary for the functioning and the continuity of the Centre)

  * funding of key positions non-earmarked

  * "burden-sharing" - minimum percentage of non-earmarking for each donor.

..3..

- The Treatment Centres as a project with special funding.
- Reserve Fund and contributions shared among donors for covering overdraft endowment.
- Secondment of staff.
- Administrative and financial management.
- Programme of the Centre (for research, service and training) and its priorities.
- Main tasks of the Centre (related to research, service and training) and its scope (e.g. how far should aspects related with diarrhoea such as respiratory diseases be part of the Centre's work; services given by the Centre itself or helping other bodies to give better service,basic or applied research.)
- Evaluation of the Programmes and their activities.
- Expectations and needs of the partners: Management and Centre's staff, Board, Government of Bangladesh, donors.
- Balance between local scientists, scientists from other developing countries and scientists from developed countries.
- Personnel policy and career ladders for local and expatriate staff.
- [The Ordinance?]

Dr. I. Cornaz
Member, BOT

IC:ls

November 24, 1986

9/BT/NOVEMBER 1986

REPORT OF THE FINANCE COMMITTEE

REPORT OF THE FINANCE COMMITTEE MEETING HELD ON NOVEMBER 22,1986

Members Present:	Prof.R. Feachem, Chairman Prof. D.Bell, Chairman of the Board Prof. R.Eeckels, Director Dr. P.Sumbung (part)
Also Present:	Dr. I.Cornaz Prof. D.Habte Dr. M. Merson Dr. K.A.Monsur
Members absent:	Mr. M.K.Anwar Dr. Nyi Nyi
Invited:	Mr. M.R.Bashir Mr. H.A.N.Janssen

INTRODUCTION

Professor Feachem opened the meeting by highlighting some major features of the financial status of the Centre. In 1985 there was a cash deficit (the difference between receipts and expenditures) of $ 1.2 million. Due to the stringent measures decided upon by the Board at its November 1985 and June 1986 meetings, the support of the donors, and the dedication of the Director and his staff, 1986 is expected to produce a surplus of $181,000. However, due to the large outstanding overdraft, the difficulty in achieving further reductions in expenditure, the pressure to adjust salaries in line with inflation, and the unpredictability of certain revenues, the financial situation remains extremely vulnerable. Professor Feachem noted that the cost cutting measures, as well as strenuous efforts to increase revenue

and decrease debt servicing commitment, would be required in 1987.

Professor Feachem thanked those concerned for the greatly improved documentation available to the Committee. He noted, however, two continuing deficiencies. First, that major issues were not always presented clearly and separately from less important items. Second, that clear policy options are not presented, so that the Committee is placed in the position of having to develop policy from scratch during its meeting.

FINANCIAL SITUATION AND OUTLOOK

1986 FINANCE REPORT (SEE TABLES 1-a,b)

The Board at its June meeting requested the Director to take measures that would achieve further reductions of $200,000 in expenditure from the unrestricted core budget during the period July 1,1986 to June 30,1987.

Core expenditures are now estimated to total $2,497,000 for 1986, a reduction of $396,000 from the June estimate. A summary of the sources of this reduction follows:

- lower overdraft interest costs:- $150,000
  the decrease reflects a lower average overdraft outstanding and a decline in interest rates;
- reduction in overtime:- $40,000
- capital expenditures lowered:- $50,000
- other economy measures:- $54,000

a variety of economy measures were undertaken, including a sharp drop in transport mileage by rationalising staff pick up and drop routes;

- transfer from core to project expense:- $102,000.

The reduction of $396,000 in core funded expenditures will not entirely flow through to an equivalent improvement in the surplus/deficit position. The reason is an offsetting reduction of $254,000 in unrestricted revenue. Therefore, the net improvement will amount to an increase in the operating fund surplus of $142,000, more than two thirds of the $200,000 target reduction in core expenditures to be achieved by June 30,1987. The operating surplus for 1986 is now estimated to be $181,000 (exclusive of depreciation).

These results are gratifying and the management is to be congratulated for achieving them. When 1986 expected results are compared with the 1985 actual, the turnaround in Centre finances are dramatic:

	1985 (actual)	1986 (estimate)
	(Thousands of U.S. Dollars)	
INCOME	7,455	7,980
EXPENDITURE	8,677	7,799
NET SURPLUS/(DEFICIT)	(1,222)	181
YEAR-END OVERDRAFT	2,800	2,100

A review of the income and expenditure details indicates that just under one quarter of the source of the turnaround

is attributable to additional unrestricted income and over three-quarters to reductions in core funded expenditures.

These results are impressive indeed and suggest that, cetaris paribus, it will be possible for the Centre to achieve the cost reduction target established at the June Board meeting by the deadline of June 30,1987.

In June it was estimated that the 1986 year-end overdraft would be some $700,000 higher,at $3.5 million,than at the end of 1985. The estimate presented to the Committee has been revised sharply downwards to an overdraft of about $2.1 million at year-end and may go down even further.

The main reason for the large improvement has been a willingness by donors to advance funds for research which in the event will not all be spent in 1986, but carried forward into 1987. The total amount of carry forward is expected to be at least $1.1 million and is substantially higher than the amount carried forward from 1985 to 1986.

The main benefit of the reduced overdraft is lower interest charges. However, only sustained operating surpluses will improve the fundamental financial condition of the Centre. To illustrate this point, the amount of income received from donors in 1986, which will be carried forward into 1987, represents an obligation to spend the money or to repay it and amounts to about $1.1 million. Had the entire amount been spent for the relevant research purposes in 1986, the year-end overdraft would have been $3.2 million, and higher

than the 1985 year-end overdraft. The Centre remains vulnerable to external factors, such as a rise in interest rates or decreased core support.

LOAN SUPPORT

There are two matters which detract from these good results and are a matter of concern to the Committee. The first is the non-extension by the Government of Bangladesh (GOB) of the interest free $1.2 million UNROB loan. The second is the failure to make any progress in securing a long-term "soft loan" to replace the expensive overdraft. In order to make progress on both matters the active assistance of the GOB is required. Management advises that this cooperation has not been forthcoming, perhaps because of some unhappiness of the GOB with the conduct of the affairs of the Centre.

In the case of the UNROB loan, there is a possibility that the loan arrangement may have no legal basis. For information purposes, the Committee proposes that management seek a legal opinion on the nature of the arrangement. As the UNROB funds were provided by the UNDP, it is also proposed that the matter be reviewed with them. A report should then be prepared for the next meeting of the Board. In the interim, the Board should request the GOB to extend the loan on an interest free basis to June 30,1987.

Finance had proposed that some or all of the $900,000 set aside as a reserve for the potential repayment of the UNROB loan be used to reduce the overdraft. This would achieve savings of up to $20,000, representing the annual difference between the cost of the overdraft and the earnings on the deposit. However, such action might be regarded unfavourably by the GOB and thus jeopardise the negotiations to extend the loan. The Committee therefore proposes not to reduce the reserve and instead directs the management to ensure maximum earnings on reserve funds and minimum overdraft costs, consistent with prudent financial practices.

Concerning the possibility of obtaining a long-term soft loan through the World Bank or the Asian Development Bank, the Committee considered it better to raise the matter again with the GOB in the context of the donor consortium meeting to be held in Dhaka in March 1987.

1987 BUDGET (SEE TABLES 2a to d)

The 1987 budget, as presented to the Committee, was just balanced, showing an operating surplus of $32,000 (excluding depreciation). This assumes that expenditure levels are held to 1986 levels, and that no provision is made for two announced UN salary increases for local staff.

In preparation for the upcoming donors consortium meetings, the Committee considered it important to be able to demonstrate that the Centre was making continued and significant inroads into the accumulated deficit so as to be

able to reduce the overdraft. The Committee proposes that the Centre have a target operating surplus of $223,000 (excluding depreciation) in 1987, nearly $200,000 more than proposed by management and $42,000 higher than the 1986 estimated actual surplus.

The Committee reviewed separately the salary increases announced by the UN but not implemented by the Centre. The Committee concurs with the advice of the Director that an increase in salary must be provided to the local GS and NO staff. The lower paid staff are facing rising food costs and large rental increases. The Committee proposes that the January 1,1985 increase be granted effective from January 1,1987, without retroactivity. This will provide GS 1 to 6 and NO staff with a 10 and 17 percent increase respectively. The total additional cost is about $328,000, of which up to $200,000 will come from core-funded expenditures.

The Committee recognizes that the Board is asking the Director simultaneously to improve the budgetary surplus while increasing expenditures. In doing so the Committee is taking account of the reasonable prospect of additional core income, such as the Danida grant,which is not included in the 1987 budget documents prepared by Finance. Notwithstanding this pay adjustment, the Committee believes that the target for a 1987 operating surplus of $223,000 should still be achieved.

Finally, concerning the 1987 budget, the Committee wishes to bring to the attention of the Board the financial implications of the possible hiring during 1987 of 4 new Associate Directors. (Administration and Finance, Laboratory Sciences, Clinical Sciences, and Community Medicine). The first three of these are advertised. The first two posts may be funded by USAID (although not necessarily held by US citizens). The remaining two will have to be funded either by other donors or out of core funds. These options need careful consideration in the light of the need for international balance and clear autonomy at this level, and the major drain on core resources that these salaries would create.

OTHER MATTERS

DONOR CONSORTIUM

The Committee believes that new initiatives are urgently needed to increase the amount of unrestricted (core) income. The donor consortium, planned for March 1987, is an ideal forum to launch such initiatives. A clear statement of the financial status of the Centre, and the considerable achievements since mid-1985, should be presented to the donors. A discussion paper on restricted and unrestricted funding should also be prepared. This paper should invite the donors to consider a uniform policy under which each donor would give X% of its total contribution in an unearmarked form. The Committee suggests that X should

equal 50. While such a policy represents a fundamental departure from existing donor-by-donor negotiations on overheads and unrestricted funding, it would create a much sounder financial base for the future work of the Centre. A precedent for this approach exists in the multi-donor agreements with the extra-budgetary programmes of WHO.

In addition to the above, the Committee recommends that the Director vigorously pursue his attempts to get certain major core-funded activities onto project funding. The most important example is the Treatment Centres, currently under discussion with DANIDA. Other examples might include donor support for senior non-project scientific posts, designed to provide leadership and direction in a whole branch of research at the Centre. This could include one or more of the Associate Director posts discussed above.

APPOINTMENT OF AUDITORS

The management has proposed, and the Committee agrees, that the firm of Rahman Rahman and Huq & Co. who are associated with Price Waterhouse & Co. be appointed auditors of ICDDR,B at a fee of $8,000 for the 1986 financial statements.

FINANCIAL SYSTEM DEVELOPMENT

The Centre is required by USAID to develop and negotiate an indirect cost accounting system. Funds for this work have been provided by USAID through the UVP grant. In

discussions with USAID it has been agreed that Len Chang, whose position as budget and finance officer has been abolished from June 30,1987, is the ideal candidate to do this important work. The Committee concurs.

TABLE 1 - a

BUDGET AND REVENUE AND EXPENDITURE ESTIMATE FOR 1986

		Budget	Estimated Actual
A.	Revenue	(In thousand U.S. Dollars)	
	Committed firm	8,523	7,411
	Estimated	1,065	200
		9,588	7,611
	Add: 1985 Commitments received and expended in 1986	324	369
		9,912	7,980
B.	Expenditure		
	Local salaries	3,183	3,033
	Inter'l salaries	1,946	1,775
	Consultants	315	415
	Mandatory committees	107	107
	Travel	332	349
	Supply and materials	1,323	1,264
	Other contractual services	1,096	834
	Interdepartmental services	1,151	1,324
		9,453	9,101
	Less: Recovery	1,331	1,685
		8,122	7,416
	Add: Capital expenditure	362	383
		8,484	7,799
	Add: Project research costs not yet budg'd in detail	1,389	
		9,873	7,799
C.	Surplus/-deficit		
	Surplus/ Deficit before Depreciation	39	181
	Depreciation	-500	-500
	Total Deficit US $	-461	-319

MRK:12.11.1986

TABLE 1 - b

INCOME AND EXPENDITURE PROJECTION 1986

(In thousand U.S. Dollars)

	1986 BUDGET			ESTIMATED (ACTUAL) 1986		
INCOME						
Funded Research (Direct Cost)		6,656			5,302	
Funded Research (Indirect Cost)	986			962		
Unrestricted Contributions	1,946	2,932	9,588	1,716	2,678	7,980
PENDITURE						
Funded Research (Direct costs)		6,656			5,302	
Scientific Management	570			415		
Research Support	706			719		
Administration and Logistics	1,617	2,893	9,549	1,363	2,497	7,799
SURPLUS BEFORE DEPRECIATION			39			181
Allowance for depreciation			500			500
DEFICIT			-461			-319

MRK:12.11.1986

TABLE 2 - a

INCOME AND EXPENDITURE BUDGET FOR 1987

	Estimated (Actual) 1986	Projected 1987
A. Income	(In thousand U.S. Dollars)	
Contributions - Core	1,716	1,350
Contributions - Project	5,302	6,184
Overhead	962	1,173
Total Income	7,980	8,707 *
B. Expenditure		
Local salaries	3,033	3,375
Inter'l salaries	1,775	1,905
Consultants	415	381
Mandatory committees	107	120
Travel	349	564
Supply and materials	1,264	1,287
Other contractual services	834	1,074
Interdepartmental services	1,324	1,247
Total Operating	9,101	9,953
Less: Recovery	1,685	1,600
Net Operating	7,416	8,353
Add: Capital expenditure	383	322
Total Expenditure	7,799	8,675
C. Surplus/-deficit		
Surplus/ Deficit before Depreciation	181	32
Depreciation	-500	-500
Total Deficit for the year US $	-319	-468

* Does not include: Danida estimate of $450,000 due to uncertainity of information, USAID Co-op. Agreement $659,000 and $490,000 in miscellaneous other donor income estimated to be receivable in 1987 because expenditure detail is not yet available.

MRK:12.11.1986

TABLE 2 - b

INCOME AND EXPENDITURE PROJECTION FOR 1986 AND 1987

(In thousand U.S. Dollars)

	ESTIMATED (ACTUAL) 1986			BUDGET 1987		
INCOME						
Funded Research (Direct Cost)		5,302			6,184	
Funded Research (Indirect Cost)	962			1,173		
Unrestricted Contributions	1,716	2,678	7,980	1,350	2,523	8,707
EXPENDITURE						
Funded Research (Direct costs)		5,302			6,184	
Scientific Management	415			98		
Research Support	719			754		
Administration and Logistics	1,363	2,497	7,799	1,639	2,491	8,675
SURPLUS BEFORE DEPRECIATION			181			32
Allowance for depreciation			500			500
DEFICIT			-319			-468

MRK:12.11.1986

TABLE 2 - C

INCOME AND EXPENDITURE BUDGET 1987

(In thousand U S Dollars)

INCOME	CORE	PROJECT	TOTAL
Contributions	1,350	7,357	8,707
Overhead	1,173	-1,173	0
	2,523	6,184	8,707
EXPENDITURE			
Scientific Research		5,920	5,920
Scientific Management	98	164	262
Research Support	-229		-229
Hospitals(Dhaka,Matlab&Teknaf)	983		983
Logistics	320		320
Management	1,319	100	1,419
	2,491	6,184	8,675
SURPLUS/-DEFICIT	32	0	32

MRK:12.11.1986

TABLE 2 - d

MONTHLY CASH FLOW 1987

	Receipts	Payments	Balance
Opening bank overdraft as at January 1,1987			2,110
January	1,270	530	1,370
February	163	527	1,734
March	841	787	1,680
April	1,828	555	407
May	50	702	1,059
June	709	877	1,227
July	418	632	1,441
August	670	702	1,473
September	1,211	982	1,244
October	403	637	1,478
November	407	797	1,868
December	885	977	1,960
	8,855	8,705	
Closing bank overdraft as at December 31,1987			1,960

MRK:12.11.1986

ATTACHMENT TO

9d/BT/NOV. 86

BUDGET FOR 1987

ICDDR,B
BUDGET SUMMARY FOR 1987:

A:TOTBUD86.

BUDGET CODE NO.	PROGRAMME TITLE		LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST
01	Disease Transmission	Funded	453,687	444,091	150,881	15,470	28,000	248,346	32,281	353,234	1,725,990	63,100	1,789,090
		Unfunded	0	0	0	0	0	0	0	0	0	0	0
		Sub-total	453,687	444,091	150,881	15,470	28,000	248,346	32,281	353,234	1,725,990	63,100	1,789,090
02	Pathogenesis & Theraphy	Funded	37,640	44,811	15,543	200	1,000	10,657	4,865	121,506	236,222	2,500	238,722
		Unfunded	0	0	0	0	0	0	0	0	0	0	0
		Sub-total	37,640	44,811	15,543	200	1,000	10,657	4,865	121,506	236,222	2,500	238,722
03	Host Defense	Funded	55,499	35,919	4,686	0	10,550	45,121	3,520	34,755	190,050	8,510	198,560
		Unfunded	0	0	0	0	0	0	0	0	0	0	0
		Sub-total	55,499	35,919	4,686	0	10,550	45,121	3,520	34,755	190,050	8,510	198,560
05 A	Population Science & Extension	Funded	852,639	453,628	77,880	50,100	29,200	86,624	342,276	99,007	1,991,354	88,636	2,079,990
		Unfunded	0	0	0	0	0	0	0	0	0	0	0
		Sub-total	852,639	453,628	77,880	50,100	29,200	86,624	342,276	99,007	1,991,354	88,636	2,079,990
05	Community Services Research	Funded	497,873	187,764	45,000	14,463	31,420	123,936	35,203	162,694	1,098,353	53,400	1,151,753
		Unfunded	19,872	61,368	13,824	0	0	700	9,400	2,700	107,864	0	107,864
		Sub-total	517,745	249,132	58,824	14,463	31,420	124,636	44,603	165,394	1,206,217	53,400	1,259,617
06	Research Support Facilities	Funded	0	0	0	0	0	0	0	0	0	0	0
		Unfunded	1,092,659	113,194	1,600	1,566	0	422,748	149,340	238,622	2,019,729	50,000	2,069,729
		Sub-total	1,092,659	113,194	1,600	1,566	0	422,748	149,340	238,622	2,019,729	50,000	2,069,729
07	Training, Extension & Comm.	Funded	133,450	62,400	0	69,561	197,200	23,735	51,850	30,215	568,411	6,030	574,441
		Unfunded	0	0	0	0	0	0	0	0	0	0	0
		Sub-total	133,450	62,400	0	69,561	197,200	23,735	51,850	30,215	568,411	6,030	574,441
08	Maintenance & Logistics	Funded	0	0	0	0	0	0	0	0	0	0	0
		Unfunded	270,856	0	0	1,060	0	58,110	12,600	12,320	354,976	0	354,976
		Sub-total	270,856	0	0	1,060	0	58,110	12,600	12,320	354,976	0	354,976

Continued to next page.

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BUDGET CODE NO.	PROGRAMME TITLE		LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST
09	Management	Funded	0	0	0	0	0	0	0	0	0	0	0
		Unfunded	313,290	251,480	18,176	1,410	17,900	93,944	222,500	58,918	977,618	50,000	1,027,618
		Sub-total	313,290	251,480	18,176	1,410	17,900	93,944	222,500	58,918	977,618	50,000	1,027,618
10	Resources Development	Funded	0	0	0	0	0	0	0	0	0	0	0
		Unfunded	19,388	105,192	18,168	100	19,400	1,950	9,700	3,200	177,098	0	177,098
		Sub-total	19,388	105,192	18,168	100	19,400	1,950	9,700	3,200	177,098	0	177,098
11	Mandatory Committee	Funded	0	0	0	0	0	0	0	0	0	0	0
		Unfunded	6,577	0	19,230	250	68,500	900	1,050	4,000	100,507	0	100,507
		Sub-total	6,577	0	19,230	250	68,500	900	1,050	4,000	100,507	0	100,507
12	Employees Benefit	Funded	0	0	0	0	0	0	0	0	0	0	0
		Unfunded	29,367	0	0	459	0	9,090	7,790	3,740	50,446	0	50,446
		Sub-total	29,367	0	0	459	0	9,090	7,790	3,740	50,446	0	50,446
13	Project Development	Funded	37,755	146,799	33,740	13,758	58,900	8,700	11,433	2,897	313,982	1,200	315,182
		Unfunded	0	0	0	0	0	0	0	0	0	0	0
		Sub-total	37,755	146,799	33,740	13,758	58,900	8,700	11,433	2,897	313,982	1,200	315,182
14	Staff Development	Funded	0	0	0	0	0	0	0	0	0	0	0
		Unfunded	585	0	0	100	0	200	720	100	1,705	0	1,705
		Sub-total	585	0	0	100	0	200	720	100	1,705	0	1,705
16 & 17	Guest House & Cafeteria	Funded	0	0	0	0	0	0	0	0	0	0	0
		Unfunded	46,194	0	0	0	0	2,418	12,500	1,400	62,512	0	62,512
		Sub-total	46,194	0	0	0	0	2,418	12,500	1,400	62,512	0	62,512
	TOTAL US $	Funded	2,068,543	1,375,412	327,730	163,552	356,270	547,119	481,428	804,308	6,124,362	223,376	6,347,738
		Unfunded	1,798,789	531,234	70,998	4,945	105,800	590,060	425,630	325,000	3,852,456	100,000	3,952,456
		Total	3,867,332	1,906,646	398,728	168,497	462,070	1,137,179	907,058	1,129,308	9,976,818	323,376	10,300,194
	Recovery	Service	0	0	0	0	0	0	0	0	0	0	1,129,308
		Cash	0	0	0	0	0	0	0	0	0	0	381,987
	Total recovery		0	0	0	0	0	0	0	0	0	0	1,511,295
	TOTAL PROJECT COST	Funded	2,068,543	1,375,412	327,730	163,552	356,270	547,119	481,428	804,308	6,124,362	223,376	6,347,738
		Unfunded	1,798,789	531,234	70,998	4,945	105,800	590,060	425,630	325,000	3,852,456	100,000	2,441,161
		Total	3,867,332	1,906,646	398,728	168,497	462,070	1,137,179	907,058	1,129,308	9,976,818	323,376	8,788,899

ICDDR,B
BUDGET SUMMARY FOR PROJECTS, PROTOCOLS AND BRANCHES.

DISEASE TRANSMISSION WORKING GROUP.

A:BUD86DTW

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL - PROJECT COST	1986 TOTAL OPERATING COST
FUNDED													
01 01 00	Disease Transmission W. Group	7,554	0	0	450	0	2,000	2,100	4,300	16,404	0	16,404	60,912
01 01 02	DTWG-Co-Op.(Epidemio.)	16,687	75,660	0	0	0	500	0	400	93,247	0	93,247	64,458
01 01 04	DTWG - (PDF)	0	34,320	0	0	0	0	0	0	34,320	0	34,320	0
01 34 00	Nandipara Clinic	0	0	0	0	0	0	0	0	0	0	0	1,590
01 49 00	Surveillance activity,Dk. Hosp	11,077	0	0	0	0	845	300	24,539	36,761	0	36,761	40,200
01 70 01	Cholera Vaccine Trial	242,894	118,876	127,370	5,000	18,000	152,900	16,400	205,700	887,140	20,000	907,140	647,073
01 79 00	A R I	19,946	0	2,400	0	0	3,071	2,440	3,550	31,407	0	31,407	7,950
01 84 00	Shigella suicidal	4,273	0	1,041	0	0	3,155	500	1,500	10,469	2,900	13,369	20,200
01 85 00	Vit. A level in breast milk	9,761	0	690	20	0	630	2,500	5,870	19,471	0	19,471	10,362
01 86 00	Vit. A def. study	11,309	0	0	0	0	920	200	3,575	16,004	0	16,004	13,003
01 88 00	Vibrio Antigens	1,275	0	0	0	0	3,920	2,341	3,000	10,536	0	10,536	6,247
-- -- --	Shigellosis	128,912	215,235	19,380	10,000	10,000	80,405	5,500	100,800	570,232	40,200	610,432	0
	TOTAL FUNDED US $	453,687	444,091	150,881	15,470	28,000	248,346	32,281	353,234	1,725,990	63,100	1,789,090	871,987
UNFUNDED													
01 01 00	Disease Transmission W. Group	0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL UNFUNDED US $	0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL FUNDED + UNFUNDED US $	453,687	444,091	150,881	15,470	28,000	248,346	32,281	353,234	1,725,990	63,100	1,789,090	871,987

AZIZ-1".

ICDDR,B
BUDGET SUMMARY FOR PROJECTS, PROTOCOLS AND BRANCHES.

PATHOGENESIS WORKING GROUP.

A:BDG86PTW

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST	1986 TOTAL OPERATING COST
FUNDED													
02 01 00	Pathogenesis Working Group	13,713	0	0	0	0	1,800	3,300	5,400	24,213	0	24,213	64,811
02 01 01	PTWG - (PDF)	0	20,000	0	0	0	0	0	0	20,000	0	20,000	0
02 58 00	Typhoid Fever: Determination	1,299	0	0	0	0	100	225	12,993	14,617	0	14,617	24,319
02 61 00	Role of Prostracycline	1,991	11,408	0	0	0	0	0	0	13,399	0	13,399	200
02 74 00	Rice Salt ORS	2,269	0	0	0	0	104	200	1,850	4,423	0	4,423	42,948
02 75 00	Oral Rehydration with Glucose	687	950	9,000	0	0	500	0	7,603	18,740	0	18,740	25,947
02 76 00	Double blind control	8,260	12,453	0	0	0	2,053	0	19,783	42,549	2,500	45,049	50,500
02 77 00	Doxyciline	718	0	0	0	0	0	500	14,781	15,999		15,999	8,300
02 80 00	Bereerine in children	922	0	0	0	0	4,400	370	10,166	15,858	0	15,858	5,230
02 81 00	Comparative efficacy	2,413	0	0	200	0	800	0	15,860	19,273	0	19,273	7,000
02 82 00	Food poten. efficacy of ORS	5,369	0	6,543	0	1,000	900	270	33,070	47,152	0	47,152	10,827
	TOTAL FUNDED US $	37,640	44,811	15,543	200	1,000	10,657	4,865	121,506	236,222	2,500	238,722	240,082
UNFUNDED													
02 01 00	Pathogenesis Working Group	0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL UNFUNDED US $	0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL FUNDED + UNFUNDED US $	37,640	44,811	15,543	200	1,000	10,657	4,865	121,506	236,222	2,500	238,722	240,082

ICDDR,B
BUDGET SUMMARY FOR PROJECTS, PROTOCOLS AND BRANCHES.

HOST DEFENSE WORKING GROUP.

A:BDG86HDW

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	1987 INTL. SALARIES	1987 CONSULTANT	1987 LOCAL TRAVEL	1987 INTL. TRAVEL	1987 SUPPLIES	1987 OTHERS	1987 INTER DEPTL.	1987 TOTAL DIRECT OPERAT. COST	1987 CAPITAL EXPENDITURE	1987 TOTAL PROJECT COST	1986 TOTAL OPERATING COST
FUNDED													
03 01 00	Host Defense Working Group	18,423	0	0	0	0	3,000	500	500	22,423	0	22,423	34,815
03 29 00	Antibody response to Shig. OMP	4,510	0	0	0	2,550	1,950	150	6,155	15,315	0	15,315	13,939
03 30 00	OMP in Shigella grown	1,172	9	996	0	0	995	140	900	4,212	0	4,212	14,028
03 31 00	Antigenic composition of OM	4,479	0	0	0	0	3,654	500	1,500	10,133	660	10,793	3,580
03 32 00	Magnesium breath hydrozen test	0	0	0	0	0	1,307	100	900	2,307	4,700	7,007	1,500
-- -- --	Imonological parameters	6,557	11,970	0	0	4,000	11,100	750	9,450	43,827	3,150	46,977	0
-- -- --	Immunogenicity of Shigella OMP	6,697	11,970	0	0	0	3,025	200	3,800	25,692	0	25,692	0
-- -- --	Antigenic & Immunogenicity	8,320	11,970	0	0	4,000	13,900	800	9,450	48,440	0	48,440	0
-- -- --	Adhesive factors of Shigella	5,341	0	3,690	0	0	6,190	380	2,100	17,701	0	17,701	0
	TOTAL FUNDED US $	55,499	35,919	4,686	0	10,550	45,121	3,520	34,755	190,050	8,510	198,560	67,862
UNFUNDED													
03 01 00	Host Defense Working Group	0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL UNFUNDED US $	0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL FUNDED + UNFUNDED US $	55,499	35,919	4,686	0	10,550	45,121	3,520	34,755	190,050	8,510	198,560	67,862

ICDDR,B
BUDGET SUMMARY FOR PROJECTS, PROTOCOLS AND BRANCHES.

POPULATION SCIENCE & EXTENSION DIVISION.

A:BDG86NWG

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST	1986 TOTAL OPERATING COST
FUNDED													
05 03 01*	DSS	325,891	161,356	40,450	8,000	6,000	35,000	217,504	21,607	815,808	58,036	873,844	476,500
05 46 01	MCH-FP, Dhaka	173,078	171,372	37,430	15,000	23,200	15,015	62,610	34,700	532,405	20,300	552,705	436,480
05 45 03	MCH-FP, Sirajgong	101,059	0	0	12,200	0	12,727	28,546	1,900	156,432	1,650	158,082	74,710
05 46 04	MCH-FP, Noapara	97,976	0	0	12,200	0	13,156	27,566	2,000	152,898	1,650	154,548	86,650
-- -- --	New Upazila FWA exp.	25,704	0	0	2,200	0	5,031	550	0	33,485	0	33,485	0
05 46 11	MCH-FP, Matlab	81,776	0	0	400	0	1,495	0	37,800	121,471	0	121,471	84,340
05 57 00	ICDDR,B/JHU Collabo. Project	0	0	0	0	0	0	0	0	0	0	0	4,890
05 63 00	Infant mortality	3,143	0	0	0	0	300	0	600	4,043	0	4,043	1,640
05 99 00	Population Science & Extension	44,011	120,900	0	100	0	3,900	5,500	400	174,811	7,000	181,811	30,240
	TOTAL FUNDED US $	852,639	453,628	77,880	50,100	29,200	86,624	342,276	99,007	1,991,354	88,636	2,079,990	1,195,450
UNFUNDED													
00 00 00	Population Science & Extension	0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL UNFUNDED US $	0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL FUNDED + UNFUNDED US $	852,639	453,628	77,880	50,100	29,200	86,624	342,276	99,007	1,991,354	88,636	2,079,990	1,195,450

* Incuding 05 03 04 & 05 55 00 budget.

COMMUNITY SERVICES RESEARCH WORKING GROUP.

A:BDG86CSR

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST	1986 TOTAL OPERATING COST
FUNDED													
05 47 05	Urban Volunteer Programme-Dk.	180,715	111,000	19,000	8,000	9,030	44,070	8,000	55,567	435,382	18,000	453,382	239,520
05 47 06	Urban Volunteer Programme-Ctg.	21,329	0	0	1,063	0	14,776	7,913	5,000	50,081	19,300	69,381	
05 48 02	Mirzapur Handpump Project	109,393	0	21,000	3,300	20,340	17,000	4,700	14,000	189,733	0	189,733	79,950
05 49 00	Chandpur ORS Study	44,584	0	5,000	500	0	7,010	3,800	6,090	66,984	800	67,784	66,702
05 51 00	Impact of Measles Immunization	3,017	0	0	100	0	0	0	4,100	7,217	0	7,217	12,300
05 60 00	Matlab MCH-FP Services	109,395	44,028	0	1,500	0	40,000	10,000	49,500	254,423	12,000	266,423	311,150
05 62 00	Breast feeding weaning	9,543	0	0	0	0	210	100	117	9,970	0	9,970	2,324
04 40 02	Epidemiological Studies	19,898	0	0	0	2,050	870	690	28,320	51,828	3,300	55,128	0
-- -- --	Epidemiological Studies-(PDF)	0	16,368	0	0	0	0	0	0	16,368	0	16,368	0
-- -- --	An Anthrop. Study-(PDF)	0	2,728	0	0	0	0	0	0	2,728	0	2,728	0
-- -- --	Socio Environ. Deter.-(PDF)	0	13,640	0	0	0	0	0	0	13,640	0	13,640	0
	TOTAL FUNDED US $	497,873	187,764	45,000	14,463	31,420	123,936	35,203	162,694	1,098,353	53,400	1,151,753	711,946

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UNFUNDED

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BUDGET CODE NO	PROJECT/PROTOCOL/BRANCH TITLE	LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST	1986 OPRT. COST
05 01 00	C.S.R. Working Group	2,587	61,368	13,824	0	0	700	9,400	2,700	90,579	0	90,579	199,275
-- -- --	An Anthropological Study	15,313	0	0	0	0	0	0	0	15,313	0	15,313	
04 40 00	Socio Enviromental Determinant	1,972	0	0	0	0	0	0	0	1,972	0	1,972	24,978
	TOTAL UNFUNDED US $	19,872	61,368	13,824	0	0	700	9,400	2,700	107,864	0	107,864	224,253
	TOTAL FUNDED + UNFUNDED US $	517,745	249,132	58,824	14,463	31,420	124,636	44,603	165,394	1,206,217	53,400	1,259,617	936,199

ICDDR,B
BUDGET SUMMARY FOR PROJECTS, PROTOCOLS AND BRANCHES.

RESEARCH SUPPORT FACILITIES.

A:BD686RTS

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST	1986 TOTAL OPERATING COST
06 01 01	Physician - Dhaka Hospital	85,064	24,718	0	0	0	1,146	8,100	6,100	125,128	0	125,128	90,230
06 01 02	General Ward - Dhaka Hospital	127,607	0	0	0	0	20,448	23,500	131,547	303,102	0	303,102	341,040
06 01 03	D.D. Treatment Centre - Dhaka	89,704	0	0	0	0	53,974	27,000	27,000	197,678	0	197,678	227,230
06 01 04	Clinical Pathology Laboratory	32,420	0	0	0	0	11,200	500	450	44,570	0	44,570	37,756
06 01 06	X-Ray Unit	6,633	0	0	0	0	2,800	800	77	10,310	0	10,310	9,480
06 01 08	Pharmacy - Dhaka Hospital	12,742	0	0	0	0	51,100	400	9,268	73,510	0	73,510	82,460
06 01 10	Clinical Research Ward - Dhaka	61,743	0	0	0	0	6,005	9,700	3,900	81,348	0	81,348	87,490
06 01 11	Traveller's Clinic	0	0	0	0	0	0	0	0	0	0	0	17,670
04 45 00	Feeding & Rehabilitation Unit	15,109	0	0	60	0	300	4,100	900	20,469	0	20,469	18,150
06 02 01	Matlab Health Services	116,341	0	0	500	0	26,600	8,800	24,700	176,941	0	176,941	100,760
06 02 02	Matlab Administration	57,491	0	0	300	0	5,200	3,500	1,800	68,291	0	68,291	55,780
06 02 03	Land Transport - Matlab	4,169	0	0	20	0	7,525	100	380	12,194	0	12,194	11,730
06 02 04	Water Transport - Matlab	28,801	0	0	216	0	93,000	200	1,400	123,617	0	123,617	120,600
06 02 05	Transport Maintenance - Matlab	31,154	0	0	20	0	300	100	60	31,634	0	31,634	28,100
06 02 08	Health Centre - Matlab		0	0	0	0	0	0	0	0	50,000	50,000	0
	Sub total	668,97[illegible]	24,718	0	1,116	0	279,598	86,800	207,582	1,268,791	50,000	1,318,791	1,228,476

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BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST	1986 OPER. EXP.
06 03 01	Teknak Clinical Service	21,669	0	0	70	0	100	100	200	22,139	0	22,139	17,470
06 04 01	Microbiology Branch	5,903	0	1,600	0	0	5,000	400	950	13,853	0	13,853	
06 04 01A	Clinical Microbiology	48,574	0	0	0	0	2,700	400	8,900	60,574	0	60,574	203,420
06 04 01B	Microbiology	107,242	0	0	350	0	53,500	1,900	4,400	167,392	0	167,392	
06 04 02	I.V. Fluid	14,448	0	0	0	0	7,700	120	1,950	24,218	0	24,218	26,390
06 05 01	Biochemistry Branch	71,021	0	0	0	0	22,800	900	5,800	100,521	0	100,521	102,174
06 06 01*	Immunology Branch	0	0	0	0	0	0	0	0	0	0	0	5,740
06 07 01	Data Management Branch	10,288	0	0	0	0	80	140	170	10,678	0	10,678	22,580
06 07 02	Medical Record	2,752	0	0	0	0	20	0	20	2,792	0	2,792	3,630
06 08 01	Animal Resources Branch	38,612	0	0	20	0	18,300	700	2,400	60,032	0	60,032	61,365
06 09 01	Computer Information Services	27,152	88,476	0	0	0	11,100	14,000	1,900	142,628	0	142,628	182,228
06 10 01	Community Studies	14,772	0	0	0	0	-50	20	700	15,542	0	15,542	8,220
06 11 01	Library Services Unit	19,447	0	0	10	0	6,700	26,500	1,600	54,257	0	54,257	68,187
06 11 02	Publication Unit	18,996	0	0	0	0	1,000	8,700	1,000	29,696	0	29,696	37,305
06 12 01	Medical Illustration Cell	19,614	0	0	0	0	2,500	10	950	23,074	0	23,074	21,290
06 13 01	Xerox Services	3,192	0	0	0	0	11,600	650	50	15,492	0	15,492	19,386
06 14 00	Telex Services	0	0	0	0	0	0	8,000	50	8,050	0	8,050	10,870
	TOTAL US $	1,092,659	113,194	1,600	1,566	0	422,748	149,340	238,622	2,019,729	50,000	2,069,729	2,018,731

* Budget includes 01 70 01.

Training, Extention and Communication

A:BDG86TEC

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST	1986 TOTAL OPERATING COST
FUNDED													
07 01 00	TEC Working Group	2,752	0	0	10	0	400	900	700	4,762	0	4,762	47,913
07 03 00	Training Department	34,748	0	0	0	0	2,700	1,100	2,600	41,148	0	41,148	57,352
07 06 31	Research Traineeship	10,238	0	0	0	0	0	0	0	10,238	0	10,238	1,268
07 06 32	International Fellowship	0	0	0	3,000	0	50	100	0	3,150	0	3,150	
07 06 --	Training Courses (Intl.)	0	0	0	9,000	197,200	9,000	8,000	8,000	231,200	0	231,200	128,300
07 10 00	Epidemic Control P.P.	49,403	62,400	0	57,551	0	8,285	6,500	15,465	199,604	6,030	205,634	77,893
07 11 01	DISC - Japan Govt.	19,640	0	0	0	0	0	10,500	250	30,390	0	30,390	11,800
07 11 02	DISC - IDRC	16,668	0	0	0	0	3,300	24,750	3,200	47,918	0	47,918	32,760
07 14 02	Traning Material Developer	0	0	0	0	0	0	0	0	0	0	0	80,000
	TOTAL FUNDED US $	133,450	62,400	0	69,561	197,200	23,735	51,850	30,215	568,411	6,030	574,441	437,286
UNFUNDED													
07 01 00	TEC Working Group	0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL UNFUNDED US $	0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL FUNDED + UNFUNDED US $	133,450	62,400	0	69,561	197,200	23,735	51,850	30,215	568,411	6,030	574,441	437,286

ICDDR,B

BUDGET SUMMARY FOR PROJECTS, PROTOCOLS AND BRANCHES.

MAINTANANCE AND LOGISTICS.

A:BDG86MNT

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST	1986 TOTAL OPERATING COST
08 01 01	Supply Branch	32,984	0	0	130	0	3,440	2,500	2,150	41,204	0	41,204	48,491
08 01 02	Supplies & Material Store	7,988	0	0	30	0	1,000	450	670	10,138	0	10,138	31,627
08 01 03	Tools & Spare Store	6,701	0	0	0	0	470	60	120	7,351	0	7,351	10,621
08 02 01	Transport Management Branch	99,047	0	0	900	0	40,000	7,400	6,500	153,847	0	153,847	146,830
08 03 01	Maintenance Branch	75,297	0	0	0	0	4,700	700	1,500	82,197	0	82,197	112,022
08 03 04	Bio Medical Engineering Branch	15,419	0	0	0	0	600	20	280	16,319	0	16,319	18,300
08 03 06	Vehicle Maintenance Branch	33,421	0	0	0	0	7,900	1,500	1,100	43,921	0	43,921	40,409
	TOTAL US $	270,856	0	0	1,060	0	58,110	12,630	12,320	354,976	0	354,976	410,300

MANAGEMENT.

A:8DG86MNG

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST	1986 TOTAL OPERATING COST
09 01 01	Director & Supporting Staff	28,135	114,564	0	460	16,900	3,900	6,400	6,900	177,259	0	177,259	456,322
09 01 02	Consultants	0	0	12,600	0	0	10	0	360	12,970	0	12,970	2,000
09 01 03	Advisory Council	0	0	0	0	0	0	0	100	100	0	100	990
09 01 05	Research Review Committee	1,472	0	1,292	150	0	100	190	170	3,374	0	3,374	5,512
09 01 06	Ethical Review Committee	1,472	0	4,284	0	0	150	100	600	6,606	0	6,606	7,933
09 01 07	Director's Prog. Development	0	0	0	0	0	0	60	50	110	0	110	6,313
09 01 10	Procurement of I.V. Acetate	0	0	0	0	0	72,956	0	0	72,956	0	72,956	8,880
09 01 11	ICDDR,B Annual Report	0	0	0	0	0	0	10,000	0	10,000	0	10,000	0
09 02 01	Finance	4,816	82,440	0	0	1,000	200	191,500	300	280,256	50,000	330,256	55,278
09 02 02	Personnel	40,290	26,748	0	60	0	4,528	7,200	12,660	91,486	0	91,486	113,996
09 02 03	Travel Office	9,825	0	0	0	0	170	1,000	450	11,445	0	11,445	10,020
09 02 04	Estate Office	16,457	0	0	0	0	1,700	1,600	5,828	25,585	0	25,585	24,608
09 02 05	General Service Branch	121,227	0	0	20	0	3,200	450	4,400	129,297	0	129,297	104,475
09 05 01	Budget & Finance Office	80,471	27,728	0	700	0	6,500	3,200	26,700	145,299	0	145,299	153,320
09 06 01	Administrative Service Office	9,123	0	0	20	0	530	800	400	10,873	0	10,873	6,812
	TOTAL US $	313,290	251,480	18,176	1,410	17,900	93,944	222,500	58,918	977,618	50,000	1,027,618	956,459

ICDDR,B
BUDGET SUMMARARY FOR PROJECTS, PROTOCOLS AND BRANCHES.

RESOURCES DEVELOPMENT.

A:BUD86RD

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST	1986 TOTAL OPERATING COST
10 01 00	Resources Development	8,256	105,192	18,168	0	19,400	1,900	9,200	2,100	164,216	0	164,216	146,700
10 02 00	Public Relation & Information	11,132	0	0	100	0	50	500	1,100	12,882	0	12,882	12,469
	TOTAL US $	19,388	105,192	18,168	100	19,400	1,950	9,700	3,200	177,098	0	177,098	159,169

AZII-17.

ICDDR,B
BUDGET SUMMARY FOR PROJECTS, PROTOCOLS AND BRANCHES.

MANDATORY COMMITTEE.

A:BDG86MC

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST	1986 TOTAL OPERATING COST
11 01 00	Board of Trustee	0	0	0	100	68,500	800	900	3,600	73,900	0	73,900	68,380
11 03 00	External Scientific Review	0	0	12,600	0	0	0	0	0	12,600	0	12,600	32,700
11 06 00	Programme Coordi. Committee	6,577	0	6,630	150	0	100	150	400	14,007	0	14,007	5,893
	TOTAL US $	6,577	0	19,230	250	68,500	900	1,050	4,000	100,507	0	100,507	106,973

AZI2-17.

ICDDR,B
BUDGET SUMMARARY FOR PROJECTS, PROTOCOLS AND BRANCHES.

EMPLOYEES BENEFIT.

A:BD686E8

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST	1986 TOTAL OPERATING COST
12 01 01	Staff Clinic - Dhaka	16,994	0	0	0	0	7,010	400	610	25,014	0	25,014	39,390
12 01 02	Staff Clinic - Matlab	7,846	0	0	0	0	2,000	300	570	10,716	0	10,716	11,000
12 02 01	Staff Welfare Assoc. - Dhaka	4,527	0	0	300	0	30	7,000	1,100	12,957	0	12,957	13,906
12 02 02	Staff Welfare Assoc. - Matlab	0	0	0	149	0	40	90	1,460	1,739	0	1,739	2,527
12 02 03	Staff Welfare Assoc. - Teknaf	0	0	0	10	0	10	0	0	20	0	20	223
	TOTAL US $	29,367	0	0	459	0	9,090	7,790	3,740	50,446	0	50,446	67,046

AZIZ-17.

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	1987 INTL. SALARIES	1987 CONSULTANT	1987 LOCAL TRAVEL	1987 INTL. TRAVEL	1987 SUPPLIES	1987 OTHERS	1987 INTER DEPTL.	1987 TOTAL DIRECT OPERAT. COST	1987 CAPITAL EXPENDITURE	1987 TOTAL PROJECT COST	1986 TOTAL OPERATING COST
FUNDED													
13 14 00	Dirrhoeal Cont. Centre-Dammam	15,917	70,776	0	4,008	30,000	1,200	11,000	1,697	134,598	0	134,598	192,300
13 15 00	Dirrhoeal Cont. Centre-Riyadh	21,838	76,023	22,950	9,750	28,900	7,500	433	1,200	168,594	1,200	169,794	137,100
13 16 00	Cereal Based ORS Res. Studies	0	0	10,790	0	0	0	0	0	10,790	0	10,790	17,936
	TOTAL US $	37,755	146,799	33,740	13,758	58,900	8,700	11,433	2,897	313,982	1,200	315,182	347,336

ICDDR,B
BUDGET SUMMARARY FOR PROJECTS, PROTOCOLS AND BRANCHES.

STAFF DEVELOPMENT.

A:BDG86SD

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST	1986 TOTAL OPERATING COST
14 01 00	Staff Development - Scientific	585	0	0	0	0	0	120	50	755	0	755	38,370
14 02 00	Staff Development - Others	0	0	0	100	0	200	600	50	950	0	950	680
	TOTAL US $	585	0	0	100	0	200	720	100	1,705	0	1,705	39,050

AZIZ-17.

BUDGET CODE NO.	PROJECT/PROTOCOL/BRANCH TITLE	1987 LOCAL SALARIES	INTL. SALARIES	CONSULTANT	LOCAL TRAVEL	INTL. TRAVEL	SUPPLIES	OTHERS	INTER DEPTL.	TOTAL DIRECT OPERAT. COST	CAPITAL EXPENDITURE	TOTAL PROJECT COST	1986 TOTAL OPERATING COST
16 01 01	Guest House - 1	8,201	0	0	0	0	600	7,200	600	16,601	0	16,601	16,025
16 01 02	Guest House - 2	5,821	0	0	0	0	576	4,700	450	11,547	0	11,547	11,099
16 02 01	Guest House - Matlab	1,514	0	0	0	0	0	0	0	1,514	0	1,514	5,391
17 01 01	Cafeteria - Dhaka	28,181	0	0	0	0	1,242	600	300	30,323	0	30,323	26,454
17 02 01	Cafeteria - Matlab	2,477	0	0	0	0	0	0	50	2,527	0	2,527	1,330
	TOTAL US $	46,194	0	0	0	0	2,418	12,500	1,400	62,512	0	62,512	60,299

DATE OF NEXT BOARD MEETING.

DATES OF NEXT MEETING

In June 1986 it was decided that the tentative dates for the June 1987 meeting would be Sunday, 14 June, to Friday, 19 June, 1987 inclusive. It was also decided that two days be set aside for Committee Meetings, 1 day for report writing and 3 days for the full Board Meeting. The June 1987 dates would be as follows:

Sunday, 14 June & Monday, 15 June	-	Committee meetings
Tuesday, 16 June	-	Free for report writing
Wednesday, 17 June	-	Full Board Meeting commences
Thursday, 18 June	-	Full Board Meeting continues
Friday, 19 June	-	Full Board Meeting concludes

Tentative dates for November are 1987 are:

Sunday, 22 November to Friday, 27 November, 1987 inclusive.