DRAFT PROGRAMME

BOARD OF TRUSTEES MEETING

27 MAY - 2 JUNE, 1988

Thursday, 26 May *

Programme Committee Members arrive

Friday, 27 May **

9.00 a.m.	-	9.30 a.m.	Presentation on Urban Volunteers Project - Dr D. Silimperi
9.30 a.m.	-	10.15 a.m.	Open discussion on the Project
10.15 a.m.	-	10.45 a.m.	TEA
10.45 a.m.	-	12 noon	Programme Committee discussion of Urban Volunteers Project
12 noon	-	2.00 p.m.	LUNCH
2.00 p.m.	-	2.30 p.m.	Presentation on Laboratory Sciences Division - Future Directions (Immunology) - Dr I. Ciznar
2.30 p.m.	-	3.15 p.m.	Open discussion on Dr Ciznar's presentation
3.15 p.m.	-	3.45 p.m.	TEA
3.45 p.m.	-	5.00 p.m.	Programme Committee discussion of Dr Ciznar's presentation

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* If members are able to arrive Tuesday, 24 or Wednesday, 25 May the additional time may be spent at field sites (e.g. Urban Volunteers, Shigellosis), and/or seeing laboratory facilities, esp. Pathology and Biochemistry, hospital improvements, etc.

** Remaining Board Members arrive

Saturday, 28 May *

9.00 a.m.	10.15 a.m.	Personnel & Selection Committee Mtg.
10.15 a.m.	10.30 a.m.	TEA
10.30 a.m.	12.30 p.m.	Personnel & Selection Committee Mtg.
12.30 p.m.	2.00 p.m.	LUNCH
2.00 p.m.	3.45 p.m.	Personnel & Selection Committee Mtg.
3.45 p.m.	4.00 p.m.	TEA
4.00 p.m.	5.00 p.m.	Joint Meeting of Programme Committee and Standing Committee of Programme Co-ordination Comittee (PCC)

Sunday, 29 May *

9.00 a.m.	5.00 p.m.	Programme Committee Meeting (Tea and Lunch breaks as for Saturday, except a/noon tea break is at 3.30 p.m.)

Monday, 30 May *

9.00 a.m.	3.00 p.m.	Finance Committee Meeting (Morning tea and lunch breaks as for Saturday)
3.00 p.m.	3.30 p.m.	TEA
3.30 p.m.	5.00 p.m.	Meet with scientific staff

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* Trustees not involved in committee meetings on this particular day are encouraged to go on field trips, e.g. Matlab, Mirzapur, etc.

Tuesday, 31 May	-	Board Meeting:
8.30 a.m. - 9.00 a.m.		Welcome, Approval of Agenda; Approval of November 1987 Minutes
9.00 a.m. - 10.15 a.m.		Presentation and discussion of Director's Report
10.15 a.m. - 10.30 a.m.		TEA
10.30 a.m. - 12.30 p.m.		Discussion of draft papers for Donors' Meeting
12.30 p.m. - 2.00 p.m.		LUNCH
2.00 p.m. - 3.30 p.m.		Presentation and discussion of Programme Committee Report
3.30 p.m. - 3.45 p.m.		TEA
3.45 p.m. - 5.00 p.m.		Discussion and resolutions of Programme Committee Report
Wednesday, 1 June		
8.30 a.m. - 10.15 a.m.		Presentation and discussion of Personnel & Selection Committee Report
10.15 a.m. - 10.30 a.m.		TEA
10.30 a.m. - 12 noon		Discussion and resolutions of Personnel & Selection Committee Report
12 noon - 12.30 p.m.		Meet with representatives of the Staff Welfare Association
12.30 p.m. - 2.00 p.m.		LUNCH
2.00 p.m. - 3.30 p.m.		Presentation and discussion of Finance Committee Report
3.30 p.m. - 3.45 p.m.		TEA
3.45 p.m. - 5.00 p.m.		Discussion and Resolutions of Finance Committee Report

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Thursday, 2 June

8.30 a.m. - 9.15 a.m.	Selection of Trustees
9.15 a.m. - 9.45 a.m.	Election of Chairman of the Board
9.45 a.m. - 10.15 a.m.	Dates of Next Meeting
10.15 a.m. - 10.30 a.m.	TEA
10.30 a.m. - 12.30 p.m.	Miscellaneous
12.30 p.m. - 2.00 p.m.	LUNCH
2.00 p.m. - 4.00 p.m.	Passage of all resolutions
4.00 p.m.	Closure of meeting

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

The Finance and Personnel and Selection Committee meetings will be held in the Director's Conference Room (2nd Floor)

6.4.88

AGENDA

BOARD OF TRUSTEES MEETING

31 MAY - 2 JUNE, 1988

AGENDA

BOARD OF TRUSTEES MEETING

31 MAY - 2 JUNE, 1988

1. Approval of Agenda - 1/BT/MAY 88

2. Approval of Draft Minutes of Board Meeting November, 1987 - 2/BT/MAY 88

3. Director's Report (including 1987 Annual Report) - 3/BT/MAY 88

4. Draft papers for Donors' Meeting - 4/BT/MAY 88

5. Programme Committee Report - 5/BT/MAY 88

   (a) Review of Urban Volunteers Projects; Review of Laboratory Sciences Division (Immunology).

   (b) Scientific Priorities of the Centre.

   (c) Teknaf Paper.

   (d) Plans for improvement of the Hospital.

   (e) Update on Scientific External Review.

   (f) Paper on Safety Measures at the Centre.

6. Personnel & Selection Committee Report - 6/BT/MAY 88

   (a) Appointments.

   (b) Salary Policy for International and NO Staff.

   (c) Compensation for International Staff for Devaluation of Dollar.

   (d) Paper on Secondment Policy.

7. Finance Committee Report - 7/BT/MAY 88

   (a) Resources Development Report.

   (b) Approval of 1989 Budget.

   (c) UNROB Loan.

   (d) Reserve Fund.

   (e) Protocol approval and funding procedures.

8. Selection of Trustees - 8/BT/MAY 88

9. Election of Chairman of the Board - 9/BT/MAY 88
   (a) Membership of Committee of the Board.

10. Dates of Next Meeting -10/BT/MAY 88

11. Miscellaneous -11/BT/MAY 88

    (a) Board Procedures (Prof.Rowley)

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APPROVAL OF DRAFT MINUTES

BOARD MEETING, NOVEMBER 1987

DRAFT

Minutes of the meeting of the Board of Trustees, ICDDR,B held in Bangkok, Thailand, November 24-26, 1987.

Members Present

Dr A.R. Al-Sweilem
Mr M.K. Anwar
Prof. D. Bell - Chairman
Prof. R. Eeckels - Secretary
Prof. R. Feachem
Prof. D. Habte
Prof. V.I. Mathan
Dr M. Merson
Dr K.A. Monsur
Mr T. Rahman
Dr P. Sumbung
Prof. H. Tanaka

Members Absent

Dr D. Ashley
Dr I. Cornaz
Prof. A. Lindberg
Dr Nyi Nyi
Prof. D. Rowley

Invited Staff

Mr M.R. Bashir, Associate Director, Resources Development (except for agenda 5)
Mrs J. Chowdhury, Executive Assistant to the Director
Mr M.A. Mahbub, Head, Administration, Personnel and Finance (except for agenda 5)

The Chairman of the Board, Professor D. Bell, opened the meeting at 2 p.m. on Tuesday, 24 November, 1987 and welcomed his colleagues to the meeting, which was held unexpectedly in Bangkok instead of Dhaka. He thanked everyone for re-arranging their schedules at such short notice.

Professor Bell introduced Mr Anwar as a returning member of the Board. He introduced the new members, Professors V.I. Mathan and H. Tanaka from Vellore, India and Tokyo, Japan, respectively. Professor Bell said that there are two other new members who were unable to attend, namely, Prof. A. Lindberg from the Karolinska Institute, Sweden and Dr D. Ashley from the Ministry of Health in Jamaica. He said that both were delighted to be on the Board and apologized for not being able to be present. Professor Bell said that Dr Cornaz, Dr Nyi Nyi and Professor Rowley had all sent their apologies for not being able to attend the meeting.

Professor Bell concluded by thanking the staff of the Centre for the quick arrangements they had made for the meeting to be held in Bangkok and said that these arrangements are most satisfactory.

Agenda 1: Approval of Agenda

The agenda was accepted as presented.

Agenda 2: Approval of Draft Minutes of Board Meeting, June 1987

The draft minutes of the Board of Trustees meeting held in Dhaka from June 16-18, 1987 were approved without change.

Agenda 3: Director's Report

Professor Eeckels presented his report which is attached as annex 1. In his report, Professor Eeckels highlighted the recent widespread floods in Bangladesh and expressed his gratitude to the countries who gave aid to the Centre (Belgium, France, The Netherlands and Switzerland) which enabled it to assist in the flood relief programme. He said how grateful he was for the assistance of Messrs. Bashir and Mahbub for arranging this Board Meeting at such short notice in Bangkok.

Other points mentioned by Professor Eeckels included:-

(a) the fact that the Centre is now in a better financial position and it is felt that it has now regained the confidence of the donors;

(b) the large turnover in staff he has seen since he joined and the constant help of Mr Bashir, during this time, which went far out of the Resources Development field. He welcomed Mr Mahbub to his first meeting and said that with the Chief Personnel Officer, Mr Zaman, having joined very recently, the administration is now being built up;

(c) Research money is available again now, and the Centre is desperately in need of senior researchers to inspire the staff. He said he will miss Dr Ciznar, who leaves mid next year, and requested the Board to help find a replacement. He said that he is extremely pleased that Dr Mahalanabis will join shortly, as Head of the Clinical Sciences Division, and thanked Dr Merson for helping to make this possible.

(d) Research has been going ahead. Two examples were mentioned. About a fortnight ago, preliminary results were obtained of the second year of the vaccine trial. They indicate that a protection rate of about 60% is being maintained. Dr. Clemens will probably leave in the autumn of 1988 and his replacement is very important to continue surveillance. Dr Mahbubur Rahman, back from training in Brussels, has already developed a new method for rapid diagnosis of cholera and shigellosis. These staphylococcus co-agglutination methods still need to be field-tested but are quite promising;

(e) Service has been continuing and some donors continue to show particular interest in this. The first year of the DANIDA grant has been completed and two years remain. Dr Kofoed is expected to join shortly. Effort has gone into improving the MCH-FP activities in Matlab and Holland has expressed interest in funding the Matlab activities.

(f) Training has remained a problem in the sense that how far our training activities should extend is a question which must be solved;

(g) Contacts with donors is extraordinarily important and the efforts to establish a closer relationship with the donors must be pursued vigorously;

To conclude, Professor Eeckels said that the Board has to think about what ICDDR,B should be. He said that he believed it should become a firmly rooted institution, a meeting place where doctors from all nations can meet and work together for the improvement of the health of the Third World.

Professor Bell thanked Professor Eeckels for his report and requested the Trustees to discuss points which will not come up in later agenda items.

Professor Eeckels was asked about the flood relief activities of the Centre. He responded by saying that the Epidemic Control Preparedness Programme teams had joined with their Government counterparts to set up makeshift hospitals and to give hands-on-training in the affected areas on proper management of diarrhoeal cases. Twenty-four teams had been sent out from the Centre in all. Other aspects are an increased workload in the Dhaka hospital; increased production of ORS; and emergency kitchens set up in the Matlab area - France and Holland assisted in the funding for this last effort.

Mr Anwar gave a more detailed account of how the floods affected Bangladesh as a whole. He said that the floods were very bad, the most widespread in 70 years, with nearly 50 per cent of the country under water. He said that ICDDR,B contributed very promptly and were visible in the medical field - the Government of Bangladesh is appreciative of this. Among other points Mr Anwar particularly asked how, if the cholera vaccine is successful, the Centre will realign its programmes; requested that Dr Rahman's discovery be followed-up; and said that training is a major function of the Centre and, as such, requested that it be looked at further.

Professor Eeckels responded to Mr Anwar's question on training while Dr Merson responded to that about the vaccine trial.

Professor Eeckels said re training, that it is more a question of where and whom we should train; what type and level of collaboration we should have with WHO, etc. He said that the Dhaka Treatment Centre is now recognized as a training institution by the Bangladesh Medical Research Council and that he is hoping that it will receive similar recognition from Dhaka University.

Dr Merson said that based on the efficacy rate WHO wouldn't go ahead with the oral cholera vaccine, however, it is interested in the fact that the mortality rate also seems to have declined, which is very impressive. The way the vaccine was given is not practical and the company is working on an "alka-seltzer" type tablet. If this is successful, another field trial is needed with the new formulation. If the same results are obtained, then we can go ahead. In Matlab two different vaccines were given. The one containing B subunit is better but the cost is exorbitant. It needs to be decided whether to go with two or three doses. So, there are a lot of questions to be answered before deciding whether the vaccine should be produced for general use.

It was suggested that in future, there should be a more detailed report from the Director which takes into account the work of the different scientific departments, administration, activities outside Bangladesh, etc., the difficulties faced and how the Centre hopes to overcome these. Professor Bell said that this could be an attachment and not part of the brief overview. It was thought that the Director might benefit from receiving more specific guidelines on what the Board wishes to have in the Director's Report. Professor Bell agreed to provide these guidelines before the next Board Meeting and said that he would welcome suggestions from his colleagues in this respect.

Agenda 4: Programme Committee Report

Professor D. Habte, Acting Chairman of the Committee, presented the Committee's Report which is attached as annex 2.

(a) Review of Laboratory Sciences Division

It was initially proposed that as the review was unable to take place this meeting, it be held next meeting, i.e. May/June 1988. However, it was later agreed that the Committee should look at one or two of the larger projects which are underspending and get a full report (both scientific and financial). These projects are the Urban Volunteers Project, the MCH-FP Extension Project, and, time permitting, the Matlab MCH-FP Project. The Board said that they would like to know what format the review would take and requested the Director to contact the Chairman of the Programme Committee on this, reminding him that he (the Chairman) should inform staff accordingly. It was suggested

that the projects prepare a report (for circulation with other Board papers ahead of the meeting) on what they have done and what they plan to achieve. These reports should be no longer than 15 pages each.

(b) Teknaf Field Station

At its meeting in June 1987, the Board resolved that Teknaf could be retained as a field study area provided that three conditions be fulfilled:

1. a document suitably describing shigella studies and justifying the choice of the Teknaf area is presented to the Programme Committee for its approval;

2. a suitable leader for these studies is identified with epidemiological skills; and,

3. project money is available.

At the present meeting, the Committee reviewed the documents put before it covering Teknaf, and found that they did not fulfill the conditions established in June. Specifically, the Committee found that the study proposals submitted did not present a convincing case concerning the scientific quality of the research programme, nor did they propose suitable arrangements for on the ground scientific leadership. Furthermore, the Committee concluded that the continued postponement of a firm decision on Teknaf is delaying the implementation of some important research at the Centre.

It was pointed out that closing of Teknaf Station will affect the service components provided through the Centre which is likely to create undesirable social problems; and even if the Centre is not used as a research station its service functions have to be continued.

The Board considered the above concentrating on two points:-

1. the Board must be able to come to the conclusion that Teknaf is not necessary scientifically. It is not enough to say the Centre must withdraw because of certain difficulties.

2. If it is decided that Teknaf is not needed for the scientific programme of the Centre, what should be done with Teknaf?

Three clear reasons were given as to why Teknaf should close:-

1. It is too far away and the investment in accommodation, water supply, etc. would be enormous.

2. It is too difficult to get scientists to work there.

3. The epidemiology: Teknaf is not a good site as a primary site for a Shigella vaccine trial. It is atypical, therefore, it is better to look elsewhere and spend the money to set up a site there.

It was emphasized that shigellosis is one of the major problems to be solved in the Third World and that the Centre should do its part. Given the limited personnel resources this study should be in a typical area, not an atypical area, so, scientifically, Teknaf is not the place to study shigellosis, and the Director should be given the mandate to do it elsewhere.

Thus, it was clarified that there are logistic and scientific reason why the Centre should not continue with research in Teknaf.

In response to the caution that if the Centre has been providing service activities as a by-product of research, it is obligated to continue with this infra-structure, it was pointed out that earlier Mr Manzoor-ul-Karim had said that he felt that the Government would be able to take over the service activities being carried out by the Centre.

The Board agreed on a resolution which appears later in these minutes.

(c) External Scientific Review

The recommendation of the Committee that the Clinical Sciences Division be reviewed in 1988 was accepted. The review team will consist of

Dr M.K. Bhan (All India Institute of Medical Science)
Dr M.S. Akbar (Shishu Hospital, Dhaka)
Dr R. Hamilton (McGill University, Canada).

It was noted that Dr J-P. Desjeux (INSERM, Paris) was held as a reserve in the event Dr Hamilton is not available.

(d) Authorship in Centre's Publications

There was unanimity in the Board on the importance of this issue and on the significance of the issue to the Centre. Further work on this is needed. The Director's present system is acceptable to the Board, but all staff should be made aware of the problem, and senior staff in particular must ensure that fairness is done in reporting the results of the Centre's research.

(e) Patent Rights

A resolution was passed in this connection.

The following resolutions were passed:-

Resolution 1/Nov. 87 The Board resolved that:

1. Research functions at Teknaf be closed no later than June 30, 1988 and only service functions be continued.

2. Discussions be initiated with the Government of Bangladesh and others to ensure uninterrupted continuation of the service functions at Teknaf and effect smooth transfer of the same.

3. All efforts be made to absorb in other employment field staff of the Centre who may be displaced by the closure of the research functions at Teknaf.

Resolution 2/Nov. 87 The Board requests the Director to seek legal and other advice on the issue of patent rights and their implications for the Centre, and to present a paper on this subject to the Board.

Agenda 8: Miscellaneous

(a) Election of New Board Members

Two questions were posed by the Director's paper - one relating to the general schedule for selection of new Trustees, and the other relating to the replacement of Professor Bell whose last meeting will be in May/June 1988. The Board agreed that in the future the Personnel & Selection Committee should scrutinize and recommend new members to the Board in November (which is one year before the first meeting new members would attend), rather than in June (less than six months before) as is presently done.

It was agreed that Professor Bell's replacement should come from the United States, and that a Canadian should be considered among the candidates for the next round of Board replacements (1989), in view of the fact that the present Board representation includes one North American and three Europeans. A number of names of persons were suggested as possible replacements for Professor Bell and it was agreed that some biographical information would be circulated.

The meeting adjourned at 6.25 p.m.

The meeting reconvened at 8.30 a.m. on Wednesday, 25 November, 1987.

Speech from President, SWA

The speech from the President of the Staff Welfare Association was distributed to all Trustees. This was read very carefully and the Board considered each of the points raised by SWA in the relevant agenda items.

Agenda 5: Personnel and Selection Committee Report

Mr Taslimur Rahman, Acting Chairman of the Committee, presented the report which is attached as annex 3.

(a) Recruitments

1. Senior Scientist (Head, Laboratory Division)

The Board agreed that both persons submitted to them for further consideration and decision were qualified to head the Division. After discussion it was decided that Dr John P. Heggers be appointed.

In view of the time it takes to recruit suitable staff, the Board decided that an active search should commence now for Dr Heggers' replacement at the appropriate time.

2. Head, Laboratory Services Department

The Board agreed that Dr Shanti S.I. Kasatiya should be appointed to this position.

3. Senior Scientist (Head, Community Medicine Division)

In view of the lack of a curriculum vitae being available, Dr Merson gave an overview of Dr Dibley's career. After discussion (and later an informal meeting with Dr Dibley) it was resolved that the search for a suitable person for this position be continued with active assistance from the Board Members.

It was further resolved that Dr Dibley is qualified for the post of Scientist/Senior Scientist (Epidemiology) and that he be considered along with other candidates for this position.

4. Scientist/Senior Scientist (Population Studies - DSS)

The Board approved the recommendation of the Committee that Dr Rallapalli S.S. Sarma be appointed to this position at P5, Step 10.

5. Computer Information Systems Manager

It was noted that the position of Technical Services Manager has been collapsed and merged with the Computer Information Systems Manager position. Thus, it is expected that the successful candidate will be competent in both areas. However, it was recognized that consultant assistance may be required and the

Centre is presently trying to arrange an institutional linkage with a Canadian organization.

The appointment of Mr A.H. Mostafa at P3 level was approved. It was suggested that he be offered the appointment at P3 Step 1 but the Director has the discretion to use extra steps if necessary.

For all recruitments the Board felt that interview results should be available to both the Personnel & Selection Committee and the full Board. Mr Mahbub should arrange for the Chief Personnel Officer to review the format of the interview sheets; to review the procedures for recruitment at the Centre generally, and in particular for the international level staff positions. It was felt that the procedures are not sufficient and that the Board should be more involved. The question was raised whether the Board should have a search committee for senior posts which are difficult to fill.

(b) Seconded Staff Appointments

It was resolved that in future the report to the Board on seconded staff appointments should include a brief curriculum vitae of each person, their job descriptions, and a summary of their research output.

(c) Contract Renewals

The Board approved the renewal of contracts, for a period of three years, of:

Mr Iqbal Ali
Mrs Judith Chowdhury
Professor Roger Eeckels

and passed a resolution on each renewal.

(d) New International Level Positions

1. Scientist/Senior Scientist (Immunology) - P4/P6

It was agreed that this position may be advertised and a resolution was passed to enable the Director to proceed with recruitment for a replacement for Dr Ciznar.

2. Scientist (Clinical Pathology) -P3/P4

This is a new position and a resolution was passed approving recruitment.

(e) Working Papers

1. Secondment Policy

Full discussion of this was deferred until next meeting when the Director will present a revised paper, taking into consideration the comments made by the Personnel and Selection Committee in its report.

2. Evaluation of International Scientific Professional Staff

The Board agreed with the recommendation of the Personnel and Selection Committee and passed two resolutions to this effect.

3. International Level Staff Compensation Survey

This item was discussed jointly by the Personnel and Selection Committee and the Finance Committee. The Board agreed that at present the Centre should continue to follow the WHO system, using the various options available within that system.

1. Local Staff Salary Survey

This item too was discussed jointly by the Personnel and Selection and Finance Committees. The Board accepted the two recommendations that:

- one third of the UN increase (ranging from 9% to 22%) be implemented as from 1 January, 1988. Provision should be made to accommodate all such increases in the project budgets;

- no commitment be made at this stage for the remaining portion of the rise, but that this should be considered at a later meeting.

(f) Miscellaneous

1. Reclassifications - International Staff

Dr V. Fauveau - The Board agreed that Dr V. Fauveau should receive a meritorious increase and a resoltuion was passed to this effect.

Dr F. Henry - The Board agreed that Dr F. Henry should receive a personal promotion and a resolution was passed to this effect.

2. Pension Fund Contribution - Dr D. Mahalanabis

The Board agreed that Dr Mahalanabis may stay with the WHO system and that the Centre is authorized to pay 14.5% as employer's contribution to the pension fund for Dr Mahalanabis.

3. Director's Workload

It was resolved that a decision on the Director's proposal to strengthen his office be deferred, and the Director would further consider the various options discussed with the Personnel and Selection Committee and the Board.

4. Proposed Amendments & Revisions of Rules and Regulations (SR and Manual)

Nomenclature - this change was agreed to, i.e. the title should revert to the original designation.

Within Grade Increases - this paper should be resubmitted to the full Board, through the Personnel and Selection Committee, with full justification for the change.

Meritorious Within-Grade Increase - the change requested was approved and a resolution to this effect passed.

The following resolutions were passed:-

Resolution 3/Nov. 87 — Resolved that Dr John P. Heggers be appointed as Head Laboratory Sciences Division at an appropriate step of P6 level.

Resolution 4/Nov. 87 — Resolved that Dr Shanti S. Kasatiya be appointed as Head Laboratory Services Department at an appropriate step on level P4.

Resolution 5/Nov. 87 — Resolved that Dr Rallapalli S.S. Sarma be appointed as Senior Scientist (Population Studies DSS) at an appropriate step on level P5.

Resolution 6/Nov. 87 — Resolved that Mr Abdullah Hel Mostafa be appointed as Computer Information Systems Manager at an appropriate step on level P3.

Resolution 7/Nov. 87 — Resolved that as a general rule Board Members be approached to assist in the recruitment of all international positions; notices of employment, job descriptions and other relevant papers should be sent to all Board Members.

Resolution 8/Nov. 87 — Resolved that the Management should ensure that presentation of cases of appointment are appropriately supported by standard documents of evaluation.

Resolution 9/Nov. 87 — Resolved that Mr Iqbal Ali's contract, at the P1 level, be extended by another 3 years, effective June 16, 1988.

Resolution 10/Nov. 87 — Resolved that Mrs Judith A. Chowdhury's contract, at the P1 level, be extended by another 3 years, effective June 16, 1988.

Resolution 11/Nov. 87 — Resolved that Prof. Roger Eeckels' appointment be extended by three years effective April 1, 1988. With respect to the modifications in his contract proposed by Prof. Eeckels, Dr Merson will consult with the Chief of Personnel, WHO, to ascertain what can be done within the WHO rules to respond to Prof. Eeckels' proposals, and will report his findings to the Chairman of the Board.

On the basis of Dr Merson's report, the Chairman,

in consultation with Mr Anwar, is authorized to negotiate an extension of contract with Prof. Eeckels. If the negotiations are successful, a contract may be signed. If the negotiations are not successful, the Chairman is authorized to convene an Executive Committee of the Board, consisting of Mr Anwar, Dr Cornaz, Dr Merson, the Director and the Chairman. The Executive Committee is authorized to act for the Board with respect to the position of Director, and to any other personnel issues, in the interim before the next Board Meeting.

Resolution 12/Nov. 87 — Resolved that the Director proceed with the recruitment of the position Scientist/Senior Scientist (Immunology) at P4-P6 level.

Resolution 13/Nov. 87 — Resolved that a new international position Scientist (Clinical Pathology) be created at P4 level and the Director proceeds with the recruitment.

Resolution 14/Nov. 87 — Resolved that international level scientific staff be externally reviewed only after six years and then only if they are competing for their own or another position at the Centre.

Resolution 15/Nov. 87 — Resolved that appropriate evaluation forms be developed for evaluation of staff due for confirmation, promotion and renewal of contract and that this be submitted to the Personnel & Selection Committee at its next meeting.

Resolution 16/Nov. 87 — Resolved that Dr V.A. Fauveau be granted a raise in salary at three steps above his present salary at the same level in view of his meritorious performance.

Resolution 17/Nov. 87 — Resolved that Dr F. Henry, Nutritionist-Epidemiologist having served commendably for four years and now at the final step of the level of salary enjoyed by him be promoted to level P3 on a personal basis.

Resolution 18/Nov. 87 — Resolved that "20 years" be deleted from the qualification for within-grade increase.

Agenda 6: Finance Committee Report

Professor Richard Feachem, Chairman of the Committee, presented the report which is attached as annex 4.

(a) 1987 Financial Report

1. Contributions from Donors

The Board noted with satisfaction the magnitude of donor contributions estimated for 1987 ($10.1 million) and projected for 1988 ($10.3 million), and the pleasing number of different donors in 1987 (22) and expected in 1988 (19). The Board considered that it is important to continue to increase the number of different donors and to reduce gradually the proportion of the budget contributed by any single donor.

2. Income and Expenditure, 1987

The Board reviewed the revised projection of income and expenditure for the year 1987 and noted with satisfaction the estimated surplus of $499,000, which is $199,000 higher than the target set by the Board in June 1987.

It was queried why Management/Services and Community Health have increased in 1987 to a greater extent than Research. The Board said it is uncomfortable about this and would like this to be explained in the Annual Report. Professor Eeckels said that this is caused by the local salary rises and the under-spending on research projects due to lack of staff.

3. Overdraft, 1987

The Board noted with satisfaction that prompt payment by donors has led to a small positive cash balance at the end of 1987, and also resulted in lower interest payments for 1987.

(b) 1988 Budget

It was agreed that the budget needs to be re-organized; for example, some items presently shown under "service" are actually research costs and should be shown as such. These categories should be sorted out immediately so the 1988 and 1989 budgets, using the new categories, can be ready for the June 1988 Board Meeting and for circulation to donors.

As regards the total budget, Mr Mahbub and the Director were encouraged to make conservative estimates of expenditures, especially in the service areas. The 1988 budget, which will be updated and reviewed at the next Board Meeting, should reflect actual expenditures during the early months of 1988.

With reference to the surplus, the Management is asked to aim at $300,000 in 1988. At the same time, it is expected that the Management should try to exceed this figure and a progress report on this should be given at the June 1988 Board Meeting. It was pointed out that the cumulative deficit must be got down and at present the only way to achieve this is by having a surplus.

(c) NO and GS Level Salary

1. Salary Award

The Board agreed with the Committee's recommendation and passed a resolution on this.

2. Ranking

Again, the Board agreed with the Committee's recommendation and passed a resolution.

(d) International Staff

1. Post Adjustment

Implementation of this is delayed until 1 July, 1988 - a resolution to this effect was passed.

(e) Reserve Fund and Overdraft

The resolution passed on the above summarizes discussions.

(f) UNROB Loan

The Board agreed with the recommendation of the Committee and passed a resolution.

(g) Banking Arrangements

The Board noted Mr Anwar's offer of assistance, should the Management request such assistance, in making renewed contact and holding discussions with selected banks.

(h) Protocol Approval and Funding Procedures

The Board agreed with the recommendation of the Committee that the guidelines on protocol approval and funding prepared at the request of the Board (Resolution 7/June 87) raised several questions and requested that new guidelines be put before the May/June 1988 Board Meeting. These guidelines should come to the Board through the Finance Committee. They should not over-emphasize the role of the Resources Development Office, should allow more dialogue between scientists and donors (within the rules and procedures), and should be fully discussed and agreed upon by the senior staff at the Centre before submission to the Board.

(i) Payment to Trustees

1. Per Diem

A resolution was passed on this subject.

2. Honorarium

The Board agreed that members should continue to receive only two-thirds of the normal honorarium (i.e. $100 per day) for the time being.

(j) Miscellaneous

1. Systems Development

A resolution was passed on this.

2. Donor Consortium Expenses

A resolution was passed in this connection.

The meeting adjourned at 7.10 p.m.

The meeting reconvened at 8.30 a.m. on Thursday, 26 November, 1987.

Agenda 6: Finance Committee Report

(k) Donor Relationships

This subject was discussed at length. The Board began by agreeing that a good deal was accomplished by the Donor Consortium meetings in March and June 1987, and centered its discussion on the question of how the Centre can build effectively on what has been achieved, realizing there's still a long way to go.

Resolutions 28 and 29/Nov. 87 summarize the decisions made by the Board in respect to the Donors' Consortium and the documents to be prepared and circulated by the Centre prior to its 1988 meeting. Professor Bell agreed, as Chairman of the Board, that he would write to the donors after this Board Meeting reporting on the meeting and attaching a copy of the resolutions adopted with respect to donor relationships.

As regards the date of the next Donors' Meeting it was agreed that the end of October/early November be suggested to Mr Rothermel for discussion with the donors. UNDP's view on the venue is also needed. It was suggested that Professor Eeckels and other Trustees could make informal contacts with

donors during the WHO meetings in Geneva at the end of June, 1988.

Although the next Donors' Meeting will not be held until towards the end of 1988, the budget and related documents should be prepared in draft for review by the Board at its May/June meeting. The documents can then be completed and circulated to donors with requests for funds before the late June, 1988, WHO meetings. In order to achieve this the budget line items need to be revised, the 1989 figures added, and a half-page description of the activities in 1989 included for each line item. The Director was encouraged to call on members of the Board, particularly members of the Finance Committee, for assistance in preparing and reviewing the documents for the donors, including the possibility of a meeting in Europe, should he consider it desirable, like the one held in Geneva in May 1987 to revise the draft document then in preparation for the June 1987 donors' meeting.

One document requested by the Board in Resolution 29/Nov. 87, the guidelines on the operation of the 50:50 funding principle, needs to be prepared on an earlier timetable so that it can guide the Centre's fund-raising activites as soon as possible. A draft was requested, if possible by the end of the year, which could then be reviewed by Mr Anwar, Prof. Bell, Dr Cornaz, Dr Merson and the Finance Committee.

(l) 1987 Annual Report

It was suggested that this report should follow the new format developed for the 1989 programme budget. It should be factual and not too long, making use of key tables and graphs rather than long descriptions. It was suggested that a scientific editor is needed, and that if possible the report should be printed on a laser printer. Abstracts on research being done could be a supplement to the report.

(m) Plans for Improvement of the Hospital

It was agreed that the Board supports the Director in seeking to explore the best ways and means for improvement of the Dhaka Treatment Centre (hospital). A revised paper should be submitted to the Board next meeting. This paper should outline what needs the treatment centre is expected to serve in the future, what is required to make it a more satisfactory facility for patients and for research, and plans for improvement. It would be helpful to have some

information about present and anticipated patient loads. The Board would like to have expert advice on the plans, beginning with the existing architects but not limited thereto. The report should include appropriate exploration of ways to improve the present structure with respect to ventilation and sanitation. The Director should look at the possibility of decentralizing on the existing property, e.g. putting ORT patients in a separate building. Estimates of construction costs and recurrent costs should be included with the plans.

The following resolutions were passed:-

Resolution 19/Nov. 87 — The Board reviewed the 1988 budget. The Board approved an increase in total expenditure from an estimated $8.2 million in 1987 to a budget figure of $9.9 million for 1988. The Board notes that this increase is due to a major pay award to NO and GS level staff (costing $0.6 million) and to the anticipated increase in the rate of spending of several major projects. The Board approves the budget and stipulates that a surplus before depreciation of at least $300,000 be achieved.

Resolution 20/Nov. 87 — The Board resolves that one third of the UN salary increase for NO and GS level staff, announced August 19, 1987, be awarded to staff of the Centre from January 1, 1988 without retroactivity. The approved increases by grade are:

GS 1-4	22%
GS 5	18%
GS 6	12.33%
NO A-E	9.33%

Resolution 21/Nov. 87 — The Board approves the additional expenditure on salaries of $19,000 for 1987 that arises from the re-ranking of scientific staff that was approved by the Board at its last meeting (Resolution 17/June 87). The Board further approves a provision of $100,000 in the 1988 budget to cover the likely outcome of the continuing re-ranking exercise.

Resolution 22/Nov. 87

The Board notes the change of the UN post adjustment factor for international staff in Dhaka from negative 10 to zero effective from September 1987. The Board approves the implementation of this change for international staff at the Centre from July 1, 1988, without retroactivity.

Resolution 23/Nov. 87

The Board reviewed the current situation with respect to overdraft requirements and the Reserve Fund. The Board resolves:

(a) to seek to place the Reserve Fund on longer term deposit where it may attract a higher rate of interest;

(b) in view of the unlikelihood of requiring an overdraft over $1.5 million in 1988, to negotiate with the Centre's bankers the spread of interest between the deposits and the borrowings in the hope of reducing this to 1%.

The Board requests the Management to prepare a report for its next meeting on the implementation of this resolution and on options for further changes to the banking arrangements relating to the overdraft and the Reserve Fund.

Resolution 24/Nov. 87

The Board resolves that the Centre should renew its plea to the Government of Bangladesh concerning the UNROB loan. The Board draws to the attention of the Government the substantial improvement in the Centre's financial situation that has been achieved since 1985 and the powerful consolidating effect that a conversion of the UNROB loan to a grant would have. This measure would be welcomed by other donors and would strongly reinforce the Centre's negotiating position at the forthcoming Donors' Consortium meeting.

Resolution 25/Nov. 87

Resolved that all Trustees be paid per diem when on Board business and that such payment be made according to WHO rules. Trustees attending Board business at their respective home station will be paid 50% of the standard per diem as per WHO rules.

Resolution 26/Nov. 87

The Board notes the efforts in developing Asset Accounting and Inventory Management Systems and authorises the expenditure of up to US$ 50,000 for these purposes.

Resolution 27/Nov. 87

The Board approves the expenditure of US$ 2,276 in respect of two delegates from China and Bangladesh who attended the Donors' Consortium meetings in Dhaka and Geneva.

Resolution 28/Nov. 87

The Board notes with satisfaction the firm foundations for more effective and closer relationships between the Centre and its financial supporters created by the Donors' Consortium meetings held in March and June of 1987. The Board affirms its intention to establish during 1988 new arrangements and procedures concerning the relationship between the Centre and the Donors.

A. The Board recognizes that the details of these new arrangements and procedures must be developed in full consultation with the donors and in particular, with UNDP.

The Board resolves to propose to the Donors the following arrangements.

(a) There will be an annual Donors' Consortium meeting, usually in late October or early November in Dhaka, at which the Centre will welcome a full and frank discussion of its plans, programmes and priorities;

(b) A programme description and a programme-based budget for the following year, together with other material on the activities, plans and priorities of the Centre, will be sent to Donors well in advance to allow full study and preliminary discussion prior to the Donors' Consortium meeting.

B. The Board welcomes the support given by Donors at the two Consortium meetings in 1987 to the 50:50 funding principle, and intends to continue working energetically with the donors to put this into effect.

Resolution 29/Nov. 87 The Board requests the Director to present for review at the next Board meeting the following documents relating to the Donors' Consortium.

1. A programme description and programme-based budget for 1989.

2. An outline programme and indicative programme-based budget for the five year period 1989-93.

3. Guidelines on the operation of the 50:50 funding principle.

Agenda 7: Dates of Next Meeting

In view of the need to review and complete the documents for the 1988 donors' meeting in time for their initial use in informal discussions in late June 1988, it was agreed that the next Board Meeting should be held from **Saturday, 28 May until Thursday, 2 June, 1988 inclusive.**

It was noted that the Programme Committee and Board have to review the scientific priorities of the Centre next June as resolved in June 1987. In order to economize on time, it was suggested that presentations to the Programme Committee could be done in the evenings and that Board Members could come a day or two earlier to visit projects.

The dates of the November 1988 Board Meeting will depend on the dates of the Donors' Meeting, as it is expected that the Board Meeting will immediately follow the Donors' Meeting.

Professor Bell thanked everyone for their patience and understanding and said that he looked forward to the next meeting in Dhaka.

Professor Eeckels thanked the Board Members for their very important contributions, especially the new Board Members.

Professor Eeckels was requested to pass on the Board's appreciation to the staff for their hard work.

The meeting closed at 3.45 p.m. on Thursday, 26 November, 1987.

17.2.88

RESOLUTIONS FROM THE NOVEMBER 1987 BOARD MEETING

DRAFT

Resolutions from the November, 1987 Board Meeting

Resolution 1/Nov. 87

The Board resolved that:

1. Research functions at Teknaf be closed no later than June 30, 1988 and only service functions be continued.

2. Discussions be initiated with the Government of Bangladesh and others to ensure uninterrupted continuation of the service functions at Teknaf and effect smooth transfer of the same.

3. All efforts be made to absorb in other employment field staff of the Centre who may be displaced by the closure of the research functions at Teknaf.

Resolution 2/Nov. 87

The Board requests the Director to seek legal and other advice on the issue of patent rights and their implications for the Centre, and to present a paper on this subject to the Board.

Resolution 3/Nov. 87

Resolved that Dr John P. Heggers be appointed as Head Laboratory Sciences Division at an appropriate step of P6 level.

Resolution 4/Nov. 87

Resolved that Dr Shanti S. Kasatiya be appointed as Head Laboratory Services Department at an appropriate step on P4 level.

Resolution 5/Nov. 87

Resolved that Dr Rallapalli S.S. Sarma be appointed as Senior Scientist (Population Studies DSS) at an appropriate step on P5 level.

Resolution 6/Nov. 87

Resolved that Mr Abdullah Hel Mostafa be appointed as Computer Information Systems Manager at an appropriate step on P3 level.

Resolution 7/Nov. 87 — Resolved that as a general rule Board Members be approached to assist in the recruitment of all international positions; notices of employment, job descriptions and other relevant papers should be sent to all Board Members.

Resolution 8/Nov. 87 — Resolved that the Management should ensure that presentation of cases of appointment are appropriately supported by standard documents of evaluation.

Resolution 9/Nov. 87 — Resolved that Mr Iqbal Ali's contract, at the P1 level, be extended by another 3 years, effective June 16, 1988.

Resolution 10/Nov. 87 — Resolved that Mrs Judith A. Chowdhury's contract, at the P1 level, be extended by another 3 years, effective June 16, 1988.

Resolution 11/Nov. 87 — Resolved that Prof. Roger Eeckels' appointment be extended by three years effective April 1, 1988. With respect to the modifications in his contract proposed by Prof. Eeckels, Dr Merson will consult with the Chief of Personnel, WHO, to ascertain what can be done within the WHO rules to respond to Prof. Eeckels' proposals, and will report his findings to the Chairman of the Board.

On the basis of Dr Merson's report, the Chairman, in consultation with Mr Anwar, is authorized to negotiate an extension of contract with Prof. Eeckels. If the negotiations are successful, a contract may be signed. If the negotiations are not successful, the Chairman is authorized to convene an Executive Committee of the Board, consisting of Mr Anwar, Dr Cornaz, Dr Merson, the Director and the Chairman. The Executive Committee is authorized to act for the Board with respect to the position of Director, and to any other personnel issues, in the interim before the next Board Meeting.

Resolution 12/Nov. 87 — Resolved that the Director proceed with the recruitment of the position Scientist/Senior Scientist (Immunology) at P4-P6 level.

Resolution 13/Nov. 87 — Resolved that a new international position Scientist (Clinical Pathology) be created at P4 level and the Director proceeds with the recruitment.

Resolution 14/Nov. 87 — Resolved that international level scientific staff be externally reviewed only after six years and then only if they are competing for their own or another position at the Centre.

Resolution 15/Nov. 87 — Resolved that appropriate evaluation forms be developed for evaluation of staff due for confirmation, promotion and renewal of contract and that this be submitted to the Personnel & Selection Committee at its next meeting.

Resolution 16/Nov. 87 — Resolved that Dr V.A. Fauveau be granted a raise in salary at three steps above his present salary at the same level in view of his meritorious performance.

Resolution 17/Nov. 87 — Resolved that Dr F. Henry, Nutritionist-Epidemiologist having served commendably for four years and now at the final step of the level of salary enjoyed by him be promoted to level P3 on a personal basis.

Resolution 18/Nov. 87 — Resolved that "20 years" be deleted from the qualification for within-grade increase.

Resolution 19/Nov. 87

The Board reviewed the 1988 budget. The Board approved an increase in total expenditure from an estimated $8.2 million in 1987 to a budget figure of $9.9 million for 1988. The Board notes that this increase is due to a major pay award to NO and GS level staff (costing $0.6 million) and to the anticipated increase in the rate of spending of several major projects. The Board approves the budget and stipulates that a surplus before depreciation of at least $300,000 be achieved.

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17.2.88

3/BT/MAY 88

DIRECTOR'S REPORT

(INCLUDING 1987 ANNUAL REPORT)

4/BT/MAY. 88

DRAFT PAPERS FOR DONORS' MEETING

PLANS AND PROSPECTS

SUPPLEMENT
JUNE 1987

INTERNATIONAL
CENTRE
FOR
DIARRHOEAL
DISEASE
RESEARCH,
BANGLADESH

C O N T E N T S

INTRODUCTION

The ICDDR,B Donors' Consortium, meeting in Dhaka, Bangladesh on March 25 and 26, 1987, made a number of recommendations which are appended. In recommendation 15, the Consortium members agreed to meet again in Geneva, on Saturday, June 27, 1987 to discuss the following issues:

- Statement of policies and priorities (see recommendation 4);
- Proposals on the financial issues (recommendations 6 and 9);
- Future arrangements for the Donors' Consortium, including its relationship to the Board of Trustees and the timing and venue of its meetings.

This document covers these three topics, as background for the forthcoming Geneva meeting. It is complementary to the "Plans and Prospects" which were discussed by the donors in March 1987. It is, however, still a draft, prepared by the Centre's Director and his senior collaborators, and amended by some Board Members. It will be reviewed by the full Board in mid-June after which the final version will be submitted to the Donors' Consortium. In the meantime, this draft will have been circulated.

I. POLICIES AND PRIORITIES

A. BACKGROUND

The following is the full text of the Consortium's request in recommendation 4 for a statement on policies and priorities:

"The Consortium emphasized the need for the Centre to develop a more detailed statement of its policies and priorities, both programmatically and geographically, in the fields of research, training and services over the next five years. This statement should take into account the policies and priorities of the WHO/CDD Programme and other international initiatives related to the work of the Centre. This statement should include, inter alia,

- a clarification of the Centre's international role in research, training and services;
- guidelines on the relative importance of research, training and services; on the mix of basic and applied research, on the Centre's role in operational research; on the types of training to be specially emphasized; and on policy towards all forms of services activity;
- a statement of the specific priorities within research, training and services, including an indication of the timing of various elements and of elements that would be emphasized if the funds being sought were not available;
- the implications for the future staffing of the Centre. ..."

Before dealing with these issues, it is probably useful to quote two pieces of background which constitute the Centre's basic mandate. The first quote is extracted from the Centre's Ordinance as published by the Government of Bangladesh at the end of 1978:

"4. Headquarters of the Centre.

(2) The Centre may establish such subsidiary offices or research stations as may be decided by the Board as being necessary for effective conduct of its programme subject to the approval of the respective governments.

5. Aims and objectives of the Centre.

(1) The aims and objectives of the Centre shall be:

(a) To function as an institution to undertake and promote study, research and 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 for the prevention and control of diarrhoeal diseases and improvement of public health programmes with special relevance to developing countries.

(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.

(2) In fulfilling the above aims and objectives, the Centre shall have responsibilities:

(a) To conduct clinical research, laboratory and animal experiments, epidemiological and survey research, field investigations, demonstration projects, within the applicable laws and regulations, or concurrence where necessary, of the Government and other countries where it may be appropriate; to hold meetings and to arrange lectures, seminars, discussions and conferences, both international and national, on clinical medicine, epidemiology, basic medical sciences, bio-statistics, demography, fertility and other social sciences relating to studies of diarrhoeal disease control and public health, in this section referred to as the studies.

(b) To publish books, periodicals, reports and research and working papers on the studies.

(c) To establish and maintain contact with scholars and their work on the studies through collaborative studies, seminars, exchange of visits or otherwise.

(d) To undertake studies on behalf of or in collaboration with other institutions.

(e) To maintain hospitals, clinics, laboratories, animal research facilities, libraries, reading rooms, scientific equipment and instruments, as

well as vehicles, boats and other transport for its proper functioning.

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

(g) To undertake a systematic staff development programme.

(h) To institute fellowships for different categories of professional workers on the studies.

(i) To create within itself, from time to time, branches, divisions, sections and other units for proper and efficient conduct of the activities of the Centre in different fields of the studies.

(j) To accept endowments, gifts, donations, grants, other funds, payments for services and to earn income.

(k) To take such other actions as may further the aims and objectives of the Centre."

The second quote is from the report of the Interim International Committee (IRC) convened in Geneva, early in 1979:

"Careful attention will be given to co-ordination of research and training activities of the Centre with those of Bangladeshi institutions as well as with regional and global efforts."

B. Clarification of the Centre's International Role

1. Both documents indicate that the Centre is expected to play an international role "with special relevance to developing countries" and not simply a national role in Bangladesh.

2. Though the Centre's three areas of activity, research, training and service are explicitly mentioned in the

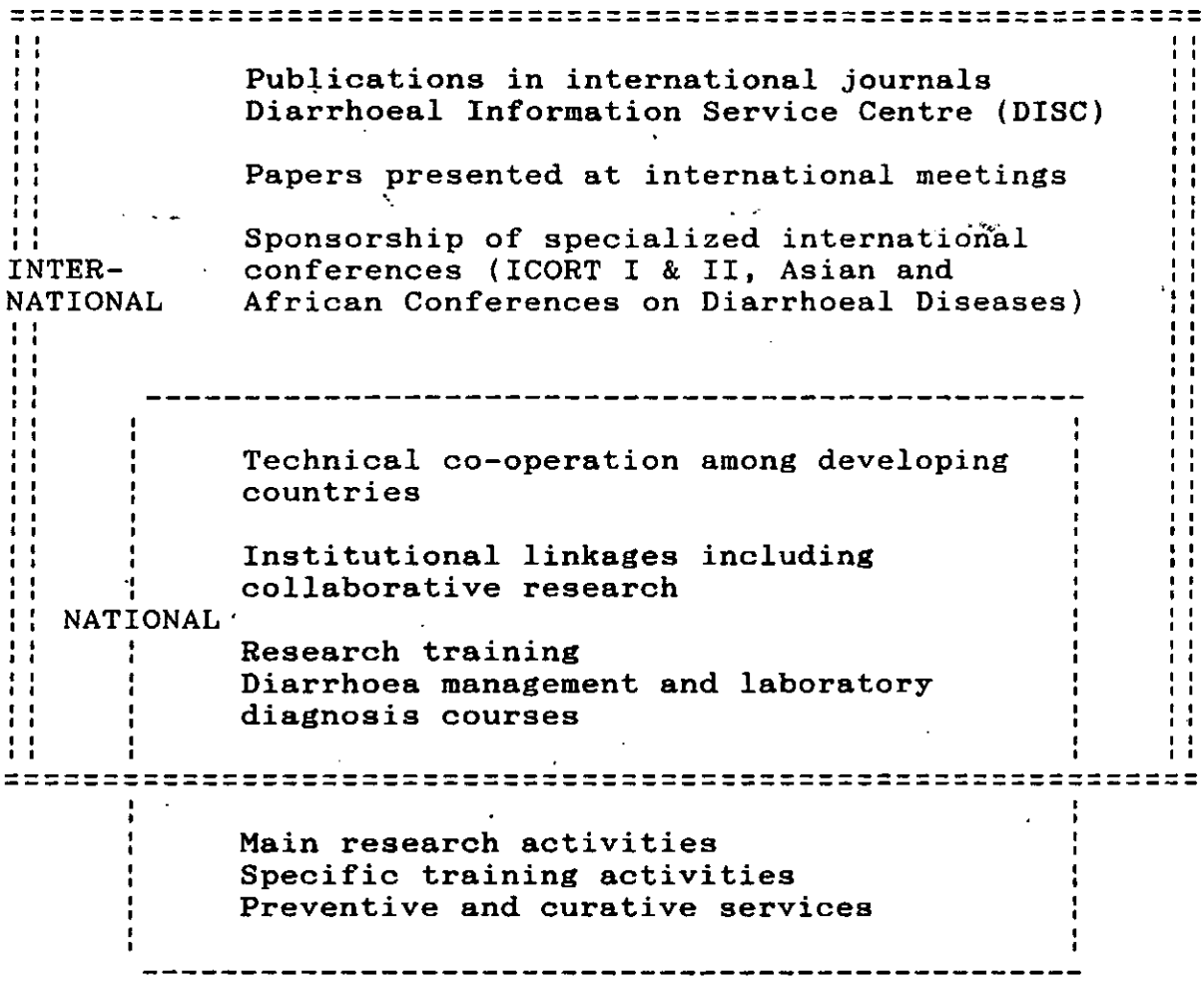
Ordinance (5. (1) (a) and (2) (e)), guidelines on geographic or programmatic priorities have been left to the Centre's Board of Trustees and its senior management.

3. As a relatively small research-oriented organization, the ICDDR,B cannot and should not aspire to be active in all developing countries. Nor does ICDDR,B deal with country-wide activities or programmes. What it does do is deal with many types of diarrhoea-related problems and with health professionals of many nationalities. In fulfilling its international role, the geographical extension of the Centre's activities varies according to the nature of those activities. See Figure 1, next page.

4. International Activities

4.1 Publication: scientific papers contributed for publication in international journals constitute, by definition, a world-wide, and possibly the best, mode of mass communication with other scientists. In addition, ICDDR,B itself, under its programme "Diarrhoeal Information Service Centre", publishes The Journal of Diarrhoeal Diseases Research (JDDR) quarterly, Glimpse a bimonthly information bulletin, and the Annotated

Figure 1. Geographical extension of ICDDR,B's activities. (For details, see text).



Bibliography series, reaching an audience in 118 developing and 33 industrialized countries.

4.2 Presentations at meetings, seminars, congresses. (There is no participation without presentation and only if funding for travel is available).

4.3 ICDDR,B, in a limited number of cases, has joined others in co-sponsoring and helping to organize

international conferences. (Since 1985 no core funds have been used for this purpose). The two international conferences on Oral Rehydration Therapy, ICORT I and II, called by USAID, with UNICEF, the World Bank, WHO and ICDDR,B as co-organizers, offered good mutual contacts for scientists and health administrators world-wide.

It would seem that the Asian and African conferences have considerably stimulated the interest for research and care in diarrhoeal disease. The role played by ICDDR,B, which participated together with UNICEF, WHO and interested donors, has been appreciated by the organizing committees. This role was mainly to help find funding, to participate in the practical organization and to give technical assistance for abstract- and report writing.

Future involvement of ICDDR,B in international conferences will depend on an evaluation of the needs, the wishes of the scientific communities in the countries involved, further interest of UNICEF, WHO and possibly other international organizations (such as the "Centre International de l'Enfance" (CIE), Paris) and level of donors' support.

4.4 Technical co-operation among developing countries

(TCDC). This has never been more than a small part of ICDDR,B's activities. It is presently limited to helping run two diarrhoeal treatment centres in Saudi Arabia. Also, ICDDR,B's scientists sometimes act as short-time consultants in other developing countries on request, subject to specific funding being provided. In the recent past, consultants went to China, Egypt, Kenya, Saudi Arabia, Viet-Nam and Zimbabwe. Requests to go to Sudan and Yemen had to be refused because of lack of staff.

4.5 Institutional linkages and collaboration: The ICDDR,B has contacts with individuals and institutions from both developing and industrialized countries including Australia, Bangladesh, Belgium, Burma, Canada, China, Denmark, Finland, France, India, Japan, Kenya, Saudi Arabia, Sweden, Switzerland, United Kingdom and USA, and from WHO. Collaborative research and institutional linkages should be strengthened. Donors are urgently being requested to earmark special funds for this purpose.

4.6 Briefing of decision-makers: Short visits (hours to 1 or 2 days) of Ministers of Health and/or health officials to the Dhaka Treatment Centre and Matlab area. The two last groups of visitors came from Nigeria and Iran and were invited by an

international organization.

4.7 Research training: Medium (weeks) to long-stay (months) visits of scientists; from the developing countries at the request and with the support of governments, private foundations or international organizations, mainly UNICEF and WHO; from developed countries with the support of their own government or private means.

4.8 Training courses: The place of Bangladesh on the world-map, English as the country's international language and Islam as its main religion all influence ICDDR,B's international activities, especially in the field of training. Thus it is easy to understand that the Centre has been requested to organize training courses for health professionals from 35 Asian, Pacific and Anglophone African countries (Table 1, next page). The absence of Francophone African, and Central and South American countries is conspicuous, but not surprising.

5. National Activities

5.1 Research: ICDDR,B does its research mainly in Bangladesh. The results, however, have global relevance through training, publications, and collaboration with individuals and institutions in many countries (see para 4.5 above).

Table 1.

Countries from which nationals have received training at ICDDR,B

Asia and Pacific			Africa
Afghanistan	Kuwait	Saudi Arabia	Egypt
Bangladesh	Malaysia	Sri Lanka	Ethiopia
Bhutan	Maldives	Syria	Sierra Leone
Burma	Marianas	Thailand	Sudan
China	Marshall Islands	Tonga	Swaziland
Eastern Caroline Islands	Nepal	Vanuatu	Tanzania
Hong Kong	Pakistan	Viet-Nam	Uganda
India	Philippines	Yemen	Zambia
Indonesia	Republic of Korea		
Iran			

5.2 Training: In the training area, many more Bangladeshi than other nationals have profited. Of more than 10,000 persons trained since 1979, 90% have come from our host country, the majority being primary health care professionals, medical students, NGO workers, urban volunteer workers, family welfare assistants, etc. The foreign students generally sought a much higher level of training. Nevertheless, far more Bangladeshi scientists than other nationals participated in high-level research training (both at ICDDR,B and abroad).

5.3 Service: Quite logically, the medical, service-related activities are purely national. Yet, it

should be stressed that health care, be it patient or community oriented, is a necessary support for training and research. As such it acquires an international dimension (see also pp. 18).

6. Relation of "national" and "international" activities of the Centre

While most of the Centre's activities are conducted in Bangladesh, with rare exceptions their purpose is to contribute to the general, international body of knowledge on how to deal effectively with diarrhoeal diseases and closely related questions of nutrition and fertility. Because it is the site of the Centre's main work, Bangladesh benefits directly from the Centre's activities, in important ways more than other developing countries:

- Advances in knowledge made at the Centre are immediately available for application in Bangladesh, without having to wait for publication or reports at international meetings;
- Bangladeshi scientists are involved in all of the Centre's work and their steady growth in competence adds to the ability of the Bangladesh scientific community to deal with diarrhoeal diseases;

- The service activities of the Centre, which support its research and training activities, at the same time directly benefit the health of many tens of thousands of Bangladesh citizens each year;
- Field research activities of the Centre, such as the MCH-FP project, the MCH-FP extension project, and the Urban Volunteers Project, yield findings that are applicable in Bangladesh for replication throughout the country;
- Training activities of the Centre are more easily available to Bangladeshis than to citizens of other countries, if only because of proximity and ease of access, and it is not surprising that several times as many Bangladeshis have been trained at the Centre as citizens of other countries.

All these benefits to Bangladesh are natural and appropriate, because Bangladesh is the host country for the Centre, and contributes in important ways to the Centre's functioning. At the same time, the Board of the Centre is continually aware of the need to maintain a proper distribution of the energies of the Centre in two respects:

First, it is important to ensure that the benefits of the Centre's work are made rapidly and effectively

available to other developing countries, and not only to Bangladesh. The normal processes of publication and presentations at international meetings are important for this purpose. So are the various types of training courses offered by the Centre. At present, the Board considers that greater emphasis needs to be placed on encouraging research trainees from other developing countries to work at the Centre; it welcomes the recent initiative of the South Asian Association for Regional Co-operation (SAARC) in this direction. Furthermore, the Board believes it will be important for the Centre to develop sustained collaborative research relationships with scientific centres in other developing countries. Such collaborative research relationships will not only enhance the extent and quality of the research that is underway, but will also create strong communications networks to make research ideas and findings quickly available in a number of developing countries.

Second, it is important to ensure that the Centre maintains its role as an international research and training agency, and does not become simply a part of the health system of Bangladesh. To take an extreme example, simply to illustrate the point: it would clearly be wrong if the Centre were asked to take responsibility for guiding and directing a national

anti-diarrhoeal disease campaign in Bangladesh. That should clearly be the task of a national Bangladeshi institution, and would not be appropriate for an international organization like the Centre.

7. On the co-ordination with WHO, UNICEF and other international organizations

The ICDDR,B, though an independent international organization, needs to have close links with other far more important health-related organizations with far broader mandates, more particularly WHO and UNICEF. The links with WHO can be summarized as follows:

(i) The WHO/CDD research priorities serve as a guide to the Centre's scientists;

(ii) Senior scientists and alumni from ICDDR,B are among those advising WHO/CDD on the choice of priorities;

(iii) The ICDDR,B receives funding from WHO/CDD for several of its scientific protocols. The number of ICDDR,B protocols has sharply increased over the last years. Presently, six protocols are funded for a total figure of $171,000;

(iv) WHO/CDD has stimulated, and contributed to, the development of certain protocols it felt were of high priority and fitted the ICDDR,B's capabilities.

(v) A major project, the oral cholera vaccine trial, has been carried out in close collaboration with WHO/CDD (and the Government of Bangladesh);

(vi) Several ICDDR,B scientists or alumni are members of the steering committees of the CDD programme;

(vii) Visits from CDD staff to ICDDR,B have contributed to our scientific programmes and to our teaching activities and their evaluation.

(viii) It is expected that before the end of 1987, one of the senior staff members of WHO/CDD will become a scientific associate director of ICDDR,B;

(ix) The Director, WHO/CDD programme, serves on the Board of Trustees of ICDDR,B and the Director, ICDDR,B serves on the CDD Technical Advisory Group.

There is, as it logically should be, an almost total agreement between the WHO/CDD scientific priorities and the scientific activities of ICDDR,B, the latter being of course more limited than the former. The following table lists the CDD priorities that are the subject of research protocols at ICDDR,B. (Based on "Biomedical and Epidemiological Research Priorities of Global Scientific Working Groups - WHO/CDD/RE8/86.8 with numbers in brackets referring to this document).

Table 2. WHO/CDD priorities being the subject of ICDDR,B research protocols.

	WHO/CDD priorities	ICDDR,B research protocol
2.1.1.2	Rotavirus antibodies and prior infection	(+)
2.2.1.1	Cholera vaccine trial	+ * ^
2.2.1.3	Shared ETEC antigens	+
2.2.1.4	S. dysenteriae I vaccine	+ ^
2.2.3	Simple diagnostic tests	+
2.2.3.1	V. cholerae 01 phage typing	(+)
3.1.1	Improved defined-solutes ORS	+ * + * ^
3.1.2	Cereal based improved ORS	+ + ^
3.2.1	Early home therapy	+ ^
3.3	Nutritional management of acute diarrhoea	+ ^
3.4.1	Testing of antidiarrhoeal drugs	+ *
3.4.2	Traditional therapies	+
3.4.3	Antimicrobial agents	+ + *
3.4.4	Treatment of severe shigellosis	+
3.5.1	Clinical studies of persistent diarrhoea	+ (+)
4.2.2	Impact of personal and domestic hygiene	+ ^
4.2.3	Effect of Vit. A. deficiency	+ (+)
4.2.4	Impact of water and sanitation	+
4.2.6	Protective effect of breast-feeding	+
4.2.7	Measles-associated diarrhoea	+ ^
4.2.8	Role of zoonotic reservoirs	(+)
4.3.1	Risk factors for severe diarrhoea	+
4.3.2	Persistent diarrhoea	+ ^
4.3.3	Epidemiology of poorly understood agents	+
4.3.3.1	V. cholerae reservoirs	+
4.3.3.2	S. dysenteriae I transmission	+ *
4.3.3.6	Giardia lamblia population studies	(+)

( ) finished or planned protocol
+/++ one/more protocols
^ WHO/CDD highest priority
* funded by WHO/CDD

As a matter of fact, all biomedical research protocols at ICDDR,B concern topics included in the WHO/CDD priorities and almost all these priorities are represented in ICDDR,B research activities. Only the important areas covered by demographical studies and family planning studies stand on their own.

Links with UNICEF have been more limited but are very important:

(i) Several ICDDR,B research and teaching activities have been and are being funded by UNICEF;

(ii) The EPI strategy as advocated by UNICEF is being implemented and evaluated in the Matlab area;

(iii) UNICEF has been one of the first donors to give extra support to ICDDR,B when the latter's financial crisis became apparent;

(iv) UNICEF is represented on the ICDDR,B Board of Trustees.

There have been brief but positive contacts between the "Centre International de l'Enfance" in Paris and ICDDR,B.

While limited to Bangladesh, the collaboration between several INGO's, more particularly the "Save the Children Fund", and ICDDR,B is very rewarding.

8. Summary and Conclusions

Considering figure 1 and the explanatory paragraphs on pages 4 to 10, it would seem that, in the past, the ICDDR,B has not unsuccessfully fulfilled the mandate stipulated in its Ordinance, including its role as an international organization.

Looking to the future, the anticipated directions would be according to the following priorities and will have to take into account constraints and needs. The sequence followed below is that of figure 1 on page 6.

Future Directions	Constraints/Needs	Priorities
6.1 Publications in international journals		
Increase, with quality more important than quantity.	More senior scientific staff. More research collaboration.	High
6.2 Diarrhoea information service publications		
Maintain and improve.	Further donor support. More staff. Possible closer collaboration with Bangladesh National Medical Library.	High

Future Directions	Constraints/Needs	Priorities
6.3 Papers read at international meetings		
Not a priority area; only if scientists have high research productivity.	Earmarked funds. Teaching seminars to be preferred above big international congresses.	Low to Medium
6.4. Sponsorship of conferences		
On an "ad hoc" basis.	Only if in collaboration with other international organizations and funding available.	Low to Medium
6.5 Technical co-operation (TCDC)		
On an "ad hoc" basis.	Only if specific requests, and funding available.	Medium
6.6 Institutional linkages and collaborative research		
An absolute requirement.	More senior staff to organize and direct collaboration, and ensure "counterpartship". More earmarked funds. Collaboration with WHO.	Very High
6.7 Research Training		
For own staff special efforts in statistical demography, epidemiology, clinical specialities, writing skills. Great opportunities for scientists from developing and industrialized countries.	More senior staff, more laboratory bench space and office space. Collaboration with WHO.	Very High

Future Directions	Constraints/Needs	Priorities
6.8 Clinical management and laboratory courses		
Infrastructure for diarrhoea management and laboratory courses in 3rd-world setting certainly a strength of ICDDR,B. Training of trainers still very important.	Evaluation of needs in Asia and Africa. Close collaboration with other institutions, including WHO and UNICEF (and CIE?).	High
6.9 Main research activities		
The "raison d'être" of ICDDR,B. To be maintained and fostered with all available means.	Lack of top-level senior scientists. Better salaries and career structure to attract and maintain local and regional scientists. Salaries for international level scientific staff is becoming critically low. Capital funds to maintain and upgrade research infrastructure.	Very High
6.10 Specific (national) training		
Clearly to be continued at all levels.	Funds.	Very High
6.11 Health care services		
To be maintained because of ethical obligation and as necessary support for research and training.	Support from Govt. of Bangladesh and all other donors.	Very High

It is obvious that the scores given here are very skewed. "Very high priority" appears five times, "high" three times, "medium" once, "medium to low" twice and low not at all. It is submitted that this corresponds to the reality: none of the activities performed at ICDDR,B are not explicitly mentioned in the Ordinance; Research is the backbone, with health care, training and dissemination of information as its necessary complements; to perform its tasks ICDDR,B does need, among other things, institutional linkages: science cannot be done in isolation.

C. GUIDELINES

1. On the relative Importance of Research, Training and Service

The Ordinance mentions research, training and health care, without specifying the relative importance of the three components, a matter which is viewed differently by various donors.

Research, training and health care are interrelated. Health care services are the necessary basis for research and training. Training requires the support of both service and research lest it lose its contact with reality; research needs clinical and

epidemiological data to maintain a proper focus.

ICDDR,B is carrying out clinical and pathophysiological research on sick persons, and field research on population groups in which health is at best precarious, in a poor country with high levels of morbidity and mortality and very limited health resources. In these circumstances, an institution like ICDDR,B and its donors have to accept the moral obligations and the practical necessity of providing preventive and curative care. In the case of ICDDR,B it must also be stressed that what is called "service" or "health care" comprises not only service as such, but also research support without which applied research including operations research cannot be accomplished. Furthermore, our close contacts, which are to be maintained and strengthened, with the Ministry of Health and Family Planning, and with Bangladeshi colleagues, should lead to sharing an increasing part of our activities with national institutions, especially in the service area. Yet, this will take time and will also require further funding.

The evolution of the distribution of the Centre's expenditures since 1981 is not unsatisfactory (Tables 3 and 4, pages 23 & 24 respectively). The figures since 1985 compare very favourably with those of the International Agricultural Research Centres, which have

no services component. Management and central services, inevitably expensive in a country like Bangladesh, have fallen from 44% to 21% of the total budget or, in absolute terms, from US$ 2,528,000 (1981) to $ 1,886,000 (1987 projected); in the meantime, the ICDDR,B has grown considerably.

Taking the costs for research as 100%, the corresponding percentages for training, health care, and management and central services in 1981, 1983, and 1986 are shown in Table 4.

Table 3: Shares of total expenditure 1981 - 1987 (in US $ thousands and column percentages)

	1981	1982	1983	1984	1985	1986	1987*
Rsch	2,174	1,797	2,137	3,975	4,721	3,823	4,460
%	37	40	38	50	52	50	51
Trng	370	186	333	363	598	834	847
%	6	4	6	5	7	11	10
Hlth Care	741	564	796	995	1,372	1,397	1,654
%	13	13	14	12	15	18	18
^Mgmt & Ctrl Serv.	2,528	1,957	2,398	2,595	2,324	1,655	1,806
%	44	43	42	33	26	21	21

* projected
^ includes the 5 most senior scientific staff members

Table 4: Proportions of total expenditures spent for research, training, health care, and management and central services (M & CS). Research expenditures taken as 100%.

	Research	Training	Health Care	M & CS
1981	100	17	34	116
1983	100	16	37	112
1986	100	22	36	43

In 1981, for every 100 US$ spent for research, an unacceptably high figure of $116 was required for management and central services; in 1986, the corresponding figure is $43, 63 per cent less than in 1981 and 62 per cent less than in 1983.

Some suggested guidelines for future expenditure are as follows:

(i) Research is our "raison d'être". It has become and must remain ICDDR,B's most important activity. The existence of health care activities must be acknowledged as a necessity. They contain an important research support component, and have also their own value.

(ii) The proportion of expenditures for research (50%) to those for training (11%), health care (18%), and management (21%), achieved in 1986 is not unsatisfactory.

(iii) Still, the cost of Management and Central Services must be further reduced, if at all possible.

(iv) Research costs must remain at least 50% of total expenses or above.

(v) Training must receive full attention. The needs for training must be evaluated, and ICDDR,B's specific strengths in this area should be used as efficiently as possible (see p.30).

(vi) Health care should be maintained but need not be further expanded, except in terms of quality, and of its contribution to research and training. The recently obtained specific financing for health care should, if at all possible, be increased.

2. On the mix of basic and applied research and on operational research

Clearly, owing to its location and the problems it is mandated to deal with, the ICDDR,B has to focus on applied research, including operations research. It is therefore that 94 per cent of the research budget is for applied research. For the same reasons important applied research infrastructures have been set up including the Dhaka Treatment Centre, Matlab and Teknaf Stations, the Urban Volunteer Programme and the Extension Programme.

Potential policy and programme implications are always

considered when planning the ICDDR,B's research (also basic research) and service activities. In that context, operations research plays a significant role by

- analysing problem situations and examining the causes for success or failure of intervention activities be they research or service oriented;
- testing new strategies in service delivery (for cost-effectiveness, feasibility, acceptance rate, etc.);
- evaluating alternative interventions in clinical and especially field settings.

Some examples of the Centre's ongoing work with an operations research component are trials with different types of oral rehydration therapy, EPI strategies, maternal and child health-family planning approaches, and low-cost, self-help service delivery in the slums of Dhaka.

Operations research should be a part of all ICDDR,B research and service activities. As a formal discipline, it should be practised more intensively, which would require an increase in expert senior staff.

Notwithstanding its orientation towards applied and operations research, the Centre does devote a rather

limited amount of its resources to basic research which in future could open up new frontiers on the applied side. For, in the biomedical sciences, what is considered basic now, might be applied a few years later. Thus, the choice of topics in the area of basic research itself is made keeping in view their potential interaction with applied research and implications for future applications in better clinical management and service operations.

It is interesting to recall, in this context that the ORS story began with a basic physiological discovery which led to important practical applications. On the other hand, the clinical observation of a U.S.A. doctor that a boy with anaemia had peculiarly shaped red blood cells led to identifying sickle cell anaemia. While this hardly has helped the millions of patients suffering from this severe disease, it was the starting point of much basic research, increasing our knowledge of genetics, molecular biology and protein chemistry. Which type of research, basic or applied, leads to which type of discovery, if any, is impossible to predict.

Being located in a developing country, it is of course necessary for ICDDR,B, in its research activities to put heavy emphasis on clinical, epidemiological, field

and applied laboratory research, supported by high-quality but limited own basic laboratory research.

One of the fundamental ideas that led to the creation of ICDDR,B was to bring the scientists where the problems are. The idea is still fully valid but the Centre has not enough financial means to satisfactorily realize it and hire a sufficient number of scientists at the national or international salary level. With its present infrastructure, despite a chronic lack of capital funds, ICDDR,B is a very powerful research tool. Yet, it is severely underutilized.

To partially compensate for this and to achieve rapid research advances, ICDDR,B needs to be more closely linked to a number of centres having strong competence in, and facilities for, a wide variety of scientific disciplines such as epidemiology, clinical research, biostatistics, statistical demography and advanced biotechnology. Together, its collaborating partners and ICDDR,B will be able to bring to bear the full range of research methodologies to attack the very urgent problems of ICDDR,B's mandate.

However important institutional linkages with centres in industrialized countries may be, ICDDR,B must be able to stand on its own feet, and also to offer help

and collaboration to centres in its host country, its surrounding region and other developing countries. ICDDR,B has to be an equal partner, and has to share its relative advantages with others.

In the last two years, progress has been made in the areas outlined in this section.

- Basic research, especially in the fields of antimicrobial immunology and bacterial genetics, has been expanding at ICDDR,B. Still, for 1987, out of a total research budget of $4,400,000 basic research will cost $275,000 or only 6 per cent. In the following years, this should be allowed to rise to about 10%, but in any event the Centre should retain its heavy emphasis on applied research.
- Institutional linkages and/or collaborative research have been strengthened or initiated
  * in developing countries, with centres in Bangladesh, Burma, China and Kenya (collaboration with Indian and Pakistani institutions being prepared);
  * in industrialized countries, with centres in Australia, Belgium, Denmark, France, Japan, Sweden, Switzerland, the United Kingdom and the United States.

3. On the types of training to be specially emphasized

Training and other forms of dissemination of knowledge are one of the mandated activities of ICDDR,B. The Ordinance is very clear in that respect: see 2 (5. (1) (a) & (b)) and p.3 (5. (2) (a)m (b), (c), (g), (h)).

Training as such has four main aspects at ICDDR,B:

(i) Various training activities

(ii) Formal training Courses

(iii) Staff Development

(iv) Research training

What is called here rather vaguely various training activities responds to a great variety of training needs: courses for trainers from the Bangladesh Rural Advancement Committee, Civil Surgeons and other government doctors, a customized training in laboratory methods for a doctor from Sierra Leone, health education sessions for mothers in the Dhaka slums, training of urban volunteers or community health workers. There is much activity, much variety, and a lot of good work going on almost unnoticed.

The formal training courses have been mentioned on page 9. ICDDR,B's Dhaka Treatment Centre might well be one of the best places in the world to see, in a third-world setting, up to 350 patients per day being treated

for all types of diarrhoea, using simple, cheap, and reproducible methods: it certainly is eminently suited for courses on "Management of Acute Diarrhoea". The ability of the ICDDR,B's laboratories to diagnose the exact cause of diarrhoea in great numbers of patients, the abundance and variety of specimens, explain both the existence and the success of the "Laboratory Diagnosis of Infectious Diarrhoea" courses. However regrettable, ICDDR,B has, for the time being, lost the staff required for well-conducted courses in epidemiology. Yet, such a course recently given by WHO in close collaboration with ICDDR,B, and on the latter's premises, was a success.

Staff development has continued unabated, despite the Centre's financial problems. Table 5 (next page) shows the number of professional staff presently engaged in higher training abroad. It is to be noted that no central funds have been used.

As is well known, long-term training abroad can yield very positive results for the person concerned and his institution; it can also lead to brain drain or to deep frustrations. One of the ways to promote the former and prevent the latter is to make long-term training part of a well-conceived institutional linkage.

Research training. Defining "medium" and "long" as in

Table 5: Number of ICDDR,B staff who went abroad for higher training in the first five months of 1987 (Short-term ≤6 months; Medium-term >6 ≤12 months; Long-term >12 months)

Type of Training	Institution	Funding*
Long-Term		
3 Medical research training	Univ. of Buffalo (2) Inserm, Paris (1)	U.S.A. France
1 Ph.D. Population dynamics	Johns Hopkins	U.S.A.
1 Ph.D. Demography	A.N.U.	Australia
1 Ph.D. Microbiology	Ross Institute	U.K.
1 Dr. Public Health	Johns Hopkins	U.S.A.
1 M.A. Population planning	Univ. of Michigan	U.S.A.
1 M.P.H.	Johns Hopkins	U.S.A.
1 Technical training Microbiology	Univ. of Brussels	Belgium
Short-term		
1 Data analysis	A.N.U.	Australia
1 Library automation	I.D.R.C.	Canada
1 Research methodology course	WHO/CDD	W.H.O.

* Only the country (or organization) is mentioned, not specific agencies.

the legend to table 5, research training has been offered in 1987 to 16 individuals. (The starting date of their stay at ICDDR,B may have been prior to 1

January, 1987). Thirteen are medium-stay, three long-stay. Thirteen also are from Bangladesh; this figure includes 11 M.Sc. students from Dhaka University who are doing their thesis-work at ICDDR,B. The three other ones are from China, Finland and Holland, respectively.

The guidelines for the future seem obvious

(i) As a mandated activity, ICDDR,B must continue its training for "Bangladeshi and other nationals ... in collaboration with national and international institutions"; clearly, the two most important institutions are UNICEF and WHO. Collaboration with both of them must be further expanded.

(ii) In case of funds being limited, the stress should be laid on "various training activities", followed by staff development and research training.

(iii) The considerable strengths of ICDDR,B as a rather unique venue for courses must, however, again be stressed. These strengths are clinical and field diagnosis and treatment, including epidemic prevention and control, and laboratory diagnosis of diarrhoeal diseases. Outside diarrhoeal diseases, demography and family planning are to be mentioned.

(iv) To properly use ICDDR,B's strengths in training, one should, in close collaboration with UNICEF, WHO and interested donors, establish the training needs and requirements in countries and regions that already have a long association with ICDDR,B in this area. This evaluation should be started without delay.

(v) A competency-based, learner-centred approach to training and training of trainers are important general guidelines.

4. On policy towards all forms of service activity

The ICDDR,B, like any other research institution of its kind, must accept some responsibility for providing services in two broadly differing situations.

Most clinical research is carried out on sick patients whose health and welfare is the prime consideration. Responsibility for patients being cared for in ICDDR,B facilities lies squarely with the ICDDR,B. This must be the case as our research premises are not located in a hospital run by another organization, nor can the bulk of our clinical research be readily carried out in another institution. Furthermore, it is not possible to selectively attract and admit only individual patients of research interest, nor is it reasonable to

redirect large numbers of sick patients to other treatment facilities which are often relatively inaccessible. Our Dhaka Treatment Centre must and does confine itself to diarrhoea and related diseases. The annual case load has become more or less steady in terms of numbers though, appropriately enough, it is the more seriously ill patients who seek our help.

Studies in the community bring with them a different kind of responsibility. Most involve repeated contact with people, sometimes well, often sick. In this situation the ICDDR,B must assume some responsibility for helping the seriously ill to obtain treatment. Even in the case of very limited financial resources, we must provide treatment at least for the diseases we study: diarrhoea and related illnesses. When our project infrastructure permits, we should also provide selected preventive services. When ICDDR,B provides regular large-scale services it does so in a systematic way which permits evaluation and research of operational methods. Again, the separation of service from research and training is rather artificial. Though our community studies have increased and the quality of selected services improved, the proportion of our total costs which is devoted to services has increased only marginally.

The following guidelines are being proposed:

(i) ICDDR,B should not seek to run wholly service activities in the community.

(ii) Wherever possible, members of our patient communities should be encouraged to use existing Government of Bangladesh and NGO preventive and treatment facilities. This option is becoming increasingly realistic and is actively pursued.

(iii) Still, health care activities do have a value as such. Maintaining them at the present level or even decreasing that level when possible does not mean that costs will remain stable. To the contrary, costs are bound to increase; in Bangladesh, the rise in UN salaries will play an important role in this process. Anyhow, further and expanded funding for the existing services should be sought.

(iv) Finally, it shall be understood that the question of the mix of service with research and training is not an open-ended question. It is largely constrained by the nature of our research activities, the environment in which we work, and the accessibility and effectiveness of other sources of health care dealing with the diseases which we study.

D. Specific priorities within research, training and services, including an indication of the timing of various elements and of elements that would be emphasized if funds being sought were not available.

From 1981 to early 1985, the ICDDR,B has considerably increased its scope of activities. For the last two years, the Centre has strictly contained its costs, defined its priorities and started to repay its debts. Options were limited because of, amongst many other things, a drop in central (core) funding by 70% from 1984 to 1985. A major pre-occupation has been to bring to a successful conclusion established core-funded studies and to maintain the integrity of ICDDR,B's infrastructure.

Any ranking within the Centre's three main areas of activity might, if applied to pare down these activities, weaken the Centre further and possibly endanger its very existence.

To allocate different levels of priority to programmes and projects one must ignore the fact that more than 80% of the Centre's activities are project-funded; the exercise is thus a theoretical one. One must also take into account that a high level of subjectivity is inevitably involved, determined by a person's background and scientific discipline. Also, ranking might very well change with time, if and when unforeseen factors would intervene: a researcher holding a key position in a particular area may leave the

Centre or the relative importance of a topic is changed unexpectedly by new discoveries.

It is with all these caveats in mind that the following table should be read:

Table 6: Ranking of ICDDR,B's activities according to priority

	High Priority	Medium Priority	Low Priority
Research	Shigellosis Cholera vaccine trial Chronic diarrhoea Child survival Demographic studies	Rehydration studies Extension project	Environmental microbiology New vaccine trials
Training	Staff development	Research, clinical, & microbiological training	Other international courses
Services (including research & training support)	(no ranking possible - see text)		

The above ranking is mostly based on the specific strengths of ICDDR,B. Part of these strengths such as trained staff, patients' confidence and physical plant have been built up over the years. Others are based on the geographical location of the Centre. It has also been taken into account which topics can be studied elsewhere, other than at ICDDR,B.

Still, any ranking scheme of the research areas will generate controversy. The ranking within the training area is rather obvious and based on very pragmatic criteria. The service activities have two main components: urban (Dhaka Treatment Centre and Urban Volunteer Programme), and rural (Matlab and Teknaf). Both are of equal value and thus impossible to rank.

The timing of various elements can be considered together with the choices which ought to be made if funding being sought were not available.

The level and type of funding is clearly of major importance. Two possibilities should be looked into. First, what would happen if the requests that were made during the March donors' consortium and which are repeated in the last parts of this document were to be refused? These requests constitute a package: a new system for defining the proportion of earmarked/unearmarked funds, cancelling the existing debt, providing money for a reserve/endowment fund and for capital funds. The last item is obviously somewhat less urgent but not less important than the others. The ICDDR,B Board of Trustees and senior management believe that such a refusal would amount to a vote of non-confidence by the donors and make impossible the survival of ICDDR,B as an international centre. Even if year-to-year funding would continue more or less at the present level, the situation would mean a continuing uphill and losing fight. Second,

what would happen if the existing financial deficits were made good, but the yearly budgets were to be considerably reduced. In practice this would occur if one or a few major donors would stop funding the projects they presently support and no other donor could be found. Serious upheaval would be caused, but the Centre might survive. Still, as in the past two years, too much time would have to be spent on issues of survival, hindering or slowing down the Centre's mandated activities. We cannot afford to continue to dissipate the talents of key scientific staff by diverting their attention and efforts to permanent crisis management.

In case of serious cuts in funding and supposing the Centre itself could define its actions, the timing element would be of importance. Slowing down research would be counter-productive: really good research must not only be of high quality and relevance, it must also proceed quickly. Training could - if absolutely required - be scaled down and spread over a longer time. On the other hand, health care services cannot be slowed down, certainly not in the curative area. Scaling down or handing over to national organizations would require much time, and funding, possibly from bilateral sources, would still have to be found. It should not be forgotten that a smaller service component would lead to less research opportunities.

Before ending this section, it should be stated again that,

to justify past investments, to make proper use of the ICDDR,B research potential and to allow the Centre to fulfil its task efficiently, more money is required, not less. The total amount involved would still be very low compared to health expenditures in industrialized countries and third-world research expenditures in non-medical areas.

E. The implications for the future staffing of the Centre

The ICDDR,B has been able to bring under control its financial crisis - not yet to resolve it. It is now facing problems with its staffing and salaries.

As to future staffing, it is proposed that the Centre needs a number of key posts at the international level in science and administration. These are the director, the heads of the four Scientific Divisions, and the heads of Resources Development and General Administration. (It has been argued by some external consultants that to these seven positions three more should be added: chief finance officer, chief personnel officer and grants administration officer - they are not included in the 1987 budget). In addition, 14 senior scientific positions should be added for the heads of the departments and main projects which, coming under the Scientific Divisions, form the backbone of the Centre (see p.50 and table 8).

To make full use of the Centre's potential, to develop and carry out research of high scientific quality, and to keep abreast of the quick pace of science it would be necessary to add at least one junior international-level scientist to 12 of the 14 heads of departments (the two biostatisticians in table 8 being excluded). They could be hired from central or project funds, or come to ICDDR,B in the framework of institutional linkages.

Over the past 6 months it has become only too obvious that the international salaries presently paid by ICDDR,B have become too low to attract well-qualified scientists, especially those with medical degrees. Salaries offered by North-American universities have risen considerably and are now much higher than those offered by the Centre. For Western Europe, the fall of the U.S. dollar against European currencies has cut the value of the Centre's salaries (expressed in the currency of the country of origin) by about 45% to 50% over the last two years. Coming to or staying at ICDDR,B amounts now to a financial sacrifice for persons from industrialized countries. The Centre has to urgently recruit for two of its four key scientific positions and at least four of its 14 senior scientific positions, and we have as yet not been successful.

Another even more worrisome problem is that of the salaries of the non-international staff, the General Services (GS) and professional National Officers (NO) staff. The Ordinance, in

its section 14(2) is brief, explicit and clear. "Salaries and emoluments of non-international level positions should be comparable to those paid by the United Nations organizations in Bangladesh". The salary increases granted or announced by the U.N. bodies since July 1984, and the Centre response are given in the table below.

Table 6a: Actual and announced UN salary increases in Bangladesh (limited here to the GS1 and the NO categories)

	Increase	Date Implemented	Retroactivity	Effective date of ICDDR,B implemtn.	Delay
Actual					
GS1	9%	1.7.84	1.1.83 (18 months)	1.1.83	none
NO	4%	1.7.84	1.1.83 (18 months	1.1.83	none
GS1	10.8%	1.7.85	1.10.84 (9 months)	1.1.86	15 months
NO	8%	1.7.85	1.10.84 (9 months)	1.1.86	15 months
GS1	10%	1.11.85	1.1.85 (10 months)	1.1.87	24 months
NO	17%	1.11.85	1.1.85 (10 months)	1.1.87	24 months
GS1	8.42%	1.10.86	1.12.85 (10 months)	not implemented	19 months*
NO	16.98%	1.10.86	1.12.85 (10 months)	not implemented	19 months*
Announced (under review)					
GS1	+64%	soon	?	?	?
NO	+25%	soon	?	?	?

* as per 1.7.87

The last increases, of 64% and 25% respectively, are expected in the near future. Those already implemented amount to a rise in nominal value of 44% (GS1) and 54% (NO) in somewhat more than two years. The announced increases will raise the above figures to 136% (GS1) and 92% (NO). From 1985 onwards, ICDDR,B had not only to delay the successive implementations but also to rule that salary increases cannot be retroactive, can only be implemented at the beginning of a new budgetary (= calendar) year, and only if included in a Board approved budget that has to show a surplus. The ICDDR,B Board of Trustees is grateful to the Centre's GS and NO staff for having accepted the necessity of this rule.

The oncoming U.N. salary increase is particularly important. To implement it from January 1988 onwards, which probably will again constitute substantial delay, the Centre needs an extra US$ 1.2 million. This salary problem illustrates the Centre's vulnerability and the gap between its funding mechanism on the one hand and its legal obligations and practical necessities on the other hand. It is obvious that ICDDR,B must rigidly control the number of its employees; it is also obvious that this will not remove the present incompatibility between financial obligations, operational means and budgetary necessities.

II. FINANCIAL ISSUES

A. Financial Needs of the Centre

One of the financial issues discussed at the March donors' meeting concerned the mechanism for future funding of the Centre and draft guidelines were prepared. There were a number of interpretations regarding the formulation which proposed that at least 50 per cent be in unearmarked funds. This section proposes an approach in developing a formula for the future funding of the ICDDR,B by using the 1987 budget as a reference point. This does not imply any judgement about whether or not the budget is too large or too small, but only to suggest how the existing activities could be allocated so as to result in a division between earmarked and unearmarked funds.

It may be helpful in developing a formula for funding ICDDR,B to begin with a number of definitions:

Central Funds - are unrestricted or unearmarked funds, and funds a donor has directed towards one of the three main programmes of the Centre - research, training and dissemination of knowledge, and health care services;

Project Funds - are project restricted or project earmarked and include both direct and indirect costs;

Direct Costs - are those expenditures which can be accurately and wholly identified with particular projects i.e. if the project were discontinued, those direct project costs would not be incurred;

Indirect Costs - are those expenditures which cannot be clearly charged to specific projects without great effort and/or expense in record keeping. Examples include service departments such as supply, finance and personnel. Included in the Centre's 1987 indirect cost pool amounting to US$ 1.9 million are the following:

- the senior scientific direction of the Centre including the Director and heads of the Clinical Sciences, Laboratory & Epidemiological Sciences, Community Medicine and the Population & Extension Divisions	US$	395,000
- the Resources Development Division including public information services	US$	159,000
- the Administrative Services Division including the common finance, personnel, supply and other administrative services required to support all Centre programmes	US$	1,382,000
	US$	1,936,000

In order to determine what might constitute an appropriate split between central and project funding, reference to the 1987 budget may be useful. As table 7 (next page) indicates

Table 7:

INCOME AND EXPENDITURE ACTUAL FOR 1986 AND BUDGET FOR 1987
(In thousand US $ Dollars)

PROGRAMME AREAS	1986 Actl. Expenditures	1987 Expenditures	1987 Income Sources: Project Direct	Funds Indirect	Central Funds
1. RESEARCH					
Shigellosis	194	800	800		
Vaccine Trials	1,076	900	900		
Rehydration and Feeding	284	185	185		
Chronic Diarrhoea	7	120	120		
Child Survival	195	300	300		
Extension of Research/Services	896	1,040	1,040		
Demographic Surveillance and Studies	775	805	805		
Environmental Microbiology	0	100	100		
Other	396	210	210		
Sub-total	3,823	4,460	4,460		
2. TRAINING AND EXCHANGES					
Courses	222	347	347		
Int.Conference	62				
TCDC	550	500	500		
Inst.Linkage					
Sub-total	834	847	847		
3. HEALTH CARE SERVICES					
Treatment Centres	907	1,000	300		700
*Community Health	490	650	650		
Sub-total	1,397	1,650	950		700
4. MANAGEMENT AND CENTRAL SERVICES					
Scientific Management	317	395	265		130
Central Services	1,372	1,541		1,144	397
Sub-total	1,689	1,936	265	1,144	527
GRAND TOTAL	7,743	8,893	6,522	1,144	1,227

* includes 90 percent of Urban Volunteer Programme and all of MCH-FP health services.

the main budget items are Research, Training, Health Care and Management and Central Services. Distributing the Management and Central Services costs of US$ 1.9 million and prorating these indirect costs to each programme gives the following results:

1987 BUDGET
(U.S.$ thousands)

PROGRAMME	PROGRAMME COSTS DIRECT	INDIRECT	TOTAL	%
RESEARCH	4,460	1,241	5,701	64%
TRAINING	847	236	1,083	12%
HEALTH CARE	1,650	459	2,109	24%
	6,957	1,936	8,893	100%

INDIRECT COSTS AS A PERCENT OF TOTAL COSTS 21.8%
INDIRECT " " " " " DIRECT " 27.8%

In the Plans and Prospects document dated February 1987 the reasons supporting the ICDDR,B requirement for central funds are discussed in some detail:

"- to provide an assured source of funding for the senior leadership of the Centre, who are responsible for designing and managing the Centre's programme; there will only be a limited number of these senior leaders, but their positions require the assurance of independence and continuity that unearmarked central 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 programme ideas; and

- to support continuing relationships and 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."

For the most part these expenditures are now a part of the 1987 budget (see table 7, p.47), and therefore also do not imply an expansion in the total budget but rather a shift from project to central funds. The proposed direct costs include:

(i) Scientific Leadership - US$ 0.7 million

Fourteen key scientific positions have been identified at the international level, in addition to the senior scientific management (Director and four Associate Directors) to provide leadership and project management. Of those fourteen, eleven are currently included in the 1987 budget at a cost of US$ 700,000. What is proposed is that they all be paid from central funds to stress the nature of their relationship to the Centre and to provide continuity. A list of the key

positions is shown in table 8.

Table 8: Key scientific management and scientist positions

	DIRECTOR			
CLINICAL SCIENCES DIVISION	LAB. & EPID. SCIENCES DIVISION	COMMUNITY MEDICINE DIVISION	POPLN. SCIENCES & EXTENSION DIVISION	TOTAL
Associate Directors				4
Departmental or Project Heads				12
- Child Hlth. - Research - Clin.Care	- Lab. Serv. - Research	- U.Vol.Prog. - MCH-FP - Nutrition - Epidemiology	- D.S.S.(2) - MCH-FP Ext.	
Biostatistitian (1-2)				1-2

Notes: The Director and Associate Directors are designated as scientific management and the others as providing the necessary minimum scientific leadership. Of the fourteen, eleven are now on staff or expected to join and included in the 1987 budget. Three (a demographer and the two biostatisticians) are not budgeted for but required.

(ii) Treatment Centres - US$ 1.0 million

In 1987, of the US$ 1.7 million in Health Care Services costs, US$ 1.0 million was for the treatment centres and the balance associated with the urban volunteer and MCH-FP programmes.

Treatment Centre costs should be part of centrally funded operations. Because of their very nature they cannot, like most projects, be dropped if project funding should cease. It is recognized that for 1987 about $ 300,000 of the total cost will be provided by Danida through their $500,000 in project funding. Nevertheless it is proposed that $ 1.0 million be included for treatment centres as part of central funds for formula calculation purposes.

(iii) Scientific Innovation and Project Development Fund - US$ 1.5 million

The Centre should have assured annual access to US$ 1.5 million for projects that are not dependent on project funding. The main purpose would be to further strengthen institutional linkages and continue or start projects which do not fit easily with any donor priorities but are part of the previously reviewed and agreed programme priorities of the Centre. It would also support scientific innovation and exploratory research initiatives, including basic research, which may or may not lead to project proposals.

(iv) Research Training and Dissemination of Knowledge - US$ 0.5 million

In order to provide research training, disseminate knowledge and strengthen national institutions: a minimum of $ 500,000 should be available on a

continuing basis in future years.

The following table summarizes the foregoing expenditures proposed for payment from central funds:

- key scientific leadership	$ 0.7 million
- treatment centres	1.0
- research projects	1.5
- research training & dissemination	0.5
TOTAL CENTRAL FUNDED DIRECT COSTS	$ 3.7 million

The 1987 budget presented in the table on page 48 of this document would now look as follows (in US$ thousands):

	CENTRAL FUNDS		PROJEC FUNDS		TOTAL	
PROGRAMME	DIRECT COSTS	INDIRECT COSTS	DIRECT COSTS	INDIRECT COSTS	US$	%
RESEARCH	2,200	612	2,260	629	5,701	64
TRAINING	500	140	347	96	1,083	12
HEALTH	1,000	278	650	181	2,109	24
	3,700	1,030*	3,257	906*	8,893	100

*The indirect costs amount to 27.8% of direct costs and total US$ 1.9 million (see p.46 of this document).

The following diagram illustrates how the split between central funded and project funded programme expenditures

would translate into central funding requirements:

	PROGRAMME COSTS		
	DIRECT COSTS	INDIRECT COSTS	TOTAL
CENTRAL FUNDS	$ 3.7 m	$ 1.0 m	$ 4.7 m
PROJECT FUNDS	$ 3.3 m	$ 0.9 m	$ 4.2 m
TOTAL	$ 7.0 m	$ 1.9 m	$ 8.9 m

Therefore the Centre would need to receive at least approximately half of the total funds in the form of central funds ($ 4.7m/$8.9m=53%). Therefore the formula would be:

- for every project dollar earmarked by a donor, including both direct and indirect costs, the donor would also, as a minimum, be requested to provide an equal amount in central funds (also providing for direct and indirect costs)

This would be the general working rule with the express purpose of providing the Centre with ongoing access to central funds. We hope that some donors will continue to provide only central funds and they are encouraged to do so.

It is proposed that any contribution not exceeding US$ 250,000 annually be exempt from this rule.

The granting of unearmarked funds does not imply a complete loss of control by donors. The programmes supported by unearmarked funds would be subject to donor review, comment and influence. It is the mechanism for dealing with this issue and others which is the subject of the next section on the donors' consortium.

B. Dealing with the accumulated deficit:

In March the donors' consortium requested that they be presented with options for eliminating the deficit. In addition it was believed desirable for the Centre to build up an Endowment Fund.

There are two methods in principle for dealing with both issues. The Centre could receive outright donor contributions earmarked for the two purposes and the Centre could budget for an annual surplus.

1. Eliminating the Deficit

At the end of 1986, the accumulated cash deficit, that is to say before a provision for depreciation, was $ 2.7 million (see table 9, next page, for details). Part

Table 9: Operating Fund Results 1981 to 1986*
(Thousands of U.S. dollars)

	1981	1982	1983	1984	1985	1986
REVENUE	4,103	4,574	5,375	6,864	7,455	7,892
EXPENDITURE	5,421	4,349	5,664	7,136	8,678	7,743
OPERATING FUND SURPLUS (DEFICIT)	(1,319)	226	(289)	(272)	(1,223)	149
LESS: TRANSFER TO RESERVE FUND	-	100	300	442	-	-
TOTAL SURPLUS (DEFICIT)	(1,319)	126	(589)	(714)	(1,223)	149
CUMULATIVE TOTAL DEFICIT	(443)	(317)	(906)	(1,620)	(2,843)	(2,694)

* Before provision for depreciation, a non-cash expense. Numbers may not total due to rounding.

of the financing for the deficit has been provided by 1.2 million in UNROB funds.(1) Donors requested options for repayment of the remaining $ 1.5 million debt.

(1) The Centre has noted the request made by the Consortium that the Government of Bangladesh, the Centre and UNDP bring the matter of discussion concerning the UNROB funds to a satisfactory conclusion. At the time of writing the matter had not progressed beyond preliminary contacts.

The $ 1.5 million represents about 16 percent of the 1987 estimated income. Therefore, if donors were to make extra contributions of, on average, 16 percent more in 1987, the entire remaining debt of $ 1.5 million would be eliminated in one year.

However, many donors will not be able to subscribe funds earmarked for the specific purpose of deficit reduction, for policy considerations. For these donors it is proposed that they provide additional central funds for general Centre support. In the former case the additional funds subscribed are set aside in a separate account earmarked for the purpose of reducing the deficit. The total set aside would not be reflected in the income and expenditure statement for 1987 but would flow straight through to a reduction in the accumulated deficit.

In the latter case the additional funds form a part of the general pool of central funds available for Centre operations during 1987. Depending on the outcome, any surplus arising from income exceeding expenditures would reduce the accumulated deficit. Moreover, any reported surplus would be reduced to the extent of depreciation, a non-cash expense, charged to the accounts. In other words the Centre could produce an operating fund surplus of up to US$ 500,000 (the

estimated amount of depreciation for 1987) without showing a reportable surplus on its income and expenditures statement.

2. Endowment Fund

The Centre currently has no method for generating working capital to provide funding for donor contribution shortfalls, to bridge the timing gap between receipts and expenditures, to provide financing for projects funded by donors who pay only upon completion of the project and to provide an emergency reserve.

In 1984 the Ford Foundation funded a consultancy (1) which resulted in the establishment of the rules for operating, using and managing the Endowment Fund. In 1985 the Ford Foundation contributed $ 500,000 towards a proposed $ 10 million target. An offer has subsequently been received from the Population Council's professional money managers to also manage the Centre's Fund.

In order to build upon the $ 500,000 Ford Foundation grant, special subscriptions to the fund or annual transfers from any annual surplus (after having repaid

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(1) James Bausch, Vice President and Secretary of The Population Council.

all debt) would be the principal sources of capital. If considered desirable by some donors, their contributions could remain their property, to be returned if the Centre's affairs were wound up.

The amount subscribed annually will determine the speed with which a $ 10 million target is achieved. For example an average twenty per cent additional annual contribution would result in achieving the target by 1991. On this basis $ 1.7 million would be the 1987 subscription target, bringing the total potentially to $ 2.2 million. At the level of US$ 2.2 million, the Fund would be able to provide for the temporary bridge financing of expenditures and receipts formerly financed through commercial lines of credit from banks.

III. SUGGESTIONS REGARDING THE CONSORTIUM

The Board of Trustees of the International Centre for Diarrhoeal Disease Research, Bangladesh suggests to the donors' community that, in order to resolve the present problems of the ICDDR,B, and to ensure its optimal functioning in the years to come, a Donors' Consortium, under the chairmanship of the United Nations Development Programme, should be formally set up on June 27, 1987.

The Board of Trustees submits to the donors that the most pressing matters to be dealt with at the June 27, 1987 meeting in Geneva are

- the cancelling of the existing debt (pp.54-57);
- the central funds (pp.45-54) for 1987 and 1988;
- the reserve and endowment funds (pp.57-58).

As important, but possibly requiring more time, are

- the funding formula (p.53);
- the special funding for institutional linkages (p.8, p.51).

It is further suggested that the Donors' Consortium should play a regular, co-ordinated and supportive role in the

policies, priorities and programmes of ICDDR,B's activities. It is hoped that, concurrently, the Donors' Consortium will accept the corresponding financial responsibilities.

Finally, it is suggested that the Donors' Consortium would meet annually with representatives of the Board of Trustees being present, and at least every other year in Dhaka.

* * * * * *

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

Recommendations of a Meeting of the Donors' Consortium Dhaka, Bangladesh, March 25-26, 1987

1. A meeting of the ICDDR,B Donors' Consortium was held in Dhaka, Bangladesh during March 25-26, 1987, under the chairmanship of UNDP. A list of those attending is attached as Annex II.

2. The Consortium recognized the important scientific achievements of ICDDR,B and its potential to make further major contributions to maternal and child health in general, and diarrhoeal diseases control in particular.

3. The Consortium welcomed the forceful and comprehensive steps that have been taken since mid-1985 by the Director, the Board of Trustees and the staff to improve the financial and scientific management of the Centre.

4. The Consortium emphasized the need for the Centre to develop a more detailed statement of its policies and priorities, both programmatically and geographically, in the fields of research, training and services over the next five years. This statement should take into account the policies and priorities of the WHO/CDD Programme and other international initiatives related to the work of the Centre. This statement should include, inter alia,

   - a clarification of the Centre's international role in research, training and services;

   - guidelines on the relative importance of research, training and services; on the mix of basic and applied research, on the Centre's role in operational research; on the types of training to be specially emphasized; and on policy towards all forms of services activity;

   - a statement of the specific priorities within research, training and services, including an indication of the timing of various elements and of elements that would be emphasized if the funds being

sought were not available;

- the implications for the future staffing of the Centre.

The Consortium considered that the responsibility for preparing this statement is the Board's.

5. The Consortium recognized the importance of institutional linkages between ICDDR,B and university departments or research institutions both in the donors' countries and in developing countries. Specific funding for these linkages should, whenever possible, be part of the support given to ICDDR,B.

6. The Consortium recommended that, following appropriate discussion donors should support the policies and priorities, as elaborated by the Centre and endorsed by the Board, as a whole and should give positive and sympathetic consideration to the financial issues outlined in paragraphs 8-13 below.

7. The Consortium stressed the need for donors to be adequately informed about the implementation and outcomes of Centre projects and to receive, on a regular basis, evaluations, financial reports, management reviews and planning documents.

8. At the end of 1985 the Centre faced a major financial crisis, with a bank overdraft of $2.8 million (against an agreed facility of $3.0 million) and a rate of overspending of approximately $100,000 per month. The Consortium noted that this financial crisis was precipitated, in part, by the sudden move from central (core) funding to project funding (central funding comprised 67% of all contributions in 1983, 42% in 1984 and 13% in 1985). The Consortium was of the opinion that a reasonable level of central funding is essential to the continued effective operation of the Centre. The Consortium noted that a non-commercial research organization, with an accompanying programme of training and services, cannot be creative and innovative on project funds alone. The Consortium thanked those donors which continue to make all or most of their contributions to central funds, and reaffirmed that this remains the preferred mode of funding. To accommodate donors wishing to contribute to specific programmes or projects, the Consortium recommended that all donors be invited to subscribe to draft guidelines

(Annex I) on the relative size of central (unearmarked or undesignated) and project (earmarked or designated) contributions.

9. The Consortium noted that the financial difficulties during 1981-85 had led to an accumulated deficit of $2.7 million. The Consortium recognized that the continued existence of this deficit placed a heavy debt-servicing burden on the Centre and was a deterrent to donors wishing to contribute to central funds. $1.2 million of this deficit is financed by UNROB funds (see paragraph 10). The Consortium recommended that donors should be presented with options for repaying the remaining debt at their next meeting.

10. The Consortium noted the continuing discussions between the Centre and the Government of Bangladesh concerning the UNROB funds. The Consortium requested that the Government of Bangladesh, the Centre and UNDP bring this matter to a satisfactory conclusion.

11. The Consortium noted that some donors had formal multi-year agreements with the Centre while others contributed on an annual basis. The Consortium recommended that donors should attempt, if permitted by their individual procedures, to enter into agreements of 3 years or more with the Centre. Such agreements could, where appropriate, be in the form of a funding plan, to be confirmed on an annual basis.

12. The Consortium noted the existence of a small Endowment Fund of $500,000 provided by the Ford Foundation. The Consortium believed that it is desirable for the Centre to build up this Fund, to a level of perhaps $10 million. The interest earned from this Fund would finance scientific innovations and new initiatives and the capital could, under most carefully prescribed conditions, provide a buffer against unexpected needs.

13. The Consortium noted the needs for capital expenditure on buildings and recommended that the Centre prepare a plan for investment in new building and building rehabilitation. This plan should be closely related to the priorities of the Centre in research, training and services and should explore any risk that a major capital investment would distort these priorities.

14. The Consortium welcomed the review of personnel and salary structure which had been initiated by the Board and looked forward to learning of the outcome. It was confirmed that the experience in these matters of the International Agricultural Research Institutes might prove relevant and instructive.

15. The Consortium recommended that it should reconvene in Geneva on Saturday, June 27th, 1987, to:

- consider the statement of policies and priorities (paragraph 4);

- consider proposals on the financial issues described in paragraphs 6 and 9; and

- consider future arrangements for the Donors' Consortium, including its relationship to the Board of Trustees and the timing and venue of its meetings.

Annex I - Draft Guidelines on ICDDR,B Project Funding

Given the rules laid down for TDR funding and those observed for CGIAR funding, the contribution of each donor for ICDDR,B should comprise an adequate amount of central funding, i.e.

- at least 50% (?) of the total annual contribution should be central funding;
- a maximum of 50% (?) can be project funding, all the direct and indirect costs attributable to the project being included in the budget of the project.

Total contributions of not more than an average of $100,000 (?) per year can, if the donor wishes, be entirely project funding including an appropriate amount of indirect costs.

Contributions directed to one of the programme areas (i.e. research, training and exchanges, health care services), but not to one or several specific projects within those programme areas, will be considered as central funding.

Annex II - List of Participants attended the ICDDR,B Donors' Consortium Meeting held on 25-26 March, 1987
Chaired by Mr. T. Rothermel, Director, DGIP, UNDP-NY

Sl #	Agency/Country		Name with address
1.	Aga Khan Foundation	:	(a) Dr. Ronald G. Wilson Director, Health Programme, AKF, Geneva (b) Mr. Roshanally M.H. Hirji Chairman, AKF, Dhaka (c) Mr. Mansur A. Hirji Member, National Committee, AKF, Dhaka
2.	Australia	:	(a) H.E. Ms. Susan J.D. Boyd High Commissioner The Australian High Commission, Dhaka (b) Ms. Gillian Mellsop Second Secretary (Development Cooperation) The Australian High Commission, Dhaka
3.	Bangladesh	:	Mr. Manzoor ul Karim Secretary, Ministry of Health & Family Planning Government of Bangladesh, Dhaka
4.	Belgium	:	Mr. X. P. Gobin Head, Development Cooperation Embassy of Belgium, Dhaka
5.	Canada	:	Mr. V. R. Carvell Counsellor The Canadian High Commission, Dhaka
6.	China	:	Dr. Cao Qing Deputy Director, Ministry of Public Health People's Republic of China
7.	Denmark (DANIDA)	:	(a) Mr. K.B. Andersen Counsellor, DANIDA Mission, Dhaka (b) Mr. Torben Bellers Attache, Development Cooperation DANIDA Mission, Dhaka
8.	EEC	:	Mr. Joel Fessaguet Resident Representative European Economic Commission (EEC), Dhaka

Sl #	Agency/Country		Name with address
9.	Ford Foundation	:	Dr. George Rubin Programme Officer, The Ford Foundation Dhaka
10.	France	:	Mr. Dominique Chatton Second Secretary Embassy of France, Dhaka
11.	Japan	:	(a) Mr. Kenji Ikeda Chief Officer, Multilateral Coop Div. Economic Coop Bureau Ministry of Foreign Affairs, Japan (b) Mr. Katsuo Iwata Second Secretary, Embassy of Japan, Dhaka
12.	Norway	:	Ms. Elisabeth Eie Programme Officer, NGO Dev. Cooperation, Norwegian Embassy, Dhaka
13.	Malaysia	:	Mr. Zulkifli Yaacob Second Secretary Malaysian High Commission, Dhaka
14.	Population Council	:	Dr. Barnett F. Baron Senior Representative, South & East Asia The Population Council, Bangkok
15.	Sweden	:	(a) Dr. Bo Bengtsson Director General, SAREC, Sweden (b) Ms. Hellen Ohlin Research Officer, SAREC, Sweden
16.	Switzerland	:	(a) Dr. Immita Cornaz Swiss Development Cooperation and Humanitarian Aid Section Asia I Berne, Switzerland (b) Mr. Hans Meier Charge d'Affaires Embassy of Switzerland, Dhaka (c) Dr. Markus Mueller Deputy Head, SDC, Dhaka

Sl #	Agency/Country		Name with address
17.	UNDP	:	(a) Mr. Frank Hartvelt Senior Programme Officer UNDP, New York (b) Mr. Y. Kishi Assistant Resident Representative UNDP, Dhaka
18.	UNFPA	:	(a) Mr. Hasse B. Gaenger Representative, UNFPA, Dhaka (b) Dr. I. B. Peters MCH-FP Advisor, UNFPA, Dhaka
19.	UNICEF	:	Mr. Anthony A. Kennedy Representative, UNICEF, Dhaka
20.	USAID	:	(a) Dr. Kenneth J. Bart Director, Office of Health & Science Technology Cooperation USAID, Washington (b) Ms. Sharon Epstein, Director, Health & Population Office, USAID, Dhaka (c) Mr. Gary W. Cook Deputy Director Office of Population & Health USAID, Dhaka
21.	UK	:	(a) Dr. Penelope Key Senior Medical Advisor Overseas Development Admn. (ODA), UK (b) Ms. Margaret Rutter Nursing and Health Services Advisor ODA, UK
22.	World Bank	:	Dr. Bonita Stanton MCH Specialist The World Bank, Dhaka
23.	WHO	:	(a) Dr. Mike Merson Director, CDD WHO, Geneva, Switzerland (b) Dr. Aung Myat Representative, WHO, Dhaka

Programme-based budget for 1988-1989

Detail project/protocol wise budget will be presented at the November Board meeting. A programme wise allocation is shown in table 1 & 2.

Any suggestion or comment from the Board will be taken into account while preparing a detailed budget for 1989.

TABLE 1

INCOME AND EXPENDITURE BUDGET FOR 1988 & 1989

		Budget 1988	Budget* 1989
A.	**Income**	(In thousand US Dollars)	
	Central Funds	1,899	1,894
	Project Funds (Direct Cost)**	8,438	9,608
	Project Funds (Indirect Cost)	1,100	1,265
Total	Income	11,437	12,767
B.	**Expenditure**		
	Local salaries	5,665	6,516
	Inter'l salaries	1,789	2,057
	Consultants	372	427
	Mandatory committees	82	94
	Travel	461	530
	Supply and materials	1,111	1,278
	Other contractual services	1,052	1,210
	Interdepartmental services	1,670	1,921
	Depreciation	1,000	1,000
Total	Operating	13,202	15,083
	Less: Recovery	1,670	1,920
Net	Operating	11,532	13,113
	Add: Capital expenditure	455	523
Total	Expenditure	11,987	13,636
C.	**Surplus/-deficit**	-550	-869

* Preliminary

** Income projected on accrual basis taking into account carry over from previous year and receipts during the year.

TABLE 2

INCOME AND EXPENDITURE BUDGET FOR 1988 & 1989

		Budget 1988			Budget 1989 *		
		(In thousand US Dollars)					
A.	Income	CENTRAL	PROJ.	TOTAL	CENTRAL	PROJ.	TOTAL
	Central Funds	1,899		1,899	1,894		1,894
	Project Funds(Direct Cost)**	650	7,788	8,438	650	8,958	9,608
	Project Funds (Indirect)	1,100		1,100	1,265		1,265
Total	Income	3,649	7,788	11,437	3,809	8,958	12,767
B.	Expenditure						
	Local salaries	2,526	3,140	5,665	2,905	3,611	6,516
	Inter'l salaries	437	1,352	1,789	502	1,555	2,057
	Consultants	21	350	372	24	403	427
	Mandatory committees	82	0	82	94		94
	Travel	44	417	461	50	480	530
	Supply and materials	559	552	1,111	643	635	1,278
	Other contractual services	498	554	1,052	573	637	1,210
	Interdepartmental services	553	1,117	1,670	636	1,285	1,921
	Depreciation	1,000		1,000	1,000		1,000
Total	Operating	5,720	7,482	13,202	7,427	8,606	15,033
	Less: Recovery	1,670		1,670	1,920		1,920
Net	Operating	4,050	7,482	11,532	5,507	8,606	13,113
	Add: Capital expenditure	149	306	455	171	352	523
Total	Expenditure	4,199	7,788	11,987	5,678	8,958	13,636
C.	Surplus/-deficit	-550	0	-550	-869	0	-869

* Preliminary

** Income projected on accrual basis taking into account carry over from previous year and receipts during this year.

TABLE 3

PROGRAMMEWISE EXPENDITURE FOR 1988-92
(in thousands of U.S. Dollars)

PROGRAMME AREAS	1988	1989	1990	1991	1992
1. CLINICAL RESEARCH	672	773	889	1,022	1,176
2. MICROBIOLOGY AND IMMUNOLOGY	634	729	838	964	1,109
3. EPIDEMIOLOGY AND DISEASE PREVENTION	1,651	1,899	2,183	2,511	2,888
4. POPULATION STUDIES	813	935	1,075	1,236	1,422
5. HEALTH CARE SYSTEMS RESEARCH	3,202	3,682	4,235	4,870	5,600
6. HEALTH CARE SERVICES	1,613	1,855	2,133	2,453	2,821
7. TRAINING AND EXCHANGES	852	980	1,127	1,296	1,490
8. MANAGEMENT AND SUPPORT SERVICES	1,550	1,783	2,050	2,357	2,711
TOTAL -	10,987	12,636	14,530	16,709	19,217

TABLE 3.a

PROGRAMMEWISE EXPENDITURE FOR 1988-92
(in thousands of U.S. Dollars)

PROGRAMME AREAS	1988	1989	1990	1991	1992
1. CLINICAL RESEARCH	672	773	889	1,022	1,176
2. MICROBIOLOGY AND IMMUNOLOGY	634	729	838	964	1,109
Environmental Microbiology	65	75	86	99	114
3. EPIDEMIOLOGY AND DISEASE PREVENTION	1,651	1,899	2,183	2,511	2,888
Vaccine Trial	756	-	-	-	-
4. POPULATION STUDIES	813	935	1,075	1,236	1,422
Demographic Surveillance	805	926	1,065	1,224	1,408
Demographic Research	8	9	10	12	14
5. HEALTH CARE SYSTEMS RESEARCH	3,202	3,682	4,235	4,870	5,600
UVP	832	957	1,100	1,265	1,455
MCH-FP Ext.	1,257	1,445	1,662	1,912	2,198
MCH-FP	644	740	851	979	1,125
Child Health Programme	237	273	313	360	415
ORT Implementation	130	150	172	198	227
6. HEALTH CARE SERVICES	1,613	1,855	2,133	2,453	2,821
Dhaka Treatment Centre	1,021	1,174	1,350	1,553	1,786
Matlab Treatment Centre	453	521	599	689	792
Teknaf Treatment Centre	139	160	184	211	243
7. TRAINING AND EXCHANGES	852	980	1,127	1,296	1,490
Courses - Bangladesh	45	52	60	68	79
Professional training	252	290	333	383	441
- trainers					
- research					
- post doctoral					
Technical Cooperation	301	346	398	458	526
DISC	141	162	186	214	247
Library, Publication & Illustration	113	130	149	172	198
8. MANAGEMENT AND SUPPORT SERVICES	1,550	1,783	2,050	2,357	2,711
Central Scientific Management Support Services - Director	284	327	376	432	497
- Administration, Finance & Personnel	1,005	1,156	1,329	1,528	1,758
- Resources Development	194	223	257	295	339
TOTAL	12,087	13,896	15,990	18,368	21,217

Guidelines on the Operation of the 50:50 Funding Principle

1. In his report to the November 1987 Board of Trustees, the Associate Director Resources Development said, amongst other things: "It was also tentatively agreed that each donor should give at least 50% of their grants to the ICDDR,B's central fund. To achieve this the Board of Trustees should develop a set of guidelines, keeping in view the divergent nature of the Centre's multifarious donors.".

2. The Board returns the ball in its Resolution 29/Nov. 87 "The Board requests the Director to present for review at the next Board meeting ... 3. Guidelines on the operation (sic) of the 50:50 funding principle (sic).".

3. Mr Bashir was requesting the Board to guide the Centre's management as to how to deal with donors, including our two biggest ones, who might not be willing to use the 50:50 formula.

4. This request remained unanswered, but the Board instructed me to draw up guidelines for the donors (at least I suppose so). I confess to feeling somewhat confused.

5. I'd like to ask my fellow Board Members to read or read again the two "Plans and Prospects" documents. It may help to quote from them, and from a "Note to the Board" and a letter to all Trustees by Dr I. Cornaz.

5.1 Note to the Board of Trustees, Dr I. Cornaz, 24 November, 1986.

"Points which should be examined at the Donors Meeting ...

- 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..

5.2 Plans and Prospects, February 1987 (p.74).

"It would also help if donors could agree on a new formula for meeting the overall costs of the Centre's programmes on some common basis, instead of only in individually determined ways which amount to a piecemeal approach and leave it to the management somehow to make that work. As has already been discussed at other venues, there are at least two possibilities:

* The first possibility is to follow the TDR/CDD model or some similar format whereby donors, acting as a group, approve the total budget, individually commit funds for specific purposes and also contribute an agreed minimum percentage of that amount to central funds. Various percentages for such 'matching contributions' have been considered by donors, including a 50-50 formula.

* The second possibility is that the Centre continue to operate on a project-financed basis with the probability of a diminishing amount of central funds (in both absolute terms and proportionally). However, there would need to be some accommodation reached with donors regarding the sharing of pooled indirect costs and the financing of treatment centre activity.".

5.3 Plans and Prospects, Supplement, June 1987.

Recommendations of a Meeting of the Donors' Consortium, Dhaka, Bangladesh, March 25-26, 1987.

"... The Consortium was of the opinion that a reasonable level of central funding is essential to the continued effective operation of the Centre. The Consortium noted that a non-commercial research organization, with an accompanying programme of training and services, cannot be creative and innovative on project funds alone. The Consortium

thanked those donors which continue to make all or most of their contributions to central funds, and reaffirmed that this remains the preferred mode of funding. To accommodate donors wishing to contribute to specific programmes or projects, the Consortium recommended that all donors be invited to subscribe to draft guidelines (Annex I) on the relative size of central (unearmarked or undesignated) and project (earmarked or designated) contributions.".

Annex I - Draft Guidelines on ICDDR,B Project Funding

"Given the rules laid down for TDR funding and those observed for CGIAR funding, the contribution of each donor for ICDDR,B should comprise an adequate amount of central funding, i.e.

- at least 50% (?) of the total annual contribution should be central funding;
- a maximum of 50% (?) can be project funding, all the direct and indirect costs attributable to the project being included in the budget of the project.

Total contributions of not more than an average of $100,000 (?) per year can, if the donor wishes, be entirely project funding including an appropriate amount of indirect costs.

Contributions directed to one of the programme areas (i.e. research, training and exchanges, health care services), but not to one or several specific projects

within those programme areas, will be considered as central funding.".

6. Letter to all ICDDR,B Trustees by Dr I. Cornaz, 28 JULY, 1987.

"This letter ... is to inform the Board on the donors' meeting which was held on June 27 in Geneva and on its conclusions ... In his letter, Mr Rothermel says: 'In my judgement the Director of ICDDR,B and his colleagues at the Centre, as well as its Board of Trustees, have gone to extraordinary lengths to carry out the recommendations adopted at the initial meeting of the Donors' Consortium which took place in March. ...'

... At the forthcoming Board meeting we will have to examine the mechanism for achieving this (the interaction between donors and the Centre). ... such an interaction should help both the Centre and the donors but should not create a supplementary burden for the Centre's management. I would appreciate if you could make proposals as how to achieve this, before the next Board meeting, either to David Bell or to me who will follow up this question. ...".

7. The last paragraph of the draft guidelines quoted above (p.4) should be read with care. The term "specific project" is far from clear. Depending on how it is interpreted, a particular donor's contribution can be

considered as 50:50, if not even more in favour of the core, or as lagging far behind. As a matter of fact, the word "core" cannot easily be defined. What is "core expenditure" one year can become "project expenditure" the following year, but it is still not "central funding". This can be defined as money that, in terms of accrual budgeting, the Centre can consider as its property without having to spend it. It would then seem that the last paragraph of the Draft Guidelines negates the first one.

8. Whatever that may be, I do not believe we can do much better than what the donors already did in March 1987. Documents to be prepared for the November 1988 Donors Consortium have to be based on the recommendations made by the donors in 1987. (Plans and Prospects, Supplement, June 1987, pp. 1-5 at the back of the document). Might I urge my fellow Board Members to read these recommendations and actively help the Centre's management with the urgent task ahead.

RE:jc

5.5.88

5/PT/MAY 88

PROGRAMME COMMITTEE REPORT

REPORT OF THE PROGRAMME COMMITTEE
June 1988

The meeting began with the presentation from Dr. Diana Silimperi about the Urban Volunteers Programme. She described the characteristics of the volunteer workers, how they were recruited and trained so that the slum areas of the study which housed between 38-152,000 children under 5 were covered by about 1800 trained volunteers with 1 field supervisor per 40 volunteers. The inputs into the community which are mainly educational will relate to diarrhoieal diseases, nutrition, family planning and hygiene and it is hoped that the effects of these may be measured on morbidity and mortality. The task of organising this large team into a functional unit has been formidable and Ms. Silimperi has done extremely well so far. It was however felt that while the emphasis on service was strong the research issues even on health service delivery questions had not yet been well defined. Several aspects of this large project would benefit from integration with other groups of the Centre and with National Health Services.

Dr. Ciznar told us about the researches of the Laboratory Sciences Division. He has established some very impressive immunochemical methods which have enabled him and his colleagues to purify and characterise surface antigens of V. cholerae and of Shigella dysenteriae. His colleague Dr. Zia Ahmed has isolated mutants from Shigella dysenteriae which are temperature sensitive and require thymine for growth - one of these has been shown to be a potential useful vaccine against dysentery and is being further developed. THis group under Dr. Ciznar has a strong research training involvement via several M.Sc students of Dhaka University.

SCIENTIFIC PRIORITIES OF THE CENTRE

The scientific priorities of the Clinical Sciences, Laboratory Sciences, Community Medicine and the Population Divisions were presented by the respective Associate Directors and were discussed. The Programme Committee felt that the documentation represented a very positive step and it would help the Centre develop an integrated research programme based on identified priorities.

The Programme Committee recommends that the horizontal integration in the research programme between divisions should be developed further.

DOCUMENT FOR THE DONORS MEETING

Discussion then centred on the presentation of the 1989-93 programme to the Donors in November. A research training programme should be developed for inclusion of the documents. More work was needed to assemble the booklet which would describe to the Donors the reasons for our chosen scientific priorities more adequately and would cover the distribution of energy between research, training and service. Some time scales should be linked with the expected achievements of these areas and realistic predictions made about the staffing and funding required. This was considered to be a most important task for the Director and his senior scientific colleagues to achieve before the next Donor meeting in November. If requested by the Director a small group from the Programme Committee will be willing to come to Dhaka and assist in the formulation of this document.

TEKNAF

The Director briefed the Programme Committee of the problems and progress of the implementation of Board Resolution No. 1/Nov. 87 regarding Teknaf.

1. At present there is no research carried out at Teknaf, apart from the DSS activities. Committed funds for the DSS are available till end of 1988 and are likely to be available for future years (till 1991).

2. The Government of Bangladesh has been approached regarding the take over of the service functions and the Director will continue further negotiations.

   Funds for the support of the service activities are committed and available till end of 1999.

..3

3. The third paragraph of Res. 1/Nov. 1987 envisages the possibility of alternate employment for the DSS personnel and the Director would like to continue the DSS activities for 2 more years till arrangements are made for absorbing as many of the staff as possible.

After discussion it was decided to recommend to the Board:

To authorize the Director to continue the DSS activities at Teknaf for a maximum of 2 more years till 1989, while all attempts will be made to find alternative employment for existing staff. If a resident epidemiologist can be found within the two years the position of Teknaf can be reconsidered.

HOSPITAL FACILITIES

The deplorably overcrowded and unsatisfactory conditions of the Dhaka Treatment Centre are known to most Board members. The difficulties created were described by Dr. Mahalanabis who outlined a few areas where potential improvements seem possible. Plans for this upgrading are in hand. We strongly recommend that these improvements are put into place as soon as possible and that plans for a new floor be drawn up and put before the Board in November.

SAFETY MEASURES OF THE CENTRE

A comprehensive manual has been assembled dealing with all aspects of the safety of the laboratories, including the handling of pathogens, radioactivity, animals and rules governing molecular biological experiments. These all appeared sensible and well thought out and a system of monitoring by safety officers has been established.

..4

EXTERNAL SCIENTIFIC REVIEW

Three scientists, as follows, have consented to review the Clinical Sciences Division over a period of two weeks in November:

Prof. H. Hamilton
Prof. & Chairman
Physician in Chief
The Montreal Children's Hospital
Quebec, Canada

Dr. M.K. Bhan
Department of Paediatrics
All India Institute of Medical Sciences
New Delhi
INDIA

Prof. M.S. Akbar
Joint Director
Bangladesh Institute of Child Health
Dhaka Shishu Hospital
Dhaka
Bangladesh

TERMS OF REFERENCE OF THE PROGRAMME COMMITTEE

1. The Programme Committee should assist the Director and his senior scientific staff to define the scientific priorities of the Centre in Research, Training and service.

..5..

2. The Programme Committee should review with the Director and Division Heads the implementation of the research priorities of the Institution particularly the larger research programmes and report the progress to the Board.

3. Donor initiated research projects should be approved by the Programme Committee before implementation.

4. All major scientific protocols to be implemented under Central funds should be approved by the Programme Committee.
Since the Programme Committee will meet twice a year a time schedule for developing andevaluating protocols must be worked out by the Council of Associate Directors.

5. The Programme Committee should assist the Director in preparing the documents for the annual meeting of the Donor Consortium

May 30, 1988

DR:ls

5(a)/BT/MAY.88

REVIEW OF URBAN VOLUNTEERS PROJECTS, REVIEW OF LABORATORY SCIENCES DIVISION (IMMUNOLOGY).

URBAN VOLUNTEER PROGRAM QUARTERLY REPORT
(January, February, March, 1988)

Diana R. Silimperi, MD
Director
Urban Volunteer Program

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH
GPO Box 128, Dhaka-1000, Bangladesh

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URBAN VOLUNTEER PROGRAM GOAL I

To develop and evaluate the effectiveness of a unique community-based volunteer health system which provides specific preventive health and selective interventive health services to urban slum children under 5 years of age and their mothers; and to assess the procedures necessary for expansion and replication of such a system in other urban areas.

COMMUNITY HEALTH SERVICE ACTIVITIES

GENERAL SERVICE PROGRAM

Cooperative Agreement and Revised UVP Goals

Ongoing effort was devoted to refining the cooperative agreement. Slum census information is still needed in order to finalize goals with more specific, realistic target numbers. However, a consensus was reached that next quarter a provisional draft of revised, specific goals could be implemented with a follow-up period of 3-6 months to evaluate the feasibility of such goals. The external outside program evaluation scheduled for late 1988 can be used to examine the suitability of these new program goals and targets. After evaluation, refined goals will be implemented in the revised cooperative agreement. The refined goals with corresponding objectives, tasks, and targets should be appropriate for the duration of the cooperative agreement.

Budget and Finance

Considerable time this quarter was devoted to refinement of the 1987-1988 budget as well as revisions in the remaining years' budgets. Significant revisions were necessary because of major salary increases instituted by the ICDDR,B Board (60% increases at many wage levels) as well as high levels of inflation that were not calculated in the original UVP budget. Furthermore, with the refinement of the UVP goals and objectives, a full revision of the 5-year budget was appropriate and necessary. The 1987-1988 budget and the remaining 3-year budgets will be finalized during the next quarter.

In addition, multiple discussions took place between ICDDR,B finance staff, UVP staff and USAID financial and program staff regarding the special provisions of the UVP grant. Multiple improvements in the UVP accounting and financial procedures were instituted including: a quarterly expenditure trend analysis; subproject, section or strategy expenditure analysis; and more consistent record-keeping. In addition, good channels of communication were created between the UVP staff and the ICDDR,B financial staff. Efforts were also directed to the establishment of regular communications between USAID financial staff and ICDDR,B financial staff, as well as the UVP administrative staff.

The need to establish consistent channels of communication and information exchange was clearly delineated throughout the negotiations and discussions regarding the UVP special financial provisions. Furthermore, the need for continued exchanges between USAID finance and ICDDR,B finance was made clear. As a

result of this series of discussions, it is hoped that a clear understanding of the specific requirements of the special provisions, vis-a-vis accounting reports and procedures, will be forthcoming in the next quarter, along with a channel for ongoing communications to avoid the "backlog" of unresolved issues which have come to the fore this quarter. A major portion of the UVP's Project Office Manager's and Director's time have been devoted to these issues. In addition, the service of a financial officer was obtained to maintain the UVP accounts in an appropriate and acceptable manner for USAID.

Revised Position Descriptions and Tasks for General Volunteers and Field Supervisors

Final refinements of the general urban volunteer and field supervisor position descriptions, task lists, and selection criteria were completed this quarter along with Bangla translations. Furthermore, descriptions of the training volunteers in the hospital and nutrition rehabilitation centers were also finalized. The selection criteria and standard entitlements for each of these volunteer categories was formalized.

Development of Field Supervisor Infrastruction

As noted above, development of the field supervisor position description, tasks, selection criteria and selection process was finalized this quarter. Furthermore, an additional 18 field supervisors were selected after the results of the activity analysis were compiled and thana and sub-area needs evaluated. The current field supervisors played a significant role in the process of determining ideal number of volunteers per field supervisor. It was determined that in some cases the ratio might need to be under the average due to distances between field supervisor residences and volunteers, while in other cases, due to clumping of volunteers, the number supervised might be slightly larger, but the average number of volunteers per supervisor would be approximately 35 to 40 volunteers per one field supervisor. The number of volunteers used for this purpose is the number of "active volunteers". Henceforth in this report, unless specifically noted, volunteers will refer to active volunteers; when the figures refer to the total number of volunteers ever trained, it will be so noted. Active volunteers will be used to refer to any volunteer involved in interventive service activities, preventive health education activities or referral activities performed in any one of the four UVP strategy areas.

The activity analysis revealed that only about 20% of the volunteers were receiving field supervisor contacts on a monthly or bi-monthly basis. With the new ratios, the field supervisors felt they could provide a minimum of 1 visit per volunteer per month (and in fact could aim for 1 visit per 2 weeks or 2 visits per month per volunteer.) If one considers ORS distribution alone, one might assume such improved supervision could result in significant increases in productivity during 1988.

Applications were accepted and interviews as well as written tests performed utilizing the new field supervisor selection criteria. (See Attachment 1.) Consequently, 18 new field supervisors were selected. Furthermore, a new training curriculum for these field supervisors was implemented (See Attachment 2 for details of the training.) It was determined that the current field supervisors were also in need of this orientation and supervisory training and, hence, a modified version of the new supervisor training course was also conducted for the current supervisors during this quarter. In addition to the orientation to field supervisor tasks and initial training in the areas of time management, monitoring, and supervisory skills, the new field supervisors also participated in the updated 3-week revision training course and VERC training. This was the first time that such a formal training for field supervisors had ever been conducted by the UVP, although past supervisors had participated in the VERC training course. Outlines of the field supervisor training curriculum, pre-and post-testing results, as well as evaluations of the orientation and training course are available. It is anticipated that such training for field supervisors will result in marked improvements in the level of field service activities performed by the volunteers.

Volunteer Distribution, Catchments, Slum Maps and Census Data: UVP Baseline Program Information

Clarification of the actual volunteer locations and distribution, catchment communities served, slum community mapping, and census efforts continued this quarter in order to obtain baseline information necessary for UVP project goal delineation and the development of project targets and service indicators.

Ongoing exchanges with the Bangladesh Survey Organization, Ltd. (BSO), commissioned to create the Dhaka metropolitan slum maps, finally resulted in the first draft of 12 thana maps containing slum community locations. Many hours of effort by the UVP staff were then devoted to the revision and improvement of these maps, particularly adding those slum locations which the BSO Ltd. surveyors did not chart. It is clear that this set of maps is merely a starting point and will require considerable improvement, on an ongoing basis, to attain and then maintain any

semblance of accuracy. It is planned that this slum community map information will be combined with the slum population census being performed by the Center for Urban Studies, Dhaka University (CUS, DU) as well as the activity analysis from the UVP. With the combination of the three data sets, it should be possible to locate the volunteers' residences within each slum community, estimate the percentile of all metropolitan slum clusters in which UVP volunteers are active, estimate the total catchment populations now served by these volunteers, make future projections vis-a-vis service, and ultimately, establish reasonable service targets for each of the 4 UVP strategy areas.

The Bangladesh Survey Organization, Ltd. (BSO) maps are a unique contribution to the UVP and, quite frankly, to service organizations in the Dhaka metropolitan area. No such composite slum listing exists. As noted previously, prior to commissioning the BSO maps, a thorough review of existent materials and facilities who could provide such services was performed by the UVP. As noted, information from these maps needs to be combined with the Center for Urban Studies' slum population survey to ultimately render the full UVP service picture. It should be noted that the maps are limited to the Dhaka metropolitan area and some 22% of the urban volunteers live and serve in thanas or communities considered peri-urban (and hence not shown on these maps). For those areas, additional estimates will have to be made. The BSO, Ltd. maps show approximately 300 slum communities. On the other hand, the Center for Urban Studies has estimated that the number of slum communities in Dhaka has probably increased to around 600-800. The discrepancy between these two figures is being examined. It is assumed that part of the discrepancy lies in the interpretation of slum borders, such that the BSO Ltd. has utilized confluent definitions, combining several or many slum clusters into one, whereas the Center for Urban Studies has utilized more discrete borders, counting each individual cluster separately in their tally. Differences in definition of slum community might also play a role.

Ongoing communications with the Center for Urban Studies have revealed that despite an initially optimistic forecast, the survey will not be completed this quarter. Hence, once again, the ability of the UVP to refine its goals with specific target figures must be delayed, since such refinements require essential denominator information.

The next step of combining the information from the UVP activity analysis with the mapping should allow us to begin to identify in which slum clusters the UVP volunteers now reside, and hence, move one step closer to defining the percentage of slum communities in which volunteers are active. The completion of the 1987 activity analysis brought forth new information (to be discussed below) regarding volunteer time and scope of work

which will also be used in the creation of realistic service targets for the UVP. Hopefully, all of this information will be "pulled together" in the next quarterly report.

Finally, the UVP infrastructure of field supervisors was markedly improved during this quarter with the selection and training of 18 new field supervisors. During the next quarter, with this infrastructure in place, the UVP will be able to verify and validate the activity analysis information, personnel and training information, and field service information. Last but not least, the actual location of the volunteers, the specific geographic descriptions necessary to locate these volunteers on a map will be obtained. It may, in fact, be necessary to hire a short-term staff member to track specific locations of volunteers so they can be accurately mapped.

As will also be discussed in the research section of this report, the demographic and surveillance information collected in the 70 research clusters (the sample registration system or SRS) was improved this quarter. This information will also be useful (even if it is not obtained from probability clusters) in noting catchment population estimates and demographic data for program planning purposes. It should be stressed that the information from these research clusters cannot be taken as representative of the entire slum population for the clusters are <u>not</u> probability clusters. Nonetheless, the data can be useful in beginning to create realistic project targets vis-a-vis catchment populations served by each volunteer, and hence, program service indicators and output estimates.

1-Year Volunteer Activity Analysis: (January to December, 1987)

The completion of the last quarter of the volunteer (and field supervisor) activity analysis yielded quite valuable results. The total number of volunteers identified during this quarter remained stable at approximately 1800 with the range of active volunteers varying between 773 to 838 per month. It should be remembered that "active" volunteers refer to volunteers who are engaged in service activities such as ORS distribution, and/or making referrals or providing health education information in the 4 UVP strategy areas. However, the identification of such volunteers is dependent upon the field supervisors. As previously noted in prior quarterly reports, this has clearly been a major limitation, since the number of field supervisors was inadequate for the number of volunteers being supervised. Nonetheless, for the moment, this was the best method available for field data collection and, as such, this bias remains constant throughout the year of analysis. However, the results of the analysis forcefully brought to the fore the need for an increased number of field supervisors, more clearly defined roles and tasks for the supervisors, and more training for all supervisors.

Most significantly, the activity analysis provides the UVP with a baseline of information regarding the scope of volunteer preventive health and interventive activities as well as a preliminary calculation of the number of families in the catchment of each volunteer. This information must all be considered preliminary; it will be verified next quarter when individual volunteers can be directly contacted when they come in for training. Furthermore, when the field supervisor infrastructure is in place, volunteers can be individually monitored, so that more accurate information will be collected and maintained.

During the last quarter, the number of volunteer hours spent in UVP activities per week ranged from 1 to 48 hours with an average of 15 hours per volunteer per week. The number of ORS packets distributed this quarter was quite high, 112,053 packets distributed to a total of 34,603 patients and approximately 29,000 families. The field supervisor:trained volunteer ratio this quarter was 1:86 but the field supervisor:active volunteer ratio was 1:38. The 34,603 patients treated with ORS during this quarter by the 716 average active volunteers meant that approximately 43 patients were treated per volunteer per 3-month interval. Approximately 3.2 ORS packets were distributed per patient during this time. (See Attachments 3A-3E)

The summary of volunteer activity per field supervisor (FS) can now be compared throughout the entire year with quite interesting results. (See Attachment 3B.) The percentage of active volunteers per 3-month interval per field supervisor varied widely between field supervisors and from month to month for the same supervisor. There are several reasons why the number of field supervisors changed throughout the year. During the first quarter reported, there were some new field supervisors involved who worked jointly with old ones in order to obtain practical training. At that time, more formal field supervisor training had not yet been instituted. After the transition overlap period, they began to perform individual services within their own catchment areas and, hence, submit individual data. This accounts for both the varying number of field supervisors the first quarter as well as the shift in number of volunteers for which each FS was responsible.

Another cause for the fluctuations in the number of total volunteers per field supervisor is internal urban migration. The volunteers are themselves part of the communities they serve and, hence, express the same population shifts as the entire slum community. However, when such intra-urban migration occurs, there may be a period after the migration before the volunteer is re-identified in a new field supervisor's catchment. During that interval she appears to be "inactive" due to the inability of her original supervisor to contact her. The new FS system implemented in 1988 will ensure much better tracking of

volunteers on a monthly basis so that such migration can, in fact, be promptly noted. Such changes in volunteer locations also mean that at least once a year (and potentially more often) the field supervisor:volunteer distribution must be formally re-evaluated.

During the interval January through December, 1987 a total of 1311 "active volunteers" were identified (out of 1804 volunteers who had received training from 1981 to 1987). During this year, there were 8453 field supervisor:volunteer contacts. A total of 257 volunteers (approximately 20% of the active volunteers) were contacted at least once every two months during this time interval, and roughly the same percentile of volunteers received only 1 or 2 contacts during the entire 12 month interval. Alternatively, 935 volunteers (71% of the active volunteers) received at least 4 contacts over the year (approximately every 3 months, although it should be noted that these visits may not have been spaced out equally over the year but may have been "bunched" in consecutive months). (See Attachments 3A and B for details.)

It should be borne in mind that this analysis reveals a baseline of activity for volunteers and field supervisors **prior** to the institution of much more vigorous training and service guidelines for volunteers and supervisors. This analysis was the first attempt by the UVP to identify the range and scope of individual volunteer and field supervisor activity. It clearly denoted the need for an improved field supervisory infrastructure, a more precise definition of volunteer and field supervisor tasks, and training to perform those tasks.

As will be discussed further in this report regarding field supervisor training, the new goal to achieve one field supervisor contact every 2 to 4 weeks will most likely result in a marked improvement in service. The significant increase in ORS distribution noted during 1987 following improvement in the field supervisor infrastructure stands as initial testimony to the potential of markedly improved service output.

Obviously, there was a wide discrepancy between the number of volunteers who had ever received UVP training (1981-87:1804) and the total number of "active" volunteers identified by the field supervisors within the time period of this analysis . To this end, all those volunteers who appeared on the UVP training rolls but who did not appear on the "active" volunteer list (between Jan-June '87) were divided among the existent field supervisors and an attempt made to contact and interview each of them. An interview schedule and format were established for this purpose.

Inactivity Analysis

In January and February, 1988 attempts were made by the FS to interview the 702 volunteers considered as "inactive" during the January through June, 1987 activity analysis. The purpose of the interview was to verify whether or not these volunteers were truely "inactive" and if so, why. Furthermore, through these interviews the UVP hoped to verify how many of the individuals who had ever received UVP training (all euphemistically called "volunteers") were really providing volunteer service to their communities and, hence, remained a vital part of the Urban Volunteer Program.

Needless to say, it took major efforts to even establish a rudimentary "starting" list of those who had ever received training since the inception of the urban volunteer training in 1981*. However, these efforts were continued throughout 1987, culminating this quarter with the production of the "first-ever" computerized list of volunteers! The first task was simply to identify those trained since the program's inception, and then attempt to verify or refine those numbers to reflect volunteers truely "active" in the program at this time.

For the purposes of this analysis, the "inactive" list was prepared by comparing the training and ORS code lists with the field supervisor contact list. Those failing to show any field supervisor contacts between January-June, 1987 were deemed "inactive". The field supervisors created several categories of reasons for this "inactivity" which they used during their interviews. Hence, one purpose of the interviews was to identify those volunteers who were distributing ORS, making referrals, or providing health education to their communities but who were considered "inactive" through loss of contact with their FS, at least during the 6 months under observation.

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* Obviously the type and caliber of training provided in 1981 is quite different from that provided in 1987, just as the goals and objectives of the UVP in 1981 are not at all equal to those for 1987/88. Hence, it is somewhat misleading to refer to the existence of the UVP since 1981; there were volunteers being trained under the title of the UVP, but the training itself and the scope of the program have shifted widely over these 7 years. It is probably more accurate to say that the UVP, as we now refer to it (with its current goals and objectives), has been in existence for only 1 and 1/2 years.

The interview categories were mutually exclusive. "Still active" meant the volunteer was inadvertently called inactive because of no FS contact (Jan-June) but, in fact, she had continued her service during this interval. "Irregular" referred to those volunteers who worked intermittently but who, nonetheless, were performing volunteer activities. Hence, although their number of field supervisor contacts were low, some sort of ongoing communication was maintained. Again, for the purpose of this analysis, they were wrongly categorized as inactive due to a lack of FS contact during the interval under study. "Currently inactive" was used to indicate those volunteers who truly had ceased their service due to a loss of support or contact with their field supervisors, but who would continue their volunteer activities if contact were re-established.

"Working elsewhere" referred to those volunteers having jobs in other organizations who no longer wished to perform volunteer activities. "Economic problems" referred to volunteers who had ceased performing volunteer service activities because of their extremis status. "Residence far away from community" included volunteers who had moved away from their original site and were not willing to serve in their new area (or in their original site due to distance). This category largely included volunteers trained early in the program who were not necessarily from the slums, but who initially were willing to serve slum areas near their homes. The "no contact" category indicated the volunteers who could not be located for interviewing, despite multiple attempts. In most cases this category referred to those volunteers who moved without informing their field supervisors of their new sites.

In a few cases, it was found that the volunteers were no longer performing service activities, but in fact, their tasks had been passed on to another family member! The obvious difficulty with this arrangement was that the new family member had not been trained and, therefore, was probably distributing ORS, but not performing the associated and critical health education, or in the worst case, may have been passing on inaccurate information. The "volunteer residence far from supervisor" group referred to those volunteers who had lost contact with their field supervisors primarily because of distance between their communities. It did not include loss of contact because of migration, but rather, loss of contact because of the large volunteer catchment per field supervisor.

The results of the 702 attempted interviews for those originally identified to be "inactive" during the Jan-June'87 analysis are shown in the following table.

Inactivity Analysis Interview Results

Mutually Exclusive Categories	No. of Volunteers	Percentage
Still active	190	27.1
Irregular	24	3.4
Currently not active	126	17.9
Working elsewhere	29	4.1
Economic problem	3	0.4
Residence far away from the community	5	0.7
No contact	281	40.0
Volunteer's job is done by their family members	3	0.4
Volunteer's residence far from supervisor	41	5.8
Total	702	100%

Approximately 30% (214) of the volunteers thought to be inactive were still active, but simply had not been contacted by the supervisors during the six months used for the purposes of this analysis. Another nearly 24% (167) were not active but wished to be and would be if field supervisor contact were improved (currently not active plus volunteer residence far from supervisor.) Only above 4% of the volunteers ceased their volunteer activities because of obtaining meaningful, full-time employment and not quite 0.5% ceased volunteer activities because of dire economic circumstances which prevented them from reaching out beyond their own households. By far the largest number of inactive volunteers, 281 (40%), were those for whom no information could be verified because they were not located for the interview. In all, only 46% (321) of those originally identified were truly "inactive" (the sum of the categories: working elsewhere, economic problems, residence far from community, no contact, job done by family members.)

Some 214 volunteers were identified who actually were continuing to perform service activities but had been omitted from the list because of lack of field supervisor contact during the study interval (still active or irregular). However, one can assume that most, if not all of them were included by the end of the full-year analysis. As noted, the inactivity analysis interviews were based on the results of the first six months of the year. Hence, there was most likely some overlap between this 214 and the 1311 identified to be active any time during the 1987 analysis. Obviously, if some of these 1311 were not contacted by their field supervisor during January - June, but only during the latter half of the year, they would have been considered inactive. However, the 167 volunteers identified to be truely inactive as a result of inadequate supervision or support, but

who indicated their wishes to resume activity potentially could be added to the 1311 "active" volunteers identified from the 1987 full-year analysis to obtain a new total of potentially active volunteers (1478) for 1988. Interestingly, this number is close to the 1442 volunteers identified by ORS code numbers and field supervisors. Again, the slight discrepancy between these numbers is probably due to the imperfect identification code system as well as the methodology used for data collection.

As already discussed, all prior existing program records were utilized to create an inclusive volunteer list, first noting all those ever trained and secondly, those currently active in the program. This is now being "computerized" and refinements in the volunteer coding identification system are in process. After the system is perfected, the newly - trained field supervisors will again contact each volunteer and confirm all information. Despite the discrepancies in numbers from this variety of sources and the newest information from field "tracking" interviews, it is realistic to say that approximately 1450 to 1500 volunteers are active within the UVP at this time. From the inactivity analysis, approximately 321 were truely inactive, the majority (281) of which were not interviewed because they could no longer be located. If one considers that approximately 1823* volunteers have been trained since 1981, there has only been a drop-out of 18% over 7 years or an average of <3% per year.

Furthermore, if one considers the number of recipients of ORS in 1987 (109,421) and divides this by the number of active volunteers identified in 1987 (1311), it might be determined that approximately 84 patients are treated per volunteer per year (7 patients per volunteer per month.) This does not indicate the number of families, so that those 84 patients may represent 84 different families or may only represent 15 to 20 families (if one uses the average of 5 members per family).

As already noted, when the new field supervisor infrastructure is in place, a more specific calculation of number of families served per volunteer will be obtained so that more precise estimates of catchment and service (both current and projected) can be created. Again, all of this information should be viewed as preliminary baseline information from a field service program which has evolved without specific guidelines for the volunteers vis-a-vis their service activities, targets, goals, or catchment populations to be served.

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* This now appears to be the most accurate number, based on most recent data (replacing the 1804 quoted in the Jan-Dec.,1987 analysis). Some volunteers were identified by the FS who had not appeared on the training registries.

Field Service Data Collection System

The newly proposed calendar (symbol) system of field data collection could not be instituted this quarter pending the initial training of the field supervisors. Furthermore, another pilot trial of the newly revised calendar will be necessary prior to the final printing and initiation of training, given the significant number of format changes made since the original trial nearly 1 year ago. One of the main changes in format will entail a division of volunteer activities into 3 categories: service/interventive, preventive health education, and referral. Under each of these categories, activities performed within each of the four strategy areas (diarrheal disease, nutrition, immunization, and family planning) can be noted. For example, under the service/intervention category, within the diarrheal disease strategy, one would note the number of ORS packets distributed; or under the preventive health education category, within the diarrheal disease strategy, one would mark the teaching of the 3 preventive health messages, teaching about packet ORS utilization, teaching about lobon-gur, and teaching about rice-based ORS; while under the referral category, again within the diarrheal disease strategy, one would mark referral to ICDDR,B or UVP diarrheal center. A full description of the new calender system and the results of the pilot planned for June will be reported in the next quarter or two.

In the meantime, a transition reporting form for diarrheal disease surveillance and ORS packet distribution was finalized this quarter, with implementation planned the next quarter. This form will be utilized until the calendar symbol system is fully implemented throughout the program. A transition form was deemed necessary because analysis of past diarrheal disease data indicated that there were a number of questions which needed more careful description and definition to improve the accuracy and consistency of the data collection. In addition, a new format was desireable given the incredibly eye-straining nature of the previous form. The volunteers and field supervisors have been asking for this revision for some time. However, initially it seemed realistic that the new calendar system could be directly implemented. With the recognition that the calendar system could not be implemented until the new field supervisors were trained, and that it would take approximately 3 and a half months to train all the general volunteers in this system (given the 2-3 day curriculum planned), institution of a transition form became more appropriate. The contents of this transition form are not significantly different from those of the previous form. However, the main difference will be improvement in the accuracy of information collected due to the improved format and instructions. After approximately six months of use, the data can be analyzed separately with these considerations.

The formalized drop-site distribution system has now been in effect since September, 1987. Attempts to "computerize" this information continue, with some progress in data entry over this quarter. However, the full development of the program along with appropriate range and consistency checks have not yet been instituted; there are plans to do so in the next quarter. Analysis of the drop-site ORS distribution data should complement the data from field service-ORS distribution to patients and can serve as an appropriate check on the figures tabulated from the field service system.

1987 Annual Report

A summary of the activities and progress achieved by the UVP in 1987 was presented in an annual report (See Attachment 4 for Table of Contents). The report will be presented to the ICDDR,B Director as well as the USAID Director and copies distributed to donors and Board members as deemed appropriate by the ICDDR,B Director. In addition, a revised "information sheet" on the program was also created.

During this interval, a collection of UVP slides and pictures has been formalized. Enlargements have been made into display posters for visitors to see and for program training, orientation, and group presentations. During the next year, there are plans to create a more formal UVP sound-slide show as well as an information brochure. The possibility of a UVP video is also being explored.

1987 ORS Distribution

In 1987, several improvements were implemented in the field service component of the UVP including the previously-described new ORS drop-site distribution system, a slight increase in the number of field supervisors (from 15 to 21), and more specifically, increased supervision of field supervisors in their ORS distribution. Following this set of improvements, it was quite gratifying to note resultant changes in ORS distribution from approximately April through December, 1987. Hence, the 1987 distribution more consistently reflected seasonal community diarrheal trends as well as a much larger distribution (1986 : 242,315 packets distributed to 78,761 recipients versus 1987 : 385,463 packets to 109,421 recipients).

Furthermore, the 1987 monsoon flooding precipitated an increase in diarrheal disease during the months of August through October as reflected in the number of admissions to the ICDDR,B Treatment Centre. The UVP was able to successfully respond to this increased community need as reflected by the increased number of recipients receiving ORS packets during that interval.

An analysis of the diarrheal disease trends in the research communities during that same interval will be performed next quarter. (See Attachment 5A for graphic depiction of 1986 and 1987 ORS distribution trends.)

Staff Changes During 1987

Key changes during 1987 included the arrival of the new UVP Director in April as well as the addition of a Belgian physician last summer (the latter has focused her energies in the area of nutrition). One new field research officer and one finance officer also joined the UVP and one individual served as a computer trainee during this time. Two consultants, one in immunization and one in nutrition continued their work. Furthermore, the services of a short-term nutritionist consultant were utilized to establish a supplemental feeding program and to improve the nutrition rehabilitation centers (NRC) recipes. Two staff members, the previous service coordinator and a trainer resigned during 1987, one to accept a position as an FAO consultant and the other to accept a position at the Bangladesh Rice Research Institute.

During the first quarter of 1988, approval was obtained for the filling of all vacant UVP positions, revision of current positions, and selected new positions for the following: 2 Community Health Service Coordinators (one vacant position and one new position); 1 Training Coordinator (upgrading of current position; 1 Nutrition Coordinator (change from consultant position to full staff position); 3 Trainers (upgrading of current position, filling of 1 vacant position and creation of 1 additional position); Data Management Officer (filling of current vacancy); Programmer (filling of vacant position); Junior Programmer (upgrading of trainee to permanent position); Secretary (upgrading of assistant to this position); Secretarial Assistant (addition of 1 position); Office Attendant (new position); and Driver (new position). Revised position descriptions and/or new position descriptions were created along with scopes of work and justifications. Recruitment has begun and it is hoped that the positions wil be filled within the next quarter.

COMMUNITY HEALTH SERVICE ACTIVITIES

REVIEW OF QUARTERLY ACCOMPLISHMENTS BASED ON LAST QUARTER'S PLANS: GENERAL SERVICE PROGRAM

See Attachment 6A for details of last quarter's plans.

1. Approval obtained for all newly revised position descriptions and hiring. Recruitment in process - interviews and final selection will occur next quarter.

2. Although much more data was collected from the 1987 activity analysis and the BSO maps were completed, the CUS slum census was not finished so that the specific program goals could not be completed this quarter. Will be deferred until next quarter when hopefully census data will be available.

3. Work on revised budget as well as remaining 3-year budget proposals in process - to be completed next quarter.

4. New field supervisors hired and training began for new and current field supervisors. New curriculum implemented.

5. Transition ORS data collection forms completed - to be implemented early next quarter.

6. Work continued on the new field service data collection system - final format in process. Due to significant format changes, decision made to hold another pilot trial next quarter, prior to full printing and implementation of massive training.

7. Full 1987 activity analysis completed.

8. Slum community maps completed but census data still not finalized.

9. Redistribution of volunteers per new field supervisors completed. Began work on the new volunteer PTS computer program.

10. 1987 ORS distribution put into graphic form and compared with 1986. "Cleaning" of 1987 diarrheal disease data initiated.

11. Central office analysis completed and appropriate support staff hired.

COMMUNITY HEALTH SERVICE ACTIVITIES

NEW QUARTERLY PLANS (APRIL - JUNE, 1988): GENERAL SERVICE PROGRAM

1. Utilizing the BSO maps, CUS population data, and UVP volunteer activity analysis - combine all data to determine current program service outreach, distribution and catchments.

2. Create more specific UVP goals with precise target numbers, to be discussed with USAID vis-a-vis refinements in their cooperative agreement.

3. Complete field supervisor training, including overlap of new and old for 1-month transition period, and implement new field supervisor system.

4. Implement transition forms for diarrheal disease and ORS data monitoring.

5. Finalize new symbol-calendar format and training curriculum, perform pilot study of new format, analyze results, and institute final refinements prior to volunteer training start-up in July.

6. Train all field supervisors in the new symbol-calendar field service data collection techniques.

7. Initiate development of volunteer PTS (personnel, training, and service) data base with appropriate computer programs, range and consistency checks, and reporting systems. This will entail a refinement of the identification coding system for all volunteers.

8. Begin to develop computer programs and catch-up data entry for the ORS supply (drop-site) distribution system; begin analysis of first 6-months of the system (September, 1987 - February, 1988).

URBAN VOLUNTEER PROGRAM GOAL II

To decrease the under 5 year old mortality rates in slum populations of Dhaka through selected interventions in diarrheal disease, nutrition, and immunizations provided through the Urban Volunteer Program's volunteer community health workers.

URBAN VOLUNTEER PROGRAM GOAL III

To decrease the under 5 year old morbidity in slum populations of Dhaka through preventive health education in the areas of hygiene and sanitation, nutrition, skin hygiene, immunizations and family planning provided through the Urban Volunteer Program's volunteer community health workers.

URBAN VOLUNTEER PROGRAM GOAL IV

To augment community awareness in the area of preventive health and child survival interventions focusing on diarrheal disease, nutrition, immunization and family planning.

COMMUNITY HEALTH SERVICE ACTIVITIES

DIARRHEAL DISEASE: ORS DISTRIBUTION

ORS Drop-site Distribution System and Monitoring Mechanisms

Data entry began in this new monitoring system but the full "computerization" (checks, analysis and reports) of the system will be implemented during the next quarter. See Attachment 7 for details of the amount of ORS distributed at the drop-sites this quarter.

ORS Packet Distribution and Diarrheal Patients Treated: Field Service Data

See Attachment 8 for monthly ORS distribution and diarrheal patient figures. As already noted, the creation of a transition data collection form was completed this quarter with implementation planned next quarter.

The graphic depictions for 1987 ORS packet distribution can be seen in Attachments 5A&C. The marked improvement (almost 50% increase in the amount of ORS packets distributed) between 1986 and 1987 have already been discussed and are the first fruits of the improved ORS distribution and field supervisory systems (although these improvements are just the beginning of those planned!)

A complete analysis of the 1986 and 1987 profiles of diarrheal patients treated will be presented in the next quarter. A cursory examination revealed that a significant amount of data cleaning would be necessary prior to final analysis and circulation of these figures. Comparisons between the ORS field service data and the ORS drop-site data will also be made. Finally, as much as possible, comparisons between ORS packet distribution and morbidity information will be made using the 2-week health recall information from the research clusters.

Once the field supervisor infrastructure is in place and an improved field service data collection system implemented, there are many pertinent questions regarding ORS use and distribution, as well as other oral therapies such as lobon-gur or rice-based ORS which need to be evaluated. Furthermore, the question of why so much ORS is being distributed to adults instead of those infants and young children most at risk of death from diarrheal disease will be further studied.

It is interesting to note that in 1987 an increase in ORS packets distributed during the post-monsoon season corresponded with outbreaks of diarrheal disease indicated by the increased numbers of patients seen at the ICDDR,B Dhaka Treatment Centre. In December 1987, an outbreak of watery diarrhea increased the number of patients in the Treatment Centre and again an increase in the amount of ORS distributed in the UVP communities was noted. This trend continued into 1988. Comparison of these figures with the data from research clusters regarding 2-week diarrheal disease prevalence rates (based on the 2-week health recall) will be performed during the next quarter after the data has been appropriately cleaned.

During the next quarter, the institution of the revised calendar symbol system will be limited to the pilot study and analysis of this data, as well as field supervisor training. Details have already been discussed under Goal 1.

Community Based Diarrheal Treatment Centres

Initiated analysis of the existent community-based diarrhea treatment centres - to be completed next quarter.

Field Teaching Tools: Prevention of Diarrheal Disease

During field supervisor training, a set of teaching tools will be developed that can be used in the field to share preventive health concepts. It was recognized that a major deficient in the program was the lack of appropriate field teaching materials for use by the field supervisors and volunteers when providing preventive health education in their communities. The original three preventive health messages studied by Dr. Stanton need to be taught and reinforced throughout the UVP. In order to adequately teach these messages, some of the same teaching tools utilized under Dr. Stanton should be implemented throughout the program. In fact, although the concepts have been taught, the teaching tools utilized in the research of the Water and Sanitation Project have not been replicated for general field use. To some extent, they have been used by the trainers in the program but not made available to the field supervisors and the volunteers themselves. Obviously, if the system is to work, volunteers must have their own copies to utilize when training their neighbors and community members. Hence, during the field supervisors' (new and old) orientation and training, they will develop a set of their own preventive teaching tools focusing on the 3 diarrheal disease messages. The field implementation of these messages will occur in the next two quarters; following plans to develop similar tools for all volunteers through field-based training sessions.

Furthermore, an analysis of the field supervisors, NRC volunteers and hospital volunteers' diarrheal disease knowledge at the beginning and end of the recent courses offered will be performed to give some indication of volunteer retention of knowledge in this area. (Retention from time of last training as evidenced by pre-test score, and retention through the course as evidenced by the (post-test score.) One of the key strategies of 1988 will be to focus on diarrheal disease prevention concepts through field-based training for volunteers and an improved field supervisor system.

UVP-ICDDR,B Diarrheal Treatment Center

The role of the UVP trainees in the ICDDR,B Treatment Center will be discussed under the training section of this report. The initial development of a position aimed at hospital-community follow-up of diarrheal patients is also noted in that section. The implementation of the entire UVP-hospital training program was accomplished this quarter.

COMMUNITY HEALTH SERVICE ACTIVITIES

REVIEW OF QUARTERLY ACCOMPLISHMENTS BASED ON LAST QUARTER'S PLANS: DIARRHEAL DISEASE - ORS DISTRIBUTION

See Attachment 6B for details of last quarter's plans.

1. Data entry for ORS drop-site begun as well as development of computer program and checks.

2. Transition diarrheal disease and ORS forms completed - implementation and training planned for early next quarter after new field supervisors' training completed.

3. 1986 and 1987 ORS graphics completed and compared.

4. Work continued on the new field data collection system with new pilot planned for next quarter.

5. Newly-developed diarrheal training curricula for hospital volunteers, NRC volunteers and field supervisors implemented.

COMMUNITY HEALTH SERVICE ACTIVITIES

NEW QUARTERLY PLANS (APRIL TO JUNE, 1988): DIARRHEAL DISEASE

1. Implement transition ORS field data forms.

2. Complete curriculum for the revised field data collection system (symbol calendar).

3. Institute pilot of new calendar system and evaluate the results.

4. Train field supervisors in new calendar system.

5. Perform clean up of past data and initiate analysis of field ORS data as well as diarrheal morbidity data from 2-week health recall surveys performed in the research clusters during 1986 and 1987.

6. Develop diarrheal disease prevention training tools during the field supervisors' training. Implement field supervisor use of these tools in the next quarter.

7. Complete field supervisor training.

8. Finalize analysis of 2 existent community-based diarrheal treatment centers.

9. Develop a plan for field-based reinforcement and teaching of diarrheal disease for the general volunteers.

10. Analyze course results vis-a-vis diarrheal disease knowledge (prevention and treatment) from the NRC, hospital, and field supervisor training courses.

COMMUNITY HEALTH SERVICE ACTIVITIES

VITAMIN A CAPSULE AND NEEM SOAP DISTRIBUTION, FAMILY PLANNING AND GENERAL IMMUNIZATION REFERRALS

See Attachments 9A&B for the summary of vitamin A capsule and neem soap distribution, as well as general immunization and family planning referrals made for January, February, and March, 1988. Program efforts to improve field service data collection for these activities has already been discussed, particularly vis-a-vis the new calendar symbol system.

The 1987 annual report summarizes the service activities in each of these areas. Approximately 2200 children with xerophthalmia were detected and treated with oral vitamin A. Nutrition education was augmented by distributing 2000 packets of vegetable seeds to encourage people to grow vitamin A-rich green, leafy vegetables on roof-top gardens. Approximately 3500 bars of neem soap were distributed to promote hygienic practices and to prevent scabies. The general volunteers have actively motivated and referred nearly 8000 mothers and children for vaccinations (general volunteer program) and made nearly 9500 family planning referrals in 1987.

Planning for the distribution of vitamin A capsules (preventively) in slum areas was pursued with Helen Keller, Int'l. and UNICEF. During the next quarter, more formal strategies for Dhaka metropolitan area vitamin A capsule distribution will be created. The UVP will play a significant role in this activity.

Potential UVP research activities in the area of the prevention of vitamin A deficiency were also explored, particularly the feasibility of utilizing conjunctival impression cytology for screening.

The distribution of vegetable seeds, neem soap, and vitamin A capsules should all show significant improvement once the field supervisor infrastructure is in place. Systematic education of the general volunteers to maintain a high level of knowledge, as well as systems of distribution, monitoring and supervision will also need to be implemented.

The nutrition curriculum has already been revised and the diarrheal disease and hygiene curriculum will be revised in 1988. However, the family planning curriculum needs to be fully revised with program-wide family planning training performed and the development of a metropolitan referral network initiated if the UVP volunteers are to improve their family planning referral activities. This work has begun and will be continued in the next quarter.

COMMUNITY HEALTH SERVICE ACTIVITIES

REVIEW OF QUARTERLY ACCOMPLISHMENTS BASED ON LAST QUARTERS'S PLANS: VITAMIN A CAPSULE AND NEEM SOAP DISTRIBUTION, FAMILY PLANNING AND GENERAL IMMUNIZATION REFERRALS

See Attachment 6C for details of last quarter's plans.

1. New field supervisor selection completed. New and old field supervisors' training begun.

2. Continued discussions with Helen Keller Int'l. and UNICEF regarding UVP's role in metropolitan vitamin A capsule distribution.

3. Family planning consultant's scope of work developed and initial negotiation/approval process begun.

4. Ongoing work on the development of a new family planning manual and revision curriculum pursued. Initial refinements of family planning training curricula were implemented in field supervisors' training, NRC training and hospital training this quarter.

COMMUNITY HEALTH SERVICE ACTIVITIES

NEW QUARTERLY PLANS (APRIL - JUNE, 1988): VITAMIN A CAPSULE AND NEEM SOAP DISTRIBUTION, FAMILY PLANNING AND GENERAL IMMUNIZATION REFERRALS

1. As already noted, implement pilot study for new revised calendar system.

2. Finalize calendar training curriculum and use it to train field supervisors.

3. Develop scope of work for family planning consultant to develop family planning referral network within Dhaka metropolitan area and to finalize family planning instructor's manual and trainee information pack for field supervisors and general volunteers.

4. Begin contacting existent family planning agencies already utilized by the UVP and identify other NGOs performing family planning activities within the UVP catchment areas of the NRCs.

5. Continue further discussions with UNICEF and Helen Keller, Int'l., regarding Dhaka metropolitan vitamin A distribution.

6. Begin revisions of the basic health questionnaire.

7. Pursue possibilities of Vit A research-develop concept papers per 1988 research priority plans.

COMMUNITY HEALTH SERVICE ACTIVITIES

IMMUNIZATION ACTIVITIES

Immunization Referrals

The Urban Volunteer Program continued to refer women and children to immunization centers on an informal basis. During January through March, 1988, 842 women and children were referred by UVP general volunteers and, in some cases, taken to the immunization centers. The UVP 1987 Annual Report gives a full summary of informal immunization referrals (7976 mothers and children).

Based on the findings of the pilot project, planning for the introduction of key aspects of the immunization referral project into the broader UVP was initiated. Program-wide implementation of formalized referral activities cannot take place, however, until the new field supervisor training is completed and immunization training of all general volunteers has occurred. It is estimated that the training of all general volunteers will take approximately 6 to 8 months.

An update of the immunization referral sites will also be necessary prior to program-wide implementation of the formal referral system. Each field supervisor will have to be acquainted with the immunization referral centers in the catchment areas of all of her volunteers. The field supervisors will then need to relay this information to each of their volunteers, including physically taking the volunteers to the referral centers in their area and making the appropriate introductions. The addition of immunization referrals to the new calendar data system has already been completed.

Analysis of the UVP's past immunization coverage surveys and the basic health questionnaire was performed; each will be repeated in the research clusters the next quarter, at the end of the first year of the pilot referral project. Revision of the immunization section of the basic health questionnaire was also performed this quarter.

Pilot Immunization Referral Program

In January, February, and March, 1988, our immunization volunteers referred 276 children and 212 mothers to immunization centers. (See Attachments 10A-D). The reasons for missed referrals follow in the table below.

Missed Referrals - Pilot Project: Jan-March,1988

Reasons for Missed Referrals*	Missed Visits	Visits with <5 mothers	Visits with <5 children
Mother or child ill	3	30	37
Volunteer or family ill	-	-	-
Center refusal**	-	-	-
Hartal/political disturbance	-	-	-
Volunteer working	3	-	-
Volunteer leave or family problem	5	-	-
Women or children in catchment area already immunized	2	9	5
Mother working or not at home	-	4	2
Distance too far	1	-	2
Parents not interested or afraid	-	3	-
No reason given	-	-	-
Other	-	-	-

See Attachments 10C&D for details regarding individual targets as well as figures for the completed series. During the course of 1987, the pilot project referred 794 children and 749 mothers to "immunization" centers.

The summary report of the immunization pilot project was also completed this quarter. (See Attachment 11 for Table of contents.) Copies of the report are available with plans for formal publication of the material in the near future. The immunization pilot project will continue through the next quarter so that one year's referral data can be completed. After that time, the project will be continued for an additional six months during the "start-up" of the full UVP immunization referral program. In the next several months, it will be determined whether an additional evaluation will be useful to compare the more intense referral program as evaluated in the pilot with the general immunization referral to be implemented throughout the UVP.

Transition after Departure of Immunization Consultant

This quarter, due to the incipient departure of the UVP's immunization consultant, considerable time was spent planning for the transfer of her responsibilities and duties to the community health service coordinator. It was decided that a new consultant would not be necessary, but that a temporary immunization assistant could be hired during the six months following the departure of the current consultant, in order to assist the community health service coordinator during the "start-up" of the immunization referral program throughout the UVP.

Volunteers and their Children's Immunization Status

An evaluation of the immunization status of the volunteers themselves (or their spouses) and their children was again needed in order to re-institute the immunization referral program for the volunteers' children. Planning and initial data collection began this quarter and will be completed next quarter.

Immunization Training

Immunization training was provided as part of the core training of the 12 new UVP nutrition trainees for the NRCs as well as the 22 hospital trainees and the 18 new field supervisors. The new immunization training curriculum was utilized along with the new manual. (A Bangla translation is in process.) Immunization health messages taught in the NRCs were also refined (See Attachments 12&13 for table of contents of the immunization training manual and the list of immunization-related health messages taught in the NRCs.)

Analyses of the immunization pre- and post-test results from all recent trainees are available.

UVP and Dhaka EPI

The UVP continued to play an active role in Dhaka metropolitan EPI planning through its participation in the steering committee.

Ongoing meetings with Dhaka Municipal Corporation, the Dhaka Civil Surgeon, and National EPI/UNICEF staff regarding the UVP's roles in urban immunization activities continued.

COMMUNITY HEALTH SERVICE ACTIVITIES

REVIEW OF QUARTERLY ACCOMPLISHMENTS BASED ON LAST QUARTER'S PLANS: IMMUNIZATION ACTIVITIES

See Attachment 6D for details of last quarter's plans.

1. Survey of immunization status of volunteers and their children completed. New referral system implemented.

2. NRC volunteers received immunization training as part of their core training.

3. 1-day revision training for immunization volunteers performed.

4. Immunization preventive education messages revised and implemented in new NRC maternal education service.

5. Continued to participate in Dhaka Metropolitan EPI planning.

6. Initiated first step for expansion of immunization referral strategy throughout UVP including an addition to the new calendar format, immunization training for new field supervisors, initial revision of immunization referral centers and plans, for field supervisor responsibility in program-wide immunization referral system.

COMMUNITY HEALTH SERVICE ACTIVITIES

NEW QUARTERLY PLANS (APRIL TO JUNE, 1988): IMMUNIZATION ACTIVITIES

1. Select new immunization field supervisor, orient and provide basic training.

2. Complete transition planning for departure of immunization consultant and ensure that all information has appropriately been transferred to new community health service coordinator who will assume these responsibilities. Initiate selection process for immunization assistant.

3. Initiate major immunization training for general urban volunteers: two classes simultaneously with 25 per class.

4. Complete basic health questionnaire and final immunization coverage survey for conclusion of 1 year's data for pilot immunizational referral project. Analyze data.

5. Finalize paper reporting results of immunization pilot project and submit for approval.

6. Complete revisions of immunizational referral center list. Revise referral centers per field supervisor (dependent upon catchments of their volunteers). Begin to inform each field supervisor about the centers in her volunteers' catchment areas. Begin field supervisor - immunization center introductory visits.

7. Complete EPI information packet for those taking immunization course, including EPI flip chart. Develop/order immunization "bag" for field supervisors and volunteers.

8. Ensure that all NRCs are equipped with basic immunization teaching materials, including EPI flip chart.

9. Continue to participate in Dhaka EPI planning and formalize UVP's role in the urban strategy.

10. Make decision whether or not operational research project comparing recent pilot referral program with broader, less intense referral program (similar ....that which will be implemented in the full UVP) would be useful.

COMMUNITY HEALTH SERVICE ACTIVITIES

NUTRITION

Nutrition Rehabilitation Centers (NRCs): Catchment Populations and Nutrition Specialty Volunteers

In January, 1988 a survey was performed by the nutrition team of the UVP in order to determine the catchment areas of the 3 current nutrition rehabilitation centers. The catchment population was defined as well as the borders of the area, and the number of active general volunteers in each location. Maps of the catchment slums were also drawn by the nutrition team. A survey to determine all available medical facilities within each NRC catchment area was also performed. This type of baseline information will be collected prior to the institution of any future NRC.

The scope of work for the development of a system of nutrition specialty volunteers in the catchment neighborhoods of the NRCs was also developed this quarter. Such volunteers would be specially trained in growth monitoring, preventive nutrition education, referral to the NRCs and performing follow-up of patients after discharge from the NRCs. They would supplement the duties of the NRC trainees in the centers, but through community-based preventive nutrition services. They could continue to perform general urban volunteer activities, but their focus would be on nutrition and growth monitoring.

NRCs: New Training Curriculum, Guidelines, and Monitoring Standards

A major focus this quarter was the completion of the nutrition curriculum and its utilization in the NRC training course for the 12 newly-selected trainees. The UVP nutrition team designed the curriculum and assisted the training section of the UVP during the 8-week course. (See Attachment 14.) Pre- and post-test results from the training are summarized in Attachment 15, as well as copies of the questionnaires.

The development of the NRC "information packet" which will form the basis of the nutrition manual was also finalized and translated into Bangla. This is a critical document in terms of laying a solid foundation of consistent guidelines and monitoring standards for the NRCs as well as summarizing key educational messages from the training. Actually, an entire new NRC system will be implemented once the preliminary training is completed and the new NRC trainees installed in the 3 centers. (See Attachment 16 for the table of contents of the information packet.) The full information packet is available upon request.

In each of the centers, Role 1-the NRC supervisor was also given specific symptom-based treatment training. This entailed the development of a second new curriculum and information packet designed specifically for role 1. The training and related materials were developed and implemented this quarter.

Attention was also directed to the creation of new NRC recipes, followed by field testing to assure consistent quality and calorie content, as well as feasibility and availability in the community setting.

NRCs: Community Committees and New Facilities

Frequent community meetings were held with members of the existent 3 nutrition committees to discuss the new NRC guidelines and the development of broader-based community nutrition committees. However, the establishment of new sites and facilities for 2 centers and the development of a new facility at the old site for the third center were the quarterly goals. Two of the NRCs continue to function out of temporary sites because of displacement post-flooding or inability for the community to find a suitable permanent facility. The third center was damaged in the flooding. Catastrophe relief funding from the French government was available for this purpose. Agreements were drawn up and signed (with appropriate legal documentation and support) between 2 of the nutrition committees and the landlords of the sites upon which their new facilities were to be built. A decision was made to continue the third nutrition center at the temporary site, until the committee could find a suitable permanent site. Hence, using UVP's flood relief funds, and with UVP support and supervision, Lalbagh and Keranigan,j committees were able to initiate reconstruction of their community NRCs. Although the agreement was supported by the Gandaria committee, unforeseen objections on the part of the landlord prevented final signing.

NRCs: Patients

During the period that the new trainees were participating in their preliminary training, the "old" NRC trainees continued to function in the NRCs. In the future, overlap between the old and new trainees will be planned during the last part of the new trainee course. However, because of the major changes instituted this year, overlap was minimal.

During this quarter, 32 patients were treated in the 3 existent NRCs. Due to the initiation of the new NRC program and, in fact, new facilities for two of the centers, there was a short period during which all 3 centers were closed. (See Attachment 17 for the quarterly summary of patient rehabilitation.)

NRCs: Health Messages

The maternal health education program in the NRCs (12 messages) was also revised and new teaching materials incorporated. An overview of all nutrition training materials was performed, including materials available in the NRCs and for the general nutrition training of all volunteers.

NRCs: Internal Report (1985-1987)

During this quarter, the review of the 3 NRCs from 1985 through 1987 was finalized by the current nutrition coordinator consultant. Details of the key findings, were discussed in the last quarterly report. The major revision of the NRCs and the new guidelines were strongly influenced by the findings of the internal evaluation.

NRCs: New Forms

The final development and piloting of the new NRC forms including the core admission, monitoring and discharge form as well as the follow-up form, referral form, waiting list, register book and attendance book all took place this quarter. Additional supervisory forms for the technical supervisor were also designed.

NRCs: Pharmacy

The re-organization of the NRCs' pharmacies was also completed and instituted.

Medical Quality Assurance for the NRCs

As already noted, major changes in the NRC standards and quality of care were finalized and implemented through the training of the new NRC volunteers. Note that the NRC staff are general volunteers selected for this 1-year practical nutrition training opportunity. However, prior to their initiation in the NRC practical training program, they now receive a very intensive 8-week preparatory nutrition training curriculum which has been designed and implemented this quarter, along with the new NRC guidelines. The table of contents from the NRC information packet in Attachment 16 summarizes these guidelines.

Nutrition Section Staffing

Formal position descriptions and scopes of work for the nutrition coordinator and the technical supervisor of the nutrition section were finalized. Transition plans for the selection of a nutrition coordinator and the formalization of the position (upgraded from a short-term consultant position) were instituted. The revised position description was approved and recruitment initiated. It is hoped that the new nutrition coordinator can be selected in the next quarter so that overlap with the outgoing nutrition consultant coordinator can occur. The role of the nutrition medical advisor was discussed in detail with the institution of the new-symptom-based treatment methodology in the NRCs. This will be carefully evaluated at all 3 sites.

Nutrition Training for Hospital Volunteers and Field Supervisors

The nutrition training curricula for the hospital trainees as well as for the new field supervisors were developed and instituted this quarter.

Supplemental Food Program

The implementation of the full supplemental food program was initiated this quarter after the delay imposed by the flood conditions. In addition, the supplemental food program document was completed. The complete document is available upon request.

Community Nutrition Survey - Keraniganj

A draft of the survey results was completed; it will be submitted for publication next quarter.

Extension Feeding Project: Flood Response Activity

The summary report of the extension feeding project was completed and is available for review.

Collaborations

UVP staff continue to maintain close relationships with Dhaka Treatment Center, Save the Children Fund (UK) Treatment Center, UNICEF, Helen Keller International and a variety of other NGOs and government offices involved in nutritional activities. The new role of the UVP in vitamin A capsule distribution has already been discussed. Particular attention was devoted to the development of a collaborative relationship with the Child Health Program of the ICDDR,B Treatment Center.

COMMUNITY HEALTH SERVICE ACTIVITIES

REVIEW OF QUARTERLY ACCOMPLISHMENTS BASED ON LAST QUARTER'S PLANS: NUTRITION

See Attachment 6E for details of last quarter's plans.

1. UVP nutrition training course fully implemented and evaluation performed.

2. New NRC guidelines finalized and translated into Bangla; NRC information packet completed.

3. New NRC guidelines fully implemented.

4. New trainees to start in the NRCs in April (due to delay in construction of the new NRCs).

5. Catchment surveys completed for all 3 NRCs.

6. Medical referral facility survey completed for all 3 NRCs.

7. Revised community committees instituted (to some extent) at each NRC.

8. Recruitment process for nutrition coordinator begun.

9. Role 1 - supervisor's specialized training implemented.

10. Reconstruction of 2 NRCs initiated - to be completed in April.

11. Computer program development and the analysis of past NRC data continued as well as "computerization" of UVP nutrition bibliography.

12. Extension feeding report finalized. Next draft of supplemental feeding project document and NRC survey report completed - hope to finalize both early next quarter.

COMMUNITY HEALTH SERVICE ACTIVITIES

NEW QUARTERLY PLANS (APRIL TO JUNE, 1988): NUTRITION

1. Select the new nutrition coordinator and perform orientation and baseline training.

2. Provide technical and supervisory assistance to the 3 newly implemented NRCs.

3. Continue development on the evaluation plan for the NRCs.

4. Analyze past data (1986-87) collected from participants in the NRCs (during rehabilitation and follow-up).

5. Begi n analysis of past anthropometric data collected from the research clusters.

6. Begin planning for the specialized nutrition volunteers in the NRC catchment communities.

7. Evaluate referral systems to CNU and Dhaka Treatment Center.

8. Participate in Dhaka metropolitan planning for vitamin A capsule distribution.

9. Implement new computer program with the appropriate consistency and range checks for ongoing NRC data as well as evaluation of past NRC data.

10. Continue data entry on the NRC bibliography.

11. Begin to analyze supplemental food program data. 12. Finalize supplemental food program report and program document as well as nutrition survey report for publication.

13. Analyze information collected pre-and post-flooding regarding disease morbidity and anthropometric data from research clusters.

TRAINING ACTIVITIES

New Curricula

The initiation of major new training curricula for the NRC trainees, the hospital trainees and the field supervisors were all implemented this quarter. (See Attachments 18A-C for curricula outlines.) In all cases, pre-and post-testing was given to all trainees as well as course evaluations. (Summaries are available.) Manuals have or will be created for each of these courses. The NRC training has been discussed under the Nutrition Section of this report and the field supervisor training has been noted under the General Program Section.

ICDDR,B Treatment Center (Hospital) Practical Training

During this quarter the UVP-Hospital project document was refined and finalized with implementation anticipated early in April. (See Attachment 19 for the table of contents from the project document.) A complete project document is available upon request. As noted, the entire project document was created and refined over the last two quarters.

During this quarter, the new volunteers for hospital training were selected and received their preliminary 3-week training. The hospital supervisors will be selected and trained during the next quarter.

Calendar Training

As already noted, improvements in the calendar format and curriculum continued but training was deferred until field supervisor training is completed. A pilot of the new format will be carried out in June.

Nutrition Training

The new NRC curriculum and the NRC information packet were both finalized and utilized this quarter. All materials were produced in English and Bangla. The revised nutrition curricula for hospital and field supervisor training was also implemented.

Development of Field Materials for Field Supervisors and Trainers

As already noted, the development of field materials to teach the diarrhea prevention messages was implemented as part of the field supervisor course. (See Section entitled Field Supervisor Infrastructure under Community Health Service Activities: General Program.)

Position Descriptions: Training Section Staff

New position descriptions for the Training Coordinator, Trainers, Nurse Instructor and Class Teachers were all approved. The recruitment process was initiated for the Training Coordinator and Trainer positions. It is hoped these will be filled by the next quarter.

Summary of Quarterly Training

Summary of training activities performed this quarter: 18 new field supervisors participated in field supervisor orientation and training which included the UVP core revision course; 21 current field supervisors participated in field supervisor training; 22 volunteers participated in new hospital-volunteer training which included key sections of revision training; 18 new and 1 old field supervisor participated in VERC-trainers' training; 12 volunteers participated in the new advanced nutrition course (included a VERC workshop and sections of UVP revision course); 4 volunteers participated in New Life Center health teachers' training course; and 20 UVP staff participated in a VERC workshop for trainers' entitled: Approaches and Strategies.

TRAINING

REVIEW OF QUARTERLY ACCOMPLISHMENTS BASED ON LAST QUARTER'S PLANS: TRAINING

See Attachment 6F for details of last quarter's plans.

1. NRC training course completed and evaluated.

2. Implemented the new UVP - hospital volunteer training program and evaluation performed.

3. Field supervisors' training started.

4. Instructor training manuals for each of the above courses begun. Information packet for NRC completed. Information packet for hospital volunteers will be completed next quarter.

5. Continued work on the new calendar training curriculum.

6. Recruitment initiated for permanent training section employees. Hope to finalize selection next quarter.

7. Family planning training manual initiated - first draft in Bangla. Developed scope of of work for family planning consultant.

8. Completed review and summary of all current UVP training materials and teaching aids.

TRAINING

NEW QUARTERLY PLANS (APRIL TO JUNE, 1988): TRAINING

1. Complete field supervisor training.

2. Complete curriculum for calendar training and implement pilot.

3. Continue development of field materials for field supervisors and trainers.

4. Fill staff vacancies in training section and provide new staff with UVP orientations.

5. Complete analysis of 3 recent training courses: NRC, hospital and field supervisor.

6. Finalize Bangla translation of immunization training manual.

7. Continue work on family planning training manual.

8. Initiate compilation of new revision training, nutrition training, and field supervisor training manuals.

9. Initiate volunteer PTS system, emphasizing accuracy of training status of all volunteers.

10. Participate in UNICEF's compilation of currently utilized nutrition training materials.

11. Evaluate (analyze pre- and post- test results) health education provided in the NRCs and the Supplemental Food Program.

12. Establish field training schedule for area-based meetings and utilization of trainers in field training.

URBAN VOLUNTEER PROGRAM GOAL V

To conduct service-related research and data collection in selective Dhaka slum communities to determine prevalence, incidence and risk factors involved in the development and prevention of diarrheal disease, nutritional deficiencies and malnutrition, as well as to evaluate the effectiveness of new community-based interventions for the promotion of child survival.

RESEARCH ACTIVITIES

2 Week Health Recall

Re-instituted the collection of 2-week health recall morbidity information in research clusters in order to perform a 4-year comparison of data as well as to examine rates pre- and post- flood seasons.

Sample Registration System (SRS)

Implemented major improvements in the SRS including the development of a more complete manual. Started training all research staff in new methods.

Verbal Autopsy

Training of the interviewers and FRO staff in the verbal autopsy format was completed in the beginning of this quarter, prior to the start of field work. Chart reviews continued throughout the quarter. Approximately 200 chart reviews of hospitalized death cases were completed along with 80 corresponding "blind" interviews in the field.

Supplemental Food Program

Data collection for the Supplemental Food Program continued - rounds 2 and 3 completed and round 4 initiated.

Infant Risk of Death

Ongoing refinement of the infant risk factor for death protocol continued. A new format to identify pregnant women was instituted, including the use of probing tools.

Immunization Surveys

Data collection for the immunization coverage survey and basic health questionnaire was completed in the 70 research clusters. Analysis was begun.

Research Section Improvements, Training, and Consultants

Refinement of interviewers, FROs and research coordinator position descriptions and tasks completed. Review of research volunteers' tasks also included.

Evaluation of field research techniques initiated, including instituting or, in some case, re-instituting consistency and accuracy checks, re-interviews, and random "spot" interviews performed by field supervisors. All research staff participated in a training course of research methods at VERC.

Multiple efforts were made to establish time schedules, monitoring mechanisms, and supervisory schedules within the research section. The time needed for each research survey tool (number of households per time unit per interviewer, etc.) was examined. The need for improved quality assurance checks throughout the research system, from field data collection through computer data entry was discussed and initial improvements implemented. Significant amounts of "data cleaning" will be necessary, especially of that data collected after the cessation of the Water and Sanitation Project.

Consultant obtained to assist in evaluation of current research cluster demographic data collection methodology and computer systems as well as to examine the feasibility of establishing probability clusters. Full report to follow.

Scope of work written and approval obtained for biostatistician consultant to come next quarter to assist in analysis of data collected during the past 2 to 3 years from the research clusters (and some general service data) which had never been cleaned, analyzed or reported. Also, developed a scope of work for a computer consultant to assist in the establishment of a system of documentation (source documents), filing, data cleaning (range and consistency checks), and reporting systems for every UVP computer program. He will also assist in the creation and development of the volunteer PTS (personnel, training and service) data system for the community health service and operational research of the UVP.

Diarrheal Data

Initiated review of research cluster and general field diarrheal morbidity data collected for the last 2 years but never reported or consistently analyzed!

NRC Data

Data entry of nutritional data collected from the NRCs (inter-center comparisons) and follow-up data: 1986 and 1987 was initiated.

1988-89 Research Plans

The 1988-89 research plans were reviewed with the Director, ICDDR,B and all donors.

Potential Publications

Completed drafts of the nutrition survey and immunization pilot project papers.

UVP Strategy Impact Education

Initial planning for UVP strategy-specific impact evaluation was begun.

RESEARCH

REVIEW OF QUARTERLY ACCOMPLISHMENTS BASED ON LAST QUARTER'S PLANS: RESEARCH ACTIVITIES

See Attachment 6G for details of last quarter's plans.

1. Consultant hired regarding probability clusters. Fruitful discussions. Awaiting final report.

2. SRS revisions completed and staff training performed.

3. Initiated analysis of past data from research clusters, including demographic SRS and 2-week health recall - much cleaning will be necessary before data is useful. Will need to be completed next quarter. This is also true for the general field service diarrheal disease information from the last 2 years.

4. Draft of the nutrition survey and immunization paper completed.

5. Infant death risk protocol revised - asked to delay start-up until next quarter after revisions can be discussed with new Head, CMD.

6. Continued work on maternal education protocol and polio-rotavirus protocol.

7. Continued planning UVP strategy-specific impact evaluation.

8. Vitamin A concept paper development deferred. Discussions were held with Technical Assistant regarding potential visit to ICDDR,B and UVP to pursue vitamin A research issues.

9. Continued to refine both field and computer sections of the research branch, particularly regarding documentation and quality checks. Scope of work developed for computer expert to work with the UVP research section to create quality assurance checks, documentation and filing system, and reports.

RESEARCH ACTIVITIES

NEW QUARTERLY PLANS (APRIL TO JUNE, 1988): RESEARCH ACTIVITIES

1. Complete implementation of the new SRS system.

2. Improve quality control checks on field data collection as well as documentation, filing, and cleaning of computer programs and systems.

3. Continue verbal autopsy validation study.

4. Complete nutrition survey and immunization pilot project papers. Submit for publication approval.

5. Initiate case-control protocol to evaluate risk factors for death in early infancy after refinements per request of Director of ICDDR,B.

6. Complete protocol of maternal education; impact on child survival as well draft of polio protocol. Submit for approval.

7. Complete revisions of basic health information questionnaire.

8. Utilize computer consultant and biostatistician to begin analysis of 1986 and 1987 research cluster data.

9. Summarize information and make decision about the feasibility of establishing a probability cluster surveillance system.

10. Explore the feasibility of vitamin A protocol utilizing conjunctival impression cytology.

11. Develop outline for strategy-specific impact evaluation.

URBAN VOLUNTEER PROGRAM GOAL VI

To augment community development and individual personal development by facilitating opportunities for the building of income generating skills and literacy skills in the volunteer staff participating in the UVP preventive health and child survival interventive community work.

INCOME GENERATING ACTIVITIES

During this quarter, January, February, and March, 1988, one woman was given an income generating loan as noted in Attachment 20. During the same period, the catastrophe loan fund continued to function quite successfully (See Attachment 21 for summary of loan monies distributed). At this time, 165 volunteers are participating in the catastrophe loan fund.

Income-Generating and Literacy Skill-Building Facilitation Network

The scopes of work were developed for 2 consultants to create a facilitatory network of income-generating and literacy skill-building opportunities for the UVP volunteers. Discussions were held with several NGOs involved in such activities.

Perceptions of UVP Volunteers

A scope of work was completed for an anthropologist consultant to develop a protocol examining UVP volunteers' self-perception and community perception: changing images of the UVP volunteers.

INCOME GENERATING ACTIVITIES

REVIEW OF QUARTERLY ACCOMPLISHMENTS BASED ON LAST QUARTER'S PLANS: INCOME-GENERATING ACTIVITIES

See Attachment 6H for details of last quarter's plans.

All five plans were addressed, with major energy devoted to the development of a consultant's scope of work for income-generating skills and literacy building network, as well as the development of the Bangladesh Volunteer Women's Association.

INCOME GENERATING ACTIVITIES

QUARTERLY PLANS (APRIL TO JUNE 1988): INCOME GENERATING ACTIVITES

1. Initiate scopes of work for 2 consultants to begin the formalization of income-generating and literacy skill-building facilitation network.

2. Formalize the Bangladesh Volunteer Women's Association records from the past and begin to establish more consistent meetings and record-keeping for the future.

3. Start work on the concept paper : changing images of UVP volunteers.

SPECIAL ACTIVITIES

Guests and UVP Visitors

During the first 3 months of 1988, a total of 12 UVP presentations were given to approximately 25 visitors, not including several groups of individuals participating in ICDDR,B training and requesting UVP tours and presentations. In addition, one student from Johns Hopkins University did a rotation with the UVP.

A T T A C H M E N T S

ATTACHMENTS:

1 Field Supervisor Selection Criteria

2 Field Supervisor Training Outline

3 1987 Volunteer Activity Analysis
3A Active Volunteer Summary: Jan-Dec, 1987
3B Summary of Volunteer Activity Analysis per Field Supervisor: Jan-Dec, 1987
3C Volunteer, Field Supervisor and Patient Ratios: Oct-Dec, 1987
3D Volunteers Activities Quarterly Report: Oct-Dec, 1987
3E Field Supervisor Activity Comparison: Oct-Dec, 1987

4 1987 Annual Report: Table of Contents

5A Number of ORS Packets Distributed: 1987
5B Number of ORS Packets Distributed: 1986
5C ORS Recipients: 1987
5D ORS Recipients: 1986

6 Past Quarterly Plans: January to March, 1988
6A General Service Program
6B Diarrhoeal Disease: ORS Distribution
6C Vit. A Capsule and Neem Soap Distribution, Family Planning and General Immunization Referrals
6D Immunizations Activities
6E Nutrition
6F Training
6G Research
6H Income Generating Activities

7 ORS Drop-Site Distribution Summary: Jan-March, 1988

8 ORS Packet Distribution and Diarrhoeal Patients Treated:
8A January 1988
8B February 1988

9A Community Health Service Activities: Vit. A Capsule, Neem Soap Distribution, Family Planning and General Immunization Referrals

9B Field Supervisor Service Form: Jan-Mar

10A Volunteer Record Summary: Children Referral
10B Volunteer Record Summary: Mothers Referral
10C Volunteer Record Detail: Individual Record of Referrals
10D Pilot Immunization Referrals: Individual Targets
10E Pilot Immunization Referrals: Target Visits

11 Immunization Report: Table of Contents

12 Immunization Manual: Table of Contents

13 Immunization Health Messages: NRCs

14 NRC Training Curricula Outline

15 NRC Training Pre and Post Test Results

16 NRC Information Packet: Table of Contents

17 NRCs: Patient Summary

18 New Training Curricula Outlines:
18A NRC (See Attachment 14)
18B Hospital
18C Fiels Supervisor (See Attachment 2)

19 UVP-Hospital Project Document: Table of Contents

20 Income Generating Loans

21 Catastrophe Loan Fund Quarterly Summary

Attachment 1

FIELD SUPERVISOR SELECTION CRITERIA:

a) Distribution and Supervisory Ratios
b) Experience: 2 years in UVP
c) Education: Level 8 minimal
d) Training: Basic/Initial (if not received I or R within 2 years, must repeat R)
Revision/Refresher

NLC, Treatment Centre, or NRC training preferred

e) Current FS or CHSC recommendation
f) Evidence of high quality of activity as UVP volunteer during the last year
g) Personal - minimum 25 years age preferred
h) Husband's or guardians permission
i) Minimum residence in current area of 6 months and reasonable assurance of remaining in area for additional 6 months

New Field Supervisors
Revised Orientation Schedule

Date	*Topic	
March 13 - March 17, 1988	UVP Overview	Completed
March 20 - March 24, 1988	VERC	Completed
March 27 - March 31, 1988	Revision Training	
April 03 - April 07, 1988	Revision Training	
April 10 - April 14, 1988	Revision Training	
April 17 - April 21, 1988	Field Supervisors' Field Work	
April 24 - April 25, 1988	Training Materials Development	
April 26 - April 27, 1988	Calender Training	
May 01 - May 02, 1988 Tentative	Field Supervisor's Field Work Planning & Implementation Session	
May 03 - June 03, 1988	1 month Supervised Field Work with Current Field Supervisor	

* Details of Daily Topics are available

Current Field Supervisor
Orientation Schedule
Spring, 1988

Date	Topic
March 20 - March 24, 1988	UVP Overview
April 10 - April 13, 1988	Coordination of Field Supervisor's Field Work. Field Supervisors/ Volunteer Distribution
April 24 - April 25, 1988	Calender Training
April 26 - April 27, 1988	Teaching Materials Development for Field Supervisors
May 01 - May 02, 1988 Tentative	All Field Supervisors Field Work Planning and Implementation Session

"Active" Volunteer Summary: January to December, 1987

No. of total "active" volunteers = 1,311

No. of trained volunteers to date = 1,804

Total no. of field supervisor contacts = 8,453

No. of Individual Volunteers Contacted per Time Interval	No. of Contacts per 12-month Interval	Total Field Supervisor Contacts
156 volunteers	1 time	156 contacts
104 volunteers	2 times	208 contacts
116 volunteers	3 times	348 contacts
87 volunteers	4 times	348 contacts
92 volunteers	5 times	460 contacts
103 volunteers	6 times	618 contacts
90 volunteers	7 times	630 contacts
105 volunteers	8 times	840 contacts
123 volunteers	9 times	1107 contacts
78 volunteers	10 times	780 contacts
126 volunteers	11 times	1386 contacts
131 volunteers	12 times	1572 contacts
Totals: 1,311 volunteers	12 times	8,453 contacts

URBAN VOLUNTEER PROGRAM QUARTERLY REPORT

Summary of Volunteer Activity Analysis per Field Supervisor
(January - December, 1987)

Field Supervisor Code No.	Avg. # of Volunteer Visits per Month per Field Supervisor				Total # of Volunteers per Field Supervisor				# of "Active" Volunteers per 3-Month Inverval				% of "Active" Volunteers per 3-Month Interval per Field Supervisor			
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
1+19	62	72	84	82	122	130	130	130	65	88	86	85	53%	68%	66%	65%
2	31	39	30	38	91	91	91	75	39	64	44	52	43%	70%	48%	69%
3	31	36	40	43	91	55	55	82	39	45	47	49	43%	82%	85%	60%
4	109	47	35	39	252	164	164	164	144	88	60	62	57%	54%	37%	39%
5	56	33	39	33	176	176	174	174	71	53	63	59	40%	30%	36%	34%
6	30	36	47	39	74	81	81	81	48	51	50	50	69%	63%	62%	62%
7	70	68	76	58	110	136	136	133	80	83	99	91	73%	61%	73%	68%
8	26	38	32	29	103	104	104	97	37	62	45	42	36%	60%	43%	48%
9+20	41	50	51	68	130	141	141	129	64	82	80	87	49%	58%	57%	67%
10	57	19	30	46	128	130	130	120	72	29	89	68	56%	22%	68%	57%
11	65	41	59	47	84	86	86	86	66	51	66	55	79%	59%	77%	64%
12	78	27	31	32	141	51	51	51	83	31	36	32	59%	61%	71%	63%
13	*	28	38	44	*	76	76	76	*	48	44	52	*	63%	58%	68%
14	36	13	38	36	133	137	137	136	51	13	48	47	38%	9%	35%	35%
15	33	23	51	35	76	56	56	57	40	48	56	35	53%	86%	100%	61%
16	9	17	23	22	72	76	76	77	11	27	33	33	15%	36%	43%	43%
17	14	14	14	13	14	14	14	14	14	14	14	14	100%	100%	100%	100%
18	*	7	47	73	*	95	95	95	*	14	64	73	*	15%	67%	77%
21	*	16	22	18	*	25	25	26	*	25	23	22	*	100%	92%	85%
GRAND TOTALS																
21					1,744 **	1,824 **	1,822 **	1,803 **	924	916	1,047	1,008				

Volunteer, Field Supervisor and Patient Ratios

January to March, 1988

1. 1804 total volunteers: 21 field supervisors = 86:1 (volunteer:field supervisor ratio)

   796 (average) "active" volunteers: 21 field supervisors=38:1 ("active" volunteer:field supervisor ratio)

2. 34,603 patients treated with ORS during October - December, 1987 by 796 (average) "active" volunteers = 43 patients per volunteer per 3 month interval

3. 112,053 packets of ORS distributed during October - December, 1987 to 34,603 patients = 3.2 ORS packets per patient.

Volunteers Activities Quarterly Report Collected Through Field Supervisors

October – December, 1987

Name of the Month and Year	# of Total Field Supervisor	# of Total Volunteers	Total # of Active Volunteer	LOCATION			OCCUPATION					Average Hours Spent in UVP/Week	Average hrs. Spent in Organization /Week	# of ORS Packet Distributed	# of Patient Treated	# of Families Treated
				IN	SUB	OUT	House Wife	UVP	Service	Student	Others					
October, 1987	21	1804	776	598	178	-	434	122	127	74	19	15 (Aver.) 1-36 (Range)	39 (Aver.) 7-52 (Range)	38,703	11,522	9,796
November, 1987	21	1804	773	594	179	-	443	118	119	82	11	15 (Aver.) 1-40 (Range)	39 (Aver.) 7-60 (Range)	33,273	10,051	9,274
December, 1987	21	1804	838	651	187	-	464	143	130	86	15	15 (Aver.) 1-48 (Range)	40 (Aver.) 7-56 (Range)	40,077	13,030	10,805
Total:	21	1804	796 (Average)	614 (Aver)	181 (Aver)	-	1341 (Total) 447 (Aver)	383 (Total) 128 (Aver)	376 (Total) 125 (Aver)	242 (Total) 81 (Aver)	45 (Total) 15 (Aver)	15	39	1,12,053	34,603	28,875

Attachment 3-D

Field Supervisor Activity Comparison
October - December, 1987

Field Supervisor Number	Average # volunteer visits/month by Field Supervisor	% of 'active' volunteer over total volunteers of 3 months
1+19	82	65
2	38	69
3	43	60
4	39	39
5	33	34
6	39	62
7	58	68
8	29	48
9+20	68	67
10	46	57
11	47	64
12	32	63
13	44	68
14	36	35
15	35	61
16	22	43
17	13	100
18	73	77
21	18	85

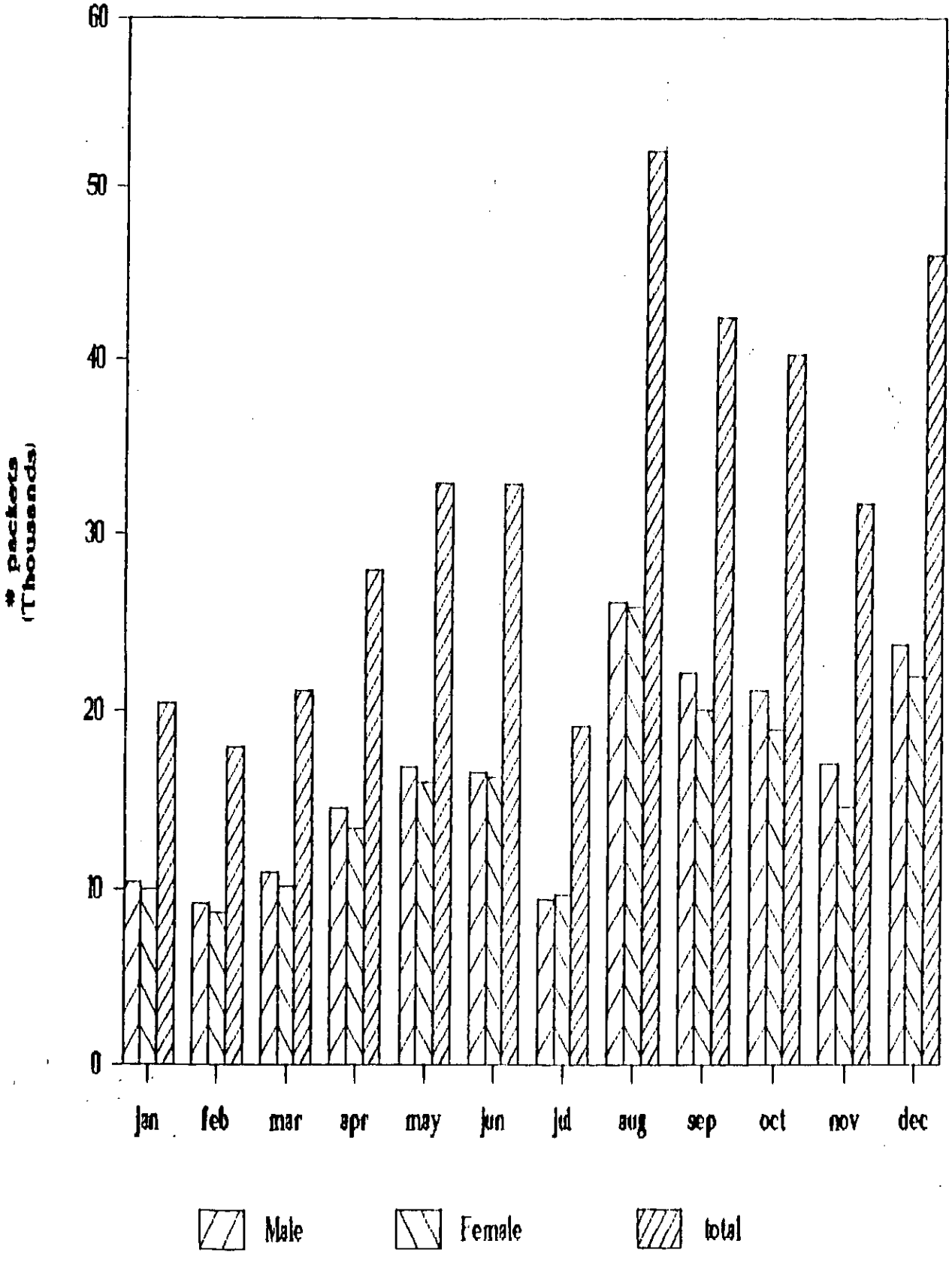
Attachment 4

1987 ANNUAL REPORT

TABLE OF CONTENTS

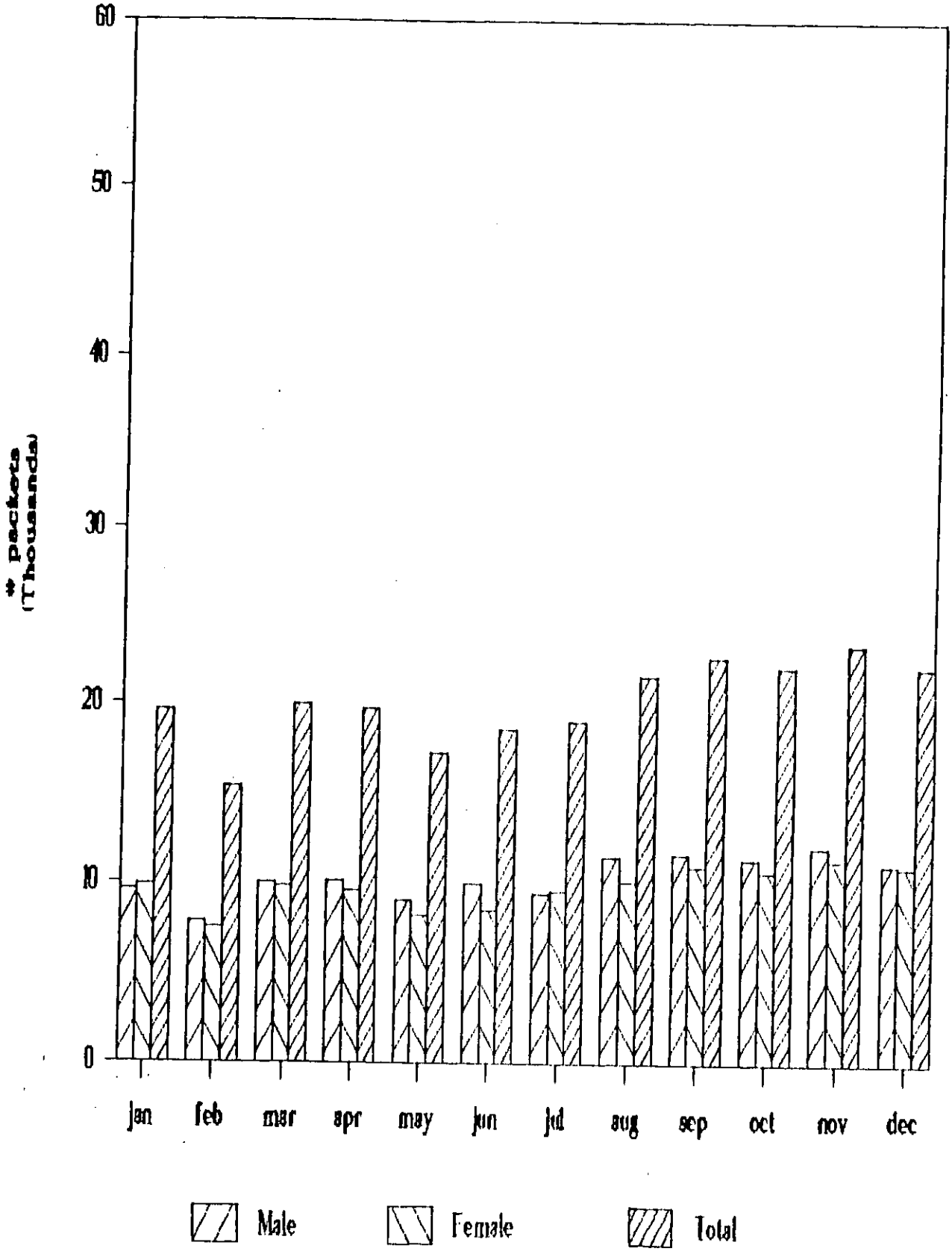
ORS packets distributed : 1987

URBAN VOLUNTEER PROGRAM



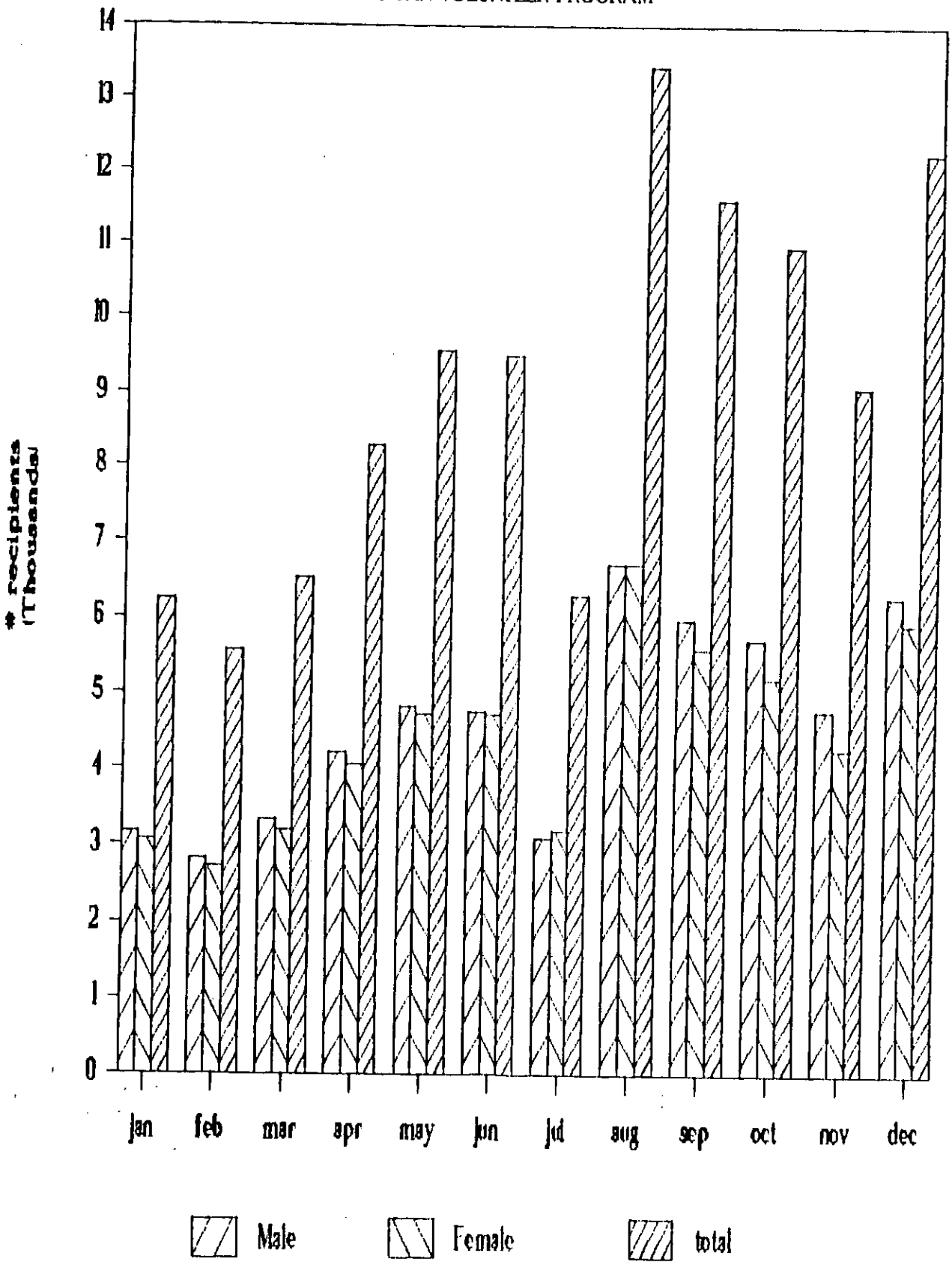
#ORS packets distributed : 1986

URBAN VOLUNTEER PROGRAM



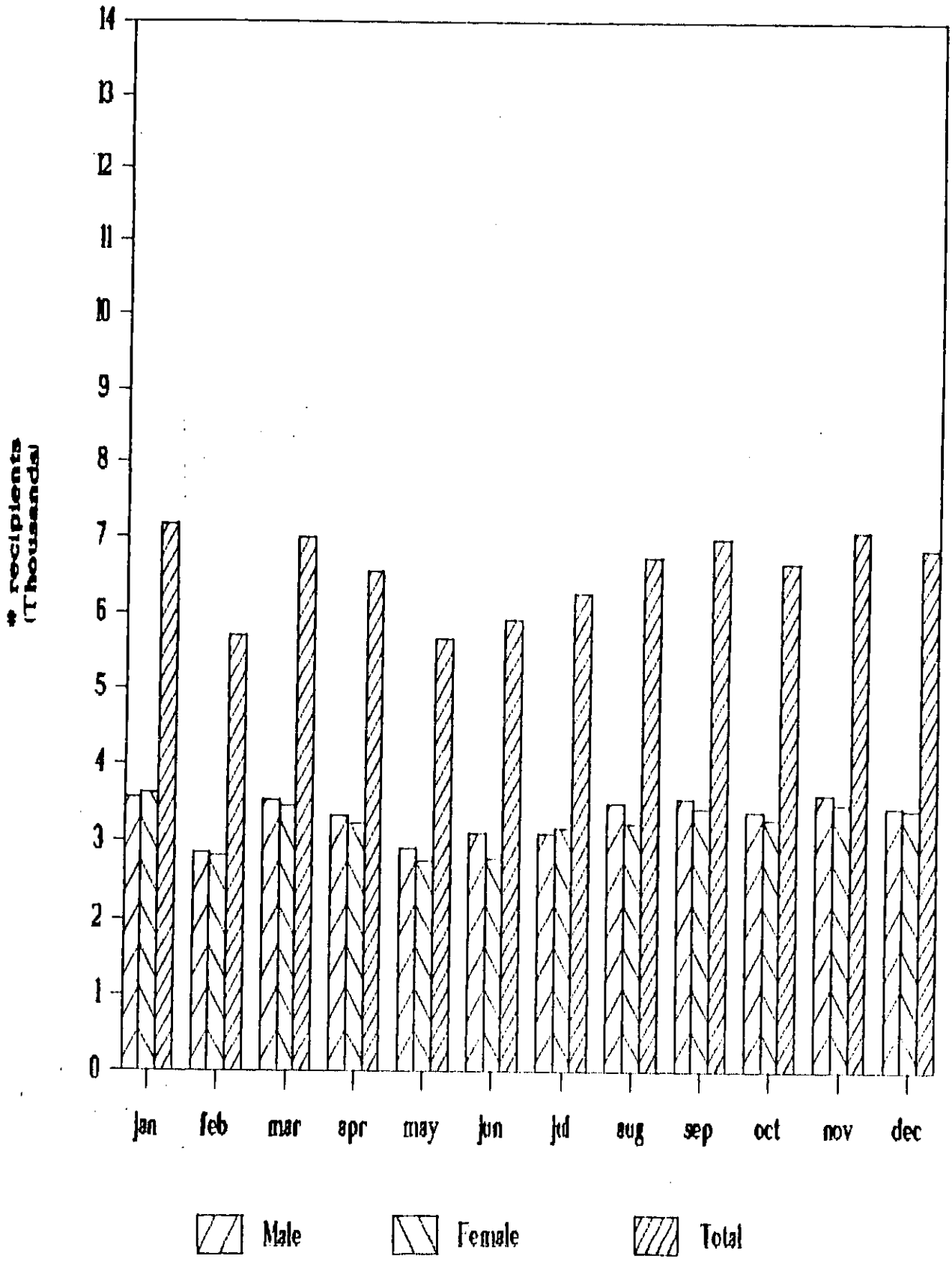
ORS recipients : 1987

URBAN VOLUNTEER PROGRAM



#ORS recipients : 1986

URBAN VOLUNTEER PROGRAM



COMMUNITY HEALTH SERVICE ACTIVITIES

NEW QUARTERLY PLANS (JAN. TO MARCH, 1988): GENERAL SERVICE PROGRAM

1. Obtain approval for hiring (according to the new revised position descriptions noted in this report) : community health service coordinators (2); training coordinator; trainers (3); nutrition coordinator; data management officer; programmer; assistant programmer; secretary; secretarial assistant, office messanger; and driver.

2. Continue to work on the development of specific program goals for the revised cooperative agreement.

3. Work closely with personnel and finance regarding the hiring of new staff and the refinement of the UVP financial system for reporting and verification of financial data. Refine the Belgian budget as well as the 5-year USAID budget, particularly reflect proposed salary increases throughout the ICDDR,B.

4. Hire new field supervisors; implement new training and orientation schedules for both new and current field supervisors.

5. Complete revision of transition ORS data collection form.

6. Continue to develop and refine new field service data collection system (calendar symbol format) and, if possible, begin training - this may not be possible due to the training of field supervisors which must obviously preceed the implementation of this new system.

7. Complete the 1987 (12-month) volunteer and field supervisor activity analysis.

8. Continue to work on the development of slum community maps and a new slum census through collaborations with the Bangladesh Survey Organization, Ltd., and the Centre for Urban Studies, Dhaka University.

9. Re-distribute the volunteers according to the new field supervisors and begin to "computerize" the volunteer, field supervisor data base.

10. Summarize and analyze the 1987 ORS distribution patterns and diarrheal disease information obtained from the general service program.

11. Complete the analysis of central office activities to determine the necessary number of office support staff, including those needed for ICDDR,B finance office (given the UVP "special provisions").

COMMUNITY HEALTH SERVICE ACTIVITIES

NEW QUARTERLY PLANS (JANUARY TO MARCH, 1988): DIARRHEAL DISEASE

1. Continue "computerization" of ORS drop-site information.

2. Complete development of transition diarrheal disease and ORS form.

3. Complete analysis and prepare graphics of 1987 ORS (field service) distribution. Compare with 1986.

4. Continue to develop improved field data collection system (symbol calendar).

5. Implement newly-developed diarrheal training for hospital volunteers, NRC volunteers, and field supervisors (includes diarrheal prevention and intervention section).

COMMUNITY HEALTH SERVICE ACTIVITIES

NEW QUARTERLY PLANS (JANUARY TO MARCH 1988): VITAMIN A CAPSULE AND NEEM SOAP DISTRIBUTION, FAMILY PLANNING AND GENERAL IMMUNIZATION REFERRALS

1. Select new field supervisors and conduct orientation and training for new as well as old field supervisors, emphasizing the new position descriptions, tasks, monitoring tools and forms. Once such training is completed, start their training of the new calendar field data collection system by mid-1988.

2. Continue discussions with Helen Keller, Int'l. and UNICEF regarding the role of the UVP in a vitamin A distribution system in urban slum communities.

3. Write a short-term consultant contract to develop a family planning referral network and revise training materials for the UVP.

4. Complete the development of the family planning section of the revision course, including the development of improved audio-visual materials. Implement this curriculum in field supervisor training, NRC training, and hospital training.

COMMUNITY HEALTH SERVICE ACTIVITIES

NEW QUARTERLY PLANS (JANUARY TO MARCH, 1988): IMMUNIZATIONS

1. Complete the survey of immunization status of volunteers and their children: finish development and implement formal on-going referral system.

2. Provide immunization training for UVP's nutrition volunteers.

3. Provide one day revision training for present immunization volunteers.

4. Implement immunization education and referral as part of UVP's community-based centers' activities.

5. Continue to participate in the development of a Dhaka metropolitan EPI plan, especially emphasizing the role of UVP's volunteers.

6. Initiate plan for expansion of immunization referral strategy throughout the UVP.

7. Draft paper of pilot project's findings.

COMMUNITY HEALTH SERVICE ACTIVITIES

NEW QUARTERLY PLANS (JANUARY TO MARCH, 1988): NUTRITION

1. Implement the new UVP nutrition training course and evaluate it.

2. Finalize the new NRC guidelines, translate all into Bangla, and create an NRC information packet for the new trainees.

3. Implement the new NRC guidelines.

4. Supervise the new trainees in their tasks at the NRCs.

5. Define the catchment populations of current NRCs.

6. Identify all existent medical referral facilities available within the NRC catchment areas.

7. Select new community representatives for each NRC and implement the new NRC guidelines (according to the new roles and responsibilities for the community nutrition committees and for the UVP).

8. Obtain final approval for the revised nutrition coordinator and nutrition technical supervisor job descriptions; begin recruitment for the nutrition coordinator.

9. Provide specialized training for all role I-supervisors on symptom-based treatments.

10. Complete reconstruction of all NRCs damaged or destroyed by flooding in 1987. Formalize the NRC-community committee - UVP agreements, particularly regarding land and facility responsibilities.

11. Continue "computerization" and evaluation of past NRC follow-up data. Continue "computerization" of the UVP nutrition bibliography.

12. Finalize the NRC survey report, the supplemental feeding project document and the extension feeding report.

TRAINING ACTIVITIES

NEW QUARTERLY PLANS (JANUARY TO MARCH, 1988): TRAINING

1. Complete the NRC training course and evaluate.
2. Implement the new UVP-Hospital volunteers' training program and evaluate.
3. Implement the field supervisor training for new and old supervisors and evaluate.
4. Begin to develop instructor training manuals for each of these courses as well as appropriate information packs for the volunteers participating in the courses.
5. Continue to work on the new calendar training curriculum.
6. Replace temporary staff positions with permanent employees, after full recruitment and selection. Orient new staff.
7. Focus on the development of improved family planning training materials. Begin a family planning training manual.
8. Complete the review of all current UVP training materials and teaching aids.

RESEARCH ACTIVITIES

NEW QUARTERLY PLANS (JANUARY TO MARCH, 1988): RESEARCH

1. Pursue further evaluation of current research clusters and the potential of establishing new probability clusters - hire a survey/demographer consultant to assist and make recommendations.

2. Complete the revisions of the SRS system; perform staff training and implement system.

3. Continue to analyze past data collected from the research clusters, including demographics, anthropometrics, and disease morbidity (2 week health recall). Also review diarrhoeal disease information collected from general field service program for past 2 years.

4. Complete nutrition survey and immunization reports/papers.

5. Start infant death risk protocol.

6. Continue work on the maternal education protocol as well as the polio-rotavirus protocol.

7. Continue to develop plans for the UVP strategy-specific impact evaluation and outcome indicators for the program.

8. Begin to develop concept papers in the areas noted in the 1988 research project document, particularly Vit A.

9. Complete refinements of all research section position descriptions and implement improved system of supervision, quality checks and data checks within the research section of the UVP. (Will entail development of documentation and quality assurance systems in the field and computer sections.)

INCOME GENERATING ACTIVITIES

NEW QUARTERLY PLAN (JANUARY TO MARCH, 1988): INCOME GENERATING ACTIVITIES

Continuation of the same set of quarterly plans. Hope to finalize consultant's scope of work vis-a-vis the creation of an income generating, skill-building network.

Attachment 7

ORS Drop-Site Distribution Summary

Jan-March, 1988

Total Packets Distributed to Field Supervisors at Drop-Sites	
January	38,000
February	34,500
March	31,500
Total:	104,000

Attachment 8A

URBAN VOLUNTEER PROGRAM QUARTERLY REPORT

(January and February, 1988)

ORS PACKET DISTRIBUTION TO DIARRHOEAL PATIENTS

Age group	Male	Female	Total (%)	Packets	
<1 year	65	62	127 (1.22)	376	January, 1988
1-5 years	895	823	1718 (16.62)	5035	
6-15 years	2145	2186	4331 (41.91)	14,193	
>15 years	2147	2009	4156 (40.22)	16,763	
Totals	5252	5080	10,332	36,367	

Attachment 8B

URBAN VOLUNTEER PROGRAM QUARTERLY REPORT

(January and February, 1988)

ORS PACKET DISTRIBUTION TO DIARRHOEAL PATIENTS

Age group	Male	Female	Total (%)	Packets	
<1 year	66	68	134 (1.15)	454	February, 1988
1-5 years	982	836	1818 (15.66)	5133	
6-15 years	2449	2243	4692 (40.44)	15,675	
>15 years	2776	2517	5293 (44.34)	22,813	
Totals	6273	5664	11,937	44,075	

Attachment 9-A

COMMUNITY HEALTH SERVICE ACITIVITIES:

Vit. A Capsule, Neem Soap Distribution, Family Planning and General Immunization Referrals

Month	Night Blindness: Vit.A Capsules Distribution	Scabies Prev. Hygiene: Neem Soap Distribution	F. Planning Referrals	General Immunization Referrals
January 1988	213	69	692	320
February 1988	163	55	637	273
March 1988	121	100	637	249
	497	224	1,966	842

Field Supervisor Service Form

February 1988

Sl.No.	Name of the Supervisor	Night blindness Vit.A Capsule	Neem soap	F.Planning Referral	Immunization Referral
01.	Mejbah	7	2	2	2
02.	Khodeja	9	0	12	7
03.	Johura	3	0	4	2
04.	Aleya	14		20	20
05.	Hurpon				
06.	Anowara				
07.	Firoza	66		40	40
08.	Maksuda	5	2	200	20
09.	Lovely	12	8	25	20
10.	Majeda		4	200	50
11.	Mahmuda	5	5	15	10
12.	Asura	4	10	20	9
13.	Shahin	4		20	10
14.	Momtaz	5	3	25	8
15.	Nurjahan			10	20
16.	Chaya Rani	2		20	30
17.	Rowshan	10	10	10	10
18.	Rokeya	7	5	6	5
19.	Rashida	5	4	3	2
20.	Nasima			4	6
21.	Rina	5	4		2
		163	57	636	273

Attachment 9-B

Field Supervisor Service Form

March 1988

Sl.No.	Name of the Supervisor	Night blindness Vit.A Capsule	Neem soap	F.Planning Referral	Immunization Referral
01.	Mejbah	17		3	
02.	Khodeja	12	0	12	9
03.	Johura	4	0	6	3
04.	Aleya	6	2	25	
05.	Hurpon				
06.	Anowara				
07.	Firoza		40	40	
08.	Maksuda	8	5	150	50
09.	Lovely	9	4	30	35
10.	Majeda		6	200	50
11.	Mahmuda	7	10	32	13
12.	Asura	6	10	30	12
13.	Shahin	3		10	6
14.	Momtaz	10	2	29	19
15.	Nurjahan	1	2	22	11
16.	Chaya Rani	6		25	10
17.	Rowshan	10	2	7	12
18.	Rokeya	5	5	5	7
19.	Roshida	6	6	3	2
20.	Nasima	5		8	8
21.	Rina	6	6		2
		121	100	637	249

Attachment 9B

Field Supervisor Service Form

January 1988

Sl.No.	Name of the Supervisor	Night blindness Vit.A Capsule	Neem soop	F.Planning Referral	Immunization Referral
01.	Mejbah	6	0	1	0
02.	Khodeja	0	0	8	5
03.	Johura	0	0	3	0
04.	Aleya				
05.	Hurpon				
06.	Anowara	8	0	40	30
07.	Firoza			100	50
08.	Maksuda		3	200	50
09.	Lovely		6	10	8
10.	Majeda		7	200	40
11.	Mahmuda	6	3	10	5
12.	Asura	3	5	9	5
13.	Shahin	2		2	3
14.	Momtaz	150		30	20
15.	Nurjahan			20	40
16.	Chaya Rani			15	30
17.	Rowshan		10	10	18
18.	Rokeya	12	10	5	7
19.	Rashida	4	20	25	3
20.	Nasima	2	0	4	6
21.	Rina				
		193	61	692	320

URBAN VOLUNTEER PROGRAM
PILOT IMMUNIZATION REFERRAL PROGRAM

(January - March 1988)

* Age	Total children referred		DPT and OPV 1	DPT and OPV 2	DPT and OPV 3	BCG	Measles	Completed series	
<12mo.	M 104 F 60	164	164	162	151	158	132	M 71 F 60	131
12-24 months	M 73 F 50	123	123	128	152	152	156	M 81 F 72	153
Total	M 177 F 110	287	287	290	303	310	288	M152 F132	284

* Age at which initial referral made

Attachment 10-B

URBAN VOLUNTEER PROGRAM
PILOT IMMUNIZATION REFERRAL PROGRAM

(January - March 1988)

Mothers	Total mothers referred	TT 1	TT 2
15 to 45 yr old women	222 mothers referred	221	246

Attachment 10-C

URBAN VOLUNTEER PROGRAM

(January - March 1988)

IMMUNIZATION REFERRAL PROGRAM
INDIVIDUAL VOLUNTEER RECORD OF REFERRALS

Name and code # of volunteer	Total mothers referred	TT 1	TT 2	Total children referred			DPT, OPV 1		DPT, OPV 2		DPT, OPV 3		BCG		Measles		Completed series
				<12m	12-24m	Total	<12m	12-24m	<12m	12-24m	<12m	12-24m	<12m	12-24m	<12m	12-24m	
1. Lalmoti(00834)	16	16	21	7	3	10	7	3	5	4	9	10	9	10	8	10	13
2. Momtaz(0083)	6	6	2	2	1	3	2	1	2	2	4	6	4	6	3	6	14
3. Hosneara(0081)	7	7	9	3	3	6	3	3	0	2	1	3	1	3	4	3	7
4. Akhter Banu(0082)	4	3	11	6	2	8	6	2	3	3	7	3	7	3	5	3	7
5. Amirun(0910)	5	3	2	4	1	5	4	1	2	6	4	9	4	3	4	3	13

Age represents age at time of initial referral

Name and code # of volunteer	Total mothers referred	TT		Total children referred			DPT, OPV 1		DPT, OPV 2		DPT, OPV 3		BCG		Measles		Completed series
		1	2	<12m	12-24m	Total	<12m	12-24m	<12m	12-24m	<12m	12-24m	<12m	12-24m	<12m	12-24m	
6. Kohinur[0913]	2	2	2	7	10	17	7	10	6	11	4	10	7	10	2	14	12
7. Saleha[09[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
8. Anowara[0[illegible]	22	22	16	12	10	22	12	10	11	10	9	9	9	9	8	9	19
9. Abeda[10[illegible]	4	4	4	9	6	15	9	6	6	6	5	11	5	11	6	6	16
10. Josna[0752]	10	10	15	2	3	5	2	3	5	5	5	5	3	5	3	5	6
11. Maleka[0839]	11	11	15	14	11	25	14	11	12	11	11	11	14	11	6	15	15
12. Nurun Nahar[1062]	17	17	12	8	9	17	8	9	6	6	7	6	8	6	9	8	14
13. Renoo[0098]	4	4	13	1	2	3	1	2	7	5	7	4	7	4	7	7	11

Name and code # of volunteer	Total mothers referred	TT 1	TT 2	Total children referred <12m	Total children referred 12-24m	Total children referred Total	DPT, OPV 1 <12m	DPT, OPV 1 12-24m	DPT, OPV 2 <12m	DPT, OPV 2 12-24m	DPT, OPV 3 <12m	DPT, OPV 3 12-24m	BCG <12m	BCG 12-24m	Measles <12m	Measles 12-24m	Completed series
14. Shirin(0645)	2	2	3	9	2	11	9	2	5	2	3	3	3	3	2	3	5
15. Shahnara(0478)	12	12	13	13	7	20	12	7	13	6	19	6	13	6	14	6	20
17. Ayesha(0106)	5	5	6	6	7	13	6	7	1	0	6	5	7	2	8	2	8
18. Fatema(0647)	3	3	1	2	0	2	2	0	1	1	1	0	1	0	1	0	1
19. Mahmuda(0110)	8	8	11	9	2	11	9	2	15	2	10	2	10	2	7	2	9
20. Jibon Nessa(0663)	9	9	3	3	5	8	3	5	3	5	3	5	3	4	3	4	7
21. Jahanara(0239)	5	5	9	5	9	8	5	3	11	7	13	10	13	12	13	12	14
22. Lailey(0664)	7	7	9	9	0	9	9	0	1	0	1	0	1	0	1	0	1

Name and code # of volunteer	Total mothers referred	TT 1	TT 2	Total children referred			DPT, OPV 1		DPT, OPV 2		DPT, OPV 3		BCG		Measles		Completed series
				<12m	12-24m	Total	<12m	12-24m	<12m	12-24m	<12m	12-24m	<12m	12-24m	<12m	12-24m	
23. Firoja(0111)	9	9	8	11	5	16	11	8	10	7	8	7	8	7	8	7	11
24. Monju Rani(0666)	1	1	1	4	2	6	4	2	5	0	6	1	5	1	4	1	5
25. Durga(0341)	9	9	13	5	6	11	5	6	5	6	6	7	6	7	4	7	11
27. Monju Rani(1103)	16	16	11	9	9	18	9	9	4	2	3	3	1	3	4	5	7
28. Nasima(0665)	10	10	16	5	4	9	5	4	5	5	4	4	4	4	4	4	8
29. Milu Rani(1365)	16	16	14	9	6	15	9	6	6	6	5	6	5	6	3	5	9
Totals	222	221	247	164	120	367	164	122	170	128	171	152	156	152	132	136	284

PILOT IMMUNIZATION REFERRAL PROGRAM
INDIVIDUAL VOLUNTEER RECORD OF REFERRALS

(January - March 1988)

	Name and code # of volunteer	Total mothers referred	Target	Total children referred	Target
1.	Lalmoti(0384)	16	15	10	15
2.	Momtaz(0383)	6	15	3	15
3.	Hosneara(0081)	7	15	6	15
4.	Akhter Banu(0082)	4	15	8	15
5.	Amirun(0910)	3	15	5	15
6.	Kohinur(0912)	2	15	17	15
7.	Saleha(0904)	3	15	2	15
8.	Anowara(0313)	22	15	22	15
9.	Abeda(1090)	4	15	15	15
10.	Josna(0752)	10	15	5	15
11.	Maleka(0309)	11	15	25	15
12.	Nurun Nahar(1062)	17	15	17	15
13.	Renoo(0098)	4	15	3	15
14.	Shirin(0645)	2	15	11	15

URBAN VOLUNTEER PROGRAM QUARTERLY REPORT
January, February, March 1988

Pilot Immunization Referral: Target Visits

Target: 1 Visit* Per Volunteer Per Month (3 Visits Per Quarter)

Actual Number of Special Immunization
Volunteer Visits to Immunization Centers

0 visits	1 visit	2 visits	3 Visits
Uzzola	Saleha	Momtaz	Lalmoti
Shahida	Fatema	Hosneara	Akhter Banu
	Durga	Amiron	Kohinur
		Josna	Anowara
		Nurun Nahar	Abeda
		Renoo	Maleka
		Shirin	Gulshanara
		Jahanara	Ayesha
		Laily	Mahmuda
		Nasima	Jibonnessa
			Firoja
			Monju Rani
			Nilu Rani

* During each visit, the volunteer's referral target is 5 children and 5 mothers.

Attachment 11

IMMUNIZATION REPORT

Table of Contents

IMMUNIZATION MANUAL

TABLE OF CONTENTS

IMMUNIZATION HEALTH MESSAGES: NRCs

1. Immunization can prevent disease. Give immunization to your child before he gets the disease.

2. Six diseases that immunization can prevent are diphtheria, whooping cough, tetanus, polio, tuberculosis, and measles.

3. Children who are very young (under 2), weak, and malnourished are most likely to get sick and to die from these diseases. Therefore they are the ones who most need immunization.

4. Among these 6 diseases neonatal tetanus and measles kill the most children.

5. Prevent tetanus in your newborn baby by getting 2 immunizations before or during the time you are pregnant. These immunizations will also protect you.

6. Prevent measles by giving 1 immunization to your baby when he is 9 months old.

7. Your baby should start receiving his immunizations when he is 6 weeks old. (He can receive his TB immunization even earlier, as soon as he is born.)

8. Women should start receiving immunization for tetanus when they are 15 years old.

9. After your child is 6 weeks old, he will need to go 3 times to complete his immunizations. He will need to go again one more time when he is 9 months old for his measles immunization.

10. Your child may have slight fever or soreness where he was given the injection. With his TB immunization, which is given in his arm, he will have a small sore for a while. These side effects are good. They mean the vaccine is working.

11. Immunization is provided free from the Government for children under 2 years and for women 15 - 45 years.

12. You and your child can receive immunization at center name and location, date and time.

13. Remember your child needs to go 3 or 4 times to finish all his immunizations, to be protected.

14. Keep your immunization card!

NRC TRAINING CURRICULA OUTLINES

Class Routine for NRC Workers Training Program

DATE	TIME			
	8.30-10.00 a.m. a.m.	10.00-10.30 a.m. a.m.	10.30-12.30 a.m. p.m.	12.30-1.30 a.m. p.m.
30.12.87	Introduction Dr.Diana	TEA	Human relation Tajkera Khair	Discussion Tajkera Khair
31.12.87	Pretest Leena Sultana Ferdousi	"	Pretest Leena Caroline Meghla	Discussion VERC Dr.Siddiqi
DATE	PLACE: ANANDA NAGAR, SAVAR, DHAKA			
3.1.88	VERC			
4.1.88	"			
5.1.88	"			
6.1.88	"			
7.1.88	"			

Class Routine For NRC Workers Training Program

DATE	8.30-10.00 a.m. a.m.	10.00-10.30 a.m. a.m.	10.30-12.30 a.m. p.m.	12.30-1.30 A.m. p.m.
10.1.88	VERC Experience Disease concept MEGHLA	TEA	Diphtheria Whooping cough Tetanus MEGHLA	Discussion Lab.visit Ferdousi Caroline MEGHLA Dr.Siddiqi
11.1.88	Measles T.B. MEGHLA	,,	Polio MEGHLA	Film Discussion MEGHLA Jahanara Nancy
12.1.88	Visit to IDH MEGHLA DR.SIDDIQI LEENA Sultana	,,	Immunisation MEGHLA	Discussion MEGHLA CAROLINE Jahanara Nancy
13.1.88	Immunisation MEGHLA	,,	Immunisation MEGHLA	Discussion MEGHLA Jahanara Nancy
14.1.88	Immunisation MEGHLA	,,	Visit to EPI Dr.Siddiqi MEGHLA LEENA	Slide show Jahanara Nancy Discussion MEGHLA LEENA

Class Routine For NRC Workers Training Program

DATE	TIME			
	8.30-10.00 a.m. a.m.	10.00-10.30 a.m- a.m.	10.30-12.30 a.m. p.m.	12.30-1.30 p.m. p.m.
17.1.88	Diarrhoea FERDOUSI	TEA	Diarrhoea FERDOUSI	Discussion FERDOUSI
18.1.88	Dehydration FERDOUSI	,,	Hospital FERDOUSI DR.SIDDIQI CAROLINE Sultana	Practical CLAIRE
19.1.88	Treatment of diarrhoea FERDOUSI	,,	Hospital FERDOUSI CAROLINE DR.SIDDIQI Sultana	Practical CLAIRE
20.1.88	Diet of diarrhoeal patient FERDOUSI	,,	Film FERDOUSI CAROLINE	Discussion FERDOUSI CAROLINE LEENA SULTANA
21.1.88	Feeding sick child FERDOUSI	,,	Evaluation FERDOUSI LEENA	Discussion FERDOUSI CAROLINE SULTANA LEENA
24.1.88	Reproductive system SULTANA	,,	F.P. SULTANA	Practical MRS.GAFUR
25.1.88	Methods of F.P. SULTANA	,,	Methods of F.P. SULTANA	Film Discussion SULTANA LEENA FERDOUSI

Class Routine For NRC Workers Training Program

DATE	TIME			
	8.30-10.00 a.m. a.m.	10.00-10.30 a.m. a.m.	10.30-12.30 a.m. p.m.	12.30-1.30 p.m. p.m.
26.1.88	Pregnancy Antenatal visit SULTANA	"	Food during pregnacy SULTANA	Discussion SULTANA LEENA FERDOUSI
27.1.88	Delivery Care of newborn FERDOUSI	"	Breast Feeding SULTANA	Discussion FERDOUSI SULTANA CAROLINE
28.1.88	Breast Feeding SULTANA	"	Weaning SULTANA	Film Discussion MEGHLA LEENA FERDOUSI
31.1.88	Weaning SULTANA	"	Personal Hygiene MEGHLA	Discussion CAROLINE LEENA
1.2.88	Personal Hygiene MEGHLA	"	Environment LEENA	Practical CLAIRE

Class Routine For NRC Workers Training Program

DATE	TIME			
	8.30-10.00 a.m. a.m.	10.00-10.30 a.m. a.m.	10.30-12.30 a.m. p.m.	12.30-1.30 p.m. p.m.
2.2.88	Food: Type Function LEENA	,,	Food: Source, Nutritious, Energy value LEENA	Discussion LEENA MEGHLA SULTANA FERDOUSI
3.2.88	Balanced diet FERDOUSI	,,	Food hygiene LEENA	Practical MRS.GAFUR
4.2.88	Food for pregnant and lactating mother FERDOUSI	,,	Food for different ages FERDOUSI	Backyard gardening FERDOUSI
7.2.88	Vit.A deficiency MRS.MITRA	,,	Vit.A deficiency MRS.MITRA	Film Discussion MRS.MITRA
8.2.88	Malnutrition CAROLINE	,,	Malnutrition CAROLINE	Practical MRS.GAFUR
9.2.88	Malnutrition CAROLINE	,,	Malnutrition CAROLINE	Discussion LEENA CAROLINE MEGHLA SULTANA
10.2.88	Anthropometry CLAIRE	,,	Anthropometry CLAIRE	Practical CLAIRE MRS.GAFUR
11.2.88	Growth chart CLAIRE	,,	Growth monitoring CLAIRE	Practical CLAIRE MRS.GAFUR

Class Routine For NRC Worker's Training Program

DATE	TIME
	8.30 a.m.-1.30p.m.
14.2.88	CNU DR.SIDDIQI LEENA MEGHLA
15.2.88	CNU DR.SIDDIQI CAROLINE FERDOUSI SULTANA
16.2.88	R.D. DR.SIDDIQI LEENA MEGHLA
17.2.88	R.B. DR.SIDDIQI LEENA SULTANA
18.2.88	P.R. LEENA CAROLINE FERDOUSI DR.SIDDIQI

Class Routine For NRC Workers Training Program

DATE	TIME			
	8.30-10.00 a.m. a.m.	10.00-10.30 a.m. a.m.	10.30-12.30 a.m. p.m.	12.30-1.30 p.m. p.m.
21.2.88	Daycare centre DR.SHAKUNTALA	Tea	Daycare centre CLAIRE	Discussion DR.SHAKUNTALA DR.CARINA CLAIRE
22.2.88	Practical DR.CARINA	,,	Practical CLARA	Discussion DR.CARINA CLARA MRS.GAFUR
23.2.88	Evaluation LEENA MEGHLA	,,	Evaluation LEENA MEGHLA	Certificate distribution DR.DIANA

URBAN VOLUNTEER TRAINING
NRC WORKERS TRAINING
PRE AND POST TEST RESULT
SUBJECT : NUTRITION

No.	Name	Pre Test	Post Test	Comment
1.	Shafiunnessa	32%	97%	Improved
2.	Kohinur Begum	74%	100%	"
3.	Anzumanara	76%	80%	"
4.	Shahida	20%	41%	Need Follow-up
5.	Farida	40%	98%	Improved
6.	Rabeya	68%	85%	Improved
7.	Shakila	8%	77%	"
8.	Nilu	78%	100%	"
9.	Monzu	74%	98%	"
10.	Hena	42%	98%	"
11.	Zahera	56%	66%	"
12.	Uzzola	56%	93%	"

URBAN VOLUNTEER TRAINING
NRC WORKERS TRAINING
PRE AND POST TEST RESULT
SUBJECT : IMMUNIZATION

No.	Name	Pre Test	Post Test	Comment
1.	Shafiunnessa	40%	97%	Improved
2.	Kohinur Begum	86%	100%	"
3.	Anzumanara	80%	100%	"
4.	Shahida	90%	84%	"
5.	Farida	Absent	86%	"
6.	Rabeya	76%	90%	"
7.	Shakila	26%	88%	"
8.	Nilu	76%	88%	"
9.	Monzu	63%	81%	"
10.	Hena	63%	86%	"
11.	Zahera	33%	86%	"
12.	Uzzola	63%	86%	

URBAN VOLUNTEER TRAINING
NRC WORKERS TRAINING
PRE AND POST TEST RESULT
SUBJECT : DIARRHEA

No.	Name	Pre Test	Post Test	Comment
1.	Shafiunnessa	16%	98%	Improved
2.	Kohinur Begum	34%	100%	"
3.	Anzumanara	42%	100%	"
4.	Shahida	52%	100%	"
5.	Farida	30%	98%	"
6.	Rabeya	48%	98%	"
7.	Shakila	20%	88%	"
8.	Nilu	70%	94%	"
9.	Monzu	42%	98%	"
10.	Hena	62%	97%	"
11.	Zahera	18%	62%	"
12.	Uzzola	22%	94%	

URBAN VOLUNTEER TRAINING
NRC WORKERS TRAINING
PRE AND POST TEST RESULT
SUBJECT : FAMILY PLANNING

No.	Name	Pre Test	Post Test	Comment
1.	Shafiunnessa	20%	96%	Improved
2.	Kohinur Begum	25%	100%	"
3.	Anzumanara	20%	100%	"
4.	Shahida	25%	57%	Need Follow up
5.	Rabeya	10%	97%	Improved
6.	Shakila	7%	77%	"
7.	Nilu	20%	73%	"
8.	Monzu	20%	95%	"
9.	Hena	20%	86%	"
10.	Zahera	16%	45%	Need Follow up
11.	Uzzola	9%	66%	Improved
12.	Farida	30%	77%	"

Follow up Schedule

Sl. No.	Name	Subject	Date and Time	Supervisor
4.	Shahida	Nutrition	20.03.88	Caroline
4.	Shahida	Family Planning	21.03.88	Sultana
10.	Zahera	Family Planning	22.03.88	Ferdousi

NRC INFORMATION PACKET

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Attachment 17

Nutrition Rehabilitation Centers: Patient Summary

(January-February-March 1988)

	No. Children Admitted for NRC Rehabilitation			Drop-out prior to complete	No. of children			No. Children Admitted to Referral Hospital
					Discharged		Currently Enrolled	
Center name	F	M	Total		No.	Range of duration of stay		
Keraniganj	9	7	16	0	16		Closed on March 1	0
Gandaria	13	3	16	7	2	2-5	6	1
Lalbagh **	-	-	-		-	-	-	-
Total	22	10	32	7	18	6	6	1

*9 children were enrolled in December, 1987
Gandaria 6
Keraniganj 3

** Closed for reconstruction

NEW TRAINING CURRICULA OUTLINES

HOSPITAL VOLUNTEERS TRAINING PROGRAM

KEY TOPICS (each day)

14.03.88 - 29.03.88

COURSE AGENDA

DAY	DATE	TIME	TOPIC	KEY POINTS	FACILITATOR
01	15.03.88	08:30-10:00 am	DIARRHOEA	1. What is diarrhoea; causes of diarrhoea 2. Types of diarrhoea.	Caroline
		10:00-10:30 am	TEA BREAK		
		10:30-01:00 pm		1. Causes of diarrhoea 2. Stool of diarrhoeal patient: colour, amount, frequency	Caroline Ferdousi
		01:00-01:30 pm	LUNCH BREAK		
		01:30-03:30 pm		1. What is dehyration, Types of dehydration a) Mild b) Moderate c) Severe	Dr. Siddiqi Leena Sultana
		03:30-04:00 pm	TEA BREAK		
		04:00-05:00 pm	PRACTICAL	Hospital Practice	Sattar

Course Agenda (cont.)

DAY	DATE	TIME	TOPIC	KEY POINTS	FACILITATOR
02	16.03.88	08:30-10:00 am	DEHYDRATION	2. Signs & Symptoms of dehydration a) Mild b) Moderate c) Severe	Ferdousi Caroline
		10:00-10:30 am	TEA BREAK		
		10:30-01:00pm	TREATMENT	Principle of treatment ORS: Types and preparation (Packet, lobongur, cereal-based) Rules of use of ORS Preparation of ORS	Caroline Sultana Leena
		01:00-01:30 pm	LUNCH BREAK		
		01:30-02:30 pm	DIET	Diet of diarrhoeal patient How to feed anorectic child Tube feeding Brest feeding & diarrhoea	Caroline Ferdousi Sultana
		02:30-03.30pm	PREVENTION	Prevention of diarrhoea - water - personal hygiene Toilet use Nail cutting - Food hygiene - Breast feeding	Caroline Ferdousi Sultana
		03:30-04:00 pm	TEA BREAK		
		04:00-05:00 pm	PRACTICAL	Hospital Practice	Biswas

Course Agenda (cont.)

DAY	DATE	TIME	TOPIC	KEY POINTS	FACILITATOR
03	17.03.88	08:30-10:00 am	FOOD	What is food, Types of food, Functions of food,	Ferdousi
		10:00-10:30 am	TEA BREAK		
		10:30-01:00 pm		Sources of food Nutritious & energy value of food. Conservation of food value during preparation, cooking & storage	Caroline
		01:00-01:30 pm	LUNCH BREAK		
		01:30-02:00 pm	BALANCED DIET	Definition : Balanced diet	Sultana
		02:00-03:30 pm		Malnutrition & Balanced diet - energy deficit - protein deficit - vitamin deficit	Leena
		03:30-04:00 pm	TEA BREAK		
		04:00-05:00 pm	Practical	Hospital Practice	Biswas
04	20.03.88	08:30-10:00 am	BALANCED DIET	How to achieve balanced diet	Ferdousi
		10:00-10:30 am	TEA BREAK		
		10:30-01:00 pm		Food hiegine: Importance of personal hygiene & cleanliness (utensil) in preperation, cooking, serving & preservation flies	Caroline
		01:00-01:30 pm	LUNCH BREAK		
		01:30-03:30 pm		Food for pregnant mother lactating mother	Sultana
		03:30-04:00 pm	TEA BREAK		
		04:00-05:00 pm	PRACTICAL	Hospital Practice	Sattar

Course Agenda (cont.)

DAY	DATE	TIME	TOPIC	KEY POINTS	FACILITATOR
05	21.03.88	08:30-10:00 am	BREAST FEEDING	Breast feeding: Preparation for breast feeding - during pregnancy - colostrum - when to start feeding - how long - how to feed - how many times	Ferdousi
		10:00-10:30 am	TEA BREAK		
		10:30-01:00 pm		Problems of breast feeding: Inadequate milk - care of nipple - breast engogrement - cleanliness	Caroline
				Breast feeding & malnutrition Bottle feeding: disadvantage Cup spoon feeding	Sultana
		01:00-01:30 pm	LUNCH BREAK		
		01:30-03:30 pm	WEANING FOOD	What is weaning food & its importance When to introduce How to introduce What are the foods	Sultana Leena
				Weaning food, diarrhoea & Malnutrition: Relationship	
				What are the foods for pregnant mother & lactating mother Why they need more food	
		03:30-04:00 pm	TEA BREAK		
		04:00-05:00 pm	PRACTICAL	Hospital Practice	Biswas

Course Agenda (cont.)

DAY	DATE	TIME	TOPIC	KEY POINTS	FACILITATOR
06	22.03.88	08:30-10:00 am	MALNUTRITION	Definition: Malnutrition Causes Types Signs & symptoms of Kwashiokor,	Caroline
		10:00-10:30 am	TEA BREAK		
		10:30-01:00 pm	MALNUTRITION	Relation between Malnutrition, Breast feeding, weaning food Diseases, immunization	Ferdousi
		01:00-01:30 pm	LUNCH BREAK		
		01:30-03:30 pm		Anthropometry: different measurements and their importance Growth monitoring -> How utilized Concept of growth & development:	Dr. Siddiqui Sultana Leena
		03:30-04:00 pm	TEA BREAK		
		04:00-05:00 pm	PRACTICAL	Hospital Practice	Sattar
07	23.03.88	08:30-10:00 am	MALNUTRITION	Management of malnutrition, Dietary management: NRU & Hospital	
		10:00-10:30 am	TEA BREAK		
		10:30-01:00 pm	MALNUTRITION	Dietary management of malnutrition Importance of follow up of malnutrition child	Caroline Ferdousi
		01:00-01:30 pm	LUNCH BREAK		
		01:30-03:30 pm	PRACTICAL	Hospital (NRU)	

Course Agenda (cont.)

DAY	DATE	TIME	TOPIC	KEY POINTS	FACILITATOR
08	24.03.88	08:30-10:00 am	IMMUNIZATION	What is immunization Importance of immunization What are the diseases preventable	Caroline
		10:00-10:30 am	TEA BREAK		
		10:30-01:00 pm		Brief: description of signs & symptoms of 6 diseases Malnutrition & these diseases (Especially T.B. Measles) When to start How many doses are needed Importance of follow up	Caroline Ferdousi
		01:00-01:30 pm	LUNCH BREAK		
		01:30-02:30 pm	IMMUNIZATION	Practical	
		02:30-03:30 pm		Immunization Schedule Tetanus injection for women (pregnant* child-bearing age)	Sultana Leena
		03:30-04:00 pm	TEA BREAK		
		04:00-05:00 pm	PRACTICAL	Hospital Practice	Sattar

Course Agenda (cont.)

DAY	DATE	TIME	TOPIC	KEY POINTS	FACILITATOR
09	28.03.88	08:30-10:00 am	PERSONAL HYGIENE	Personal hygiene: --- Cleanliness Spitting Sneezing Coughing Handling foods Toilet hygiene Sari soiling	
		10:00-10:30 am	TEA BREAK		
		10:30-01:00 pm	ENVIRONMENTAL HYGIENE	Environmental hygiene: --- Garbage Sanitation Use of toilet Water: clear water, drining water dirty water disease & water	
		01:00-01:30 pm	LUNCH BREAK		
		01:30-03:30 pm	HOSPITAL HYGIENE	Patients personal hygiene, Attendants personal hygiene, clothes, utensils, food, instruments, bed sheets etc.	
		03:30-04:00 pm	TEA BREAK		
		04:00-05:00 pm	PRACTICAL	Hospital Practice	Sattar

Course Agenda (cont.)

DAY	DATE	TIME	TOPIC	KEY POINTS	FACILITATOR
10	29.03.88	08:30-10:00 am	VIT. A DEFICIENCY	Vit A deficiency: Causes Commonly affected age group Disorders: signs & symptoms	Caroline Ferdousi
		10:00-10:30am	TEA BREAK		
		10:30-01:00 pm	VIT A DEFICIENCY	Treatment: medical Preventation: dietary Sources of Vit A Vit A capsule (UVP) distribution	Caroline Ferdousi
		01:00-01:30 pm	LUNCH BREAK		
		01:30-02:30 pm	CHILD HEALTH STIMULATION	Child stimulation: --- What is child stimulation Importance of child stimulation Mile stones of development (brief) How to give stimulation:	Monowara
		02:30-03:30 pm	PRACTICAL	NRU (child stimulation practice)	
		03:30-04:00 pm	TEA BREAK		
		04:00-05:00 pm	PRACTICAL	Hospital pracctice	Sattar

UVP-HOSPITAL PROJECT DOCUMENT

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Attachment 20

URBAN VOLUNTEER PROGRAM QUARTERLY REPORT

(January - February, March, 1988)

INCOME GENERATING PROGRAM

Name of Volunteer	Address/Area	Purpose of Loan:	No.of Vol.	Amount of Loan (in Taka)
Ms. Mahmuda	Demra	Vegetable selling	1	500/-
Totals:				500/-

Attachment 21

Comperative Analysis of UVF-Catastrophe Loan Fund

Description of Items	1987	1988											
	December	January	February	March	April	May	June	July	August	September	October	November	December
No. of new Loan Recipents each month	100	20	-	25									
Total Recipients	100	120	120	145									
Amount of new Loans granted each month	50,000	10,000	-	12,500									
Total outstanding each month	50,000	56,370	55,020	59,530									
Ideal aggregate repayment target each month (based on Tk.40/month payment per loan recipient)	-	4,000	4,800	4,800									
Actual received per month	-	3,630	4,350	4,990									
% of aggregate repayment target achieved each month		91%	91%	112%									
Total # of recipients making payments each month		81	86	95									
% of receipients making payments each month		81%	72%	79%									
No. of defaulters during each month		19	34	25									
% of defaulters each month		19%	28%	21%									

5(b)/BT/MAY.88

SCIENTIFIC PRIORITIES OF THE CENTRE.

SCIENTIFIC PRIORITIES OF THE CENTRE

This subject has been presented in detail in the two Plans and Prospects (Pl. & Pr.) documents (February 1987 and June 1987). During their March 1987 Consortium, the Donors recommended, inter alia, "... the need for the Centre to develop a more detailed statement of its policies ... in the field of research over the next five years ... The Consortium considered that the responsibility for preparing this statement is the Board's" (Pl. & Pr., Feb. 87, pp. 60 (1 and 2)). The senior management addressed itself to that issue, among many others, in the Pl. & Pr. of June 87, to which some Board Members gave their input during a one-day meeting in Geneva.

Agenda items 4 and 5(b) of the Full Board agenda for May 1988 are being addressed to in the attached documents. They are (i) a list of the Centre's present activities preceded by a narrative part; (ii) four documents, each indicating the future research areas for our four scientific divisions, prepared by the Division Heads; and (iii) a simple financial projection table, based on a 15% increase per year for each line item (the budgets are found under Agenda 4 (a) and (b)).

I regret the documents could not be circulated earlier. As such, none of them can be considered as "papers for donors". It is hoped that the Board Members will help putting the documentation presented in a form fit for the November Donors' Consortium.

Research Priorities of the Clincial Sciences Division

(1988-89)

1. Dysentery

Of the estimated 14.8 million deaths occurring annually in children under 5 years in the developing world, about 3.7 million are associated with diarrhoea. Based on data from Bangladesh (ICDDR,B) it has been estimated that 0.7 to 0.8 million children under 5 years die from dysentery each year worldwide.

Two genera of bacteria account for the great majority of identifiable causes of dysentery i.e. shigella and campylobacter, and the former is associated with most of the clinically severe disease which may result in death. Research on shigellosis, therefore is a high priority for the Centre and includes:

(a) Controlled clinical trial of antimicrobial agents e.g ciprofloxacin, pivamedinocillin (also called pivmecillinan), oral gentamycin. Treatment with an antibiotic to which the organism is sensitive decreases the median duration of illness in shigella dysentery However, emergence of resistance to drugs is a serious problem with shigellosis. Majority of the Shigellae isolated at the Dhaka Treatment Centre are already

resistant to drugs like ampicillin and TMP-SMX and the only drug available now is nalidixic acid. Therefore, evaluation of suitable drugs is a high priority.

(b) Descriptive pathophysiology of severe shigellosis. The treatment of severe shigellosis, especially that due to S. dysenteriae type 1, is often unsatisfactory, even when appropriate antibiotics are used. Studies should be done to better understand the pathophysiology of the serious forms of the disease and to develop new therapies to be used in combination with effective antibiotics. About to start is a study on the role of cytokines, circulating shiga toxins and endotoxins, and acute phase proteins in shigellosis and its serious complications.

(c) Nutritional management during and following acute shigella disease e.g. evaluation of energy dense diet and/or high protein diet in shigellosis.

(d) Evaluation of risk factors for serious outcome that would clearly indicate need for special care and referral, e.g. clinical based case control studies to further the existing knowledge on risk factors.

(e) Behaviour of mothers of children with dysentery as compared with non-dysentery diarrhoea e.g. time of seeking medical care, with-holding of food, etc. The

information may be useful for designing educational materials for health workers.

2. Persistent/prolonged diarrhoea

A proportion of episodes of diarrhoea become persistent, i.e. last more than 2-3 weeks. These are associated with progressive weight loss and increased risk of death. In a study in Lima, Peru, half of the diarrhoea associated deaths were in children who had diarrhoea for more than two weeks prior to death. In Brazil, a third of diarrhoea associated deaths in childhood followed episodes longer than two weeks of duration. In Matlab, Bangladesh, chronic diarrhoea accounted for more than half of all diarrhoea associated deaths. Likewise, in India 52% of all diarrhoeal deaths were associated with prolonged diarrhoea; although only 5% of all episodes lasted longer than two weeks, the case fatality rate was 14% in this group compared with 0.7% among those with shorter duration of diarrhoea. Thus, as many as 50% of diarrhoeal deaths may be associated with prolonged diarrhoea.

Major research priorities should be to determine the incidence of persistent diarrhoea, identify risk factors for the illness, determine its causative mechanisms, and develop effective treatment. The goal is to develop methods of prevention and treatment for this condition. The priority topics of research for the Clinical Sciences Division

include:

(a) Dietary Management

- Most beneficial and safe use of milk in patients with prolonged diarrhoea;

- Composition, safety and efficacy of fat containing diets;

- Value of micronutrient supplementation (zinc, vit. A., folic acid, Vit. B12, iron) in prophylaxis and treatment of prolonged diarrhoea;

- Optimise nutrient absorption by increasing claorie density, reducing viscocity and controlling the osmolality of diets (the use of locally available, inexpensive and acceptable foods will be stressed);

- The best tolerated and most effective forms for inclusion of carbohydrates in diets for persisten diarrhoea;

- Feeding requirements for optimal weight recovery/catch-up growth during convalescence from prolonged diarrhoea.

(b) Drug and antibiotic treatment

- Therapeutic value of antimicrobials with their minimal effective does and duration of administration.

(c) Microbial aetiology

- Role of diarrhoeagenic E. coli, particularly enteroadhesive E. coli, in prolonged diarrhoea;

- Faecal and small bowel pathogens in acute diarrhoea that terminates versus in acute diarrhoea that becomes prolonged; this should include search for new pathogens.

(d) Pathogenesis and pathophysiology

- Relationship between prolonged excretion of the initial infecting agent and the prolongation of diarrhoea;

- Role of sequential infection and of multiple infections in the prolongation of diarrhoea;

- Role of small bowel colonisation with faecal flora in the prolongation of diarrhoea; characteristics of the interaction of these organisms with small bowel mucosa;

- Role of dietary proteins and lectins, if any, in the prolongation of diarrhoea;

- Relationship between altered immunity with particular reference to impaired cell mediated immunity (CMI) and the frequency, duration and aetiology of diarrhoea; determine the most

important causes and the natural history of impaired CMI in young children.

(e) Epidemiology

- Factors determining or predicting the duration of diarrhoeal episodes with a focus on those which might be modified by specific interventions;
- Define factors which determine or predict the severity or outcome of prolonged diarrhoea.

3. Nutritional management during and following acute diarrhoea

Malnutrition due to diarrhoea can be minimised by providing optimal nutritional support during and after illness. However, knowledge on how to do this is incomplete. Detailed studies are needed to identify locally available foods that are well accepted by infants and children with diarrhoea, are adequately absorbed during diarrhoea, do not markedly worsen diarrhoea and maintain or improve the nutritonal state. These studies should consider a number of important variables including (a) age, (b) feeding status, (c) phase of illness, (d) aetiology of diarrhoea, (e) energy, protein, vitamin and mineral content of the diet and absorption of these components, (f) nutritional state at onset of illness, (g) effect of ORT on appetite, and (h) traditional attitude to feeding during diarrhoea. Priority research topics include:

- Optimal food intake in undernourished children with shigellosis;

- Germinated flour-based weaning foods during and after diarrhoea to improve nutrient intake and utilisation;

- Use of fermented milk in patients with acute diarrhoea.

4. Development of an improved Oral Rehydration Solution

The present "standard" oral rehydration salts (ORS) solution does not decrease stool volume. Recent studies show, however, that ORS solutions which actually decrease stool volume can be developed. Such improved ORS solutions would likely be more readily accepted than standard ORS because they would be viewed as rehydration/maintenance products and antidiarrhoeal medicines. Two approaches to developing improved ORS solutions have been used, (a) the use of actively absorbed organic solutes such as glucose polymers and aminoacids. (b) the use of whole cereal powders such as cooked rice powders. Both approaches deserve further study, seeking to develop an optimally formulated ORS, i.e. one which will maximally decrease stool volume during diarrhoea and can be conveniently packaged. The packaged product should be inexpensive and stable for at least two years under tropical conditions.

There is also a need to develop and evaluate home-made

solutions that can be used for home treatment of diarrhoea e.g. home made cereal-salt solutions.

Priority research topics on ORS include:

(a) Improved ORS based on defined solutes.

- Alanine and glucose-based ORS in adults and children with acute diarrhoea;
- Glutamine-based solutions in adult cholera patients (marker perfusion model);
- Glutamine and glucose-based ORS in adults with acute watery diarrhoea.

(b) Cereal-based improved ORS

- Determine whether a packaged ORS product can be developed that is stable under tropical conditions and require no cooking, and evaluate such an ORS when developed.

DM:jc

27.5.88

REPORT TO THE BOARD OF TRUSTEES

Research priorities for the Community Medicine Division

MAY 1988

Research conducted in the last few years by the Division led to the following conclusions:

1) Bloody diarrhoea and chronic diarrhoea are major causes of death for under 5 children in rural Bangladesh. Watery diarrhoea appears to have a much smaller impact.

2) Malnutrition is almost always an associated cause of death in the age group 6-36 months.

3) Absence of breast feeding is responsible for a sizeable number of deaths among severely malnourished children up to the age of 36 months.

4) Girls are at a higher risk of being malnourished and of dying than boys.

5) Acute Respiratory Infections (ARI) are the most important cause of death in post-neonates below the age of three months.

6) Past MCH-FP programmes had an impact on overall female mortality but not on the risk of death associated with each pregnancy.

Research of the Division in the coming years should focus on the

practical implications of these findings. Priority will be given to projects addressing a precise question with immediate practical relevance such as the evaluation of interventions aiming at reducing specific causes of mortality. Some topics deserve special attention.

1) Home treatment of bloody diarrhoea

ORT programmes are unlikely to have any major impact on the two main causes of diarrhoeal deaths in Bangladesh, namely bloody diarrhoea and persistent diarrhoea. Home treatment of bloody diarrhoeas by trained Community Health Workers (CWH) should help reducing case fatality rates and may prevent a sizeable number of persistent diarrhoea cases. A programme is about to be started to assess the feasibility and the impact of this type of intervention, using home treatment of dysentery with antibiotics, based on results from a previous study showing that bloody diarrhoea is frequently due to shigella infection.

2) Risk factors of persistent diarrhoea.

There is no fully effective treatment for persistent diarrhoea which could be used in the field. Prevention of persistent diarrhoea is therefore a priority. However, little is known about risk factors which predispose to this type of diarrhoea, although malnutrition is likely to be involved. Two protocols are addressing this issue in three

different areas of Bangladesh . One protocol is carried out in both urban (Zinzira) and rural(Mirzapur) communities (Dr. F. Henry), and the second is done in Matlab (Dr. A. Baqui, funded by WHO).

3) Prevention of malnutrition, case finding and treatment.

A screening programme for the detection of severe Protein Energy Malnutrition (PEM) by measurement of mid-upper arm circumference (MUAC) is going on now in Matlab as a part of MCH-FP service activities. Although quite effective, this screening programme runs into two major problems:

a) The number of cases of severe PEM associated with a high risk of death (around 200 children per month in Matlab area are found to have a MUAC less than 110mm, for a total population of around 100, 000) is still beyond treatment capacity of Matlab Treatment Centre.

b) Treatment of detected cases of severe PEM is difficult and seems to have a limited efficacy (impact of PEM treatment on long-term survival is under evaluation).

Hence, prevention by specific interventions seems the best option to reduce deaths associated with malnutrition. So far however, little is known about the epidemiology of severe PEM and there is still disagreement on the relative importance of infections and lack of adequate food as the origin of malnutrition. Studies are planned to determine

the risk factors of severe PEM (case control study in Matlab). Analysis is continuing on previous longitudinal studies which attempt to determine the relation between socio-environmental factors, diarrhoea and PEM.

4) Determinants of duration of breast feeding.

Since breast feeding reduces the risk of death associated with malnutrition, we need to determine which factors influence duration of breast feeding. Since there is little information on this subject, the question is being first addressed with qualitative methods by an anthropologist (Dr. S. Zeitlin). Quantitative studies are planned to investigate the influence of different contraceptive methods on breast feeding and malnutrition.

5) Sex-related determinants of malnutrition and death.

This question of primary importance could be addressed by comparing the situation in the Matlab and Teknaf areas: In Matlab, mortality in girls aged 12-36 months is twice that of boys but there is no sex-difference in mortality in this age group in Teknaf.

6 Sanitation and weanling diarrhoea.

The introduction of weaning foods when breast milk becomes inadequate is a principal cause of infant diarrhoea in unhygienic environments. A priority is to determine what infant foods and practices substantially increase the risk

of diarrhoea in rural Bangladesh and also what type of diarrhoea are induced by different unhygienic practices. Impact of sanitary and hygiene interventions on prevalence of different types of diarrhoea and malnutrition is to be examined.

7) Home treatment of ARI.

Home treatment of ARI has been proposed in other areas to decrease infant and child mortality. Feasibility of this approach is being tested in Matlab MCH-FP area, using CHW to detect cases, assess their severity and treat on the spot or refer to hospital according to the severity.

8) Maternity Care.

To decrease the risk of death associated with pregnancy, feasibility of an innovative maternity programme including field posting of professional midwives is currently being tested. Working in collaboration with Traditional Birth Attendants (TBA) and CHW, these midwives are expected to provide antenatal care, attend deliveries in the home and perform post-partum visits. They will also intervene in case of manageable complications or refer patients to better equipped facilities in case of major problems. In conjunction with the promotion of family planning and menstrual regulation, this programme is expected to further decline maternal and perinatal mortality.

FUTURE DIRECTION OF LABORATORY SCIENCES DIVISION (ESPECIALLY IMMUNOLOGICAL RESEARCH)

DR. IVAN CIZNAR

(A presentation to the Board of Trustees Meeting, May 1988)

FUTURE DIRECTION OF LABORATORY SCIENCES DIVISION (ESPECIALLY IMMUNOLOGICAL RESEARCH)

In the last four years the laboratories of the ICDDR,B have undergone major changes, which are visible in substantial improvements in physical facilities, and in staff development. During this period research has been directed to a limited number of priority areas. Thus from a rather wide range of studies and protocols carried out in the past, researchers in the Laboratory Sciences Division have focused more and more on the problem of shigellosis one of the major scientific priorities of the Centre.

PRESENT SCIENTIFIC ACTIVITY

Several protocols have been developed to study factors of pathogenicity and virulence of Shigella spp. and to identify protective antigens against these pathogens. In conjunction with research to develop mutants of Shigella spp. devoid of virulence but retaining protective capacity, the aim of all this is to develop a vaccine against shigellosis.

The oral cholera vaccine trial provided an opportunity to study the protective antigens of Vibrio cholerae, and to contribute also to the development of a more effective cholera vaccine.

Developing preventive measures against diarrhoeal diseases depends very much on understanding the ecology of diarrhoeal pathogens. For this reason an Environmental Microbiology Unit was established within the LSD. The occurrence of Vibrio in fresh waters and the role of plankton in maintaining their presence are being now systematically studied.

A few studies within the LSD were directed to the problem of rapid diagnostic tests for diarrhoeal pathogens, specifically Vibrio cholerae Shigella dysenteriae type 1 and Shigella flexneri, as well as to other possible causes of diarrhoeal diseases such as Bacteroides fragilis, Campylobacter jejuni, Clostridium difficile, Aeromonas and Plesiomonas spp.

FUTURE RESEARCH

Regarding the future research activities in the LSD it has been accepted that work will be further concentrated on the problem of shigellosis during the next five years. This will reflect the importance of this disease as a cause of high mortality and morbidity in developing countries.

Major emphasis will be given to:

a) Developing of mutant strains of Shigella spp. that would meet criteria for use in a vaccine.

b) Identification of the main components of Shigella dysenteriae 1 and Shigella flexneri which carry protective antigens as well

indications. In collaboration with other Divisions of the Centre and other institutions in developed countries research will be focused to the specificity of immune protection to rotavirus.

The Environmental Microbiology Unit will continue to study the ecology of V. cholerae with emphasis on water as a source of infection.

It is necessary to mention that a large part of the work of the LSD goes to provide services for research carried on by other Divisions. Clinical microbiology, biochemistry and pathology process yearly over 200,000 specimens. It is our aim to improve the quality of these services and to reduce their costs.

IMMUNOLOGICAL RESEARCH

The development of vaccines against diarrhoeal pathogens is particularly important since the introduction of preventive measures based on improved hygiene seems unlikely to become effective on a large scale in the near future. Thus immunological research aimed at elucidating defence mechanisms against diarrhoeal pathogens and constructing effective vaccines has gained prominence.

It is obvious that from the wide range of immunological question relevant to defence mechanisms against enteroinfections, preferably those should be selected for study which are methodologically feasible and highly relevant. Identification of

protective antigens of enteropathogens appears to be one of them. Thus this topic was selected for immunological studies in LSD (previously in the Host Defence Working Group) and directed as follows:

CHOLERA

Despite the progress made in the development of cholera vaccines little is known about what Vibrio cell structures carry protective antigens, and what antibodies are critical to eliminate the pathogen. Cholera stimulates immunity which lasts at least three years. Therefore it should be possible using antibodies collected from patients who have recovered, to identify antigens responsible for long term immunity. An analysis of sera and intestinal fluid from cholera patients using complex extracts of antigens and purified cell components was initiated in LSD with the aim of identifying such antigens. A comparison has been completed of the antigens in live Vibrio cholerae cells with the antigens in the oral cholera vaccines and with the antigens which stimulate antibody response during clinical disease. This study has helped to identify at least 30 important antigens in live Vibrio cholerae cells, 11 antigens in the oral cholera vaccine and between 7 to 12 antigens which stimulate antibody production during clinical cholera.

SHIGELLOSIS

A similar approach was undertaken for studies on shigellosis. Several studies have demonstrated that shigellosis is an immunising disease. From the genetics point of view Shigella bacterial have revealed a high degree of DNA homology with E. coli. Consequently, the cell components other than those expressed by "non-pathogenic strains of E. coli" should be considered a possible protective antigens. It is known that the major outer membranes proteins (a,b,c,d) and lipopolysaccharide play important role in the invasiveness of Shigella bacteria. Shiga toxin is probably another important factor. When the antigens of Shigella dysenteriae and E. coli were compared a high number of shared antigens were detected. However 7 antigens were specific to Shigella dysenteriae type 1 in the tested system.

How these antigens contribute to surface properties of the pathogen is not known. We have found that extremely virulent strains of Shigella spp. reveal a high degree of hydrophobicity which can easily be detected by their ability to bind Congo Red on agar. We assume that antigens specific to Shigella dysenteriae 1 and Shigella flexneri and located on the surface of the cells are responsible for this property, which is associated with invasiveness and virulence. A small number of surface proteins of Shigella which have adhesive properties and are antigenic were identified. Experiments have shown that potentially adhesive substances are present in a fraction that

agglutinates guinea pig erytrocytes. These "adhesins" could be critically protective antigens. Experiments are continuing to determine whether local (gut) and systemic antibodies are raised against both adhesin and OPMs in clinical shigellosis. In this regard a study has been initiated to correlate level of salivary IgA with antibodies in intestinal fluid and serum. A preference to humoral rather than cellular immune reaction responses has been given in these studies because it is believed that reactions which are effective in blocking the first steps of pathogenic mechanisms are critical to control the infection. This does not diminish the importance of cellular immunity which deserves more attention in shigellosis.

Further immunologial research oriented to protective antigens of enteropathogens and specific antibodies has had a solid base in a now well equipped laboratories, trained staff and in established collaboration with institutes in developed countries. Availability of specimens and patients for study, together with existing facilities represent a unique opportunity for elucidating of the mechanisms effective in protection against Shigella infection, and other diarrhoeal pathogens as well.

In the next years immunological research in the LSD should focus:

- on adhesin and OMPs of Shigella species and to assessing their protective effect.

- on assessing the immunity raised in animals and volunteers by mutants of Shigella spp. in collaboration with the bacterial genetics laboratory.

- on assessing the immunity raised by clinical Shigella infection.

It is expected that such oriented studies in the LSD will help to identify the major protective antigens of Shigella spp. and will contribute to research on the a effective vaccine against shigellosis.

PUBLICATIONS FROM IMMUNOLOGICAL LABORATORIES (LSD)

1. Ahsan CR, Ciznar I. Release of endotoxin by toxigenic and non-toxigenic Vibrio cholerae 01. JDDR; 5(1):7-15, 1987.

2. Qadri F, Hossain A, Ciznar I. et. al. Congo-Red and Salt aggregation test as a indicator of virulence in Shigella spp. J. Clin. Microbiology; July, 1988 (in press).

3. Ciznar I, Hussain H, Ahsan CR, et. al Cross-reactive antigens of Vibrio, Aeromonas and Plesiomonas. Vaccine (submitted).

4. Ciznar I, Ahsan CR, Rahman A, et.al Crossed-immunoelectrophoretic analysis of antigenic composition of B-subunit whole-cell and whole-cell only cholera vaccines (in preapration).

5. Qadri F, Hossain S, Ciznar I. Immunogenicity and antigenicity of Shigella dysenteriae 1 adhesin (in preparation).

6. Ciznar I, Qadri F, Huque S. Anti-OMP antibodies in patients with shigellosis (in preparation).

7. Qadri F, R. Raquib, Ciznar I. Outer Membrane proteins from Shigella dysenteriae type 1 (in preparation).

Population Science and Extension Division: Priorities of Research and Operations

Besides carrying out its own substantive research and operations, the Population Science and Extension Division (PSED) of the Centre provides indispensable support services to other Scientific Divisions of the Centre. Its work is organised through three major Projects/Departments:

Demographic Surveillance System (DSS);
MCH-FP Extension Project; and
Computer Information Services (CIS).

I. Demographic Surveillance System (DSS)

DSS is a valuable institutional resource providing high quality data on births, deaths, family formation, and population movement on a longitudinal basis - data which are nearly unparalleled in the developing countries. It has thus been recognised as a key component of the ICDDR,B field infrastructure. The system is vital as a framework for diarrhoeal and other epidemiological interventions, monitoring and evaluation, as well as for service delivery and research operations, including sampling design and follow-up of cases over long periods of time. Most of the wide range of studies in demographic and related health fields would be entirely inconceivable without DSS. In recent years it has also enabled assessment of the impact of an MCH-based family planning programme, including interventions with respect to diarrhoeal incidence, nutrition and growth monitoring. The Project (DSS: Matlab and Teknaf) has been funded by CIDA during the current phase (1984 to 1988). Continued funding for the coming four years (1989 to 1992) is under active consideration of CIDA.

The contribution of DSS is widely recognised in and outside the Centre, and it has made a marked impact on the world demographic literature. During the coming phase it will be essential to maintain and update basic demographic and socio-economic data of DSS, as related to nutrition, health, and morbidity in the areas of planned interventions; and enhance their quality and utilisation. In the process, the ongoing work on creation of a longitudinal and linked data base (DB) - already in current operational mode starting in 1982 - will be completed (for the period 1982 to 1974); and other projects of the Centre will be encouraged to link up with the DSS relational DB. The following will comprise some major activities under DSS:

a. Enhancing the operation and utilisation of the surveillance system.

b. Carrying out a new Census and Socio-economic Survey in the DSS areas (the last ones were conducted in 1982 and are already dated).

c. Completion of the DB - perhaps the only one of its scale in the developing world, and linking it with data sets of other projects of the Centre.

d. Computerisation of field data capturing (by installing PCs in the field) in light of the DSS DB architecture.

e. Substantive research on demographic and related epidemiological issues - the potentials of which have been considerably augmented as a result of the DB development.

f. Methodological research, including experimentations with a Sampling Registration System (SRS) in the DSS areas.

g. Dissemination of the Project's findings beyond the Centre, keeping in view prospects of "exportability," as underscored by the donor.

II. MCH-FP Extension Project

The Project has been established to carry out policy relevant research on the implications of an MCH-based, largely domiciliary, family planning service delivery in Matlab, and to test the transferability of successful elements of the Matlab programme into the public sector national programme. The Matlab operations are monitored through the Record Keeping System (RKS) - an MCH-FP surveillance system - in the Treatment Area in conjunction with the DSS records for the Treatment as well as Comparison Areas. The "transferability" is tested through the field areas of the Project in two Upazilas (sub-districts) of Bangladesh, and monitored through an interactive PC based Sample Registration System (SRS). The current Cooperative Agreement of the Project envisages continued funding from US AID for the years, 1988 to 1991, with technical assistance from the Population Council, New York.

During the coming phase the Project will pursue a number of objectives in three broad areas, detailed below - (a) operations research on service interventions, (b) studies on programme performance, and (c) data base development and methodological research.

(a) Operations Research:

- Continue to test and evaluate successful elements of the Matlab service programme within the constraints of the government public sector programme.

- Test and evaluate promising service delivery programmes, including the impact of an increased worker-population density at the field level.

- Strengthening the government policies nationally through dissemination of key Project results and provision of limited technical assistance when appropriate and affordable.

(b) Programme Performance:

- Through analysis of quantitative and qualitative data collected by the Project, evaluate the impact of the interventions upon fertility, mortality, and service operations.

- Carry out research on determinants of programme performance and barriers to effective service delivery within the government setting.

- Study the dynamics of health and demographic behaviour, and interaction of programmatic and non-programmatic variables.

- Evaluate the impact of the MCH-FP programme upon maternal and child health and mortality, fertility, and family planning behaviour.

(c) Methodological Research:

- Further develop, implement, and test a micro-computer based version of the Sample Registration System (SRS) in the Project areas.

- Link the Matlab Record Keeping System (RKS) to the DSS-DB, as a step toward expanding future research potentials.

- Share the SRS experience with DSS and collaborate in future experimentations with an SRS system in the DSS areas side by side with a full surveillance system.

III. Computer Information Services (CIS)

Installed with CIDA assistance as part of a grant to process DSS data, CIS is now well established as a self-sustaining unit. Its mainframe computer - IBM 4361 - along with a System 34 and a network of linked PCs represent one of the best computer configurations of the region.

Besides providing data processing facilities to DSS and MCH-FP Extension Projects of PSED - two of its major users, CIS will continue to provide crucial assistance to various other scientific and administrative operations of the Centre during the coming phase.

DSS Project
Tentative budget requirement for
the period January 1989 to December 1993

Project components	Project's Requirements in U.S. dollar					
	1989	1990	1991	1992	1993	Total
1. Local Salaries:	564,800	649,500	747,000	859,100	987,900	3808,300
2. International Salaries:	234,400	257,800	283,600	312,000	343,200	1431,000
3. Consultants:	26,700	29,400	32,300	35,600	39,200	163,200
4. Local Travel:	5,000	5,500	6,000	6,000	6,500	29,000
5. International Travel:	7,000	7,700	8,500	9,300	10,200	42,700
6. Supplies & Materials:	20,500	22,600	24,900	27,400	30,100	125,500
7. Contractual Services:	23,600	25,900	28,500	31,300	34,400	143,700
8. Inter-depart Services:*	257,500	146,500	159,200	173,100	188,400	924,700
Total Operating Cost:	1139,500	1144,900	1290,000	1453,800	1639,900	6668,100
Add: 25% Admin Support Cost	284,875	286,225	322,500	363,450	410,000	1667,050
9. Capital Expenditure:	53,000	-	-	-	-	53,000
	1477,375	1431,125	1612,500	1817,250	2049,900	8388,150

*Includes Census & Socio-Economic Survey and Staff Development components.

MCH-FP Extension Project
Tentative budget requirement for the period
January 1989 to December 1993

Project components	Project's Requirements in U.S. dollar					
	1989	1990	1991	1992	1993	Total
1. Local Salaries:	611,884	673,072	740,380	814,418	895,860	3735,614
2. International Salaries:	164,243	180,667	198,733	218,607	240,468	1002,718
3. Consultants:	62,887	69,176	76,094	83,703	92,073	383,933
4. Local Travel:	58,241	64,065	70,472	77,520	85,272	355,570
5. International Travel:	30,474	33,522	36,874	40,561	44,617	186,048
6. Supplies & Materials:	70,503	77,553	85,308	93,839	103,223	430,426
7. Contractual Services:	113,140	124,454	136,899	150,589	165,648	690,730
8. Inter-depart Services:	65,000	71,500	78,650	86,515	95,167	396,832
Total Operating Cost:	1176,372	1294,009	1423,410	1565,752	1722,328	7181,871
Add: 31% Admin Support Cost	364,675	401,143	441,257	485,383	533,922	2226,380
9. Capital Expenditure:	10,000	11,000	12,100	13,310	14,641	61,051
	1551,047	1706,152	1876,767	2061,445	2270,891	9469,302

Computer Information Services
Tentative budget requirement for the period
January 1989 to December 1993

Project components	Project's Requirements in U.S. dollar					
	1989	1990	1991	1992	1993	Total
1. Local Salaries:	63,200	72,700	83,600	96,100	110,500	426,100
2. International Salaries:	102,400	112,600	123,900	136,300	149,900	625,100
3. Supplies & Materials:	27,500	30,300	33,300	36,600	40,300	168,000
4. Contractual Services:	112,900	124,200	136,600	150,300	165,300	689,300
5. Inter-depart Services:	3,200	3,500	3,900	4,300	4,700	19,600
Total Operating Cost:	309,200	343,300	381,300	423,600	470,700	1928,100

SCIENTIFIC PRIORTIES OF THE CENTRE

ICDDR,B PRESENT SCIENTIFIC STUDIES

This document gives an overview of the ICDDR,B's present scientific studies. It does so by listing the Centre's protocols and some of its projects. These two terms, as used at ICDDR,B, will first be explained.

Protocols and Projects

There are differences between projects and protocols. A protocol (the term has no such meaning in British English) is a written research plan submitted by one or more investigators (the "principal investigator(s)") and having been reviewed and approved by the rather formal two or three-tiered system used at ICDDR,B. The prescribed lay-out is attached; it is considered as unsatisfactory by the majority of the Centre's researchers. Protocols can be limited in scope or very ambitious, requiring for their execution, either relatively small or huge amounts of effort, time and money. A protocol can be initiated by any researcher. Even if it proceeds to its final approval, funding is not automatically ensured. Funding (rarely found by the investigator himself) is usually decided by the director,

advised by his associate directors or heads of divisions. Since mid-1985 no core funds have been used for research.

"Project" would semantically be far more appropriate a term for our protocols. At ICDDR,B, however, a project means a defined part of the Centre's activities funded through a formal agreement between ICDDR,B and one or more donors. The agreement usually covers several years. 'Projects are not necessarily research-oriented (whereas protocols are). An example of an important non-scientific project is the Diarrhoea Information Service Centre (DISC) Project (which funding by IDRC is almost ending). Other projects are mainly service-oriented, or have also research and research-support as their aim. Whereas protocols have principal investigators, projects have directors. The Centre currently runs the following service or research projects.

- The Demographic Surveillance System (Director: yet to be appointed; funding: CIDA), under the Population Sciences & Extension Division

- The MCH-FP Extension Project (Director: M. Koenig; funding: USAID-Dhaka), under the Population Sciences & Extension Division

- The Matlab Maternal and Child Health/Family Planning Project (Director: V. Fauveau; funding: NORAD/WUSC), under the Community Medicine Division

- The Dhaka Treatment Centre Child Health Programme (Director: P-E Kofoed; funding: DANIDA), under the Clinical Sciences Division

- The Urban Volunteers Programme (Director: D. Silimperi; funding: USAID-Dhaka/Japan/Belgium), under the Community Medicine Division

- The Epidemic Control Preparedness Programme (Director: AKM Siddique; funding: Ford Foundation), under the Community Medicine Division

Projects, per definition, are funded. They also carry a certain overhead. The agreement with the donor is a document based on the donor's requirements in such matters; it can be very detailed and complex, with many special provisions, or very brief and straightforward. The scope of work of a project, especially its research activities, can be submitted as a protocol, with the project's director as principal investigator. As such it can become an "umbrella protocol", covering several distinct research plans, usually related to each other.

It should be understood that the distinction between core-funded activities, protocols and projects is not always clear. An essential core-funded activity can become a project if earmarked money is made available; if a project financing an essential activity comes to its end and no donor is found, core monies may have to be used. Protocols can be

part of projects, explicitly or implicitly. The latter is exemplified by the protocols on shigellosis or cholera. Since our agreement with USAID-Washington allows, under its line item "Targeted Research", studies on both these subjects, the protocols could be grouped as "Shigellosis Project" and "Cholera Project".

To conclude this section, I'd like to make one point.

- The time has probably come to critically review the manner in which research protocols are generated, and approved at ICDDR,B. An ad-hoc Committee has been set up in 1987, but has not yet started its work. It should do so as soon as possible.

* * * * * * * *

Lists of scientific studies and comments

The list is presented separately. Project and protocols are grouped under 9 major headings:

1. Shigellosis
2. Cholera
3. Other causes of diarrhoea
4. Acute diarrhoea in general
5. Persistent diarrhoea
6. Parasitology
7. Nutrition
8. Child survival
9. Demography

These headings are far from logically consistent: they

include well-defined diseases (1 and 2), ill-defined ones (4 and 5), a number of aetiological agents (3), scientific disciplines (6, 7, 9) and a rather broad area (8). Any suggestion to improve the classification, and the various subheadings, will be welcome.

The list, with 81 protocols and projects, certainly reflects the diversity and multiplicity of the scientific activity at ICDDR,B. The diversity is probably justified: ICDDR,B has a broad mandate. The multiplicity has always been a matter of concern to me. I fear we run too many protocols at the same time with too few people or, to put it in another way, team-work is not an ICDDR,B tradition. Furthermore, too many researchers do not heed what Armitage has stated so aptly in his "Statistical Methods in Medical Research" (Blackwell, 1985, p.9): "There is a temptation to attempt to collect more information than is clearly required ... the collection of marginally useful information may detract from the value of the essential data". Generally speaking, we are quite good at collecting (too many?) data, but not so good at quickly analysing and publishing them. Still, whereas there might still not be enough team-work and team-spirit at ICDDR,B, there is indeed quite some collaboration. The Department of Laboratory Sciences (LSD) very efficiently gives support to many protocols requiring laboratory investigation. The Demographic Surveillance System (PSED) is indispensable in planning field trials. Much data storage,

retrieval and analaysis would be impossible without the Computer Information System (PSED) and the Data Management Branch (PSED). The Administration, Personnel and Finance is supporting everybody, and 95% of the frequently delicate negotiations with the donors and fund raising, is being conducted very ably by Resources Development.

The above can, however, not be derived from the list. It gives, under one of the nine headings and the many subheadings, only the following information:

(i) The name of the protocol/project.

(ii) The "official" number, with the two first digits indicating the year of approval and the three last ones the sequence.

(iii) The name(s) of the principal investigator(s).

(iv) The divison and the collaborating institution(s), if any.

(v) The location of the major activity.

I regret that other important information could not be presented here:

(i) Date of beginning and planned or effective date of ending.

(ii) Budget and number of staff.

(iii) Funding source.

(iv) List of all collaborators.

(v) Scientific papers planned, in progress or published.

One should keep in mind that some protocols have been going on for several years, others are just completed or about to start.

* * * * * * * *

Concluding Remarks

1. The attached table and list indicate the important scientific activities going on at ICDDR,B. The problems of diversity and multiplicity have been commented upon (p.5).

2. As presented, the list cannot be used to properly evaluate productivity of the Centre nor its cost-effectiveness. There are no proper benchmarks to do so, and the information is still incomplete.

3. For the same reasons as under 2, the list does not allow to weigh the achievements of the divisions taken separately. For that matter, comparing the divisions with each other might well be meaningless.

4. All efforts will be made to complete the information, keep it up-to-date, and communicate it to the Trustees. A still preliminary computerized data base has been set up and will be expanded.

Table: Number of projects and protocols (according to the major subjects) per division and location

	No.of Proj. & Prt.	Divisions*				Locations*						
		LSD	CMD	CSD	PSED	DLAB	DTC	DUA	MFA	MTC	TFA	TTC
1. Shigellosis	13	8	-	5	-	7	6	-	1	-	-	-
2. Cholera	9	5	-	5	-	3	4	-	4	-	-	-
3. Other causes of diarrhoea	12	10	-	3	-	8	3	-	-	-	-	1
4. Acute diar. (general)	16	1	3	13	-	1	11	-	2	-	-	-
5. Persistent diarrhoea	3	-	1	2	-	-	2	1	1	-	-	-
6. Parasit-ology	4	2	1	1	-	2	-	2	-	-	-	-
7. Nutrition	10	1	7	2	-	-	3	2	3	1	-	-
8. Child Survival	8	2	3	1	2	-	2	3	2	-	-	-
9. Demography	6	-	-	-	6	-	-	-	4	-	1	-
TOTAL	81	29	15	32	8	21	31	8	17	1	1	1

* The row totals under these headings do not tally with each other nor with the No. of projects and protocols.

List of abbreviations

(i) For the divisions:

LSD = Laboratory Sciences; CMD = Community Medicine; CSD = Clinical Sciences; PSED = Population Sciences & Extension

(ii) For the collaborating institutions, in alphabetical order

AASC	:	American Academy of Sciences
BIRDEM	:	Bangladesh Institute of Research in Diabetes, Endocrinology and Metabolism
CDC	:	Centers for Disease Control, Atlanta
Fin Acad Sc	:	Finnish Academy of Sciences
Harvard MS	:	Harvard Medical School
INSERM	:	French National Research Institute
IPGMR	:	Institute for Postgraduate Medicine & Research, Dhaka
IPH	:	Institute of Public Health, Dhaka
JHU	:	Johns Hopkins University
Kenyan MRC	:	Kenyan Medical Research Council
London SE	:	London School of Economics
LSHTM	:	London School of Hygiene and Tropical Medicine
M Vet Coll	:	Mymensingh Veterinary College
Pop Council	:	Population Council, New York
Shishu Hosp	:	Dhaka Children's Hospital

Tufts U	:	Tufts University
U Basel	:	University of Basel
UD	:	University of Dhaka
UMd	:	University of Maryland
U Mich	:	University of Michigan
WHO	:	World Health Organization

(iii) For locations, in alphabetical order

AFA	:	Abhoynagar Field Area
DLAB	:	Dhaka Laboratories
DTC	:	Dhaka Treatment Centre
DUA	:	Dhaka Urban Area
MTC	:	Matlab Treatment Centre
MFA	:	Matlab Field Area (including Chandpur)
SFA	:	Sirajganj Field Area
TFA	:	Teknaf Field Area
TTC	:	Teknaf Treatment Centre

(AED) indicates "analysis of existing data"

Encl.

RE:jc

22.5.88

LIST OF PROTOCOLS AND PROJECTS, ICDDR,B, MAY 1988

** Indicates projects and more important protocols

SHIGELLOSIS

Pathophysiology

Hyponatraemia in shigella infections
85-006 FPL Van Loon
CSD - DTC

Role of shiga toxin, endotoxins and lymphokines in shigellosis and its complications
88- M Bennish, A Salam
CSD/Tufts U - DTC/Tufts U

Treatment

Double-blind randomized trial of ciprofloxacin and ampicillin in the treatment of shigellosis
85-034 A Salam, M Bennish
CSD - DTC

One-day treatment of shigellosis with ciprofloxacin
88- A Salam, M Bennish
CSD - DTC

A high-protein diet in the nutritional management of post-shigellosis growth faltering
88- I Kabir
CSD - DTC

Immunology

Comparison of OMP-associated antigens from virulent and avirulent strains of Sh. dysenteriae type 1 and Sh. flexneri 2a
87-010 F Quadri, I Ciznar
LSD/UD - DLAB

Assessment of local and systemic antibody response to shigella OMP in patients with dysentery
86-013 I Ciznar, A Ahmed
LSD - DTC/DLAB

Secretory IgA antibody in saliva of children with shigellosis
8 - C Schultz
LSD - DLAB

Vaccine Studies

Isolation of temperature-sensitive mutants of Sh. dysenteriae type 1 and evaluation of their colonizing and protective potential in adult rabbits
85-039 Z Ahmed
LSD - DLAB

**Isolation of attenuated shigella mutants and evaluation of their safety and ability to stimulate immune protection in rabbits and monkeys
87-011 Z Ahmed
LSD - DLAB

Bacteriology

Study on the combined effect of measles virus and Shigellae on Hela cells
87-004 NS Shahid
LSD - DLAB

Association of extracellular hydrolytic enzymes and virulence of Shigellae spp.
87-025 K Haider, MS Ali
LSD - DLAB

Epidemiology

**Prospective study of risk factors for the occurence and clinical sequelae of shigellosis in rural Bangladesh
87-002 F Ahmed
LSD - MFA

CHOLERA

Pathophysiology

Gastric acidity as a determinant of disease susceptibility after immunization with oral cholera vaccine, and as an interactive risk factor for clinical and asymptomatic cholera in an unvaccinated population
85-044 FPL Van Loon, JD Clemens
LSD/CSD - MFA

The oral magnesium breath hydrogen test for measuring gastric acid output in convalescent cholera patients
88- FPL Van Loon
CSD - DTC

Pancreatic exocrine function in acute diarrhoea caused by V. Cholerae and Shigellae spp.
85-041 PK Bardhan
CSD/U Basel - DTC

Treatment

Single-dose doxycline in the treatment of cholera
85-031 AN Alam
CSD - DTC

Methylated casein (Sacolene) in cholera
87- FC Patra
CSD/Inserm - DTC

Vaccine Studies

**Field trial of oral B-subunit/whole cell and whole cell cholera vaccine
84-001 JD Clemens
LSD - MFA/DLAB

Environmental Microbiology

The role of the aquatic flora on the long-term survival of Vibrio cholerae in the environment: a mechanism for the maintenance of endemic cholera
85-010 MS Islam
LSD/LSHTM - MFA

**Study on the seasonal distribution of V. Cholerae, as related to occurence of plankton and to water chemistry in natural waters in Matlab, Bangladesh
86-027 A Huq, S Ali
LSD/U Md - MFA/DLAB

Structure of O-antigenic side-chains of V. mimicus and V. fluvialis lipopolysaccharides
87-005 MM Zaman, I Ciznar
LSD - DLAB

OTHER CAUSES OF DIARRHOEA

B. fragilis

Bacteroides fragilis as an aetiologic agent in diarrhoea
87-008(P) BA Kay
LSD - DLAB

E. coli

Evaluation of phage patterns as a marker to follow E. coli infections from index case to contacts
84-050 KA Monsur
LSD - DLAB

Incidence of diarrhoea due to E. coli
87-022 KA Monsur
LSD - DLAB

DNA probe analysis of paediatric diarrhoeal patients for five virulence-associated characteristics of E. coli
88- N Strockbine, BA Kay
LSD/CDC - DLAB/DTC

Plesiomonas shigelloides

Plesiomonas shigelloides as a cause of diarrhoea at the ICDDR,B Dhaka Treatment Centre
87-007 Guo Cunsan
LSD - DLAB

Salmonella typhi

Rapid diagnosis of typhoid fever by detecting Salmonella typhi O-antigen using a co-agglutination technique
87-031 M Rahman
LSD - DLAB

C-AMP and prostaglandins during Salmonella typhyi diarrhoea and comparative therapeutic trial with chloramphenicol and ceftriaxone
84-013 I Kabir, NA Alam
CSD - DTC

Campylobacter spp.

Isolation of Campylobacter spp. from domestic animals
8 - SQ Akhtar, S Shabani
LSD/M Vet Coll - DLAB

Campylobacter pylori: its association with gastroduodenal diseases in Bangladesh
8 - PK Bardhan, AKA Khan
CSD/BIRDEM/U Basel - Diabetes Hospital

Rotavirus

Co-agglutination reversed passive haemagglutination and enzyme-linked immunosorbent assay for diagnosis of rotavirus diarrhoea
8 - M Rahman
LSD - DLAB

Aetiological surveillance

Surveillance programme: the ICDDR,B Dhaka Treatment Centre
86-022 AN Alam
CSD/LSD - DTC

Surveillance programme: the ICDDR,B Teknaf Treatment Centre
8 - MH Munshi
LSD - TTC

ACUTE DIARRHOEAS IN GENERAL

Pathophysiology

Enteric protein loss in childhood diarrhoea
86-010 AN Alam
CSD - DTC

The role of endogenous prostaglandins in secretory diarrhoea
87-021 FPL Van Loon
CSD - DTC

Perfusion studies with l-glutamine/glucose ORS in adults
88- FPL Van Loon, FC Patra
CSD/WHO - DTC

SMS 201-995 and ICS 209-930 as antisecretory agents: a trial in animals
88- PK Bardhan
CSD/U Basel - DTC

Treatment

ORS

Oral rehydration therapy with l-alanine/glucose-ORS: a controlled clinical trial
85-038 FA Patra, AN Alam
CSD/WHO - DTC

Comparison of the efficacy of glucose ORS with bicarbonate and with citrate
85-041 RN Majumder, FC Patra
CSD/WHO - DTC

Comparison of glucose-ORS and maize-ORS: a field study
84-049 PR Kenya
CSD/Kenya MRC - Kakagema

Comparison of glucose-ORS and rice-ORS: a field study
83-024 A Bari, ASMM Rahman
CMD - Chandpur

Does food increase the efficacy of ORS?
86-018 NH Alam
CSD - DTC

Management of acute diarrhoea in diabetic patients
87-019 R Haider, AKA Khan
CSD/BIRDEM - Diabetes Hospital

Knowledge and practices related to diarrhoea and ORT in Matlab: an evaluation of "bari mothers"
86-038 MS Islam
CMD - MFA

Drugs

Double-blind controlled trial of berberine sulphate in childhood diarrhoea
86-010 M Shahrier, MS Akbar
CSD/Shishu Hosp - DTC/Shishu Hosp

Cholestyramine as an adjunct therapy of acute diarrhoea in children treated according to the WHO guidelines
86-040 T Rautanen
CSD/Fin Acad Sc/WHO - DTC

Health care choice and use of drugs for diarrhoea in rural Bangladesh
87- C Ronsmans
CMD - MFA

Epidemiology

**A case-control study of risk-factors for dehydrating diarrhoea in children
87-017 ASG Faruque
CSD/WHO - DTC

Pathology

Post-mortem studies of diarrhoeal diseases in childhood
84-042 SAI Ally
CSD/LSD - DTC/DLAB

PERSISTENT DIARRHOEA

Pathophysiology

Absorption of nutrients in persistend diarrhoea (Phase I)
86-033 SK Roy, MS Akbar
CSD - DTC

Intestinal permeability in malnourished children with acute and persistent diarrhoea: efficacy of zinc therapy in malnourished children
86-009 SK Roy
CSD/LSHTM - DTC/DUA

Epidemiology

**Epidemiology of persistent diarrhoea in Bangladeshi children
87- AH Baqui
CMD/WHO/JHU - MFA

PARASITOLOGY

The identification and characterization of strains of Giardia intestinalis
86-028 A Hall
LSD - DLAB

Detecting the metabolites of Ascaris lumbricoides in urine
87-018 A Hall
LSD - DLAB

Giardiasis and persistent diarrhoea in Bangladeshi children: a study of food intake, gut permeability and growth
86-021 A Hall/
CSD - DUA

Ascaris and wormy people
86-035 A Hall
CMD - DUA

NUTRITION

Vitamin A

Vitamin A levels in breast-milk following supplementation after delivery: a prospective cohort study
86-007 SK Roy
CMD - Nandipara/DUA

Impact of vitamin A intake on diarrhoeal and respiratory diseases morbidity, skin infections and nutrition, and blood levels following diarrhoea in children
86-012 PK Bardhan
CSD - DTC

Evaluation of the risk of death between two 6-monthly vitamin A capsules distributions
86-015 A Briend, V Fauveau
CMD - MFA

Vitamin A supplementation and diarrhoeal morbidity
87-014 B Henning
CSD/JHU - DTC

Detection of vitamin A deficiency by ocular impression cytology
8 - SAI Ally
LSD - DTC

Treatment

The Matlab Nutrition Rehabilitation Unit: assessment of deaths averted and costs
86-024 A Briend, V Fauveau
CMD - MTC

Is nutritional marasmus preventable by specific interventions?
88- A Briend, V Fauveau
CMD - MFA

Epidemiology - Anthropology

Breast feeding, weaning and growth of infants in rural Bangladesh
85-032 S Ahmed, A Bari
CMD - MFA

Malnutrition and morbidity: an epidemiological study comparing children from urban and rural areas
86-029 F Henry
CMD - DUA/Mirzapur

Patterns of child feeding and health-seeking behaviour in Bangladesh: two case studies
87-024 S Zeitlyn
CMD/London SE - Chandpur

CHILD SURVIVAL

Maternal and Child Health/Family Planning

**Community Health Services Project, Matlab: the revised MCH-FP services and record-keeping system
85-027 V Fauveau
CMD - MFA

Factors affecting child survival in Matlab
86-023 A Bhuiyan
SED - MFA

Adolescent pregnancy outcome in a chronically malnourished population
87-023 AKMA Chowdhury
PSED - (AED)

Causes of acute lower respiratory infections in children
84-046 F Huq, M Rahman
IPH/AASC/LSD - DTC/

**The Urban Volunteers Programme: maternal and child care in urban deprived communities
DR Silimperi
CMD- DUA

Risk of dying in early infancy: a case-control study in the Dhaka slums
86-034 DR Silimperi
LSD - DUA

**The Dhaka Treatment Centre Child Health Programme
PE Kofoed
CSD - DTC/DUA

Water and Sanitation

**Development of effective rural water and sanitation packages for Bangladesh: The Mirzapur Hand Pump Project
874-036 KMS Aziz, Bilquis
CMD/LSHTM - Mirzapur

DEMOGRAPHY

Surveillance projects

**Demographic Surveillance System, Matlab
84-025 MB Duza
PSED - MFA

**Demographic Surveillance System, Teknaf
84-026 MB Duza
PSED - TFA

Extension project

**The MCH-FP Extension Project 1987-1992
84-016 M Koenig
PSED/Pop Council - MFA,AFA,SFA

Specific Studies

Infant mortality dynamics in a population with declining fertility
86-002 AKMA Chowdhury
PSED - (AED)

Fertility and mortality transition in Matlab: a qualitative study
86-006 MB Duza, M Nag
PSED/Pop Council - MFA

Women's status and family planning in Matlab
86-037 R Simmons, M Koenig
PSED/Pop Council/U Mich - MFA

RE:jc
23.5.88

TEKNAB PAPER.

PROBLEMS AROUND TEKNAF STATION

1. Executive Summary

In November 1987, the Board of Trustees decided that the ICDDR,B Teknaf Station had to be closed. The reasons were (i) low scientific productivity in the past, (ii) proposals for new research judged to be of rather low quality; and (iii) the absence of an investigator who could spend enough time in ICDDR,B. Section 2 gives some background on Teknaf Station and quotes especially for the new Board Members, the Board's decisions on Teknaf, taken since 1985.

The Centre's senior management has felt itself unable to implement the November 1987 decision. Sections 3 and 4 explain why and indicate the reasons which, according to the Management, plead for keeping Teknaf Station open. Section 5 is a tentative development plan for Teknaf Station. Some conclusions are presented in Section 6.

2. Introduction

2.1 In November 1985, some Board Members felt that Teknaf station, which was opened in 1974, ought to be closed as per January 1, 1986. The Director raised objections against this, and eventually the following decision was

taken under the Board document entitled "Financial position and action plan for expenditure reduction" which formed a part of the Board Minutes.

"2.1 Unfunded Research and other unfunded activities

Unfunded research will cease from January 1, 1986. This includes the closing of unfunded activities in Teknaf and surroundings.".

2.2 Since then, Teknaf Station has had two main fully funded activities:

- The Demographic surveillance system. Started in 1976, it is continuing till today.
- Preventive and curative services. They are limited in scope, concentrating on ORS distribution and Teknaf Treatment Centre activities, with about 6,500 patients per year, of whom 300 are inpatients.

2.3 The costs of running Teknaf Station have been rather limited. In 1986 and 1987 they were $120,000 and $150,000 respectively, which were fully funded. Funding agencies are CIDA for the DSS and DANIDA for the Medical Services.

2.4 In June 1987, the Board again considered closing Teknaf Station, mainly because of its low scientific productivity. It resolved as follows:

Resolution 4/June 87

"The Board resolves that Teknaf can be retained as a field study area provided three conditions be fulfilled. These are: first, a document suitably describing shigella studies and justifying the choice of the Teknaf area is presented to the Programme Committee for its approval; second, a suitable leader for these studies is identified with epidemiological skills; and, third, project money is available.".

2.5 Lack of senior staff made this task difficult. In November, 1986, Dr Sack, then Head of the Laboratory Sciences Division had come back from Teknaf convinced that it had great scientific potential. His report could never be discussed with the Board Members. It is attached. Drs Ciznar (who succeeded Dr Sack), Siddique and Hlady made another visit in September 1987 and found Dr Sack's ideas fundamentally sound. Five draft protocols, admittedly with scope for improvement, were submitted to the November 1987 Board; they were considered as totally inappropriate. The Management reported that it was still trying to identify a scientific supervisor for Teknaf.

2.6 The Board then decided as follows:

Resolution 1/Nov. 87

"1. Research functions at Teknaf be closed no later than June 30, 1988 and only service functions be

continued.

2. Discussions be initiated with the Government of Bangladesh and others to ensure uninterrupted continuation of the service functions at Teknaf and effect smooth transfer of the same.

3. All efforts should be made to absorb in other employment field staff of the Centre who may be displaced by the closure of the research functions at Teknaf.".

3. Evolution of the problem since the last Board Meeting

3.1 I (R.E.) returned from the Board meeting with an uneasy feeling. Closing Teknaf Station seemed to have many disadvantages. I was also concerned about my senior scientific colleagues not having been consulted, whereas the decision taken would, if implemented, be irreversible.

3.2 The matter was repeatedly discussed at the Council of Associate Directors. A consensus was reached that (i) we could not close Teknaf Station on July 1, 1988, time being too short and too many questions unresolved; (ii) the views of the Council should be put before the Board; (iii) at least a one-year's delay should be obtained if the Board maintained its decision; (iv) preferably, Teknaf Station should be kept open and its capacity for research built up in a planned way.

4. Reasons for maintaining Teknaf Station

4.1 Teknaf represents a unique resource for the Centre. Unlike Matlab it has not been "contaminated" by many interventions over the years and has maintained a demographic surveillance system for several years. Therefore, instead of closing it down, activities especially research should be augmented (see below).

4.2 CIDA has already approved the Teknaf DSS budget for 1988 and has in principle agreed to support DSS for another four years i.e. 1989 to 1992. The Teknaf Treatment Centre is now being funded by DANIDA and this will hopefully be continued.

4.3 The reaction of the donors, especially those who have already funded Teknaf Station, will probably be negative. There would be no financial gain to the Centre.

4.4 The Government of Bangladesh would definitely regret the closure of Teknaf Station. It would only be able to take over the ICDDR,B service activities, but would request financial assistance from ICDDR,B for doing so.

4.5 Concerning scope for research, the area is hyperendemic for shigella disease due to multiple drug resistant shigellae; this offers a unique opportunity for the study of shigella epidemiology, natural history of shigellosis and testing of vaccines. The place is also suited for drug trials in shigellosis. Furthermore, there is no excess female mortality in 1 to 4 year-old children in Teknaf, which is in sharp contrast with Matlab. For ICDDR,B, having two stations with radically different sex related mortalities is a unique opportunity to explore a problem that is so important in the subcontinent. In addition, research programmes related to MCH, EPI intervention and other intervention oriented programmes e.g. hand washing, health education, and immunization are well suited for Teknaf and many of them are of low cost.

4.6 CDC collaboration - Recently Dr Roger Glass and Dr David Addiss visited the Centre and it appears that a possibility exists for an epidemiologist from CDC to come and work on projects in Teknaf.

4.7 The Teknaf protocols have recently been reviewed by Dr Brad Sack of Johns Hopkins University. While underscoring the importance of keeping the Teknaf Station open, he has rated some of the protocols as of considerable value, and has put forward a number of

suggestions toward strengthening Teknaf based research. We also got the opinion of Drs Kay Wachsmuth and Robert Tauxe from CDC, Atlanta. All these have been copied to the Chairman, Scientific Programme Committee. The file is available to the Board Members.

4.8 As it has been true for Matlab, it is not essential for an investigator to be fully resident at Teknaf, provided he is primarily assigned to Teknaf research projects and he is willing to make long field visits with junior collaborators resident in Teknaf. It may be noted that nearly all studies carried out at Matlab have been accomplished without senior scientists residing there.

4.9 If need be, the Teknaf study area can be considerably trimmed e.g. by dropping the remote coastal villages which are not readily accessible in the rainy season.

4.10 Teknaf Station is the only other field area of the Centre besides Matlab Station with a well established demographic surveillance system. It would be hazardous to close it down prior to developing an alternative field area with demographic surveillance.

4.11 The present somewhat more favourable financial position of the Centre, good donor support, unique scope for

research and the recent interest by CDC for collaborative research at Teknaf strongly support continuing with Teknaf Station and augmenting its research activities.

4.12 With appropriate input from the Board Members, the Centre can develop a strong research agenda on Teknaf.

5. Tentative development plan for Teknaf Station

5.1 Reduce the DSS and intervention area by phasing out all activities except that of the ORS depot holders in the outlying coastal villages.

5.2 Maintain close contact through regular visits by Community Medicine Division/Department of Epidemiology staff; continue efforts to identify a Teknaf Station scientific supervisor.

5.3 Request the Government to use part of the excellent inpatient and outpatient facilities in the new upazilla Health Centre (not essential).

5.4 Improve water supply; install generator; study possibility of using short-wave communication with Dhaka (probably quite difficult); build guest-house/residence/office.

5.5 Improve the laboratory facilities, and bring the laboratory under the Laboratory Services Department.

5.6 Introduce computerized DSS and bio-medical record keeping (portable battery-operated computer).

5.7 Scientifically, concentrate on a stepwise approach:

- maintain DSS;
- maintain present medical activities, with emphasis on epidemiology of shigellosis; improve and make full use of present "verbal autopsy" and surveillance systems;
- expand MCH-EPI activities, with special attention given to the "M" component, with maximum co-operation from the population;
- to begin with, introduce <u>one</u> of the existing "Teknaf-protocols"; the cohort study might be the most promising.

6. Conclusions

6.1 It is proposed that some Board Members would visit Teknaf, and help the Centre's scientists to further critically evaluate and develop the plans under Section

6.2 It is further proposed that, whatever the Board's decision might be, it should provide for ample time for its execution. Giving its full potential to Teknaf, or terminating its activities, would require at least two or three years.

Encl. (1)

DM:MBD:RE:jc

3.5.88

INTERNATIONAL CENTRE FOR
DIARRHOEAL DISEASE
RESEARCH, BANGLADESH

Memorandum

TO: Director

FROM: David A. Sack

Date: 12.11.86

SUBJECT: ALTERNATIVES FOR TEKNAF

I travelled to Teknaf with Dr Spika and my wife on 5 Nov and returned 9 Nov to Dhaka. Our direct Dhaka-Cox's Bazar flight was met by Dr Munshi. Return flights could not be confirmed from Dhaka so we drove to Chittagong to take the train. I wish to thank Dr Munshi and Mr. Ahmed (SFRO) who did so much to make the trip comfortable and productive.

Over the past year several events have occurred which leaves Teknaf station in a tenuous position. These relate both to finances, scientific productivity, as well as to forward planning. With the departure of Dr M.M. Rahman and Dr. K.M.S. Aziz the senior scientific support for Teknaf Station was lost. With this, the decision to stop unfunded research in Teknaf halted the activities of the "Water Sanitation Project". Current activities are now funded entirely by the DSS project. Administratively the project is split between the Divisions of Population Studies and Community Medicine. Currently Teknaf is assured to continue until December 31, 1987 through DSS funding. Plans have not been made beyond that point, nor have plans been made to close Teknaf. Clearly the project employees are anxious as to their future.

Teknaf Station includes in its activities the operation of a continuing Demographic Surveillance System as well as treatment facilities in 3 locations (one main treatment center in Teknaf plus 2 subcenters). In addition "offices" are maintained in villages under surveillance. About 20 patients are seen daily at the treatment centers. Unlike Matlab, >80% of the patients are from the DSS area. This is optimal since we don't want to spend excessive amounts on routine care for patients not in our area. Over 50% of stool specimens are positive for either shigella or cholera using techniques which are not standard but are (perhaps) cost effective. A "new" information (for me) was the high number of cholera patients in Teknaf. This is a change since 1980.

The geographic area under the Teknaf DSS is very large with some villages up to 30 miles away from Teknaf. Travel is difficult at many times. Jeeps ply on the beach to reach the remote villages (cost is 60 Taka one way) but the jeeps are limited by tides and weather conditions. Frequently there are days when no jeeps at all ply the beach.

/2..

The new physical plant at Teknaf is excellent, though with any increase in activities, additional space will be needed. Constraints are the lack of running water or consistent water, the lack of consistent electricity (WAPDA runs a few hours each evening) and the lack of many equipment items in the laboratory. The laboratory operates with a kerosene egg incubator, kerosene refrigerator, water cartridge for media water, and pressure cookers for media preparation. Clearly an increase in activities in laboratory will require new lab equipment. Lab space is adequate (20x30 feet total lab space).

Other constraints are the lack of communication facilities between Dhaka and Teknaf. A telegram takes 4 days; letters, 3-10 days. Telephone service sometimes exists between Teknaf and Cox's Bazar. Buses regularly travel from Cox's Bazar and will deliver messages to the project office. Transportation to/from Dhaka likewise is a constraint. Unless planned well in advance air tickets from Cox's Bazar to Dhaka must be purchased in Cox's Bazar. Likely any major increase in travel/communications will require an agent/administrator in Cox's Bazar to deal with these services.

The DSS system appears to be collecting data in an excellent manner. The supervisory system is especially well developed. Since we were particularly interested in the "cause of death" data we noted a significant problem in this aspect. Though the diagnosis is provided by the physician, the diagnostic code number was assigned by a coding assistant. This results in mistakes in assigning the proper code. In the future I understand the physician will assign the diagnostic code number. This will correct the problem. Unfortunately cause of death data will have to be recoded for the last several years.

Dr. Munshi has initiated recently a morbidity surveillance also. This is for the benefit of physicians treating patients with serious illness. Plans to computerize this data have not been finalized.

During informal discussion with Dr. Munshi concerning the future of Teknaf it seemed that a long term plan is needed for the Teknaf project whether or not it continues as a station of ICDDRB., Together, we developed a list of potential activities if the decision is to continue in Teknaf (see appendix 1). My appraisal is that many of these are potentially fundable and could maintain Teknaf as a viable and productive station for at least 5 years.

If the decision is for ICDDR,B to discontinue its activities in Teknaf, then plans must be made to "phase out" during the coming year and to transfer the service activities to another organization if possible. Of these two options I strongly favour the former i.e. to build up Teknaf, to find funding, and to utilize this unique resource. An option I believe we should not consider is the maintenance of Teknaf as it is.

/3..

We discussed the solution to some of the contraints in Teknaf. Certainly the physical facilities need to be improved. Water and electricity needs must be resolved. Laboratory space needs improvement with new equipment and new furniture. I have already talked with Dr. Kay and Biomedical Engineering about solving some of these problems. I am investigating a battery powered incubator and a battery powered microscope. These should be available at minimal costs. An ice lined refrigerator may work nicely and this is available from the vaccine trial. A water treatment system can be obtained at minimal cost for the laboratory. (See Appendix 2).

Other physical plant needs will be more difficult to correct - e.g. guest house and office space. Approximately $10,000-20,000 will be needed. Also needed is a "dune buggy" or similar all - terrain vehicle to reach the village reliably. Cost is about $3000 but could be recovered from projects on a mileage basis.

In addition a treatment subcenter is needed in the remote area to carry out reliable morbidity surveillance and specimen collection activities as well as provide care.

The suggested protocols appear to form a long list. Since this is a conservative area, we will have to proceed cautiously. Before introducing any studies, especially those which require consent, we will have to explain these carefully to the community leaders. Likewise an EPI intervention will need careful explanation. The religious leaders are especially important in this regard. Unlike Matlab there is no history of experimentation; hence, "baggage of ill feeling" does not exist in Teknaf. If we do proceed cautiously, the process could be quite successful.

In summary, I found Teknaf to be a unique resource for the center and an area in which projects can be carried out which would be difficult to do in other areas. The DSS provides a basis for population based epidemiological studies. Interventions could be added, the impact of which could be clearly measured because of the lack of intereference from competing interventions. Both ARI and shigellosis are common and are life threatening problems and both problems can be addressed in a manner not possible in any other location.

The constraints are real but many of these are simply logistic and can be managed. The unalterable constraint is the distance which will prevent day trips. Scientists must be willing to spend several days with each trip... though in some respect, this may be seen as an advantage.

DAS:sc

cc : Associate Directors
Dr John Spika
Dr Munshi
Dr B. Kay
Dr Bogdan Wojtyniak

Appendix I

Projects which can be considered at Teknaf during next 5 years.

Immediate Projects (1987)

1. Media study to compare TFA with other media, including the new coagglutination tests of Mahbubur Rahman (funded by Shigella Project).

2. Treatment study in shigellosis due to resistant S. dysenteriae. Consider using Mecillinan vs Gentamicin. (Funded by Shigella Project).

3. Shigella cohort and family studies. (Funded by Shigella Project).

4. LARI epidemiology study including retrospective description of LARI over last 5 years in age group 1-60 months. (This analysis is underway now). This can be supplemented with prospective morbidity study of LARI and potentially with vaccine studies in the future. (Funded by vaccine fund of USAID or IDRC).

5. EPI intervention. If carefully planned I believe an EPI intervention evaluation could be done. I would think UNICEF would be interested in funding this. One could argue that this should be done prior to a pneumococcal vaccine trial; though this depends on the scientific question being asked.

Mid Range Projects (1-3 years)

1. Respiratory vaccine trials, especially pneumococcal vaccine. This would require a surveillance system in place for a time prior to the trial. (Lab diagnosis is not required).

2. Other MCH strategy intervention, e.g. TBA training. (There is a very high neonatal mortality rate which suggests the need for both tetanus vaccination and TBA assistance).

3. Possible cholera vaccine trial. (There were more than 100 isolations in 1985).

4. Vitamin A distribution project to test the effectiveness of "Depot method" as a way to distribute Vit A. This has worked effectively with ORS in Teknaf.

Long Range Projects

1. Shigella vaccine trial. (During the last month over 10 isolation of Shigellae spp. daily).

2. "Experimental" ARI vaccines e.g. conjugated S. pneumo and H. flu vaccines. Trials of these vaccines could await their testing in other geographic locations first. E.g. the question re: these vaccines would not be safety/efficacy but rather the effect/impact of such a vaccine in a developing country setting.

Appendix 2

Capital Investments needed if we are to maintain Teknaf Station.

1. Laboratory.

   a. New Incubator (? if Sobhani can make)
   b. New refrigerator (? ice lined refrigerator in stock)
   c. New laboratory furniture
   d. Water purification system
   e. Microscope (? from training lab)

2. Physical facilities
   a. Facilities for running water. This will require either a drilled deep tube well (to go through the rocky layer, a large cistern system to collect rainfall or a dam with reservoir in the hills with a storage tank.
   b. A generator to provide electricity when needed. (24 hour power is expcted to arrive within 1-2 years).

3. Guest House cum Office Building

4. Communication system for Teknaf Station with base at Teknaf and peripheral stations at each subcenter. Likely citizens band would be sufficient.

Appendix 3

Administrative and procedural changes recommended if Teknaf is to be maintained.

1. Clear lines of authority for the Head of Teknaf Station. Currently Dr Munshi reports to Drs Rowland, and Bogdan. Clearly the scientific output will come from analysis of DSS data yet Dr Munshi must stay in Teknaf to manage the station.

2. Addition of physician or Chief Physician to Teknaf staff to be funded by clinical projects.

3. Recruitment of an agent with telephone in Cox's Bazar to

   a. arrange travel for visitors
   b. pass messages back and forth.

4. New subcenter treatment center, possibly 2.

5. Computerize treatment center records.

6. Computerized morbidity surveillance of some family visitors card.

7. Laboratory to come under Laboratory Services Department. (Brad Kay) with adoption of standard methods.

8. One international epidemiologist should take a major interest in Teknaf. This could be accomplished with recruitment of epidemiologists.

5(d)/BT/MAY.88

PLANS FOR IMPROVEMENT OF THE HOSPITAL.

5(d)/BT/May-88

PLANS FOR IMPROVEMENT OF THE HOSPITAL

Second Floor Dhaka Treatment Centre

Plans and Construction

As agreed upon during the November 1987 Board Meeting, the architect, Mr Rashid Ahmed Khan, was asked for his comments and advice. His memo. is attached. No fundamental changes were made to the lay-out presented in November 1987, except for the location of the autopsy-room and related area, with which I disagree. The excellent suggestion made by Dr Merson, viz. to build a separate facility for outpatients between the western wing of the DTC and the road was judged not realizable by Mr Khan because of lack of space. Also, the new foundations which would be required would make a new building much more expensive than using the present one.

Mr Khan also pointed out that adding one floor at a time (if one supposes that, as in the original plans, more than one storey would be built) will be far more expensive than finishing the whole building. This may be true, but I submit we cannot even consider the second option.

Further steps to be taken

- I think we have a good plan, that has been thoroughly discussed by all staff concerned. Some slight modifications might still be required. For these, the advice of Mr Rafiqul Hussain, Department of Architecture, Engineering University, Dhaka could be asked. He is the author of a recent Ph.D. thesis (University of Leuven): "The Planning and Design of District Hospitals in Bangladesh".

- Plans should be finalized, costing done, and potentially interested donors approached as soon as possible. As to the latter, I'd request the advice, help and support of the Board Members.

Construction and Renovation

1. Matlab

The construction of our new facility in Matlab is progressing according to schedule. The process is being closely watched by a Building Implementation Committee, chaired by Mr Bashir. It has representatives from UNDP, the consultancy firm (architect), the contracting firm and ICDDR,B (Mr Mahbub, Mr Shahabuddin). There has been very heavy rains during the past 10 days, and it can only be hoped that an early monsoon

will not delay the work. The target for completion is still July 1989.

2. Dhaka Renovations

The renovations of both research and clinical laboratories in the IPH building and the Dhaka Treatment Centre are now completed, thanks to the untiring efforts of Dr Kay and his associates.

A Clinical Research Office next to the Research Ward has also been completed. The members of the Board are invited to visit these areas.

Plans for the near future are:

(1) creating extra usable space in the DTC by using part of the northern entrance hall;

(2) renovating the Research Wards and Intensive Care Unit;

(3) finding space for a transmission electron microscope donated by the University of Baltimore.

Space is still very limited at ICDDR,B. Adding one (or two) floors to the warehouse, and connecting them with the laboratories is being considered. It may be noted here that in view of the pressing problem of space in the animal house - aggravated by the imminent arrival of monkeys for shigella

research - the MCH-FP Extension Project is now being relocated in a commercially rented building outside the Centre. This is not a satisfactory arrangement, and the Centre must build additional accommodation not only for hospital needs but for other pressing needs as well - Extension Project, Library and the like.

We will go on improving our physical plant. Until now, no core monies have had to be used. The most urgent need remains better and more space for our patients. This, however, will also be the most difficult task in that area of our activities.

Encl.

RE:jc

25.5.88

BRIEF REPORT OF ICDDR,B DHAKA TREATMENT CENTRE

Construction of ICDDR,B Hospital building started in early 1981. Before that the design of the proposed building has been approved after consultation with the authorities. It was agreed that, to facilitate the existing research, administration and hospital services in a single building, a seven storey building would be necessary. The first phase of the construction was limited to first floor only. The building is a concerete structure, R.C.C. frame, shear walls, duct walls and core walls. Since we could not foresee the type of use of the building on the remaining six floors, adequate numbers of duct space has been provided for maximum flexibility.

Fair face concrete wall and ceiling has been kept to give the building a natural look in harmony with the floor which is of mosaic tiles.

It was suggested that the whole hospital building will be centrally airconditioned for which double loaded corridor with wards, offices, and research facilities on both side has been planned.

Anodized aluminium windows with fly-proof screens were provided for better hygenic condition. Anodized aluminium goes with overall natural colour of concrete and it is easy to install.

Because of the fly-proof screens, the cross ventilation of the building has been curtailed to certain extent. We still feel that introduction of split type airconditioners in patient care areas will increase the efficiency of the hospital.

After commissioning of the ground floor treatment area, it was found that the area is not sufficient enough to serve patients efficiently. Because of the following reason :

(a) The onrush of patients sometime is much when corridors are used for patient care.

(b) Adequate space has not provided for attendants (sometime more than one attendant comes with one patient).

../2.

(c) Since no aircondition has been provided, treatment areas remain very hot. Natural ventilation is not possible because of the wire netting, the building's concept and the double loaded corridor.

(d) Frequent changes in arrangement of the ground floor even after construction from time to time by the concerned authority has also contributed to a great extent for non-functioning of the whole area.

After careful consideration we have designed for 1st floor with addition and alteration to ground floor which will definitely improve the condition of the treatment centre.

The structure will be same as ground floor R.C.C. frame, shear walls, duct walls. Finishing will be same as that of ground floor. We shall strongly recommend split type aircooler in treatment area for better efficiency.

To keep harmony with the ground floor structure the construction of the first floor got to be identical structurally, architecturally and aesthetically, at least from the outside.

On the ground floor all the short-stay patients have been accommodated with the first floor for patients who will be staying for longer periods. Clinical ward, Nutrition Rehabilitation ward, Seminar room, Research and Offices has also been housed on the first floor.

The location as shown in the drawing are not final but it will be appreciable if a final decision on the location of different facilities is taken by the authorities before construction commences.

Rashid Ahmed Khan,
Director,
Sthapati Sangshad Ltd.

3.5.88

5(e)/BT/MAY.88

UPDATE ON SCIENTIFIC EXTERNAL REVIEW.

Update on Scientific External Review

At its last meeting, the Board resolved that the Clinical Sciences Division be subjected to peer review by three external reviewers. The following three reviewers were selected:

Prof. R. Hamilton
Professor & Chairman
Physician in-Chief
The Montreal Children's Hospital
Quebec, Canada

Dr. M.K. Bhan
Department of Paediatrics
All India Institute of Medical Sciences
New Delhi, India

Prof. M.S. Akbar
Joint Director
Bangladesh Institute of Child Health
Dhaka Shishu Hospital
Dhaka, Bangladesh

Invitation letters have been sent and all have agreed to participate.

Dates have been finalised from the end of the second week of November (Nov. 11) for two weeks, slightly overlapping with the November 1988 Board meeting.

On receipt of confirmations regarding suitability of dates, arrangements with regard to documentation to assist the reviewers, travel and accommodation will be made.

Note: If any information is received after this document is distributed, a further update will be provided.

Dr. D. Mahalanabis
Associate Director
Clinical Sciences Division

April 14, 1988

5(f)/BT/MAY. 88

PAPER ON SAFETY MEASURES AT THE CENTRE.

SAFETY MEASURES AT THE CENTRE

The Board of Trustees has decided in June 1987 that only research protocols involving human beings should be submitted to the ICDDR,B Ethical Review Committee (ERC).

In his letter (attached) dated 20 December, 1987, Prof. Kamaluddin Ahmad, Chairman, ERC has raised the problem of the potential danger to individuals, the community and the environment of some laboratory procedures performed at ICDDR,B. In the past, some Board Members have also asked questions about the safety guidelines in our laboratories.

This is to inform the Board that:

1. A Safety and Security Committee exists at ICDDR,B.
2. There is a Safety and Security Officer, Mr Md. Abul Hossain Miah.
3. A "Safety Guidelines" manual has been produced covering (i) laboratory work with enteropathogens and experimental animals; (ii) experiments with recombinant DNA; (iii) experiments with aggressive toxin chemicals, and (iv) experimental work with radioactive materials. A copy of this 21-page document has been submitted to the Chairman of the Scientific Programme Committee. Another copy is at the disposal of the Board. The Chairman ERC has also received a copy.

4. The safety guidelines are being taught to all employees involved in potentially hazardous work through seminars, and practical exercises. All new employees will be instructed in the safety guidelines before beginning with their work.

5. The renovations of our laboratories make implementation of the safety guidelines much more easy than in the past.

6. It is realized that constant watchfulness will be required.

Encl.

RE:jc

24.5.88

INTERNATIONAL CENTRE FOR
DIARRHOEAL DISEASE
RESEARCH, BANGLADESH

Phone: 600171-78
Telex: 65612 ICDD BJ
Cable: Cholera Dhaka
G.P.O. Box 128 Dhaka-2 Bangladesh.

December 20, 1987

Prof. Roger Eeckels, M.D., D.T.M.
Director
ICDDR,B
Dhaka

Subject: Resolution 3/June 1987 of the Board of Trustees of ICDDR,B.

Dear Professor Eeckels:

May I invite your kind attention to your letter of October 14, 1987 (copy attached for ready reference) concerning resolution No.3/June 1987 of the Board of Trustees on the document on "Powers, functions and duties of ERC" and inform you that the Ethical Review Committee discussed the letter in its meeting held on December 09, 1987. While the Committee would be glad to confine its review to protocols involving human subjects only, it felt concerned about ethical aspects of studies which could involve experiments with hazardous materials including dangerous micro-organisms, natural or developed through genetic engineering. The safety of investigators and the environment cannot be ignored. It hoped that the Centre would take necessary measures in this regard and keep the ERC informed of such measures.

The Committee, so, resolved that protocols having involvement of human subjects only shall come to the ERC for consideration and approval. Other protocols may be cleared by the Director, ICDDR,B who will ensure safety of the scientists and staff of the laboratory from all types of hazards.

It would be highly appreciated if you would kindly convey the concern of the Committee to the Board of Trustees of ICDDR,B.

With kind regards.

Yours sincerely

K Ahmad

Prof.Kamaluddin Ahmad
Chairman
Ethical Review Committee

KA:zbmb

6/BT/MAY.88

PERSONNEL & SELECTION COMMITTEE REPORT.

REPORT OF THE PERSONNEL & SELECTION COMMITTEE MEETING

28 AND 29 MAY, 1988

1. Overview of staffing situation and connected problems

The Committee examined an overview paper prepared by the Centre, at the request of the Committee Chairman, which gave very useful information on the staffing situation. It noted the problem of the new increase in the staffing numbers, after a reduction in 1986, mainly due to the Centre's need for project personnel. For fixed term project staff the Committee recommends that the Centre, at the end of the contracts either seeks to employ staff for other research projects - thus forming a pool of experienced staff and encouraging the project heads to use these resources rather than to recruit new staff - or, if this is not possible, be strict and terminate the employment as was stipulated at the beginning.

The Committee recognized the endeavour to seek for a possible reassignment for the 20 local staff members declared redundant by the respective projects and encouraged the Centre to continue to do so, and asked to inform the Committee in November as to measures taken.

The Committee, however, expressed its concern about the high number of administrative staff - 486 out of a total of 1497 - and of the high percentage of the Centre's budget for personnel. It noted also with interest the marked increase in seconded staff - 25 for 1988 against 15 for the last years, whicle there are now 12 international professional staff (the number went from 17 to 11 in 1987).

The Committee commended the Centre for the development of organograms for each Division.

The Committee recommends that the donors should be briefly informed in the documentation for the Donors' Meeting, about the staffing situation and measures taken to reduce staff when possible.

2. Recruitments

2.1 New international level staff

- **Senior Scientist, Head, Laboratory Sciences Division**

  Dr J.P. Heggers was appointed to this position in November 1987 but subsequently declined.

  The Committee considered the candidature of Dr Quadri (examined by the Board November 1987), Dr S. Kasataiya (who was recruited for the position of

Head, Laboratory Services Department) and Dr S. Tzipori from Australia, new candidate.

The Committee recommends the recruitment of Dr Tzipori at level P6, while Dr Monsur expressed his dissent, considering Dr. Tzipori less qualified than the 2 other candidates and considering it inappropriate to propose a candidate who was born in Israel and had served in the Israeli army.

- Head, Community Health Division

The Committee commends the Director for appointing Dr A. Briend as Acting Head. None of the candidates were considered fully suitable for appointment. It was strongly felt there was a need for a search strategy.

- Senior Scientist, Head, DSS

The Committee recommends the appointment of Dr. Michael A. Strong at P5 level.

The Committee further requests the Director to consider the possibility of finding a suitable position for Dr. R. Bairagi, Bangladeshi, Dr. of Science, from Johns Hopkins University, whose qualifications were recognized to be of great value but whom the Committee did not find suitable for the post under consideration.

- Scientist/Senior Scientist Research Immunology

  Selection is in process.

- Scientist Operations Research MCH-FP Extension Project

  Selection is in process.

- Research Pathologist

  The Board recommends the appointment of Dr. Moyenul Islam, Clinical Pathologist, at P4 level (with an appropriate definition in the terms of reference, the advertisement asking for a "Research Pathologist").

2.2 Seconded Staff

The Committee approves the appointment of the following seconded staff:

- DANIDA/Child Health Department including the Nutrition Rehabilitation Units:

  * Poul-Eric Lund Kofoed,
    Head of Project

  * Shakuntala H. Thilsted,
    Nutrition Coordinator

  * Ninna Sorensen-Nielsen,
    Coordinator, Teaching

- CIDA:

  * Dr. Lokky Wai,
    Demographer

2.3 Renewal of Contracts

- The Committee recommends the renewal of the following 3 contracts:

  * Dr. N. Alam, Dhaka Treatment Centre (P3, upgraded to P4, see section 3), as from 1.10.89.

  * Mr. H. Ashraf, Software Manager, CIS, (P3 upgraded to P4, see section 3), as from 11.08.88.

  * Dr. V. Fauveau, Head Matlab MCH-FP Programme (P3 upgraded P4, see section 3), as from 01.01.89.

- The requested renewal of Mr. M.R. Bashir, Associate Director, Resources Development, as from 1.7.89, was carefully considered by the Committee which requested the Chairman of the Board and the Chairman of the Committee to further examine the question.

3. Grading of Staff

3.1 General Consideration

Overall the international positions at ICDDR,B have been graded conservatively. Ms Flynn, WHO, was expected to come to Dhaka for a consultancy to revise grades of the various posts; her consultancy had to be postponed till beginning 1989.

3.2 Proposed Adaptations of Post Grading

In the meantime, on the basis of post descriptions, Ms. Flynn proposed the adaptation of the following posts:

	Grade	
	Present	proposed
- Head, Dhaka Treatment Centre	P3	P4
- CIS Hardware Manager	P3	P4
- CIS Software Manager	P3	P4
- Head, Matlab MCH-FP	P3	P4

The Committee supports these proposals and recommends that the incumbents be accordingly upgraded.

Given the high market value of computer specialists and the difficulties the Centre may have to find a qualified candidate for a mid P4 level, the Committee advises that the Director be allowed to give the new CIS software manager if necessary at a high step within P4 grade.

3.3 Proposed Upgrading of Staff

The Committee recommends that

- Dr. I. Ciznar, Associate Director, Laboratory Services Division, receive a personal promotion to

P6, Step 3, from June 1, 1988.

- Mr. M.A. Mahbub, Associate Director, Administration, Personnel and Finance be placed at P6, Step 1, after completion of this first year of contract; the Committee recalled that the Board, when authorizing the Director to recruit Mr. Mahbub had foreseen the P6 level.

4. Salary

4.1 International Staff Salary Adjustment to Compensate for losses due to Exchange Fluctuations

Several expatriate international level staff have faced in the last three years important losses in their salary in terms of their home currency due to changes in exchange rates. For some of them the loss amounts to 50%. A paper was presented to the Committee elaborating on two possible solutions to compensate for part of the losses. Both solutions would apply to 50% of the salary, taking into account that the international staff have to keep substantial financial obligations in their home country, the other 50% being adjusted with the Bangladesh Post Adjustment Factor. The solution "A" proposed, for the internationally adjusted part, an equal adjustment for all expatriate members, calculated on the basis of a basket of

exchange rates of leading currencies; the solution "B" proposed to adjust the 50% "international part" of the salary of expatriate staff with the Post Adjustment Factor of his or her country of permanent residence.

After a long discussion the Committee felt that the Centre should not commit itself to such policy changes without careful study of the implications and that it should also take into account the need for equitable treatment for all staff members, i.e. including Bangladeshi staff.

The Committee recommends to take the following 3 measures:

(i) As an immediate measure, the renewal of the Director's contract should foresee a special Director's allowance as proposed by a sub-committee, consisting of the Chairman of the Board, the Chairman of the Personnel & Selection Committee, Mr. Anwar and Dr. Merson, to make a proposal.

(ii) As a long term measure the Centre's management should prepare, for the November 1988 meeting proposals for a general salary increase (see below section 4.2).

(iii) The management should examine the current

situation of Dr. Fauveau, given the promotion of November 1987 and the proposed post upgrading - June 1988, and forsee for the extension of the contract step adjustments within grade P4.

New candidates should be informed of the efforts of the Centre to revise its salaries.

4.2 Salary Scale for International Level Staff

It is more and more recognized that WHO salary is low and unattractive for qualified staff. The Centre however must be able to employ very capable scientists. It is therefore needed to offer better salaries, in other terms to change the WHO salary scale.

The Committee recommends the preparation by the Centre for the November 1988 meeting

a) proposals for a general salary increase, i.e. increases for the various grades of the WHO salary system, matching as far as needed the salary scales of institutions where ICDDR,B can find staff candidates and comparable with other international research institutes;

b) indicate the financial implications for the Centre of the proposed increases.

4.3 Post Adjustment Factor for International Staff in Bangladesh

The Committee recommemds that the +3 P&F should be implemented with effect from 1 July, 1988.

4.4 Salary NO and GS Staff

The Committee recommends to implement the remaining 2/3 of the salary revision of April 1987, after the increase of 1/3 approved by the Board in November 1987, if the financial situation of the Centre allows such an increase.

4.5 Secondments

The Committee examined the paper submitted by the Centre, at the request of the Board on the secondment policy. It recognized the value for the Centre of the secondments, while recognizing the risks of tied aid which may also imply secondments. The Committee noted with satisfaction that the number of seconded staff had substantially increased since 1987. The Committee noted that staff on leave of absence should not be considered as seconded, seconded staff being paid by their home institution.

The Committee proposes the following rules for adoption replacing the previous rules concerning secondments:

- Any secondment should be consistent with the Centre's scientific programme and interest;
- No Head of Division (or any higher position) should be seconded;
- The individual seconded must be qualified for the post and his/her appointment must have the Director's approval;
- All seconded personnel should be responsible to the Director through their Department/Division Head;
- Each seconded staff should have a salary grade;
- Seconded staff on a reimbursable basis should have the same salary as if they were employed by the Centre;
- The Board should be informed of all secondment agreements.

6. Evaluation of Staff

Following the resolution of the Board in November 1987, the Centre is developing an evaluation system and asked the Board for its guidance for further developments. After examination of the prepared draft evaluation

forms, the Committee made several suggestions and recommendations, in particular: to develop a special form for professional staff (international and NO level) providing also for self evaluation; to foresee, for professional staff, two levels of supervisors; to have a suitably simple system for lower levels; to give the necessary guidance to the supervisors; and to ensure confidentiality as may be required. The Committee also suggested to ask BRAC for advise.

7. Recruitment Procedure

The Committee considered the steps proposed by the Centre for the recruitment procedure and made recommendations and suggestions, concerning i.a. the interview sheet, the collection of references if possible before the interview and whenever feasible by telephone, and for the setting up of a data bank of the applicants.

The Committee recommended that the Board be informed of all announcements of vacancies for international level staff and requested to circulate these announcements, in order to increase the chances of finding good candidates. For the final selection however the Board should be involved only for positions at P5 level and above. For P1-P4 level the Director is

requested to submit to the Board only his final decision for approval (and seek the Board's advice if needed). The Committee expects to receive full documentation for all recruitments.

8. Changes in Rules and Regulations Manual

The Committee recommends the approval of the revision of SR 560.3, M 5.370 and M 5.390 which are drafted as follows:

SR. 560.3

A staff member may be promoted to a higher pay level resulting from a reclassification of the post he occupies if he is judged capable of performing the higher level duties by his immediate supervisor, the concerned Associate Director and the Chief Personnel Officer.

M. 5.370

A staff member is not ordinarily promoted to another post unless he has been selected competitively for the post after it has been announced to all appropriate groups of staff.

M. 5.390

A staff member is not ordinarily promoted to the reclassified post he is currently holding unless he has been selected competitively for that post after it has

been announced to all appropriate groups of staff. However, a staff member may be promoted upto general service pay level 4 in accordance with staff Rule 560.3.

The Committee requsted the Centre to revise the proposed amendments concerning the renewal of contracts keeping in mind the Committee's concern not to bind the Centre to permanent contracts.

9. Election of New Trustees

For the replacement of Prof. D. Bell, the majority of the Committee recommends the election of Dr. D.A. Henderson as proposed by Prof. Bell in his letter to the Chairman of the Committee. The qualities of Dr. J. Byrant who had also been nominated were also recognised.

The Committee recommends also the re-election of Prof. Feachem and Prof. Tanaka.

It requests the Chairman of the Board to write to the Government of Bangladesh and to the Executive Director of UNICEF to draw their attention to the expiry date of Dr. Monsur's and Dr. Ramalingaswami's respectively, first term.

The Committee also asked its Chairman to elaborate a new selection procedure which would allow for better informed decisions. The elections should take place at the November meetings.

EC:jo

21.6.88

APPOINTMENTS

Senior Scientist, Head Laboratory Sciences Division

1. The present Head, Dr Ciznar, is leaving this summer. Despite two years of advertising, and pursuing the matter vigourously with all other means, there is still not solution.

2. Dr John P. Heggers had been apointed in the November Board Meeting, but he has declined the position. When this was communicated to the Board Members, Dr Al-Sweilem and Prof. Monsur advised me to appoint Dr Quadri. I informed them that I was not authorized to do so.

3. We now have a new candidate, Dr S. Tzipori, an Australian national. He has visited the Centre and is considered by Dr Ciznar and me as by far the best candidate we have had. He has been interviewed by three Board Members, Prof. Monsur, Prof. Rowley and me. His c.v. is attached.

4. Dr Tzipori could join in July-August and come for at least two years, possibly for a longer period. He left Dhaka very enthusiastic about the research possibilities of the Division. He confirmed his interest, but could not yet make a firm commitment. He

promised to let me know around May 15.

Recommendation

If Dr Tzipori accepts the position, I'd strongly recommend the Board appoint him as senior scientist (P6, Step 5).

Encl. (1)

RE:jc

4.5.88

Royal Children's Hospital
Melbourne, Victoria

Department

Flemington Road,
Parkville, Victoria, 3052,
Australia
Telephone: (03) 345 5522
Facsimile: (03) 345 6700
Telex AA37281

Dr Roger Eeckele,
Director, ICDDR,B,
GPO Box 128, Dhaka 2
Bangladesh.

27 Jan 1988

Dear Dr Eeckele,

I received a telephone call from Dr Greg Lawrence of the Queensland Institute for Medical Research in Brisbane inquiring whether I would be interested to fill a vacancy for a Senior Scientist at the ICDDR. He will have telexed to you back indicating my interest. He suggested that I should send brief notes on my background. I on my part would appreciate more details regarding the position and the Center. I am well aware of the Center's activities and know many scientists who were involved or worked at the Center over the past decade.

You will note that I am a veterinary graduate and have since 1975 been involved in research on infections of the gastrointestinal tract, initially of domestic animals, but in recent years of medical importance. I have a particular interest in the host response to infection of the gut - clinical pathological and immunological - with particular reference to zoonosis. In the past three years as the Deputy Director of the Department of Microbiology at this hospital, I have been directly involved with the diagnosis and management of infectius disease of children with particular emphesis on gastroenteritis. From the enclosed bibliography you will note that I have extensive experience with viral bacterial and protozoan infections of the gut.

I enclose a list of research projects which currently are been conducted in my laboratory. They include the utilization of 8 DNA probes for the detection by colony hybridization of each of the 4 categories of diarrhoeagenic *E.coli* (ETEC, LT and ST; EPEC, LA and DA; EIEC, plasmid-probe; EHEC, plasmid-probe and VT-I and VT-II). Other projects include; the development of an immunodiagnostic assay which will simultaneously detect 4 enteric pathogens (*Cryptosporidium*, *Giadria*, rotavirus and enteric adenovirus); and studies on the pathogenesis of haemorrhagic colitis (caused by EHEC) and cryptosporidiosis. This, plus the enclosed notes should give you an indication of my background and experience.

I hope to hear from you shortly,

Yours sincerely,

S Tzipori

Saul Tzipori.

LIST OF RESEARCH PROJECTS CONDUCTED AT THE RCH

1. Treatment of chronic diarrhoea due to cryptosporidiosis with hyperimmune bovine colostrum.

2. Pathogenesis of cryptosporidiosis in humans: The role of enterotoxin(s).

3. Development of an immunodiagnostic assay for *Cryptosporidium*.

4. Studies on the association between hemolytic uraemic syndrome (HUS) and verotoxin (VT) producing *E.coli*.

5. Characterisation of enterohaemorrhagic *E.coli* strains (EHEC) isolated from children at the Royal Children's Hospital.

6. Pathogenesis of haemorrhagic colitis caused by *E.coli* 0157:H7 and other EHEC serotypes studied in the gnotobiotic piglet: The role of various virulent factors.

7. Detection of pathogenic *E.coli* by DNA colony hybridization using 9 probes.

8. Development of an immunoassay for the simultaneous detection of 4 gastrointestinal pathogens(2 viruses and 2 protozoa).

9. Nontypable *Haemophilus influenzae*: a) Characterization of monoclonal antibodies and development of an antigen detection assay. 2) Studies on the pathogenic mechanisms and the role of various underlying factors.

10. The role of microbial products in Sudden Infant Death Syndrome (SIDS).

11. *Campylobacter pylori* and gastritis and /or duodenal ulcers in children in Victoria.

12. Rotavirus live vaccines: Elucidation of the nature of attenuation in vivo.

Projects planned for future collaboration with CVD, Baltimore, USA.

1. A grant submitted to the National Institute of Diabetes and Kidney Diseases (NIDDK), USA for 1988-1991, to study the relationship between diarrhoea and growth faltering (wasting) in HIV-positive infants. The information will be used to formulate therapeutic or prophylactic interventions.

2. A grant submitted to the National Institutes of Health, USA for 1988-1991, entitled "Studies of the *Yersinia enterocolitica* virulence plasmid".

CURRICULUM VITAE

NAME: SAUL IZIPONI

1966-1971; Attended the Veterinary School at the University of Queensland and graduated with first class honours.

1971-1974; Studied for a Ph.D degree at the Veterinary School, University of Queensland. The title of the thesis is: "Bovine Ephemeral Fever: Virological Investigations Related to the Production of Vaccine". Bovine Ephemeral Fever or BEF is a viral disease affecting cattle in the tropics. This work was subsequently published in a series of 12 scientific papers. After the completion of my Ph.D thesis I was awarded a postdoctoral fellowship, principally to complete the development and preliminary field testing of an attenuated cell culture vaccine against bovine ephemeral fever virus. In 1975 I was awarded the Fred Z. Eager Research Prize by the Senate of the University of Queensland for my work on this disease and for the development of an attenuated cell culture vaccine which was released for commercial use in Queensland in early 1985.

1975-1985; Occupied the position of Senior Research Scientist at the Attwood Veterinary Research Laboratory, Victorian Department of Agriculture and Rural affairs. The laboratory had a staff of 95 divided into five sections: I was head of one of the sections. During this period I initiated a research programme into the aetiology, pathogenesis and control of enteric infections affecting calves piglets lambs and foals. I was responsible for the development of gnotobiotic animal facilities in the Institute for the derivation by caesarian section and maintanance of piglets calves lambs and foals. They were used extensively in the investigation of diseases of animals, and more recently into diseases of medical importance. for this work which appeared in some 50 scientific publications, I was awarded the degree of Doctor of Veterinary Science (DVSc) by the University of Melbourne. It is only the 4th non-honorary DVSc awarded by this university since the reopening of the Veterinary School in 1967.

In 1980 I spent 12 months at the Moredun Research Institute in Edinburgh, Scotland, as a visiting scientist. As head of the Gastroenterology Section, I began my research work on cryptosporidiosis. Together with colleagues, I demonstrated the significance of this protozoa as an enteric pathogen particularly of humans and domestic ruminants; that it is a single

species genus and therefore a potential zoonosis; and that the infection is widespread in vertebrates worldwide.

By 1983 my research work had resulted in the identification of a considerable number of enteric pathogens previously unrecognized, or ill-defined, and led to a better understanding of the mechanisms by which they induce disease. The relative economic significance of prominent enteric pathogens perpetuating in Australian herds which had emerged from this work, led to the development of means for their control.

Between 1983 and 1985 I began research, in collaboration with Biotechnology Australia, Sydney, on the development of a vaccine against piglet enteritis using recombinant DNA hybridization technology. The vaccine 'Neoguard' which is the first product to be produced by this new technology in Australia, was released in early 1986 for commercial use. After my resignation from the Department of Agriculture and Rural Affairs, I continued this work as a consultant with Biotechnology Australia while working at the Hospital. A prototype rotavirus vaccine in calves was also successfully tested under field conditions. A second vaccine orginally intended to passively protect calves against cryptosporidiosis, the hyperimmune bovine colostrum is now being tested in clinical trials in the USA and Denmark for treatment against chronic diarrhoea due to this infection in immunologically compromised individuals particularly in patients with AIDS.

1985-Present; Appointed Deputy Director in the Department of Microbiology at the Royal Children's Hospital. It was a newly established department within the Division of Pathology. The department is divided into 2 separate sections, Bacteriology and Virology. I am the scientific and administrative head of the Bacteriology with direct responsibilities for the diagnostic and consultative service, staffing, budgeting, and research. I am responsible to the medical director and to the Division of Pathology Executive of which I am a member.

Administration. My initial tasks were: a) To rationalise diagnostic and consultative services in the face of budgetry constraints. Each department now operates independently with an allocated annual budget which includes salaries, equipment and operating costs. b) Upgrade and streamline diagnostic services which included the introduction of a host of new rapid and sophisticated antigen-detection systems. c) Restructuring a staff of 30, of whom approximately two third are scientists, and create new opportunities for promotion. d) Introduce a computer recording-reporting system. d) Plan, with the hospital engineers, and oversee renovations to modernise the Bacteriology laboratory and help establish the new Research Laboratory. The structure and areas of my direct responsibilities within the Division of Pathology, are outlined separately.

Consultative. I provide advice to clinicians and paediatricians on various aspects of infections, but in particular my specialty is paediatric gastrointestinal infections, including management of patients. I take part in weekly ward-rounds to help assess and discuss the progress of patients of particular problems associated with infections.

Teaching. The RCH is a teaching hospital affiliated with the University of Melbourne's Medical School, and where I hold an appointment of 'Senior Associate' in the Department of Paediatrics. For more details see under 'Teaching Experience'.

Research. One of my tasks was to help establish a research program in the newly created Department of Microbiology. I now have 7 research personnel, whose salaries or scholarships are paid by outside research granting bodies. A list of my current and past grants are included separately. My research staff at present comprises of 2 Ph.D students, 2 graduate research assistants and 3 technical assistants. My bibliography will indicate the nature of research (a list of projects is enclosed separately) and the organisations with which I am collaborating. I collaborate most intensively however with scientists from the Center for Vaccine Development, University of Maryland, Baltimore, and from the Centers for Disease Control, (CDC) Atlanta, Georgia. Within Melbourne I work closely with scientists from the Department of Microbiology, University of Melbourne. In the last 12 months I was able to obtain finance on behalf of my department to purchase a transmission and a scanning electron microscopes.

Teaching Experience

I hold 2 appointments of 'Senior Associate' at the University of Melbourne, in the Department of Microbiology, Faculty of Science, and in the Department of Paediatrics, Medical School. In 1974 I was responsible for organising the virology course to fourth year veterinary students at Queensland University. Since 1976 I have been involved with the supervision of postgraduate students from; the Department of Microbiology; the Department of Paediatrics; the School of Agriculture and the Veterinary School, University of Melbourne. I regularly lecture to third-year medical students and final year science-course and honours students on enteric infections, pathogenesis of infectious diseases, and aspects of host-pathogen relationship, and to medical graduates in paediatric gastroenteritis.

Consultant and Advisory

Member of the the WHO/FAO sub committee on rotaviruses, which was part of the working team on Reoviridae, under the chairmanship of Dr. J. Brain Derbyshire of Guelph, Canada, 1977-1983.

Sub-editor of the Journal of Cell Biology and Immunology (formerly, Australian Journal of Experimental Biology and Medical Science), 1986-.

Consultant to the American Medical Association's Publications, 1983-.

Consultant to Biotechnology Australia (Sydney) between 1983 and 1986 for Research and Development of recombinant DNA animal vaccines.

Assessor for NATA (National Association of Testing Authority of Medical Laboratory Accreditation)

A member of the advisory body to the Royal Children's Hospital Research Foundation.

A member of the Post-Graduate Committee in the Departments of Microbiology and Paediatrics.

I referee between 4 and 7 manuscripts per month mostly for international scientific, medical and veterinary journals.

I regularly review grant applications and offer recommendations to medical, private and veterinary support agencies of which more than half are from overseas.

I regularly review applications for fellowships and over the years have examined numerous theses for PhD, MSc, MVSc, and honours degrees.

In 1985 I was the convenor of an international seminar entitled 'Diarrhoea in the Young: Strategies for Control in Humans and Animals', which was held at Deakin University in Geelong. The seminar attracted 180 scientists from 17 countries. I was also responsible for raising a budget of $170,000, of which ADAB contributed $72,000, to cover the costs of this conference. Half the participants were veterinary and medical scientists from South East Asia and the South Pacific who were invited to attend and their expences were paid by the Committee. The conference was considered successful and the Proceedings of the seminar of which I was the chief editor, received excellent reviews in the scientific literature.

SUMMARY OF PERSONAL DETAILS

NAME: Saul Tzipori.

DATE OF BIRTH: May 20, 1941.
Australian nationality

MARITAL STATUS: Married with one 18-year-old daughter

ADDRESS: 11 Warrick St., Ascot Vale, Victoria 3032.

PRESENT POSITION: Deputy Director of the Department of Microbiology, Royal Children's Hospital, Melbourne, since early 1985. Salary $56,000 per annum.

ACADEMIC QUALIFICATIONS:

BVSc (with first class hons.); University of Queensland, 1971

PhD; University of Queensland, 1974.

MRCVS; Royal College of Veterinary Surgeons, London, 1980.

DVSc; University of Melbourne, 1985.

STATEMENT

Since graduation in 1971, I have written over 90 scientific communications which were published in international scientific, medical and veterinary journals. Approximately 13 publications resulted from my PhD work on bovine ephemeral fever virus, 60 from my work on enteric infections at the Attwood veterinary research laboratory, and 20 since my appointment to this hospital three years ago. I have contributed several reviews to various publications over the last 5 years.

My research work has led directly to the development of 2 (world first) vaccines which are available now commercially. I have recently successfully treated several patients with immunodeficiencies, including AIDS, who had persistent and life-threatening diarrhoea due to cryptosporidiosis, with hyperimmune cow colostrum produced specifically against the parasite. The therapeutic value of colostrum in the treatment of this infection will soon be assessed in clinical trials in the USA - in collaboration with the Center for Vaccine Development, University of Maryland, Baltimre, and St Vincent Hospital, New York - and in Denmark. A commercial company in the United Kingdom is currently assessing this vaccine for use in dairy calves, in combination with rotavirus and K99, for the prevention of calf diarrhoea. An immunodiagnostic test is being developed at present in my laboratory with the view, hopefully, to decrease time

and costs involved in the diagnosis of 4 common enteric infections. This should indicate to the Selection Committee the nature of my research experience and my deep commitment to application and utilization of scientific knowledge to combat veterinary and medical problems, and to improve diagnostic procedures. I have always maintained an interest in comparative medicine. A major project currently in my department involves the development and use of DNA probes in diagnosis and epidemiology of infectious diseases.

My scientific expertise, while in recent times was largely confined to disorders of the gastrointestinal tract, extends over a number of branches of microbiology (virology, bacteriology and protozoology) and to other disciplines related to the study of enteric infections. These include: pathology and pathogenesis; pathophysiology of digestion and nutrition; epidemiology; immunity and immunization; microbial interaction; mechanisms of diarrhoea; microbial association with mucosal surfaces; in vivo studies related to aspects of the host's clinical response; and antigenic and genetic determinats relevent to diagnosis.

My major contribution to science to date, has been in the following areas; a) Microbial interaction; b) Development of animal models for the study of human and animal enteric infections; c) Studies on bovine ephemeral fever in cattle and development of live attenuated virus vaccine; and d) Cryptosporidiosis.

The committee will note, as outlined in my CV, that I have expetience in the application of DNA hybridization technology to the development of vaccines, for epidemiological investigations and as a tesearch tool. In early 1987 I had completed a practical course on DNA hybridization at Monash University.

CRITICAL REVIEWS, BOOK CHAPTERS, MONOGRAPHS.

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Tziporl, S. 1985. A comparative study on important pathogens causing diarrhoea in calves and piglets. In Infectious Diarrhoea in the Young, ed. S. Tziporl, Excerpta Medica, Elsevier, Amsterdam: 371-379.

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JOURNAL ARTICLES

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Tziporl, S. and Makin, T. 1978. Propagation of human rotavirus in young dogs. Vet. Microbiol. 3:55-63.

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enteritis syndrome and diagnosis of infection. Laboratory diagnosis in neonatal calf and pig diarrhoea. Current Topics Vet. Med. Anim. Sci. Ed.P.W. de Leeuw & P.A.M. Guinee. Commission of European Communities 13:196-198.

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EXTRAMURAL GRANTS

a. Animal Industries

1. Diarrhoea in calves, Australian Meat Research Committee (AMRC), 1975-1981 - $250,000

2. Diarrhoea in calves, Australian Dairy Research Committee (ADRC), 1981-1985 - $33,000

3. Piglet enteritis, Australian Pig Industry Research Committee (APIRC), 1975-1985 - $300,000

4. Development of a vaccine against colibacillosis in piglets by DNA hybridization technology, Biotechnology-Australia, 1983-1985- $93,000.

5. Diarrhoea in Foals, Australian Equine Research Foundation (AERE), 1978-1985. - $25,000

b. Medical Research

1. Actiology and mechanisms of disease associated with specific enteric infections. Royal Children's Hospital Research Foundation (RCHRF). 1985-1988 - $158,000.

2. The role of microbiology in sudden infant death syndrome (SIDS). Australian Rotary Health Research Fund, 1986 - $18,000.

3. Detection of pathogenic E.coli by DNA colony hybridization, Clive and Vera Parnaciatti Foundation, 1987-1988 - $49,500

4. Development of antigen detection assays for rapid dingnosis of opportunistic infections. Developmental Grant, 1987-1989, - $100,000.

5. Immunology and serocpidemiology of rotavirus infection. Joint project with the Department of Gastroenterology to NH & MRC, 1986-1988 - $363,000.

6. Production of hyperimmune cow colostrum for the treatment of chronic cryptosporidiosis in patients with immunodeficiency. National Institute of Health, Bathesda, Washington, DC, 1988 - - $40,000.

CONFERENCES AND INTERNATIONAL MEETINGS.

Australian Society for Microbiology - "Laboratory and Field trials with bovine ephemeral fever vaccine" Adelaide, May 1974.

Outbreak of enteritis amongst neonates in the Melbourne Zoo" Brisbane, May 1976.

"Human rotavirus in young domestic pets", Melbourne, May 1977.

Germ-free research in Australia", Sydney, May 1978.

Second International Symposium on Neonatal diarrhoea (VIDO)

(1). "The pathogenicity and immunogenicity of rotavirus isolated from humans, calves and pigs in gnotobiotic calves, lambs and piglets".

(2). "Infection of 3-4 weeks-old piglets with rotavirus and/or enterotoxigenic E.coli at weaning".

Saskatoon, Canada, October 1978.

British Veterinary Teachers and Research Workers Conference

"The relative important of 2 interacting enteropathogens in calves and piglets" Scarborough, UK, March 1980.

International Workshop on neonatal diarrhoea (Commission of European Communities)

(1). "RNA gel electrophoresis: A technique to monitor laboratory cross-contamination amongst rotavirus isolates".

(2). "Cryptosporidiosis in Calves: significance within the enteritis syndrome and diagnosis of infection".

(3). "Piglet enteritis: field and laboratory evaluation of enteropathogens associated with 3 disease entities"

(4). "Mixed infections in Calves: the relative importance of 2 interacting agents".

Lelystand, Holland, June 1980

Sixth International Pig Veterinary Society Conference

"The role of rotavirus in the pathogenesis of piglet enteritis".

Copenhagen, July 1980

British Annual Veterinary Congress

"Aetiology and diagnosis of calf diarrhoea" York, UK, September 1980.

Third International Symposium on Neonatal Diarrhoea (VIDO) (presented on my behalf by Dr D.R.Snodgrass)

"An outbreak of calf diarrhoea associated with cryptosporidial infections in the absence of other enteropathogens" Saskatoon, Canada, October 1908.

Seventh World Congress on Animals, Plants and Microbial Toxins (TOXICON)

"The action of enterotoxins of Escherichia coli and rotavirus infection on intestinal mucosa" Brisbane, Australia, July 1982.

Eighth International Symposium on Intestinal Microecology

"Clinical manifestation and pathogenesis of enteritis associated with rotavirus and enterotoxigenix Escherichia coli in domestic animals" Boston, US, August 1982.

Australian Veterinary Association: a formal address to the Annual Conference of the Tasmanian Division

"Recently discovered viruses affecting domestic animals in Australia", Strachn, Tasmania, March 1983.

Eighth International Symposium of the World Association of Veterinary Microbiologists and Immunologists

"Recent advances on the aetiology of enteric infections in newborn foals", Perth, Australia, August 1983.

The Australian Institute of Medical Laboratory Science: a formal address to the

Annual Conference

"Cryptosporidiosis: infection and disease in humans and domestic animals" Gippsland Institute of Advanced Education, Vic., April 1984.

Infectious Diarrhoea in the young: strategies for Control of Humans and animals.

(1). Cryptosporidiosis: infection and disease

(2). A comparative study on important pathogens causing diarrhoea in calves and piglets

Deakin University, Geelong, February 1985

Third Asian Conference of Diarrhoeal Diseases

Cryptosporidiosis: Infection and Disease

Bangkok, Thailand, June 1985.

International Symposium and Workshop on Verotoxin-Producing Infections.

Characteristics of enterohaemorrhagic *E.coli* serotypes in gnotobiotic piglets.

Toronto, Canada, July 1987.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

VACANCIES

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), is a non-profit international medical research institution situated in Dhaka, Bangladesh. Its aims are research, training and service activities in diarrhoeal diseases and related subjects of nutrition and fertility, and to develop improved health programmes for control of diarrhoeal diseases in developing countries. It is also involved in major demographic surveys. There are four scientific divisions: Clinical Sciences, Laboratory Sciences, Community Medicine and Population Sciences. Salary scales, rules and regulations are similar to those followed by the UN. The 1,400 employees include 200 researchers coming from 11 different countries. ICDDR,B is supported by 21 countries and international organizations, including WHO and UNICEF.

Candidates are being sought for the following two positions which require qualifications, similar to those expected from a full professor in academe. Candidates will have a record of successfully competing for financial support for independent collaborative research, and proven scientific creativity as evidenced by a record of publications in peer-reviewed international scientific journals. Experience in developing countries would be advantageous. Good relations with scientific institutions in developed and developing countries is required. The appointees will be expected to generate and to direct multi-million dollar research programmes in diarrhoeal disease and related health problems.

1. SENIOR SCIENTIST AND HEAD, LABORATORY SCIENCES DIVISION

(Salary and grade level will be based upon an applicant's experience up to a maximum of UN equivalent P6. The position is vacant.)

Duties/Functions

To co-ordinate and direct the research, service and training activities of ICDDR,B's Laboratory Sciences Division which includes microbiology, clinical pathology, immunology, biochemistry and morbid anatomy. It has approximately 200 scientific and technical staff.

Qualifications & Experience

A medical degree or PhD with recognized speciality in medical microbiology.

2. SENIOR SCIENTIST AND HEAD, COMMUNITY MEDICINE DIVISION

(Salary and grade level will be based upon an applicant's experience up to a maximum of UN equivalent P6. The position is vacant.)

Duties & Functions

To co-ordinate and direct the activities of the Community Medicine Division. Epidemiological studies and the design and evaluation of health interventions in rural and urban communities are the main activities of this Division.

The main locations, of the Division's work are in Dhaka and Matlab (approximately 40 km from Dhaka). The Division has 150 scientific, medical and support staff.

Qualifications & Experience

A medical degree with specialization in public health or epidemiology is required. Experience in primary health care and health services research in devloping countries is needed.

Applications for the above positions with a detailed curriculum vitae together with names and addresses of 3 referees should be sent to the Personnel Manager (International), ICDDR,B, GPO Box 128, Dhaka-1000, Bangladesh.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

GPO BOX 128, DHAKA - 1000, BANGLADESH

Title: Senior Scientist - Head, Laboratory Sciences Division

Grade: P4 - P6 (UN Scale)

Objectives: To contribute to a better understanding of pathogenesis of diarrhoeal diseases, pathogenicity of etiological agents and the development of diarrhoea control methods.

Duties:

- To coordinate and direct the research, service and training activities of ICDDR,B's Laboratory SCiences Division.
- To evaluate, review and edit scientific research materials and to actively participate in scientific and managerial committees of the Centre.
- To foster active collaboration with research institutions in Bangladesh and abroad.
- To obtain international competitive research grants.
- To actively take part in the ICDDR,B teaching activities as appropriate.

Qualifications:

Education: A medical degree of PhD, with a speciality in medical microbiology.

Experience: A minimum of 15 years experience in research of enteropathogens and at least 5 years as a senior team leader. Authorships of at least 15 papers in peer-reviewed scientific journals is expected.

Language skills:	Excellent knowledge of spoken and written English.
Salary range:	US$ 32,605 to US$ 49,287 (with dependents) US$ 30,275 to US$ 45,283 (Single status) depending on experience and qualification. The above salaries are base salaries, added to this are the usual UN benefits and allowances.
Date of Joining:	As soon as possible.

POSITIONS	PUBLICATIONS	DATE OF PUBLICATIONS	LEVEL
Senior Scientist & Head Laboratory Division	The Lancet, U.K. The Lancet, U.S. American Journal of Public of Health The Bangladesh Observer The Holiday The Dainik Bangla The Epidemiology Monitor The New England Journal of Medicine.	May 23, 1987 June 20, 1987 August, 1987 May 9, 1987 May 15, 1987	P-6
Senior Scientist & Head Community Medicine Division	The Lancet, U.K. The Lancet, U.S. American Public Health Association Inc. International Health News The Banladesh Observer The Holiday	February, 1987 January, 1987 April, 1987 Febraury, 1987 December 26, 1986 December 26, 1986	P-6
(Readvertised)	The Lancet, U.K. The Lancet, U.S.A. American Journal of Public Health International Health News The Bangladesh Observer The Dainik Bangla The Epidemiology Monitor The New England Journal of Medicine	May 23, 1987 June 20, 1987 August, 1987 August, 1987 May 9, 1987 May 15, 1987	
Senior Scientist, Population Studies	The Lancet, U.K. The Lancet, U.S. American Journal of Public Health International Health News The Bangladesh Observer The Dainik Bangla The Holiday	May 23, 1987 June 20, 1987 August, 1987 August, 1987 May 9, 1987 May 15, 1987	P-5

POSITIONS	PUBLICATIONS	DATE OF PUBLICATIONS	LEVELS
Scientist/Senior Scientist Epidemiologist	The Lancet, U.K.	May 23, 1987	P-5
	The Lancet, U.S.	June 20, 1987	
	American Journal of Public Health	August, 1987	
	International Health News	August, 1987	
	The Bangladesh Observer	May 9, 1987	
	The Dainik Bangla		
	The Holiday	May 15, 1987	
	The Epidemiology Monitor	July, 1987	
	The New England Journal of Medicine		
Research Immunologist	Bangladesh Observer	December 26, 1986	P-5
	The Lancet U.K.	January 16, 1987	
	The Lancet U.S.		
Operations Research Scientist	The Lancet, U.K.	September 19, 1987	P-4
	The Lancet, U.S.		
	The Bangladesh Observer	August 18, 1987	
	The Daily Ittefaq		
Pathologist	Bangladesh Observer	December 26, 1986	P-4
	The Lancet, U.K.	January 16, 1987	
	The Lancet, U.S.		

Advertisement Distribution List for:

Senior Scientist & Head Laboratory Div
Senior Scientist & Head, Community Medicine Div.
Senior Scientist Population Studies
Research Immunologist
Operations Research Scientist
Pathologist

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1. Dr. Carl W. Tyler
Director, EPO
Centers for Disease Control
Atlanta, Georgia 30333

2. Dr. Marge Koblinsky
Child Survival Program
320 East, 43rd Street
New York., N.Y. 10017

2. Dr. Robert Reznik
Secretary
Australian Epidemiological Association
184 Glebe Point Road
Glebe New South Wales 2037
Australia

4. Dr. Ian Riley
Tropical Health Program
Medical School
University of Queensland
Herston Road, Herston
Brisbane QLD 4006
Australia

5. Dr. Kim Streatfield
Coordinator
Child Survival Project
The Australian National University
Dept. of Demography
Internaitonal Population Dynamics Program
20 Balmain Crescent
GPO Box 4, Canberra
ACT 2601

6. Dr. Peter Underwood
Coordinator
Community Health Research &
Training Unit
Dept. of Community Practice
Claremont Community Health Centre
328 Stirling Highway
Claremont, Western Australia 6010

contd../2

7. Mr. Herman Opgenhaffen
Charge d' Affaires
Embassy of Belgium
House-22
Road No.140
Gulshan Avenue
Gulshan
Dhaka-12

8. H.E. Mr. Anthony G. Vincent
High Commissioner for Canada
House No.16A, Road No.48
Gulshan
Dhaka-12

9. Mr. K.B. Anderson
Counsellor
DANIDA Mission in Bangladesh
House No.NW(E) 1
Road No.51
Gulshan
Dhaka-12

10. Mr. J. Fessaguet
Representative
Commission of the European
Economic Communities (EEC)
House No.CES (E) 19
Road No.128
Gulshan
Dhaka-12

11. H.E. Mr. Stanislas Filliol
Ambassador of France
House No.18
Road No.108
Gulshan
Dhaka-12

12. Dr. Charles R. Bailey
Representative
The Ford Foundation
House No.6, Road No.3
Dhanondi R/A
Dhaka

13. H.E. Mr. Klaus Max Franke
Ambassador of the Federal Republic of Germany
178 Gulshan Avenue
Gulshan
Dhaka-12

contd../3

14. Mr. Roshanally M.H. Hirji
Chairman
The Aga Khan Foundation
56-57 Siddeswari Road
Dhaka

15. H.E. Mr. Yoshitomo Tanaka
Ambassador of Japan
Plot No.110, Road No.27
Block A, Banani
Dhaka

16. H.E. Dr. Sandro Maria Siggia
Ambassador of Italy
House No.NWD(4)
Road No.58/62
Gulshan
Dhaka-12

17. H.E. Mr. J.H.J. Jeurrissen
Ambassador of the Royal Netherlands
House No.49, Road No.90
Gulshan
Dhaka-12

18. Mr. B. Johannessen
Development Cooperation Sec. (NORAD)
The Royal Norwegian Embassy
House No.9, Road 111
Gulshan
Dhaka-12

19. Dr. Paul E. Koehling
Resident Director
Asian Development Bank
Bangladesh Steel House
Old Airport Road
Karwan Bazar
Dhaka

20. Mr. Francis van Gigch
Chief of Mission
World Bank
222 New Eskaton Road
Dhaka

21. Mr. Erling Dessau
Resident Representative
United Nations Dev. Programme
House No.60
Road No.11A
Dhanmondi
Dhaka

contd../4

22. Ms P.M. Boughton
Director,
USAID
Jiban Bima Bhaban
Dilkusha C/A
Dhaka

23. H.E. Mr. T.G. Streeton
High Commissioner
The British High Commission
Abu Bakr House
Plot No.7
Road No.84
Gulshan
Dhaka-12

24. Mr. Anthony A. Dennedy
Representative
unicef
House No.52, Road 4A
Dhanmondi R/A
Dhaka

25. H.E. Miss Eva Heckscher
Ambassador of Sweden
73 Gulshan Avenue
Gulshan
Dhaka-12

26. Mr. Hans Meier
Charge d' Affaires
Embassy of Switzerland
House No.5
Road No.104
Gulshan
Dhalka-12

Senior Scientist, Head Community Medicine Division

1. As in all other similar cases, we have been trying very hard to identify and attract suitable candidates; Prof. Feachem gave considerable help -- for which I'm very grateful -- but despite this we have been totally unsuccessful.

2. Therefore, I have appointed Dr Briend as acting Head, Community Medicine Division.

3. I'm confident that Dr Briend will do an excellent job, but we have to continue looking for a suitable senior scientist. Only one person has shown considerable interest. He is Dr Mathu Santosham, Associate Professor at Johns Hopkins University Medical School. He has all required qualifications. Yet, he would only be available by mid-1989.

4. Before further considering this possibility, we have to wait for the Board's reaction to the "Secondments" document. Dr Santosham would be deputed from Johns Hopkins. Unless we can resume the former salary-reimbursement system we had with that institution, Dr Santosham will not be able to join ICDDR,B.

5. Recommendations

5.1 I request to be authorized to maintain an active contact with Dr Santosham as to his candidature.

5.2 To be able to do this, the existing refundable secondment ruling should be abrogated.

RE:jc

4.5.88

NAME: Mathuram Santosham, M.D., M.P.H.

CURRENT APPOINTMENTS

HOSPITAL:

UNIVERSITY: Associate Professor,
Department of International Health,
The Johns Hopkins University
School of Hygiene and Public Health.
Department of Pediatrics.
Joint Appointment, Department of Pediatrics
The Johns Hopkins University School of Medicine.

OFFICE ADDRESS: The Johns Hopkins University
School of Hygiene and Public Health
615 N. Wolfe Street
Baltimore, MD 21205
Telephone: 301/955-6931

HOME ADDRESS: 1217 Clearfield Circle
Lutherville, MD 21093

DATE OF BIRTH: February 26, 1944

PLACE OF BIRTH: Vellore, India

CITIZENSHIP: U.S.A.

MARITAL STATUS: Married Patricia James
(M.D., Anesthesiologist)

CHILDREN: Son (Vasanth) March 29, 1976
Daughter (Shireen) October 30, 1978

CURRICULUM VITAE:

1956 - 1962	Kelvinside Secondary School, Glasgow, Scotland.
1962 - 1963	Pre-university Course, Tagors Arts College, Pondicherry, India.
1963 - 1970	Jawaharlal Institute of Post Graduate Medical Education and Research, Madras University, India, Degree: M.B.B.S.
1970 - 1971	Rotating Intern, Church Home and Hospital, Baltimore, MD.
1971 - 1973	Assistant Resident, Department of Pediatrics, Baltimore City Hospitals, Baltimore, MD.
1972 - 1974	Post-doctoral Fellow, The Johns Hopkins University, School of Medicine, Department of Pediatrics. Baltimore, MD.
1973 - 1974	Chief Resident, Department of Pediatrics, Baltimore City Hospitals, Baltimore, MD.

1974 - 1975	Master of Public Health Course, The Johns Hopkins University, School of Hygiene and Public Health, Department of Maternal and Child Health, Baltimore, MD.: Degree M.P.H.
1974 - 1975	Instructor, The Johns Hopkins University, School of Medicine, Health Associate Program.
1975 - 1976	Instructor, The Johns Hopkins University, School of Medicine, Department of Pediatrics.
1975 - 1976	Fellow in Infectious Diseases, Johns Hopkins Hospital, Department of Pediatrics.
1976 - 1981	Director, Pediatric Outpatient Department, Baltimore City Hospitals, Baltimore, MD Director, Children and Youth Project, Baltimore City Hospitals, Baltimore, MD
1977 - 1981	Assistant Professor of Pediatrics, Johns Hopkins University School of Medicine, Department of Pediatrics.
1981 - 1985	Resident Coordinator, Johns Hopkins University School of Medicine, Infectious Enteric Disease Study Center, White Mountain Apache Indian Reservation, Whiteriver, Arizona. Joint Appointment, Assistant Professor of Medicine, Johns Hopkins University School of Medicine, Department of Medicine, Division of Geographic Medicine.
1984 - Present	Associate in Pediatrics, University of Arizona Tucson, Az.
July 1986 -	Associate Professor, Department of International Health, Johns Hopkins University, School of Hygiene and Public Health, Baltimore, MD. Joint Appointment, Department of Pediatrics, Johns Hopkins University School of Medicine.

CERTIFICATION:

October, 1975	Certified by American Board of Pediatrics.
June, 1974	Passed FLEX Exam; obtained license to practice in Maryland.
February, 1970	Passed ECFMG Exam.

MEMBERSHIP IN PROFESSIONAL SOCIETIES:

American Academy of Pediatrics (Fellow)
Chesapeake Physicians, P.A.
American Society of Microbiology
Infectious Disease Society of America

OTHER PROFESSIONAL ACTIVITIES:

1977 - 1981 Chairman, Ambulatory Care Committee, Baltimore City Hospitals.

1976 - 1981 Hospital Infection Committee Baltimore City Hospitals

Oct. 1985-Present Immunization Working Group, Johns Hopkins University, Baltimore, MD.

ARTICLES IN MEDICAL JOURNALS:

1. Hong, R., Santosham, M., Schulte-Wissermann, H., Horowitz, S., Hsu, S.H., Winkelstein, J.A. Reconstitution of B and T lymphocyte function in severe combined immunodeficiency disease after transplantation with thymic epithelium. Lancet ii:1270, 1976.

2. Santosham, M., Moxon, E.R. Detection and quantitation of bacteremia in childhood. J. Pediatrics 91:719-721, 1977.

3. Santosham, M., Kallman, C., Moxon, E.R., Neff, J. Absence of increasing incidence of Haemophilus influenzae B meningitis in Baltimore (1965-1975). J. Infect. Dis. 140:1009-1012, 1979.

4. Santosham, M., Chipps, B.E., Strife, J., Moxon, E.R. Sequelae of Haemophilus influenzae type b empyema. J. Pediatrics 95:160-161, 1979.

5. Santosham, M., Sack, R.B., Froehlich, J.L., Aurelian, L., Greenberg, H.B., Yolken, R., Kapikian, A.Z., Javier, C., Medina, C., Orskov, F., Orskov, I. Biweekly prophylactic doxycycline for travelers diarrhea. Current Chemotherapy and Infectious Disease Proceedings of the 11th ICC and the 19th ICAAC, American Society of Microbiology, 922-924, 1980.

6. Millan, J.C., Santosham, M., Khaneja, S., Winkelstein, J.A., Schulte-Wisserman, H., Horowitz, S., Hong, R. Long term observation on a patient with severe combined immunodeficiency after transplantation with cultured thymus epithelium. Clin. Immun. Immunopath. 17:382-388, 1980

7. Santosham, M., Ancona, R., Reading, D.L. Current concepts in the treatment of pyogenic meningitis. Indian J. Pediatrics 47:457-462, 1980.

8. Santosham, M., Sack, R.B., Pierce, N.F., Sack, D. Hyperkalemia and glucose electrolyte solutions. Lancet ii:583, 1980.

9. Santosham, M., Sack, R.B., Froehlich, J.L., Aurelian, L., Greenberg, H.B., Yolken, R., Kapikian, A.Z., Javier, C., Medina, C., Orskov, F., Orskov, I., Biwecklys prophylactic doxycycline for travelers diarrhea. J. Infect. Dis. 143:598-602, 1981.

10. Sheridan, J.F., Aurelian, L., Barbour, G., Santosham, M., Sack, R.B., Ryder, R.W. Traveler's diarrhea associated with rotavirus infection: analysis of virus-specific immunoglobulin classes. Infect. Immun. 31:419-429, 1981.

11. Santosham, M., Jackson, K., Bertrando, R., Foster, S., McBride, C., Black, R. Oral electrolyte solutions for infantile diarrhea. N. Engl. J. Med. 305:581, 1981.

12. Headings, D.L., Santosham, M. Kawasaki disease associated with serological evidence of Rocky Mountain spotted fever. Johns Hopkins Med. J. 149:220-221, 1981.

13. Santosham, M., Sack, R.B., Lochlear, E., Foster, S., Garret, S., Pousey, D., Evans, S., Black, R. Storing oral rehydration solution. Lancet i:797, 1982.

14. Santosham, M., Daum, R.S., Dillman, L., Rodriguez, J.L., Luque, S, Russell, R., Kourany, M., Ryder, R.W., Bartlett, A.V., Rosenberg, A., Benenson, A.S., Sack, R.B. Oral rehydration therapy of infantile diarrhea: a controlled study of well-nourished children hospitalized in the United States and Panama. N. Engl. J. Med. 306:1070-1076, 1982.

15. Sack, D.A., Santosham, M., Bertrando, R., Foster, S., Garbet, S., Sack, R.B. Risk of hypernatremia with oral rehydration. J. Pediatrics 101:154-155, 1982.

16. Leggiadro, M., Dover, G., Morse, M., Santosham, M. Lung abscess in sickle cell disease. Am. J. Ped. Hemotology/Oncology Summer: 215-217, 1982.

17. Santosham, M., Pathak, A., Kottapalli, S., Vergara, J., Wong, S., Froehlich, J., Sack, R.B. Neonatal rotavirus infection. Lancet i:1070-1071, 1982.

18. Santosham, M., Bertrando, R., Foster, S., Garret, S. Oral electrolyte solutions for infantile diarrhea. (letter) Pediatrics 69:503, 1982.

19. Sack, R.B., Santosham, M., Daum, R.S. Oral rehydration for diarrhea. N. Engl. J. Med. 107:153, 1982.

20. Santosham, M., Carrera, E., Sack, R.B. Oral rehydration therapy in well-nourished ambulatory children. Am. J. Trop. Med. & Hyg. 32:804-808, 1983.

21. Santosham, M., Yolken, R.H., Quiroz, E., Dillman, L.L., Oro, G., Reeves, W.C., Sack, R.B. Detection of rota-virus in respiratory secretions of children with lower respiratory pneumonia. J. Pediatrics 103:585-585, 1983.

22. Santosham, M., Foster, S., Sack, R.B. Oral rehydration in acute infantile diarrhea. Arch. Dis. Child. 57:888, 1983.

23. Yolken, R., Leister, F., Whitcomb, L.S., Santosham, M. Enzyme immunoassays for the selection of bacterial antigens utilizing biotin-labelled antibody and peroxidase biotin-avidin complex. J. Immunology Methods 56:319-327, 1983.

24. Smith, C.C., Aurelian, L., Santosham, M., Sack, R.B. Rotavirus associated traveler's diarrhea: neutralizing antibody in asymptomatic infections. Infect. Immun. 41:829-833, 1983.

25. Sack, R.B., Santosham, M., Froehlich, J.L., Medina, C., Orskov, F., Orskov, I. Doxycycline prophylaxis of travelers' diarrhea in Honduras, an area where resistance to doxycycline is common among entero-toxigenic Escherichia coli. Am. J. Trop. Med. Hyg. 33:460-466, 1984.

26. Santosham, M., Foster, S., Rousey D.B., Garrett, S., Evans, S., Nagder, L., Benson, L., Ireland, T., Spira, W.M., Black, R.E. Outpatient use of oral rehydration solutions in Apache population: effect of instructions on preparation and contamination. J. Ped. Gastroenterology and Nutrition 3:687-691, 1984.

27. El-Mougi, M., Santosham, M., Hirschhorn, N., El-Hadi, M., El-Akkad, N., Khalek, A.H., Osni, O. Accuracy of mixing oral rehydration solution at home by Egyptian mothers. J. Diar. Dis. Res. 3:159-161, 1984.

28. Losonsky, G., Santosham, M., Sehgal, V., Zwahlen, A., Moxon, R., Haemophilus influenzae disease in the White Mountain Apaches: molecular epidemiology of a high risk population. Ped. Infect. Dis. 3:539-547, 1984.

29. Santosham, M., Burns, B., Nadkarni, V., Foster, S., Garrett, S., Croll, L., O'Donovan, U., Pathak, R., Sack, R.B. Oral rehydration therapy for acute diarrhea in ambulatory children: a double-blind comparison of four different solutions. Pediatrics 76:159-166, 1985.

30. Santosham, M., Foster, S., Reid, R., Bertrando, R., Sack, R.B. Role of soy-based, lactose-free formula during treatment of acute diarrhea. Pediatrics 76:292-298, 1985.

31. Santosham, M., Yolken, R., Wyatt, R., Bertrando, R., Black, R.E., Spira, W.M., Sack, R.B. Epidemiology of rotavirus diarrhea in a prospectively monitored American Indian population. J. Infect. Dis. 152:778-783, 1985.

32. Anderson, P., Pichichero, M., Insel, R., Farsad, P., Santosham, M. Capsular antigens noncovalently or covalently associated with protein as vaccines to Haemophilus influenzae type b: comparison in two-year-old children. J. Infect. Dis. 152:634-636, 1985.

33. Santosham, M., Reid, R., Duncan, B., Foster, S., Croll, L., Marshall, W.N., Burns, B.A., Letson, W., Powlesland J., Garrett, S., Wai, H.H., Almeido-Hill, J., Sack, R.B. Glycine-based oral rehydration solution reassessment of safety and efficacy. J. Pediatrics 109:795-801, 1986.

34. Santosham, M., Brown, KH., Sack, RB. Oral rehydration therapy and acute childhood diarrhea. Pediatrics in Review (in press).

CONSULTANT ACTIVITIES:

May 8th to 31st 1983: Consultant to National Diarrheal Diseases Control Project-Egypt

Feb 13 - 29 1984: Consultant World Health Organization assigned to United Nations Relief and Welfare Agency, Gaza for conducting a training course on oral rehydration therapy.

July 9 - 28 1984: Consultant to National Diarrheal Diseases Control Project-Egypt.

April 11 - May 12, 1985: Consultant to USAID for the Evaluation of the Integrated Rural Health Project, New Delhi, India.

July 25 - August 3, 1985: Consultant to National Diarrheal Disease Contr Project-Egypt.

August 4 - August 8, 1985: Consultant World Health Organization, Global Diarrheal Disease Control Program - Geneva, Switzerland.

January 27 - February 9, 1986: Consultant USAID, Dietary Management of Diarrhea Project - Nigeria, Africa.

February 19 - March 3, 1986: Consultant to National Diarrheal Diseases Control Project-Cairo, Egypt.

March 17 - 21, 1986: Consultant World Health Organization Control of Diarrheal Diseases Program - Dar es Salaam, Tanzania.

August 16 - 31, 1986: Consultant World Health Organization, Fuzhou and Harbin, China.

OOK SECTIONS:

1. Moxon, E.R., Santosham, M. Haemophilus influenzae and Rotavirus Infections. In: Current Pediatric Therapy. In Beache W.B. Saunders Co., 9th edition, pp 1925-1932, 1980.

2. Santosham, M. Nutritional benefits related to oral therapy. In: Acute Diarrhea. Its Nutritional Consequences. MARCH 13. J.A. Bellanti, ed. Raven Press, 1983.

3. Nagel, J.E., Chrest, J., Adler, W.H., Santosham, M. The effect of viral infection on the ability of human lymphocytes to develop antibody producing cells after mitogen stimulation in vitro. Pediatric Research.

PRESENTATIONS AT NATIONAL AND INTERNATIONAL SCIENTIFIC MEETINGS

1) 20th INTERSCIENCE CONFERENCE ON ANTIMICROBIAL AGENTS AND CHEMOTHERAPY-BOSTON, 1980: Biweekly prophylactic doxycycline for travelers' diarrhea.

2) 21st INTERSCIENCE CONFERENCE ON ANTIMICROBIAL AGENTS AND CHEMOTHERAPY-CHICAGO, 1981: Daily doxycycline prophylaxis for Travelers' diarrhea in an "antibiotic-resistant" area.

INTERNATIONAL, NUTRITIONAL WORKSHOP - ACUTE DIARRHEA - ITS NUTRITIONAL CONSEQUENCES - WASHINGTON, D.C., MAY 7 - 10, 1982: Nutritional benefits related to oral rehydration.

4) INTERNATIONAL CONFERENCE ON ORAL REHYDRATION THERAPY - BALTIMORE, MD., MARCH 15-17, 1982: Oral Therapy of Infantile Diarrhea: A controlled study in well-nourished children in the U.S.A. and Panama.

5) SECOND INTERNATIONAL WORKSHOP ON CAMPYLOBACTER INFECTIONS BRUSSELS, BELGIAM., SEPTEMBER 6 - 9, 1983: Transmission of Campylobacter infections in an American Indian population case/control study.

6) XVII INTERNATIONAL CONGRESS OF PEDIATRICS - MANILA, PHILIPINES., NOVEMBER 7 - 11, 1983: Oral rehydration in well-nourished children.

7) XI INTERNATIONAL CONGRESS OF TROPICAL MEDICINE AND MALARIA- CALGARY, CANADA., SEPTEMBER 16 - 22, 1984: role of soy-based, lactose-free formula during the treatment of acute diarrhea.

8) AMERICAN SOCIETY OF TROPICAL MEDICINE - SYMPOSIUM; ENDEMIC ACUTE INFECTIOUS DIARRHEAL DISEASE IN DEVELOPING REGIONS- BALTIMORE, MD., DECEMBER 4, 1984: The incidence and etiologies of diarrheal disease in a prospectively monitored American Indian population.

9) AMERICAN SOCIETY FOR MICROBIOLOGY - SEMINAR RECENT ADVANCES IN ETIOLOGY AND PREVENTION OF VIRAL GASTROENTERITIS - LAS VEGAS, NEVADA., MARCH 6, 1985: Longitudinal Studies of Rotavirus and Other Enteric Infections in the White Mountain Apache Indian Population in Arizona.

10) NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES ROTAVIRUS VACCINE WORK GROUP MEETING - BETHESDA, MD., MARCH 13, 1985: Proposed Rotavirus Vaccine Trial Among White Mountain Apache and Navajo Indian Populations in Arizona.

11) SECOND INTERNATIONAL CONFERENCE ON ORAL REHYDRATION THERAPY - WASHINGTON, D.C., DECEMBER 10 - 13, 1985: Use of Oral Rehydration Therapy for Hydernatremia and Hyponatremia.

12) FIRST REGIONAL OPT CONFERENCE-CAIRO, EGYPT, APRIL 4, 1986: use of Oral Rehydration Therapy in Hypernatremia.

13) NON-ANTIMICROBIAL ANTIDIARRHEAL AGENTS - NATIONAL INSTITUTES OF HEALTH - BETHESDA, MARYLAND MAY 8 - 9, 1986: Glycine-based Oral Rehydration Solution-Reassessment of Safety and Efficacy.

14) XVIII INTERNATIONAL CONGRESS OF PEDIATRICS - HONOLULU, HAWAII - JULY 7 - 11, 1986: Oral rehydration therapy in developed countries.

15) NATIONAL SYMPOSIUM ON CONTROL OF DIARRHEAL DISEASES - HARBIN, CHINA - AUGUST 25 - 29, 1986.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

GPO BOX 128, Dhaka-1000, Bangladesh

Title: Senior Scientist - Head Community Medicine Division

Grade: P4 - P6 (UN Scale)

Objectives: To direct and conduct epidemiological studies and design and evaluate health intervention studies related to diarrhoeal diseases including shigellosis and chronic diarrhoea and other major causes of childhood morbidity and mortality in the context of rural and urban health programme.

Duties:

- To coordinate and direct the research, service and related activities of the Community Medicine Division.
- To develop and carry out scientific protocols.
- To administer the overall functions of the division and advise the scientific staff.
- To evalute and direct the activities of the Matlab Field Station.
- To contribute to the development of career structure for the scientific and clinical staff and attempt to integrate the inservice training with that carried out by appropriate national institutions.
- To foster active collaboration with research institutions in Bangladesh and abroad.
- To obtain International competetive research grants.

Qualifications:

Education: A medical degree with specialization in Public Health and/or Epidemiology.

Experience: A minimum of 15 years experience in primary health care or health services research including tropical medicine; out of which at least 5 years as a Senior Team Leader. Must have proven scientific ability as evidenced by a record of original work published in International peer-reviewed scientific journals. Good connections with International Scientific Institutions.

Language skills: Excellent knowledge of spoken and written English.

Salary range: US$ 32,605 to US$ 49,287 (with dependants) US$ 30,275 to US$ 45,283 (single status) depending on experience and qualifications. The above salaries are base salaries, added to these are the usual UN benefits and and allowances.

Date of joining: As soon as possible.

Senior Scientist (Head, DSS)

Dr. Michael A. Strong has been selected for the position. Necessary documentations are presented in the following pages.

AH:au

ADVERTISEMENT

SCIENTIST/SENIOR SCIENTIST, POPULATION STUDIES

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) is a non-profit international medical research institution situated in Dhaka, Bangladesh. Its aims are to conduct research and training in diarrhoeal diseases and related subjects of nutrition and fertility, and to develop improved health programmes for control of diarrhoeal diseases in developing countries. It is also involved in major demographic surveys. There are four scientific divisions: Clinical Sciences, Laboratory Sciences, Community Medicine and Population Sciences. Salary scales, rules and regulations are similar to those followed by the UN. The 1,400 employees include 200 researchers coming from 11 countries. ICDDR,B is supported by 21 countries and international organizations, including WHO and UNICEF.

ICDDR,B seeks for immediate employment a scientist or senior scientist to direct its Demographic Surveillance System (DSS) in the Division of Population Sciences. The main objectives of the DSS are maintaining and upgrading demographic registration in Matlab, a rural community of about 200,000 people, 45 km SE of Dhaka, and conducting demographic and related health research.

Requirements: PhD or equivalent degree with specialization in population studies with a strong background in biostatistics, public health research, and computer applications; outstanding record of publications in peer-reviewed international journals and research monographs; post-doctoral resarch experience in reputed scientific institutions; substantial field experience in developing countries; strong international scientific contacts; and broad supervisory experience and ability to execute scientific leadership.

The DSS is based on computerized longitudinal data base system using both a mainframe computer (IBM 4361), part of the Centre's Computer Information System, and a PC network. Its staff of about 150 people include demographers, statisticians, computer technicians and field personnel. It collaborates closely with ICDDR,B epidemiologists and other health scientists in various research protocols.

Appointment will be made for 3 years at UN salary level P-3 up to P-5 according to experience and qualifications. Reply with curriculum vitae and the names of three referees to: Mr Aminul Huque, International Personnel, ICDDR,B, GPO Box 128, Dhaka-1000, Bangladesh.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLDESH

GPO BOX 128, Dhaka-1000, Bangladesh

Title: Scientist/Senior Scientist - Director, Demographic Surveillance System (In the Population Sciences Division)

Grade: P3 - P5 (UN Scale)

Objectives: To maintain and upgrade demographic registration in the ICDDR,B field areas, and conduct demographic and related health research.

Duties:

- To direct the Demographic Surveillance System, both in Dhaka and the field areas, and supervise and guide its staff of about 150.
- To conduct and direct demographic research.
- To foster active collaboration with institutions in Bangladesh and abroad.
- To contribute in obtaining international competitive research grants.
- To provide demographic and statistical expertise to other ICDDR,B scientists.
- To actively take part in the ICDDR,B training programme.

Qualifications:

Education: A PhD or equivalent degree with specialization in population studies with a strong background in biostatistics, public health research, and computer applications.

Experience:	A minimum of 10 years research experience in scientific institutions and field experience in developing countries. Good record of publications in peer-reviewed international journals and/or research monographs. Supervisory experience and proof of scientific leadership.
Language skills:	Excellent knowledge of spoken and written English.
Salary range:	US$27,294 to US$46,340 (with dependants) US$25,474 to US$42,638 (single status) depending on experience and qualifications. The above salaries are base salaries, added to this are the usual UN benefits and allowances.
Date of Joining:	As soon as possible.

UNIVERSITY of PENNSYLVANIA

Population Studies Center
3718 Locust Walk
Philadelphia, PA 19104-6298

School of Arts and Sciences

December 16, 1987

Personnel Manager (International)
ICDDR, B
GPO Box 128
Dhaka - 1000, Bangladesh

Dear Sir or Madam:

I am interested in applying for the position as Project Director of the Demographic Surveillance System in the Population Sciences Division. Dr. Jane Menken and Dr. Koray Tanfer, both of whom have recently visited ICDDR, B, have encouraged me to write to you regarding this position.

I believe that my background in population studies and computer applications, as well as my previous work in developing countries and my experience as Director of a large data-base creation project here at Penn, qualify me for this position. I have enclosed a copy of my curriculum vitae outlining this experience.

Could you please send me more information about the position, especially the scope of work, how the DSS is integrated into the Centre, and technical details such as access to computer resources and the current size of the data base and the survey population?

Thank you for this information and for considering me for this position.

Sincerely yours,

Michael A. Strong, Ph.D.
Director, 1910 Census Project

MAS/aw
Enclosure

Curriculum Vitae
December 1987

MICHAEL A. STRONG

Address
Population Studies Center
3718 Locust Walk
University of Pennsylvania
Philadelphia, PA 19104-6298
USA
Telephone: (215) 898-6441

Citizenship and Date of Birth
United States of America; 3 December 1946

Languages
English, French

Education
Cornell University, Ithaca, New York - 1969-1973
B.A. Economics and History 1973
Areas of study: International economics, historical demography, computer science.

Yale University, New Haven, Connecticut - 1973-1975
Areas of Study: Economic theory and economic history

Cornell University, Ithaca, New York - 1975-1979
M.A. Economics 19
Ph.D. Economics 1983
Areas of Study: Economics (economic development, economic theory)
Demography (demographic methods, migration)
Computer Science (social science data base management)
Dissertation: Female Migration in Guatemala: Estimates from Own-Children Methods

Employment
1984-present Director, 1910 Census Public Use Sample Project, Population Studies Center, University of Pennsylvania.

1983-present Research Associate, Population Studies Center, University of Pennsylvania.

1980-83 Programmer/Analyst, Population Studies Center, University of Pennsylvania.

1978-80 Research Associate, Differential Fertility and Mortality in Central America Project, Cornell University.

1976-78 Research Assistant for M.R. Haines, Department of Economics, Cornell University.

Other Professional Activities

1987 Discussant, National Academy of Sciences, Workshop on Microcomputer-based Software for Population and Development Planning.

1986 Discussant, Population Association of America Annual Meeting, Session on Microcomputers in Demography.

Taught course on Use of Microcomputers in Developing Countries, University of Pennsylvania.

1985 Taught at International Union for the Scientific Study of Population Workshop on Advanced Demographic Methods, Nairobi, Kenya.

Resource Person, East West Population Institute Summer Seminar "Fertility Estimation Using Microcomputers," Honolulu, Hawaii.

Advisor on Data Processing Advisory Board on Demographic and Health Surveys, Westinghouse Public Applied Systems.

Organizer, first Population Association of America Annual Meeting Session on Microcomputers in Demography.

Consultant, Centers for Disease Control, on Survey Data Entry in Developing Countries, Atlanta, Georgia.

Consultant, Population Council Project in Nairobi, Kenya; selected and installed microcomputer and taught its use for demographic surveys and research.

Directed Data Entry of Sexual Harassment Survey Questionnaires, University of Pennsylvania.

1984 Lecturer, University of Pennsylvania, course on Survey Research and Computers.

Advisor on Scientific Advisory Board on Demographic and Health Surveys, Westinghouse Public Applied Systems.

Consultant, Rockefeller Foundation Project in Ife, Nigeria; selected and installed microcomputer and taught its use for demographic surveys and research.

Consultant, Population Council Projects in Ife, Nigeria and Lome, Togo; selected and installed microcomputer and taught its use for demographic surveys and research.

1984 Participant, Conference at Sahel Institute, Bamako, Mali; EMIS Infant Mortality Surveys.

1983 Consultant, Office of Population Research, Princeton University; planning microcomputer purchase and use.

Advisor to Mr. Baba Traore, of the Sahel Institute, on statistical computing and demographic techniques.

1982 Consultant, Population Council Project at Sahel Institute, Bamako, Mali; selected and installed microcomputer and taught its use for demographic surveys and research, set up data entry procedures.

Professional Associations
American Economic Association
Population Association of America
American Statistical Association

Publications

Data Entry Using Microcomputers (in preparation).

Software for Demographic Research, Population Index, 53(2):183-99, Summer, 1987.

L'utilisation des micro-ordinateurs pour le traitement et l'analyse des enquêtes du type EMIS, Les actes du séminaire sur le plan d'analyse des enquêtes EMIS, CRDI Canada et l'Institut du Sahel, 1986.

Effects of Mortality Declines on Marriage Patterns in Developing Countries, with S. Preston, in Consequences of Mortality Trends and Differentials, Population Studies No. 95, United Nations, New York, 1986.

Publications (continued)

Differentials in Infant and Child Mortality and Their Change Over Time: Guatemala, 1959-73, with M. Haines and R. Avery, Demography, November 1983.

Comparative Patterns of Child Mortality Differentials in Developing Countries, with B. Mensch, S. Taber, and N. Denton. Presented at the Annual Meeting of the Population Association of America, 1982, and included in the U.N. Monograph Series.

Female Migration in Guatemala: Estimates from Own-Children Techniques. Ph.D., Dissertation, Cornell University, 1983.

Computers as Logical Decision Making Tools in Demography. Presented at the Annual Meeting of the Population Association of America, 1979.

An Increment-Decrement Life Table Program, Cornell University, 1978. Mimeo.

An Introduction to Computer Assisted Research in Demographic History, Cornell University, 1974.

References

Professor Samuel H. Preston, Population Studies Center, University of Pennsylvania, 3718 Locust Walk, Philadelphia, Pennsylvania 19104-6298, USA.

Professor Etienne van de Walle, Population Studies Center, University of Pennsylvania, 3718 Locust Walk, Philadelphia, Pennsylvania 19104-6298, USA.

Professor Michael R. Haines, Department of Economics, Wayne State University, Detroit, Michigan 48202, USA.

No Reference Letters of

Dr. Michael A. Strong

THE UNIVERSITY OF MICHIGAN

DEPARTMENT OF POPULATION PLANNING AND INTERNATIONAL HEALTH
SCHOOL OF PUBLIC HEALTH

ANN ARBOR, MICHIGAN 48109-2029
(313) 764-7516
CABLE POPLANUM
TELEX 4320815UIOFM UI

21 February 1988

Dr. Roger Eeckels
% Prof. David Bell
Harvard School of Public Health
665 Huntington Ave.
Boston, MA 02115

Dear Dr. Eeckels,

Thank you very much for considering me for the position of Director of Research for the Demographic Surveillance System at ICDDR,B. Although I have no direct experience with the DSS, it is well known to researchers as a pre-eminent data source for biometric and demographic studies.

I am a social demographer and demographic methodologist oriented toward empirical analysis of public policy, with a concentration on contraception and fertility issues. My dissertation (completed in 1986) developed methods to correct U.S. contraceptive failure rates for under-reporting of induced abortion. This work led to a substantive interest in the level and pattern of spontaneous abortion and its influence on completed fertility. In Bangladesh, I would hope to pursue studies of spontaneous abortion and contraceptive failure.

Another aspect of my current work is in developing concepts and methods to assess the potential demographic impact of family planning programs. Charles Westoff and I developed a general model for the potential reduction in fertility and abortion if contraception reduces or eliminates unwanted pregnancies in Europe. This sort of research addresses the policy-relevant question of optimal mix of contraceptive methods, and would be applicable to Bangladesh.

I would also mention that my overall level of computer and statistical expertise is relatively higher than that of most demographers.

Enclosed you should find a copy of my current curriculum vitae. Four recommendations are on their way to you under separate cover.

I look forward to meeting you in Boston on March 3, and to learning more about the position. If I can be of any assistance before that time, please call me at (313) 764-7516.

Yours Sincerely,

Charles R. Hammerslough

Charles R. Hammerslough, Ph.D.
Assistant Professor

March, 1988

CHARLES R. HAMMERSLOUGH

Curriculum Vitae

Office Address:
Department of Population Planning
and International Health
School of Public Health
The University of Michigan
Ann Arbor, Michigan 48109-2029
(313) 764-7516

Home Address:
619 East University Avenue
Apartment C-3
Ann Arbor, Michigan 48104
(313) 747-8077

SSN: 048-38-0734

Employment

Current:

Assistant Professor of Population Planning and International Health, The University of Michigan School of Public Health. 1986 - present.

Past:

Summer Researcher, Division of Reproductive Health, Centers for Disease Control, Atlanta, GA. Summer, 1984.

Computer Programmer and Research Assistant, Office of Population Research, Princeton University. September, 1980 - August, 1981.

Education

Ph.D. (Sociology), Princeton University, Princeton, New Jersey, 1987.

M.A. (Sociology), Princeton University, Princeton, New Jersey, 1984.

B.A. (Cultural Anthropology), Yale College, New Haven, Connecticut, 1980.

Diploma (Cum Laude Society), The Taft School, Watertown, Connecticut, 1976.

Fellowships

Garden State Graduate Fellowship
Princeton University Tuition Fellowship

Courses Taught

Graduate Seminar on Contraceptive Efficacy (2 times)
U.S. Family Planning Policies and Programs (2 times)
Data Analysis for Population Planning and International Health (1 time)

Publications

Hammerslough, Charles R. Leviticus to Emily Post: The Cultural Implications of Food. *Yale Scientific Magazine* 53(4): 8-13. Summer, 1979.

Trussell, James and Charles R. Hammerslough. A Hazards Model Analysis of the Covariates of Infant and Child Mortality in Sri Lanka. *Demography* 20(1): 1-26. February, 1983.

Hammerslough, Charles R. Characteristics of Women Who Stop Contracepting. *Family Planning Perspectives* 16(1): 14-18. January/February, 1984.

Goldman, Noreen, Charles F. Westoff, and Charles R. Hammerslough. Demography of the Marriage Market in the United States. *Population Index* 50(1): 5-25. Spring, 1984.

Friede, Andrew, Carol J.R. Hogue, Lee Lee Doyle, Charles R. Hammerslough, Joseph Sniezek, and Henry Arrighi. Do the Sisters of Childbearing Teenagers Have Increased Rates of Childbearing? *American Journal of Public Health* 76(10): 1221-1224. October, 1986.

Kenen, Regina H. and Charles R. Hammerslough. A Comparison of Reservation and Non-Reservation Native American Mortality, 1970-1978. *Social Biology* 34(1-2): 26-36.

Westoff, Charles F., Charles R. Hammerslough, and Lois Paul. Potential Impacts on Fertility and Abortion in Western Countries of Improvements in Contraception. Forthcoming in *European Journal of Population.*

Submissions

Hammerslough, Charles R., Risë A. Futterer, and George S. Simmons. The Potential Demographic Impact of Defunding Family Planning International Assistance. Submitted to *Studies in Family Planning.*

Hammerslough, Charles R. Potential Births Not Averted Following Family Planning Program Termination. Submitted to *Demography.*

Hammerslough, Charles R. Indirect Estimation of Spontaneous Abortion. Submitted to *Demography.*

Hammerslough, Charles R. "Individual and Contextual Determinants of Infant and Child Mortality in Sine-Saloum, Senegal". Submitted to *Population.*

Manuscripts (available)

Hammerslough, Charles R. "Correcting Survey-Based Contraceptive Failure Rates for Abortion Under-Reporting".

Hammerslough, Charles R. "Contraceptive Use-Failure Rates in the United States: Results from the 1982 NSFG". (Presented at PAA, 1987).

Hammerslough, Charles R. "Estimating a Model of Contraceptive Continuation from Limited Data".

Hammerslough, Charles R. and Abby R. Harris. "Health and Fertility Impacts of the Withdrawal of the IUD". (Presented at NFPRHA, 1988)

Professional Activities

Reviewer, *Demography*

Reviewer, *Family Planning Perspectives*

Reviewer, *East-West Center Monograph Series*

Participant, Fifteenth Annual Summer Seminar in Population, East-West Population Institute; Summer, 1984.

Witness at Hearings on Medicaid Funding for Abortion, Michigan House of Representatives Committee on Social Services and Youth, April, 1987.

Program Committee Member, 1988 Annual Meetings of the Population Association of America.

Participant, United Nations Experts Group on Contraceptive Continuation and Failure in Less-Developed Countries, 1988.

Consulting

Centers for Disease Control, 1984.
Family Health International, 1985.
Alan Guttmacher Institute, 1986-present.
Planned Parenthood Federation of America, 1987-present.

Professional Associations

Population Association of America
American Public Health Association
American Sociological Association
American Statistical Association

Personal

Born September 2, 1958. U.S. Citizen. Married, no children.
Fluency in French; some proficiency in Turkish.

References

Prof. Jane A. Menken, Princeton University, Office of Population Research, 21 Prospect Avenue, Princeton, NJ 08544

Dr. Anne R. Pebley, Princeton University, Office of Population Research, 21 Prospect Avenue, Princeton, NJ 08544

Mr. David A. Smith, Director of Systems Support, Planned Parenthood Federation of America, 810 Seventh Avenue, New York, NY 10019

Prof. Linda G. Martin, East-West Population Institute, 1777 East-West Road, Honolulu, HI 96848

UNIVERSITY of PENNSYLVANIA

School of Arts and Sciences
Department of Sociology
3718 Locust Walk
Philadelphia, PA 19104-6299
Jane Menken
UPS Foundation Term Professor in the Social Sciences

March 2, 1988

Dr. Roger Eeckels
Dr. M. Badrud Duza

RE: Charles Hammerslough

Dear Roger and Duza,

Just for the record, I am attaching a copy of the most recent letter of recommendation I wrote for Charlie. Clearly, I think he has promise to be both a good demographer and a good administrator.

Sincerely yours,

Jane Menken
Professor of Sociology and Demography
UPS Foundation Term Chair in the Social Sciences

Visiting Professor of Public and International Affairs
Princeton University

December 26, 1987

Joseph R. Bookmyer
Manager, Fellowship Office
The Rockefeller Foundation
1133 Avenue of the Americas
New York NY 10036

Re: Charles Hammerslough

Dear Mr. Bookmyer,

Charlie Hammerslough is an outstanding candidate for a social science research fellowship in agriculture and population studies. He is just the kind of person we had in mind when I was member of the Advisory Committee to the Population Program and several of us recommended that this type of fellowship program be established. He has a fine record of independent research and works extremely well in different kinds of institutions.

Charlie had an unusually productive research career as a graduate student at Princeton, as evidenced by the work he has published in several areas, including hazard modelling in demography, contraceptive continuation rates in the U.S., and demography of the marriage market in the U.S. In each case, he collaborated well with faculty or staff members at OPR. His thesis research is on estimating the effect of abortion on our estimates of contraceptive failure rates. He developed a model to investigate the potential effects of varying situations with respect to the relationship between prior contraceptive use and the likelihood of terminating an unintended pregnancy by abortion and arranged for several states to supply data that could be used to make reasonable estimates. The work is completely original; in fact, when he first proposed a project in this area, several of us were quite discouraging. Charlie persisted and convinced us that he has an idea well worth pursuing. He has continued to collaborate with people here, primarily Charles Westoff, who, I assume has already written to you. I believe that Charlie will continue to be an original thinker on a broad range of demographic subjects and that his work will branch out into other areas of sociology; I have little doubt that he will continue to be resourceful and productive in his research.

Charlie is a good computer programmer and a good methodologist. He was a fine teaching assistant both in the basic quantitative analysis course that James Trussell and I taught and in my more advanced statistics course. Students found him a clear teacher and a good preceptor. He was unfailingly willing to help students in these classes and his peers as well. I have been

told that he was unusually helpful to other students, particularly those from developing countries, when he participated in the East-West Population Institute Summer Seminar a few years ago. I am sure these skills carry over into his teaching and supervision, both formal and informal, in any developing country institution.

While Charlie was a graduate student, he had the opportunity to work outside OPR as a consultant for the Alan Guttmacher Institute, the Centers for Disease Control, and Family Health International. Each institution expressed strong interest in hiring him as part of its permanent staff or continuing to have him as a consultant if he chose, as he did, to accept an academic position. I expect him to be able to continue to be both an academic researcher and a valued consultant to applied research projects.

Charlie also contributes to university life: he and his wife were assistant masters in one of the undergraduate colleges during their last year at Princeton. They spent a great deal of time with their students. The senior faculty associated with the college were unanimous in their praise of Charlie's work. This experience, again, should transfer well to a developing country setting.

Charlie was a pleasure to have at OPR; he is generous with his time and thoughtful in his responses. He is a fine colleague.

I recommend him highly.

Sincerely yours,

Jane Menken
Visiting Professor of Public and International Affairs

Professor of Sociology and Demography
University of Pennsylvania

Planned Parenthood®
Federation of America, Inc.

February 25, 1988

Dr. Roger Eeckles
c/o David Bell
Harvard School of Public Health
665 Huntington Street
Boston, MA 02115

Re: Candidate Charles R. Hammerslough, PhD

Dear Dr. Eeckles:

As the person responsible for either conducting or brokering strategic and special studies for the Planned Parenthood Federation, I worked extensively with Dr. Charles Hammerslough in the Spring and Summer of 1987. I am glad to have the opportunity to recommend him for the position of Director of Research, Demographic Surveillance System, ICDDR Bangladesh.

Dr. Hammerslough served as Principal Investigator in a study commissioned by this organization to assess the potential demographic consequences if our overseas operations were to be closed down. The study was both politically sensitive and extremely important to us. It plowed new ground in developing a methodology for evaluating family planning programs, and it provided us with important documentation in dealing with changes in U.S.A.I.D. policies with respect to programs conducted under our auspices by non-governmental organizations in less-developed countries. The report he produced has been used to good effect with congressional and other audiences.

Dr. Hammerslough's performance in carrying out this assignment was superior in every respect. He came to a swift understanding of the issues. He was able to develop a methodologically sound proposal almost immediately. He then worked effectively with both our senior staff and our Advisory Committee for the study (Dorothy Nortman of the Population Council, John Ross at Columbia University and Al Hermalin at Michigan) to refine the methodology and the analytic procedures so that all might feel confident in the resulting product.

To obtain the data and case study material for the study, Dr. Hammerslough conducted interviews with both U.S. and overseas staff of this organization, and, in some instances, had to work out cooperative relationships with persons of other cultures working in grantee organizations. He was reported to be comfortable and effective in communicating and able to work flexibly with all concerned.

810 Seventh Avenue New York, New York 10019 212/541-7800

I found Dr. Hammerslough's writing to be quite good. He worked both flexibly and with integrity -- a sometimes difficult combination -- in dealing with questions and editorial suggestions from our executives.

In short, I have no hesitation in recommending him.

Sincerely,

David Smith

David A. Smith
Director, Systems Support

East-West Center

Population Institute

1777 EAST-WEST ROAD HONOLULU, HAWAII 96848, CABLE EASWESCEN TELEX 989171 TELEPHONE (808)944-7444

February 19, 1988

Dr. Roger Eeckels
Director, ICDDR,B
c/o Dr. David Bell
Harvard School of Public Health
665 Huntington Avenue
Boston, Massachusetts 02115

Dear Dr. Eeckels:

I am pleased to write in support of Dr. Charles Hammerslough's application to direct the Demographic Surveillance System of ICDDR,B.

I have known Charlie (as he is known by his friends) since 1984, when he spent five weeks in Honolulu and Japan as a participant in the East-West Population Institute's 15th Summer Seminar in Population, which I directed. The seminar brought together approximately 70 mid-career government officials, university professors, and graduate students, two-thirds of whom were from Asia and the Pacific, and a third from the United States.

It takes a special individual to fit well into such a multicultural group, and Charlie was a great success. In the past, we have had mixed results with participants from Princeton, in part because their demographic training is so much better than many of the other participants, and some of them have not been willing to make the effort to communicate with others. (I have been especially concerned about this issue, since I did my graduate work at Princeton.) Charlie, however, became very popular within his workshop and showed great interest in trying to help others solve their research problems. He was friendly and flexible, at the same time that he made important intellectual contributions to his group.

As I am sure that Jane Menken will also tell you, Charlie is a first-rate demographer. Although I have not taught or worked directly with him, I have been impressed by his research output. He has made remarkable contributions for someone just beginning his career. Of particular importance has been his 1983 Demography article with James Trussell on hazard model analysis. This article was mentioned in a recent review of the most frequently cited articles in the social sciences in the last few years.

Given my favorable impression of Charlie's ability to work well in a multicultural, interdisciplinary environment, together with his excellent educational and research credentials, I can recommend him to you highly. Although I have only a brief acquaintance with ICDDR,B and your staff, I would think that he would fit in well and prove to be a valuable, productive staff member.

With best regards,

Sincerely,

Linda G. Martin

Linda G. Martin
Research Associate

Scientist/Senior Scientist (Research Immunology)

This position was advertised internationally. No shortlisting has yet been done.

AH:au

ADVERTISEMENT

RESEARCH IMMUNOLOGIST

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), is a non-profit international medical research institution situated in Dhaka, Bangladesh. Its aims are to conduct research and training in diarrhoeal diseases and related subjects of nutrition and fertility, and to develop improved health programmes for control of diarrhoeal diseases in developing countries. It is also involved in major demographic surveys. There are four scientific divisions: Clinical Sciences, Laboratory Sciences, Community Medicine and Population Sciences. Salary scales, rules and regulations are similar to those followed by the UN. The 1,400 employees include 200 researchers coming from 11 countries. ICDDR,B is supported by 21 countries and international organizations, including WHO and UNICEF.

The ICDDR,B seeks a senior scientist for immediate appointment to direct its Department of Immunology and Bacterial Genetics in the Division of Laboratory Sciences. The main objectives of the department are to identify protective antigens of Shigellae, Vibrios and other enteropathogens.

Requirements: PhD, MD or equivalent degree from an accredited institution; at least 10 years research experience in immunology or immunochemistry; at least 10 publications in peer-reviewed scientific journals; experience with isolating, purifying and identifying antigens associated with both the local and systemic immune responses to pathogens, particularly enteric organisms; experience with vaccine development and monoclonal antibody techniques would be an asset. The appointed person will be expected to supervise about sixteen scientists and technicians as well as students; to work with other scientists within the ICDDR,B, and to foster national and international collaboration. The appointed person will be expected to obtain funds for research by competing internationally.

The department is well equipped to perform ultracentrifugation, electrophoresis of proteins and nucleic acids, immunoelectrophoresis, ELISA, Western blotting, and a variety of chromatographic techniques including FPLC. There are good facilities for experimental animals.

The appointment will be made for three years at UN salary level P-4 up to P-6 according to experience and qualifications; Applicants should send their curriculum vitae and the names of three referees to:
Mr Aminul Huque, International Personnel, ICDDR,B, GPO Box 128, Dhaka-1000, Bangladesh.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

GPO BOX 128, DHAKA - 1000, BANGLADESH

Title: Scientist/Senior Scientist - Research Immunologist/Head of Department of Immunology and Bacterial Genetics
(Laboratory Sciences Division)

Grade: P4 -P6 (UN Scale)

Objectives: To develop protocols and carry out research leading to better understanding of immunity against enteroinfections with particular emphasis on shigellosis. Identification of protective antigens of shigellae and vibrios is the primary goal.

Duties:

- To direct and conduct immunological research in the Department of Immunology and Bacterial Genetics.
- To foster active collaboration with scientific research institutions in Bangladesh and abroad.
- To obtain international competitive research grants.
- To actively take part in teaching activities of the Department.
- To promote the development of candidate vaccine strains of Shigella spp.
- To collaborate with other Divisions of the Centre in planning and carrying on research involving immunological or immunochemical methods.

Qualifications:

Education: PhD, MD or equivalent degree with postgraduate training in immunology/immunochemistry.

Experience:	At least 10 years research experience, at least 10 publications in peer-reviewed scientific journals, supervisory experience and proof of scientific productivity.
Language skills:	Excellent knowledge of spoken and written English.
Salary range:	US$ 32,605 to US$ 49,287 (with dependents) US$ 30,275 to US$ 45,283 (single status) depending on experience and qualification. The above salaries are base salaries, added to this are the usual UN benefits and allowances.
Date of Joining:	As soon as possible.

Scientist (Operations Research - MCH-FP Extension Project)

This positions was advertised. Shortlisting is in the process.

AH:au

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OPERATIONS RESEARCH SCIENTIST

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) is a non-profit international medical research institution situated in Dhaka, Bangladesh. Its aims are to conduct research and training in diarrhoeal diseases and related subjects of nutrition and fertility, and to develop improved health programmes for control of diarrhoeal diseases in developing countries. It is also involved in major demographic surveys. There are four scientific divisions: Clinical Sciences, Laboratory Sciences, Coumminity Medicine and Population Sciences. Salary scales, rules and regulations are similar to those followed by the UN. The 1,400 employees include 200 researchers coming from 11 countries. ICDDR,B is supported by 21 countries and international organizations, including WHO and UNICEF.

ICDDR,B seeks for immediate employment an Operations Research Scientist who will carry out operations research on various aspects of the national Maternal and Child Health - Family Planning (MCH-FP) programme in Bangladesh, within the framework of the MCH-FP Extension Project of ICDDR,B. This will involve design, execution, and evaluation of pertinent interventions in the field; testing new strategies in service delivery; conducting related research with emphasis upon qualitative studies; and supervision of scientific staff.

Requirements: Doctoral degree in management, social, or public health sciences with a strong background in operations research; practical field experience in MCH-FP programmes in a developing country, preferably in South Asia; post-doctoral research experience in reputed scientific institutions; and outstanding record of publications in peer reviewed international journals.

Appointment will be made for 3 years at UN salary level P-2 up to P-4 according to experience and qualifications. Reply with curriculum vitae and the names of three referees to: Mr. Aminul Huque, Personnel Manager (Professional) ICDDR,B, GPO Box 128, Dhaka-1000, Bangladesh.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

GPO BOX 128, Dhaka-1000, Bangladesh

Title: Operations Research Scientist
(MCH-FP Extension Project; Population Sciences Division)

Grade: P2 - P4 (UN Scale)

Objectives: To conduct operations research on various aspects of the national Maternal and Child Health-Family Planning (MCH-FP) programme in Bangladesh within the framework of the MCH-FP Extension Project of ICDDR,B.

Duties:

- To conduct appropriate research on various aspects of MCH-FP.
- To design, execute and evaluate the pertinent interventions in the field.
- To test new strategies in service delivery.
- To conduct related research with emphasis upon qualitative studies.
- To supervise scientific staff and extend scientific cooperation to ICDDR,B.

Qualifications:

Education: A PhD or equivalent degree in Management, Social or Public Health Sciences with a strong background in operations research.

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for

OPERATIONS RESEARCH SCIENTIST

1. CENTRE FOR POPULATION & FAMILY HEALTH
Columbia University
60 Haven Avenue
New York, NY 10032
USA

2. CENTER FOR POPULATION PLANNING
School of Public Health
The University of Michigan
Ann Arbor
Michigan 48109
USA

3. EAST-WEST POPULATION INSTITUTE
1777 East-West Road
Honolulu
Hawaii 96848
USA

4. INTERNATIONAL PUBLIC HEALTH PROGRAMS
School of Public Health
201H, University of North Carolina
Chapel Hill
NC 27514
USA

5. DEPARTMENT OF HEALTH POLICY & ADMINISTRATION
263 Rosenau Hall
201H, School of Public Health
University of North Carolina
Chapel Hill
NC 27514
USA

6. MANAGEMENT SCIENCES FOR HEALTH
165 Allandale Road
Boston
Massachusetts 02130
USA

7. DEPARTMENT OF INTERNATIONAL HEALTH/
POPULATION DYNAMICS
Johns Hopkins University
615 N. Wolfe St.
Baltimore, M.D. 21205
USA

8. CENTRE FOR POPULATION PLANNING/
INTERNATIONAL HEALTH
School of Public Health
University of Michigan
Ann Arbor
Michigan 48104
USA

Experience:	A minimum of 5/7 years practical field experience in MCH-FP programme in a developing country, preferably in South Asia; post doctoral research experience in reputed scientific institutions and outstanding record of publications in peer reviewed international journals.
Language skills:	Excellent knowledge of spoken and written English.
Salary range:	US$ 22,675 to US$ 41,308 (with dependants) US$ 21,261 to US$ 38,101 (single status) depending on experience and qualifications. The above salaries are base salaries, added to these are the usual UN benefits and allowances.
Date of joining	As soon as possible.

RESEARCH PATHOLOGIST

The job description as approved by the Board is appended. The position was advertised and 9 candidates applied.

1. Dr S.M. Ali (Bangladesh). Presently in Kuwait.
   MBBS, MRC Path, FRC Path.

2. Dr S.A.I. Ally (Bangladesh). Presently at ICDDR,B.
   MBBS, Board Certification, 1986, American Board of Pathology.

3. Dr E. Bugovics (Hungary). Presently at Gyor Hospital, Hungary.
   MD, Specialization in pathology (?).

4. Dr Suraiya Hossain (Bangladesh). Presently in private practice.
   MD (Berne), MSc (Edinburgh), DPH (Dundee).

5. Dr M.M. Islam (Bangladesh). Presently in private practice.
   MBBS, MRS Path, FRC Path.

6. Dr H. Lin (USA). Presently Chief of Pathology, ? Hospital, CA, USA.
   Ph.D. parasitology, MD (UCAL), completed pathology residency, USA.

7. Dr Md. H. Rashid (Bangladesh). Presently Ass. Prof. Pathology, Barisal.
   MBBS, M Phil Pathology (Karachi).

8. Dr W.O.M. Roberts (Sierra Leone). Presently SMO Path, Hong Kong.
   MD (Moscow), Diplomas and Certificate in Pathology (London, Switzerland).

9. Prof. A.B.Md. Sattar (Bangladesh). Presently in private practice.
   MBBS, M Phil Pathology (Karachi).

The short-listing committee consisted of Drs Ciznar, Eeckels, Kay and Mahalanabis. The candidates were graded independently. The criteria applied were as follows:

Research publications	100
Education	50
Professional Experience	50
Work experience in developing countries	30
Age (ideally below 50)	20
Total	250

The absence of an MRC Path or a Board certification or an equivalent title and lack of research publications were considered an exclusion criteria.

During its meeting, the Committee agreed that six persons should be removed from the short-list

- Lack of required titles: Nos 4 and 9
- Good publication record (exclusively on parasitology) and no publications since 1974 (No. 6)
- Professional qualifications probably less than required, no scientific productivity (Nos. 2, 7 and 9).

The three remaining candidates were graded as follows

	C	K	E	M	T	Av.
Moyenul Islam	200	210	165	200+	795	200
Syed Ally	200	210	125	175	710	180
SM Ali	210	200	120	125	660	160

Only the two first candidates were considered as having the necessary qualifications though not the sufficient ones. (In the meantime, Dr SAI Ally has accepted another employment and will leave the Centre shortly).

26.5.88.

26/5/88

Encl.

RE:jc

26.5.88

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RESEARCH PATHOLOGIST

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) is a non-profit international medical research institution situated in Dhaka, Bangladesh. Its aims are to conduct research and training in diarrhoeal diseases and related subjects of nutrition and fertility, and to develop improved health programmes for control of diarrhoeal diseases in developing countries. It is also involved in major demographic surveys. There are four scientific divisions: Clinical Sciences, Laboratory Sciences, Community Medicine and Population Sciences. Salary scales, rules and regulations are similar to those followed by the UN. The 1,400 employees include 200 researchers coming from 11 countries. ICDDR,B is supported by 21 countries and international organizations, including WHO and UNICEF.

ICDDR,B seeks for immediate employment a physician with a medical speciality in pathology (Morbid anatomy, Histopathology).

Requirements: MD or equivalent degree from an accredited university; at least 4 years experience in pathology; board certification (or eligibility), or MRC PATH or PhD in Morbid Anatomy/Histopathology; authorship of at least 3 papers in peer-reviewed journals. Experience in gastrointestinal pathology in a developing country is desirable. The position will require a commitment to obtain donor funding and to foster national and international collaboration with other institutions. Support to the Clinical Sciences Division, training and administrative activities are also required.

The histopathology laboratory is modern and well-equipped and has two full-time technicians. Appointment will be made for three years at UN salary level P-2 up to P-4 according to experience and qualifications. Reply with curriculum vitae and the names of three referees to:
Mr. Aminul Huque, International Personnel, ICDDR,B, GPO Box 128, Dhaka-1000, Bangladesh.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

GPO BOX 128, Dhaka - 1000, Bangladesh

Title: Research Pathologist (Histopathologist, Morbid Anatomist)
(Laboratory Services Department in the Laboratory Sciences Division)

Grade: P2 - P4 (UN Scale)

Objectives: **To contribute to a better understanding of the pathology of diarrhoeal diseases, especially those due to invasive organisms.**

Duties:

- To direct and expand the Histopathology Laboratory, and supervise and guide its staff.
- To conduct and direct clinical and experimental research within ICDDR,B priority areas, and train counterparts.
- To foster active collaboration with institutions in Bangladesh and abroad.
- To obtain international competitive research grants.
- To collaborate with the Clinical Sciences Division, including performing autopsies and training other staff in its techniques.
- To provide expertise for colleagues planning research and to be involved in pathological aspects of any current research.
- To actively take part in teaching especially clinicopathological conferences, lectures, and seminars.

Qualifications:

Education:	A medical degree (MD, or equivalent) from an accredited University with post graduate qualification in pathology (Board Certification or MRC PATH).
Experience:	A minimum of 4 years experience in pathology, of which at least 3 years should be formal training as a full-time resident. Authorship of at least 3 papers in peer-reviewed medical journals. Experience in gastro-intestinal pathology in a developing country is desirable.
Language skills:	Excellent knowledge of spoken and written English.
Salary range:	US$ 22,675 to US$ 41,308 (with dependants) US$ 21,261 to US$ 38,101 (Single status) depending on experience and qualification. The above salaries are base salaries, added to this are the usual UN benefits and allowances.
Date of Joining:	As soon as possible.

Agreement Between Danida and ICDDR,B

Regarding financial and technical support to the International Center for Diarrhoeal Disease Research, Bangladesh.

Danida and ICDDR,B have agreed as follows:

ARTICLE I

Scope of the Agreement

Danida will support ICDDR,B, financially and technically, in organizing and operating a Child Health Programme.

As the center operates as an entity, the support will not only be limited to one component, but will include other units at the center, in accordance with the project document (annex 1) and the budget in this agreement. The support to these units will put special emphasis on preventive child health, allowing ICDDR,B to continue to develop and expand activities in this area.

ARTICLE II

The Commitments of Danida

1) to finance on a grant basis activities according to the project documents (annex 1) within an amount of 10,8 million Danish Kroner (outside the country frame for Bangladesh). These activities comprise support of:

The ICDDR,B Dhaka Treatment Centre

- *The Child Health Department including the Nutrition Rehabilitation Units and related activities.*
- *In-patient and out-patient units.*
- *Clinical Research Center.*

The ICDDR,B Rural Treatment Centres.

The budget set aside for the in-patient and out-patient units, and the Clinical Research Center, will be equally shared between these units.

2) to second a Head for the Child Health Programme and up to four other professional support staff.
The seconded personal will be financed over and above the 10,8 million Danish Kroner. This financing will include not only salary support, but logistic support, such as assistance with housing, shipment of personal effects, health insurance and schooling for children. The ICDDR,B will provide support for obtaining visas and other documents required for residence and employment in Bangladesh.

The person seconded to head the Child Health Programme will be appointed Head of the Child Health Department, Clinical Science Division and will report directly to the head of the Division or his delegate authority.
The Head of the Child Health Programme will be responsible for the Nutrition Rehabilitation Unit and nutrition services of the Treatment Center, as well as the other child health activities outlined in annex 1. These include the immunization programme, education and training of patients, family and medical personnel other than physicians, and coordinating continuing care with the Urban Volunteer Program.

ARTICLE III

The commitments of ICDDR,B

1)
to submit audited accounts of the Center to Danida at the end of each fiscal year, normaly by April of the following year. Financial Reports showing the utilization of the Danida funds, including detailed statements specifying the allocations for the receiving units, will be prepared annually by the Center and forwarded by 28 February each year.
Danish auditors shall be allowed to study reports, accounts, inventory lists and other pertinent material in order to evaluate the implementation of the activities in terms of the agreement.

2) to submit a detailed budget for the coming fiscal year, on basis of which Danida will transfer 50 pct. of the budgeted amount. The remaining 50 pct. will be transferred on receipt of the audited accounts from the previous year. For 1987, 50 pct. of the budgeted amount will be transferred upon signing of the agreement 1987 and the rest on the 1 April 1987.

3) to submit yearly reports and make available all relevant information to Danida as described in Article IV.

4) to pay all customs duties and taxes or arrange for exemption for all equipment imported under the project.

5) to participate in Project Reviews.

ARTICLE IV

Project Monitoring, Reviews, Evaluation and Information

1) Danida is entitled to monitor, and evaluate the project. ICDDR,B will be informed well in advance of reviews and evaluations.
The first review is envisaged to take place in the beginning of 1988.

2) ICDDR,B shall furnish Danida with such relevant reports, accounts, records, statements, documents and other information as may be requested by Danida concerning the Project and its execution.

3) Reports, accounts etc. are to be submitted through the Danida Mission, Dhaka.

ARTICLE V

Suspension or termination of Assistance

Danida or ICDDR,B may, by written notice, suspend or terminate the assistance to the project, if in the judgement of Danida or ICDDR,B any circumstance arises which interferes with or threatens to interfere with the successful completion of the project or the accomplishment of its objectives. Danida or ICDDR,B may, in the same or a subsequent written notice, indicate the conditions under which they are prepared to resume the assistance to the project.

ARTICLE VI

General Provisions

1) This agreement may be modified by a written agreement between the parties.

2) The obligations assumed by ICDDR,B under Article IV, concerning Monitoring, Reviews, Evaluation and information, shall extend beyond the expiry or termination of this Agreement.

3) The obligations of ICDDR,B under this agreement shall not be affected by any arrangements it may enter into with other agencies.

4) Any change in the utilization of funds stated in the budget and the project documents or any re-allocations of funds between the supported units will need the approval of Danida.

ARTICLE VII

Entry into force and termination

This agreement shall come into force upon signature, with effect from the 1 January 1987 and shall remain valid for three years, unless terminated earlier by either party by six months written notice.

SUMMARY BUDGET

CHILD HEALTH PROGRAMME

Items.	Danish Kroner	$U.S.
TOTAL DONATION 1987:	3,400,000	492,753
Child Health Department	874,000	126,666
Inpatient Unit, Dhaka Treatment Centre	690,000	100,000
Outpatient Unit, Dhaka Treatment Centre	690,000	100,000
Clinical Research Department	320,000	46,377
Rural Treatment Centres	326,000	47,246
Indirect	500,000	72,463

Below are the budgets for 1988 and 1989. The distribution between units will be approximately the same. The kroner figures have not been converted into $U.S. as the $ amount will depend on the exchange rate in force the time of the transfer of funds.

TOTAL DONATION 1988	3,600,000
TOTAL DONATION 1989	3,800,000

Under the terms of the contract, for 1987 half of the funds will be transferred upon signing of the agreement, and the other half on April 1, 1987. In subsequent years half of the funds will be transferred to the ICDDR,B on presentation to Danida of a detailed budget for that year, and the remainder will be transferred when Danida receives audited accounts of the previous year's expenditures.

For calculations an exchange rate of 6.90 D.kr. = 1 U.S.$ have been used.

Done in duplicate in the English language at Dhaka this 23rd March 1987

On behalf of ICDDR,B

Dr. Roger Eeckels
Director
ICDDR,B

On behalf of Danida

Poul H. Nyborg
Counsellor
Head of Danida Mission, Dhaka

CURRICULUM VITAE

PERSONAL DATA:

Name	:	Poul-Erik Lund Kofoed
Cpr. No.	:	150553-2127
Address	:	House 25, Road 107 Gulshan, Dhaka

EDUCATIONAL QUALIFICATION:

June 1980	:	Graduate in medicine (M.D.). The University of Odense. Average number of marks 9,8.
January 1981	:	ECFMG examination (the American Educational Commission of Foreign Medical Graduates).
November 1985	:	Bachelors degree (B.A.) in social anthropology. The University of Arhus. Average number of marks 9,5.
November 1987	:	Paediatrician.

POSITIONS HELD:

1. September 1, 1980 - March 31, 1981: Department of Gynaecology and Obstetrics, Hospital of Karlskrona, Sweden.

2. April 1, 1981 - September 31, 1981: Department of Pediatrics, Hospital of Uddevalla, Sweden.

3. October 1, 1981 - March 31, 1981: Department of Neurology, University Hospital of Linköping, Sweden.

4. April 1, 1982 - June 30, 1982: Department of Surgery, Hospital of Svendborg.

5. July 1, 1982 - November 30, 1982: Department of Orthopaedics, Hospital of Svendborg.

6. December 1, 1982 - June 30, 1983: Department of Internal Medicine, Hospital of Svendborg.

7. July 1, 1983 - August 31, 1986: Department of Pediatrics, University Hospital of Odense. Last 16 months as senior registrar.

8. September 1, 1986 - November 30, 1987: Senior registrar at the Department of Pediatrics, Hospital of Kolding.

9. Since November 28, 1987: Head of the Child Health Programme, ICDDR,B.

PUBLICATIONS:

1. Poul-Erik Lund Kofoed. Jarish-Herxheimer reaction in falciparum malaria. Brit Med J 1984;289:161.

2. Per Dahl Christense, Poul-Erik Lund Kofoed and Kjartan Seyer-Hansen. Painless muocardial infarction in diabetes mellitus - a myth. Acta Med Scand 1984;215(suppl.)685:24 (abstract).

3. Poul-Erik Lund Kofoed. Medicinsk antropologi (Medical anthropology). Ugeskr Laeger 1984;146:3662-3663.

4. Poul-Erik Lund Kofoed and Jens Kamper. Extrapyramidal reactions caused by antiemetics during cancer chemotherapy. J Pediatr 1984;105:852-853 (correspondence).

5. Poul-Erik Lund Kofoed. Traditional birth attendants and perinatal and neonatal mortalities. Coll Antropol 1985;9:63-70.

6. Per Dahl Christensen, Poul-Erik Lund Kofoed and Kjartan Seyer-Hansen. Painless myocardial infarction in diabetes mellitus - a myth? Danish Med Bull 1985;32:273-275.

7. Roberto Zori and Poul-Erik Lund Kofoed. Persisterende pulmonal hypertension hos det nyfødte barn (Persistent pulmonary hypertension in neonates.) Ugeskr Laeger 1986;148:168-170.

8. Poul-Erik Lund Kofoed and Jens Kamper. Extrapyramidal reactions to Domperidone. J Pediatr 1986;108:630-631 (correspondence).

9. Poul-Erik Lund Kofoed. Etnografi i lægevidenskaben (Social anthropology in medical science). Bibl Laeger 1986;2:105-113.

10. Birgit Guldhammer Skov, Poul-Erik Lund Kofoed and Bjarne Nielsen. Gastrointestinal perforation caused by absence of intestinal musculature. Acta Kir Scand 1987.

11. Poul-Erik Lund Kofoed, Arne Høst, Bo Elle and Claus Larsen. Ultralyd-sundersøgelse af hypertrofisk pylorusstenose. Ugeskr Laeger 1987;149: 2975-2977.

12. Poul-Erik Lund Kofoed, Arne Høst, Bo Elle and Claus Larsen. Hypertrophic pyloric stenosis: determination of muscle dimensions by ultrasound. Br J Radiol 1988;61:19-20.

13. Poul-Erik Lund Kofoed and Grethe Simonsen. Some perinatal risk factors in a developing country. East Afr Med J (in press).

14. Poul-Erik Lund Kofoed and Grethe Simonsen. Neonatal tetanus in Machakos area, Kenya. East Afr Med J (in press).

15. Søven Egil Clemensen, Poul-Erik Lund Kofoed and Tove Dreyer. Kamplihationer til kapillaer blodprøvetagning pa nyfødte. Ugeskr Laeger (correspondence). In press.

PAPERS AND POSTER PRESENTATIONS:

1. Poul-Erik Lund Kofoed. Sekundaer temperaturstigning efter behandling af falciparun malaria med Fansidar (Relapsing temperature in the treatment of falciparum malaria with Fansidar). Danish Society of Tropical Medicine. Copenhagen, February 3, 1984.

2. Knud Erik Petersen, Ernst Hasch, and Poul-Erik Lund Kofoed. Ultralyddiagnosticeret galdesten hos 5 mdr. gammel dreng. Danish Paediatric Society. Copenhagen, February 3, 1984.

3. Per Dahl Christensen, Poul-Erik Lund Kofoed, and Kjartan Seyer-Hansen. Smerter ved myocardieinfakt hos diabetikere (Pain following myocardial infarction in diabetic patients. 39th Congress in internal medicine. Herlev, June 7, 1984.

4. Per Dahl Christensen, Poul-Erik Lund Kofoed, and Kjartan Seyer-Hansen. First myocardial infarction in diabetic patients. Anglo-Danish Diabetes Club. Copenhagen, June 21, 1984.

5. Poul-Erik Lund Kofoed. Traditional birth attendants and perinatal and neonatal mortalities. At the Conference of Anthropology and health: biological and socio-cultural contributions, strategies for research and practice in applied medical anthropology. Dubrovnik (Jugoslavia), August 17, 1984.

6. Per Dahl Christensen, Poul-Erik Lund Kofoed, and Kjartan Seyer-Hansen. Anterior infarction site in diabetic patients. Poster presentation at the 4th European Symposium on Metabolism. Padua (Italy), May 29, 1985.

7. Bo Elle, Arne Høst, Poul-Erik Lund Kofoed, and Claus Larsen. Ultralydsundersøgelse af pylorusstenose (Sonographic examination of hypertrophic pyloric stenosis. Danish Society of Radiology. Odense, January 16, 1986.

COURSES AND STUDY TOURS:

1. July 2 - September 26, 1979: Study tour to Thailand organized by Mahidol University, Bangkok, including stays at departments of paediatrics in Bangkok and Chaing Mai and participation in under-five clinics.

2. August 3 - August 28, 1981. International Medicine (Tropical Medicine and Hygiene. University of Copenhagen.

3. September 1 - September 11, 1981. Paediatric priorities in the developing world: prevention of handicap from malnutrition and other causes. Institute of Child Health, University of London.

4. November 11 - December 18, 1982. Study tour to Kenya with special emphasis laid on perinatal mortality and neonatal tetanus in Katangi, Machakos area.

5. May 25, 1984. Nutrition - problems in the 3rd world. Danish Society of Tropical Medicine.

6. August 13 - August 24, 1984. Anthropology and health: biological and socio-cultural contributions, strategies for research and practice in Applied Medical Anthropology. Arranged by the Universities of Zagreb, Vienna, and Newcastle upon Tyne, and Georg Washington University Medical Centre. Dubrovnik (Yugoslavia).

7. February and March 1985. Methodology in Medical Research. Danish Medical Association.

8. April 1985. Microcomputer - basic training for doctors.

9. March 17 - March 20, 1986. Organisation of health services/administrative duties of the specialised physician. Helsinge.

10. May 12 - May 16, 1986. Pediatrics in developing countries. Institute of Child Health, University Hospital of Uppsala, Sweden.

11. September 8 - September 19, 1986. Fifth European course in Tropical Epidemiology. Arranged by the University of Heidelberg, London School of Hygiene and Tropical Medicine, University of Antwerp, Royal Tropical Institute, Amsterdam, and Liverpool School of Tropical Medicine. Heidelberg, Germany.

12. March 1987. Mikrobiology. Herlev.

ADMINISTRATIVE EXPERIENCE

1974 - 1980: Representative of IMCC (International Medical Cooperation Committee). Chairman of the Committee of exchange of medical students.

1976 - 1977: Member of the Odense section of DIL (a nation wide association of medical students).

1980 - 1981: Delegate to the council of the Association of Younger Doctors in Denmarks (FAYL).

Since 1985 : Committee member of Danish Pediatric Association's Committee of education.

Since 1986 : Committee member of the Association of Younger Pediatricians.

Since 1987 : Committee member of Danish Pediatric Association's Committee of Pediatrics in Developing Countries.

TEACHING EXPERIENCE:

Since 1984 : Teaching embryology and pediatrics at the Nursing School of Odense.

1985 - 1986: Lecturer in pediatrics at the University of Odense.

Given lectures in diabetic societies.

CURRICULUM VITAE

Name: Shakuntala Haraksingh Thilsted

Date of birth: October 29, 1949

Place of birth: Trinidad, West Indies

Marital status: Married

Language: English (mother tongue), Danish

Education:

G.C.E. Ordinary Level (Cambridge), 1965
G.C.E. Advanced Level (Cambridge), 1967

B.Sc. Tropical Agriculture, Upper Second Class Honours (Animal Production Option), 1971, University of the West Indies, Trinidad.

Postgraduate Course in Physiology of Animal Nutrition, 1976, Veterinary Faculty for FAO Fellows, The Royal Veterinary and Agricultural University, Denmark.

Internordic Postgraduate Course in Animal Nutrition: Feed conservation and feed evaluation, Agricultural University of Norway, 1 - 12 August, 1978.

Internordic Postgraduate Course in Animal Nutrition: Protein utilization in farm animals, The Royal Veterinary and Agricultural University, Denmark, 13 - 23 August, 1979.

Internordic Postgraduate Course in Animal Nutrition: Beef Production, University of Helsinki, Finland, 24 - 30 August, 1980.

Ph.D. 1980 (Physiology of Nutrition), Dept. of Animal Science, The Royal Veterinary and Agricultural University, Denmark.

Employment:

Agricultural Officer, World Bank Small Farms Project, September 1971 - January 1974, Ministry of Agriculture, Lands and Fisheries, Trinidad and Tobago.

Research Assistant, February - May, 1974, Faculty of Natural Sciences, University of the West Indies.

Laboratory Assistant, February - September, 1975, Institute for Cancer Research, Århus, Denmark.

Ph.D. Scholar, 1977 - 1980, Department of Animal Science, The Royal Veterinary and Agricultural University, Denmark.

FAO Associate Expert, October 1980 - September 1981, Department of Zoology and Marine Biology, University of Dar es Salaam. Guest Lecturer at Department of Physiology, Division of Veterinary Science, University of Dar es Salaam, Tanzania.

Lecturer, December 1981 - July 1982, Development Cooperation Bureau, The Royal Veterinary and Agricultural University, Denmark.

Lecturer, September 1982 - December 1984, Department of Animal Physiology, The Royal Veterinary and Agricultural University, Denmark.

Senior Lecturer, January 1985 - present, Department of Animal Physiology, The Royal Veterinary and Agricultural University, Denmark.

Employment : Nutrition Coordinator, June 1987 - December 1987,
Urban Volunteer Programme.
The International Centre for Diarrhoeal Diseases
Research, Bangladesh (ICDDR,B).

Nutrition Coordinator, January 1988 - present,
Child Health Programme.
ICDDR,B.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

POST DESCRIPTION FOR PROFESSIONAL POSTS

FOR USE OF PER ONLY

1. Present Title of Post: Coordinator, Nutrition	2. Post Number(s)
3. STATUS ☐ NEW - to be established attach ICDDR, B-#9 ☐ VACANT - for issuance of a vacancy notice, attach ICDDR, B-#8 ☐ OCCUPIED - revised duties ☐ OCCUPIED - proposed change in grade, attach ICDDR, B-#8 ☐ OTHER - explain	4. Present Grade: DANIDA seconded 5. Division/Programme: CSD 6. Unit/Office/Field Activity: Child Health Programme 7. Official Station and Country: Dhaka, Bangladesh

Effective date:

Approved Title

CCOG | Classified grade

Comments:

Authorized by

Title | Date

8. **ORGANIZATIONAL SETTING:** Attach the current organizational chart which clearly shows the overall structure of the programme, division, unit, or field activity, as appropriate. Identify each post by title, post number and classified grade.

9. Identify the objectives of the programme, and of the immediate unit or field activity as appropriate.

At ICDDR,B a new Child Health Programme (CHP) has just started, and is funded by DANIDA, initially for 3 years. The CHP focuses on initiating and expanding programme in education/training, nutrition, immunization, and patient follow-up. The programme is headed by a Danish Paediatrician. Four Danish Public Health Nurses with four Bangladeshi counterparts will be responsible for each one of the above mentioned areas.

10. Summarize the assigned responsibilities.

- To help plan and supervise the diets and the feeding of children at the Nutrition Rehabilitation Unit and at the Treatment Centre.
- To develop nutrition education programmes for the patients and their attendants, for urban volunteers and for the staff.
- To coordinate the activities of the Nutrition Rehabilitation Programme with those of the Urban Volunteer Programme - Matlab, Teknaf, NGOs and government institutions in Dhaka.

11. Indicate	Essential minimum qualifications required to perform the work	Additional desirable qualifications
a) Knowledge, abilities & skills, including personal qualities & human relationships	N/A	N/A
b) Level & field of study, and extent of specialization	N/A	N/A
c) Length & nature of practical experience at the national and/or international level	N/A	N/A
d) Languages required and the level & nature of their use	Fluency in spoken and written English.	Should learn Bengali.

12. Identify the main objectives of the work (usually 4-6 reasons why the post exists). Within each objective, identify the duties performed to achieve the objective. Objectives should be presented in order of importance with an indication of the percentage of annual workload required for each objective.

1) To help plan and supervise the diets and the feeding of children at the Nutrition Rehabilitation Unit and at the Treatment Centre.

2) To develop nutrition education programmes for the patients and their attendants, for urban volunteers and for the staff.

3) To coordinate the activities of the Nutrition Rehabilitation Programme with those of the Urban Volunteer Programme - Matlab, Teknaf, NGOs and government institutions in Dhaka.

4) To participate in administration and budgeting of the Nutrition Rehabilitation Programme.

5) To provide ongoing evaluation of the programme and to evaluate the 'long-term' effects in cooperation with the UMP.

6) Responsible for writing quarterly reports and annual activity and financial reports.

13. Indicate the guidelines which are available (for example the decisions of legislative bodies, publications, policies, regulations, accepted practices, research techniques, project documents, etc.).

1) Internationally recognised medical textbooks and articles
2) Accepted practices and procedures
3) Research techniques

Describe the interpretation and/or deviation permitted, and the authority to establish new guidelines.

14. Describe:

- the type and extent of the supervision given to the post:

  Direct Supervision by the Head, Child Health Programme.

- how assignments are given:

  Mostly verbally.

- the guidance and assistance provided by the supervisor and/or others:

- the review and verification of the work while in progress or on completion:

15. Indicate the typical contacts required outside the immediate work unit. Explain the purpose of the contacts as clearly as possible, e.g. to obtain information on ..., to represent the Organization at ..., to provide advice on ... etc.

a) Inside the Organization

Title & level	Purpose
Project Director, UVP	For collaborative work.

b) Outside the Organization

Title & level	Purpose

16. a) Professional posts DIRECTLY supervised:

Title	Classified Level	Post Number(s)

b) Total number of professional posts supervised directly and through subordinate supervisors: _____

c) Total number of general service posts supervised directly and through subordinate supervisors: _____

d) Title, classified grade and post number of supervisor's post: _____

17. Describe the most important decisions that the incumbent is authorized to take

Decisions regarding improvement of NRP diets.

18. Describe the most important recommendations expected of the incumbent

May recommend to the concerned authority to take necessary action related to improve care, treatment, and immunization of children of D.T.C. and community.

19. Describe the most damaging involuntary errors in the work and the effects these would have on the programme objectives identified in sectio on the Organization, and on the immediate unit.

N/A

20. If this is a revised post description, indicate the changes that have occurred in the duties and responsibilities.

N/A N/A

21. Certified as an accurate description of the work assigned (and performed if the post is occupied): Post No.

	Name	Signature	Date
First level supervisor	Mrs. Rahima Khatoon	R Khatoon	5/4/88
Second level supervisor, or Chief of Unit	Dr. Poul-Erik Lund Kofoed	Poul Erik Kofoed	31/3/88
Regional or Divisional Director Programme Manager	Dr Dilip Mahalanabis	Mahalanabis	7/4/88

Also, please certify the organizational chart as correct by signing and indicating the effective date.

D.S.
2 kontor

APPLICATION FORM

MINISTRY OF FOREIGN AFFAIRS
DANIDA
DANISH INTERNATIONAL DEVELOPMENT AGENCY
2. Asiatisk Plads, DK-1448 Copenhagen K., Tel. 01 / 92 00 00

5

Application for position as:

Public Health Nurse

in Bangladesh
(country)

D Bil.
21.9.87
ad 104. Bang. Idad

File No.:

Last name:	First names:	Surname at birth, if applicable:
Sørensen	Ninna	Nielsen
Occupation: Public Health Nurse at present Nursing Officer	Address: Stenhøjen 6, 7100 Vejle	Telephone: 1) at home: 05-881882 2) place of work: 05-533222 ext.1357, 1469
CPR No. or date of birth: 220848-1668	Nationality: Danish	Have you ever been convicted of any crime? yes ☐ no ☒

Place of birth: Lindved, 7100 Vejle

Marital status: single ☐ married ☒ cohabitating ☐ separated ☐ divorced ☐ widowed ☐

Have you completed your compulsory military service? yes ☐ no ☐

Full name of spouse/cohabitant:	CPR No. or date of birth:	Occupation of spouse/cohabitant:
Per Kristian Sørensen	110346-2157 Place of birth: Lindved, 7100 Vejle	lock smith educated as an agriculture mechanic

Will your spouse/cohabitant join you to the post? yes ☒ no ☐

Full names of all children	CPR No. or date of birth:	Place of birth:	Will your children join you to the post	Are your children receiving education or training? If so, which?
Dianna Sørensen	030772-2216	Vejle	yes	State Secondary School 9th year
Heino Sørensen	291074-1961	Vejle	yes	State Secondary School 7th year

Education and training (do not enclose diploms, journeyman's test certificate, references, etc.; they should be brought by the applicant if he is asked to appear for an interview)

From	To	Institution	Examination, if any	Month	Year
Apr 1956	Apr 1959	Primary School 1-3 class			
Apr 1959	Jun 1965	Secondary School 4-10 cl.	G.C.E. "O" level	June	1965
Aug 1965	Jun 1968	Grammar School	G.C.E. "A" level	June	1968
Aug 1968	June 1969	College, U.S.A.			
Aug 1969	Dec 1969	Basic Nursing School			
Jan 1970	Jun 1973	Nursing School	State Registered Nurse	June	1973
Aug 1980	Jun 1981	Nursing High School	Public Health Nurse	June	1981
Oct 1986	Jun 1987	Teacher-training College	Health project-report(written)	June	1987
Sep 1986	Jun 1987	Business School	Touch-typing Niveau 1	June	1987

POSITIONS HELD
(listed in chronological order)

From	To	Employer	Reference: I do not know the
July 1968	June 1969	Karsten Hess 32 Parker Ave., San Francisco California, U.S.A.	Name: present adress Address: Telephone: Relationship to applicant: May be contacted ☐ To be contacted by prearrangement only ☐

Exact title of your post
in English: House keeper and student
in original language: husassistent and studerende

Description of your responsibilities and duties; include number and type of subordinates:

I lived with the family, took care of the three children and all kinds of duties in the house.
At the same time I studied at the California State College, subject: American Society.

From	To	Employer	Reference: Nursing Director
July 1973	Aug 1980	Vejle Hospital Kabbeltoft 25 7100 Vejle	Name: Rigmor Christiansen Address: Klokkeager 5, 7100 Vejle Telephone: 05-816635, 05-826144 Relationship to applicant: employer, ward sister in casualty dept. May be contacted ☒ To be contacted by prearrangement only ☐

Exact title of your post
in English: State Registered Nurse and District Nurse
in original language: sygeplejeassistent and hjemmesygeplejerske

Description of your responsibilities and duties; include number and type of subordinates:

Nursing in the following wards: surgical, medical, casualty, out-patient, children's and children's psychiatry.
May - Aug 1979: I worked as a District Nurse in the municipality of Vejle.

Description of responsibilities and duties; include number and type of subordinates.

Public Health Nurse in Billund.

The job included:

- Primary health care of small children from 0-6 years, schoolchildren from 6-16 years and their parents.
- co-ordinater and groupleader of parents- and childrengroups with common problems and needs.
- supervisor and teacher in health-educational and -promotive questions and subjects arranged for children and parents.
- as a member of an interdisciplinary team I took part in an experimental project in Doctors Centre, Billund formulating aims and teaching methodology for chosen primary health activities.
- I also took part in describing and formulating aims and workingmethodologies for primary health services in the local municipality.

Public Health Nurse in a Primary Health Project Group in Gizan, Saudi Arabia.

The job included:

- Collection and analysis of baseline data on problems and needs for primary health in Gizan area.
- description and preparation of a primary health program for children from 0-2 years in co-operation with paediatrician Niels Henning Pedersen. The program is available for reference and includes:
- teaching materials for nurses and doctors, subjects: immunization, development and growth, breastfeeding, supplementary food, hygiene, diarrhoea, daily care etc.
- health educational materials for parents on the same subjects including a poster to illustrate connections between immunization, development and growth and nutrition.
- health educative demonstrations for nurses, parents and children.
- preparation of an appointment card for the parents to keep and the nurses to fullfil.
- preparation of an implementationplan for the program in the area (plan available).
- teaching of student nurses and servicetraining to educated nurses in public health tasks from different countries e.g. Saudi Arabia, India, Phillippines and Egypt by means of an English-Arabic interpreter.

I was in Charge of an unknown number of nurses, midwives, doctors etc.

Nursing Officer in Paediatric Depts., Kolding Hospital.

I am in charge of nursing in three children's depts. and one children's out-patient dept. which include about 100 subordinates: three ward sisters, nurses, student nurses, assistent nurses, pedagogues etc.

I am under direct supervision of nursing director and deputy nursing director and responsible to them.

The job includes:

- aims and methodologies for nursing.
- promotion of education and teaching of nursing in the wards.
- personal funktions e.g.: staffbudgetting, efficiency of manpower, distrubution, employment.
- economic affairs e.g.: supplies, budgets, inventaries.
- co-operative activities.

During my employment I prepared in interdisciplinary groups:

a report of future structuring in two depts. and

a planning structure in the out-patient dept.

esent employment situation:

Under notice ☐ Not under notice ☒ Unemployed ☐

How soon are you available:

January 1988

y do you wish to leave your present job?

My present job as Nursing Officer is a deputyship that lasts until Dec. 31st 1987, but my employment in Kolding Hospital will continue till I resign.

Why are you applying for this particular position?

I have always wanted to be acquainted with the work in a developing country. It is my belief therefore, that the establishment of a team within the Health Servives in a developing country would be a position, where I can use my experience and the same time get new inspiration.

Have you studied or worked abroad for longer periods? Yes ☒ No ☐

Place	Purpose of stay	From	To
California, U.S.A.	see above	July 1968	June 1969
Gizan, Saudi Arabia	see above	Dec. 1984	Nov. 1985

Are you a member of any professional association? If so, please indicate its name:

Danish Nursing Counsil, Vimmelskaftet 38, 1008 København K.

If applicable, do you want your professional association to be notified of the salary offered by DANIDA? Yes ☒ No ☐

Present annual salary (gross). Specify the individual elements of the salary:

181.167,60 kr.

Do you have a driver's licence? Yes ☒ No ☐

How did you learn about the position for which you are applying?

Through Poul Erik Kofoed, paediatrician and chief of the project, whom I co-operate with in Kolding Hospital and through job-advertissement in "Sygeplejersken" 34/87.

Vejle 21.09.87.

Anna Jensen

From	To	Employer	Reference: Chief of Social Services
July 1981	Feb 1987	Social- og sundhedsforvaltning Centervej 1 7190 Billund	Name: Gunni Højvang Address: Sønderkær 251, 7190 Billund Telephone: 05-331318, 05-331100 Relationship to applicant: employer May be contacted ☒ To be contacted by prearrangement only ☐

Exact title of your post
in English: Public Health Nurse
in original language: sundhedsplejerske i kombineret ordning

Description of your responsibilities and duties; include number and type of subordinates:
See attached enclosure

Reference: General Practioner
Niels Laurvig Pedersen
Kærvej 315, 7190 Billund, 05-338737
colleague and School Medical Office.
May be contacted

From	To	Employer	Reference: Paediatrician
Dec. 1984	Nov. 1985	Danish National Board of Health St. Kongensgade 1 1264 København K.	Name: Niels Henning Pedersen Address: Hørsholm Kongevej 36, 2970 Hørsholm Telephone: 02-869717, Relationship to applicant: colleague in Primary Health Project Group May be contacted ☒ To be contacted by prearrangement only ☐

Exact title of your post
in English: Public Health Nurse in Primary Health Project Group
in original language: Sundhedsplejerske i projektgruppe working in Gizan, Saudi Arabia.

Description of your responsibilities and duties; include number and type of subordinates:
See attached enclosure

Reference: Hospital Director
Karsten Hundborg
Gadekær 15, 6200 Åbenrå, 04-686242
Chief of Primary Health Project Group. May be contacted

From	To	Employer	Reference: Nursing Director
March 1987	Dec 1987	Kolding Hospital Skovvang 6000 Kolding	Name: Knud Ole Pedersen Address: Ulkjærvej 23, 7100 Vejle Telephone: 05-851406, 05-533222 ext 1430 Relationship to applicant: employer May be contacted ☒ To be contacted by prearrangement only ☐

Exact title of your post
in English: Nursing Officer in Paediatric Depts.
in original language: Oversygeplejerske i pædiatrisk område

Description of your responsibilities and duties; include number and type of subordinates:
See attached enclosure

Reference: Chief paediatric physician: Niels Hobolth
Kolding Hospital
05-533222 ext. 1485
May be contacted

Any additional information on your theoretic and practical experiences with relevance to the position applied for:
During my stay in Saudi Arabia I became acquainted with people from Bangladesh, who also worked there. I got a good impression that these people are capable, kind and energetic. I have a great respect of them, their culture, way of living and belief.
Besides I have had experience of working with people of the Islamic faith. To me it was a big challenge to meet these people and to adapt my program to their way of living.
In my capacity as a public health nurse I acquired a broad and all-round experience in teaching and preparation of materials. The teaching has been planned for and performed to many different groups of children and adults professionnally and interdisciplinaryly. The subjects have been based on my professional knowledge and experience as a public health nurse my attitudes, experience of interdisciplinary co-operation, research activities and project-reports.
Through Oct. 1986 - June 1987 I participated in a Health-promotive course at Esbjerg Teacher-training College. The course was based on the background of the aims of WHO."Health to all year 2000". I took part in description of the project: "The growing Child" a proposal of health-promotion for schoolaged children from 6-11 years.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH
POST DESCRIPTION FOR PROFESSIONAL POSTS

FOR USE OF PER ONLY

1. Present Title of Post: Coordinator, Teaching
2. Post Number(s):
3. STATUS
   - ☐ NEW - to be established attach ICDDR, B-#9
   - ☐ VACANT - for issuance of a vacancy notice, attach ICDDR, B-#8
   - ☐ OCCUPIED - revised duties
   - ☐ OCCUPIED - proposed change in grade, attach ICDDR, B-#8
   - ☐ OTHER - explain
4. Present Grade: DANIDA seconded
5. Division/Programme: CSD
6. Unit/Office/Field Activity: Child Health Programme
7. Official Station and Country: Dhaka, Bangladesh

Effective date:

Approved Title

CCOG | Classified grade

Comments:

Authorized by

Title | Date

8. ORGANIZATIONAL SETTING: Attach the current organizational chart which clearly shows the overall structure of the programme, division unit, or field activity, as appropriate. Identify each post by title, post number and classified grade.

9. Identify the objectives of the programme, and of the immediate unit or field activity as appropriate.

The Child Health Programme, which has just started, focuses on initiating and expanding programme in education/training, nutrition, immunization, and patient follow-up. The programme is headed by a Danish Paediatrician. Four Danish Public Health Nurses with four Bangladeshi counterparts will be responsible for each one of the above mentioned areas.

10. Summarize the assigned responsibilities.

- Improve the current education programme for patients and their attendants.
- Upgrade the training of the urban volunteers.
- Collaborate with and coordinate the training at the Treatment Centre.
- Training of health staff of DTC.

11. Indicate	Essential minimum qualifications required to perform the work	Additional desirable qualifications
a) Knowledge, abilities & skills, including personal qualities & human relationships	N/A	N/A
b) Level & field of study and extent of specialization	N/A	N/A
c) Length & nature of practical experience at the national and/or international level	N/A	N/A
d) Languages required and the level & nature of their use	Fluency in spoken and written English	Should learn Bengali

12. Identify the main objectives of the work (usually 4 6 reasons why the post exists). Within each objective, identify the duties wh formed to achieve the objective. Objectives should be presented in order of importance with an indication of the percentage of annual workload required for each objective.

1) Improve the current education programme for patients and their attendants by

   a) reaching all patients at the Treatment Centre;

   b) working out curriculums for training of the different categories of patients and their attendants in ORS pavilion, TC and GW (including home management and prevention of diarrhoea, breast feeding and nutrition, immunization, family planning);

   c) working out training programmes on a formal base (group discussions, lectures with flip charts, demonstrations, films) and on an informal base (bedside teaching mainly by urban volunteers).

2) Upgrade the training of the urban volunteers by

   a) working out job descriptions for UVs involved in child health training;

   b) training UVs in order to increase their ability to teach on health subjects at the Centre and at a later stage inthe field;

   c) working out job descriptions for and by training supervisors for the UVs involved in child health training;

   d) coordinating the training of the UVs at the Centre with the training given by UVP;

   e) giving the overall supervision of the child health training.

3) Collaborate with and coordinate the training at the Treatment Centre with

   a) Urban Volunteer Programme;

   b) Treatment Centre at Matlab;

   c) Treatment Centre at Teknaf;

   d) NGOs and government institutions in Dhaka.

4) Training of health staff of DTC by

   a) working out curriculum and training programmes in cooperation with Nursing Manager, Chief Physician, Training Branch etc.;
   b) planning courses for staff members.

5) Responsible for

   a) budgeting for the training part of the Child Health Programme;
   b) writing quarterly reports and annual reports.

13. Indicate the guidelines which are available (for example the decisions of legislative bodies, publications, policies, regulations, known pr accepted practices, research techniques, project documents, etc.)

(1) Internationally recognised medical textbooks and articles
(2) Accepted practices and procedures
(3) ICDDR,B policies

Describe the interpretation and/or deviation permitted, and the authority to establish new guidelines.

17. Describe the most important decisions that the incumbent is authorized to take.

N/A

18. Describe the most important recommendations expected of the incumbent

- May recommend to the concerned authority to take necessary action related to improve care, treatment and immunization of children of D.T.C. and community.

19. Describe the most damaging involuntary errors in the work and the effects these would have on the programme objectives identified in section 3, on the Organization, and on the immediate unit.

N/A

20. If this is a revised post description, indicate the changes that have occurred in the duties and responsibilities.

N/A

21. Certified as an accurate description of the work assigned (and performed if the post is occupied): Post No. .....

	Name	Signature	Date
First level supervisor	Mrs. Rahima Khatoon	R K Rahim	5/4/88
Second level supervisor, or Chief of Unit	Dr. Poul-Erik Lund Kofoed	Poul-Erik Kofoed	31/3/88
Regional or Divisional Director Programme Manager	Dr. Dilip Mahalanabis	Dilip Mahalanabis	6/4/88

Also, please certify the organizational chart as correct by signing and indicating the effective date.

14. Describe:

- the type and extent of the supervision given to the post:

Direct supervision by the Head, Child Health Programme.

- how assignments are given:

Mostly verbally.

- the guidance and assistance provided by the supervisor and/or others:

- the review and verification of the work while in progress or on completion:

15. Indicate the typical contacts required outside the immediate work unit. Explain the purpose of the contacts as clearly as possible, e.g. to obtai information on ..., to represent the Organization at ..., to provide advice on ... etc.

a) Inside the Organization

Title & level	Purpose
Project Director, UVP	Collaborate with and coordinate the training.
Head, Dhaka Treatment Centre	-do-
Head, Matlab Treatment Centre	-do-
Head, Teknaf Treatment Centre	-do-

b) Outside the Organization

Title & level	Purpose

16. a) Professional posts DIRECTLY supervised:

Title	Classified Level	Post Number(s)

b) Total number of professional posts supervised directly and through subordinate supervisors:

c) Total number of general service posts supervised directly and through subordinate supervisors:

d) Title, classified grade and post number of supervisor's post:

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH
GPO BOX 128, DHAKA - 1000, BANGLADESH

Title: Demographer - Scientist

Grade: P4

Objectives: This is one of the two international positions of Demographers in the Demographic Surveillance System (DSS) Project, which is meant to provide a longitudinal framework and linked data base (DB) for carrying out epidemiological and demographic studies and interventions in a rural population exceeding 200,000 in Matlab and 75,000 in Teknaf. The Project is unique in terms of extensive and high quality demographic field methodology and data in the context of the entire developing world.

Duties:

- The incumbent will carry out original research in substantive demographic and related epidemiological issues within the framework of the Centre's scientific priorities;
- Formulate and execute alternative field methodology for continuous demographic surveillance as well as multiround demographic-epidemiological surveys;
- Provide consultative service to the Centre's scientists with respect to design of experiments, monitoring, and evaluation:
- Overview the field operations in Matlab and Teknaf;
- Supervise data management staff;
- And provide scientific guidance to junior researchers of the Project.

Experience: Substantial field experience in developing countries,a nd proven capability of guidance of junior researchers.

contd...P/2

Demographer-Scientist (contd.)

Language Skills	Proficient in English; willing to pick up working knowledge of spoken Bengali.
Salary Range	US$ 32,605 to US$ 41,308 (with dependents) US$ 30,275 to US$ 38,101 (single status) depending on experience and qualification. The above salaries are base salaries, added to this are the usual UN benefits and allowances.
Date of Joining	

CURRICULUM VITAE

LOKKY WAI

Home:
43 Country Lane
London, Ontario
N5Y 2H4
Canada

Phone:519-672-3412

Office:
Sociology Department
University of Western Ontario
London, Ontario
N6A 5C2
Canada

EDUCATION:

Ph.D. — University of Western Ontario (1987)
Social Demography, Sociology Department, London, Ontario, Canada

Thesis Title: "Social Status, Value of Children, and Fertility in Mardan, Pakistan"

M.A. — University of Waterloo (1979)
Sociology Department, Waterloo, Ontario, Canada

Thesis Title: "Status Inconsistency and Fertility: The Canadian Case"

B.A. (Honours) — University of Waterloo (1977)
Sociology Department, Waterloo, Ontario Canada

WORK EXPERIENCE:

Research

Consultant — Women in the Barani Farming System Survey, Punjab, Pakistan, under the sponsorship of Agriculture Canada. (1987,July-Present)

Duties: — Preparing questionnaires and codebooks, verifying, processing, and analyzing data collected from the survey (SPSSX), and advising the Project Advisor in preparing the final report.

Consultant — Centro Latino Americano De Demografia, United Nations, Santiago, Chile. (1987,February-May)

Duties:	Systematizing and revising existing economic-demographic models for micro-computers, writing manuals and reports concerning use and application of these models, and the design of a econo-demograhic model for Peru.
Survey Specialist	SCARP MARDAN Evaluation Project, Peshawar, Pakistan, under the joint sponsorship of CIDA and the World Bank. (1984-1986)
Duties:	Design of courses for field investigators, supervision of research team, sampling of population, liaison with various international organizations, managing in-field aspects of the evaluation project, designing and implementation of a variety of evaluation research strategies, data collection, computerization, analysis of data (dBase, SPSSX, and SAS) and report writing.
Researcher	Supervisor: Professor E. Jimenez, Department of Economics, University of Western Ontario. "Demand for Housing and Finance in Developing Countries" project sponsored by the World Bank. (1982-1984)
Duties:	Computer programming (SHAZAM, SPSS, and FORTRAN), data management, and data analysis.
Research Assistant	Population Studies Centre and Sociology Department, University of Western Ontario. (1981-1984) Supervisor: Professor Balakrishnan "Bibliography of Canadian Demography" project. Supervisor: Professor Burch "Measures of Household Composition and Headship" project. Supervisor: Professor Ebanks "Infant, Child Mortality, and Fertility in Guyana, Jamaica, and Trinidad and Tobago" project. Supervisor: Professor Stone "Social Services for the Elderly in Developed Countries" project
Duties:	Writing research papers and abstracts, designing research methodology, computer programming (SPSS), and data analysis.

Researcher	"Survival and Adjustment of Dialysis Patients" project, Health Care Research Unit and Faculty of Nursing, University of Western Ontario. (1980-1982)
Duties:	Writing research papers and proposals, preparing conference abstracts, programming (BMDP, SPSS, SIR), and data analysis.

Teaching

Instructor	Department of Sociology. The University of Western Ontario, London, Ontario. (present)
Duties:	Teaching of a course entitled "Advanced Statistics" which focuses on advanced and intermediate statistical techniques such as tests of hypotheses (parametric and non-parametric), multiple regression and correlation, partial correlation, analysis of variance and path analysis.
Instructor	Faculty of Part-time and Continuing Education. The University of Western Ontario, London, Ontario. (May-August,1987)
Duties:	Teaching of a course entitled "Canadian Population and Social Policy" which examines Canadian population dynamics and their implications for policy in selected areas of public concern.
Instructor	SCARP Mardan Project, Peshawar, Pakistan. (1985-1986)
Duties:	Instruction of survey and interview techniques, coding, information management, and computing (DBASE) for an interdisciplinary team.
Teaching Assistant	Sociology Department, University of Western Ontario. (1980-1982)
Duties:	Conducting weekly tutorials, grading essays and examinations, and teaching an SPSS computing module. Courses: "Introductory Sociology" and "Introductory Statistics and Research Methods".
Teaching Assistant	Sociology Department,

University of Waterloo.
(1978-1979)

Duties: Conducting tutorials, grading of undergraduate assignments and examinations.
Course: "Introduction to Social Statistics".

PUBLICATIONS:

Social and Demographic:

"Discussion Paper on Adaptation of ESCAP Econo-demographic Models for Peru"
Wai, Lokky (forthcoming, CELADE, Santiago, Chile)

"Measures of Household Composition and Headship Based on Aggregate, Routine Census Data."
Burch, T.K., S.S. Halli, A.K. Madan, K. Thomas, and Lokky Wai in John Bongaarts et al (eds.) Family Demography, Methods and their Application. (1987) Oxford: Clarendon Press.

Annotated Bibliography of Canadian Demography, 1966-1982
Wai, Lokky, Sue Shiel and T.R. Balakrishnan (1984).
Centre for Canadian Population Studies, London, Ontario.

"Geographic Mobility of the Elderly in Canada",
Wai, Lokky and Roderic Beaujot
Canadian Journal on Aging. Vol.1, No. 1-2, 1982.

Medical and Health:

"Finances and Adaptation to Illness", The Social Work/ Le Travailleur Social, Vol.53, No.2 - Summer, 1985.
Palmer, S.E., L. Canzona, and L. Wai.

"Helping Families Respond Effectively to Chronic Illness: Home Dialysis as a Case Example."
Palmer, S.E., L. Canzona, and L. Wai.
Social Work in Health Care Vol.8, No. ., 1982.

"Physiological and Psychological Factors Predicting the Outcome on Home Hemodialysis."
Richmond, J., R.M. Lindsay, H.J. Burton, J. Conley and L. Wai. in Clinical Nephrology (Ed. R. Kluthe, Freiburg) 1982.

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Freedman, J., Lokky Wai, Ake Blomqvist, and Mahmood Khan

(authored 3 chapters: Ch. 1, Research Design; Ch. 2, The Quality of Life; Ch. 3, Focus on Women)
The University of Western Ontario for The Canadian International Development Agency, 1987.

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"A Re-consideration of the Relationship between Ethnicity and Fertility."
Wai, Lokky and S.S. Halli
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Ottawa, June, 1982.

"Population Growth and Economic Growth: A Cross National Study."
Wai, Lokky and Serena Ng
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Halifax, May, 1981.

"Geographic Mobility of the Elderly in Canada."
Wai, Lokky and Roderic Beaujot
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Halifax, May, 1981.

"The Fertility of Native and Foreign-Born Women in Canada"
Halli, S.S., F. Trovato, L. Wai, and W. Marshall.

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Medical and Health:

"A Comparison of Predictive Models in Determining Psychological Adaptation of Patients on CAPD."
Burton, Howard J., et al.
The 6th World Congress of the International College of Psychosomatic Medicine. Montreal, September, 1981.

"Stresses Associated with Sexual Adjustment of End Stage Renal Disease."
Burton, Howard J., et al.
Canadian Psychological Association 42nd Annual Convention. Toronto, June, 1981.

REFERENCES:

Professor Edward Ebanks
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Professor James Freedman
Anthropology Department
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London, Ontario
N6A 5C2 Canada

Professor Roderic Beaujot
Director,
Canadian Population Studies Centre
The University of Western Ontario
London, Ontario
N6A 5C2 Canada

PERSONAL DATA:

Date of Birth:	August 29, 1954
Marital Status:	Married with two children
Citizenship:	Canadian

Renewal of Contracts

I am recommending to the Board that the contracts of the following persons be renewed:

Senior Management

Mr M.R. Bashir, Associate Director and Head, Resources Development (P6/core).

Professional Staff

Dr N. Alam, Head, Dhaka Treatment Centre (P3/core)

Mr H. Ashraff, Software Manager, CIS (P3/project)

Dr V. Fauveau, Head, Matlab MCH-FP Programme (P3/project)

I grade these persons' performances from very good to excellent. They hold, each at their level, key positions in the Centre.

Note: My grading has been based on frequent, and for one person daily, contacts and close collaboration. I have checked my evaluation with that obtained by using the Performance Evaluation Report presently used at the Centre (blank copy appended).

Encl.

RE:jc
25.5.88

STRICTLY CONFIDENTIAL

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH
Mohakhali, Dacca-12

PERFORMANCE EVALUATION REPORT
Supervisory/Non-Research Level - V to NO-F

Period Reviewed From _____ To _____

PERSONAL PARTICULARS

Name of Employee: _____ Area of Work: _____

Hiring Date: _____ Position: _____

Branch/Office: _____ Previous Rating Date: _____

Note: Be sure that you have fully understood the instructions accompanying this Form before proceeding to the attached Format.

OVERALL RATING:

Percentage Rating	Adjective Rating
100 - 90	Excellent
89 - 70	Very Good
69 - 50	Good
49 - 30	Below Average
29 and below	Poor

NARRATIVE COMMENTS:

A. List the employee's greatest strengths, as evidenced by specific examples of unusually good performance or of the kind of work done best. (The areas in which the employees excels are important indications of the direction in which his/her development should be planned).

B. List the areas in which his performance can and should be improved. Be specific. (Definite knowledge is necessary in making plans to assist the employee in improving his performance).

Evaluated by: _____ Date: _____

Employee's signature: _____ Date: _____

Reviewed by: _____ Date: _____
(Department Head)

INSTRUCTIONS

TO THE RATER: The ratings are to represent your appraisal of the employee's actual performance of their present job. The value of the rating depends upon the impartiality and sound judgment you use. Rate the employee's performance during the above period only. The performance during other periods should not influence this rating.

TO HELP YOU MAKE A CAREFUL ANALYSIS, THE FOLLOWING SUGGESTIONS ARE OFFERED:

1. Base your rating on facts and not on impressions. The best way to obtain correct facts is to constantly and carefully observe the employee's general performance during the whole rating period, not just the period immediately prior to this report.

2. Consider only one factor at a time. Do not let your rating in one trait influence your rating of another.

3. Base your judgment on the requirement of the job and the employee's performance in it compared to others doing similar work and of similar rank.

4. Take plenty of time to rate your subordinate(s). Do not be influenced by prejudice or pity. The efficiency of your department/office/section depends largely on your fair appraisal of those working under your supervision.

5. Carefully read the description of each trait and specification of each factor, then make your entry. This method gives the rater alternatives to award various point values for each trait rated.

6. An empty box opposite the point values is provided for every gradation. The rater may then enter the points which he/she feels appropriate.

7. Upon completion, review and check your rating.

8. Add the points. Boxes are provided in the lower portion of every column. Get the sum to arrive at the total quantitative factor points.

9. Compare the total points on the reverse page of the form to determine the adjective rating. Encircle the equivalent adjective rating.

10. Narrative comments. This portion permit raters to express the personal feelings and candid assessment of the employee's performance.

    a. The areas in which the employee excels are important indications of the direction in which employee development should be planned.

    b. Weak points shall also be indicated in this portion to determine training needs and plans to assist the employee in improving performance.

11. Upon completion, the result should be discussed by the rater with the person rated. Both the rater and employee concerned should affix their signatures to signify that the result of the evaluation has been discussed. Should there be questions, the problem should be elevated to the department head for further review. If still unresolved, the Department Head forwards to Personnel Office for appropriate action.

****

1. Job Knowledge: Completeness of information employee has in all types of work needed by, expected of, and related to the position.	15 14 13 Exceptional mastery of the work, no assistance required.	12 11 10 Adequate knowledge of the job.	9 8 7 Sufficient knowledge requires direction sometimes.	6 5 4 Insufficient knowledge, requires direction from time to time.	3 2 1 Very little knowledg of the job. Requir direction at all tim
2. Quality of Work: Ability to work with thoroughness and accuracy regardless of volume.	10 9 Works outstandingly, accurate and complete attaining right quality of work possible.	8 7 Does thorough accurate work; rarely commits error.	6 5 Acceptable quality with few errors.	4 3 Fairly complete works with various errors or rejections.	2 1 Too many errors or rejections.
3. Quantity of Work: Individual productivity, rapidity in performing tasks.	10 9 Exceptionally good producer. Finishes work rapidly.	8 7 Good producer. Works rapidly most of the time.	5 5 Finishes regular amount of work within a reasonable time.	4 3 Sometimes fails assignment, needs help.	2 1 Fails to produce as expected, needs help constantly.
4. Dependability: Employee executes assignment and completes it without need of follow-up.	15 14 13 Highly reliable and conscientious.	12 11 10 Dependable under most circumstances, rarely needs checking.	9 8 7 Average reliability, delivers work without requiring special supervision.	6 5 4 Irregular in being dependable, sometimes unreliable.	3 2 1 Undependable, needs constant and close supervision.
5. Judgment: Ability to grasp situation, thresh out facts from surmises and draw a correct logical conclusion.	15 14 13 Good judgment on varied situations.	12 11 10 Good judgment on routine matters.	9 8 7 Fair judgment on routine matters.	6 5 4 Judgment sometimes unreasonable causing delays.	3 2 1 Judgment cannot be relied on.
6. Leadership: Consider his ability in gaining the cooperation of his subordinates, assess also his ability in instilling others the willingness and desire to achieve a given job.	10 9 Very capable and effective leader.	8 7 Instruct very will. Explains procedure clearly and able to make his men perform efficiently.	6 5 Has good control of his men and maintains good discipline.	4 3 Inadequate ability to motivate and coordinate.	2 1 Insufficient ability to control his subordinates.
7. Planning & Organization: Consider his ability in planning and organizing the work in his unit to make most effective use of personnel, materials and equipment.	10 9 Plans and organizes exceptionally well even under difficult situations.	8 7 Plans and organizes effectively well.	6 5 Effective planner and organizer under normal circumstances.	4 3 Usually good planner but poor organizer.	2 1 Insufficient planni and organizational ability.

Contd. to pg.2.

8.	Training & Developing Subordinates: Consider his interest in training and developing subordinates in order to obtain maximum efficiency in the performance of their jobs.	5 Very capable and active in training and developing subordinates.	4 Has sufficient ability to train and develop the potentials of his subordinates.	3 Has average ability in training subordinates and developing their aptitude.	2 Has interest but insufficient ability and determination to train and develop subordinates.	1 Minimal interest to train and develop subordinates.
9.	Attendance: Regularity and punctuality in attendance, frequency in reporting to work and proper observance of break period.	5 Exceptionally excellent attendance and punctual in observing working hours.	4 Rarely absent or late, observes proper working hours.	3 Average absence and lateness except for extreme emergency.	2 Frequent absence/ lateness indicating little concern for time lost.	1 Frequent absence/ tardiness for trivial reasons.
10.	Capacity to Develop: Potentials for advancement considering educational attainment, acquired skills, team work, adaptability and capacity to accept additional responsibilities.	5 Great future growth, shall go far with opportunities.	4 Very promising promotional material.	3 Shows sign or promise for future positive.	2 Moderate development to be expected.	1 Future growth doubtful.

Total Quantitative Factor Points

STRICTLY CONFIDENTIAL

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH
Mohakhali, Dacca-12

PERFORMANCE EVALUATION REPORT
Supervisory/Research Level - V to NO-F

Period Reviewed From _____ To _____

PERSONAL PARTICULARS

Name of Employee: _____ Area of Work: _____

Hiring Date: _____ Position: _____

Branch/Office: _____ Previous Rating Date: _____

Note: Be sure that you have fully understood the instructions accompanying this Form before proceeding to the attached Format:

OVERALL RATING:

Percentage Rating			Adjective Rating
100	-	90	Excellent
89	-	70	Very Good
69	-	50	Good
49	-	30	Below Average
29	and	below	Poor

NARRATIVE COMMENTS:

A. List the employee's greatest strengths, as evidenced by specific examples of unusually good performance or of the kind of work done best. (The areas in which the employee excels are important indications of the direction in which his/her development should be planned).

B. List the areas in which his performance can and should be improved. Be specific. (Definite knowledge is necessary in making plans to assist the employee in improving his/her performance).

Evaluated by: _____ Date: _____

Employee's signature: _____ Date: _____

Reviewed by: _____ Date: _____
(Department Head)

INSTRUCTIONS

TO THE RATER: The ratings are to represent your appraisal of the employee's actual performance of their present job. The value of the rating depends upon the impartiality and sound judgment you use. Rate the employee's performance during the above period only. The performance during other periods should not influence this rating.

TO HELP YOU MAKE A CAREFUL ANALYSIS, THE FOLLOWING SUGGESTIONS ARE OFFERED:

1. Base your rating on facts and not on impressions. The best way to obtain correct facts is to constantly and carefully observe the employee's general performance during the whole rating period, not just the period immediately prior to this report.

2. Consider only one factor at a time. Do not let your rating in one trait influence your rating of another.

3. Base your judgment on the requirement of the job and the employee's performance in it compared to others doing similar work and of similar rank.

4. Take plenty of time to rate your subordinate(s). Do not be influenced by prejudice or pity. The efficiency of your department/office/section depends largely on your fair appraisal of those working under your supervision.

5. Carefully read the description of each trait and specification of each factor, then make your entry. This method gives the rater alternatives to award various point values for each trait rated.

6. An empty box opposite the point values is provided for every gradation. The rater may then enter the values which he/she feels appropriate.

7. Upon completion, review and check your rating.

8. Add the points. Boxes are provided in the lower portion of every column. Get the sum to arrive at the total quantitative factor points.

9. Compare the total points on the [illegible] page of the form to determine the adjectival rating. Encircle the [illegible] adjective rating.

10. Narrative comments. This portion permit raters to express the personal feelings and can did assessment of the employee's performance.

    a. The areas in which the employee excels are important indications of the direction in which employee development should be planned.

    b. Weak points shall also be indicated in this portion to determine training needs and plans to assist the employee in improving performance.

11. Upon completion, the result should be discussed by the rater with the person rated. Both the rater and employee concerned should affix their signatures to signify that the result of the evaluation has been discussed. Should there be questions, the problem should be elevated to the department head for further review. If still unresolved, the department head forwards to Personnel Office for appropriate action.

1. Job Knowledge-Completeness of information employee has in all types of work needed by, expected of, and related to the position	15 14 13 Exceptional mastery of the work, no assistance required.	12 11 10 Adequate knowledge of the job.	9 8 7 Sufficient knowledge, requires direction sometimes.	6 5 4 Insufficient knowledge, requires direction from time to time.	3 2 1 Very little knowledge of the job. Requires direction at all times.
2. Quality of Work-Ability to work with thoroughness and accuracy regardless of volume.	15 14 13 Works outstandingly, accurate and complete attaining right quality of work possible.	12 11 10 Does thorough accurate work; rarely commits error.	9 8 7 Acceptable quality with few errors.	6 5 4 Fairly complete works with various errors or rejections.	3 2 1 Too many errors or rejections.
3. Quantity of Work-Individual productivity, rapidity in performing tasks.	10 9 Exceptionally good producer, Finishes work rapidly.	8 7 Good producer. Works rapidly most of the time.	6 5 Finishes regular amount of work within a reasonable time.	4 3 Sometimes fails assignment, needs help.	2 1 Fails to produce as expected, needs help constantly.
4. Scientific Integrity-Soundness of results based on firm adherence to scientific procedures and ethics.	15 14 13 Outstanding integrity in research.	12 11 10 Commendable standard of honesty in research.	9 8 7 Generally reliable scientifically.	6 5 4 Scientific integrity leaves something to be desired.	3 2 1 Unreliable scientifically.
5. Judgment-Ability to grasp situation, thresh out facts from surmises and draw a correct logical conclusion.	10 9 Good judgment on varied situations.	8 7 Good judgment on routine matters.	6 5 Fair judgment on routine matters.	4 3 Judgment sometimes unreasonable causing delays.	2 1 Judgment cannot be relied on.
6. Leadership-Consider his ability in gaining the cooperation of his subordinates, assess also his ability in instilling others the willingness and desire to achieve a given objective.	10 9 Very capable and effective leader.	8 7 Instruct very well. Explains procedure clearly, and able to make his men perform efficiently.	6 5 Has good control of his men and maintains good discipline.	4 3 Inadequate ability to motivate and coordinate.	2 1 Insufficient ability to control his subordinates.
7. Initiative & Creativeness-Consider his ability to discover new ideas or methods in doing the work and use them to attain his objectives.	10 9 Exceptionally capable of developing and utilizing new ideas, new methods and better techniques.	8 7 Highly constructive and resourceful.	6 5 Has average creativity and initiative that is normally required by his job.	4 3 Imaginative and progressive but lacks initiative.	2 1 Has minimal initiative and creativeness.

Contd. to pg.2.

8. Training & Developing Subordinates-consider his interest in training and developing subordinates in order to obtain maximum efficiency in the performance of their jobs.	5 Very capable and active in training and developing subordinates.	4 Has sufficient ability to train and develop the potentials of his subordinates.	3 Has average ability in training subordinates and developing their aptitudes.	2 Has interest but insufficient ability and determination to train and develop subordinates.	1 Minimal interest to train and develop subordinates.
9. Attendance-Regularity and punctuality in attendance, frequency in reporting to work and proper observance of break period.	5 Exceptionally excellent attendance and punctual in observing working hours.	4 Rarely absent or late, observes proper working hours.	3 Average absence and lateness except for extreme emergency.	2 Frequent absence/lateness indicating little concern for time lost.	1 Frequent absence/ tardiness for trivial reasons.
10. Capacity to Develop-Potentials for advancement considering educational attainment, acquired skills, team work, adaptability and capacity to accept additional responsibilities.	5 Great future growth, shall go far with opportunities.	4 Very promising promotional material.	3 Shows sign of promise for future positive growth.	2 Moderate development to be expected.	1 Future growth doubtful.

Total Quantitative Factor Points

GRADING PROBLEMS

- Overall, international positions at ICDDR,B have been graded conservatively. Prof. Monsur has repeatedly indicated this (for medical doctors). Dr Merson has asked why the salary scale at ICDDR,B ended at P6/D1 (except for the Director) and why D2 has never been used.

- ICDDR,B never has had qualified experts trained in the complex grading procedures as applied by the U.N. bodies. Moreover, the consultants in personnel matters who came to ICDDR,B have stressed the inappropriateness of the UN/WHO grading system for our Centre. Still, devising a better system has hitherto not been possible.

- The problem is now compounded by the wide swings of the US dollar exchange rate, affecting mainly staff from Western-Europe.

- Despite the Board's and the Management's efforts, strange inequalities persist at ICDDR,B. For example, why is the Director DSS at P5, and the Heads, Dhaka Treatment Centre or Matlab MCH-FP Programme at P3?

- I consider the following proposals as most important to improve our grading structure. They concern two individuals and four positions.

Individuals

Dr Ciznar, Associate Director and Head, Laboratory Sciences Division since 1.8.87 is at P5 Step 7. He has served the Centre for four years, and has to return to his home country in September 1988. His performance can be graded as excellent. The Board has fixed the normal level for an associate director at P6.

I propose that Dr Ciznar should be promoted to P6 Step 3 with retroactivity as of 1.8.87. The financial implication is less than $2,000.

Mr M.A. Mahbub, Associate Director, Administration, Personnel and Finance has worked for one year now. He has shown to be hard working, competent and dedicated. He was appointed at P5 Step 5.

I propose that Mr Mahbub should be promoted to P6 Step 1. The financial implication is $1,000 per year.

Positions

The post descriptions have been carefully reviewed and

graded. The following adaptations are proposed

	Grade Present	Proposed
- Head, Dhaka Treatment Centre	P3	P4*
- CIS Hardware Manager	P3	P4
- CIS Software Manager	P3	P4*
- Head, Matlab MCH-FP	P3	P4*

* Applicable to present appointees

General Considerations

- The proposed grades are still relatively low, and may make appointments based on truly international competition almost impossible. The ICDDR,B rules allow for an appointment at 1 or 2 levels below the grade. At UNICEF, appointments can be made at 1 level below or 1 level above the grade.

- I propose that from now on we should use the UNICEF system.

Note: We may have to advertise one of the above positions, i.e. that of CIS Software Manager, immediately and in light of this I request that the above proposal be approved now. (Mr Ashraf Hira has a Canadian landed-immigrant permit which

he must avail of before 31 December, 1988. We have been trying every avenue to have this extended but, at this stage, there appears to be little hope. In the event of the permit not being extended Mr Hira will leave the Centre in July/August of this year.)

RE:jc

26.5.88

SALARAY POLICY FOR INTERNATIONAL AND NO STAFF

Salary Policy for International & NO Staff

The Centre adopted the WHO/UN Salary for the International Professional Staff members and maintains a comparability with the UN agencies in Bangladesh in respect of the salary for its National and General Service staff. During the November 1987 meeting the BOT was appraised of the problems encountered by the Centre due to adoption of the said salary policies.

It is observed that the WHO/UN salary as applied at ICDDR,B for the International Staff is at the low end for the recruitment of Scientists with medical degrees engaged in basic scientific research, and is considerably lower for those in clinical research, particularly for applicants from Western Europe and North America. The UN/WHO system cannot offer a comparable compensation for those coming from US or West Europe due to variations in the Post Adjustment factors. Again the Centre was stringent about the classification of its International Staff and now it is felt that some misclassifications exist e.g. the D2 pay level was never utilized. The newly appointed Chief Personnel Officer was, however, scheduled to visit WHO headquarters to revalidate the classification of all the International Professional Staff members using the UN Master Standard. This visit has been delayed.

The UN/WHO salary was not revised since 1980. This also is a factor which adds to the frustration. Salary and allowances constitute the primary incentive for an individual coming out to take up a job in the Centre because the Centre is unable to offer career progression and stability due to the six years clause. A detailed paper addressing this issue is presented at Agenda 5(b).

Again for the National Officer & General Service categories, clause 14(2) of the ICDDR,B Ordinance stipulates that salaries and emoluments of non-International level positions should be 'comparable' to those paid by the UN organizations in Bangladesh. The Centre is thus legally obligated to be in line with the UN Salary system.

As already presented to the Board in November 1987, the Centre is not able to implement repeated salary raises of the UN Agencies due to inherent difficulties in obtaining retroactive incremental project funding.

AH:WZA:au

COMPENSATION FOR INTERNATIONAL STAFF FOR DEVALUATION OF DOLLAR.

PAPER ON SECONDMENT POLICY

SECONDMENTS

Introduction and Executive Summary

This document on Secondments is a completely new version of a paper submitted to the Board of Trustees November 1987 Personnel & Selection Committee, and that was considered as inadequate.

What has made writing this paper and its first version difficult is that I do not know what has motivated the Board's request to have them submitted, and what the Board's concerns in this area are.

I fear the following 24 pages make for tedious reading. Board Members not aware of previous discussions might prefer to first read section 4 where some considerations and decisions of the Board are quoted.

This paper tries to define secondments (section 1) and to indicate, for ICDDR,B, their "raison d'être" (section 2). Section 3 deals with the different types of secondments at ICDDR,B. Eight types (with a total of sixteen subtypes) are mentioned. Describing and discussing two of them involving only a few individuals have required six pages, for which I apologize. This section ends with comments. As already

stated, section 4 quotes some Board's considerations and decisions. From my viewpoint as Chief Executive of the Centre, some have done more harm than good or may do so in the future. Section 5 discusses some issues immediately related to secondments and some more general ones.

Indeed, I submit that the subject of this paper leads to issues far more important than secondments as such. They include (i) the division of executive powers between the Board and the Centre's Director; (ii) the Board's decision making process. I further submit that it is in this light that the present paper could be discussed.

1. Definition and background

"Secondment" is defined here as a set of mechanisms that allow individuals to come and work at ICDDR,B while retaining their position at their parent institution or organization. Secondments can exist as such, or be part of various more complex arrangements, involving for example direct financial support to the Centre, or scientific collaboration. As to their duration, secondments can last for a few days only (e.g. consultants paid by UNDP of the French Co-operation) or for years. The ICDDR,B and its predecessor, the CRL, have always known secondments of various types; secondments are, for that matter, to be found world-wide, amongst others in most universities, research institutions and national or international organizations.

2. "Raison d'être"

2.1 Secondments would not seem to need any justification. They happen to be various systems to attract or maintain staff that, for financial or administrative reasons, cannot be hired directly by the Centre.

2.2 At ICDDR,B secondments serve several purposes:

2.2.1 Strengthening the international character of the Centre.

2.2.2 Strengthening links with other institutions.

2.2.3 Acquiring particular talents not obtainable otherwise.

2.2.4 Making the Centre better known internationally.

2.2.5 Easing the financial burden of the Centre.

2.2.6 Responding to offers of help made by donors, improving the contacts with these donors and gaining their good will.

2.3 A set of circumstances make secondments of particular importance to ICDDR,B. They include:

2.3.1 The location of the Centre making contacts

with other institutions difficult, as well in the region as outside it.

2.3.2 The many disciplines practised at the Centre, requiring a great variety of skills not easily obtainable.

2.3.3 It is becoming more and more difficult to attract staff even for the best-paid positions. There seem to be several reasons. They include: the conditions of life and work at ICDDR,B frequently perceived as not very attractive; the international salaries considered by many as too low; the "spouse rule" (see 4.2).

2.3.4 The still existing financial problems of the Centre.

Obviously, secondments cannot resolve all these problems, but they can contribute to making their impact less severe.

3. Types of Secondments

There are many types of secondments at ICDDR,B. The main distinction depends on whether the Centre extends help ("Secondment to") or receives help ("Secondment from").

3.1 "Secondment to"

3.1.1 SAARC fellowships

Financed by ICDDR,B these fellowships allow professionals from Bangladesh and other SAARC countries to update their skills in the field of diarrhoeal disease.

3.1.2 Strengthening of the Henan Diarrhoeal Treatment and Research Centre, Republic of China

Dr Guo was the first recipient of a one-year training grant at ICDDR,B. Dr Fu is the second and present one.

3.1.3 Collaboration with Dhaka University

MSc and MPhil students from Dhaka University receive a small stipend, bench space and preceptorship at ICDDR,B.

3.2 "Secondment from"

3.2.1 Leave of absence

This well-known system allows staff to come and work at ICDDR,B while retaining their position at their parent institution, an arrangement without which they could not have joined. There are at least three subtypes:

* Leave of absence with full salary support (e.g. Drs A. Hall, T.

Rautanen).

* Leave of absence with salary paid by the Centre according to its own rules (e.g. Drs T. Butler, I. Ciznar, R. Eeckels).

* Leave of absence with salary paid by the Centre through the parent institution according to the latter's salary scales (e.g. Drs W.B. Greenough, D. Sack and B. Kay). This rather straightforward system has been abrogated by the Executive Committee decision of March 1987 (see below para. 4.1), if the institutions's salaries are higher than the Centre's - which they usually are.

3.2.2 Technical Assistance

These individuals are put at the Centre's disposal with all costs paid by a donor agency. There are two subtypes

* The staff members are employed by the donor agency, either for the time of their stay at ICDDR,B or as regular employees (e.g. WUSC staff and probably also DANIDA staff for the former, BADC staff and Dr A. Briend for the latter).

* The staff members are paid by a donor

agency, but employed by another institution. This can overlap with leave of absence and full salary support (see 3.2.1).

In most cases, Technical Assistance is part of a more complex agreement with a donor (e.g. BADC, DANIDA, WUSC). In these agreements, no monetary value is given to the technical assistance staff, though their presence at the Centre is very valuable.

3.2.3 Deputed Staff, Reimbursable

* In 1986 , a new and generous Co-operative Agreement was signed between USAID Washington and ICDDR,B, covering the fiscal years 1986 through 1989. The donor indicated that he would favour the involvement of American institutions in epidemiological and "targeted" research. The Agreement has a line item called "Epidemiologists". It stipulates that the money should be used to foster the collaboration between ICDDR,B and the CDC in Atlanta. A CDC staff deputed by CDC to ICDDR,B is to be paid by CDC, and ICDDR,B reimburses CDC. Only if no CDC

personnel is available can the line item be used to pay other epidemiologists. The system is not very different from technical assistance,' except that its monetary value is spelled out. It is also more flexible, but it carries no overhead (neither, of course, do Technical Assistance schemes).

* Similar but not identical is an arrangement based on the same co-operative agreement. The line item "Targeted Research" (Total of US$ for 4 years) has allowed to continue the oral cholera vaccine trial, and considerably expand work on shigellosis. For about the last two years talks have been underway with Tufts University to launch a common research on shigellosis. No formal agreement has yet been signed. In the meantime, Tufts has already sent a senior consultant (Prof. J. Keusch), a researcher (Dr M. Bennish, an ICDDR,B alumnus) and a fellow (Dr Judith Nerat) to ICDDR,B. A three-year protocol "Role of cytokines in shigellosis" has been approved by RRC and ERC and should

start in June. The costs related to the Tufts personnel involved will be deducted by USAID from the co-operative agreement money and paid to Tufts through the Boston-based Applied Diarrhoeal Disease Research foundation (ADDR). For the time being, no overhead is requested by Tufts.

3.2.4 Deputed Staff, Non-reimbursable

* This situation arose out of a set of difficulties compounding one another. In November 1986, the then director of the Urban Volunteer Programme resigns. Her accumulated leave reduces the notice-period to a fortnight. The Co-Operative Agreement with USAID Dhaka stipulates that (i) the director must be replaced within three months and (ii) her replacement must be approved by USAID.

Initially, no suitable replacement can be located. Then Prof. R.B. Black (JHU) proposes Dr D. Silimperi. JHU adamantly refuses any other salary arrangement than the one formerly applied for Drs Greenough, Sack and Kay (see 3.2.1) which, in the meantime,

has been abrogated by the Board, as already indicated (see para. 4.1), Dr Silimperi visits Dhaka and is declared acceptable by USAID. The Centre's Director requests USAID Dhaka to find a way to pay Dr Silimperi directly or through JHU, which is initially refused, USAID pointing out the considerable administrative difficulties it would have to overcome, and the fact that there is ample money, with overhead to ICDDR,B, in the project document. USAID also requests the position to be filled as soon as possible.

Eventually, after consultation with the Chairman of the Board and with his approval, the Director reaches an agreement with USAID Dhaka. He will immediately hire Dr Silimperi and pay her with project money through JHU. USAID Dhaka, in exchange, promises to try and find a way to pay Dr Silimperi through other channels, in order to allow the Director to comply with the Board's ruling.

This is the situation at the beginning

of the Board's June 1987 meeting. At the Personnel and Selection Committee misunderstandings arise between some Members and the Director as soon as the problem of the UVP director is broached. This potentially serious situation is defused when, the very morning the full Board is scheduled to discuss the problem, the Director receives an unsolicited call from USAID Dhaka informing him that Dr Silimperi will be paid with new funds through ADDR in Boston. As a consequence, the UVP director's salary line item disappears from the co-operative agreement.

* As such, the matter is not worth the time it took to summarize it, neither the time needed to read and understand it. There have been two positive outcomes. The UVP has a new director, who arrived in Dhaka as quickly as possible (April, 1987); the letter of the Board's decision was respected. There are many negative outcomes. The Centre, has lost the overhead it would have received by using the available project money to pay Dr Silimperi

straightaway through JHU; this overhead now goes to JHU. USAID Dhaka has had to resolve complex administrative matters for reasons it cannot but consider as rather petty. Time-consuming discussions involving JHU, ADDR, USAID-Dhaka, USAID-Washington and ICDDR,B are still going on; they have caused irritation, loss of time and of good will.

Taking all this into account, this particular problem might still deserve the Board's attention if it leads to clear and simple decisions. As a possible guideline, a slight adaptation of a Roman proverb might be appropriate: "De minimis non curant praetorae et praetores" (apologies are presented for the neological feminine plural!).

3.2.5 Partially Funded Secondment

This constitutes an exception. The individual is seconded from his organization with a partial, mutually agreed level of funding for direct and indirect costs, met by the collaborative organization/funding agency [e.g. Hartley Janssen, (WUSC)]. The

WUSC staff expected this year will be fully funded.

3.2.6 "Topping up"

Well-known in the U.N., this system does not yet exist at ICDDR,B. Some countries such as the F.R.G. and Japan give a salarial supplement to their nationals working for the U.N. Employees from other countries have protested against this situation which they consider as discriminatory.

3.2.7 Training Secondments

A considerable number of Bangladeshi staff members have received training abroad. Since mid-1985, no core money (or very little) has been used for that purpose. Still it has been possible to further ensure training by obtaining stipends or specific grants. Recent examples of long-term training are

Mr A. Bhuiya*	(ANU)	- demography
Ms H. Begum*	(ANU)	- demography
Dr I. Kabir	(Cleveland)	- gastroenterology
Dr P. Bardhan	(Basel)	- gastroenterology
Dr S.K. Roy	(London)	- MSc
Dr G.H. Rabbani*	(Buffalo)	- research techniques
Dr A.K. Azad*	(Buffalo)	- research techniques

Dr S. Nath*	(Paris)	- experimental research
Dr A.H. Baqui**	(JHU)	- Ph.D.
Dr A.S.G. Faruque**	(JHU)	- Ph.D.

* (Still abroad)
** (Running an ICDDR,B protocol for their thesis work)

It is obvious that the Centre has been much more successful in finding training opportunities for its own staff than in offering similar training to professionals from outside the Centre (para. 3.1). For these persons, however, very active short-term training programmes exist. Also, the Centre cannot give degrees.

3.3 Comments

The present situation regarding long-term secondments is summarized in the attached table I.

3.3.1 Secondments involve a considerable number of donor-countries and institutions. They include

Australia, Bangladesh, Belgium, Canada, China, Czechoslovakia, Denmark, Finland, France, Japan, SAARC Countries, Switzerland, U.K., U.S.A.

ADDR

Aga Khan Foundation

Arab Gulf Fund

Australian National University

Finnish Academy of Sciences

Ford Foundation

Free University of Brussels

INSERM, Paris

Johns Hopkins University Medical School

Katholieke Universiteit Leuven

London School of Hygiene & Tropical Medicine

ORSTOM, Paris

Population Council

Research Institute of Preventive Medicine, Bratislava

Rockefeller Foundation

Tufts University

UNDP

University of Adelaide

University of Basel

University of Buffalo

University of Cleveland

University of Dhaka

University of Goteborg

University of Pennsylvania

University of Tampere

3.3.2 Board Members who have facilitated training secondments include Prof. D. Bradley, Dr I. Cornaz, Prof. J. Holmgren, Prof. K.A. Monsur,

Prof. D. Rowley; Prof. H. Tanaka has been instrumental in opening opportunities for technical assistance from Japan. Last but not least, Prof. Bell has extended generous help in the delicate and complex negotiations with ADDR, JHU, Tufts University and USAID Washington.

3.3.3 The Scientific Associate Directors of the Centre have established many important contacts. Difficult funding issues were successfully resolved by the Associate Director, Resources Development.

3.3.4 One has to realize that the above classification in 8 types and 16 subtypes of secondment do not fully reflect the complexities involved.

For example, leaves of absence and technical assistance can come with or without research money, gifts in kind, logistical support, etc.

Also, for simplicity's sake, the short-time secondments, frequently very precious, have not been discussed.

3.3.5 It is interesting to compare the secondments in e.g. December 1985 and 1988 (see Table II).

4. Board Considerations and Decisions

Considerations and decisions by the Board on personnel matters related to secondments are being quoted here.

4.1 Reimbursable secondments (Executive Committee Minutes March 1987)

"... i.e., the Centre would reimburse the institution for the budget cost at mid-level of the level agreed to for the seconded person and would pay local benefits to that person in Dhaka. This ensures that the Centre would pay no more for reimbursable secondment personnel than it would if it recruited the person directly."

4.2 Husband-and-wife teams (Special Board attachment to Nov. 1985 Board Minutes)

"The employment of both partners of a married couple on international grades is inappropriate and does not conform to WHO practice. In future only one partner will be permitted to hold an international post. If it is plainly desirable for the scientific work of the Centre to recruit the spouse also, he/she may be appointed at NO level. ...".

4.3 Seconded staff appointments (Draft P&S Mins, page 4, Nov. 87)

"It was requested that in future more information be

given i.e. whether the persons are on reimbursable or non-reimbursable secondments, along with a paragraph on the work each person was (sic) doing in the Centre with the post description and curriculum vitae of that person."

4.4 Secondment Policy (Draft P&S Mins, pages 8 & 9, Nov. 87)

"Full discussion of this paper was deferred until next meeting when a revised paper should be submitted considering the following points, among others, as a matter of procedure regulating seconded appointments:

(a) The basic framework for a secondment needs to be an agreement between the Centre and the seconding institution.

(b) In future, the Board should have approval over anyone that comes on secondment to the Centre. However, it is realised that it may not always be possible for the Centre to select the person to come on secondment.

(c) For quick decisions on secondment the Director should consult with the Chairman of the Personnel & Selection Committee and the Chairman of the Board. If their approval is obtained, action may be taken and the Board informed at its next meeting.

(d) Before seeking approval, the management should carefully work out the cost aspect and recommend

only viable ones.

(e) Seconding institutions should receive the job description as a guide for selection and the Board would have the freedom to rank the person seconded. It was recognized that in some instances the person may arrive at the Centre and only after arrival will he/she be placed in a position."

4.5 Secondment Policy (Draft Board Minutes, page 12, Nov. 87)

"Full discussion of this was deferred until next meeting when the Director will present a revised paper, taking into consideration the comments made by the Personnel and Selection Committee in its report.".

4.6 Resolution 7/Nov. 87

"Resolved that as a general rule Board Members be approached to assist in the recruitment of all international positions; notices of employment, job descriptions and other relevant papers should be sent to all Board Members."

4.7 Assignment of specific tasks by the Director (P&S Minutes, April 1984)

"... The principle that although the Board appoints any international level staff the Director holds the

authority to assign or re-assign responsibility within the Centre was discussed and felt to be correct."

4.8 Approval of Secondment Policy (Resolution 7/Nov. 86)

"(a) The Board approves the secondment policy as outlined by the Management, stressing the importance for the Centre to be fully involved in the final selection of the seconded personnel and emphasizing that any research funding provided to the Centre in support of a seconded person should be controlled by the Centre."

5. Discussion

Addressing myself to colleague - Trustees and friends, I trust I will be allowed to express my thoughts frankly and candidly. I hope this will contribute to an open discussion and appropriate decisions.

5.1 Recruitment procedures

The November 1987 P&S Committee (see para. 4.4) has focused its attention on recruitment procedures. There are almost as many of them as there are types and subtypes of secondments. Time pressure makes it mostly impossible to inform the Board prior to agreeing to the secondment. Also, many secondments are part of more complex agreements with donors. The Director has always been empowered by the Board to sign such

agreements. Should that be changed?

That "the basic framework of a secondment needs to be an agreement between the Centre and the seconding institution" (see 4.4 (a)) is self-evident. Yet, is it implied that till now there were no such agreements?

I have to express here some doubts, about the appropriateness of para. 4.4 (b) and 4.4 (c). They ask for prior approval by the Board, but include also a second clause that, in practice, might nullify the first one. Can the Board not delegate its powers, as it did in the past?

Para. 4.4 (d) states the obvious. Has the present management ever been careless about costs?

Para. 4.4 (e) proposes a rule that is rarely applicable, and at the same time includes an escape clause.

5.2 Reimbursement to other institutions

The Executive Committee decision of March 1987 (see para 4.1) abrogated a practice that had existed for years. It has made the recruitment of the UVP director very difficult and led to many misunderstandings. It has also caused the Centre to lose overhead and get itself entangled in still ongoing administrative difficulties.

More importantly, however, it may make it exceedingly difficult, not to say impossible, to attract medium and high-level scientists from North America and, possibly even from Western Europe.

It has never been spelled out what the decision meant to achieve. A discussion based on principles is hence not possible. In practice, this decision has shown to be counterproductive. I suggest it should be abrogated. The former system was working well. It should be reinstated.

5.3 Information to the Board

The Centre's management has constantly tried to give as much information as possible to the Board and will continue to do so. Yet, as I said in November 1987, "the more information we give, the more is requested". I don't believe this spiral should go on. The Board's time is limited and precious. We run the risk of losing ourselves in details. Information does not alwyas require action, and certainly not immediate action. Referring to para. 4.3, is the Board as a body really interested in the curricula vitae and the job descriptions of e.g. Dr Kofoed or Ms Thilsted? If so, I'd request to be allowed to ask "why?".

5.4 More general issues

5.4.1 The division of executive powers between the Board and the Centre's director

I don't think it would be appropriate for me to make any concrete proposals here. It is clear, however, that there is a level below which the Board ought not to be involved, and a level above which the Director should not act independently. I do think the Board is presently involved in too many minor issues. I'd be grateful if the Board would let me know whether I've shown too much independence.

5.4.2 The Board's decision-making process

* After more than three years' experience, I still don't understand what the responsibilities and powers are of the Board's Committees. Too frequently a problem is discussed exhaustively in a Committee, a consensus is reached, a decision is formulated, and flatly turned down at the full Board Meeting because of an objection raised by a single Member who was not present at the Committee meeting. This is, to say the least, extremely inefficient.

* I further submit that it is not always clear on what grounds the Board's decisions are based, or, to say it in legalese, what the "reasons adduced" are. A good example is the "spouse rule" (see para. 4.2). Why is "the employment of both partners of a married couple on international grade ... inappropriate"? Is it appropriate at the NO level? Is it because it does not conform with WHO practice? What are the grounds for this practice? Do they apply to ICDDR,B?

  More and more professionals are married to other professionals. Why curtail our hiring possibilities that are already extremely limited? I have scrupulously adhered to this rule while knowing it was harming the Centre. Creating artifically a job for a spouse is bad policy. Making it impossible to hire a couple that fits the Centre's needs is even worse. I propose the rule should be abolished.

* I submit it would be worthwhile to consider clearly stating the grounds for each important ruling or decision by the

Board and introducing a second reading for the most important ones.

6. Conclusions and Suggestions

6.1 As to the matter at hand, I submit that secondments should be considered as beneficial to the Centre, some types admittedly more so than others.

I further submit that decisions regarding secondments are part of the daily management of the Centre and should be left to the Director, advised by his Council of Associate Directors. The Board has, of course, to be kept informed through its Personnel and Selection Committee.

I suggest that the Board should abrogate its rulings or considerations quoted under paras. 4.1 (Level of Reimbursement) and 4.4 (Secondment Policy and Recruitment Procedures), and also the "spouse rule" (para. 4.2).

6.2 As to the more general issues (see para. 5.4), I hope the Board might agree to address itself to the division of executive powers between the Board, and the Director and his senior collaborators. This, rather than being settled in one Board meeting, could be a body of rulings, progressively built up, keeping in mind that

the Ordinance, by giving all powers to the Board, necessarily implies delegation of powers.

The Board might also want to consider clearly defining "the delegation (of) its functions and powers" to its Committees, as indicated by the Ordinance, Section 12, Article (6).

I further submit that the Board might seriously consider (i) clearly stating the grounds for its rulings, and (ii) introducing a second reading for some of them.

Finally, I'm convinced that the Board's deliberations, both in its committees and its full sessions, would be greatly facilitated if my senior collaborators, the associate directors and heads of divisions, would be present. Obviously, some closed sessions will be needed, but except for those, the presence of the full management team would be extremely useful.

RE:jc

26.4.88

Table I

SECONDED STAFF AS OF MAY 1988

Sl. No.	Name	Nationality	Status*	Position	Start Date	End Date	Funding Status Core (C)/Project(P)
1.	Bingnan, Dr. Fu	China	TA(DA)	Visiting Scientist	11.04.88	Jan. 1989	-
2.	Bennish, Dr. Michael	U.S.A.	DS(R)	International Research Associate	31.10.88	Open	P
3.	Briend, Dr. Andre	France	TA(DA)	Scientist	29.12.83	Open	P
4.	Ciznar, Dr. Ivan	Czechoslovakia	LA(C)	Senior Scientist	01.01.84	31.12.89	C
5.	Eeckels, Prof.Roger	Belgium	LA(C)	Director	01.04.85	31.03.88	C
6.	Felsenstein,Dr. A.	Belgium	TA(DA)	Biologist	01.04.87	30.04.89	-
7.	Hall, Dr. Andrew	U.K.	LA(FSS)	Visiting Scientist	09.05.84	28.02.89	-
8.	Henning, Dr. Beth	Canada	TA(DA)	Visiting Scientist	04.01.88	03.10.88	-
9.	Hlady, Dr. Gary	U.S.A.	DS(R)	International Research Associate	14.08.87	13.08.89	P
10.	Kay, Dr. Brad	U.S.A.	LA(PI)	Microbiologist	01.08.84	30.06.88	P
11.	Koenig, Dr. Michael	U.S.A.	TA(DA/I)	Scientist	17.02.84	Open	-
12.	Kofoed, Dr.Foul Eric	Denmark	TA(DA)	Head,Child Health Programme	29.11.87	28.11.89	-
13.	Lenders, Dr. Carine	Belgium	TA(DA)	Physician	31.05.87	30.5.89	-

Sl. No.	Name	Nationality	Status*	Position	Start Date	End Date	Funding Status Core (C)/Project(P)
14.	McElrath, Mr. Thomas	U.S.A.	TA(DA/I)	Fellow	11.04.88	Jan.1989	P
15.	Nerad, Dr. Judith	U.S.A.	DS(R)	Research Fellow	07.01.88	June 1988	P
16.	Patterson, Dr.David	U.S.A.	TA(DA)	Demographer	22.09.87	21.09.89	-
17.	Ronsman, Dr. Carine	Belgium	TA(DA)	Physician	30.08.87	29.08.89	-
18.	Schultz, Ms.Constance	Netherlands	TA(DA)	Fellow	10.10.87	09.10.88	P
19.	Silimperi, Ms. Diana	U.S.A.	DS(NR)	Project Director,UVP	20.04.87	19.04.90	P
20.	Sorensen, Ms. Nina	Denmark	TA(DA)	Teaching Coordinator	05.03.88	04.03.90	P
21.	Stewart, Dr. Kate	U.S.A.	TA(DA)	Fellow	Jan. 1988	--	P
22.	Thilsted,Ms.Sakuntala	Denmark	TA(DA)	Nutrition Coordinator	05.03.88	04.03.90	P
23.	Van Loon, Dr. F.	Netherlands	TA(DA)	Gastro-Enterologist	24.07.84	31.07.89	-
24.	Wai, Dr.Lokky	Canada	TA(DA/C)	Demographer	15.04.88	14.04.89	P
25.	Zeitlyn, Dr.Shushila	U.K.	TA(DA)	Int'l Res. Associate	Jan. 1988	Open	P

*TA = Technical Assistance; (DA) = paid by donor agency; (DA/C) = paid by donor agency via Centre; (DA/I) = paid by donor agency via other Institution; DS = Deputed Staff; (R) = Reimbursable; (NR) = Non-reimbursable; LA = Leave of Absence; (C) = Paid by Centre; PI = Paid by Centre through Institution; (FSS) = Full Salary Support.

Table II

COMPARATIVE STATUS OF SECONDED STAFF BETWEEN DECEMBER 1985 AND MAY 1988

Summary

December 1985		May 1988
Leave of absence	4	4 *
Technical assistance	12	17 **
Deputed staff	-	4
Total	16	25
Names appear in the Table II.a		Names appear in the Table I

* To be reduced by 2 (Dr. Ciznar, Dr. Kay)
** To be increased by 5 (WUSC & JICA)

COMPARATIVE STATUS OF SECONDED STAFF BETWEEN DECEMBER 1985 AND MAY 1988

Summary

December 1985		May 1988
Leave of absence	4	4
Technical assistance	12	17
Deputed staff	-	4
Total	**16**	**25**
Names appear in the Table II.a		Names appear in the Table I

Table II.a

SECONDED STAFF AS OF DECEMBER 1985

	Name	Nationality	Position	Start date	End Date	Funded by
1.	Banerjee, Mr. Ranjan	Canada TA(DA)*	Computer Analyst, CSRWG	01.09.84	30.08.86	WUSC
2.	Briend, Mr. Andre	France TA(DA)	Scientist, Nutrition	01/84	open	ORSTOM
3.	Chibba, Mr. Michael	Canada TA(DA)	Health Economist, CSRWG	16.09.84	15.09.86	WUSC
4.	Hurrell, Ms. M.	Canada TA(DA)	Health Educator, CSRWG	16.09.84	15.09.86	WUSC
5.	Kay, Dr. Brad	U S A LA(PI)	Microbiologist	01.08.84	24.06.88	JHU
6.	Koenig, Dr. Michael	U S A TA(DA/I)	Project Head, MCH-FP	01.07.85	Open	Pop Council
7.	Moonens, Ms. Francoise	Belgium TA(DA)	Research Physician,CSRWG	24.02.85	23.02.87	BADC
8.	Rahman, Dr. M.	Canada TA(DA)	Computer Statistician, CSRWG	01.09.84	30.08.86	WUSC
9.	Sack, Dr. D.	U S A LA(PI)	Senior Scientist	01.07.84	30.06.87	JHU
10.	Van Loon, Dr. F.	Netherlands TA(DA)	Gastro-Enterologist,PTWG	24.07.84	23.07.86	WOTR
11.	Vesters, Ms. Isabella	Belgium TA(DA)	Nurse Physician's Asstt. PTWG	30.03.81	30.06.86	BADC
12.	Wroot, Mrs. Brenda	Canada TA(DA)	Health Educator, TE&C	16.09.84	15.09.86	WUSC
13.	Wroot, Mr. Richard	Canada TA(DA)	Materials Developer, TE&C	16.09.84	15.09.86	WUSC
14.	Ciznar, Dr. Ivan	Czechoslovakia LA(C)	Senior Scientist	01.01.84	31.12.89	USAID Cooperative
15.	Eeckels, Prof. Roger	Belgium LA(C)	Director	01.04.85	31.03.88	ICDDR,B
16.	Janssen, Mr. A.N. Hartley	Canada TA(DA)*	Chief Finance Officer	01.04.85	30.06.87	WUSC

* Partial salary support

7/BT/MAY 88

FINANCE COMMITTEE REPORT

REPORT OF THE FINANCE COMMITTEE MEETING OF THE BOARD OF TRUSTEES HELD ON MAY 30, 1988

Members Present:	Mr M K Anwar
	Prof D Bell, Ex-Officio (Chairman of the Board
	Prof R Feachem, Chairman, Finance Committee
	Dr P Sumbung
	Dr K A Monsur
	Dr M Merson
	Prof H Tanaka
Members Absent	Dr R Eeckels
Invited Staff	Mr M R Bashir
	Mr M A Mahbub
	Mr R Khalili
	Ms L Saldanha

1. Approval of the Agenda

   The Agenda was approved.

2. Approval of the Minutes

   It was felt that the two sections, Minutes and Report, were not necessary. The Minutes were approved.

3. 1987 Financial Report

3.1. Auditors' Report

The Audited Statements and the Auditors' Report for the year ending December 31, 1987, were received. The Committee recommends acceptance of these by the Board. The comments by the auditors, and the Centre's responses, were noted. The Committee considered that the number of critical comments in the Auditors' Report were too numerous for comfort, especially in the area of Stores and Spares. The Committee urged the management to continue its efforts to rectify these deficiencies and not to lose site of the detailed points made by the Auditors.

3.2. Income and Expenditure, 1987

Income and Expenditure data for 1987 are shown in tables 1 and 2. A surplus for 1987 of $1.07 million was achieved before depreciation. Allowing for depreciation at $0.95 million reduces this surplus to $121,000. The Committee warmly welcomed this financial outcome for the year. The surplus was increased over that anticipated at the November 1987 meeting of the Board due to a combination of delays in recruitment, additional contributions from Belgium, Japan and Switzerland, and an increase in the recovery of indirect costs.

3.3 Overdraft, 1987

The overdraft touched $2 million at mid-year but declined to a positive balance of $0.7 million (excluding reserve funds) by the end of the year. This result must be seen in the light of the following:

(i)	funds received for expenditures not yet incurred	$2.2 million
(ii)	expenditures incurred but not yet reimbursed	$0.8 million

If these temporal artifacts were removed the Centre would have ended 1987 with an overdraft of $0.7 million ($0.7 million - $2.2 million + $0.8 million).

The declining overdraft, caused largely by the receipt of funds ahead of expenditure, has had a positive impact on debt servicing commitments. Interest paid on bank overdrafts since 1984 is shown below:

1984	$162,000
1985	$285,000
1986	$240,000
1987	$ 70,000

3.4 Accumulated Deficit

The accumulated deficit (excluding depreciation) was $2.7 million at the start of 1987. This has reduced to $1.6 million by the end of the year, the difference being the size of the 1987 surplus ($1.1 million).

While the Committee welcomed the decline in the accumulated deficit, the level remains too high. the achievement of cash surpluses in 1988 and beyond remains the only method at our disposal by which the deficit may be further reduced.

4. 1988 Budget

4.1. Contributions from Donors, 1988

Anticipated contributions from donors in 1988 are shown in Annex A. A total of 18 donors are expected to contribute $10.4 million. This compares with contributions of $10.1 million from 21 donors in 1987.

The Committee noted that full and correct presentation of contributions in kind is important, could still be improved, and needed further development.

The Committee returned to its concern about the proportion of total contributions coming from the single major donor. This proportion was 46% in 1987. The projected proportion for 1988 is 44%. The Committee reiterated its opinion that it would be prudent to move towards a situation in which not more than 30% of total contributions come from any single donor. The Committee welcomed the steps being taken to interest new Donors, such as Finland and Italy in the work of the Centre.

4.2 Income and Expenditure, 1988

Income and Expenditure budget figures for 1988 are shown in Tables 1 and 2, in comparison with figures for 1987.

The surplus (before depreciation) is shown as $450,000. However, this surplus is threatened by several recent events, and by decisions that may be taken at this meeting of the Board. These will create additional expenditures from central funds as follows:

(i) supervision of Matlab hospital construction $60,000

(ii) salary increase to NO & GS staff $282,000

(iii) international Post Adjustment $ 6,000

The Committee recommends that a surplus of $500,000 be achieved in 1988, notwithstanding these additional expenditures.

The Committee discussed at length, and expressed concern regarding the increase in budget from $8.7 million in 1987 to $12.0 million in 1988 (Table 1) - a 38% increase. More specifically, the Committee was concerned by the increase in expenditure for local salaries from $3.7 million to $5.7 million, a 54% increase.

The Committee recommends acceptance of the 1988 budget while recognizing that it is probably unrealistically

high. The Committee requests that a revised and more realistic 1988 budget be prepared in June, in good time for submission to the Donors' Consortium meeting. This should be accompanied by a clear statement of the reasons for the increase from 1987. The revised budget should show a surplus of at least $500,000.

4.3. Overdraft, 1988

The projected overdraft situations during 1988 is shown in table 3. During the year there is a fluctuation between a maximum positive balance of $0.8 million and a maximum overdraft of $0.5 million.

5. Donors' Consortium Papers

5.1 Introduction

The Committee noted that little progress has been made, since the last Board meeting, in the preparation of the documents which were requested and discussed at that Board meeting. This is a matter of considerable concern. The whole Board will not meet again before the Donors' Consortium in November, 1988. It is of the utmost importance that high quality documents be prepared by the Centre and that at least some members of the Board have the opportunity to contribute to them before they are finalised and presented to the donors. A mechanism to permit this needs to be agreed by the Board.

5.2 Programme-based Budget

The Committee welcomed the initial structure for a programme-based budget shown in tables 4 and 5. This structure was drafted at the Board meeting in bangkok in November, 1987. It is now necessary that the Director and Associate Directors improve it in order that it can form a basis for the presentation of both the programme and the programme-based budget. The Committee offered the following suggestions for improvement of the structure:

(i) the heading "clinical research" needs sub-sections;

(ii) the heading "microbiology and immunology" needs sub-sections in addition to "environmental microbiology;

(iii) the sub-sections under "population studies" need further thought. The impression given is that large amounts of surveillance lead to very small amounts of research;

(iv) special attention needs to be given to the cross-cutting research initiatives on shigellosis and persistent diarrhoea. One possibility is to include these as sub-sections in 2 or 3 different sections. Another is to create special sections for these programmes.

Once the structure has been decided, it is necessary to construct the programme statement around it. Each section and sub-section needs a paragraph of explanatory text which will state the history of the activity, where it is now, and where it is going and why.

5.3 The 1989 Budget

Tables 4 and 5 show a preliminary 1989 budget. The Committee rejected this because it is based on nothing more than a 15% increase on all items in the 1988 budget. It is necessary to develop a 1989 budget which is based on intended developments of each of the activities named in section and sub-section headings. The Committee recommends that, bearing in mind that the total 1988 budget is likely to be around $10 million, the 1989 budget total should be in the region of $11 to $11.5 million.

5.4 50/50 Funding Principle

The Committee reiterated the importance of making progress towards the clarification and implementation of the 50/50 funding principle. After lengthy discussions the following was resolved:

(i) that a clear statement of the nature and operation of the principle should be prepared, reviewed and finalised in time for the Donors' Consortium meeting.

(ii) that a report be produced which summarizes the level of agreement already achieved on the principle with each of the Centre's donors.

6. UNROB Loan

A new request has been made to the Government of Bangladesh to convert the UNROB loan to a grant. There is nothing further to report.

7. Banking Arrangements

The Committee reviewed a background paper on the banking arrangements. The Centre's banking is currently split between the Agrani Bank and the American Express Bank. This does not conform with the letter of the Ordinance which requires banking with "nationalised banks or banks in Bangladesh". Limited progress towards the requirement of the Ordinance has been made. The Committee resolved that this should continue with the objective of coming fully into compliance with the Ordinance at the earliest possible time.

8. Reserve Fund

The Reserve Fund stands at $1.6 million including $0.5 million contributed by the Ford Foundation. Some of these deposits have been moved in order to increase the rate of interest. The entire Reserve Fund is banked with American Express and is security for the

overdraft facility. The new arrangements have produced a spread of interest between the deposits and the borrowing of about 1%, as requested at the November, 1987 Board meeting.

9. Local Salaries

The Committee recommends that the remaining 2/3 of the UN salary increase (Revision 12), which was implemented by the UN agencies effective August 1, 1986, be granted from July 1, 1988, to all NO and GS level staff. The estimated cost of this measure to central funds will be $282,000 in 1988 (see para 4.2).

10. Pension Fund Contributions

The UN has recently uncreased the employees pension fund contribution to 14.8%. ICDDR,B currently pays 14.0%. The Committee recommemds that no action be taken at this time and the matter be discussed at the November Board meeting.

11. International Post Adjustment

The UN has recently increased the post adjustment factor for Dhaka to +3. The Committee recommends that this be implemented from July 1, 1988 at a cost to central funds of $6,000 in 1988 (see para 4.2).

12. Approval of Research Projects

The Committee decided to pass this issue back to Centre management and scientists. If the management and the scientists perceive a problem they should make specific recommendations to the Programme Committee in November. The Committee considered that comment and approval by the finance office must be an essential factor of any approval procedure.

13. Appointment of Auditors

It was agreed that Price Waterhouse, Calcutta, and Hoda Vasi Chowdhury and Co., Dhaka, be appointed joint auditor for the year 1988 at a fee not exceeding $10,000.

14. Consultancy Services

The Committee recommends approval of consultancy services in the field of financial administration, to be paid for out of earmarked funds ($153,000) within the USAID Agreement on the Urban Volunteer Programme.

15. Documentation for the Finance Committee

Further improvements in the documentation provided to the Finance Committee is necessary. The required features, currently lacking, are:

(i) a logical order of presentation, as, for example,

in this report;

(ii) better synthesis and distillation of the key issues, facts and decision points.

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TABLE 1

INCOME AND EXPENDITURE FOR 1987 & 1988

	Actual 1987	Budget 1988
A. Income	(In thousand US Dollars)	
Central Funds	1,611	1,899
Project Funds (Direct Cost)	6,088	8,438
Project Funds (Indirect Cost)	1,099	1,100
Total Income	8,798	11,437
B. Expenditure		
Local salaries	3,718	5,665
Inter'l salaries	1,233	1,789
Consultants	368	372
Mandatory committees	99	82
Travel	357	461
Supply and materials	1,107	1,111
Other contractual services	890	1,052
Interdepartmental services	1,229	1,670
Depreciation	953	1,000
Total Operating	9,954	13,202
Less: Recovery	1,656	1,670
Net Operating	8,298	11,532
Add: Capital expenditure	379	455
Total Expenditure	8,677	11,987
C. Surplus/--deficit	121	-550

TABLE 2

INCOME AND EXPENDITURE FOR 1987 & 1988

	Actual 1987			Budget 1988		
	(In thousand US Dollars)					
	CENTRAL	PROJ.	TOTAL	CENTRAL	PROJ.	TOTAL
A. Income						
Central Funds	1,611		1,611	1,899		1,899
Project Funds(Direct Cost)	907	5,181	6,088	650	7,788	8,438
Project Funds (Indirect)	1,099		1,099	1,100		1,100
Total Income	3,617	5,181	8,798	3,649	7,788	11,437
B. Expenditure						
Local salaries	1,756	1,962	3,718	2,526	3,140	5,665
Inter'l salaries	419	814	1,233	437	1,352	1,789
Consultants	82	286	368	21	350	372
Mandatory committees	98	1	99	82	0	82
Travel	68	289	357	44	417	461
Supply and materials	670	437	1,107	559	552	1,111
Other contractual services	501	389	890	498	554	1,052
Interdepartmental services	503	726	1,229	553	1,117	1,670
Depreciation	953		953	1,000		1,000
Total Operating	5,050	4,904	9,954	5,720	7,482	13,202
Less: Recovery	1,652	4	1,656	1,670		1,670
Net Operating	3,398	4,900	8,298	4,050	7,482	11,532
Add: Capital expenditure	98	281	379	149	306	455
Total Expenditure	3,496	5,181	8,677	4,199	7,788	11,987
C. Surplus/-deficit	121	0	121	-550	0	-550

TABLE 3

MONTHLY CASH FLOW 1988

(In thousand US Dollars)

	Receipts	Payments	Balance
Opening bank balance as at January 1, 1988			742
January	108	419	431
February	939	926	444
March	258	954	(252)
April	1,320	750	318
May	50	797	(429)
June	1,665	872	364
July	378	822	(79)
August	430	803	(452)
September	1,284	992	(160)
October	1,010	847	3
November	1,073	907	169
December	1,493	832	830
	10,009	9,921	
Closing bank balance as at December 31, 1988			830

TABLE 4

PROGRAMMEWISE EXPENDITURE FOR 1988-92
(in thousands of U.S. Dollars)

PROGRAMME AREAS	1988	1989	1990	1991	1992
1. CLINICAL RESEARCH	672	773	889	1,022	1,176
2. MICROBIOLOGY AND IMMUNOLOGY	634	729	838	964	1,109
3. EPIDEMIOLOGY AND DISEASE PREVENTION	1,651	1,899	2,183	2,511	2,888
4. POPULATION STUDIES	813	935	1,075	1,236	1,422
5. HEALTH CARE SYSTEMS RESEARCH	3,202	3,682	4,235	4,870	5,600
6. HEALTH CARE SERVICES	1,613	1,855	2,133	2,453	2,821
7. TRAINING AND EXCHANGES	852	980	1,127	1,296	1,490
8. MANAGEMENT AND SUPPORT SERVICES	1,550	1,783	2,050	2,357	2,711
TOTAL -	10,987	12,636	14,530	16,709	19,217

TABLE 5

PROGRAMMEWISE EXPENDITURE FOR 1988-92
(in thousands of U.S. Dollars)

	GRAMME REAS	1988	1989	1990	1991	1992
1.	CLINICAL RESEARCH	672	773	889	1,022	1,176
2.	MICROBIOLOGY AND IMMUNOLOGY	634	729	838	964	1,109
	Environmental Microbiology	65	75	86	99	114
3.	EPIDEMIOLOGY AND DISEASE PREVENTION	1,651	1,899	2,183	2,511	2,888
	Vaccine Trial	756	-	-	-	-
4.	POPULATION STUDIES	813	935	1,075	1,236	1,422
	Demographic Surveillance	805	926	1,065	1,224	1,408
	Demographic Research	8	9	10	12	14
5.	HEALTH CARE SYSTEMS RESEARCH	3,202	3,682	4,235	4,870	5,600
	UVP	832	957	1,100	1,265	1,455
	MCH-FP Ext.	1,257	1,445	1,662	1,912	2,198
	MCH-FP	644	740	851	979	1,125
	Child Health Programme	237	273	313	360	415
	ORT Implementation	130	150	172	198	227
6.	HEALTH CARE SERVICES	1,613	1,855	2,133	2,453	2,821
	Dhaka Treatment Centre	1,021	1,174	1,350	1,553	1,786
	Matlab Treatment Centre	453	521	599	689	792
	Teknaf Treatment Centre	139	160	184	211	243
7.	TRAINING AND EXCHANGES	852	980	1,127	1,296	1,490
	Courses - Bangladesh	45	52	60	68	79
	Professional training	252	290	333	383	441
	- trainers					
	- research					
	- post doctoral					
	Technical Cooperation	301	346	398	458	526
	DISC	141	162	186	214	247
	Library, Publication & Illustration	113	130	149	172	198
8.	MANAGEMENT AND SUPPORT SERVICES	1,550	1,783	2,050	2,357	2,711
	Central Scientific Management - Director	284	327	376	432	497
	Support Services - Administration, Finance & Personnel	1,005	1,156	1,329	1,528	1,758
	- Resources Development	194	223	257	295	339
	TOTAL -	10,987	12,636	14,530	16,709	19,217

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ANNEXURE-A

RESOURCES DEVELOPMENT REPORT
BOARD OF TRUSTEES MEETINGS, MAY '88

ICDDR,B DONORS 1988 PROJECTIONS
(In US dollars)

A. Unrestricted-Core

Donors	Committed	Estimated	Total
1. Australia/ADAB	180,000	-	180,000
2. Bangladesh	34,000	-	34,000
3. Saudi Arabia	70,000	-	70,000
4. Switzerland	801,000	-	801,000
5. UK/ODA	260,000	-	260,000
6. UNICEF	-	250,000	250,000
7. USAID	275,000	-	275,000
SUB-TOTAL	1,620,000	250,000	1,870,000

B. Restricted-Core

Donors	Committed	Estimated	Total
1. CIDA/DSS	750,000	-	750,000
2. DANIDA	500,000	-	500,000
3. Japan	310,000	-	310,000
4. UNDP/Cl. Res.	300,000	-	300,000
5. USAID (Wash)	2,100,000	-	2,100,000
6. WUSC:Matlab TC	417,800	-	417,800
SUB-TOTAL	4,377,800	-	4,377,800

1988 PROJECTIONS

C. Restricted-Projects

	Donors	Committed	Estimated	Total
1.	Aga Khan Fndn.	150,000	-	150,000
2.	Belgium	200,000	-	200,000
4.	Ford Foundaiton/ ECPP	200,000	-	200,000
5.	NORAD/MCH	358,000	-	358,000
6.	Saudi Arabia/ Dammam/Riyadh	500,000	-	500,000
7.	Switzerland	-	350,000	350,000
8.	WHO	75,600	-	75,600
9.	World Bank/ Mirzapur	138,000	-	138,000
10.	USAID/MCH-FP Ext.	1,160,000	-	1,160,000
11.	USAID/UVP	750,000	-	750,000
12.	WUSC/MCH	294,500	-	294,500
SUB-TOTAL		3,826,100	350,000	4,176,100

	COMMITTED	ESTIMATED	TOTAL
A.	1,620,000	250,000	1,870,000
B.	4,377,800	-	4,377,800
C.	3,826,100	350,000	4,176,100
GRAND TOTAL :	US$ 9,823,900	600,000	10,423,900

IN-KIND CONTRIBUTION

1.	Bangladesh	$ 1,200,000
2.	Belgium	$
3.	Switzerland	$

RESOURCES DEVELOPMENT REPORT

RESOURCE DEVELOPMENT REPORT

In our report to the Board in November 1987, we had projected the Centre's 1988 income at US$ 10.2 million. This amount was US$ 0.4 million more than the US$ 9.8 million that was projected in June 1987. We are now pleased to inform the Board that ICDDR,B has already received donor commitments in the amount of US$ 9.8 million and hope to receive commitments for another US$ 0.6 million soon. This will bring the total funds available to ICDDR,B in 1988 to US$ 10.4 million.

A review of the various kinds of funds received by ICDDR,B would indicate that, with careful handling of funds and applying strict financial orthodoxy, the Centre should have no particular financial problems in 1988. The following table gives a breakdown of the funds we hope to receive by core, restricted core, projects and the amount of overhead which will become available during 1988.

CORE (A) (In US$)	RESTRICTED CORE (B)	PROJECT (C)	OVERHEAD (D)	(A+D)
1,870,000	4,378,000	4,176,000	1,370,000	3,240,000

The above table shows that a total of US$ 3,240,000 would be available during the year for application towards core

expenditures, provided the Centre can properly manage its funds. Annexure "C" details the calculation of overheads.

We are pleased to report that for 1988 the Resources Development has been able to raise funds that result in a direct increase in the Centres core funds. This new grant, obtained from WUSC, will fund two management positions and the Matlab treatment centre. The main feature of the WUSC grant is that it will pick up project costs that have hitherto been met out of core funds.

A significant feature of the Centre's financial situation during the current reporting period was that there was little need for bank overdrafts. This was achieved through close and constant follow-up of donors by the Resources Development Division, resulting in an improved cash-flow. It is expected that given the current level of donor follow-up and co-operation, and with proper financial controls at the Centre, it is unlikely that there will be any need for important bank overdrafts in the near future.

Following is a brief report on the status of the ICDDR,B donors during the first half of 1988:

CORE

Donors to the Centre's core fund, namely, Australia, Bangladesh, Saudi Arabia, Switzerland and the United Kingdom have continued their support in 1988. We expect UNICEF to renew their grant this year and have requested UNICEF to confirm their

commitment which we hope to receive in early June. USAID, under the 5-year Co-operative agreement is committed to support the Centre's core fund. The annual agreement for 1988 is expected to be signed shortly.

RESTRICTED CORE

The World University Service of Canada (WUSC) has announced a major multi-year grant to the Centre. WUSC, which had earlier provided the Centre with personnel support, has given a grant in the amount of US$ 418,000 for the Matlab treatment centre, as reported earlier.

USAID/Washington had made a commitment of US$ 2,300,000 for restricted core activities which included US$ 200,000 for collaboration with the Gamble Corporation. USAID has now deferred its payment for the Gamble collaboration until 1989, therefore, the USAID contribution to the restricted core fund, which includes Targeted Research, Project Development Fund and an epidemiologist, now stands at US$ 2,100,000.

We have requested UNDP to continue their annual contribution of US$ 300,000 for Clinical Research activities in 1988 and we hope that an agreement to this effect will be finalised soon.

CIDA has extended its support to the DSS for another year, and is expected to lead to a four-year second phase support to the project.

Japan and DANIDA have continued their support to the Centre in 1988.

RESTRICTED

The Aga Khan Foundation has continued its partial support to the Centre's collaborative activities in China and has given a new grant for the Centre's technical assistance programme in Kenya. Belgium is giving financial support at a somewhat increased level this year. The Ford Foundation, NORAD, Saudi Arabia, World Health Organisation, World Bank, and USAID/Dhaka have also continued their support to the Centre's project activities.

WUSC, as already reported earlier, has become a new donor to the Centre. WUSC has extended its support to the Centre's MCH activities in Matlab.

Negotiations are also in advanced stages for SDC funds for the ICDDR,B Staff Development Programme and the Library and Publications Branch. Both of these activities were to date mostly funded out of the Centre's core fund.

Under the Co-operative agreement signed between ICDDR,B and USAID/Dhaka for the latter's financial assistance to the Urban Volunteer Project, an additional amount of US$ 500,000, channelled through USAID/Washington and ADDR, was committed for technical assistance and secondment of personnel from the Johns Hopkins University. This arrangement has, however, led to

financial loss to the Centre. An agreement has also been reached for scientific collaboration and secondment of staff with the Tufts University.

Details of the Centre's projected income in 1988 is provided in Annexure "A."

Attention needs to be drawn to an alarming situation in the Centre's fund flow status where, due to the shortfall in the expenditure, mainly in the Targeted Research and Project Development Fund (USAID/W), the UVP and the MCH-FP Extension projects, an amount of approximately US$ 2,000,000 will have to be carried over from 1987 to 1988. This will adversely affect donor disbursement and in turn the Centre's cash flow. Financial management, especially budget control, must further improve to avoid major over/under expenditures for the sake of maintaining the current favourable cash flow situation.

UNROB Loan

As directed by the Board in its last meeting, a new request has been made to the Government of Bangladesh to convert the UNROB loan into a grant.

Donors' Meeting

The initial invitation letter for the next Donors' Meeting has already been sent out and the formal letter of invitation along with relevant documents will be sent out after the meeting of the Board of Trustees.

Capital Development

The UNCDF grant for construction of the Matlab treatment centre was revised to accommodate the increase in construction costs. The total grant amount approved by UNCDF is US$ 809,000, an increase of US$ 117,000 over the original grant. This increase was necessitated by design amendments requested by UNCDF and by inflation. The construction work has now begun and is expected to be completed towards the middle of next year.

IN KIND SUPPORT

The Host Country of the ICDDR,B, the People's Republic of Bangladesh continues to be a major donor to the Centre and will provide the Centre with "in kind" support in the amount of approximately US$ 1.2 million during 1988. This amount represents the rent, taxes and utilities which will not be charged by the Host Country.

The Belgian Administration for Development Cooperation has continued to provide the Centre with the services of three scientists and additional "in kind" support is expected from them during the year.

The Centre has also received scientific personnel on secondment from DANIDA.

1989 INCOME PROJECTIONS

The Centre's income projections for 1989 are provided in the Annexure "B" appended to this report. The total amount expected

to be raised for 1989 is US$ 10,016,000. It should be noted that these figures are very tentative, and are subject to changes during the course of the year.

ANNEXURE-A

7(a)/BT/May 88

RESOURCES DEVELOPMENT REPORT
BOARD OF TRUSTEES MEETINGS, MAY '88

ICDDR,B DONORS 1988 PROJECTIONS
(In US dollars)

A. Unrestricted-Core

Donors	Committed	Estimated	Total
1. Australia/ADAB	180,000	-	180,000
2. Bangladesh	34,000	-	34,000
3. Saudi Arabia	70,000	-	70,000
4. Switzerland	801,000	-	801,000
5. UK/ODA	260,000	-	260,000
6. UNICEF	-	250,000	250,000
7. USAID	275,000	-	275,000
SUB-TOTAL	1,620,000	250,000	1,870,000

B. Restricted-Core

Donors	Committed	Estimated	Total
1. CIDA/DSS	750,000	-	750,000
2. DANIDA	500,000	-	500,000
3. Japan	310,000	-	310,000
4. UNDP/Cl. Res.	300,000	-	300,000
5. USAID (Wash)	2,100,000	-	2,100,000
6. WUSC:Matlab TC	417,800	-	417,800
SUB-TOTAL	4,377,800	-	4,377,800

1988 PROJECTIONS

C. Restricted-Projects

	Donors	Committed	Estimated	Total
1.	Aga Khan Fndn.	150,000	-	150,000
2.	Belgium	200,000	-	200,000
4.	Ford Foundaiton/ ECPP	200,000	-	200,000
5.	NORAD/MCH	358,000	-	358,000
6.	Saudi Arabia/ Dammam/Riyadh	500,000	-	500,000
7.	Switzerland	-	350,000	350,000
8.	WHO	75,600	-	75,600
9.	World Bank/ Mirzapur	138,000	-	138,000
10.	USAID/MCH-FP Ext.	1,160,000	-	1,160,000
11.	USAID/UVP	750,000	-	750,000
12.	WUSC/MCH	294,500	-	294,500
SUB-TOTAL		3,826,100	350,000	4,176,100

	COMMITTED	ESTIMATED	TOTAL
A.	1,620,000	250,000	1,870,000
B.	4,377,800	-	4,377,800
C.	3,826,100	350,000	4,176,100
GRAND TOTAL :	US$ 9,823,900	600,000	10,423,900

IN-KIND CONTRIBUTION

1.	Bangladesh	$ 1,200,000
2.	Belgium	$
3.	Switzerland	$

ANNEXURE-B

7(a)/BT/May 88

ICDDR,B DONORS 1989 PROJECTIONS
(In US dollars)

A. Unrestricted-Core

Donors	Committed	Estimated	Total
1. Australia/ADAB	-	180,000	180,000
2. Bangladesh	-	34,000	34,000
3. Saudi Arabia	-	70,000	70,000
4. Switzerland	-	801,000	801,000
5. UK/ODA	-	260,000	260,000
6. UNICEF	-	250,000	250,000
7. USAID	300,000	-	300,000
SUB-TOTAL	300,000	1,595,000	1,895,000

B. Restricted-Core

Donors	Committed	Estimated	Total
1. CIDA/DSS	-	850,000	850,000
2. DANIDA	550,000	-	550,000
3. Japan	-	310,000	310,000
4. UNDP/Cl. Res.		300,000	300,000
5. USAID (Wash)	2,200,000	-	2,200,000
6. WUSC:Matlab TC	434,500	-	434,500
SUB-TOTAL	3,184,500	1,460,000	4,644,500

1989 PROJECTIONS

C. Restricted-Projects

	Donors	Committed	Estimated	Total
1.	Aga Khan Fndn. /China/Kenya	115,000	-	115,000
2.	Belgium	-	200,000	200,000
4.	Ford Foundaiton/ ECPP		0	0
5.	NORAD/MCH		0	0
6.	Saudi Arabia/ Dammam/Riyadh	-	525,000	525,000
7.	Switzerland	-	350,000	350,000
8.	WHO	-	70,000	70,000
9.	World Bank/ Mirzapur		0	0
10.	USAID/MCH-FP Ext.	1,160,000	-	1,160,000
11.	USAID/UVP	750,000	-	750,000
12.	WUSC/MCH	306,500	-	306,500
SUB-TOTAL		2,331,500	1,145,000	3,476,500

	COMMITTED	ESTIMATED	TOTAL
A.	300,000	1,595,000	1,895,000
B.	3,184,500	1,460,000	4,644,500
C.	2,331,500	1,145,000	3,476,500
GRAND TOTAL :	US$ 5,816,000	4,200,000	10,016,000

RESOURCES DEVELOPMENT 1988 OVERHEAD REPORT

Donors	Grant Amount	Overhead %	Amount
Restricted-Core			
CIDA/DSS	750,000	25	150,000
DANIDA	500,000	16	69,000
Japan	310,000	31	73,000
UNDP/Cl. Res.	300,000	none	
USAID/Wash.	2,100,000	31	320,000
WUSC:Matlab TC	417,800	25	84,000
SUB-TOTAL	4,377,800		696,000

Donors	Grant Amount	Overhead %	Amount
Restricted-Projects			
Aga Khan Foundation	150,000	31	35,000
Belgium	200,000	none	
Ford Foundation/ECPP	200,000	none	
NORAD/MCH	358,000	31	85,000
Saudi Arabia/Dammam/ Riyadh	500,000	17	73,000
WHO	75,600	none	
World Bank/Mirzapur	138,000	31	33,000
USAID/MCH-FP Ext.	1,160,000	26	239,000
USAID/UVP	750,000	25	150,000
WUSC/MCH	294,500	12.5	59,000
SUB-TOTAL	3,826,100		674,000
TOTALS	8,203,900		1,370,000

APPROVAL OF 1989 BUDGET

Approval of 1989 Budget

Preliminary budget for 1989 presented in the Table 1 & 2 has been drawn on the basis of following assumptions:

a) 15% increase on all heads of expenditure

b) existing core employees who are assigned to the various projects will continue to be funded from projects.

Any suggestion or comment from the Board will be taken into account while preparing a detailed budget for 1989.

TABLE 1

INCOME AND EXPENDITURE BUDGET FOR 1988 & 1989

		Budget 1988	Budget* 1989
A.	**Income**	(In thousand US Dollars)	
	Central Funds	1,899	1,894
	Project Funds (Direct Cost)**	8,438	9,608
	Project Funds (Indirect Cost)	1,100	1,265
Total	Income	11,437	12,767
B.	**Expenditure**		
	Local salaries	5,665	6,516
	Inter'l salaries	1,789	2,057
	Consultants	372	427
	Mandatory committees	82	94
	Travel	461	530
	Supply and materials	1,111	1,278
	Other contractual services	1,052	1,210
	Interdepartmental services	1,670	1,921
	Depreciation	1,000	1,000
Total	Operating	13,202	15,083
	Less:Recovery	1,670	1,920
Net	Operating	11,532	13,113
	Add:Capital expenditure	455	523
Total	Expenditure	11,987	13,636
C.	**Surplus/-deficit**	-550	-869

* Preliminary

** Income projected on accrual basis taking into account carry over from previous year and receipts during the year.

TABLE 2

INCOME AND EXPENDITURE BUDGET FOR 1988 & 1989

		Budget 1988			Budget 1989 *		
A.	Income	(In thousand US Dollars)					
		CENTRAL	PROJ.	TOTAL	CENTRAL	PROJ.	TOTAL
	Central Funds	1,899		1,899	1,894		1,894
	Project Funds(Direct Cost)**	650	7,788	8,438	650	8,958	9,608
	Project Funds (Indirect)	1,100		1,100	1,265		1,265
Total	Income	3,649	7,788	11,437	3,809	8,958	12,767
B.	Expenditure						
	Local salaries	2,526	3,140	5,665	2,905	3,611	6,516
	Inter'l salaries	437	1,352	1,789	502	1,555	2,057
	Consultants	21	350	372	24	403	427
	Mandatory committees	82	0	82	94		94
	Travel	44	417	461	50	480	530
	Supply and materials	559	552	1,111	643	635	1,278
	Other contractual services	498	554	1,052	573	637	1,210
	Interdepartmental services	553	1,117	1,670	636	1,285	1,921
	Depreciation	1,000		1,000	1,000		1,000
Total	Operating	5,720	7,482	13,202	7,427	8,606	15,033
	Less:Recovery	1,670		1,670	1,920		1,920
Net	Operating	4,050	7,482	11,532	5,507	8,606	13,113
	Add:Capital expenditure	149	306	455	171	352	523
Total	Expenditure	4,199	7,788	11,987	5,678	8,958	13,636
C.	Surplus/-deficit	-550	0	-550	-869	0	-869

* Preliminary

** Income projected on accrual basis taking into account carry over from previous year and receipts during this year.

UNROB LOAN

UNROB LOAN

As directed by the Board in its last meeting, a new request has been made to the Government of Bangladesh to convert the UNROB loan into a grant.

Mr Manzoor ul Karim promised his support but to date no reply has been received.

15.5.88

RESERVE FUND

RESERVE FUND

Balance as on 31st December, 1987 stands at US$1,552,920. In order to obtain higher interest rate we have recently transferred our deposits with American Express from Singapore to Dhaka. This will earn an interest rate of 7% (slightly higher than Singapore). Since the entire fund is under lien to American Express against overdraft, at the moment investment with a Bank other than the American Express Bank is not possible. However, on liquidation of overdraft, investment opportunities which can earn higher return will be explored for earning higher rate of return.

PROTOCOL APPROVAL AND FUNDING PROCEDURES.

Approval of Research Projects, Negotiations with Donors for Funding of Protocols and other Related Matters

1. Background

1.1 Two Board's resolutions should be quoted here

* Resolution 7/June 87

"The Board requests the Management to present to the Finance Committee at its November, 1987 meeting the relevant (sic) rules and regulations of the Centre relating to the approval of research projects, negotiations with donors for funding of protocols, and other related matters, along with comments of the Director regarding their compliance.".

A memo. was prepared by the Associate Director, Resources Development, and approved by the Council of Associate Directors, chaired by the Director. When presented at the November 1987 Board Meeting, this memo. elicited the following comments

* Board draft minutes November 1987

Protocol Approval and Funding Procedures

"The Board agreed with the recommendation of the Committee that the guidelines on protocol approval and funding prepared at the request of the Board (Resolution 7/June 87) raised several questions and requested that new guidelines be put before the

May/June 1988 Board Meeting. These guidelines should come to the Board through the Finance Committee. They should not over-emphasize the role of the Resources Development Office, should allow more dialogue between scientists and donors (within the rules and procedures), and should be fully discussed and agreed upon by the senior staff at the Centre before submission to the Board.".

1.2 It is of some interest to attach three memoranda issued in 1984, 1986 and 1988 by Dr Greenough, myself and Dr Ciznar (when he was Acting Director), respectively. It should be stressed that they were written independently from each other.

Dr Greenough's memo., though rather vague, refers to "several incidents" that, at the time of writing, must have been in everybody's mind. The two last sentences are germane to the problem at hand.

I think my memo. says rather clearly what it intended to convey. A similar message can be found in the last paragraph of Dr Ciznar's memo.

2. Comments

2.1 The June '87 Resolution

Being a resolution, it clearly deals with an important

subject. Yet, the attentive reader cannot be but puzzled. At least two matters are being dealt with: (i) approval of research projects, and (ii) negotiations with donors for funding of protocols (projects and protocols have not the same meaning at ICDDR,B). The resolution prompts a number of questions, the most important ones being (i) what exactly is meant? (ii) what are the grounds for asking the information?

Instead of submitting a memo. to the November 1987 Board, the management should, I think, have asked for clarification.

2.2 The November '87 Draft Minutes

They only add to the confusion. Only protocols are being mentioned now, and "negotiations with donors" has been dropped. Is it to be understood that the "funding procedures" are those used within the Centre, or is fund raising meant? Apparently the latter is true, but this is not clear. That one should not "over-emphasize the role of the Resources Development (and) should allow more dialogue between scientists and donors" implies grounds or reasons adduced, but they are not spelled out. What are they? Furthermore, what is meant by "the senior staff"? The heads of the scientific divisions or also other researchers and, if so, of what level? Whatever the answer to this, why must the

undefined "senior staff" agree with the guidelines? This implies a power of decision. Though I am personally much in favour of consensus (or are we talking about a kind of majority vote?) I do not know of any bio-medical institution, university department, or similar structure functioning on democratic principles. At ICDDR,B, even the Council of Associate Directors has only an advisory capacity.

Finally, the rather complex matters involved would seem to be of interest mainly to the Scientific Programme Committee, not the Finance Committee. Why did the latter initiate the process?

3. Conclusions

I firmly believe that the ICDDR,B research community has far more profited from the continuing efforts of Resources Development (working hand-in-glove with the Director and the Senior Scientists) than it has been hindered by them.

Approval of protocols is presently too complex a procedure and should be simplified, with a strong input from the researchers. That process has been initiated.

Developing projects and finding funding for them are difficult matters, with many intricacies, different from donor to donor. Only this topic would require a

lengthy position paper.

I ask to be allowed not to elaborate further. Before being able to present a detailed document to the Board, the grounds and the questions asked ought to be formulated in a clear and unambiguous way.

Encl. (3)

RE:jc

4.5.88

INTERNATIONAL CENTRE FOR
DIARRHOEAL DISEASE
RESEARCH, BANGLADESH

Memorandum

TO : All Staff

FROM : Director

DATE : 21st August, 1984.

SUBJECT : RELATIONS WITH ALL COUNTRIES

As an International Centre we are entirely dependant on the goodwill and support of all countries. No country is unimportant. Often our interest in assisting a least developed country leads to support from a donor country or agency.

Each employee of the Centre by his or her attitude or actions will convey to our visitors, guests and staff from other countries a feeling of goodwill and co-operation or something negative. When problems arise which seem insoluble or neglect, they should be discussed and solutions sought.

Several incidents recently have decreased the Centre's prestige in the view of the local international community. I hope in the future we can avoid these difficulties. The Associate Director for Resources Development will be happy to advise any staff member should any questions arise regarding our relation with any country or agency. He is responsible for all donor and participating country contacts and public relations.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

Memorandum

TO : All Scientific Staff

FROM : Director

DATE: 27.3.86

SUBJECT : FUNDING FOR PROTOCOLS

Let me stress again, that BEFORE you approach any embassy, donor agency, pharmaceutical company, etc. for funding for your work, you MUST first consult with the Resources Development Office. This office will assist you and advise you how best to approach the particular organization and may be able to suggest additional organizations to contact.

I would appreciate being kept informed also.

Thank you.

mjc

cc: Mr Bashir
Scientific Associate Directors

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

Ref: Personnel/

Memorandum

TO : All Seconded Staff

FROM : Acting Director

DATE: 21.3.88

SUBJ : POLICY GUIDELINES

Many of you are new to the Centre, so I am circulating this memo. to be sure that you are aware of the Centre's rules regarding seconded staff; and as a reminder to those of you who have been here for some time.

Firstly, all seconded personnel are advised that during the tenure of their secondment to the Centre their loyalty should be to the Centre and that they are to be guided by the ICDDR,B Staff Rules and Regulations (except where particular points are stated otherwise in the individual contracts). All seconded staff are appointed to a Division and all memos., leave forms, etc. should be directed through the Division Head and supervisor (e.g. Departmental Head) as appropriate. If you are not sure which Division you belong to, please contact the Chief Personnel Officer who will advise you.

Secondly, while there are no objections to maintaining contacts with donors, it is necessary that the Resources Development office is informed and particularly subsequent action such as funding proposals, preliminary reporting as well as copies of memos., or direct letters re problems associated with the project should not go to any donor or outside agency without first advising the Resources Development office. This ensures that the Centre speaks with "one voice" and avoids misunderstandings. Also, the Resources Development office may have information of which you are unaware and vice versa so this route assists not only you but the Centre too.

Your assistance and understanding in these matters is greatly appreciated.

IC:jc

cc: Associate Directors
CPO
Director

SELECTION OF TRUSTEES

SELECTION OF TRUSTEES

According to the suggestion last meeting that election procedures commence one year beforehand (June) and, if anyhow possible, finalize the choice at the November meeting, I have listed not only those members whose terms finish at this Board Meeting but also those who will complete their terms in June 1989.

The following notations are used to explain the status of the appointment of certain Trustees:

* Not eligible for reappointment after completion of current term without a break

\+ Please note the following [Ordinance Section 8(6)] "Vacancies in seats of members at large shall be filled by the Board. A member appointed to a vacancy arising from a cause other than the normal expiration of a term shall serve for the remainder of the term of the member being replaced. No member may serve more than two consecutive three-year terms or portion thereof, ...".

Outgoing Board Members June 1988

* Prof. D. Bell
\+ Dr H. Tanaka (completed Dr Takeda's term)
Dr M.H. Merson
Prof. R. Feachem
\+ Prof. V. Ramalingaswami (completed Dr Nyi Nyi & Dr Joseph's term)
\+ Dr K.A. Monsur (completed Maj. Gen. Huq's term)
Prof. R. Eeckels

Outgoing Board Members June 1989

* Dr A.R. AlSweilem
* Dr I. Cornaz
* Prof. D. Rowley
  Dr P. Sumbung
+ Mr T. Rahman (completed Messrs K.G. Rahman, Late S.A. Rahman and Mr Manzoor ul Karim's term)

List of Board Members as at June 1988

	Joined Board	End of Term
Prof. D. Bell	1 July 1982	30 June 1988*
Dr A.R. AlSweilem	1 July 1983	30 June 1989*
Dr I. Cornaz	1 July 1983	30 June 1989*
Prof. D. Rowley	1 July 1983	30 June 1989*
Prof. R. Feachem	1 July 1985	30 June 1988
Dr M.H. Merson (WHO)	1 July 1985	30 June 1988
Prof. R. Eeckels	1 July 1985	30 June 1988
Prof. V. Ramalingaswami (completing Dr Nyi Nyi & Dr Joseph's term - UN)	March 1988	30 June 1988
Dr P. Sumbung	1 July 1986	30 June 1989
Dr D. Habte (completed Dr Sebina's term)	1 July 1986	30 June 1990*
Dr K.A. Monsur (completing Maj.Gen. Huq's term - GOB)	12 Nov 1986	30 June 1988
Mr T. Rahman (completing Mr Karim's term - GOB)	8 June 1987	30 June 1989
Mr M.K. Anwar (completing Mr A.K. Chowdhury's term - GOB)	9 Sept 1987	30 June 1990
Prof. H. Tanaka (completing Prof. Y. Takeda's term)	1 July 1987	30 June 1988
Dr D. Ashley	1 July 1987	30 June 1990
Prof. A. Lindberg	1 July 1987	30 June 1990
Prof. V.I. Mathan	1 July 1987	30 June 1990

Board of Trustees - Terms

3 years from July 1982

Dr Y. Takeda
Prof. D. Bell
Maj. Gen. M.S. Huq
Dr F. Assaad

3 years from July 1983

Dr A.R. AlSweilem
Mr ABM Ghulam Mostafa
(Mr Manzoor ul Karim)
Dr I. Cornaz
Prof. D. Rowley

3 years from July 1984

Mr Munir-uz-Zaman (Mr M.K. Anwar/
Mr A.K. Chowdhury)
Dr D. Sebina (Prof. D. Habte)

3 years then 3 yrs from July 1985

Prof. D. Bell*
Maj. Gen. M.S. Huq (Dr K.A.
Monsur from Nov. 86)

3 years from July 1985

Dr M.H. Merson
Prof. R. Feachem
Dr S. Joseph (Dr Nyi
Nyi from April 86/
Prof. Ramalingaswami
from March 88)
Prof. R. Eeckels

3 years then 3 yrs from July 1986

Dr A.R. AlSweilem*
Mr Manzoor ul Karim (Messrs S.A. &
K.G.Rahman/T. Rahman from June 87)
Dr I. Cornaz*
Prof. D. Rowley*

3 years from July 1986

Dr P. Sumbung

3 years then 3 yrs from July 1987

Mr A.K. Chowdhury (Mr M.K. Anwar
from Sept. 87)
Dr D. Habte* - completed
Dr Sebina's term

3 years from July 1987

Dr D. Ashley
Prof. A. Lindberg
Prof. V.I. Mathan

* unable to compete for another 3-year term without a break
() completing another's term so only eligible for one 3-year term after that

9/BT/MAY 88

ELECTION OF CHAIRMAN OF THE BOARD

ELECTION OF CHAIRMAN OF THE BOARD

Previous Chairmen of the Board are as follows:-

Dr J. Sulianti Saroso	1979-80 and 1980-81
Prof. M.A. Matin	1981-82
Prof. D.J. Bradley	1982-83
Prof. J. Kostrzewski	1983-84
Dr I. Cornaz	1984-85
Prof. D. Bell	1985-86, 1986-87 and 1987-88

MEMBERSHIP OF COMMITTEE OF BOARD

MEMBERSHIP OF COMMITTEES OF BOARD

As per resolutions 24, 25 and 26/June 87, the present (1 July, 1987 to 30 June, 1988) membership of the Committees is as listed below. The Chairman of the Board and Director of the Centre are both ex officio members of all Committees.

Personnel & Selection Committee

Prof. D. Bell
Prof. R. Eeckels
Dr I. Cornaz (Chairman of Cttee.)
Dr M. Merson
Prof. K.A. Monsur
Mr T. Rahman
Prof. D. Rowley

Finance Committee

Prof. D. Bell
Prof. R. Eeckels
Prof. R. Feachem (Chairman of Committee)
Mr A.K. Chowdhury *
Dr Nyi Nyi **
Dr P. Sumbung

Programme Committee

Prof. D. Bell
Prof. R. Eeckels
Prof. D. Rowley (Chairman of Cttee.)
Dr A.R. Al-Sweilem
Prof. D. Habte
Dr M. Merson
Prof. K.A. Monsur

All Board Members are encouraged to participate in all Committees, especially the Programme Committee.

Board Members appointed subsequent to above resolutions and not yet formally appointed to a Committee

Mr M.K. Anwar
Dr D. Ashley
Prof. A. Lindberg
Prof. V.I. Mathan
Prof. V. Ramalingaswami
Prof. H. Tanaka

* replaced by Mr M.K. Anwar
** replaced by Prof. V. Ramalingaswami

DATES OF NEXT MEETING

DATES OF NEXT MEETING

To tie in with the dates of the Donors' Meeting (20 and 21 November, 1988) and in order to have one day for each Committee meeting, the November 1988 dates would be as follows:-

Wednesday, 23 November	-	Programme Committee Meeting/ Meet with scientific staff
Thursday, 24 November	-	Personnel & Selection Committee Meeting
Friday, 25 November	-	Finance Committee Meeting
Saturday, 26 November	-	Free for report writing/ Meet with Programme Coordination Committee
Sunday, 27 November to Tuesday, 29 November	-	Full Board Meeting

May 1989 Meeting

Tentative dates for the May 1989 meeting may be:-

Wednesday, 24 May to Tuesday, 30 May

OR

Friday, 26 May to Thursday, 1 June

MISCELLANEOUS

March 30, 1988

ICDDR(B) BOARD/QUESTIONS RAISED BY D ROWLEY

Having been on the Board of the Centre for about five years I should have a good idea of the responsibilities and plans of the Board. Unfortunately I don't have a clear vision of how the Board intends to perform. If that is my fault there is no problem since I will be leaving it in one year. If on the other hand, my feelings are common to other Board members, then we should have a look at ourselves collectively to see if we can perform better.

The Board in general should ensure that the Centre has objectives and plans to achieve them and must know what these are. It must make sure that the Centre is managed effectively by the Director, in line with the Board's policy.

In some detail the Board should give attention to the following:

(a) There should be an on-going review of the policy in relation to the mandate of the Centre.

(b) The overall organisational structure of the Centre.

(c) The financial viability and cost effectiveness.

(d) The scientific priorities of the Centre and the budget to meet them.

(e) The determination of the personnel policies.

(f) The performance and terms of employment of the C.E.O.

(g) Constant monitoring of the foregoing items.

All Board members should clearly understand their individual duties in helping achieve these collective goals.

Other points worth discussing are -

(1) Formation of a Board Selection and Reappointment Committee

This could be a small (3 member?) Committee attached to the Research Committee with some guidelines, other than

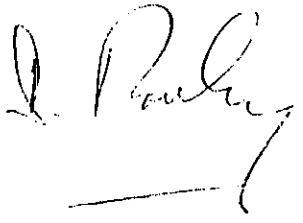
hearsay evidence and old boy network. There should be a serious attempt to elect a more balanced Board - females, financial experts, as well as scientists.

2. The 3 + 3 term of appointment should not be automatic.

3. There should be a file of potential members with adequate curriculae.

4. The Chairman of the Board should have a defined term of office - (2-3 years) and should be selected a year in advance.

5. Because of the importance of the Centre's programme to both the Board and the Donors, the Programme Committee should be the most active subcommittee of the Board - how to achieve this?



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