INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

REPORT OF

BOARD OF TRUSTEES MEETING

NOVEMBER 24-30, 1992

PROGRAMME

ICDDR,B BOARD OF TRUSTEES MEETING

NOVEMBER 24-30,1992

DRAFT
21.10.92

PROGRAMME

BOARD OF TRUSTEES MEETING

24-30 NOVEMBER, 1992

Venue: All meetings will be held in the new Sasakawa International Training facility on the first floor of the hospital building.

Monday, 23 November	Trustees participating in Programme Committee Review of the Laboratory Sciences Division arrive
Tuesday, 24 November to Thursday, 26 November	Programme Committee Review of the Laboratory Sciences Division
Thursday, 26 November	Remaining Trustees arrive

Friday, 27 November

8.00 a.m. - 10.15 a.m.	Programme Committee Meeting (Open)
10.15 a.m. - 10.45 a.m.	TEA
10.45 a.m. - 12.30 p.m.	Programme Committee Meeting continues
12.30 p.m. - 2.15 p.m.	LUNCH

Friday, 27 November (Cont'd)

2.30 p.m. - 3.30 p.m.	Personnel & Selection Committee Meeting (Closed)
3.30 p.m. - 3.45 p.m.	TEA
3.45 p.m. - 5.00 p.m.	Personnel & Selection Committee Meeting continues (Closed)
5.00 p.m. - 7.00 p.m.	Programme Committee Meeting (Closed)

Saturday, 28 November

9.00 a.m. - 10.15 a.m.	Finance Committee Meeting (Open)
10.15 a.m. - 10.45 a.m.	TEA
10.45 a.m. - 12 noon	Finance Committee Meeting continues
12 noon - 12.30 p.m.	Meet with Staff Welfare Association Exectutive Committee (Closed)
12.30 p.m. - 2.15 p.m.	LUNCH
2.15 p.m. - 5.00 p.m.	FREE for report writing/visit to Division of area of interest/tour of Centre

Sunday, 29 November

8.00 a.m. - 8.30 a.m.	TEA
	FULL BOARD MEETING COMMENCES (OPEN)
8.30 a.m. - 8.45 a.m.	Welcome and Approval of Agenda
8.45 a.m. - 9.00 a.m.	Approval of Draft Minutes of May 1992 Meeting
9.00 a.m. - 10.00 a.m.	Presentation and Discussion of Director's Report

Sunday, 29 November (Cont'd)

10.00 a.m. - 10.30 a.m.	TEA
10.30 a.m. - 11.30 a.m.	Presentation and Discussion of Programme Committee Report (including Programme Committee Review of Laboratory Sciences Division)
11.30 a.m. - 12.30 p.m.	Presentation and Discussion of Finance Committee Report
12.30 p.m. - 2.00 p.m.	LUNCH
2.15 p.m. - 5.00 p.m.	CLOSED Session of Board Meeting
2.15 p.m. - 3.15 p.m.	Presentation and Discussion of Personnel & Selection Committee Report
3.15 p.m. - 3.45 p.m.	Selection of Trustees
3.45 p.m. - 4.00 p.m.	TEA
4.00 p.m. - 4.15 p.m.	Dates of next meeting
4.15 p.m. - 5.00 p.m.	Free for outstanding discussion
5.00 p.m.	Closure of meeting

Monday, 30 November — Support Group Meeting

APPROVAL OF AGENDA

DRAFT

25.8.92

FULL BOARD AGENDA

29 November, 1992

1. Approval of Agenda

2. Approval of Draft Minutes of meeting held in May 1992

3. Director's Report

4. Programme Committee Report
   (including Report on Laboratory Sciences Division Review)

5. Finance Committee Report

6. Personnel & Selection Committee Report

7. Selection of Trustees

8. Dates of next meeting

9. Any other business
   (a) Report from Staff Welfare Association (SWA)

Note: Papers submitted and discussed in Committee meetings are in the folders for those Committee meetings only

APPROVAL OF DRAFT MINUTES OF MEETING

31 MAY, 1992

REVISED DRAFT

Minutes of the meeting of the Board of Trustees, ICDDR,B held in Dhaka, Bangladesh on 31 May 1992

Members Present

Mr S.Ahmed
Dr Y.Y. Al-Mazrou
Dr D. Ashley
Mr E.A. Chaudhury
Prof. Dr K.M. Fariduddin
Prof. D. Habte - Secretary
Prof. J.R. Hamilton
Dr R.H. Henderson
Dr M. Law
Prof. V.I. Mathan
Prof. F. Mhalu (Agendas 1-5)
Prof. A.S. Muller
Dr J. Rohde
Dr P. Sumbung - Chairman

Apologies

Prof. J.C. Caldwell
Prof. A. Lindberg
Prof. T. Wagatsuma

Invited Staff (Agendas 1-5)

Dr R. Bairagi
Dr M. Bateman
Mrs J. Chowdhury (Minute Secretary - all agendas)
Dr J. Haaga
Dr D. Mahalanabis
Mr M.A. Mahbub
Dr R. Maru
Mr N. Paljor
Dr R.B. Sack
Dr M. Strong
Mr K. Tipping
Mr G. Wright

Observers (Agendas 1-5)

Dr P. Arnold, Swiss Development Cooperation, Dhaka
Dr C. Kenna, Australian High Commission, Dhaka
Mr W. Fisher, UNDP, Dhaka
Mr W. Goldman, USAID, Dhaka
Dr P. Gowers, The World Bank, Dhaka
Dr J. Ross, The Ford Foundation, Dhaka

Dr P. Sumbung, Chairman of the Board of Trustees, opened the 26th meeting of the Board at 8.30 a.m. on Sunday, 31 May 1992. He welcomed the Trustees, Donors, the Director and Staff of the Centre to the meeting. The Chairman introduced the new member of the Board; Mr Syed Ahmed, Secretary, Ministry of Health and Family Welfare, Bangaldesh. He also congratulated Prof. Dr K.M. Fariduddin on his promotion to the rank of Secretary and subsequent posting to the Planning Commission, Bangladesh. Dr Sumbung noted that three members have been unable to attend the Board meetings due to important commitments at home. They are Professors J.C. Caldwell from Australia, A. Lindberg from Sweden and T. Wagatsuma from Japan.

In his opening statement, the Chairman remarked on the good footing on which the Centre now finds itself. He said there is a better climate in the Centre and not only is the research output excellent but the staff are working well together. He said that the Programme Coordination Committee is pleased with the developments at the Centre and satisfied that the Centre is supporting National research institutions to carry out research. He commented on the close cooperation which has developed between the Centre and the Government of Bangladesh. Dr Sumbung noted that the Centre has increased its international visibility through

participation at conferences and through consultancy services to South America and elsewhere.

Agenda 1: Approval of Agenda

The agenda was adopted as presented.

Agenda 2: Approval of draft minutes of the Board's meeting held in November 1991

The revised draft minutes of the meeting of the Board of Trustees held on 13 November, 1992 were approved with the following addition:

Page 1, Members Present - an asterisk should be put against the names of Mr M.M. Haque and Dr J. Rohde with a note to indicate that these Trustees were present during Committee meetings.

Agenda 3: Director's Report

The Director, Professor D. Habte, highlighted some of the most important scientific and management activities which have taken place since the last Board Meeting.

He said that the Centre has maintained its efforts of consolidating the positive changes and practices instituted over the last few years. These include increased research productivity, more visibility of the Centre and its staff at both national and international levels, recruitment of

an able consultant to assist the office of the Director, construction of premises to house the Community Health Division and the Training complex and eradication of the accumulated cash deficit of the Centre and further improvement in presentation of financial information.

There has been a significant increase in the number of publications, with 97 papers either published or in press and 61 research protocols/programmes in progress from November 1991 until the end of April 1992.

The Community Health Division has continued to grow, both in numbers of personnel and research projects, and in diversity of interests and involvement. In the past six months, i) three international level staff have been added: Sandra Laston, Nancy Fronzak and Massee Bateman. (Peter Miller, on secondment from the Population Council is also working part-time with the Division); ii) two new protocols on Vitamin A, and another on the evaluation of women's empowerment, have started; iii) two workshops on issues of water and santiation were conducted; and iv) the Division moved into its new premises above the library. The regional workshop was held in Comilla and was entitled "Water and Sanitation: Priorities for the 1990's". The national workshop, co-sponsored by UNICEF, targetted Bangladeshi issues. The Behavioural Sciences group has developed a major concept paper which includes five research protocols on behavioural issues in public health.

The Clinical Sciences Division has maintained its involvement in providing health care, participating in training and conducting clinical

research. Coordination of activities has been achieved through regular meetings of the research task forces and other management groups. An international fellow has been recruited to the Division from Australia and is expected to report for work in June 1992. A major responsibility of the staff is patient care, which is steadily increasing; the patient load at the Clinical Research Centre last year jumped by 50% from the previous two years (i.e., from an average of approximately 60,000 to over 90,000 patients). This year's trend is similar to that of last year's with the tent erected and corridors filled with beds. The staff has been pre-occupied with patients for the better part of six months. The Division's staff also carried out international and national courses in clinical management of diarrhoeal diseases (coordinated by the Training Branch).

Dr R. Bradley Sack (Associate Director, Community Health Division) was, in addition, appointed Associate Director for the Laboratory Sciences Division on 1 January, 1992. The Laboratory Sciences Division has undergone changes in its Divisional structure, being divided into two groups, the Department of Laboratory Research and the Department of Laboratory Services. The Division has continued to be productive in its research on basic mechanisms of diarrhoea as well as in its support of clinical and epidemiological studies of other divisions at the Centre. There are presently eight masters level students from Dhaka University doing their thesis work in the Division. New state-of-the-art technology has been introduced (i.e., the establishment of the PCR technique for identification of enteric pathogens); the HT29 tissue culture (human colonic cell line) assay for the detection of Bacteroides fragilis has been established; and evidence of the diarrhoeagenic properties of

several organisms not known to be definitely associated with diarrhoea, Hafnia alvei, Providencia liquefaciens has been found.

Two important initiatives concerning the Population Science and Extension Division were started or continued since the last meeting. The first relates to the Ford Foundation's commitment to improving the social sciences at ICDDR,B through two grants. One will create a Bangladesh Consortium on Reproductive Health as part of Ford's global concern for women's health. This group, made up of five key research institutions in Dhaka, will share resources, such as visiting scholars, training activities, and libraries, as well as joint research activities. The other Ford initiative concerns the ICDDR,B/BRAC project, following the socio-economic intervention activities and analyzing their impact in terms of a broad range of social and health indicators. The Programme Committee Review recommended that "there should be a major adjustment of internal organization" within the Division. After discussion, it was decided to split the Demographic Surveillance System into two units; one still called the DSS and the other the Population Studies Centre. The MCH-FP Extension Project is a collaborative effort of the ICDDR,B and the Ministry of Health and Family Welfare of the Government of Bangladesh. As such, a significant event during the period was the meeting of a reconstituted National Steering Committee. USAID (Health and Population) is currently reviewing the assistance for the next five years, including its support for the MCH-FP Extension Project.

During the six month reporting period, the Training Branch ran eight courses, administered three fellowship programmes, and assisted forty

project-based research trainees. A total of 628 people were trained and/or given orientation through brief lectures, visits and demonstrations. The Centre is giving increased emphasis to health research training.

In Matlab the contraceptive prevalence rate in married women continues to increase, and is now at a level of 61%. The immunization rate for measles in the intervention area is now 94% in children 9-23 months of age. Although much reduced in absolute numbers, measles continues to occur in infants under 9 months of age.

The Urban Health Extension Programme, which has replaced the Urban Volunteer Programme, is developing reports from the data generated from the previous several years from the Urban Volunteer Programme experience in areas such as diarrhoea, acute respiratory infections, immunization, and socio-demographic profiles of urban slums.

A Computer Advisory council has been formed and is currently reviewing the current and project environments inside the Centre and outside in the computer market place, in order to develop, and subsequently implement, a coordinated computer strategy. We may eventually phase out the mainframe computer and install a new system to substitute for it in three years' time.

The Swiss Development Cooperation grant for the Diarrhoeal Diseases Information Service Centre (DISC) and its activities finished in December 1991 and DISC is now being financed from core funds. The Centre is grateful to SDC for what it has done.

In addition to its usual photographic work, the Audio Visual Unit has created new designs and layouts for JDDR, Glimpse and the new Bangla newsletter ("Shastho Sanglap").

At recent Board meetings we have been reporting decreases in staff. However, for the first time we now have to report an increase in the number of fixed term staff due to conversion of employment contracts from short-term/special service agreements to fixed term.

Construction of the "Sasakawa International Training Centre" has commenced on top of the hospital, funded by a grant of $US 300,000 from the Sasakawa Foundation. The work is expected to be completed by the end of September 1992.

To secure a continuous power supply, one 825 KVA stand-by generator has been ordered and will be installed by September 1992 at a cost of $US 131,000. One 800 KVA transformer, along with other electrical sub-station equipment, is to be installed by July 1992. Funds for these have been provided by SDC.

A professional engineer from the International Executive Services Corp (IESC) provided a consultancy to the Engineering Branch for 2 months. His recommendations for contracting out some services in the carpentry, motor vehicle and lathe worshops are in the process of being implemented. Another IESC Volunteer consultant was with the Centre for six weeks to study and recommend improvements in the Centre's purchase and inventory systems. These are in the process of being implemented.

As of 31 March, 1992 twenty seven staff were studying or training abroad. Two major scientific conferences (Commonwealth Conference on Diarrhoea and Nutrition in New Delhi and XIth International Biennial Conference of the Pakistan Paediatric Association in Islamabad) were attended by a total of nineteen staff members. The Centre was also represented at the African Conference on Diarrhoeal Diseases held in Lagos in March.

Mr Ken Tipping arrived in October 1991 to take over the position of Associate Director, Finance. A composite financial analysis of the Centre from its inception in 1979 to the end of 1991 was made. This was undertaken to: i) build a financial history data base covering the major items of income and expenditure; and ii) to determine the annual and cumulative operating cash surplus. The result of this analysis showed that the Centre had a cumulative operating cash surplus to December 1990 of $US 131,000 compared to a reported deficit of $US 896,000. The major part of the difference was caused by transfers to the Reserve and Fixed Asset Replacement Funds being reflected as operating cash costs rather than an appropriation of the surplus.

The Centre has prioritized its equipment and other capital investment needs, and has used this to plan the utilization of the Fixed Asset Replacement Fund for the year.

A Resources Development Advisory Council will be established in the next months. People from all over the world with fund raising experience are being approached to join this Council. It is hoped that this Council will develop a viable resource development strategy for the Centre over

the next year.

As mentioned by the Chairman, the Centre's excellent collaboration with the Programme Coordination Committee continues.

A booklet "Partnership in Progress: ICDDR,B's Contributions to and Collaboration with Bangladesh" has been prepared. This will be used to assist in public relations exercises, and for Government and donor liaison purposes. It captures some of the many ways that ICDDR,B works both in and with Bangladesh. The new health newsletter, to be issued initially tri-monthly in Bangla to thousands of front-line health workers in Bangladesh, is an important step forward in the Centre's attempts to broaden and deepen the dissemination of its results.

At the request of the Government of Bangladesh, the Centre's epidemic control teams have been working in Barisal since 12 April. They established a twenty bed hospital and have treated thousands of patients in the course of implementing epidemic control measures. The Centre still needs donor funds over the next 3-5 years to develop the capabilities of national institutions to respond to major epidemics.

The Centre's expertise and technical assistance continues to be sought by the Governments of Peru and Ecuador, and several ICDDR,B staff are assisting in the fight against the cholera epidemic raging through these countries. Also, one staff member has just returned from giving assistance in Yemen.

Finally, the Director reported on the growing collaboration with UNICEF. Two months ago, UNICEF staff from the SAARC health offices came to the Centre to learn what resources we have. In turn, we learned what problems they have and thus what research UNICEF would like us to concentrate on.

In thanking the Director for his report, the Chairman noted the significant increase in publications and research protocols. He said that the Director's Report was now open for discussion.

Members of the Board had several comments. These are outlined below and the Centre's response given, as required.

1) The increase in training activities and completion of the Sasakawa Training Centre will put pressure on the Centre to have a more structured and integrated view of the long term training plans to enable them to meet constitutents' needs.

2) The initiative of the Bangla newsletter is appreciated and it is hoped that the Centre will continue in this direction. The newsletter can be used to reinforce training messages and the government's health policies.

3) The Centre has not been addressing the need to fund depreciation. This is a critical issue which the Centre has to tackle as quickly as possible. In the meantime, members were pleased to learn that a new transformer and generator have been ordered.

4) The steps taken in Resources Development are commendable. The

strategy should take into consideration the fact that good science is in the final analysis what draws support of donors and that activities should be linked with research capability strengthening in Bangladesh and other countries. The Clinical Sciences Division was acknowledged as an example of how international leadership and the Centre's resources had developed young Bangladeshi doctors into dynamic and competent young researchers (as brought out in the External Review).

5) The recent visit to the Centre of UNICEF field staff in the SAARC region was most appreciated and the quality of briefing was nothing short of outstanding. It is important that the Centre addresses the research questions posed by the SAARC health officers. This exercise is mutually beneficial to UNICEF and the Centre. UNICEF hopes for a quick response to its queries as they will use these responses to guide their policy and programmes for children in Asia. UNICEF may also consider sending people from other parts of the world to the Centre on a similar exercise.

6) The collaborative role of the Centre in South America was acknowledged. It was proposed that the Centre build-up its expertise in diarrhoeal disease control so it can be used more actively, for example, in Africa too.

7) The Director was congratulated on appointing the Associate Director, Laboratory Sciences Division. He was cautioned, however, to ensure that the search for a separate head of the division not be discontinued.

8) The excellent collaboration between the Centre and the Government of Bangladesh was acknowledged. In this connection the following were mentioned: i) the National Steering Committee of the MCH-FP Extension Programme; ii) the Centre's assistance in cyclone relief activities and equipping a diarrhoea centre in Chittagong; iii) assistance with diarrhoea outbreaks in Southern Bangladesh, where the Centre worked side-by-side with the Government. However, it is appreciated that the Centre is international and that it should explore its ability to respond internationally too.

9) It was noted that the incidence of diarrhoea in Matlab is still quite high and queried why this would be so.
The Director responded that the cause of diarrhoea is multi-factorial, deep rooted and not related to health only. Therefore, the health sector cannot resolve this on its own.

The Donors were given an opportunity to comment on the Director's Report.

Donors present expressed support of the accomplishments of the Centre and supported the various initiatives undertaken including the creation of endowments for long term financial sustainability of the Centre, the publication of a Bangla health newsletter "Shastho Sanglap" and of "Partnership in Progress", the increasing focus on social science and behavioural research, and the workshops on water and sanitation. They pledged continued support.

The Director said he appreciated the kind remarks of the donors and indicated that if the Centre hadn't received their assistance it wouldn't

be where it was today.

The interest of donors in the endowment funds was appreciated. Donors were asked to give proposals suggesting ways in which they would like to help the Centre regarding endowment funds and development of fund raising strategies.

The Chairman thanked the Trustees and donors for their comments. He said that any comments on the Resources Development Strategy (given as an addendum to the Director's Report) would be appreciated and that these should be given to the Director in writing.

On behalf of the Board, the Chairman thanked the Director and staff for the exciting developments and hoped they would continue doing an excellent job.

Agenda 4: Programme Committee Meeting

(including External Review Committee Report on the Clinical Sciences Division)

The Chairman of the Committee, Professor J.R. Hamilton, highlighted the Committee's Report.

He said that the Centre provided a clear and detailed response to the issues raised by the Programme Committee's earlier Review of the Population Sciences and Extension Division. The Division is in the process of implementing many of the Committee's recommendations, with a

special emphasis on enhancing communications at all levels within the Division. A Population Studies Centre has been created in the Division. The Demographic Surveillance System has been established as a core activity. The Division gave due consideration to the Review Committee's recommendation on the matter but plans to continue to develop a rolling census.

The Community Health Division's extensive accomplishments and plans for its five major interest groups had been summarized for the Committee by the Associate Director, Dr Sack. As the recently appointed Associate Director of the Laboratory Sciences Division, Dr Sack also provided a presentation of the accomplishments and plans of this Division. He has restructured the Division, dividing it into two major departments, laboratory research and laboratory services.

The status and plans of the Urban Health Extension Project were presented to the Programme Committee by Mr N. Paljor. Dr Baqui discussed some of this group's research activities and presented preliminary data.

The Chairman of the External Review Committee Dr. Grant Gall, presented this Committee's Report on the Clinical Sciences Division to the Programme Committee. Dr Gall expressed a very positive opinion of the Division's accomplishments. The Committee made fifteen specific recommendations designed to further strengthen the patient care, training and research activities of the Division.

In the closed session of the Programme Committee Meeting the following matters were discussed and agreed upon:

1) it was decided that for the next meeting the Associate Directors should present their accomplishments and plans but need not prepare an extensive written statement since this information has been contained in the Director's Report;

2) the Programme Committee applauded the prompt, extensive, constructive response of the Population Science and Extension Division and its Associate Director, Dr Strong, to the Review Committee recommendations;

3) the Committee expects to receive the Centre's response to the External Review Committee Report of the Clinical Sciences Division at its meeting in November 1992;

4) The Committee was reassured that the Centre has no intention at this time of embarking on large scale production and use of the killed whole cell/B subunit oral vaccine in Bangladesh, and that the Centre was conducting a feasibility study, strictly in line with the guidelines of the Board. Dr Sack informed the Committee of the current status of this feasibility study in progress related to the evaluation of the production, quality control and effectiveness of the vaccine. No trial of effectiveness is envisaged for the next one year. The Committee concluded that the Centre's involvement is appropriate, being confined to research activities which are within its expertise and capacity, and that inappropriate costs are not being incurred by the Centre through its involvement in this project. They concluded that the consideration of the use of this vaccine is of sufficient importance to Bangladesh and they urged

that the WHO Control of Diarrhoeal Disease programme (CDD) be kept informed of progress related to these feasibility studies.

The Programme Committee's Report was opened for discussion.

Board members commended the Centre on its progress and gave its full support to the Centre's increasing incorporation of social science in its agenda. The Centre was encouraged to examine gender issues in the research it undertakes. It was suggested that an item be included in the protocol submission check list to ensure that the issue of gender has been considered when appropriate.

The donors, too, endorsed the report. They suggested that in looking at gender issues the Centre first utilizes the DSS as a data resource, and that a review group may be constituted to consult on the issue of gender with respect to science and policy.

The Programme Committee Report was accepted. Dr Sumbung thanked the Chairman and members of the Programme Committee for their report. He also thanked the External Review Committee for their report.

Agenda 5: Finance Committee Report

Professor V.I. Mathan, Chairman of the Finance Committee, presented the Committee's report. He highlighted the following points:-

a) **1991 Audited Financial Statements & Auditors' Report**

The audit of accounts for the year 1991 was completed and signed on 18 March, 1992. After providing for depreciation of $US 568,772 (1990 $US 865,041), a net operating cash surplus for the year of $US 447,222 was available (the Centre's first net surplus since 1987) compared to a net deficit of $US 384,325 for 1990.

It was pointed out that although the Centre does not have a net operating cash deficit, the significant deficit in funding depreciation, which as of 31 December 1991 was $US 5,495,805, is of great concern to the Centre's management and the Board of Trustees. This is a major deterrent in the development of fixed assets and the maintenance of appropriate technological capability.

There was much discussion regarding the allocation of the funds available at the end of 1991. Centre management provided the details of the integrated plan for the development of the physical plant which involves the completion of the entire floor over the hospital. The Committee felt that under the terms already approved for the utilization of the Fixed Asset Acquisition and Replacement Fund, the Centre management has the freedom to use these funds to continue the construction activity on this floor, while pursuing their application for funding from the Sasakawa Foundation.

b) **1992 Budget Update**

The cash surplus for 1992 is anticipated to be $US 487,000, which after

the expected charge for depreciation of $US 575,000 will result in an operating deficit of $US 88,000.

The Committee was concerned that there was an anticipated shortfall of $US 88,000 in funding depreciation. The Committee urged the Centre's management to ensure that depreciation was fully funded and that a net cash surplus of at least $US 100,000 should be available at the end of 1992. Stringent measures of cost containment and careful monitoring of staff strength is essential to achieve this.

c) International Staff Salaries

The Finance Committee met jointly with the Personnel & Selection Committee in a closed session to consider the revision of emoluments for international staff. The basic issues involved had been discussed in the meeting of the Personnel & Selection Committee the previous day.

The current salary offered by ICDDR,B to its international professional staff is not adequate to attract and retain scientists of high calibre and repute and this subject has been discussed in a number of Board meetings in the past.

There was a long, thoughtful, and sympathetic discussion in which all members of the Board present took part. It was reiterated that the international level scientific staff are the major strength of the institution and that recruitment of crucial personnel was essential for the Centre to continue to be scientifically productive.

The financial implications of a full revision to UN level as at 1 July 1992 were presented. Implementation of UN salary and allowances, on an annual basis, would raise salary costs by $US 105,000 (15.8%) and allowances by $US 66,000 (18.9%). Of this total cost of $US 171,000, $US 103,000 would be funded by projects and a minimum of $US 30,000 per annum would be contributed through the discontinuance of IIE payroll services from 1 July 1992, leaving only $US 38,000 to be funded by core.

Two other issues were also given serious consideration. First, the impact of international salary revision on the question of parity of NO and GS staff with UN scales. At present NO is at 89% and GS at 85% of UN local salary levels, while international is only at 82%. The Board has decided that international salary revision would be considered at the June meeting and NO and GS salary at the November meeting. It was clearly recognised that market forces of supply and demand are major factors in determining salary levels.

The group also considered the impact of the planned mid-year revision, particularly on project budgets, but were aware of the fact that donors are sympathetic to the need to recruit top level international staff.

d) **Appointment of Auditors**

It was pointed out that one of the two firms had been auditors for four years, but Centre management felt that it was appropriate to extend both audit firms for one more year.

e) **Investment Loan for Income Tax Reduction**

81.3% of eligible employees applied for investment loans for the 1992 tax year compared to 66.7% for 1991. The loans granted were $US 679,000 for 1992 compared to $US 526,000 for 1991. The increase is very encouraging particularly as the maximum allowable amounts were reduced by the National Board of Revenue from Taka 200,000 to Taka 100,000. The Centre will save $US 169,000 in income tax payments in 1992 compared to $US 130,000 for 1991. It was suggested that the Centre should explore the possibility of re-investing the savings (either whole or in part) to improve staff salaries.

f) **Hospital Endowment Fund**

The balance of the Hospital Endowment Fund at 31 December, 1991 was $US 15,577. Receipts for the first four months of 1992 were $US 2,223, giving a closing balance at the end of April 1992 of $US 17,800. No expenditure has been charged against this Fund since its inception.

Other points discussed by the Finance Committee appear in resolutions, which are self-explanatory.

Professor Mathan took the opportunity of having the floor to share one or two concerns with the Board. He noted that several donors were present. He said that the Centre has come a long way since he joined the Board five years ago. Much of the change is because of the support of the Government of Bangladesh and the fact that the Centre has been able to

recruit eminent scientists and a Director. The Board has also played a role, interacting with the Centre and donors, and donors have played an active role too. It is crucial to the Centre's future that there be positive interaction between the Board, Director, staff and donors. New persons have to be instilled with this spirit. Secondly, he thanked Dr Sumbung, whose term ends on 30 June. He said that Dr Sumbung has been a source of inspiration and leadership not only to the Centre, but to the Board too. He has had the attitude that everything can be solved, and needs to be solved, as the Centre is "worth it".

Dr Sumbung thanked Professor Mathan for his sentiments and said that it has not only been him but that all Board members have contributed. He opened the Finance Committee Report for discussion.

In response to a query as to whether the Centre was supporting projects from core money, the Director responded in the affirmative and advised that the DSS is now considered a core activity but the financial statements have not been changed to reflect this as yet.

Replying to a question on the Reserve Fund, Professor Mathan said that the Reserve Fund had $US 1,978,248 and with the interest of $US 131,557 this makes the current balance $US 2,109,695. The target amount for the Reserve Fund is $US 15 million.

Dr Sumbung thanked the donors and members of the Finance Committee for

their report.

The following resolutions were passed:

Resolution 1/May 92 — The Board resolved to accept the audited Statement of Accounts and Balance Sheet for 1991 (Appendix 1).

Resolution 2/May 92 — The Board resolved to approve the following changes in Fund descriptions:

Present Name	New Name
Capital Development Fund	Fixed Assets Fund
Capital Development Reserve Fund	Fixed Asset Acquisition and Replacement Fund

Resolution 3/May 92 — The Board resolved that for the year 1991 depreciation of $US 568,772 be fully funded and transferred to the Fixed Assets Acquisition and Replacement Fund and that the net cash surplus of $US 447,222 be also transferred to the Fixed Assets Acquisition and Replacement Fund (Total transfer $US 1,015,944).

Resolution 4/May 92 — The Board resolved to revise the International level staff salaries and allowances to 100% of the UN rate at 1 July 1992. The Director is authorised to take necessary actions to fix the individual salaries appropriately and to vary the post adjustment in line with the rate as issued from time to time by the UN.

It was further resolved that the dependent allowance for

all future international level employees be limited to a maximum of two dependent children.

Resolution 5/May 92

The Board resolved to appoint M/s Deloitte Haskins & Sells, Calcutta, and Hoda Vasi Chowdhury & Co., Dhaka, as Auditors for the year 1992 at a fee not to exceed $US 12,500.

Resolution 6/May 92

The Board resolved to authorise the continuation of the overdraft facility of up to $US 2 million with the American Express Bank for 1992.

Resolution 7/May 92

The Board resolved to approve that all fixed assets of $US 200 or below be depreciated to $US 1 in the year of purchase starting from 1992, and that existing fixed assets costing $US 200 or less be depreciated to $US 1 in 1992.

Resolution 8/May 92

The Board resolved to accept and approve the expenditure of $US 57,746 from the Fixed Asset Acquisition and Replacement Fund for 1991.

Resolution 9/May 92

The Board resolved to direct the Centre management to continue efforts to ensure cost containment, and to end 1992 with a surplus, after providing for depreciation, of $US 100,000.

The Chairman thanked those donors and senior staff present for participating in the open sessions of the Board.

Professor F. Mhalu also left the meeting. He apoligised for having to leave before the proceedings were completed and thanked members for their understanding. Dr Sumbung thanked Professor Mhalu for his participation.

Agenda 6: Personnel & Selction Committee Report

Dr D. Ashley, Chairperson of the Personnel & Selection Committee, presented the Committee's Report.

She reported that:

a) The position of Head, Clinical Research Centre will be abolished. The Division is depleted of international research staff so it has been proposed that the position, which is primarily for the clinical service, be replaced by one or more positions for international research staff.

b) Mr Graham Wright is working as a Consultant in the Director's Office to assist him in resource development and other activities.

c) Contacts with "head hunting" firms were unsuccessful. The Director has appointed Dr R.B. Sack, as Associate Director, Laboratory Sciences Division, in addition to his duties as Associate Director, Community Health Division. The Committee supported the Director and agreed with his decision. However, the position of Head, Laboratory

Sciences Division, should be considered to be open. If a suitable candidate for this position is identified he or she should be recruited. Alternatively, if there is a suitable candidate for the Head of CHD, Dr Sack, being qualified for both postions, could continue as Head of LSD and the candidate recruited as Head, CHD.

d) The revision of salary for international level staff was discussed at length and it was agreed that no recommendation would be made on this item in the Personnel & Selection Committee but that a decision would be made at a joint meeting of the Personnel & Selection and Finance Committees, after the Finance Committee had deliberated the issue.

Resolutions on other points appear below.

In discussing the Anthropologist position, it was agreed that the title of the position should be "Social Anthropologist" and that the Centre management should have an expert in the field re-write the job description.

There was little other discussion on the report and its recommendations as the majority of Trustees had been present in the Committee meeting.

Dr Sumbung thanked Dr Ashley and the Personnel & Selection Committee for their report.

The following resolutions were passed.

Resolution 10/May 92 — The Board resolved to accept the Report of the Personnel & Selection Committe.

Resolution 11/May 92 — The Board resolved to endorse the appointment of Dr R. Bairagi (Bangaldesh) as Scientist, Population and Statistics, P4 level, for three years from 15 January, 1992.

Resolution 12/May 92 — The Board resolved to endorse the appointment of Dr O. Massee Bateman Jr. (U.S.A.) as Epidemiologist, P4 level, for three years from 29 March, 1992.

Resolution 13/May 92 — The Board resolved that the post of Social Anthropologist at P3 level be created.

Resolution 14/May 92 — The Board resolved that the posts of International Research Associate (P2-P4), International Research Coordinator (P2-P3) and two posts of International Research Fellow (P1-P2) be created, subject to the availability of funds.

Agenda 7: Selection of Trustees

a) Replacement for Dr Sumbung

This item was discussed in the Personnel and Selection Committee. The Committee was impressed by the long list of able and outstanding

candidates which made the task of selection even more difficult. After consideration of all factors, four persons were short-listed for the Board's consideration. Copies of the curriculum vitae of these persons were circulated. In short-listing persons, the geographical representation, the gender, the country (preference was given for a country not previously represented on the Board), and the discipline of the candidate were considered.

The Board reviewed all four candidates. Recognizing that each candidate was outstanding, there was a secret ballot. Dr Chen Chunming (People's Republic of China) was elected.

b) **Nomination for Trustees to replace members-at-large whose terms end on 30 June, 1993**

It was agreed that the management should start the process now for seeking replacements for Dr D. Ashley and Professors A. Lindberg and V.I. Mathan, all of whom complete six years on the Board on 30 June 1993. This will allow the Personnel & Selection Committeee and the Board to review progress at the November 1992 meetings.

The following resolution was passed:

Resolution 15/May 92 — The Board resolved that Dr Chen Chunming (People's Republic of China) be appointed as a Trustee of the Centre for three years from 1 July 1992.

Agenda 8: Election of Chairman of the Board

Dr Deanna Ashley was unanimously elected Chairperson of the Board of Trustees for one year from 1 July, 1992.

a) Appointments to Committees

Professor A.S. Muller was elected as the new Chairman of the Finance Committee, Professor V.I. Mathan having completed the agreed two years as Chairman. Dr Maureen Law was elected Chairperson of the Personnel & Selection Committee. Professor J.R. Hamilton agreed to continue as Chairman of the Programme Committee for another year. Dr Y.Y. Al-Mazrou agreed to transfer to the Personnel & Selection Committee and it was agreed that Dr Chen Chunming should join the Programme Committee.

The following resolutions were passed:

Resolution 16/May 92

The Board resolved that Dr Deanna Ashley be appointed Chairperson of the Board for a one year term 1 July, 1992 to 30 June, 1993.

Resolution 17/May 92

The Board resolved that the following members be appointed to the Personnel & Selection Committee for a one year term effective 1 July, 1992.

Dr M. Law (Chairperson)

Dr Y.Y. Al-Mazrou

Mr S. Ahmed

Dr J. Rohde

Chairman of the Board and Centre Director are ex officio members.

Resolution 18/May 92

The Board resolved that the following members be appointed to the Finance Committee for a one year term effective 1 July, 1992.

Prof. A.S. Muller (Chairman)

Mr E.A. Chaudhury

Dr R.H. Henderson

Prof. V.I. Mathan

Prof. T. Wagatsuma

Chairman of the Board and Centre Director are ex officio members.

Resolution 19/May 92

The Board resolved that the following members be appointed to the Programme Committee for a one year term effective 1 July, 1992.

Prof. J.R. Hamilton (Chairman)

Prof. J.C. Caldwell

Dr Chen Chunming

Prof. Dr K.M. Fariduddin

Prof. A. Lindberg

Prof. F. Mhalu

Chairman of the Board and Centre Director are ex officio members.

Agenda 9: Dates of Next Meeting

It was agreed that the next meeting of the Board should be held in Dhaka from 27-29 November 1992. The schedule will be as follows;

Monday, 23 November	Programme Committee Reviewers arrive in Dhaka
Tuesday, 24 to Thursday, 26 November	Programme Committee Review of the Laboratory Sciences Division
Thursday, 26 November	Remaining Trustees arrive
Friday, 27 November	Programme Committee Meeting Personnel & Selection Committee Meeting
Saturday, 28 November	Finance Committee Meeting Report writing, lectures, etc.
Sunday, 29 November	Full Board Meeting
Monday, 30 November	Support Group Meeting

Professor Muller indicated that he will not be available for the meetings on 29 and 30 Novmeber as he will have to leave Dhaka on 29 November.

It was agreed that Professor Mathan would Chair the Programme Committee Review of the Laboratory Sciences Division and that Professors A. Lindberg and K.M. Fariduddin would be members. In addition one Bangladeshi microbiologist and one other external reviewer should be co-opted to the team.

a) **June 1993 Meeting**

The Board reconsidered its earlier suggestion that once in every two years a meeting of the Board should be held outside of Bangladesh. The success of the meeting in Jakarta was largely due to the presence of Dr Peter Sumbung, and, it was felt that it would be preferable to have a Trustee "on site" whenever a meeting is held outside Bangladesh. This not only ensures that arrangements for the meeting are easily coordinated but also that all opportunities to disseminate information on the Centre's achievements to universities and other institutions are utilized. The Board kept the option of holding meetings outside of Bangladesh, but agreed that the meetings will normally be held in Dhaka.

It was agreed that the June 1993 meeting would be held in Dhaka and the dates were set as follows:

Monday, 7 June	Trustees arrive
Tuesday, 8 June	Programme Committee Meeting Personnel & Selection Committee Meeting
Wednesday, 9 June	Finance Committee Meeting Report writing, lectures, etc.
Thursday, 10 June	Full Board Meeting

Agenda 10: Any other business

a) **Report from Staff Welfare Association (SWA)**

As part of its agenda, the Board met with the Staff Welfare Association

(SWA) Executive Committee at 12 noon on Saturday, 30 May, 1992.

The SWA President, Dr A.S.M. Mizanur Rahman, presented a plea to the Board for i) an increase in salary for NO and GS staff so they are on par with UN scales; ii) the Centre to take action on Retirement Fund contributions (employees are losing in terms of payments towards the fund); iii) reversing the decision that dependents' allowance only be given to two children; and iv) action regarding promotion for scientific support and administrative staff.

The Chairman of the Board responded by assuring SWA that the Board would discuss these matters.

The Board discussed the four issues in its meeting on 31 May and agreed to take up the issue of NO and GS salaries it its November 1992 meeting. The Director was requested to meet with the SWA Executive Committee on the remaining three points to explain: i) the positive elements of devaluation on the retirement fund; ii) that present staff are receiving allowances for more than two children; and iii) that there is provision for promotion in the rules and that staff can also apply for staff development to improve their skills.

A resolution was passed expressing the gratitude of the Board for Dr Peter Sumbung's excellent contribution. It was agreed that a letter of appreciation be sent to the Government of Indonesia. Although Dr Sumbung was on the Board in his individual capacity, his contribution can be

considered as a real contribution of Indonesia to the Centre.

The following resolution was passed:

Resolution 20/May 92 — The Board resolved to record its gratitude and the greatest appreciation of the contributions made by Dr Sumbung during the last six years as a member of the Board of Trustees and for the past three years as its Chairman.

Dr Sumbung thanked the Board, Director and staff plus the Government of Bangladesh for their cooperation.

The meeting closed at 2 p.m.

:jc
8.6.92

DIRECTOR'S REPORT

DIRECTOR'S REPORT

1.0 OVERVIEW

The second half of 1992 has been another busy period for the staff of the Centre. As the year comes to a close it has become clear that the volume of research undertaken at the Centre is steadily increasing in number and that a significant rise in community based field studies is taking place. This has meant that the progressive reduction in number of staff evident over the last few years cannot be sustained anymore. However, the utilization of research trainees in protocols has kept the salary burden of NO and GS staff on the Centre's budget at the same level. At the same time, this initiative contributes to the health research manpower development in this country.

Major research programmes embraced studies on Vitamin A and other micro-nutrients; dietary and drugs management of dysentery and persistent diarrhoeas; development of energy dense infant/child food, operations research on family planning, urban health care, control of dysentery, acute respiratory infections, etc.; etiology and pathogenesis of diarhoeas; and the challenging undertaking with BRAC to look into the health outcomes of non-health interventions.

The research training programme at the Centre turned a new leaf with the acceptance of three health and training fellows, one each from China, Nigeria and Peru. This is further proof of the ongoing re-orientation of the training bureau to focus on measures that contribute to building research capability in the developing world. Other activities included research methodology workshop and courses on biostatistics and on epidemiological methods in public health.

Provision of health care at the two hospitals - Matlab and Dhaka - has

been marked by increased activity during the epidemic months. In particular, attendance at the hospital in Matlab has broken an all time record stretching the resources of the hospital and Centre to the limits. In view of such major dislocations of the Centre's activities and finance, efforts are underway to design treatment services in the locality of Dhaka from which most of the patients are drawn (in cooperation with NGO's working in these areas). The role of ICDDR,B will be to provide technical assistance to NGO's and its name (viz. ICDDR,B field station). Opening of a temporary field diarrhoea treatment facility in Matlab thana during the recent epidemic yielded valuable experience. Such measures, it is hoped, will relieve the Dhaka hospital from recurrent congestion while taking health services to the people.

Centre's staff have been engaged in providing technical assistance not only in Bangladesh but also in South America, the Middle East and Asia (see 10.1).

Preparations are under full swing for the Second Annual Scientific Conference scheduled for 16-18 January, 1992. The theme for this year is "Health Research and Policy Perspectives". At this annual conference the First ICCDR,B Annual Lecture will be given by Professor W.B. Greenough III, opening a tradition that we hope will be maintained.

The resource development consultant, Mr Graham Wright, has been busy not only in establishing the requisite donor data base, donor related reference library, and producing publicity materials, etc. but also in finalizing the first draft of a resouce development strategy (see appendix E). I am proud to state that for the first time the Centre has a resource development office worthy of the name.

Construction of the first floor of the hospital building has proceeded smoothly with completion of the first phase. The Training Coordination Bureau and part of the training laboratories (clinical diagnostic laboratory and histopathology) are now located in their new premises. The rest of the floor will be completed by April 1993 at which time all the

training research laboratories will have been accommodated. Finance has also moved to the ground floor of the IPH/ICDDR,B building (formerly occupied by Training).

Finally, the process of developing the Centre's strategic plan has started. It is hoped that this will constitute the main agenda for the May/June 1993 Board of Trustees meeting.

2.0 RESEARCH AND RELATED ACTIVITIES

2.1 Research Output

The following table (Table 1) provides details on the number of publications and research protocols of the various scientific divisions. A high level of productivity has been maintained. Lists showing papers published, etc. by Division, are available in Appendix A to D.

Table 1: Research Output

	CHD	CSD	LSD	PSED	Total
Papers published					
1 Nov 90-30 Apr 91	3	9	5	8	25
1 May - 30 Sept 91	6	8	10	4	28
1 Oct 91-31 Mar 92	11	15	26	8	60
1 Apr - 30 Sept 92	8	11	17	8	44
Papers in press					
1 Nov 90-30 Apr 91	10	15	18	2	45
1 May - 30 Sept 91	7	14	15	5	41
1 Oct 91-31 Mar 92	9	12	9	7	37
1 Apr - 30 Sept 92	5	14	10	11	40
TOTALS					
1 Nov 90-30 Apr 91	13	24	23	10	70
1 May - 30 Sept 91	13	22	25	9	69
1 Oct 91-31 Mar 92	20	27	35	15	97
1 Apr - 30 Sept 92	13	25	27	19	84
Research protocols/ programmes in progess					
1 Nov 90-30 Apr 91	17	31	12	4	64
1 May - 30 Sept 91	12	24	11	3	50
1 Oct 91-31 Mar 92	18	23	16	4	61
1 Apr - 30 Sept 92	24	28	17	4	73

Note: Dates have been revised, from the last report, to reflect the actual period for which information was collected. The numbers remain as they were reported earlier.

2.2 Research in Progress

Table 1 shows the number of research protocols currently being carried out by the Centre and appendix A to D list these.

Some of the major research programmes that have pre-occupied the Centre's scientists during this period follow.

2.2.1 VITAMIN A AND OTHER MICRONUTRIENTS

Studies examining the safety and feasibility of administering Vitamin A through the EPI programme in infants under six months of age has been completed in rural and urban settings. The results from this will assist to arrive at a policy decision by governments and international agencies.

Other studies look into the effect of megadoses of Vitamin A in the outcome of pneumonics and shigella dysentery; and on ways of increasing dietary intake of B-carotene in infants and children.

The effect of micronutrients such as Vitamin A and zinc on morbidity and mortality from ARI and diarrhoea is being investigated in both the clinic and community setting.

2.2.2 DIETARY AND DRUG MANAGEMENT OF DIARRHOEA

A number of studies aiming to develop optimum strategy for the dietary treatment of dysentery and persistent diarrhoea are in progress, as also are drug trials in these disorders.

2.2.3 NUTRITION IN HEALTH & SICKNESS

Studies using amylase enriched four to increase energy density of infants and children during weaning and illness are in progress. This offers hope for the development of cheap food using simple technology.

2.2.4 OPERATIONS RESEARCH

Modalities of health interventions in dysentery, acute respiratory tract infections, family planning, urban health care are being examined across several divisions but mainly in the Matlab MCH-FP, the Urban Health Extension and the MCH-FP Extension projects. This work will include quantitative and qualitative studies investigating the quality of care in the Government's family planning programme; continued work with the Ministry of Health and Family Welfare to expand the home delivery of injectable contraceptives, which has been so successful in Matlab and the Project sites; and work on interventions to improve the management of the national family planning programme at all levels, from the union and thana up to the Management Information Systems (MIS) Unit in the Ministry.

2.2.5 BRAC-ICDDR,B PROJECT

This project in Matlab, attempting to document the process and quantify the impact of non-health interventions on health, has aroused considerable interest. The baseline study has been started following obligation of funds by Ford Foundation.

2.2.6 ENVIRONMENTAL HEALTH

Research in issues related to water supply and sanitation is being conducted in a number of areas including environmental determinants of child mortality, water quality impacts of embankments, environmental risk factors for diarrhoeal diseases, and simple sanitation interventions, particularly handwashing. The development of an appropriate handwashing intervention illustrates the multidisciplinary approach that characterizes water and sanitation research at the Centre. An engineer, epidemiologists, anthropologists, and microbiologists are working together to describe current handwashing behaviour and its cultural determinants, evaluate traditional techniques of handwashing, such as using mud, for efficacy in removing micro-organisms from the hnands, and to develop an appropriate educational intervention focussing on handwashing to prevent the transmission of diarrhoeal

disease.

A demographic study investigating the impact of the Matlab embankment on mortality, fertility, health and nutrition is also underway.

2.2.7 ETIOLOGY AND PATHOGENESIS

Finding the "missing" pathogens causing diarrhoeal diseases constitutes an important activity of laboratory scientists, and this has required the adoption of state-of-the-art diagnostic techniques.

2.2.8 VACCINE STUDIES

The groundwork has been done for vaccine trials of pneumococal vaccine in pregnant women and a new measles vaccine. Heat stability of the oral cholera vaccine is also under study.

2.2.9 POPULATION STUDIES

The new Population Studies Centre (PSC) is the locus of all population research not specifically tied to other programmes or projects. During the next year a major focus of the PSC will be to synthesize a number of recent studies on the effects which parents' preference for sons instead of daughters has on fertility and family planning, as well as on mortality. Other studies will look at the fertility impact of the Grameen Bank, another large rural development project in Bangladesh, and at the effects of fetal loss on human reproduction, using a highly sensitive and specific enzyme immonassay to determine parameters for a simulation model.

2.3 Divisional Highlights

2.2.1 COMMUNITY HEALTH DIVISION

Some highlights of the research and related activities in the past six months follow:

(i) In Matlab a protocol was started, and most of the field work completed, to evaluate possible side effects of giving Vitamin A supplementation with each EPI contact. Preliminary communication and protocol development has begun on the possibility of carrying out a vaccine trial with an improved measles vaccine to be used below nine months of age.

(ii) The Urban Health Extension Project (UHEP) is engaged in the preparation of a new Cooperative Agreement with USAID that may result with it being a discrete component of a larger project including the MCH-FP Extension project.

There is an understanding that the next phase of the project will be undertaken in partnership with an NGO and with active participation and involvement of the government counterpart(s), where the NGO would be responsible for the service components and the UHEP would be responsible for the technical assistance and research component. The UHEP has also been occupied with producing a number of reports and preparing for a workshop to disseminate the results of several years of research effort.

(iii) In addition to the Rajendrapur NGO workshop mentioned in the last report, the Environmental Health interest group has been involved in a variety of activities. The proceedings from the regional workshop held in Comilla in November 1991 were published in June and have been well received, with comments and support for the further development of a regional applied research centre from a number of quarters, including UNICEF.

(iv) Members of the Social Sciences interest group continue to be occupied in a number of protocols. A large study, aimed at developing a dietary intervention to improve Vitamin A intake in small children, began in April.

(v) The Epidemic Control Preparedness Programme (ECPP) studied the risk factors for death from cholera during epidemics based on the analysis of data collected by ECPP teams.

(vi) In conjunction with John Cleland of the London School of Hygiene and Tropical Medicine, preparations were made by the

Matlab MCH-FP Project and Urban Health Extension Project to design studies of various aspects of contraceptive use dynamics. These studies will include: analysis of ways of reducing the costs of delivering family planning services in Matlab, the development and testing of village-based contraceptive depots, and models of cost-effective family planning service delivery systems in the slum of Dhaka.

The staff participated in a number of conferences and workshops (see 10.3).

Nine medical and public health students have visited and worked in the Division recently - all from different schools including University of California San Francisco, Harvard, Columbia, State University of New York Stoney Brook, the University of Washington, and the School for International Training Vermont in the United States, McGill in Canada, Oxford University and The Liverpool School of Tropical Medicine and Hygiene in England. Three doctoral students from The Johns Hopkins University are developing thesis projects to be carried out within the Division.

2.2.2 CLINICAL SCIENCES DIVISION

An external review of the Clinical Sciences Division took place in May 1992. In general the review appreciated the work of the Division and made several recommendations. The Division has prepared a formal response which will be presented to the Programme Committee.

Dr Mahalanabis visited Montreal (McGill University) and attended and assisted Prof. J.R. Hamilton (Chairman, Programme Committee) in organizing an Expert Group meeting to advise the Centre about future research on basic mechanisms of diarrhoea. A draft report with recommendations will be available at the time of the Board Meeting. He also visited USAID office in Washington, D.C. and reviewed the

status of AID funded projects. He visited the University of Alabama in Birmingham, the Sparkman Centre and Department of Nutrition at the University of California, Davis to discuss collaborative studies.

The Division has been engaged in several studies. Some of the finding are as follows:

(i) In a study promoted by WHO to study the risk factors for dehydrating diarrhoea in infants and children, the following were concluded

- withdrawal of breastfeeding during diarrhoea was associated with five times higher risk of dehydration compared with those who continue to breastfeed during diarrhoea at home;
- lack of oral rehydration therapy with either complete formula or a salt and sugar solution at home was associated with 57% higher risk of dehydration compared with those who received a reasonable amount of oral rehydration salt solution at home.

(ii) In another study it was shown that continued breastfeeding reduced the risk of xerophthalmia in infants and children under three years by as much as 74%; this protection was evident even in the third year of life if breastfeeding was continued. As high as 49% of the mothers were still breastfeeding in the third year of their child's life.

(iii) Two clinical trials with administration of zinc in infants and children with acute diarrhoea and with persistent diarrhoea respectively showed that in the sub-group of under-nourished children daily zinc administration for two weeks reduced the severity and duration of diarrhoea, and resulted in better weight gain and improvement in height which persisted for three months after the cessation of the intervention.

(iv) Several studies are evaluating the role of energy dense weaning food made from thick sticky porridge made liquid by adding amylase rich germinated wheat flour. Some preliminary analysis of data from these studies show that use of liquified

energy dense porridge using amylase rich germinated wheat flour increase calorie intake by about 50% in infants and children with acute watery diarrhoea, with dysentery due to shigellosis and in severely malnourished children convalescing from acute diarrhoea. In addition this recipe of energy dense liquid porridge was well accepted by the mothers and their children.

A research methodology workshop on clinical epidemiology and clinical/field intervention trials was conducted with participants from Bangladesh, Nepal, Sri Lanka, Pakistan and India and selected staff from the Clinical Sciences and Community Health Divisions. Faculty included international consultants (Drs M.K. Bhan, J.P. Muliyil and Sheila Gore). The workshop included practical sessons on data management and statistical analysis using microcomputers.

Two medical students from Newcastle, UK received training on diarrhoeal diseases for 2-3 weeks at the Clinical Research Centre. Dr Karen Meyer from The Johns Hopkins University also spent 5 weeks at the CRC.

Several staff participated in international scientific conferences (see 10.3).

2.2.3 LABORATORY SCIENCES DIVISION

Major research accomplishments of the Division during this period include:

(i) Blue-green algae (cyanobacterium-like body) has been identified for the first time in Bangladesh in patients with persistent diarrhoea; and newly described serotypes of S. dysenteriae 11, 12 and 13 have been identified in some patients in Bangladesh.

(ii) Slime polysaccharide, produced by S. dysenteriae 1 under haemagglutinating condition, has been shown to confer

resistance on the organism to serumcidal activity and phagocytosis.

(iii) Characterization of monoclonal antibodies produced against LPS of S. dysenteriae 1, 13, Shiga toxin and bundle-forming pilus antigen of EPEC are being carried out.

(iv) Survival studies of S. dysenteriae 1, using water from pond, lake, river and drainage, showed the existence of viable but non-culturable forms of the organism up to 6 weeks, suggesting that water samples containing non-culturable but viable shigellae can act as potential vehicle of infection.

(v) In consultation with leading Vitamin A laboratories in the United States, the Nutrition-Biochemistry Unit has established methods to assess Vitamin A status (Relative Dose Response and Modified Relative Dose Response).

(vi) A pilot study of enteric adenovirus mucosal immunity has commenced following seven infants for a period of 22 months. Adenovirus reinfection is commonly detected and stool antibodies have been found following 58% of episodes of adenovirus excretion.

(vii) Analysis of isolates of classical V. cholerae in Bangladesh between 1962 and 1992 suggested existence of two different clones of the classical biotype. This substantiates the hypothesis that El Tor biotype never completely replaced the classical biotype in Bangladesh.

The Clinical laboratories continued to provide diagnostic services as well as research support to clinical and epidemiological studies. Workload in the clinical laboratories and demand for on-payment service increased by 20% this year. Measures are being taken to replace ageing equipment.

Five scientists of the Division attended international conferences in August 1992 (see 10.3). One scientist is now in Japan doing collaborative research with Professor Y. Takeda of Kyoto university. Two PhD students enrolled with Karolinska Institute, one PhD student

of University of California (Davis) and one PhD student of Dhaka University are now carrying out their research in LSD laboratories. Five M.Phil and 4 MSc students of Dhaka University are also undertaking their dissertation work. The Division participated in conducting the Centre's international course on Laboratory Diagnosis of Common Enteric Pathogens.

2.2.4 POPULATION SCIENCES & EXTENSION DIVISION

In September we received confirmation that the Ford Foundation had approved a grant of $667,000 for support of community-based research on reproductive health and women's empowerment. This will fund two PSED proposals. The first is an umbrella project linking the ICDDR,B, BRAC, BIDS, BIRPERHT, the Population Council, and Ford, into a Consortium on Reproductive Health to examine women's health issues. A major focus of this project will be developing the research skills and capacities of the consortium members and other institutions in Bangladesh. The second proposal which this grant funds is for the Centre's portion of the Consortium field work in the BRAC/ICDDR,B Matlab area (see below). This three year grant will enable the ICDDR,B to make major progress in its social science research, and research training, initiatives.

In 1992, the Bangladesh Rural Advancement Committee (BRAC) is intorducing its Rural Development Programme (RDP) into Matlab thana. In each RDP village eligible households, those owning less than one-half acre of land or selling manual labour for at least 100 days per year, are identified. The RDP then invites members of these households to join male or female Village Organizations, which have about 50 members. Group identity is established through meetings and a savings plan, and a non-formal primary school is started. Eventually credit and vocational training are added to the group activities. Due to the presence of the ICDDR,B in Matlab, a unique opportunity arises to carry out research on the impact of social and economic development that occurs in the presence or absence of

special maternal and child health and family planning programmes. The fundamental goal of the collaborative research envisaged - between BRAC and the ICDDR,B as well as other members of the Consoritum on Reproductive Health - is to help improve the well-being of the rural poor, especially women.

Following a visit by senior officials of ODA/UK, discussions continue on exploring further assistance to DSS and on funds for operational research on contraceptive use dynamics. Working with John Cleland we were able to devise projects to: find out if costs of family planning services can be reduced in Matlab; develop and test village-based contraceptive supply depots; suggest ways in which contraceptive use, continuation, and speed of method switching can be improved; develop and test cost-effective family planning services among the slum population of Dhaka; and measure the prevalence of reproductive tract infections and devise ways of detecting and treating these. This proposal will be finalized when ODA completes its decentralization of bilateral activities to the local mission.

Although the Centre had asked UNFPA, as a major international donor in the population field, to fund the Demographic Surveillance System, UNFPA decided to fund seminars and workshops, as well as the DSS Project Director, but not other essential DSS activities as requested. (In addition, no overhead is provided.) This has required some major revisions in our planned activities: we are now in the process of arranging courses in areas such as applied demography, longitudinal surveillance and analysis, and operational research for improving family planning programme effectiveness.

As recommended by the Programme Committee Review and discussed at the May 1992 Board Meeting, the PSED has decided to modify its organizational structure. It is now made up of the following units:

- the Population Studies Centre
- the Demographic Surveillance System

- the MCH-FP Extension Project
- the Data Archiving Unit
- the Computer Information Services.

The new Population Studies Centre, under the direction of Dr R. Bairgai as Studies Director, has been established. This group is the locus of population studies at the ICDDR,B apart from applied and operational research being carried out by the Extension Project. This group is free to undertake population studies at the national or international level, although it will continue its special relationship with Matlab. Researchers from throughout the ICDDR,B undertaking population studies, as well as visiting scholars, will be affiliated with this group for research support. In addition, the PSC will provide frequent discussions, group meetings, host workshops, and serve as a source of technical assistance for the Government and others. Among the current activities of the PSC are: supervising the data collection and processing of the baseline survey for the BRAC/ICDDR,B Matlab project; initiating a study supported by the Rockefeller Foundation of the fertility impact of the Grameen Bank; completing work on a paper for UNICEF on the projected impact of raising the age of marriage to 18 in Bangladesh; and a contribution to a forum on adult health in the developing world which looks at adult mortality and its consequences in Matlab.

DSS activities during this period have included: streamlining and reorganizing the project following the creation of the PSC; conducting operations research on solving the problem of unrecorded household splits; improving the data base, especially the pregnancy history table; and extracting data for various studies. During 1992 the DSS Annual Reports for 1985, 1986, 1987, and 1988 will have been finalized and published.

USAID (Dhaka) is currently reviewing the master plan for the next five years, including support to the Extension Project. Preliminary indications are that the budget which we have submitted to them will

be accepted with few revisions. The Extension Project continues to address a number of USAID's concerns. Management research will continue to help the family planning be "sustainable". A number of Project activities, such as research on contraceptive choice, management and supervision, and training, fall under the theme of "quality of care". USAID is starting to include MCH with family planning even more, so the Project's experience in areas like satellite clinics and access to ICDDR,B health expertise make it increasinly relevant for USAID and Bangladesh. The Project had its Mid-term Assessment by a USAID team headed by Sallie Craig Huber. The team noted a number of strengths and made several recommendations which are being examined by the Centre and the Project.

3.0 TRAINING

During the six month reporting period, the Training Branch ran six courses, administered the six fellowship programmes, and assisted 52 project-based research trainees. A total of 324 people were trained and/or given orientation through brief lectures, visits and demonstrations. The Centre has initiated an international fellowship programme to encourage dissemination of knowledge to, and exchanges with scientists from Asia, Africa, and South America. The Asian (a Chinese national) is already working in the Centre, and the African representative (from Nigeria) is expected to arrive in December. The South American fellow, from Peru, is expected by the end of the year. The activities are summarized in the Table 2 (below).

Table 2: Summary of Training Activities - 1 April to 30 September 1992

Description of activities			Number of courses	Number of participants
1. International training course			2	28
2. Study visit			1	5
3. National training courses			3	44
4. Fellowship programmes:				
a) Trainee Research Asst.		- 1		
b) SAARC fellowship		- 0		
c) GOB fellows		- 6		
d) Project-based fellows:				
- Physicians	- 19			
- Health Assistant	- 20			
- Nurses	- 10			
- Others	- 3			
		- 52		
e) International fellows		- 16		
f) Dhaka Uni. students		- 11		
				86
5. Short orientation training				161
Total				324

4.0 SERVICE - HEALTH CARE

4.1 Clinical Service Department

4.1.1 DHAKA

The hospital has instituted a new organization which ensures accountability and continuity of care to patients. Three medical teams have been formed, each team responsible for all the patients admitted during the 24 hours that it is on duty until their discharge. This has created healthy competition and improved quality of care.

The patient load was again up in comparison to the same period last year (see Table 3, Page 19). In mid October, a major cholera epidemic has required the Centre to take emergency measures to cope with the rush of severely dehydrated patients. The growing resistance of cholera strains to tetracycline is a worrying trend and has increased the duration of stay.

The Child Health Programme (CHP) continued to provide preventative health education, immunization, and outpatient follow-up to patients attending the Dhaka hospital. A total of 153 severely malnourished children were rehabilitated, and family planning devices were provided to 289 mothers. In addition operations research activities have commenced within the programme.

4.1.2 MATLAB

In Matlab, the patient load was twice that of the same period last year, and broke all previous records for hospital admission. This increase reflects not only a major cholera epidemic but also the increasing size of the catchment area. Patients are coming from further and further afield (in some cases as far as 35km) to use the Matlab hospital. The number of patients remaining in hospital for

more than 24 hours increased four fold, reflecting increasing tetracycline resistance rates which are currently over 60% (see Table 4, Page 20).

Table 3: Patient Load at Clinical Research Centre - Dhaka - 1 April to 30 September 1992

Month	Visits		Admissions		
	OPD		IPD & ICU		
	<12 hours	≥12 hours	<1 day	1-7 days	>7 days
April	8,513	4,007	22	493	115
May	5,787	3,313	16	501	131
June	3,946	2,126	6	321	117
July	3,940	2,059	8	296	111
August	4,982	2,282	12	312	126
Sept.	4,377	2,203	12	293	340
Total	31,545	15,990	76	2,216	940

4.2 MCH-FP Activities in Matlab

Over 3,500 patients were treated in the various MCH-FP wards (the nutrition rehabilitation centre, delivery room, mothers' and respiratory tract infection wards), and an additional 18,500 were seen in the out patient department (see Table 5, Page 20).

Table 4: Number of patients with duration of stay at Matlab Diarrhoea Treatment Centre - 1 April to 30 September, 1992

Month	< 1 day	1 day	2-6 days	> 7 days	Total
April	984	739	333	18	2,074
May	565	560	410	21	1,556
June	428	431	326	17	1,202
July	442	521	352	15	1,330
August	815	813	537	13	2,178
September	659	872	692	11	2,234
Total	3,893	3,936	2,650	95	10,574

Table 5: Number of patients who visited Matlab MCH-FP Clinic

Month	Short stay	24 hours stay	1 week stay	Above 1 week stay	Total
April	402	2	49	26	479
May	429	2	45	27	503
June	446	3	52	18	519
July	558	1	64	29	652
August	600	3	71	33	707
September	576	12	110	22	720
Total	3,011	23	391	155	3,580

4.3 Urban Health Care

The Urban Health Extension Project continued to provide health commodities, education and referral services through its network of circa 450 volunteers. In the six months to September 30, 1992 over 155,000 packets of ORS were distributed to 55,804 clients, and health education was provided as follows:

Education Provided	# of clients
ORS Preparation	43,872
Hygiene	43,785
Nutrition	30,905
Immunization	13,014
Family Planning	9,094
Total	140,670

During the six months, the volunteers and their supervisors 3,255 patients were referred to static health facilities.

5.0 TECHNICAL SERVICES

5.1 Computer Information Services (CIS)

As a result of the effort put into increasing the usage of the Centre's mainframe computer, this has risen by 20% during the six months to September 1992. Initial attempts to sell CIS resources to outside organizations have resulted in 4% of the period's utilization by external organizations.

The Glimpse and Annual Report mailing system was redesigned and installed in the Library using Foxbase, and some major data cleaning and report generation programmes were written for CHD.

In response to Centre user needs, an Analyst Programmer is currently undergoing training on data communication and computer networking at the Asian Institute of Technology, Bangkok.

5.2 Diarrhoeal Diseases Information Services Centre (DISC)

DISC, with 11 regular staff members and one part-time editor, continued the Centre's information and publication services activities. SDC grant for DISC and its activities, which began in 1988 finished in December 1991, and DISC is now being financed from Core funds.

5.2.1 LIBRARY SERVICES

There were a total of 7,436 outside readers in the library and 165 MEDLINE and POPLINE searches were made during the six months April 1992 - September 1992, of which 73 were for ICDDR,B staff.

5.2.2 PUBLICATIONS SERVICES

Twelve issues of the Current Awareness Service Bulletin were issued, and the publication schedule for the JDDR has been maintained. The

1991 Annual Report was published and distributed in May. ICDDR,B's new Bengali newsletter "Shasthya Sanglap" was launched at a ceremony in early April 1992, and two issues (10,000 and 15,000 copies) have already been circulated to Government and NGO front-line health workers throughout the country. In total, nearly 42,000 copies of ICDDR,B publications were distributed outside the Centre, and revenue of $2,574 was generated.

5.3 Animal Research Branch

During the period, the ARB performed a series of tests and assays including the RITARD model, Ilela loop and sereny on over 500 guinea pigs, rats and mice. The small animal clinic treated around 100 cases, and earned a revenue of $ 640.

5.4 Audio Visual Unit

In addition to its usual photographic and graphic design work, the Unit has been training to build its video-making capabilities. The Unit has also been active in the preparation of publicity materials for the Hospital Endowment Fund and the Centre as a whole.

The Unit has assisted with the development and production of the booklet "Partnership in Progress: ICDDR,B's contribution to and collaboration with Bangladesh".

5.5 Bio-Engineering Cell

In addition to routine repair and maintenance, the key work of the Cell during this period was the installation of a Sorval centrifuge in the Micro-biology Laboratory. Assistance was provided to the Bangladesh Institute of Public Health.

6.0 ADMINISTRATION & PERSONNEL

6.1 Staffing Changes

The Centre during the period, continued with its sustained efforts in maintaining the Personnel costs at an acceptable level. However, in the light of discussions at the earlier BOT meetings on job security and staff morale, a few conversions of employment contracts from short-term/ contractual service agreements to Fixed-term (mainly project positions) were allowed after careful scrutiny and in view of the pressing needs of the concerned projects. Since the last reporting for the BOT meeting, 17 staff members were separated from the service of the Centre while 28 additions were made out of which 11 were new recruits (mainly for the projects) and the rest were conversions. The details of the changes in staffing are provided in the table below :

Additions			Separations		
NO & GS			NO & GS		
a) Conversions from short-term, contractual service agreement	:	16	a) End of contract	:	3
			b) Retirement/Termination or Health Reasons/Death	:	5
b) New appointments	:	11	c) Resignation	:	8
		27			16
International Professional					
a) New appointments (Fixed term)	:	1	a) End of contract	:	1
		1			1
Total		27			11

6.2 International Professional staff

6.2.1 RECRUITMENT OF INTERNATIONAL PROFESSIONAL STAFF

During the period, only one fixed-term International Professional Staff has joined the Centre (May 01, 1992). She is Ms. Leanne Unicomb, an Australian national and by profession, a Virologist.

6.2.2 SEPARATION OF INTERNATIONAL PROFESSIONAL STAFF

Dr. A. N. Alam (Head, CRC) has been released effective June 30, 1992, on completion of his six years of service at the international professional level.

6.3 Achievements/New developments

New performance appraisal forms for different categories of staff have been developed and would be administered upon approval of the management effective January 01, 1993.

The Centre's Staff Rules and Manual have been updated in line with UN/WHO and have been submitted for BOT/Management approval.

6.4 Support Services

6.4.1 ESTATE OFFICE

A new digital 200 lines PABX system for the Centre has been installed.

6.4.2 TRAVEL OFFICE

This office continued to render its services to the staff, visitors and guests for their travel arrangements and obtaining necessary visas and landing permits.

6.4.3 STAFF CLINIC

The Staff Clinic provided health care services to the national staff members and their dependents. A total of 11,254 patients attended the staff clinic since the last BOT meeting.

6.4.4 TRANSPORT

The transport pool rendered road and water transportation facilities to the staff members, course participants, and the visitors. It has rented out 25 Centre vehicles to the International Professional Staff members in addition to running a pool of 15 vehicles.

6.4.5 MAINTENANCE AND ENGINEERING BRANCH

Construction of the "SASAKAWA TRAINING CENTRE" on top of the Hospital Building covering approximately 17000 sq. ft. at a total project cost of approximately US $430,000.00 has been completed. The Project costs cover air-conditioning and interior decorations. The area will house the Training Branch, Lecture Hall, two Seminar Rooms, Clinical Pathology Laboratory and part of the Laboratory Sciences Division Laboratories.

Construction of the Generator house for installation of a 825 KVA Generator at a cost of US$ 30,000.00 has been completed.

Electrical sub-station equipments including 800 KVA transformer, H.T. and L.T. switch gears have been procured and are awaiting installations.

One 825 KVA stand-by Generator set of US$ 131,000.00 has arrived which is being installed and commissioned.

Construction of the southern wing on top of the Hospital building has commenced and so far 20% of the work has been executed.

6.4.6 SUPPLY OFFICE

The Supply Office introduced "Quality Circle" meetings with the requisitioners with a view to solving problems through discussions and minimizing the lead times. It has issued 1250 purchase orders valued approximately at US$ 648,515.00 against 1500 requisitions received during the period.

6.4.7 GENERAL SERVICE BRANCH

This branch has been continuing to render the necessary security services to the Centre. It also provided logistics support and made physical arrangements for holding meetings and conferences during the period. Moreover this branch also arranged for the mail despatch and delivery services of the Centre.

6.5 Staff Development

During the six months to September 30, 1992, 12 of the Centre's staff returned to Bangladesh having completed their studies and/or training abroad and 17 staff left the Centre to commence study and/or training. As of September 30, 1992, 14 staff were studying for Doctorates or MRCP, 10 staff were taking Masters courses in a wide variety of disciplines including microbiology, demography, Community/Public Health and PHC, and another 6 were undergoing short-term training.

7.0 FINANCE

From 1 July, 1992 the Centre has handled all salary payments for expatriate staff with the only involvement of IIE being retirement and separation funds, insurance and specialty services as and when required. This change will save the Centre at least $30,000 per annum in direct costs and will relieve the many frustrations we have experienced with them. We have been able to absorb this increased work load by rearranging duties and increased productivity.

In August 1992, IIE advised that they will discontinue all services to us from December 31, 1992. We are negotiating with Association of International Agricultural Research Centres to act as a conduit with Generali and Van Breda respectively on the International Staff Retirement Fund and insurance requirements. We are also negotiating directly with Accurecord and Generali on the National Staff Retirement Fund.

Unpaid personal advances are now deducted from employees payroll and where full deduction cannot be made or the employees are seconded we are charging interest. This has reduced personal advances by approximately 75%.

A new reporting system was introduced to monitor utilization of funds allocated to budget. This system should ensure compliance of expenditure and avoid unnecessary refunds to donors.

A donor funding status report was developed and this now forms part of the monthly reporting.

81% (1991 67%) of National employees were granted investment loans which will save the Centre $69,000 in income tax for 1992. The amount is approximately $100,000 less than advised to the May Board meeting because of the Government's budget changes on deductions from investment. Much of

the credit for increased employee participation goes to the President of SWA.

After years of discussion with Generali, it has been finally agreed to credit interest to individual National employees retirement accounts on a quarterly basis as opposed to an annual basis. This has been a bone of contention for a long time as previously an employee leaving in December would have received no income for that year. Whilst there is no cash benefit to the Centre, it is a morale booster for employees.

8.0 RESOURCE DEVELOPMENT

8.1 Background

In a year characterized by deepening recession throughout the world, finding finance for ICDDR,B has proved increasingly difficult. Several key donors, including Australia, Japan, and UNICEF, continue to maintain their contribution at the same levels as 1989 or even before. As a result of internal budgetary constraints it appears that NORAD is being forced to reduce its contribution. However, NORAD is keen to finance the Centre through bilateral channels should the Government of Bangaldesh request this. It is particularly disappointing that the ICDDR,B continues to face basic core funding problems after the remarkable progress that the Centre has made in the last four years.

This year ICDDR,B has essentially completed the implementation of the staff rationalization and austerity measures recommended by the "External Review of the International Centre for Diarrhoeal Disease Research, Bangladesh" authored by C.E. Gordon Smith and D.J. Spencer on behalf of the donor support group. The Centre's scientific productivity has reached new highs, and the improvements in its management and organization are recognized throughout the international health community. The majority of donor financed health programmes (both Government and Non Government Organization implemented) rely heavily on findings from, and research and/or training conducted at, ICDDR,B. And yet funding levels remain approximately the same as in 1986.

Increasingly, ICDDR,B is being told to go to the private sector, or to access bilateral funds, to finance its operation. The Centre has spent some considerable time and resources to investigate these two possibilities. It is clear that although the private sector can make some contribution to the Centre's operation, it will never be able to replace the key core funding provided by Government and multilateral agencies (see the Revised Resource Development Strategy for an analysis of this).

ICDDR,B will have to access bilateral funds to finance many of its activities. Some of the Centre's activities (the hospitals are the most commonly cited example) form an integral part of Bangladesh's health service system. Increasingly, donors are questioning why they should finance these elements of ICDDR,B's activities, and advocating that the Government of Bangladesh should fund the hospital to a level on a par with Government hospitals.

8.2 Activities during the year

In addition to the maintenance and development of traditional funding sources, the Resource Development Office has worked to try to broaden the Centre's network of supporters. For details of the total revenue expected in 1992, see Table 6 on page 32.

Several public relations publications were prepared including the proceedings of the 1991 Donors' Support Group meeting, and "Partnership in Progress". Other public relations exercises continued, and several ambassadors and missions visited the Centre to review its work.

To strengthen the resource development monitoring, a new system has been developed in conjunction with the Budget and Finance Office, to track donations (receivable and received). To improve resource development capabilities and in preparation for the formal launch of the endowment funds, a small resource development library containing foundation listings, manuals etc. has been assembled.

In July and September, a tour was undertaken to look into broadening the Centre's resource development base in the private sector and into endowment funding. This tour included visits to the UK, Canada, the US, Japan and Australia. The information and contacts gained on this tour has led to:

a. an increased impetus in resource development activity, and a raised profile for the Centre in these countries

b. a clear understanding of the complexity of running large scale fund-raising campaigns and generating funds from the private sector,

c. the development of the revised draft ICDDR,B Resource Development Strategy (which has been circulated separately).

The second half of the year has seen increased collaboration and the signing of a new collaborative agreement with the International Child Health Foundation (ICHF). This improved collaboration should allow ICDDR,B to use its network in the USA and Canada more effectively. In addition, an outline of the Centre's UK/Europe strategy is being developed in conjunction with consultants, one of whom will be selected to implement this. This will eventually lead to the Centre's charitable registration in the UK, thereby allowing tax-free donations in Britain (and possibly, later, Europe).

Preliminary research is being conducted into US and UK foundations to identify those with a history of funding international health research, population activities, and training. Furthermore, ICDDR,B has initiated contacts with selected foundations with which the Centre has reasonable connections. The Rockefeller Foundation has expressed interest in working with the Centre under its new five year health research programme, which is specifically targeting research conducted in developing countries by developing country scientists. The Rockefeller Foundation is beginning to foster an informal international health network through its "Global Alliance Against Tropical Diseases", and has shown interest in funding the Centre to further these attempts through a conference at its international conference centre at Bellagio.

Initial contacts in attempts at international health research networking under the Global Alliance Against Tropical Diseases sponsored by NIH/NIAID and the Rockefeller Foundation. This should lead ICDDR,B to be involved as one of the Centre's for Tropical Disease Research under the NIAID programme.

Table 6: Summary of Fund Status as of September 1992 by Donor

Name of Donor		Estimated Revenue $
A.G. Fund	...	350,000
Aga Khan Foundation	...	10,000
Australia - AIDAB	...	234,417
Bangladesh	...	26,000
Bayer-AG	...	117,020
Belgium	...	362,306
Canada/CIDA	...	856,075
Cyclone/Disaster	...	76,112
Denmark/DANIDA/CHP	...	287,000
Ford Foundation	...	87,418
French	...	16,545
George Town University	...	11,897
Helen Keller International	...	14,828
IDRC	...	64,000
Japan	...	380,000
Netherlands	...	134,169
Norway/NORAD	...	75,000
Rockefeller Foundation	...	42,445
Saudi Arabia	...	50,000
SKF-Albendazole	...	10,663
Sweden/SAREC	...	404,000
Switzerland	...	1,281,762
UNDP	...	396,671
UNFPA	...	212,000
UNICEF	...	324,063
U.K./ODA	...	334,258
USAID/Dhaka	...	1,490,000
USAID/Washington	...	2,193,000
WHO	...	163,255
Total		$10,004,904

9.0 COORDINATION/MANAGEMENT

The Centre's mandatory coordination and management committees have continued to function smoothly. The broad diversity of national institutions with which the Centre interacts is now particularly worthy of note.

9.1 Management Committees

Meetings of the Consultative Management Committee (1) and of the Council of Associate Directors (17) have continued regularly, as have those of the Divisional scientific and management bodies.

9.2 Review Committees

9.2.1 RESEARCH REVIEW COMMITTEE (RRC)

The RRC meet five times during the period from April 1992 to September 1992, to consider 16 protocols of which 14 were approved.

The Chairman of the Ethical Review Committee (ERC) has been invited to become a member of the RRC.

9.2.2 ETHICAL REVIEW COMMITTEE (ERC)

The ERC met five times during the period from April 1992 to September 1992, to consider 11 protocols of which all were given ethical clearance.

9.2.3 ANIMAL EXPERIMENTATION AND ETHICS COMMITTEE (AEEC)

The AEEC did not meet during the period, but cleared three protocols involving the use of animals by circulation of the protocols.

9.3 Programme Coordination Committee

As a follow-up to PCC recommendations, a third "Course on Epidemiological Methods in Public Health" was organized by the Centre in July 1992. Faculty drawn from ICDDR,B, NIPSOM, BIRPERHT and the Institute of Epidemiology and Disease Control Research worked with 20 trainees in a successful course.

During the last six months five PCC-collaborative research protocols (with Dhaka University, Dhaka Shishu Hospital, Chittagong University), were completed. Final reports have been submitted. Two PCC-collaborative research protocols (with BIRPERHT and Sirajganj Maternal and Child Health Centre) are continuing in collaboration with ICDDR,B scientists.

10.0 MISCELLANEOUS

10.1 International Technical Assistance

ICDDR,B staff provided technical assistance to the Ministry of Public Health to control epidemics of cholera and dysentery in the Republic of Yemen. They also conducted two training courses on the clinical management of diarrhoeal diseases. In Iran, Centre staff conducted two weeks of training courses on the clinical management of diarrhoeal diseases, and provided technical assistance in preparation for the establishment of the Diarrhoeal Training and Treatment Units in Shiraz and Isfahan. Three of the Centre's senior physicians conducted a week long clinical course on diarrhoeal diseases with special emphasis on the management of cholera, in Phnom Penh. Discussions were held on developing collaboration between ICDDR,B and the National Paediatric hospital, where Cambodia's only diarrhoea treatment unit was recently established.

10.2 Relief Activities

Between July and October 1992, the Epidemic Control Preparedness Programme (ECPP) was called upon by the GoB health services to assist in epidemics in 26 upazilas. Physicians of the programme spent 73 man-days, treating over 1,155 acute watery diarrhoea patients and conducted epidemiological investigations in the affected upazilas. The ECPP physicians collaborated with the GoB health staff in setting up 17 temporary treatment centres and providing orientation training for about 30 local GoB physicians. A total of 227 rectal swabs were collected from patients and analyzed at the Centre's laboratories. 70% of the swabs collected were positively identified as containing *Vibrio Cholerae.*

10.3 Research Communication & Dissemination

In February 1992 ICDDR,B received the report of the AID, Washington

communications consultant, Dr. Michael Mueller. The report called for the establishment of a Communication and Dissemination Office, the development and implementation of communication and dissemination strategy and the training of a local counterpart to run the office. The Centre has already implemented most of the recommendations relating to internal communication, but recognizes the need for assistance in disseminating its findings more effectively. A project proposal to assist the Centre to develop its dissemination and communication capabilities has been prepared, however a donor has not yet been found to support this activity.

Attendance of ICDDR,B staff at international conferences/workshops has increased considerably in 1992 and raised the visibility of the Centre as a productive centre of excelllence. Eighteen persons attended thirteen conferences/workshops (see Table 7).

Table 7: Attendance at overseas seminars and workshops by ICDDR,B staff 1 April - 30 September, 1992

No.	Name of Staff	Conference
Clinical Sciences Division		
1.	Dr Samir K. Nath	Annual meeting of the American Gastroenterological Assoc., San Francisco, USA
2.	Dr Rukhsana Haider	Lactation management, London, UK
3.	Dr M.A. Salam	International Society for Chemotherapy, Munich, Germany
Community Health Division		
4.	Dr Kirk Deardon	National Council for International Health, Washington, USA

5.	Dr Abdullah Baqui	Govt./NGO/ICDDR,B joint delgn. to Aga Khan University Conf. on Urban Health, Pakistan
6.	Dr Martin Desmet	- do -
7.	Dr Sushila Zeitlyn	Social Science and Medicine Conf., Scotland
8.	Dr Martin Desmet	- do -
9.	Dr Bilquis A. Hoque	2nd Asian Pacific Conf. on Disaster Medicine, Japan
10.	Dr Bilquis A. Hoque	Workshop on Testing of Training Modules on Women in Water Supply and Sanitation, Bangkok

Laboratory Sciences Division

11.	Dr R.B. Sack	US/Japan Cholera Conference, Tokyo, Japan
12.	Dr John Albert	- do -
13.	Dr Tasnim Azim	7th Congress on Mucosal Immunology, Prague, Czechoslovakia
14.	Dr Ferdous Quadri	- do -
15.	Mr M.A. Wahed	Workshop on MRDR of Vitamin A, Iowa, USA

Population Sciences & Extension Division

16.	Mr Nikhil C. Roy	23rd Summer Seminar on Population, East West Centre, Hawaii, USA
17.	Mr Kashem Sheikh	- do -

Finance

18.	Mr Aziz uddin Ahmed	SAAF Seminar, Nepal

10.4 Institutional Collaboration

As indicated under 2.2 and 10.1 the Centre's linkages with institutions abroad is expanding, and the man visiting reearchers working in its various branches reflect this trend.

By the end of the year at least three international research fellows, one each from Asia, Africa and South America, will be working at the Centre as part of the health research training programme. On completion each of them will form the nucleus for sound institutional linkages with developing country institutions.

10.5 Strategic Planning

In preparation for the revision of the ICDDR,B Strategic Plan, Professor Mathan spent seven days at the Centre working with senior management to prepare and discuss an issues paper. This has formed the basis to stimulate the Centre's senior management and commence the strategic planning process. A first draft of the Strategic Plan will be presented to the Board of Trustees in May 1993.

10.6 Hospital Endowment Fund

Fees for immunization services provided through the Travellers' Clinic and by the CHP to clients who do not belong to the programme's target group are being contributed to the Hospital Endowment Fund. The sale of T shirts and a dinner dance that is to be held December are also expected to contribute to the Fund.

APPENDIX A

PAPERS PUBLISHED DURING 1 APRIL - 30 SEPT, 1992

1. Chowdhury AI, Fauveau V., and Aziz KMA. Effect of Child Survival on contraceptive use in Bangladesh. J Biosoc. sci 1992:24, 427-432

2. Clemens JD, Van Loon FPL, Rao M, Sack DA, Ahmed F, Chakraborty J, Khan MR, Yunus M, Harris JR, Svennerholm AM, Halmgren J.Non participation as a determinant of adverse health outcomes in a field trial of Oral Cholera Vaccines. *Am J Epidemiol* 1992 Apr 15;135(8):865-74.

3. Siddique AK, Zaman K, Baqui AH, Akram K, Mutsuddy P, Eusof A, Haider K, Islam S, Sack RB. Cholera Epidemics in Bangladesh: 1985-1991. J Diarrhoeal Dis Res 1992 Jun: 10(2):79-86.

4. Baqui AH, Black RE, Sack RB. Epidemiological and Clinical characteristics of acute and persistent diarrhoea in rural Bangladeshi children. Acta Paediatrica Suppl 381 (1992):15-21.

5. Fauveau V, Stewart MK, Chakraborty J and Khan SA. Impact on mortality of a community-based programme to control acute lower respiratory tract infections. WHO Bulletin 1992, 70(1):109-116

6. Fauveau C, Siddiqui M, Briend A, Silimperi D. Limited impact of a target food supplementation programme in Bangladeshi urban slum children. Annals of Tropical Paediatrics (1992) 12, 41-48.

7. Hughart N, Khatun J, Silimperi D. A new EPI strategy to reach high risk urban children in Bangladesh: Urban Volunteers. Tropical and Geographical Medicine, Vol. 44 (1992), 142-148.

8. Bilqis AH, Sack RB, Bateman M, Zeitlyn S. Proceedings of the workshop on "Water and Sanitation Priorities for the 1990's". ICDDR,B (1992).

PAPERS IN PRESS

1. Clemens JD, Sack DA, Rao M, Chakraborty J, Khan MR, Kay BA,Ahmed F, Banik AK, Van Loon FPL, Yunus M, Harris JR. Evidence that inactivated Oral Cholera Vaccines both Prevent and Mitigate Vibrio Cholera 01 Infections in a Cholera Endemic Area. *J Infect Dis* 1992 (In press).

2. Baqui AH, Sack RB, Black RE. Enteropathogens associated with acute and persistent diarrhoea in Bangladeshi children under five years of age. Journal of Infectious Disease.

3. Baqui AH et al. Malnutrition, cell-mediated immune deficiency and

diarrhoea: A community-based longitudinal study in rural Bangladeshi children. American Journal of Epidemiology.

4. Chowdhury AI, Bairagi R and Koenig MA. Effects of sex composition on fertility preference and behavior in rural Bangladesh, J. Biosocial Science.

5. Bilqis AH, Hoque MM. Environment and Development in Bangladesh. University Press Ltd. Dhaka, Bangladesh.

PROTOCOLS IN PROGRESS

PI - A de Francisco

1. Matlab MCH-FP Programme: Design, implementation and monitoring of MCH-FP services and Record Keeping System in Matlab/ since 1986. (300711)

2. Safety and Efficacy of Vitamin A Supplementation in infancy using the EPI as an entry point: An urban and rural project. [(305111 (RURAL)]

3. An approach to the management of acute respiratory infections in children in rural Bangladesh. (30 22 21)

4. An approach to improving maternity care. (30 12 31)

5. Nutritional Surveillance System. (30 34 11)

6. Measles Surveillance System. (30 14 41)

7. Measles Maternal Antibody Decay in Infants (38 38 11)

PI - AH BAQUI

8. Safety and Efficacy of Vitamin A Supplementation in infancy using the EPI as an entry point: An urban and rural project. 30 51 21 (urban)

9. A comparative study on the correct utilization and sustained use of rice packet ORS vs. standard glucose packet ORS by urban community mothers in Bangladesh.

PI - KMA Aziz

10. Development and implementation of nutrition education strategy for promotion of Beta-carotene rich foods as a source of vitamin A in children. (30 52 11)

11. Socio-economic, demographic and cultural factors related to patients at Matlab Diarrhoea Treatment Centre: an epidemiological and ethnomedical analysis. (30 33 11)

PI - MR N PALJOR

12. Urban Health Extension Project. (30 02 41)

PI - DR KIRK DEARDEN

13. Empowering women for health: Assessing the impact of training and service delivery in Dhaka slums. (30 02 61)

PI - DR BILQIS A HOQUE

14. Water Quality Impacts of Meghna-Donagoda Embankment. (304511)

15. The Environment and Shigella Related Dysentery. (10 77 11)

16. Promotion of safe water and sanitation practices through schools and women clubs: A feasibility study. (30 49 31)

17. Environment and child survival in rural Bangladesh. (30 44 11)

18. Water Supply and Sanitation beyond the project period in Mirzapur (30 50 11).

19. Environmental Health Science (Service and Technical Assistance). (210250)

PI - Dr. A.K. Siddique

20. Emergency Epidemic Control - Dr AK Siddique · (30 46 91)

PI - DR NIGAR SHAHID

21. Impact of infection at birth with rotavirus strain on subsequent rotavirus infection. (30 47 11)

PI - DR JACQUES MYAUX

22. The Effectiveness of trivalent oral polio vaccine in children with gastroenteritis. (30 48 11)

23. Dysentery: Surveillance system for children under five/MCH-FP Matlab

24. Intervention to reduce deaths from dysentery in the Matlab MCH-FP area.

Appendix B

CLINICAL SCIENCES DIVISION

PAPERS PUBLISHED

Alam NH, Ahmed T, Khatun M, Molla AM. Effects of food with two oral rehydration therapies: a randomised controlled trial. GUT 1992, 33.

Bennish ML, Salam MA. Rethinking options for the treatment of shigellosis (leading article). J. Antimicrob Chemother 1992; 30: 243-47.

Faruque ASG, Mahalanabis D, Islam A, Hoque SS, Hasnat A. Breastfeeding and oral rehydration at home during diarrhoea prevents dehydration. Arch Dis Child1992; 67:1027-9.

Henning B, Stewart K, Zaman K, Alam AN, Brown KH and Black R.E. Lack of therapeutic efficacy of vitamin A for non-cholera, watery diarrhoea in Bangladeshi children. Journal of Clinical Nutrition (1992) 46: 437-443.

Islam MA, et al. Can mothers safely prepare labon-gur salt-sugar solution after demonstration in a diarrhoeal hospital ? Trop Geog Med 1991; 43(4): 81-85.

Mitra AK. An approach to protect workers' health. Bangladesh Priv Med Pract Journal 1992; 2(1): 204-206.

Roy SK, Akramuzzaman SM, Khatun M, Haider R, Akbar MS, Alam AN. Persistent diarrhoea: factors affecting absorption and clinical prognosis during management with a rice based diet. Acta Paediatrica Scandinavica Suppl., 1992; 381:1-6,(Paper 26).

Salam MA. Ciprofloxacin in the treatment if Shigellosis. JAMA SEA (Suppl.) June 1992.

Sarker SA, Gyr K. Non-immunological defense mechanisms of the gut. GUT, 1992; 33(7): 987-993.

Van Loon FPL, Rabbani GH, Rask-Madsen J, Bukhave K. Indomethacin decreases jejunal fluid, secretion, in addition to luminal release of prostaglandin E , in patients with acute cholera. GUT,May 1992.
2

Van Loon FPL, Gyr K, Banik AK. Perfusion studies in cholera: Methods and Procedures. J Diarrhoeal Dis Res 1992 (3):133-138.

Book Chapters - Published

Rabbani GH and Greenough WB III. Clinicopathological aspects of cholera. In: Barua D et al (Ed.) :Cholera" Plenum Press, Boston.

PAPERS IN PRESS (accepted)

Bennish ML, Salam MA, Wahed MA. Enteric protein loss during shigellosis. Am J Gatroenterology.

Bennish ML, Salam MA, Khan WA, Khan AM. Treatment of shigellosis III. Randomised, blinded comparison of one or two-dose ciprofloxacin with standard 5-day therapy. Ann Intern Med., 1992: 117:

Kabir I, Butler T, Underwood LE, Rahman M. Effects of a protein-rich diet during convalescence from shigellosis on catch-up growth, serum proteins and insulin-like growth factor-1 (IGF-1) Paeditr Res. 1992.

Kabir I. Impact of feeding a high protein diet to children during convalescence from shigellosis. Clinical Nutrition 1992.

Mitra AK, Rabbani GH. Activity of Bioflorin Streptococcus faecium (SF 68) in acute diarrhoea (letter). Gastroenterology.

Mitra AK. Bacterimia and Meningitis.

Rahman MM, Kabir I, Mahalanabis D, Malek MA. Decreased food intake in children with severe dysentery due to Shigella dysenteriae 1 infection. European Journal of Clinical Nutrition, 1992.

Rahman MM, Mahalanabis D, Islam MA, Biswas E. Can infants and young children eat enough green leafy vegetables from a single traditional meal to meet their daily vitamin A requirements ? European Journal of Clinical Nutrition 1992; 46.

Rahman MM, Roy SK, Ali M, Mitra AK, Alam AN, Akbar MS. Maternal nutritional status as a determinant of child health. J Trop Paed.

Roy SK, Tomkins AM, Haider R, Behrens R, Akramuzzaman SM, Mahalanabis D. Impact of zinc supplementation on clinical outcome, morbidity and mortality in bangladeshi children with acute diarrhoea. BMJ

Roy SK, Haider R, Tomkins AM, Behrens R, Wahed MA, Akramuzzamannnn SM, Mahalanabis D. Impact of zinc supplementation on intestinal permeability in Bangladeshi children with acute diarrhoea and persistent diarrhoea syndrome. J Ped Gastro & Nutrition.

Roy SK, Akramuzzaman SM, N. Majid, Khatun M, Haider R, Akbar MS, Alam AN. Persistent diarrhoea: factors affecting recovery and prognosis during management with a rice-based diet. Acta Paediatrica Scandinevica Supplement, 1992.

Roy Sk, Rahaman M, Mitra A, Md. Ali, AN Alam, MS Akbar. Mothers ability to identify malnutrition in their children. Health Pol and Plann, 1992.

Struelens MJ, Mondol G, Kabir I, Salam MA, Nath SK, Patte D, Roberts M, Baldwin T, William PH. Pathogenesis of Shigella septicimia: bacteria and host factors. Euro J Clin Invest.

Clinical Sciences Division: Ongoing protocols 1992

1. ICDDR,B Surveillance Programme-Dhaka Hospital

   Dr. D. Mahalanabis, Dr. AN Alam

   106711
2. The role of cytokines in the pathogenesis of shigellosis

   Dr. M.A. Salam

   104211
3. Comparison of two L-alanine-glucose based oral rehydration solutions with the standard WHO-ORS formula in adults and children with acute watery diarrhoea

   Dr. D. Mahalanabis (Dr. FC Patra)

   104021
4. Trial of coconut oil based communited chicken meat diet in persistent diarrhoea in children

   Dr. P.K. Bardhan

   103921
5. Evaluation of trimethoprim-sulphamethaxazole in the treatment of infants and children with persistent diarrhoea

   Dr. P.K. Bardhan

   104111
6. High nutrient feeding of undernourished children with shigellosis during acute stage

   Dr. D. Mahalanabis (Dr. R. Majumder)

   103721
7. Evaluation of the beneficial effects of supplementation with a mixture of trace elements on growth and morbidity

   Dr. A.K. Mitra (Dr. Akramuzzaman)

   105111
8. Prognostic and risk factors for prolongation of acute diarrhoea: a clinic based cohort study

   Dr. D. Mahalanabis & Dr. ASG Faruque

105011

9. Small bowel microbial ecology of severe persistent diarrhoea with particular reference to diarrhoeagenic E.coli: a descriptive study of pathogenesis and pathophysiology of severe persistent diarrhoea

   Dr. D. Mahalanabis & Dr. J. Albert

106511

10. Controlled trial of energy dense porridge for children with acute watery diarrhoea

    Dr. A.K. Mitra

106411

11. Controlled trial of an energy dense porridge for children with acute dysentery.

    Dr. D. Mahalanabis (Dr. Ramendra Majumder)

107011

12. Impact of ready-to-use packaged rice ORS and response of mothers when provided as an antidiarrhoeal medicine in rural Bangladesh

    Dr. ASG Faruque and Dr. D. Mahalanabis

107311

13. Evaluation of diets based on cooked rice powder liquified by amylase rich germinated wheat cereal flour and yoghurt in persistent diarrhoea

    Dr. Asma Islam & Dr. D. Mahalanabis (Dr. FC Patra)

(107911)

14. Role of micronutrient mixture containing zinc, selenium,iron, copper, folate in reducing the incidence and severity of acute diarrhoea and acute respiratory infections, and in improving nutrition in children: a randomised community intervention trial.

    Dr. ASG Faruque, D. Mahalanabis

107711

15. Environment & Shigella Dysentery (CHD collaborative)

    Dr. Bilquis Hoque & Dr. D. Mahalanabis

101051

16. Double-blind randomised study of the safety and efficacy of ciprofloxacin in the treatment of childhood shigellosis

    Dr. M.A. Salam

108131

17. Role of Vitamin A and zinc in reducing diarrhoea duration and rate of persistent diarrhoea and improving nutritional recovery: a randomized double-blind clinic based trial with community follow-up.

Dr. D. Mahalanabis

108151

18. Safety and efficacy of Vitamin A supplementation in infants less than 6 months of age using the immunization programme as an entry point

Dr. Mujibur Rahman

108141

19. Vitamin A supplementation in the treatment of shigellosis in children

Dr. Shahadat Hossain

108121

20. RDR and MDR techniques for vitamin A status (LSD collab.)

Mr. M.A. Wahed & Dr. Mujibur Rahman

108111

21. Study of the effect of Vitamin A status and its supplementation to disease process of pneumonia.

Dr. AN Alam (Shishu Hospital Collaborative)

108311

22. Algorithm for the management of persistent diarrhoea in hospitalized children in Bangladesh.

Dr. A.K. Mitra

101061

23. Comparison of single-dose ciprofloxacin therapy with single-dose doxycycline in the treatment of cholera in adults: a double-blind randomised trial.

Dr. Wasif Ali Khan

108411

24. Effect of folic acid in acute darrhoea in children.

Dr. Hasan Ashraf

108211

25. Volatile fattty acid (FVA) in experimental cholera and shigellosis

Dr. G.H. Rabbani

107811

26. An ethnographic study on feeding behaviour and the acceptability of ARGC fortified weaning food

Dr. Sushila Zeitlyn and Dr. D. Mahalanabis

105421

27. The role of entamoeba histolytica in adults

Dr. P.K. Bardhan

108511

28. Therapeutic efficacy of 5 ASA in acte shigellosis

Dr. MR Islam, Dr. PK Bardhan

Appendix C

LABORATORY SCIENCES DIVISION

List of papers published April 01 - September 30, 1992

1. Albert MJ, Qadri F, Ansaruzzaman M, Kibriya AKMG, Haider K, Neogi PKB, Alam K, Alam AN. Characterization of Aeromonas caviae antigens which cross-react with Shigella boydii 5. J Clin Microbiol 1992; 30:1341-1343.

2. Albert MJ, Ansaruzzaman M, Alim ARMA, Mitra AK. Fluorescent antibody staining test for rapid diagnosis of Shigella dysenteriae 1 infection. Diag Microbiol Infect Dis. 1992. 15:359-361.

3. Albert MJ, Qadri F, Ansaruzzaman M, Kibriya AKMG, Haider K, Neogi PKB, Alam K and Alam AN. Cross-reacting antigens of Aeromonas caviae and Shigella boydii 5. J Clin Microbiol, 1992; 30:1341-1343.

4. Albert MJ, Kabir I, Neogi PKB and Kibriya AKMG. Vibrio mimicus bacteremia in a child. J Diarr Dis Res. 1992; 10:39-40.

5. Butler T, Dunn D, and Colmer. Concomitant intestinal adenovirus infection and pulmonary cytomegalovirus infection in children causing fatal enteritis and pneumonia. 1992; Trans Roy Soc Trop Med Hyg. 86:298-300.

6. Ciznar I, Ahsan CR, Rahman A, Shahabuddin M, Bartkova G, Clemens JD, Sack DA. Crossed immunoelectrophoretic analysis of antigenic composition of B-subunit/whole-cell and whole- cell only killed oral cholera vaccines. Vaccine. 1992. 10:591-596.

7. Clemens JD, van Loon FFPL, Rao M, Sack DA, Ahmed F, Chakraborty J, Khan MR, Yunus M, Harris JR, Svennerholm AM, Holmgren J. Nonparticipation as a determinant of adverse health outcomes in a field trial of oral cholera vaccines. Am J Epidemiol. 1992. 135:865-874.

8. Faruque SM, Haider K, Rahman MM, Alim ARMA, Baqui AH, Ahmad QS, Hossain KMB, Albert MJ. Evaluation of a DNA probe to identify enteroggregative Escherichia coli form children with diarrhoea in Bangladesh. J Diarrhoeal Dis Res. 1992. 10:31-34.

9. Ferdous AJ, Islam SN, Ahsan M, Hasan CM, Ahmed ZU. In vitro antibacterial activity of the volatile oil of Nigella sativa seeds against multiple drug-resistant isolates of Shigella spp. and isolates of Vibrio cholerae and Escherichia coli. Phytother Res. 1992. 6:137-140. p73

10. Haider K, Faruque SM, Albert MJ, Nahar S, Neogi PKB, Hossain A. Comparison of a modified adherence assay with existing assay methods for identification of enteroaggregative Escherichia coli. J Clin Microbiol. 1992. 30:1614-1616.

11. Hossain MA, Kabir I, Albert MJ, Kibriya AKMG, Alam K, Alam AN. Campylobacter jejuni bacteraemia in children with diarrhoea in Bangladesh: report of six cases. J Diarrhoeal Dis Res. 1992. 10:101-104.

12. Islam MS, Alam MJ, Tzipori S. Abundance of Aeromonas spp. in various components of pond ecoysystems in Dhaka, Bangladesh. Intern J Environ Stud 1992. 39:297-304.

13. Rahman MM, Qadri F, Albert MJ, Hossain A, Moshihuzzaman M. Lipololysaccharide composition and virulence properties of clinical and environmental strains of Vibrio fluvialis and Vibrio mimicus. Microbiol Immunol. 1992. 36:327-338.

14. Rabbani GH, Ashraf H, Islam M, Azad AK. Clinicopathological conference of ICDDR,B: A 1-year old girl with severe malnutrition, bloody-mucoid diarrhoea and fever. J Diarrhoeal Dis Res 1992 10(3):164-170.

15. Schultz C, Qadri F, Ciznar I., Bartkova G, Hossain SA, Wadstrom T. Binding of Shigella species to hydrophobic gels. Biologia (Bratislava). 1992. 47:249-256.

16. Siddique, AK, Zaman K, Zaman K, Baqui AH, Akram K, Mutsuddy, P, Eusof A, Haider K, Islam S and Sack RB. 1992. Cholera epidemics in Bangladesh: 1985-1991. J Diarr. Dis. Res. 10:79-86.

17. Strockbine NA, Faruque SM, Kay BA, Haider K, Alam K, Alam AN, Tzipori S, Wachsmuth IK. DNA probe analysis of diarrhoeagenic Escherichia coli: detection of EAF-positive isolates of traditional enteropathogenic E. coli serotypes among Bangladeshi pediatric diarrhea patients. Mol Cell Probes 1992; 6:93-99.

2.Papers in Press from April - September, 1992

1. Albert MJ, Alam K, Ansaruzzaman M, Islam MM, Rahman ASMH, Haider K, Nahar S, Ryan N, Montanaro J, Mathan MM. Pathogenesis of Providencia alcalifaciens-induced diarrhoea. Infect immun 1992.

2. Albert MJ, Faruque SM, Ansaruzzaman M, Islam MM, Haider K, Alam K, Kabir I, Robins-Browne R. Sharing of virulence- associated properties at the phenotypic and genetic levels between enteropathogenic Escherichia coli and Hafnia alvei. J Med Microbiol (In press). p73

3. Baqui A, Sack RB, Black RE, Haider K, Hossain MA, Alim ARMA, Yunus M, Chowdhury HR, Siddique AK. Enteropathogens associated with acute and persistent diarrhoea in Bangladeshi children under five years of age. J Infect Dis (in press)

4. Bennish M, Salam MA, Wahed MA. Enteric protein loss during shigellosis. Gastroenterology. (in press).

5. Faruque SM, Haider K, Rahman MM, Alim ARMA, Ahmad QS, Albert MJ, Sack RB. Differentiation of Shigella flexneri strains by ribosomal RNA gene restriction patterns. J Clin Microbiol 1992.

6. Giri DK, Ashraf MM, Ahmed ZU. Heterologous protection of bonnet monkeys from experimental shigellosis after oral immunization with Shigella flexneri serotype Y thymine- dependent temperature-sensitive mutant TSF21. Immunol Infect Dis (in press).

7. Gonzalez-Ruiz A, Haque R, Reheman T, Aguirre A, Jarmillo C, Castanon G, Hall A, Guhl F, Ruiz-Palacios A, Warhurst DC, Miles MA. A monoclonal antibody for the distribution of invasive and non-invasive clinical isolates of Entamoeba histolytica. J Clin Microb (in press)

8. Huq A, Parveen S, Qadri F, Colwell RR. Comparison of Vibrio cholerae Serotype 01 strains isolated from patients and the aquatic environment. J Tro Med Hyg (In press).

9. Islam D, Lindberg AA. Detection of Shigella dysenteriae type 1 and Shigella flexneri in faeces by immunomagnetic isolation and PCR. J Clin Microbiol (in press)

10. Jarecki-Khan K, Unicomb LE. Seroprevalence of enteric and non-enteric adenoviruses in Bangladesh. J Clin Microbiol (in press).

Research Protocols in Progress

1. Establishment of techniques to identify pathogenic strains of E. histolytica for use in clinical and epidemiological studies in Bangladesh.
P.I.: Dr. Rashidul Haque

2. Identification of enteric pathogens using specific DNA probes as an aid to clinical and epidemiological investigations.
P.I.: Dr. S.M. Faruque

3. Direct identification of enteric pathogens in biological specimens by specific DNA amplification: part I.
P.I.: Dr. S.M. Faruque p73

4. Study of the immune response to S. dysenteriae 1 in an effort to identify abnormalities leading to the development of leukemoid reaction.
P.I.: Dr. Tasnim Azim

5. Immune status of children who develop persistent diarrhoea.
P.I.: Dr. Tasnim Azim

6. Establishment and application of virological techniques to study the epidemiology of rotaviruses and other viral agents causing diarrhoea in rural and urban Bangladesh.
P.I.: Ms. Leanne Unicomb

7. Development of an immunodiagnostic assay for the detection of Shigella and identification of species/serotype specificity directly from human samples.
P.I.: Ms. Dilara Islam

8. Local and systemic immune response to shigellosis in adult humans.
P.I.: Ms. Rubhana Raqib

9. Haemagglutination (HA) ability and adhesiveness of Shigella species: (Part-II) Characterization of the adhesin/ haemagglutinin and other outer membrane components, including the use of monoclonal antibodies.
P.I.: Dr. Firdausi Qadri

10. The role and characteristics of diarrhoeagenic E. coli in clinical and epidemiological investigations.
P.I.: Dr. M. John Albert

11. Biochemical fingerprinting in the epidemiological studies of bacterial diarrhoeal pathogens in Bangladesh.
P.I.: Dr. M. John Albert

12. Genetic analysis and phenotypic correlation of the plasmids universally present in strains of S. dysenteriae type 1.
P.I.: Dr. Khaleda Haider

13. Investigation of the carrier state and the role of animate and inanimate objects as reservoirs or secondary hosts of shigellae.
P.I.: Dr. M. Sirajul Islam

14. Establishment of techniques: Relative dose response (RDR) and modified relative dose response (MRDR) to assess vitamin A status.
P.I.: Mr. M.A. Wahed

15. Cloning of gene(s) that code for toxin production by enterotoxigenic Bacteroides fragilis and development of diagnostic tests based on the toxin.
Dr. Zia U. Ahmed p73

16. Stability of killed-whole-cell cholera vaccine containing the B-subunit of cholera toxin under heat-stress conditions.
P.I.: Dr. Zia U. Ahmed

17. Pathological and microbiological studies on fatal cases of diarrhoeal illness and acute lower respiratory infections.
P.I. Dr M. Islam

Appendix D.

Population Science & Extension Division

PUBLISHED PAPERS - 8

Bairagi, R., and A.K. Bhattacharya. "Parental Sex Preference and its Effects on Fertility Intention and Contraceptive Use in Calcutta." Rural Demography. Vol. 16, No. 1-2 (1989): 43-56.

Bairagi, R., B. Edmonston, and A. Hye. "The Influence of Nutritional Status on Age Misstatement for Young Children in Rural Bangladesh." Genus. Vol. 47, No. 1-2 (1991): 193-205.

Bhuiya, A. "Village Health Care Providers in Matlab, Bangladesh: A Study of Their Knowledge in the Management of Childhood Diarrhoea." Journal of Diarrhoeal Diseases Research, Vol. 10, No. 1 (1992): 10-15.

Bhuiya, A. and K. Streatfield. "A Hazard Logit Model Analysis of Covariates of Childhood Mortality in Matlab, Bangladesh." Journal of Biosocial Science, Vol. 24 (1992): 447-462.

Koenig, M.A. and R. Simmons. "Constraints on Supply and Demand in Family Planning: Evidence from Rural Bangladesh." In Family Planning Programmes and Fertility, J.F. Phillips and J.A. Ross (eds.), Oxford: Oxford University Press (1992): 259-275.

Rahman, M., J. Akbar, J.F. Phillips, and S. Becker. "Contraceptive Use in Matlab, Bangladesh: The Role of Gender Preference." Studies in Family Planning, Vol. 23, No. 4 (July/August 1992): 229-242.

Simmons, R., R. Mita, and M.A. Koenig. "Employment in Family Planing and Women's Status in Bangladesh." Studies in Family Planning, Vol. 23, No. 2 (March/April 1992): 97-109.

Strong, M. "The Health of Adults in the Developing World: The View from Bangladesh." Health Transition Review, Vol 2, No. 2 (September 1992).

SUBMITTED PAPERS - 11

Bairagi, R. and M.K. Chowdhury. "Interrelation of Socioeconomic Status, Nutritional Status, and Mortality of Young Children in Rural Bangladesh."

Bairagi, R. and M.K. Chowdhury. "On Validity of Some Anthropometric Indices for Identifying Determinants of Mortality of Young Children."

Bairagi, R. and **M.K. Chowdhury.** "Discrimination against Female Children in Rural Bangladesh: Is It Changing."

Bairagi, R., M.A. Koenig, and **K.A. Mazumder** "Mortality Discriminating Power of Some Nutritional, Socio-demographic, and Diarrhoeal Disease Indices."

Bhuiya, A. and **G. Mostafa.** "Levels and Differentials in Weight, Height and Body Mass Index Among Mothers in a Rural Area of Bangladesh."

Chowdhury, A.Y. and **A. Bhuiya.** "The Effects of Biosocial Variables on Changes in Nutritional Status of Rural Bangladeshi Infants Pre- and Post-monsoon Flooding."

Mostafa, G., A. Foster, and V. Fauveau "The Influence of Sociodemographic Variables on Perinatal Mortality."

Rahman, F., M. Islam, and **R. Maru.** "Home Delivery of Injectable Contraceptives: An Operations Research Study in Bangladesh."

Rahman, M. and J. DaVanzo "Gender Preference and Birthspacing in Matlab, Bangladesh."

Salway, S. "Low-dose and Standard Dose Oral Pills in Rural Bangladesh: Utilization, Continuation, and Failure."

Salway, S., N.C. Roy, and **M.A. Koenig.** "Levels and Trends in Postpartum Amenorrhoea, Breast-feeding, and Birth Intervals in Matlab, Bangladesh 1978-1989."

ALSO NOTED

Habte, D. and **M. Strong.** "Health of School-age Children: Group of Lost Opportunities." Prepared for the Bellagio Conference on School-age Children, 1991.

Menken, J. and C. Campbell. "Age Patterns of Famine-related Mortality Increase: Implications for Long-term Population Growth." Health Transition Review. Vol. 2, No. 1 (April 1992): 91-100.

PROTOCOLS IN PROGRESS

1. 87-016 The MCH-FP Extension Project Protocol 1987-92
2. 88-030 Demographic Surveillance System (DSS) - Matlab
3. 91-011 Maternal mortality in Matlab, Bangladesh
4. 92-021 The demography of fetal loss in rural Bangladesh

Appendix-E

International Centre for Diarrhoeal Disease Research, Bangladesh.

ICDDR,B

Resource Development Strategy
Revised Draft

Table of Contents

Executive Summary

Overview

Traditionally, ICDDR,B and is precursors have been largely funded by Government and multilateral donors. Even discounting the effects of the current world recession, in the short and medium term ICDDR,B is unlikely to be able to affect more than a shift in emphasis in its funding mix. However, successful endowment fund campaigns could reduce the level of support required from these traditional donors and act as a buffer during leaner periods. In addition, ICDDR,B must prepare to exploit the opportunities for developing resources from competitive grants, foundations and corporations.

To develop resources from these non-traditional sources, ICDDR,B must develop and use its alumni networks, and invest in strengthening its resource development capabilities in the developed countries where the funding sources are located. The establishment of the International Child Health Foundation (ICHF) in 1985 was ICDDR,B's first attempt to develop resource development capability in the US, but the Centre's relationship with the ICHF needs to be strengthened. Institutional collaboration with universities in developed countries should provide important stimulus to resource development activities in those countries.

The Centre is trying to run two endowment fund raising campaigns (for the hospital and the research institution) simultaneously, with limited coordination between the two. There is a need to clearly differentiate between the two funds for potential donors, while maintaining close coordination between their activities.

ICDDR,B's public relations efforts outside of Bangladesh have not been adequate, and will have to be improved. Communication and dissemination efforts should include printed publications, and video materials, as well as training courses, and must be closely coordinated with the resource development office.

In the medium and long-term, the Centre should work more closely with GoB, extending more technical assistance to the national family planning, diarrhoeal disease control and urban health service delivery programmes. The training and development of national health professionals and research scientists should also be expanded. Increasingly, these activities will have to be funded from bilateral sources, and under the national 5 year health and population plans. ICDDR,B's Dhaka hospital must be more closely integrated into the GoB urban health strategy in order to maximize the use of community diarrhoea treatment centres and minimize ICDDR,B's load.

To maintain the value of the name ICDDR,B, and at the same time reduce confusion, the Centre should maintain its current logo but present itself as follows:

ICDDR,B

Centre for Health And Population Studies

Institutional Needs

ICDDR,B's institutional needs can be summarized as follows:

Core funding for essential scientific leadership; the Clinical Research Centres, and related diagnostic laboratories; the Demographic Surveillance System; and Matlab Maternal Child Health - Family Planning programme; the Diarrhoeal Diseases Information Service Centre; and administrative support.

Hospital Endowment and **Institutional Endowment Funding** which will provide long-term, stable funding to these critical core components of the ICDDR,B institutional infrastructure.

Project funding to finance research and training projects undertaken within the core institutional infrastructure.

Capital funding to maintain the Centre's physical facilities and equipment necessary to carry out its work.

Objectives of ICDDR,B's Resource Development Strategy

A. To increase annual flow of funds by at least 10% per year through the broadening of its funding base and tender in competitive bids. (See Appendix 1)
B. To maintain the current trend of increasing long-term core funding under multi-year agreements.
C. To secure Government of Bangladesh agreement for the use of bilateral funding for the provision of health care services and projects assisting with GoB policy formulation and/or implementation.
D. To establish an Institutional Reserve Fund of $30 million in two $15 million or three $10 million phases.
E. To establish a Hospital Endowment Fund of $10 million in two $5 million phases.

Requirements to Meet Objectives

To met these objectives ICDDR,B must develop and broaden its resource development activities through the hiring of a competent Resource Development Officer and the development of representation in the US (also covering Canada) and the establishment of representation in the UK (also covering the rest of Europe). With these in place, the Centre can move to plan and successfully implement its annual funding drives and its endowment fund campaigns.

Immediate Options and Recommendation

The Centre could remain at the same level of resource development activity, but this is likely to leave ICDDR,B increasingly isolated and amateur in a fiercely competitive market. The recommended alternative is raise the level of activity in the US/Canada, and to take the preliminary steps necessary to make a decision on raising the level of activity in UK/Europe.

International Centre for Diarrhoeal Disease Research, Bangladesh.

ICDDR,B

Resource Development Strategy
Revised Draft

I. Overview

A. **Background - Current Resource Development Systems:** ICDDR,B's current resource development activities are conducted primarily by the Director and the Associate Directors, assisted by a small resource development office in Dhaka. Associate Directors and Senior Scientists prepare, submit and follow-up project proposals, while the Director and the resource development office prepare, submit and follow-up core and capital funding proposals. There is limited, largely informal coordination between the core and project resource development activities.

B. **Background - The Traditional Sources:** ICDDR,B's expertise lies primarily in raising resources from Governments and multilateral organizations. The Centre has been successful in this sector and it has proved to be an extremely cost effective method of raising funds. Currently, the Centre's only major private sector donors are the Ford Foundation, the Sasakawa Foundation, and Population Council. During the last six years a total of about $425,000 in project funds have been provided by pharmaceutical corporations.

The Centre has very little experience with private sector fund-raising outside these sources. What experience there was usually lay with foreign scientific staff who then returned to their home countries. Longer-term funding arrangements (endowments, debt for development swaps etc.) have not been seriously examined for many years, if at all.

An analysis of funding sources over the past four years shows that 80-90% of funds came from Government grants. (See Appendix 1). Comparing this funding mix with that of tropical health research institutes located in developed countries would suggest that there is scope for increasing the involvement of the private sector in the financing of the Centre. (See Appendix 2). The recognition of the importance of private sector involvement has resulted in the preparation of ICDDR,B's Resource Development Strategy.

However, it is important to stress that even discounting the effects of the current world recession, in the short and medium term ICDDR,B is unlikely to be able to affect more than a shift in emphasis in its funding mix. ICDDR,B is, and is likely to remain, dependent on the government and multilateral donors that pledged to support it in 1979, and those that have come to recognize its immense value and support it since then. The Centre can and should improve and increase its private sector resource development, but this is unlikely to offer large scale replacement funding for the Government and multilateral contributions that are the mainstay of the institution. However, successful endowment fund campaigns could reduce the level of support required from these traditional donors and act as a buffer during leaner periods.

With the changing international order and the current world recession, funds are likely to get considerably more scarce. Increasingly Government agencies are encouraging the health and development organizations (including ICDDR,B) to seek funding from private sources. This will not be an easy task, particularly in the context of world recession and increased competition for private sector funds. Nonetheless, there are growing moves towards encouraging sustainable development through the establishment of endowment funds. With the current strength of the Centre, its programme and its management, ICDDR,B is well placed to make progress towards achieving the endowment fund goals. In this context it is imperative that ICDDR,B invest and enhance its resource development capabilities.

C. **Competitive Grants:** As the Cholera Research Laboratory, the Centre received funding and technical assistance through the National Institutes of Health (NIH). With the changes in emphasis by NIH, the Centre is no longer able to bid on the majority of the projects (cancer, HIV/AIDS etc.), but there are some significant areas of common interest (ARI, shigella, population etc.) These must be developed further. IDRC and WHO already have an extensive competitive grant system, and the ODA is now also moving in this direction. Approaching foundations for funding is increasingly competitive in nature, and other donors, including corporations, are likely to follow. It is clear that the Centre will have to develop its expertise in submitting proposals for competitive grants. A planned programme of training and technical assistance in competitive grant proposal writing should be instituted. This could be given by senior scientific staff or visitors. At the same time, the Centre will have to develop an effective mechanism for monitoring the submission of competitive grant project proposals to ensure that these are properly coordinated.

D. **Foundations:** The Centre has experience with several foundations (Aga Khan, Rockefeller, Sasakawa, Wellcome etc.), but has only managed to develop and maintain long-standing, high-value relationships with the Ford Foundation and Population Council. Increasingly, foundations interested in international health and development are moving towards funding organizations located in developing countries, and working with professionals drawn from those countries. This offers the ICDDR,B a considerable competitive advantage, in that the Centre can combine high standards and rigorous scientific investigation with indigenous resources. However, to translate this advantage into funding, the Centre must raise its profile and market itself more effectively to the foundations.

E. **Corporations:** In the past, and particularly in 1986/7, the Centre has received limited corporate financing. Studies have been financed by several pharmaceutical companies including Bayer AG, Norwich Eaton, Smith Kline French, and Miles. If the Centre is to increase the involvement of corporations in its activities, it must undertake an extensive campaign to market its capacity and capabilities.

1. Raising funds from the **pharmaceutical industry** presents several dilemmas, and prior to embarking on any such campaign, the Centre felt it necessary to review its policy on accepting money from this sector. (See Appendix 3 [1]). However, it should be noted that the research priorities currently being addressed by ICDDR,B only coincide to a limited extent with the interests of the pharmaceutical industry.

2. Raising funds from **non-pharmaceutical industry** corporate sources has not been extensively explored by the Centre. With the exception of a $ 30,916 contribution by IBM in 1987, and periodic payments for disaster relief activities by American Express Bank, ICDDR,B has not received any large corporate funding. The change-over from the mainframe will offer a unique opportunity for the Centre to develop relations with IBM and other computer companies. Additional funds and sponsorship should be sought from large (and particularly international) corporations operating in Bangladesh. The Hospital Endowment Fund committee have recognized the potential of this source, and have initiated attempts to tap into it. However, Drexler and Huda's report "Private Sector Funding of Development in Bangladesh" does not offer much hope of any large-scale funds coming from within the country.

---

1. Will be available after the November 29, 1992 Board of Trustees Meeting.

F. **Alumnae:** For resource development purposes, ICDDR,B's "alumnae" are as follows:

1. Employees
2. Members of the Board of Trustees
3. Consultants
4. Trainees and fellows
5. Members of other Boards and Councils members
6. Influential visitors

The Centre's alumni and other contacts constitute a powerful array of eminent and influential people, particularly in the world of health and population research. Indeed, many of them are searching for funds for their own institutions in competition to ICDDR,B. Nonetheless, if motivated and organized, the alumni could form an extremely effective network to further the Centre's cause. At present, the Centre sends some of its alumni a variety of publications, including appeals for the Hospital Endowment Fund, but is not involving them in its success, and working with them to further promote its interests. It is important that ICDDR,B keeps track of all the people who have worked at the Centre, hold regular reunion and progress report meetings in the US (east and west coast) and the UK, and develop the networks that will put the Centre in a position to locate and ask for funds.

G. **Resource Development Advisory Council (RDAC):** It is clear that ICDDR,B must invest in strengthening its resource development capabilities in the developed countries where the private sector money is located. The Centre has some representation in the USA through the International Child Health Foundation (ICHF), but does not have the charity registration in the UK that would allow tax-free giving there. In line with the USAID, Washington Cooperative Agreement funding its preparation, the first draft of the ICDDR,B Resource Development Strategy, (presented to the Board of Trustees in May 1992), envisaged the formation of a RDAC made up of experienced fund-raisers, to meet and advise the Centre on resource development. However, discussions with current and potential donors, and fund-raising experts, has cast doubt on the feasibility of forming, and indeed the need for, the RDAC. The funds that were to be invested in the RDAC would be better used in strengthening ICDDR,B's capabilities in the US/Canada, and developing capabilities in UK/Europe. Effective representation and organization in the donors' countries is a necessity if the Centre is to broaden its fund raising capabilities and funding base.

H. **International Child Health Foundation:** The establishment of ICHF in 1985 was ICDDR,B's first attempt to develop resource development capability in the US, where most of the potential funds were located. However, the misunderstandings that arose during its inception, and subsequent poor communications meant that ICHF has not worked effectively with ICDDR,B. Cooperation and collaboration between ICDDR,B and ICHF could significantly increase the yields from new funding sources. With fund-raising operations located only in Dhaka, the Centre is less able to develop and use its networks of supporters, or to approach new government agencies, private sector foundations and corporations etc..

I. **Institutional Collaboration:** In the current international economic and political climate, self-interest is one of the prime motivations of most Government donor agencies. The development of effective collaboration with key institutions in donor countries has several advantages:
   1. It provides a constituency and advocacy in the countries from where funds are coming,
   2. It improves chances of winning competitive grants,
   3. It provides answers to the question "what's in it for us ?" that is increasingly prevalent in Government offices.

J. **International Health Research Networks:** For many years, there have been attempts to foster the development of an international health research network, broadly along the lines of the CGIAR (Consultative Group on International Agricultural Research). Indeed, many have seen ICDDR,B as the prototype for such a network. While there are important and unresolved issues as to how such a network would be organized and financed, it is clearly in the interests of the Centre to promote, and assist in, attempts to resolve these issues and to develop such a network.

K. **Endowment Funds:** The Centre is trying to run fund raising campaigns for two endowments simultaneously, with limited coordination between the two. There is a need to clearly differentiate between the two funds for potential donors, while maintaining close coordination between their activities.

1. The **Institutional Endowment Fund** has a long history and little planning. The Ford Foundation have indicated an interest in providing a 2 or 3 to 1, stepped challenge grant. This would mean that for every $ 300,000 the Centre raises from other sources, the Ford Foundation would match this with $ 150,000 or $ 100,000, up to a defined maximum contribution of (say) $ 2 - 3,000,000. This Ford Foundation grant is central to the success of the Institutional Endowment Fund, since it would provide credibility and leverage other funds. If the Institutional Endowment Fund is to reach its target, the Centre must also plan, prepare and launch the campaign formally in the UK, Europe, the US and Canada.

2. The **Hospital Endowment Fund** has got off to a promising start, but will require more careful planning and coordinated implementation in Bangladesh, the UK, Europe, the US and Canada if it is to achieve its interim target of $ 5 million.

   The hospital endowment fund is the fund most likely to appeal for personal contributions to the Centre's alumni and other private individuals. Indeed, this fund has been marketed through the Centre's publications to the alumni and others interested in the Centre's work. Additional attempts to raise funds for the hospital endowment fund have been centered in Bangladesh. A local group of trustees, drawn from Bangladeshi leaders, the foreign embassies and multilateral agencies, to head the hospital endowment fund appeal would assist the local fund-raising efforts.

   In addition to private individuals, there is some scope for corporate and government financing of this endowment fund since it supports two hospitals that form an integral part of the country's health service system. In the longer-run, ICDDR,B must actively look into, and promote the use of, debt for development swaps and the Taka proceeds of Title III wheat / imported fertilizer sales to develop this endowment fund.

L. **Public Relations:** Public relations activities at the Centre have always tended to be low profile.

1. At present, ICDDR,B's public relations activities are limited. Photographs and small articles are published in the national press, and a few simple, private functions are held in Dhaka. This seems to be an appropriate strategy for an international research organization that depends on public funding. Nonetheless, if funds for the Hospital Endowment Fund are to be raised in Bangladesh, the Centre will have to increase its level of public relations activities.

   Outside Bangladesh, the Centre will have to significantly raise its profile in the developed donor countries to maintain and develop existing Government and multilateral funds, and to begin to access private sector funds. The institutional memories of donor organizations are often extremely limited, and ICDDR,B will have to look for ways of focusing attention on the importance and relevance of its work.

2. Following a review of ICDDR,B's communication efforts by a consultant, USAID, Dhaka has expressed interest in funding the strengthening the communication and dissemination efforts of the UHEP and MCH-FP Extension projects. There is a pressing need to find donors willing to supplement this by financing technical assistance to establish a communication and dissemination office for the Centre as a whole. This would not only mean more effective dissemination of research findings, but also improved visibility and stature for the Centre. Indeed, the communications and dissemination office will have to work extremely closely with the resource development office and public relations officer.

3. The Centre has some video film-making capability, but this should be enhanced. ICDDR,B videos will not only assist the Centre's public relations, dissemination and resource development activities, but would also provide opportunities for the training branch.

M. **Relations with the Government of Bangladesh (GoB):** The Centre's relations with GoB remain excellent. GoB has appointed three supportive members to the Centre's Board of Trustees, and the Centre continues to provide technical assistance to GoB in the many ways outlined in the Centre's publication "Partnership in Progress". At present, the Centre is negotiating the UNROB loan with GoB, and is hopeful that this issue will be finally resolved in the near future.

In the medium and long-term, the Centre should work closer with GoB, extending further technical assistance to the national family planning, diarrhoeal disease control and urban health service delivery programmes. The training and development of national health professionals and research scientists should be expanded to meet the growing needs of Bangladesh. Increasingly, these activities will have to be funded from bilateral sources, and under the national 5 year health and population plans.

ICDDR,B's Dhaka hospital must be more closely integrated into the GoB urban health strategy in order to maximize the use of community diarrhoea treatment centres and minimize the ICDDR,B's load.

N. **Institutional Name:** The name "International Centre for Diarrhoeal Disease Research, Bangladesh" has great goodwill value among international health research experts, but little with people from other fields. It has become clear that ICDDR,B's name creates confusion among those not familiar with it. In addition to the perceived conflict between "International" and "Bangladesh", newcomers to the name automatically assume that the Centre only works in diarrhoeal disease research. Finally, the name does not give an appealing or manageable acronym.

To maintain the value of the name ICDDR,B, and at the same time reduce confusion, the Centre should consider adding an additional descriptive line to the ICDDR,B acronym. Thus the Centre would maintain its current logo and present itself as follows:

ICDDR,B

Centre for Health And Population Studies

II. Institutional Needs

A. **Core funding:** ICDDR,B's "core" are those activities and infrastructure central to the effective functioning of the Centre as an international health research institution. The Centre's core comprises:

1. **Clinical Research Centres** - Dhaka and Matlab. These are indispensable not only for ICDDR,B's clinical research and training, but also as the secondary health care facilities necessary to back-up the Centre's primary health care and outreach programmes. The Centre is planning a detailed cost-review of the two hospitals by a health economist, and the establishment of satellite clinics to reduce the patient-load.

2. **Demographic Surveillance System (DSS).** The DSS is central to the Centre's Matlab activities, including population studies, maternal child health - family planning research, vaccine trials, and to its rural health systems and operations research. Under a new ODA grant, the DSS is to be reviewed and improvements made to the data collection and management systems.

3. **Matlab Maternal Child Health - Family Planning (MCH-FP).** For many years now, the Matlab MCH-FP project has been at the centre of ICDDR,B's pioneering rural health research. The Centre's activities in Matlab remain at the forefront of international research into child survival, maternal health, and family planning, and continuing efforts to develop more efficient and effective ways of delivering health care to the rural poor. The outreach infrastructure developed by ICDDR,B in Matlab offers unique opportunities for the investigation of specific interventions and/or components of primary health care systems.

4. **Support Services.** To function effectively as an international health research centre, two essential support services are necessary.

   a. **Laboratories.** The laboratories provide the necessary technical, logistical and training support to both core and project activities of ICDDR,B.

   b. **Diarrhoeal Diseases Information Services Centre (DISC).** DISC provides the Centre's extensive library and publication services.

5. **Scientific leadership and administration.** To maintain ICDDR,B's reputation and capability as an international centre of excellence, top quality scientific leadership must be combined with cost-effective administration. ICDDR,B is now in a position to attract leading scientists from all over the world to spearhead its work. The Centre continues to refine its financial and administrative procedures and thus to reduce the number of non-scientific staff.

These five core components of the Centre's operations form the infrastructure necessary to conduct research projects at ICDDR,B. Together, they form nearly 50% of the Centre's annual budget, although some are currently being financed under project arrangements.

In 1992 Core funding came from:
1. Government multi and bilateral agencies
2. Multilateral agencies
3. Project overhead charges

Projects contribute to the financing of core activities through the overhead component, but stable, long-term core support will always remain a necessity to ensure that the Centre can implement its strategic plans effectively. In the short and medium-term, the Centre is likely to have to depend on its traditional government and multilateral donors for this core support. In the longer term, successful endowment fund campaigns could reduce the Centre's dependence on these traditional sources. Successful endowment funds would also require the assistance of the Centre's traditional donors as partners in attempts to pursue large scale fund-release programmes. Such programmes would include debt for development swaps and blocked fund release programmes (e.g. the Taka sale proceeds of Title III wheat and imported fertilizer, or non-convertible profits of multinational corporations).

In addition, continued collaboration and partnership with foundations and corporations may allow the Centre to raise limited funding for its core activities from these sources, either directly or through the endowment fund.

In the future core funding should come from:

1. Government multi and bilateral agencies
2. Multilateral agencies
3. Foundations
4 Corporations
6. International Non Government Organizations
7. Endowment funds
8. Project overhead charges

B. **Hospital Endowment Funding:** The establishment of a Hospital Endowment Fund has been a key part of the Centre's medium and long-term Resource Development Strategy. The fund has grown to a little over $20,000 in 13 months, and its administrators are confident that, it will accumulate to reach its interim (Phase 1) target of $5,000,000. After studying the investment opportunities and a re-analysis of costs, the ultimate target for the Hospital Endowment Fund has been raised to $ 10,000,000. Two separate, consecutive campaigns will be launched to achieve this target. The Hospital Endowment Fund provides an opportunity to tap the charitable and foundation funding sources in the developed countries and Bangladesh itself.

Income arising from the Hospital Endowment Fund will be used to finance the provision of free hospital services and medicine to the poor of Bangladesh. The Director is empowered to withdraw and use the annual income of the Hospital Endowment Fund for the operating expenses of the two hospitals.

C. **Institutional Endowment (previously known as Reserve) Funding:** The ICDDR,B Reserve Fund was established in November 1981, and as of December 31, 1991, stood at $2,109,695, primarily due to the Ford Foundation grant of $500,000 in 1985. The Institutional Endowment Fund will be the focal point of the Centre's long-term resources development strategy for institutional and research oriented funding. After a review of the investment opportunities, and the target for the Institutional Endowment Fund has been set at $ 30,000,000. This will be raised in two $ 15 million or three $ 10 million phased campaigns.

In accordance with the resolutions of the Board of Trustees, the Institutional Endowment Fund will be used for three main functions:

1. To provide a source of funds to permit the scientific work of the Centre to continue, pending the receipt of committed donor funds, without the necessity and expense of borrowing interim funding, (through temporary withdrawals from capital, up to a maximum of $ 1.2 million).
2. To provide a source of flexible funds for the Centre, through its scientists, to use in exploring new lines of research or training, or supplement funding in those projects where donors are not paying the full costs of important Centre work, (to a maximum of 75% of annual income).
3. To provide funds to meet unforeseen judiciary requirements, or for safeguarding the Centre's programmes against shortfalls in expected revenues, (to a maximum of 25% of annual income).

D. **Project Funding:** The Centre undertakes research and training projects while its core institutional infrastructure provides the indispensable support.

In 1992 project funding came from:
1. Government multi and bilateral agencies
2. Multilateral agencies
3. Foundations
4. Corporations

In the future, more project financing is likely to be made on the basis of competitive project proposals, and from private sector sources.

In future project funding should come from:
1. Government multi and bilateral agencies
2. Multilateral agencies
3. Foundations
4. Corporations
5. International Non-Government Organizations

E. **Capital Funding:** To maintain its position as an "international centre of excellence", the Centre requires capital funding to maintain and develop the buildings in which it operates, and the equipment used in the course of its work.

III. Objectives of ICDDR,B's Resource Development Strategy

A. To increase annual flow of funds by at least 10% per annum through the broadening of its funding base and tender in competitive bids. (See Appendix 1)
B. To maintain the current trend of long-term core funding under multi-year agreements.
C. To secure Government of Bangladesh agreement for the use of bilateral funding for the provision of health care services and projects assisting with GoB policy formulation and/or implementation.
D. To establish an Institutional Reserve Fund of $30 million in two $15 million or three $10 million phases.
E. To establish a Hospital Endowment Fund of $10 million in two $5 million phases.

IV. Requirements to Meet Objectives

A. Finalized Resource Development Strategic plan with which to work as an initial flexible framework.
B. Competent Resource Development Officer in Dhaka capable of coordinating resource development inside the Centre and its US and UK desks.
C. A part-time resource development officer who can work with ICHF to build the alumni network in the US and Canada, and research into new funding sources.
D. Charity-maker consultant to build the networks and establish the UK charitable trust that will allow tax-free giving in the UK (and possibly Europe depending on how the financial integration of the EEC progresses).
E. Increased public relations activities in Japan.
F. Finalized Case Statement that presents the Centre's history, strengths, plans and needs.
G. A review of the markets and opportunities prior to embarking on a major formal endowment fund(s) campaign.
H. A decision on the launch of formal endowment campaign(s).
I. A decision on the establishment of an ICDDR,B desk in the UK.

V. Activities to-Date

A. A tour was undertaken to look into broadening the Centre's resource development base in the private sector and into endowment funding. This tour included visits to the UK, Canada, the US, Japan and Australia. The information and contacts gained on this tour has led to:
   1. a clear understanding of the complexity of running large scale fund-raising campaigns and generating funds from the private sector,
   2. an increased impetus in resource development activity,
   3. the development of the revised draft ICDDR,B Resource Development Strategy.

B. Improved understanding with the International Child Health Foundation (ICHF), and the signing of a new collaborative agreement with the Foundation.

C. The outline of the Centre's UK/Europe strategy which is being developed in conjunction with consultants, one of whom will be selected to implement this.

D. Preliminary research into US and UK foundations to identify those with a history of funding international health research, population activities, and training.

E. Initiation of contacts with selected foundations with which the Centre has reasonable connections. The Rockefeller Foundation has expressed in working with the Centre under its new five year health research programme, which is specifically targeting research conducted in developing countries by developing country scientists. The Foundation is beginning to foster an informal international health network through its "Global Alliance Against Tropical Diseases", and has shown interest in funding the Centre to further these attempts through a conference at its international conference centre at Belagio.

F. The assembly of a small resource development library containing foundation listings, manuals etc..

G. Initial contacts in attempts at international health research networking under the Global Alliance Against Tropical Diseases sponsored by NIH/NIAID and the Rockefeller Foundation. This should lead ICDDR,B to be involved as one of the Centre's for Tropical Disease Research under the NIAID programme.

VI. Immediate Options

A. **Remain at the same level of resource development activity:** Realistically, 1992 is not the optimal year to pursue new sources of funding for the Centre. There is a very profound world recession, Government and private sector agencies are cutting costs and relocating funds, and many foundations' assets are declining in value. Paradoxically, however, for these very reasons it is imperative that ICDDR,B does not remain at the same level of resource development activity. It is important to plan and prepare increased advocacy and fund-raising efforts for the Centre. This is necessary to counter-act the pressures to cut the Centre's funding, and the relocation of resources away from the developing world and into Eastern Europe. At the same time, with the increasing moves towards private sector and competitive grant funding, the Centre must move to position itself to make optimal use of these opportunities, particularly once the recession bottoms out. Failure to do this, and to establish a presence near to the sources of finance, will leave ICDDR,B increasingly isolated and amateur in a fiercely competitive market.

B. **Raise level of activity in US/Canada:** GIVING USA estimates that in 1991, the US private sector gave as follows:

1.	Foundations	$ 7.8 billion
2.	Corporations	$ 6.1 billion
3.	Private individuals	$ 103.1 billion

At present, ICHF's extensive network (which comprises many influential individuals previously associated with ICDDR,B), and knowledge of the resources available in the US, are not being used by the Centre. A part time ICDDR,B desk officer operating from, and in conjunction with, ICHF could significantly improve the Centre's ability to look into, and develop the contacts with, the plethora of government and multilateral agencies based in Washington, US as well as Canadian foundations and corporate donors.

C. **Raise level of activity UK/Europe:** The Charities Aid Foundation estimates that in 1990 the UK private sector gave as follows:

1.	Top 400 trusts/foundations	$ 468 million
2.	Corporations	$ 284 million
3.	Private individuals	$ 8,000 million

Clearly a great deal of this was for organizations operating in the UK, but nonetheless, there do appear to be significant opportunities for developing resources from the private sector in the UK and Europe. The first year of the proposed UK/Europe strategy would include further research into these opportunities, prior to making a decision on the need for an ICDDR,B desk in the UK.

D. **Raise the level of activity in Japan:** In addition to the clear need to raise the level of the annual contributions from the Government of Japan, there are several major Japanese foundations which the Centre should approach. However, many of these Japanese foundations have now opened liaison offices in the USA. The development of funds in Japan is a long, drawn out process, necessitated in part by the consensus decision-making process prevalent there. Furthermore, the Centre does not have an extensive network of alumnae and supporters to work with in Japan. The establishment of an ICDDR,B desk in Tokyo would be expensive, and it is important to carefully consider the costs and likely benefits of this move. In the short term however, the new ICDDR,B promotional brochure should be translated into Japanese since many of the Government and foundation officials dealing with the Centre do not speak very much English.

E. **Raise the level of activity in Australia:** There are extremely limited opportunities for resource development from private sector sources in Australia. The few foundations that do exist almost invariably only fund Australian organizations/individuals, and the corporate sector is dominated by multinationals with head offices in the US, Europe and Japan. Nonetheless, it will be important to maintain and improve communications with the Australian Government agencies and universities.

VII. Recommendation

A. An action plan detailing proposed steps to establish an ICDDR,B desk in the USA (to cover USA/Canada), and to further examine the feasibility of establishing an ICDDR,B desk in the UK (to cover UK/Europe) is attached as Appendix 4. A budget for these activities is attached as Appendix 5.

VIII. Proposed Non-Financial Targets (See Appendix 4)

I. On-Going Activities

A. Maintaining and expanding existing long-term core support
B. Diversification of Government and multilateral agency funding base
C. Collaboration with Government of Bangladesh to identify multilateral and bilateral projects and funding opportunities

II. By 1st Board of Trustees Meeting May 1993:

A. Preparation of final Resource Development Strategy
B. Preparation of 2nd draft Strategic Plan
C. Recruitment and training of new Resource Development Officer
D. Design and initial implementation of resource development coordination system within the Centre
E. Completion of alumni database
F. Completion of alumni net-working tour
G. Detailed plan for USA based resource development activities
H. Detailed plan for UK based resource development activities
I. Initiation of UK strategy implementation
    1. Research into markets
    2. Research into and development of existing networks
    3. Preparation of UK/Europe resource development strategy
    4. Initiate registration of UK charitable trust
J. Initiation of research into:
    1. Debt for Development
    2. International health research networking
    3. Title III wheat sale proceeds
    4. Offshore funding NGOs
K. Initiation of contacts with corporations
L. Initiation of contacts with other foundations
M. Competitive grant proposal training plan
N. Printing of ICDDR,B promotional brochure in Japanese

III. By 2nd Board of Trustees Meeting and Donor Support Group Meeting in November 1993:

A. Preparation and printing of final Strategic Plan
B. Preparation of draft Case Statement
C. Preparation of "Introduction to the Work of ICDDR,B": 2nd edition
D. Completion of competitive grant proposal training
E. Functioning ICDDR,B desk in ICHF office
F. Initiation of US campaign research
G. Report on:
   1. Debt for Development
   2. International health research networking
   3. Title III wheat sale proceeds
   4. Offshore funding NGOs
H. Review of endowment fund strategy
I. Decision on establishing a ICDDR,B desk in UK

IV. By 1st Board of Trustees Meeting May 1994:

A. Finalized and printed Case Statement
B. Finalized and printed "Introduction the Work of ICDDR,B": 2nd edition
C. Establishment of ICDDR,B desk in UK (?)
D. Endowment fund formal campaign plan (1st draft)

V. By 2nd Board of Trustees Meeting and Donor Support Group Meeting in November 1994:

A. All preparations for endowment campaign launch
   1. At least 20% of funds already secured
   2. Committees formed
   3. US and UK/Europe networks functioning (volunteers ready)
   4. Mailing lists
   5. Campaign plan
   6. Campaign literature/video

VI. Launch of Endowment Campaign

Appendix 1

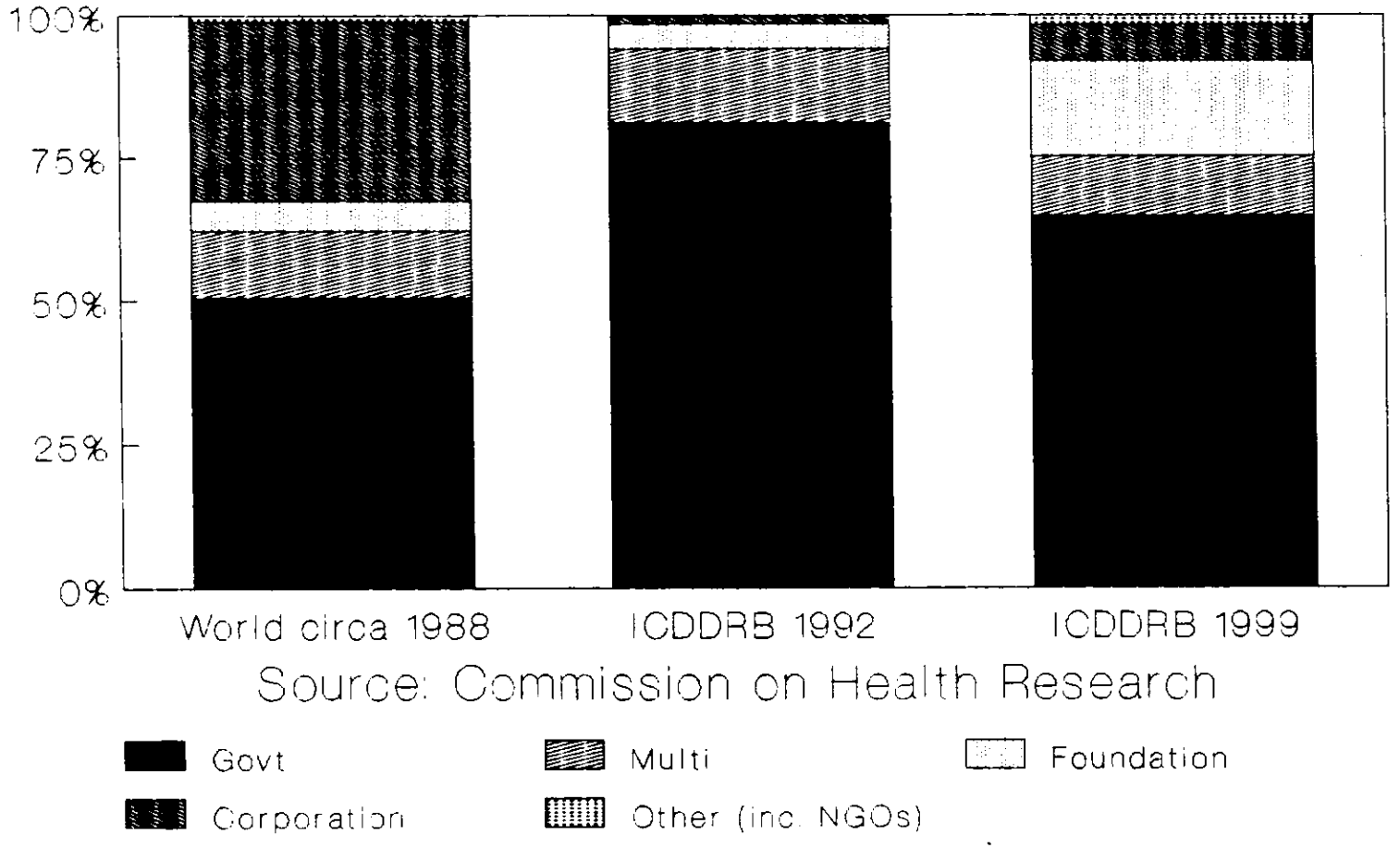
Contributions in $'000

Contributions:					Inflation =		5.0%				
	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Core	1,765	3,048	3,374	3,176	3,494	3,843	4,227	4,650	5,115	5,626	6,189
Project	10,359	7,293	5,497	6,294	7,238	8,324	9,572	11,008	12,659	14,558	16,742
Capital	272	29	351	500	300			300	400	400	300
Total	12,396	10,370	9,222	9,970	11,032	12,167	13,800	15,958	18,174	20,585	23,231
Govt	10,625	9,365	7,885	8,098	8,908	9,687	10,656	11,722	12,747	13,863	15,076
Multi	1,276	887	883	1,283	1,411	1,552	1,708	1,878	2,043	2,222	2,416
Foundation	(14)	80	359	439	530	696	1,096	1,726	2,446	3,083	3,884
Corporate	137	33	70	123	161	212	334	526	828	1,130	1,483
Other	18	5	25	27	35	56	88	138	218	298	406
Total	12,042	10,370	9,222	9,970	11,046	12,203	13,881	15,990	18,282	20,594	23,265
Increase over prior year	26.7%	-13.9%	-11.1%	8.1%	10.8%	10.5%	13.8%	15.2%	14.3%	12.6%	13.0%

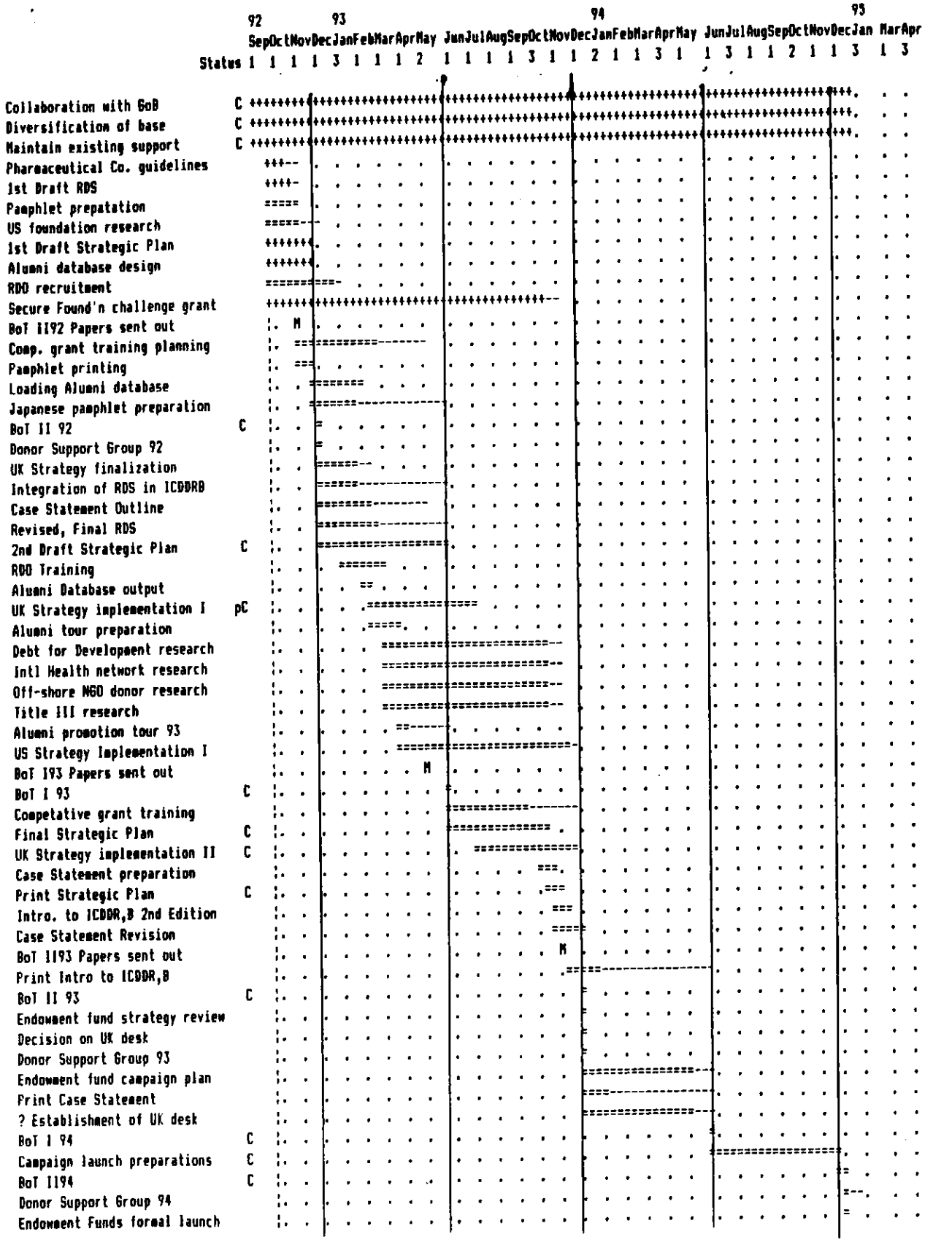
Nature/Source of contributions

Contributions:											
	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Core	14.2%	29.4%	36.6%	31.9%	31.7%	31.6%	30.6%	29.1%	28.1%	27.3%	26.6%
Project	83.6%	70.3%	59.6%	63.1%	65.6%	68.4%	69.4%	69.0%	69.7%	70.7%	72.1%
Capital	2.2%	0.3%	3.8%	5.0%	2.7%	0.0%	0.0%	1.9%	2.2%	1.9%	1.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Govt	88.2%	90.3%	85.5%	81.2%	80.6%	79.4%	76.8%	73.3%	69.7%	67.3%	64.8%
Multi	10.6%	8.6%	9.6%	12.9%	12.8%	12.7%	12.3%	11.7%	11.2%	10.8%	10.4%
Foundation	-0.1%	0.8%	3.9%	4.4%	4.8%	5.7%	7.9%	10.8%	13.4%	15.0%	16.7%
Corporate	1.1%	0.3%	0.8%	1.2%	1.5%	1.7%	2.4%	3.3%	4.5%	5.5%	6.4%
Other	0.1%	0.0%	0.3%	0.3%	0.3%	0.5%	0.6%	0.9%	1.2%	1.4%	1.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Health Research Funding Source Mix For Developing Countries' Issues



Schedule Name:
Project Manager:
As of date: 27-Sep-92 2:56pm Schedule File: D:\FILES\ASS\PLAN\BOTI192



D Done
C Critical
R Resource conflict
p Partial dependency
Scale: Each character equals 7 days

=== Task
+++ Started task
M Milestone

- Slack time (=---), or
Resource delay (-===)
) Conflict

ICDDR,B Resource Development Strategy Draft # 1

	1993	1994	1995	1996	1997	1998	1999
USA - In conjunction with ICHF	$	$	$	$	$	$	$
Fixed Costs							
Computer system	4,000				5,000		
Desk, chair etc.	750				1,000		
Initial Stationery etc.	750						
Total US based fixed costs	5,500	0	0	0	6,000	0	0
Recurring Costs							
Part-time adminstrator	18,000	37,800	39,690	41,675	43,758	45,946	48,243
Office Rental	1,800	3,780	3,969	4,167	4,376	4,595	4,824
Stationery etc.	500	1,050	1,103	1,158	1,216	1,276	1,340
Transport	1,500	3,150	3,308	3,473	3,647	3,829	4,020
Communications	1,200	2,520	2,646	2,778	2,917	3,063	3,216
Total US based recurring annual costs	23,000	48,300	50,715	53,251	55,913	58,709	61,644
UK - In conjunction with a consultant							
Fixed Costs							
Institutional establishment - consultant	37,500						
Computer system		5,000			7,000		
Desk, chair etc.		750			1,000		
Initial Stationery		750					
Total UK based fixed costs	37,500	6,500	0	0	8,000	0	0
Recurring Costs							
Consultant		13,860	11,435	6,289			
Part-time adminstrator		31,500	33,075	34,729	36,465	38,288	40,203
Office Rental		3,780	3,969	4,167	4,376	4,595	4,824
Stationery etc.		1,050	1,103	1,158	1,216	1,276	1,340
Transport		2,310	2,426	2,547	2,674	2,808	2,948
Communications		3,150	3,308	3,473	3,647	3,829	4,020
Total UK based recurring annual costs	0	55,650	55,314	52,362	48,377	50,796	53,336
Bangladesh based PR/RDO							
Recurring Costs							
RDO/PR salary	36,000	39,600	43,560	47,916	52,708	57,978	63,776
RDS Travel	20,000	22,000	24,200	26,620	29,282	32,210	35,431
Consultants	17,000	11,000	12,100	13,310	14,641	16,105	17,716
Printing and supplies	5,000	5,500	6,050	6,655	7,321	8,053	8,858
Communications	2,400	2,640	2,904	3,194	3,514	3,865	4,252
Total Bangladesh based recurring annual costs	80,400	80,740	88,814	97,695	107,465	118,211	130,033
Total Resource Development Strategy Costs	$146,400	$191,190	$194,843	$203,309	$225,755	$227,716	$245,013

4/BT/NOV.'92

PROGRAMME COMMITTEE REPORT

REPORT OF THE PROGRAMME COMMITTEE MEETING OF THE BOARD OF TRUSTEES HELD ON NOVEMBER 27, 1992

Open Meeting: 8.00 am tO 1.00 pm

Present at this meeting were:

Members

Prof. R. Hamilton (Chairman)
Dr. D. Ashley (Chairperson of Board)
Prof. J. Caldwell
Prof. K.M. Farudiddin
Prof. D. Habte (Director)
Prof. A. Lindberg
Prof. F. Mhalu

Invited Trustees

Prof. C. Chunming
Dr. R.H. Henderson
Dr. M. Law
Prof. A Muller
Dr. J. Rohde
Prof. T. Wagatsuma

Donors

Mr. J. Ross, Ford Foundation

Associate Directors

Dr. D. Mahalanabis
Dr. RB Sack
Dr. M. Strong

Scientific Staff of ICDDR,B

1. The Agenda, was accepted as proposed.

2. Response to the External Review of the Clinical Sciences Division

Dr. Mahalanabis, the Associate Director gave a concise account of his Division's response to the Review Committee's Report (prepared by Prof. Grant Gall of the University of Calgary). The Division in general agrees with the recommendations made and has begun to implement changes in response to what was a supportive assessment of the Division.

The Review Committee advised the Centre to examine the feasibility of initiating in depth basic studies of mechanisms of diarrhoea as a basis for future therapeutic initiatives. An invited expert panel met with Dr. Mahalanabis in September in Montreal to discuss this issue and strongly endorsed the feasibility and desirability of such a research direction at ICDDR,B. They emphasised the crucial importance of developing new international collaborative links to provide the critical mass with which to develop research in this fast moving field where excellent scientific opportunities are felt to exist.

Dr. Mahalanabis outlined the response of his division to each of the Review Committee's recommendations (attached) making it clear that the review process had been very beneficial to his Division.

In the Programme Committee's subsequent discussion several important points were made:

a) Efforts should continue to reduce the patient care load of those physicians expected to undertake major commitments to research. These efforts should continue to consider the use of patient care facilities outside the Centre.

b) The importance of a medical audit process, which the Division has introduced, was emphasised.

c) Caution in initiating extensive research at the Clinical Research Centre dealing with acute respiratory infections was advocated, given the need to focus available resources on the Division's wide range of existing research programs directed at diarrhoea and malnutrition.

3. Follow up - Programme Committee Review of the Population Sciences & Extension Division

At the time of the Programme Committee external review of the division a year ago, the Board had requested a follow-up report after one year. At the Committee's request, Prof. Caldwell, who had chaired the earlier review, undertook the follow-up assessment. His written

report is attached.

In general, Prof. Caldwell reported that excellent progress has been made and that he was very pleased with the current status of the Division, directed by Dr. Michael Strong. A major effort had gone into implementing the 1991 recommendations. Progress had been made toward enhancing the Division's social scientific capacity. He agreed that it was now reasonable for the DSS to proceed with a rolling census.

He identified 2 new areas for concern, drawing them to the attention of Centre management.

1. As the Population Studies Centre develops under Dr. Bairagi's direction, it is in urgent need of resources, particularly additional staff.

2. As studies in the social sciences have expanded, the placement of these individuals in the salary scale should be evaluated, since some inequities appear to exist.

4. Achievements and Plans

(a) **Community Health Division - Dr. R.B. Sack**

Dr. Sack reviewed the extensive achievements and plans for his Division. In the Work Plan for 1993-1994 (attached) he outlined the goal and the general organisation of the

Division in which there are 6 major foci of primary research interest.

Mr. Ross of the Ford Foundation asked about plans for clinical testing for HIV infection and was informed that the Centre was considering the possibility of establishing a diagnostic laboratory. This matter was discussed at length later in the meeting (see below). He suggested that counselling facilities for women in the community contemplating on abortion should be considered given the probabiity that the policies of major US AID agencies would cease to be opposed to abortion.

b) **Population Sciences & Extension Division - Dr. M. Strong**

Dr. Strong outlined the function of the 5 groups within his Division. Through internal and external sources the Division's financial status is reasonably stable and research is proceeding in a number of areas, notably

- demographic indications
- adult mortality and morbidity
- age at marriage
- injectable contraceptive use
- the role of women
- impact of the Matlab embankment

Prof. Caldwell expressed concern about the techniques used in evaluating the division of households in the Demographic

Survey. He and Dr. Rohde emphasised the importance of obtaining accurate data on cause of death among adults and the possible need to validate the verbal autopsy report procedure being used in the field.

c) **Laboratory Sciences Division - Dr. R.B. Sack**

With a stable complement of staff, this Division has expanded its productivity as measured by the receipt of peer-reviewed grants, the scope of their international activities and the expansion of their clinical work load. New laboratories have been created and steps have been taken to deal with biosafety issues.

A copy of the research plan is attached. It focuses on the characterisation of newly recognised causative agents for diarrhoea, on improved molecular diagnostic assays; on further characterisation of the WC/B cholera vaccine, on the evaluation of E.coli, pneumococcus and measles vaccines, on studies of mechanisms of antibiotic resistance, on environmental studies, and on the immunogenic properties of Shigella and Helicobacter organisms.

Since these programs had been the subject of an external review at this meeting they were not discussed in detail by the Committee at this point.

d) Clinical Sciences Division - Dr. D. Mahalanabis

Dr. Mahalanabis described the clinical, teaching and research achievements of his Division. The responsibilities of this Division are large in all 3 areas for a medical staff of approximately 30 with approximately 40 trainees and 30 nurses. Thirty four papers have been published since the last meeting and 14 are in press.

Highlights of the Division's recent work are the completion of studies showing the efficacy of pivmecillinam/methicillin in shigellosis and the beneficial impact of a high energy diet in the early management of children with Shigella.

Research planning is organised within a task force structure. In general, the work plan arises from the current areas of productive research. Trials of the use of hyperimmune cow colostrum are planned, directed against acute and chronic diarrhoea and against Shigella dysentery, after the successful use of this approach in rotavirus diarrhoea. Other studies will assess bismuth subsalicyclate as a treatment and the role of H.pylori in persistent diarrhoea. New initiatives are anticipated in major areas

- intestinal ion transport in relation to mechanisms of secretion
- energy metabolism and body composition in relation to the nutritional status of patients
- factors influencing lactation

- acute respiratory infection

5. **Review of Laboratory Sciences Division**

A Committee composed of Maj. Gen. Chowdhury, President, Bangladesh Society for Immunology, Professor T. Honda, University of Osaka and from the Board, Prof. Fariduddin, Prof. Lindberg and Prof. Mathan reviewed the Division over a 3-day period immediately preceeding the Programme Committee meeting.

Their report (copy attached) has been submitted to the Centre and a response is expected at our next meeting in June, 1993.

The Review Committee noted a vast improvement in the quality of the work of the Division compared with the situation at the time of the previous review in 1989. They recommended that studies of acute respiratory infections, hepatitis and HIV be added to the several existing very promising areas of research. They recommended also that the Division should

a) merge the clinical and research facilities

b) expand its virology laboratory

c) update existing equipment and procure new equipment to allow it to achieve its important research objectives.

6. Other Business

Proposal to field test the CVD 103-HgR live cholera vaccine at ICDDR,B

This request from Dr. M.M. Levine of the Center for Vaccine Development, University of Maryland, was discussed at the Director's request, and reviewed further at the Committee's closed meeting.

The Programme Committee expressed strong support for the principle that the Centre must remain an important resource for the field testing of candidate vaccines against cholera. Experience has shown that such studies necessitate the allocation of a large proportion of the Centre's resources over an extended peiod of time. The Committee recommends to the Centre management that it exercise great care in assessing the probable benefits of this and any other vaccines, and the potential advantages of a specific vaccine to its patients, to the Centre and to Bangladesh before committing itself to a major evaluative trial.

There being no further business the Open Meeting of the Committee adjourned at 1.00 pm.

PROGRAMME COMMITTEE MEETING - ICDDR,B

CLOSED MEETING - 17-19.00 hrs - November 27

The Committee, along with additional members of the Board met in a closed session. This second session provided an opportunity to reflect on some of the major issues raised during the earlier meeting as follows.

1. Population Studies Research

On further discussion of Professor Caldwell's report on the Population Sciences and Extension Division review, the Committee emphasised 3 areas of concern:

a) In the Extension program the need to consider carefully any change from a "doorstep" to a satellite system of delivery of services. Interpretation of results from a Satellite system would need to take into consideration the influence of a previous "doorstep" centred program in the same community. The Committee does recognise the potential need to experiment with different and potentially more cost effective delivery systems.

b) The need to allocate resources (personnel, equipment) to the Population Studies Centre if it is to develop.

c) The extreme importance of the validation of an appropriate technique for the determination of cause of death in field studies.

2. Clinical Sciences Research

The Committee recognises the need for the Centre to nurture in-depth research in this Division. The need to develop and support researchers towards the creation of a critical mass of productive national researchers is recognised. The External Review Committee suggested strategies with which to pursue this goal - strategies that the Division and the Committee support.

3. Laboratory Services

The Committee learned that the recommended expansion of virological diagnostic capacity could be achieved without expansion of the budget.

The Committee is unanimously and strongly of the opinion that the Centre must carefully study all potential complications of developing HIV diagnostic capacity before embarking on such a program. In particular, they emphasised that testing must be only one part of an overall program in any community or country, that public education on HIV should be well advanced in the community, that the WHO guidelines now in preparation should be consulted and that all legal and ethical issues related to HIV infections in Bangladesh should be carefully analysed before ICDDR,B embarks on a laboratory diagnostic testing program. At present, for individual cases, samples can be

sent out of the country for diagnosis.

4. Vaccine Trial Proposal

The Committee again affirmed its policy that ICDDR,B should whenever feasible involve itself in studies related to candidate cholera vaccines. The decision as to which, if any of the vaccines currently being developed or being assessed, should be tested at ICDDR,B, remains a matter for Centre management to decide. The decision should be determined by examining the potential benefits of the vaccine under consideration and by evaluating the priorities for resource allocation of the Centre at the time. The Committee does feel that every effort should be made by the Centre to be active in this area of research, given these considerations.

The meeting adjourned at 7.00 pm.

Prof. J.R. Hamilton
Chairman, Programme Committee

JRH:ls

ICDDR,B Board of Trustees
Programme Committee Review of
The Laboratory Sciences Division

Dhaka, Bangladesh

24-26 November, 1992

Members of the Review Committee

1. Major-General (Ret'd) M.R. Chowdhury,
   President, Bangladesh Society for Immunology,
   Dhaka, Bangladesh.

2. Professor Takeshi Honda,
   Department of Bacteriology & Serology,
   Research Institute for Microbial Diseases,
   Univeristy of Osaka, Osaka, Japan.

3. Prof. Dr. K.M. Fariduddin,
   Member, ICDDR,B Board of Trustees.

4. Prof. Alf A. Lindberg,
   Member, ICDDR,B Board of Trustees.

5. Prof. V.I. Mathan,
   Member, ICDDR,B Board of Trustees.

I INTRODUCTION

The five member review group constituted by the Programme Committee of the ICDDR,B Board of Trustees met with Dr Brad Sack, Associate Director, Laboratory Sciences Division (LSD) and Dr Moyenul Islam and Dr John Albert. An administrative overview of the Division was presented by Dr Islam. It was decided that all the scientific staff of the Division would be present when the individual presentations were made and there would be an open house meeting at the end when the members of the Division could ask questions of the Committee.

A. Background

A detailed review of the LSD was carried out in March 1989 by a group which included two of the present reviewers. At that time very specific suggestions were given about re-organization of the Division and about scientific priorities. The priority areas within the 1990-94 strategic plan - invasive diarrhoea, watery diarrhoea and persistent diarrhoea - are now the focus of research of the Group. There have been interruptions in the scientific leadership of the Division with Dr S. Tzipori leaving in August 1990 and Dr Brad Sack taking over only in January 1992. Dr Moyenul Islam was the acting Associate Director in the interim. The Division had five international level staff in 1989. It now has only four such staff. Considerable training of the Bangladeshi scientific staff has occurred in the interim.

B. Methods

The Associate Director, LSD and his senior colleagues (Dr Moyenul Islam and Dr John Albert) presented an administrative overview of the Division following which the review committee visited the present laboratories, the

animal house facility and the new clinical and training laboratories in the Sasakawa training building. We were also shown the plans for the extension of the Sasakawa training building to house all the laboratories of the LSD. This will enable reorganization of the laboratories and provide additional space. Following this the scientific presentations were made by fifteen of the scientists of the Division over two half day sessions where all scientific staff were present. Thereafter followed an open forum where the scientific staff shared their concerns with the Committee. The preliminary recommendations of the Committee were discussed with the Director and the Associate Director, LSD and his senior staff.

II DESCRIPTION OF THE DIVISION

In 1989 the LSD had a staff of 252 persons including 5 international level scientists and 32 at the national level scientist/manager. Over the last three years the Division have eliminated redundant staff and presently there are 143 persons employed: 4 in international level scientists (including the Associate Director), 14 national level scientists/managers and 125 support staff.

The laboratories of the Division are scattered over the three floors of the IPH building, and in the clinical treatment and research centres in Dhaka and Matlab. In 1992 the clinical laboratory moved into new facilities in the newly constructed first floor of the clinical treatment and research centre (Sasakawa training building), and during 1993 the activities housed in the IPH building will also move to laboratories now under construction in the Sasakawa training building. This means the Division will operate in high quality laboratories with adequate facilities for tissue culture and isotope work. To improve the ability to conduct successful research activities the new facilities should achieve much needed equipment, both as a replacement of old equipment and new additions.

A. Organization

The Laboratory Sciences Division has undergone major changes in the last three years and has evolved from a laboratory that was supporting few research programmes to a full-fledged research laboratory providing comprehensive support to other Divisions and also capable of conducting laboratory research of its own. In 1989 the Division established three new research units and the research laboratories are now organized into immunology, molecular biology, virology, enteric bacteriology, parasitology, bacterial genetics and environmental microbiology. Sixteen divisional and collaborative research programmes were developed.

B. Research within LSD

The research productivity of the Division is commendable. Between 1989 and 1992 scientists of the Division have produced 130 publications (including 16 in press), many of them in internationally renowned journals. This compares favourably with a productivity 72 papers in the five year period 1984 through 1988.

Major achievements 1989-1992

Attemps have been made to identify new agents of diarrhoea and the following agents were identified:

Bacterial pathogens

Putative agents: Three new possible pathogens have been identified. They are *Hafnia alvei*, some non-enteropathogenic serotypes of *Escherichia coli* (O2:H2, O2:H25 and O15;H2 - non-EPEC) and *Providencia alcalifaciens*. *H. alvei* and non-EPEC serotypes could produce diarrhoea by attachment-effacement type of lesion of the intestine and *P. alcalifaciens* by invading the intestinal mucosa.

Recently identified agents: Several agents including enterotoxigenic Bacteriodes fragilis, Shigella dysenteriae serotypes 11, 12 and 13 and a blue-green alga (cyanobacterium-like body) identified in other parts of the world have also been detected in several diarrhoeal patients in Bangladesh.

Escherichia coli: A year-long clinic-based study on the role of various categories of E. coli (enterotoxigenic [ETEC], enteropathogenic [EPEC], enteroinvasive [EIEC], enterohaemorrhagic [EHEC] and enteroaggregative [EAggEC]) in the aetiology of diarrhoea in children under 5 years old is nearly completed. Preliminary impressions suggest a high prevalence of infections due to ETEC, EPEC, and EAggEc and a virtual absence of infections due to EIEC and EHEC in this age group.

Viral pathogens

Year-long surveys have been conducted on group A rotavirus infection in urban (Dhaka) and rural (Matlab) Bangladesh. These studies suggest that group A rotavirus account for 15 to 25% of all cases of diarrhoea. Infections are prevalent round the year with all the four major serotypes co-circulating. A survey of two neonatal nurseries in Dhaka suggests a high prevalence of rotavirus infection in newborns. The effect of neonatal rotavirus infection on subsequent rotavirus infection in terms of severity and protection is being studied. This will have implications for the age at which a rotavirus vaccine will be administered.

Studies on enteric adenoviruses (EAdVs) suggest that their prevalence is rather low (3%) although they cause dehydrating diarrhoea, and an epidemic in a rural area of Bangladesh.

Parasite pathogens

Entamoeba histolytica (EH): To differentiate between pathogenic and non-

pathogenic forms of EH, anti-lectin monoclonal antibody based ELISA has been developed. A preliminary study of 34 patients with EH in stools identified 12 patients as being infected with the pathogenic form and the remainder with the non-pathogenic form. A larger study is being planned to assess the relative prevalence of both forms.

Improved diagnostic techniques

Establishment of nucleic acid based techniques for diagnosis and research: Several DNA probes constructed overseas for detection of diarrhoeagenic pathogens have been introduced to ICDDR,B. Comparison of DNA probe and conventional assays shows that DNA probe assays are more sensitive, convenient and cheaper for handling a large number of specimens. Moreover, some of these probes have been used to study the molecular epidemiology of certain diarrhoeal pathogens (e.b. Vibrio cholerae 01 and Shigella spp. for which subtyping systems are not easily available) by studying their restriction fragment length polymorphisms (RFLPs) and interesting results have been obtained.

The highly sensitive polymerase chain reaction (PCR) technique has been introduced for rapid detection of Shigella spp. and Vibrio choerae 01. Their usefulness in the diagnosis and transmission studies where pathogens are present in small numbers and difficult to isolate by conventional culture techniques, cannot be overemphasized. PCR-based assay systems are being introduced for other diarhoeagenic pathogens.

Shigella: The traditional culture method takes at least 48 hours for the detection of Shigella in stool, and if they are present in small numbers and if there is a long delay in processing, often Shigella may not be cultured. An indirect immunofluorescent assay has been developed for direct detection of S. dysenteriae 1. A monoclonal antibody - coated immunomagnatic particle (IMP)-based ELISA and polymerase chain reaction (PCR) techniques have also been developed for direct detection of S. dysenteriae 1 and S. flexneri spp. These assays are more sensitive than

culture, can detect dead Shigella and a diagnosis can be made in 2-7 hours.

Monoclonal antibodies have been derived to the LPS antigens of the newly recognized S. dysenteriae 13. These antibodies can be used for the detection of this serotype by simple slide agglutination. These antibodies are being used in the clinical laboratory to study the contribution of this new serotype to dysenteric illness.

Enteropathogenic E. coli (EPEC): The diagnosis of EPEC is quite cumbersome and can take several days. A highly sensitive and specific polyclonal antibody-based ELISA for localized adherent EPEC has been developed and a diagnosis can be made within 48 hours of submission of the stool specimen.

Characterization of virulence determinants of bacteria

Shigella: Virulence determinants of Shigella have been studied and the lipopolysaccharide (LPS) is the haemagglutinin/adhesion of S. dysenteriae 1. In addition the bacteria produces a polysaccharide slime when grown in a rich medium and also when inoculated into adult rabbit ileal loops. This slime seems to confer on the organism resistance to serumcidal acitivity and phagocytosis. This suggests that slime could be an additional virulence factor of S. dysenteriae 1.

A monoclonal antibody to the outer membrane protein (OMP) of S. dysenteriae 13 that recognized Shiga toxin in ELISA and immunoblot has been derived. This may suggest that a Shiga-like toxin is produced by this new serotype which may have a role in the pathogenesis of disease produced by this serotype.

Salmonella: Although Salmonella and Shigella are invasive pathogens, there are differences in the pathogenesis and clinical severity of dieases produced by these bacteria. Shigella invade the intestinal epithelium and

produce ulcerations in the colon with the resultant bloody mucoid diarrhoea. Salmonella do not cause much direct damage to the epithelium, but instead evoke a severe inflammatory response in the lamina propria and Peyer's patches. The ability of Shigella to produce invasive disease is reflected by its ability to produce keratoconjuncitivitis (kc) when inoculated into guinea pig's eye. On the other hand, Salmonella serotypes investigated so far do not produce kc. A S. weltevreden that caused an outbreak of kc in a guinea pig colony has been isolated. The same serotype isolated from patients with diarrhoea also produced kc when inoculated into guinea pig. This is a new virulence mechanism for Salmonella.

Other: H. alvei and non-EPEC serotypes were found to produce diarrhoea by attachment-effacement type of lesion. P. alcalifacisn has been found to invade the intestinal mucosa.

Identification of characterization of unique cross-reacting bacteria

Aeromonas hydrophila cross-reacting with Shigella boydii 5, and Plesiomonas shigelloides cross-reacting with Shigella flexneri 6 and a common group antigen shared between S. dysenteriae 1 and S. flexneri spp., from patients with diarrhoea have been isolated. The cross-reacting antigens are present in the somatic LPS antigens. These strains have the utility in the preparation of useful diagnostic reagents and even candidate vaccine strains. One cross-reacting P. shigelloides is being studied as a potential vaccine strain against shigellosis.

Epidemiology

A new genetic fingerprinting technique called ribotyping has been applied to differentiate strains of V. cholerae 01. It showed that the V. choerae that caused the recent South American epidemic is identical to Bangladeshi strains, suggesting that South America is part of the expanding seventh

pandemic area. Further studies with Bangaldeshi isolates suggests the existence of two clones of classical biotype in Bangladesh and also substantiate the hypothesis that El Tor biotype never completely replaced classical biotype in Bangladesh.

Ribotyping also further subdivides S. flexneri serotypes validating its utility in epidemiological studies.

Environmental microbiology

The survival of S. dysenteriae 1 was studied in a laboratory microcosm using water from pond, lake, river and drainage. The inoculated organisms were monitored by culture, flourescent antibody technique and PCR. It was observed that the organisms can be cultured for up to three weeks, beyond which they remained viable but non-culturable when studied up to 6 weeks. This suggests that water samples with non-culturable but viable Shigella can act as potential vehicles of infection.

Vaccinology

Attempts have been made to develop a live, oral vaccine against shigellosis, a major killer disease of childhood in developing countries. A thymine-requiring and temperature sensitive double mutant of S. flexneri Y named TSF-21 was derived by thymine-trimethoprim selection and ultraviolet mutagenesis, and the mutant was found to be safe, immunogenic and protective in monkeys. Because of the lack of a defined deletion the vaccine is not suitable for human studies.

Nutritional biochemistry

There is no reliable test for assessment of vitamin A status. For this purpose, a modified relative dose response (MRDR) test has been

established and is being validated. It was also found that significant (>40%) loss of beta-carotene occurs during various cooking processes of green-leafy vegetables.

To ensure adequate colorie intake by children during and after recovery from diarrhoea, an energy-dense porridge has been developed by the addition of natural amylase from germinated wheat to porridge made from starch.

A sugar probe test has been perfected to assess the permeability of the gut.

III CONCERNS AND SUGGESTIONS ABOUT ACTIVITIES

A. Organization

A firm recommendation to merge the clinical laboratory work and the research laboratories was given by the last review committee. This was given in order to integrate the research activities covered by the clinical laboratory into the other research in LSD and to ensure high quality of work in the clinical laboratories. However, the present organogram has divided the LSD into two departments, Laboratory Research under the leadership of Dr John Albert and Laboratory Services headed by Dr Moyenul Islam. The clinical laboratory, Dhaka has a total of 43 staff of whom four are involved in scientific management. The other scientific staff are 11 in clinical microbiology, 9 in clinical biochemistry and 9 in clinical pathology. A total of 88,255 specimens involving 198,134 tests have been done giving a daily average of 32.4 tests per scientific staff. The staff in this area have increased from 39 total at the beginning of 1991 to the current 43, an addition of 4 posts. This facility helps 22 protocols in the Clinical Sciences Division and also provides laboratory services to the citizens of Dhaka. Because of this as of the end of October $500,480 have been recovered of which $162,612 were in cash. This

recovery has contributed $145,963 to core funds.

The review committee had major concerns about this area. The quality control in the clinical laboratory was suboptimal and there were concerns about the clinical scientists using this laboratory for their research rather than collaborating with the LSD scientists. Should ICDDR,B develop the clinical laboratory as an area of cash income generation by expanding the scope of laboratory services provided to the Dhaka town? There are problems and advantages in such a strategy which needs to be considered by the Board.

In any case the clinical laboratory is an area with major excesses of staffing and the Committee recommends that a consultant should work out the optimal staff levels for the projected work load and Centre management should then take appropriate steps. Rotating research scientists for a short period through the clinical laboratory would strengthen the scientific quality of the output. Particularly in view of the physical proximity in the new facility, merging the clinical and research facility and reducing staff therefore should be given the highest priority.

B. ICDDR,B and Health Services Research in Bangladesh

The mandate of the ICDDR,B as given in the Ordinance is to carry out relevant research in the area of diarrhoeal diseases and related areas of nutriton, women and child health and population studies. However, the broader scope of health services research is now internationally accepted and in the context of Bangladesh there appears to be three areas where the LSD can make a significant contribution to research and to the host country.

a) Acute respiratory infections: Autopsy studies presented to us emphasized the importance of lower respiratory tract infections as a major cause of mortality in patients with diarrhoea. The LSD has already plans

to investigate the viral agents of ARI. It would appear to be worthwhile to recruit the help of an appropriate consultant to plan the detailed research on ARI as a major cause of childhood morbidity and mortality.

b) **HIV and Hepatitis viruses:** These are identified as national priorities by the Government of Bangladesh. The expertise of ICDDR,B, LSD could be made available to work in close collaboration with the Government of Bangladesh in this important area. The LSD could act primarily as an area of quality assurance and reference laboratory.

C. Biology of Host-Pathogen Interaction

The review of the Clinical Sciences Division in June 1992 identified the study of the biology of host-pathogen interaction as a priority area. LSD could profitably interact with CSD in this important area by providing the laboratory and microbiological skills that are necessary.

D. Umbrella projects

The commitee was impressed by the information generated by the umbrella projects on viral agents of diarrhoea. It would be worthwhile to consider the utility of such umbrella projects which would enhance the productive output of scientists when compared to one narrowly focussed protocol.

E. Animal House

The facilities are separately housed and include breeding rooms which are adquately separated by a physical barrier system. The temperature can be controlled but not the humidity.

The animal rooms are well kept and the animals are apparently very well taken care of. Presently the facilities are not utilized to their full

capacity, and there is room for more host-pathogen studies since they cannot yet be replaced by in vitro studies.

Presently the animals are not monitoried for their health status and the staff lacks such experience. The review committee recommends that one veterinarian is sent abroad to be trained in health monitoring of laboratory animals so that the animals used at ICDDR,B are of a guaranteed standard. The veterinarian and/or one of the animal husbandry staff should also be trained in breeding techniques so that inbred strains are maintained and of good quality.

F. Quality assurance

There are presently no formalized quality assurance programmes inside the Division. This is a weakness in particular for the units providing clinical services. Quality assurance programmes with record keeping should be developed within each unit with the help of the Division and Centre managements.

Biosafety concerns were raised by several members regarding microbiological, chemical and radiochemical agents. Dr B. Kay has recently conducted an inspection but his comments and suggestions were not yet available. The Division and Centre management should assure that all work inside the Division involves minimal hazards for the staff and the environment.

G. Equipment - Biomedical Engineering

The Bio-medical Engineering cell with its staff of three provides service to equipment of the Division and the Centre. The staff is not trained, nor does anyone have a degree in electronics. The staff should receive such training and in future recruitment the person should be a graduate with a degree in electronics.

When new equipment is procured the vendor should provide after sales service, a service manual and train the staff in required maintenance service.

IV STRATEGIC PLAN AND RECOMMENDATIONS

The Review Committee has been impreseed by the vastly improved quality of the work of the Division over the last three years. As outlined above the committee endorses that the Division incorporates in its research priorities studies of acute respiratory infections, hepatitis and HIV. Ongoing and planned research projects are of a high competitive quality and fall inside the priorities of the Centre. There are several inter-divisional research projects which contribute to strengthening and utilization of the research potential of the Centre. The Review Committee considers that the new activities can be incorporated without expanding the staffing numeral.

The review commitee recommends that the Division to fulfill its goals is strengthened through

- expansion of the virology laboratory
- procurement of equipment to replace old, inadequate instruments and to acquire new instruments needed for fulfillment of the research projects.

Motivations for these recommendations are as follows:

Proposed expansion of Virology Laboratory

Goals and Objectives

To further develop diagnostic and research capabilities of the Virology Laboratory to include, in addition to enertic and measles viruses, the etiologic viruses of acute respiratory diseases, the human

immunodeficiency virus (HIV) and hepatitis viruses, A through E.

Plan

a) Personnel

In order to do this, the Division needs a virologist, experienced in at least some of these areas, to head the laboratory. Since there is no one at ICDDR,B (after Leanne Unicomb leaves) with the expertise for this responsibility, the Division needs to recruit an expatriate virologist, PhD or MD. ICDDR,B personnel, including high level technicians, must be trained in the technical aspects of the work. This may involve outside consultants coming to ICDDR,B and technical persons being trained in other laboratories abroad.

Salary, benefits of Virologist	...	$ 70,000 per year
Salary of 2 technicians	...	$ 12,000 per year
	Total	$ 82,000 per year

b) Equipment

Additional equipment necessary for the proposed expansion in this area could be:

PCR machine	...	$ 10,000
Electrophoresis unit	...	5,000
Biosafety hood, small	...	10,000
Refrigerator and -20^0 freezer	...	5,000
	Total	$ 30,000

The following equipment is presently available and can be shared:

Ultraviolet microscope

Tissue culture facilties

ELISA reader

c) Supplies

Supplies estimated at $25,000 per year, depending on studies.

d) Space

There is sufficient space in the newly constructed building for this expansion.

Budget

Personnel	...	$ 82,000
Equipment (first year only)	...	30,000
Supplies	...	25,000
	Total	$137,000

Priority Equipment (priorities set by the Associate Director and his staff)

High

- 2 Biohazard safety cabinet (Class II)
  (Immunology and Environmental Microbiology) (new)
- Ultracentrifuge (ordered) (replacement)
- B-scintillation counter (ordered) (replacement)
- Incinerator (Animal House) (replacement - ordered)
- Sodium/Potassium analyzer (Matlab) (replacement)
- Spectrophotometer (replacement)
- Electrolyte analyzer (Clinical Biochemistry) (replacement)
- 4 water baths (replacement)
- 2pH meters (Division) (replacement)
- CO_2 incubator (Clinical Microbiology) (new)

- Plate drier (2) (1 replacement; 1 new)
- Biosafety hood (Clinical Laboratory) (new)
- Table-top centrifuge (Clinical Laboratory) (replacement)
- HPLC (for Vit. A studies) (new)
- Biosafety exhaustg cabinet (Nutritional Biochemistry) (new)
- Densitometer (Nutritional Biochemistry) (replacement)
- Microscope (Animal House) (replacement)
- Steam Cleaner (Animal House) (replacement)
- -20^{0}C freezer (Animal House) (new)
- Gel electrophoresis photographic system (replacement)
- DNA squencer (new)
- DNA synthesizer (new)
- 2 autoclaves (Media and washroom) (replacement)
- Lyophilizer (replacement)
- Power pack - high voltage (Molecular Biology)
- Centrifuge, Beckman J2-21 (Environmental Microbiology)
- Gas liquid chromatograph (replacement)

Low

- CO_2 incubator (Immunology Laboratory) (new)
- Blood gas analyzer (Clinical Laboratory) (new)
- Stereomicroscope (Clinical Laboratory) (new)
- Fermenter, bacterial (Immunology Laboratory) (new)

Priority Equipment for Division Office

- Microcomputers (replacement)
  Division Office 3, Molecular Biology 1
- Laser Printer (replacement)
  Division Office
- Photocopier (replacement)
  Division Office

Justification for procuring oligonucleotide synthesizer and DNA sequencing system for Laboratory Sciences Division

a) Laboratories throughtout the world are switching over to DNA-based techniques for diagnosis and research. Staff at ICDDR,B are already using DNA probes and PCR techniques in their studies. These techniques are rapidly becoming more common in routine diagnosis and research because of increased sensitivity and specificity and also cost effectiveness.

b) At the moment oligonucleotides are bought from overseas at a premium price and delay. In the long run with increased use, it is economical that needed oligonucleotides are synthesized at ICDDR,B.

c) ICDDR,B is the only well-recognized medical research centre with reasonably equipped laboratories to address the diarrhoea-related problems of the region. ICDDR,B should continue to provide leadership for the rest of the region in research and training. Installing these facilties will go a long way in fulfilling such needs.

d) There are diseases peculiar to this part of the world and hence a need that the Centre makes its own DNA probes to study these diseases. Therefore, it is also important to procure a DNA sequencing system.

The complete system for the oligonucleotide synthesizer includes oligonucleotide synthesizer plus fast protein liquid chromatographic system (FPLC). FPLC is required for purifying the oligonucleotides after they are synthesized.

DNA sequencing system includes (a) gel kit, (b) high-voltage power-pack, and (c) automated sequencer.

V COSTING

Costing of the tests were last done in 1988 and present recoveries are based on these computations. It was felt that costs for the laboratory tests should be worked out again including realistic figures for overheads and personnel. This would be of importance in realistic budgets for research protocols and recovery through the clinical laboratory.

Rev Cttee:jc
28.11.92

5/BT/NOV.'92

FINANCE COMMITTEE REPORT

5/BD/NOV 92

REPORT OF THE MEETING OF THE FINANCE COMMITTEE

HELD ON 28 NOVEMBER 1992 AT ICDDR,B.

PRESENT

Finance Committee Members

Dr. D. Ashley - Chairman of the Board - ex-officio member
Mr. E. A. Chowdhury
Dr. R.H. Henderson
Prof. A.S. Muller - Chairman
Prof. V.I. Mathan
Prof. T. Wagatsuma
Prof. D. Habte - Director - ex-officio member

Board Members

Mr. S. Ahmed
Prof. J.C. Caldwell
Prof. C. Chunming
Dr. K.M. Fariduddin
Dr. R. Hamilton
Dr. M. Law
Prof. A. Lindberg
Prof. Fred S. Mhalu
Dr. J.E. Rohde

Associate Directors, ICDDR,B and invited staff

Mr. K.J.J. Tipping
Dr. R.B. Sack
Dr. D. Mahalanabis
Dr. M.A. Strong
Mr. M.A. Mahbub
Mr. G.A.N. Wright
Dr. S.K. Roy
Dr. M. Rahman

The Committee convened at 9:00 a.m. on 28 November at the Training Lecture Room number 1.

1. Approval of the Agenda

The draft agenda was approved and it was decided to take up agenda items 1-4 and item 6 in open session and to consider agenda item 5 jointly with the Personnel and Selection Committee in relation to their agenda item 5 in closed session.

2. 1992 Projection

The Associate Director, Finance presented the 1992 Projection.

Core Direct Income for 1992 was budgeted at $3,798,000. This is anticipated to increase by $367,000 to $4,165,000. This increase comprises:

Arab Gulf Fund	350,000 - one time contribution promised in 1989
UNDP/DSS - Restructuring	106,000 - carry from 1991
Other	108,000 - miscellaneous and currency fluctuation

which is offset by a reduction, due to budgetary constraints, of $197,000 in the contribution from NORAD.

Project Income including indirect overhead recovery for 1992 was budgeted at $5,797,000. This is anticipated to decrease by $735,000 to $5,062,000. The decrease is partly due to delay in starting or completing planned activities:

USAID/W - Targeted	300,000 - Shigella, Diarrhoea and Vitamin A
USAID/D - MCH-FP Ext	300,000 - no cost extension has been granted
Bayer AG - Cipro Study	164,000 - formulation of medication delayed

which is offset by currency fluctuations and miscellaneous of $29,000.

Core Expenditure, after depreciation and net of other income and recoveries, for 1992 was budgeted at $5,005,000. This is anticipated to increase by $477,000 to $5,482,000. This increase comprises:

Non recovery of inter department services and overheads on delayed protocols	390,000
Depreciation shortfall	54,000
Change of International Salary to UN scale	64,000
Miscellaneous	41,000

which is offset by other receipts of $72,000.

Project Expenditure was budgeted at $5,134,000. This is anticipated to decrease by $778,000 to $ 4,356,000. This decrease is essentially in line with the expected fall in project income.

Total Net Expenditure was budgeted at $10,139,000 and is anticipated to fall by $301,000 to $9,838,000.

Net Operating Deficit after depreciation for 1992 was budgeted at $544,000. This is anticipated to increase to $611,000.

Cash Operating Surplus before depreciation for 1992 was budgeted at $31,000. This is anticipated to fall to $16,000.

3. 1993 Budget

Core Direct Income is expected to be $3,571,00 (1992 $4,165,000). This decrease of $594,000 comprises the one time funding in 1992 from Arab Gulf Fund ($350,000), UNDP ($106,000) and Netherlands ($119,000) and other funding of $19,000. The May 1992 Board meeting was advised that the Centre expected Arab Gulf Fund to continue to donate and whilst we still think they may contribute we are very uncertain as to when and how much.

Project Income of $6,884,000 (1992 $5,062,000) is expected to increase by $1,822,000 and comprises carry overs on on-going projects from 1992 of $1,208,000 and new projects sourced from competitive grants totalling $614,000 (1992 $492,000). The grants, which represent a 25% increase over 1992, will come from Australia, The Ford Foundation, NSF/Mellon, UK/ODA, USAID/ARI, USAID/CGVD and USAID/Thrasher Research Fund.

Core Expenditure, after depreciation and net of all other income and recoveries, of $5,480,000 (1992 $5,482,000) is expected to decrease by $2,000. Whilst there are ups and downs in individual items, core expenditure will be slightly less than 1992. This will be achieved by continuing tight controls over expenditure and more rational charging to projects of senior scientists' salary costs.

Funding of gross core expenditure by donors continues to fall and the percentage funded by donors will be only 58% for 1993 compared to 82% for 1991.

Project Expenditure of $5,846,000 (1992 $4,356,000) is envisaged. This is an increase of $1,490,000 over 1992. The increase is in line with the expected increase in project income after adjusting for overhead recovery.

Total Net Expenditure of $11,326,000 (1992 $9,838,000) is expected to increase by $1,488,000.

Net Operating Deficit of $871,000 (1992) $611,000) after depreciation is expected to increase by $260,000.

Cash Operating Deficit of $223,000 compares to a 1992 cash surplus of $16,000. Concerted efforts to reduce or eliminate this deficit will be made by actively seeking new donors and continuing cost constraints.

Probable Additional Funding

Netherlands - $350,000 for each of 1993 and 1994 - UHEP

Netherlands - amount not yet known - DSS

ODA - Stg.150,000 for each of the next 3 years - DSS

ODA - Stg.200,000 for each of the next 3 years - Family Planning

Japan - increased funding - amount not yet known

Sasakawa Foundation - equipment and core funding - amount unknown

Discussion

Committee members, while confirming their confidence in the Centre's Management, expressed grave concern about the figures presented. They found it difficult to accept a deficit of $223,000 before depreciation without an indication as to what the Centre will do about it. It was pointed out that the Board had insisted that there be a cash surplus and that the Centre aim at full funding of depreciation. Several members were concerned that the cost of research was still too high, though realising the difficulties involved to bring this down. Overhead costs should be reduced. High overhead costs also have a negative impact on acquiring competitive grants. There is a need to increase core funding.

In response the Director and Associate Director, Finance pointed out that the budget was prepared some two months ago and that it did not include significant new funding now committed. Also, the history of the Centre indicated that budgeted income is normally surpassed when the year is over.

Much discussion centred on the need to fund depreciation. The Associate Director, Finance advised that, although desirable, 100% funding is not essential as many of the fixed assets are donor-funded and this is likely to continue in the future.

Nevertheless the members insisted that the Director should provide an insight as to where cuts in expenditure would be made if the anticipated funding would not eventuate. It was suggested that in future the Centre prepares two versions of the budget, a best case and a worst case scenario, both producing a cash surplus.

In respect of the 1993 budget the Director agreed to submit to the Board tomorrow a revised estimate of income and its effect on the net operating and cash position.

Resolution FIN:01

The Committee resolved to recommend to the Board that the budget as presented be accepted on the proviso that a revised estimate of income would lead to an estimated cash surplus.

4. Resources Development

Mr. Graham Wright presented the ICDDR,B revised draft Resource Development Strategy, requesting the Trustees' advice before finalising the document for formal adoption at the May 1993 Board meeting.

Overview

Traditionally, ICDDR,B and its precursors have been largely funded by Government and multilateral donors, in the short and medium term the Centre is unlikely to be able to affect more than a shift in emphasis in its funding mix. However, successful endowment fund campaigns could reduce the level of support required from these traditional donors and act as a buffer during leaner periods. In addition, ICDDR,B must prepare to exploit the opportunities for developing resources from competitive grants, foundations and corporations.

To develop resources from these non-traditional sources, ICDDR,B must develop and use its alumnae networks, and invest in strengthening its resource development capabilities in the developed countries where the funding sources are located. The relationship with the International Child Health Foundation (ICHF) in the United States, is being strengthened.

The Centre is trying to run two endowment fund raising campaigns (for the hospital and the research institution) simultaneously, with limited coordination between the two. There is a need to clearly differentiate between the two funds for potential donors, while maintaining close coordination between their activities.

ICDDR,B's public reactions efforts outside Bangladesh have not been adequate and will need to be improved.

In the medium and long term, the Centre should work more closely with the Government of Bangladesh, extending more technical assistance to the national family planning, diarrhoeal disease control and urban health service delivery programmes. The training and development of national health professional and research scientists should also be expanded. Increasingly, these activities will have to be funded from bilateral sources, and under the national 5 year health and population plans.

To maintain the value of the name ICDDR,B, and at the same time reduce confusion, the Centre should maintain its current logo but present itself as:

ICDDR,B

Centre for Health And Population Studies

Objectives

1. Increase annual income by more than 10% per annum.
2. Maintain long term core funding under multi-year agreements.
3. Use of bilateral funding for health care services etc.
4. Institutional Reserve Fund of $30 million in two $15 million or three $10 million phases.
5. Hospital Endowment Fund of $10 million in two $5 million phases.

Recommendation

To establish small scale representation and raise the level of activity in the United States and Canada, and to take the preliminary steps necessary to make a decision on raising the level of activity in the United Kingdom and Europe.

Discussion

Committee members showed great interest in the initiative and the suggested strategy. Generally, preference was expressed for a cautious , step by step approach. Initial activities should be concentrated in Bangladesh rather than in the United States. Some doubts were raised as to the feasibility to realise the two proposed, large endowment funds. It would certainly be of greatest importance to look into the possibilities of acquiring bilateral funds for service activities. Several members supported the idea of a consortium of Donors for ICDDR,B. This would increase the efficiency for the Centre in maintaining regular contacts with a variety of Donors and was likely to be appreciated by Donors as well as a mechanism to increase coordination.

The committee was looking forward to being presented with a final draft of the resource development strategy document during its next meeting, which takes into account the points raised during it's deliberations.

5. National Staff Salaries and Allowances

The Finance Committee met jointly with the Personnel and Selection Committee in a closed session to consider the revision of emoluments for National staff. The basic issues involved were discussed in the meeting of the P&S Committee the previous day.

The decision of the November 1991 Board meeting to raise the base salaries of NO and GS staff by 12% and 10% respectively brought Centre salaries as a percentage of UN salary levels to 86% for NO staff and 85% for GS staff. Dependant allowance for the first 2 children was raised by 10% bringing all staff to 77% of UN allowances.

Effective April 1992 the UN salaries and dependant allowances were changed and the Centre is paying at the following percentages against UN rates:

National Officers	78%
General Service Staff	84%
Dependant Allowances	68%

To raise salaries and dependant allowances to UN rates would necessitate the following percentage increases:

National Officers	28%
General Service Staff	20%
Dependant Allowances	47%

and would cost the Centre $1,195,522.

	Core	Project	Total
National Officers	264,180	187,516	451,696
General Service	449,800	189,940	639,740
Dependants	72,863	31,223	104,086
Total	786,843	408,679	1,195,522

Implementation of each one percentage on existing salaries and dependant allowances would cost $49,503:

	Core	Project	Total
National Officers	9,345	6,697	16,042
General Service - 5/6	6,942	3,464	10,406
General Service - 1/4	15,548	6,033	21,581
Dependants	1,027	447	1,474
Total	32,862	16,641	49,503

To contain costs, the increase in post adjustment for international staff effective November 1, 1992 has not been implemented. International staff salaries plus post adjustment stand at 95% of UN scales.

Centre Management has recommended that all National Officers and General Service staff salaries will be brought to 85% of local UN rates. This would mean a nominal increase of 2% in salary to General Service staff and a 9% increase to National Officer staff at a total cost of $208,352.

	Core	Project	Total
National Officers	84,105	60,273	144,378
General Service - 5/6	13,884	6,928	20,812
General Service - 1/4	31,096	12,066	43,162
Total	129,085	79,267	208,352

Discussion

The Committee, after a long and thoughtful discussion, came to the conclusion that if a revision of the income estimates for the 1993 budget will confirm the probability of being able to realise a cash surplus for 1993 after the provision for the proposed salary increase, it would recommend the following resolution for consideration by the Board:

Resolution FIN:02

The Committee resolved to recommend to the Board to award National Officers and General Staff salary increases to an extent which will bring both to 85% of local UN levels.

The Board requests that a revised 1993 budget be presented to it at its June, 1993 meeting in which activities are adjusted to assure, on the basis of firm pledges, that a cash surplus of at least $100,000 is realised by the end of the year.

6. Presentation of Financial Statements

The Committee agreed with the recommendation of Centre Management that the annual report of the Centre only include abbreviated financial statements.

Resolution FIN:03

The Committee resolved to recommend to the Board to include only abridged financial statements in future Centre annual reports.

7. Fixed Assets Charged to Fixed Asset Acquisition and Replacement Fund

Fixed assets obtained from this fund in 1992 totalling $321,292 were discussed. Additional commitments against this fund for 1992 are $1,187,308 as of October 1992 of which $300,000 has been funded by the Sasakawa Foundation with an additional $350,000 expected in 1993.

Resolution FIN: 04

The Committee resolved to recommend to the Board to accept and approve the expenditure of $321,292 be charged to the Fixed Asset Acquisition and Replacement Fund.

8. UNROB Loan

By letter dated November 23 1992, the Government of Bangladesh has advised the Centre that litigation to recover the UNROB loan has been withdrawn and:

> all amounts (including interest) repayable by the Centre will be converted to a grant to be utilised for the implementation of programmes undertaken for human welfare and development and the total amount of the loan (including interest) will be deemed annual voluntary contribution provided by the Government of Bangladesh in advance.

Resolution FIN:05

The Committee resolved to recommend to the Board to record its greatest appreciation to the Government of Bangladesh for converting the UNROB loan to a grant and to record its gratitude to the Bangladesh Trustees for their sustained efforts to bring the issue of the UNROB loan to such a satisfactory conclusion.

9. Items for information

Investment Loan for Income Tax Reduction

At the meeting of May 1992 the Board was advised that the Centre would save $169,000 in income tax payments resulting from loans to employees to invest in approved investments. The July 1992 Government budget altered the amount of the deductibility and the Centre is now expected to save only $69,000.

Hospital Endowment Fund

The balance of the Hospital Endowment Fund at December 31, 1991 was $15,577. Receipts for the first ten months of 1992 were $18,332 giving a closing balance at the end of October 1992 of $33,909. The dinner dance planned for December 1992 is expected to raise $10,000. No expenditure has been charged against this Fund since its inception.

6/BT/NOV. '93

PERSONNEL & SELECTION COMMITTEE REPORT.

REPORT OF THE PERSONNEL & SELECTION COMMITTEE MEETING
FRIDAY, 27 NOVEMBER, 1992

The Personnel & Selection Committee met in Dhaka at 2.30 p.m. on Friday, 27 November, 1992.

1. Update from last Report

1.1 Scientist, Population & Statistics (P4)

In the last meeting of the Committee, it was suggested that, in view of the reorganization of the Population Sciences & Extension Division (PSED), the management may wish to consider proposing to the Board, at its next meeting, that this position be upgraded to P5. The Committee discussed this position and decided that it had no objection to reclassifying both the post and the incumbent.

Accordingly, the Committee agreed to recommend to the Board that the post of Scientist, Population & Statistics be reclassified to a P5 position and that Dr R. Bairagi (Bangladesh) be appointed to that position. This would be effective from 1 January, 1993.

2. Staffing

3.1 Overview of the staffing situation

The overall staffing situation of the Centre was reviewed. It was noted that the total number of fixed term staff has increased by 11 since 31

March, 1992. On 30 September, 1992 the Centre had 990 fixed term staff whereas on 31 March, 1992 there were 979. It was explained that these additions are mostly due to conversion of holders of NO and GS level short-term and contractual service agreements to fixed-term (project funded) positions. The additional project positions have been necessary as the Centre is now undertaking over 50% more community-based studies than it has in the last few years.

2.2 Contract Renewals

a) **DR L.A. DE FRANCISCO, MCH-FP PHYSICIAN (P5)**

It was advised that Dr de Francisco will complete his three years' employment contract on 5 November, 1993. As is usual, the renewal of his contract is being brought to the Board one year ahead.

After discussion, the Committee agreed to recommend to the Board that Dr L.A. de Francisco's (Colombia) contract as MCH-FP Physician (P5) be renewed for three years from 6 November, 1993.

2.3 New Positions

a) **HEAD, DEPARTMENT OF LABORATORY RESEARCH (P5)**

and

b) **HEAD, DEPARTMENT OF LABORATORY SERVICES (P4/P5)**

These positions were discussed simultaneously. The Committee agreed that, in view of the recommendations of the Programme Committee Review of the Laboratory Sciences Division just undertaken, the Centre management should first respond to the recommendations and the whole issue be taken up again next meeting.

2.4 Status of Recruitment of International Staff

a) **SENIOR SCIENTIST & HEAD, CLINICAL SCIENCES DIVISION (D1)**

This position will be advertised and the "head hunting" process initiated. Trustees were asked to assist in identifying suitable candidates to ensure that the position is filled when it falls vacant on 4 January, 1994.

b) **SENIOR ADMINISTRATIVE OFFICER & HEAD, ADMINISTRATION & PERSONNEL DIVISION (D1)**

This position falls vacant on 1 July, 1993. It will be advertised immediately and the Board will be asked to select a candidate at the June 1993 Board Meeting.

c) **DEMOGRAPHER STATISTICIAN (P4/P5)**

It is not the intention of the Centre to fill this position in 1993.

d) **SOCIAL ANTHROPOLOGIST (P3)**

The Committee agreed to recommend to the Board that the appointment of Dr Sushila Zeityln (Britain) as Social Anthropologist (P3) be endorsed. The Committee also noted that her appointment is for three years from 5 October, 1992.

2.5 Information on Seconded Staff

a) **MS SARAH SALWAY**

It was noted that Ms Sarah Salway (Britain) joined the Urban Health Extension Project in the Community Health Division on 6 May, 1992 on secondment from the London School of Hygiene and Tropical Medicine and that her assignment will continue until 30 April, 1993.

2.6 Information on International Fellows & Visiting Professionals

a) **DR ANNE RONAN, INTERNATIONAL RESEARCH FELLOW**

The Committee noted that Dr Anne Ronan, an Irish citizen resident in Australia, joined the Centre on 1 August, 1992 as an International Research Fellow in the Clinical Sciences Division. It also noted that Dr Ronan has a two year contractual service agreement and was recruited through an exchange programme between the Royal Children's Hospital, Melbourne, Australia and ICDDR,B.

The Committee noted that the Centre has offered the following fellowships (b, c and d) as part of its programme to contribute to health research manpower development of the third world.

b) **DR CARLOS SEAS, INTERNATIONAL HEALTH RESEARCH FELLOW**

Dr Carlos Seas (Peru) has been offered a fellowship on Health Research Training for a period of 1-2 years and is expected to join the Clinical Sciences Division in November 1992.

c) **DR SUNDAY ABRAHAM ALABI, INTERNATIONAL HEALTH RESEARCH FELLOW**

Dr Sunday Alabi (Nigeria) has been offered a fellowship on Health Research Training for a period of 1-2 years and is expected to join the Laboratory Sciences Division in December 1992.

d) **DR YU WEILI, INTERNATIONAL HEALTH RESEARCH FELLOW**

Dr Yu Weili (China) joined the Community Health Division of the Centre on 7 July, 1992, initially for a period of one year. Dr Yu is the National Programme Manager of the Control of Diarrhoeal Disease Programme in China.

e) **DR ADAM Y. SLOTE, VISITING FELLOW**

It was noted that Dr Adam Slote (U.S.A.) joined the Community Health Division on 13 August, 1992 for a period of one yhear, under the medical students' elective programme.

f) **MS AMY SULLIVAN, INTERN**

The Committee noted that Ms Amy Sullivan (U.S.A.) joined the MCH-FP Extension Project as a Population Council Intern on 15 June, 1992 and that she is expected to stay with the project for an initial period of six months.

g) **MS MARJORIE HASKELL, STUDENT INVESTIGATOR**

It was noted that Ms Marjorie Haskell (U.S.A.) joined the Centre on 13 September, 1992 as a student investigator in the Clinical Sciences Division. Also, that she is here as part of a Vitamin A collaborative study between the University of California, Davis, the ICDDR,B, the Dhaka Medical College and the Children's Nutrition Unit of Save the Children Fund (U.K.).

3. Selection of Trustees

3.1 Replacement for Dr Deanna Ashley, Professors Alf Lindberg and V.I. Mathan

The Director circulated the late nominations, although, according to By-law 27, all nominations must be received within the last date specified in the notice. The Committee agreed that these would only be considered if suitable nominees were not found among those submitted in time.

In short-listing persons from the different regions, criteria taken into consideration for selection were sex, geographical area, the country (preference was given for a country not previously represented on the Board) and the discipline of the candidate.

The following were short-listed and recommended to the Board for consideration.

Developing Country (South America)
Dr Julio J. Frenk (Mexico)
Prof. Adolfo Martinez-Polomo (Mexico)

Developed Country (Europe)
Prof. P. Helena Makela (Finland)
Dr Kerstin Hagenfeldt (Sweden)

Developing Country (Asia)
Dr Fehmida Jalil (Pakistan)

4. Working Papers

4.1 Salary: National Officer and General Service Category Staff

This item was discussed in a "closed" session with only Trustees present.

The Committee noted that currently the NO staff are receiving, on average, 78.31% of the UN and that the GS staff are receiving, on average, 83.55% of UN salaries. It was agreed that, as the NO professional staff constitute the backbone of the Centre, it is not appropriate that they receive a smaller percentage of the UN salary than the GS staff. This should be taken into account by the Finance Committee when it decides on the percentage rise to recommend for the NO staff. Also, the Committee received an appeal that the GS staff receive a one to two percent raise, in view of the increase in the cost of living, to bring them up to 85% of the UN salary..

The Committee agreed to the above recommendations subject to their being

funds available to manage this. In addition, in making these recommendations, the Committee cautions the Director that salary costs must be contained if the Centre is to remain competitive in the international research market - a necessity for its survival. Continued vigilence should be maintained to prevent excessive growth in personnel costs and options for limiting these costs should be kept under review.

Details of these and other agenda items appear in the minutes of the meeting.

The meeting closed at 5.20 p.m.

:jc
28.11.92

DRAFT RESOLUTIONS FROM THE P&S COMMITTEE

1. The Board resolved to accept the Report of the Personnel & Selection Committee.

2. The Board resolved that the post of Scientist, Population and Statistics (P4) be reclassified to a P5 (Senior Scientist) position and that Dr R. Bairagi (Bangladesh) be appointed as Senior Scientist, Population and Statistics from 1 January, 1993.

3. The Board resolved that Dr L.A. de Francisco's (Colombia) contract as MCH-FP Physician (P5) be renewed for three years from 6 November, 1993.

4. The Board resolved to endorse the appointment of Dr Sushila Zeitlyn (Britain) as Social Anthropologist (P3) for three years from 5 October, 1992.

5. The Board resolved that Dr Fehmida Jalil (Pakistan) be appointed as a Trustee of the Centre for three years from 1 July, 1993.

6. The Board resolved that be appointed as a Trustee of the Centre for three years from 1 July, 1993.

7. The Board resolved that be appointed as a Trustee of the Centre for three years from 1 July, 1993.

7/BT/NOV.'92

SELECTION OF TRUSTEES.

SELECTION OF TRUSTEES

According to the Ordinance Section 8(6) "Vacancies in seats of members at large shall be filled by the Board. ... No member may serve more than two consecutive three-year terms or portion thereof, ...".

A. Three vacancies need to be filled, i.e. those which will be created when Dr D. Ashley and Professors A. Lindberg and V.I. Mathan complete two three-year terms on 30 June, 1993. In the May 1992 Board Meeting the Board agreed that the process should be started immediately for seeking replacements to allow the Personnel & Selection Committee and the Board to review progress at the November 1992 meetings.

Accordingly, as required by ICDDR,B By-Law 27 (see pages 15 & 16), members of the Board, countries and agencies interested in the Centre, WHO Regional Offices, etc. were contacted and requested to provide nominations for candidates from (i) a developing country in the South American region, (ii) a developed country in the European region and (iii) a developing country in the Asian region.

It was requested that nominations reach the Centre by 15 October, 1992. The list of nominations received follows on pages 3 to to 14. A separate folder is available with the curriculum vitae of most of the nominees.

B. Professor F. Mhalu's first three-year term ends on 30 June, 1993. It is assumed that he would be willing to be considered for re-election, hence no attempt has been made to collect nominations.

A list of current Trustees with country and discipline is on page 17

and a list of current Trustees with their terms is on page 18.

Action Required

1. Select three new Trustees to replace Dr Ashley and Professors Lindberg and Mathan (these persons would start a three year term from 1 July 1993).

2. Vote on Professor Mhalu's re-election.

LIST OF NOMINATIONS FOR TRUSTEES 1991

Name	Date of Birth & Nationality	Sex	Discipline	Current Occupation	Nominated By
a) Developing Country (South America)					
Dr Cesar Victora	Brazilian	M	Community Health	Assoc. Professor, Dept. of Social Med., Federal Univ. of Pelotas	CDR-WHO
Dr Soledad Diaz	Chilean	F	Clinical Research		Ford Fdn., NY
Dr Claudio F. Lanata	Peruvian	M	Scientific Research	Epidemiologist & Research Director, Instit. of Nutrition Investigation, Lima	CDR-WHO
Dr Constanza Vallenas	3.8.1954 Peruvian	F	Paediatrician	Exec. Dir. (Head), Child Growth & Dev. Prog., Mother & Child Health Unit, Min. of Health, Lima	CIDA

Dr Eugenio Villar	13.1.1956 Peruvian	M	Int. Health, Human Resources Development	Tech. Dir. (Head) Office of Financing, Invest. & External Coopn., Min. of Health, Lima	CIDA
Dr Elizabeth Quamina	14.2.1929 Trinidad & Tobago	F	Health policies and programme formulation	Independent Consultant, in Public Health, Policy Development, Health situation analysis.	UNDP-NY/ SDC
Dr Julio J. Frenk	20.1.1953 Mexican	M	Public Health, Med. Care Organ-ization and Sociology	Director-General, National Institute of of Public Health, Min. of Health, Mexico City	CIDA
Dr Guillermo Ruiz-Palacios		M		Director, Dept. of Infectious Diseases, Nat. Inst. of Nutrition, Salvador Zubiran, Mexico	CDC
Prof. Adolfo Martinez-Palomo	1941 Mexican	M	Parasitologist/ Molecular Biologist	Prof. & Head of Experiemtnal Pathology, Cent. for Advanced Res., National Polytechnic Institute, Mexico	Centre

Insert for Page 3

Fernando C.L.F. de Barros	22.6.1947 Brazilian	M	Paediatrician	Asst. Prof., Dept. of Social Medicine, Uni. Federal de Pelotas, Brazil	Dutch Govt.

Name	Date of Birth & Nationality	Sex	Discipline	Current Occupation	Nominated By
b) Developed Country (Europe)					
Professor P. Helena Makela	early 1930's Finnish	F	Microbiologist/ Vaccine develop.	President, Finnish Acad. of Sciences & Finnish Res. Council (Nat. Public Health Institute)	Prof. Alf A. Lindberg
Prof. S. Lie	-		-	Chairman, Dept. of Paediatrics, Rikshospitalet, Oslo	CDR-WHO
Dr Ann-Marie Svennerholm	Swedish	F	Microbiologist	Dept. of Medical Microb. Univ. of Goteborg, Sweden	CDS-WHO
Dr Kerstin Hagenfeldt	Swedish	F	Medical Ethics	Dept. of Obstetrics, Karolinska Inst., Stockholm	Ford Fdn., NY
Dr Anthony R. Measham	21.4.1934 UK/Canada	M	Public Health Policy	Chief, Health & Nut. Divsn., Popln. & Hum. Res. Dept. World Bank, Washington	World Bank

Dr Felicity T. Cutts	6.10.1954 British	F	Epidemiologist/ Community Health	Senior Lecturer in Communicable Disease Epid., LSHTM	CDR-WHO
Prof. J. Patrick Vaughan	27.12.1937 British	M	Clinical & Trop. Med., Public Hlth. & Epid.	Prof. of Health Care Epid. & Head, Dept. Pub. Hlth. & Policy, LSHTM	British High Commission
Dr Andrew Tomkins	British	M	Paediatrician	Director, Inst. of Child Health, Univ. of London	World Bank
Dr David J. Bradley	Jan. 1937 British	M	Tropical & Communicable Dis.	Dean & Prof., Tropical Health Epid. Unit, LSHTM	CDC
Dr Klaus Gyr	Swiss	M	Gastroenterologist	Dept. Clinical Medicine, Kantonsspital, Liestal	SDC
Dr Pieter H. Streefland	29.8.1946 Dutch	M	Primary Health Care, Water & Sanitation, Res. evaluation	Prof. of Applied Dev. Dev. Sociology, Univ. of Amsterdam	Mr Cole P. Dodge

Dr Pieter Speelman	27.4.1946 Dutch	M	Tropical Med. & Infect. Diseases	Assoc. Prof. Unit of Infect. Diseases & Trop. Med., Academic Medical Centre, Amsterdam	Dr A.S. Muller
Prof. Vladimir Tatochenko	Russian	M	Paediatrician/ Gastroenterologist	Chief, Dept. of Infect. Dis., Inst. of Paediat., Moscow	WHO Reg. Office for Europe

Name	Date of Birth & Nationality	Sex	Discipline	Current Occupation	Nominated By
c) Developing Country (Asia) - Nominations received in response to letters of January and August, 1992.					
Dr Sudhir C. Pal	1.5.1931 Indian	M	Microbiology	Director, National Inst. of Cholera and Enteric Diseases, Calcutta	Prof. Dr. K.M. Fariduddin
Prof. Jai Satia	Indian	M	Health & Family Planning management and policy	Head, Public Health Systems Group, III-Ahmedabad	Dr M. Koenig
Dr Nirmala Murthy	Indian	F	Epidemiology & Health management	Running an independent Foundation	Dr M. Koenig
Dr Abraham Joseph	Indian	M	Physician/ Epidemiologist	Chairman, Dept. of Community Health, Christian Med. College, Vellore	Dr M. Koenig
Dr Shanti Ghosh	India	F	MCH Specialist	Consultant	SDC

Dr M.K. Bhan	9.11.1947 Indian	M	Paediatric Gastroenterology	Additional Prof. & In-Charge, Divs. of Gastro. & Enteric Infections, Dept. of Paediatrics, All India Inst. of Med. Sciences	Prof. V.I. Mathan
Dr Gita Sen	30.10.1948 Indian	F	Economist	Centre for Development Studies, Trivandrum, India	The Population Council
Dr Bando J. Coyaji	7.9.1917 Indian	F	Obstetrics & Gynaecology	Director, KEM Hospital, Pune & Chairman KEM Hosp Research Centre, Pune	The Population Council
Prof. Bina Agarwal	Indian	F	Economist	Visiting Prof. Harvard Univ., Cttee. on Degrees in Women's Studies	The Population Council
Rani Bang	Indian	F	-	-	The Population Council
Dr Fehmida Jalil	Pakistani	F	Primary Health Care/Infant & Child Nutrition/Epidem.	Prof. of Social & Preventive Paediatrics, King Edward Med. Coll., Lahore, Pakistan	SAREC

Prof. M.R. Baral	Nepalese		Paediatrician/ D.D. and MCH		Dr Y.Y. Al-Mazrou
Prof. D.A. Sonnadara	Sri Lankan		Paediatrician/ MCH		Dr Y.Y. Al-Mazrou
Dr A. Majid Molla	7.1.1941 Bangladeshi	M	Paediatrician/ ORT/Nutrition	Prof. & Chairman, Dept. Paediatrics, The Aga Khan Univ., Karachi	Aga Khan Foundation
Ms Sandra M. Kabir	Bangladeshi/ U.K.	F	Women in Development	Executive Director & Founder President, Bangladesh Women's Health Coalition	The Population Council
Dr Naila Kabeer	28.1.1950 Bangladeshi/ U.K.	F	Economist	Fellow, Institute of Development Studies University of Sussex	The Population Council
Dr Zo hair A. Sebai	1939 Saudi Arabian	M	Public Health & Health Admin.	Dean, Faculty of Med. & Health Sciences, Univ. of Abha, Saudi Arabia	WHO Office for Eastern Mediteran.
Prof. Dan Duc Trach	Vietnamese	M	-	Vice Director, National Inst. of Hyg. & Epid., Hanoi	CDR-WHO

Dr Gelia T. Castillo	Filipino	F	Rural Sociology	Prof. of Rural Sociology Univ. of Philippines, Los Banos	CIDA
Dr Mediadora C. Saniel	26.4.1949 Filipino	F	Research Scientist & Pub. Hlth. Admin.	Director, Research Inst. for Tropical Med., Philippines	WHO Reg. Office for West Pacific/ AIDAB
Dr Thelma Tupasi		F		Acute Respiratory Infect Res. Proj., Res. Inst. for Tropical Med., Manila	CDC
Dr Mary Ann Lansang	8.9. 1951 Filipino	F	Clinical Epidemiology	Assistanct Director, Research Inst. for Tropical Med., Manila	Rockefeller Foundation
Dr Perla Santos Ocampo	27.7.1931 Filipino	F	Paediatrician/ Child Health - Development Gastro & Nutrition	-	Dr R.H. Henderson
Dr Terra L. Tan Torres-Edejer	4.3.1959 Filipino	F	Clinical Econ./ Infectious /Trop. diseases/Hosp. Admin.	Asst. Prof. I, Clinical Epidemiology Unit, Dept. Medicine, Philippine General Hosp.	Rockefeller Foundation

Dr Jane C. Baltazar	27.12.1934 Filipino	F	Epidemiology	Prof. of Epid. & Dean, College of Public Health, Manila	Ford Fdn., Philippines
Dr Mercedes Conception	Filipino	F	Demographer/ Popln. Structure changes and their implications	Professor, Population Institute, University of the Philippines	Dr Takashi Wagatsuma
Dr Nafsiah Mboi	14.7.1940 Indonesian	F	Paediatrician/ Civil Servant	Office of the Secretary General, Dept. of Health, Jakarta	The Ford Foundation SE Asia Reg. Off.
Dr Yulfita Raharjo	1940 Indonesian	F	Anthropology/ Demography	Head, Centre for Popln. & Manpower Studies, Indonesian Inst. of Sc.	AIDAB
Dr Yati Soenarto DSC	Indonesian	F	Paediatrician	Diarrhoea Information Centre, c/- Community Medicine Edcn. Prog., Gadjah Mada University, Yogyakarta, Indonesia	Prof. J.R. Hamilton/ Rockefeller Foundation
Prof. Moeljona Trastotenoya	Indonesian		Paediatrician/ Research/Mangmnt.	Rector, Diponegoro University, Semarang, Indonesia	Prof. A.S. Muller

Dr Anna Alisjabana	20.2.1931 Indonesian	F	Nutrition Research	Head, Research Centre, Faculty of Medicine, Padjadjaran University, Bandung, Indonesia & Hea, WHO Coll. Centre for Research on MCH	Prof. A.S. Muller
Dr Suchitra Nimmannitya	Thai	-	-	Formerly Director of Children's Hosp. Bangkok	Rockefeller Foundation
Prof. Dr. Wandee Vararithya	Thai	F	Paediatrician/ Gastroent/Fluid elect/Clin. Res.	Dept. of Paediatrics, Rama Thibodi Hospital, Mahidol University, Bkk	Govt. of Thailand
Dr Orapin Singhadej	14.4.1942 Thai	F	Paediatrician/ Popln. dynamics/ Family Planning Admin.	Associate Director, ASEAN Inst. for Health Devt., Mahidol Univ. Salaya Campus, Thailand	Dr Takashi Wagatsuma/ HDR-WHO
Dr Sakorn Dhanamitta	Thai	F	-	Professor & Director, Inst. of Nutrition, Mahidol Univ. Salaya Campus, Thailand	Dr Takashi Wagatsuma
Prof. Earmporn Thongkrajai	Thai	F	Nursing	Dept. of Medical-Surgical Nursing, Faculty of Nursing, Khon Kaen University, Thailand	The Population Council

Dr Indra Pathmanathan	21.10.36 Malaysian	F	Medicine/Health Systems Research	Formerly Head, Divsn. of Research & Edcn., Public Health Inst., Malaysia, now short-term consultant, WHO	IDRC

d) Other

Dr Ronald G. Wilson	23.1.1941 U.S.A.	M	International Health Admin.	Director of Health Programmes, Aga Khan Foundation, Geneva	Aga Khan Foundation
Dr Ruth Bishop	Australia	F	Microbiologist	Royal Children's Hosp., Melbourne	Prof. J.R. Hamilton

BY-LAW ON SELECTION OF TRUSTEES

By-Law No. 27

"As per Resolution 8/June 81 the Board agreed to the procedure below for holding elections in seats of members at large and that it should become a By-Law.

1. For the purpose of holding elections to fill in vacancies in seats of members at large as specified in Sec. 8(1)(d), the Director of the Centre by a notification shall invite nominations from the following:
   (a) Members of the Board of Trustees.
   (b) The Countries and Agencies who have signed the Memorandum of Understanding.
   (c) The six regional offices of the World Health Organization.
   (d) The Countries who have demonstrated their interest in the functioning of the Centre.
   (e) Relevant Research Institutions.

2. All nominations must be received within the last date specified in the notice.

3. The nominated individuals shall be persons qualified to serve by reason of scientific, reearch and administrative or other appropriate experience and the nomination should be accompanied by a statement of facts to that effect.

4. All such nominations received shall be scrutinized by the Selection Subcommittee of the Board who will make recommendations to the Board keeping in view the following:
   (a) Requirement under Sec. 8(3) of the Ordinance regarding membership from developed and developing countries.
   (b) Equitable geographic distribution.
   (c) Balance of different disciplines represented in the Board.

5. The Board by secret ballot will decide acceptance or rejection of the recommendations of the Selection Subcommittee.

6. In case of negative decision by the Board in the election under rule 5 above the Board by secret ballot will elect the requisite number of trustees from amongst all the validly nominated candidates.

7. When only one member is to be elected, the person obtaining largest number of votes shall be declared elected. In case of equality of votes between two or more candidates obtaining largest number of votes, a second ballot shall be taken which shall be restricted to the candidate obtaining the largest number of votes. If votes are equally divided in the second ballot, it shall be decided by drawing lots.

8. If two elective places are to be filled at one time candidates obtaining the highest and second highest number of votes shall be declared elected. In case of equality of votes between two candidates obtaining highest number of votes, both of them shall be declared elected. In case of equality of votes between persons obtaining second highest number of votes, a second ballot shall be taken which shall be restricted to the candidates obtaining the largest number of votes. If votes are equally dividied it shall be decided by drawing lots. A similar procedure will be followed in case more than two elective places are to be filled at one time.

9. Decision will be on the basis of the votes of members present and voting.

10. The Board will select one of the trustees who is not a candidate for election to preside over the meeting in case the Chairman is a candidate for re-election as a trustee.".

LIST OF MEMBERS (AS AT OCTOBER 1992) WITH NATIONALITY, DISCIPLINE, JOINING AND ENDING DATES

Name	Country	Discipline	Joined Bd/ end date
Mr Syed Ahmed	Bangladesh	Civil Servant	1992/1995
Dr Y.Y. Al-Mazrou	Saudi Arabia	Public Health	1989/1995 *
Dr D. Ashley	Jamaica	Public Health/ MCH-FP	1987/1993 *
Prof. J.C. Caldwell	Australia	Demography	1989/1995 *
Mr E.A. Chaudhury	Bangladesh	Civil Servant	1991/1994
Prof. Chen Chunming	China		1992/1995
Prof. Dr K.M. Fariduddin	Bangladesh	Medicine	1991/1994
Prof. D. Habte	Ethiopia	Paediatrics	1989/1995 *
Prof. J.R. Hamilton	Canada	Paediatrics	1989/1995 *
Dr R.H. Henderson	WHO	Sc. Admin.	1990/1996 *
Dr M. Law	Canada	Int. Hlth/Hlth Policy & Admin	1991/1994
Prof. A. Lindberg	Sweden	Bacteriology/ Immunology	1987/1993 *
Prof. F.I. Mathan	India	Gastroenterology	1987/1993 *
Prof. F.S. Mhalu	Tanzania	Microbiology/ Immunology	1990/1993
Prof. A.S. Muller	Netherlands	Epid./Social Med./Pub Htlh/ Res. Managemt	1990/1994 *
Dr J. Rohde	UNICEF	Public Health/ Paed/Hlth Plng	1990/1996 *
Prof. T. Wagatsuma	Japan	Int. Health	1989/1994 *

* Unable to serve another term without a break

LIST OF MEMBERS (AS AT OCTOBER 1992) WITH TERMS

Name	Joined Board	End of Term
Dr Syed Ahmed	February '92	February '95
Dr Y.Y. Al-Mazrou	1 July 1989	30 June 1995 *
Dr D. Ashley	1 July 1987	30 June 1993 *
Prof. J.C. Caldwell	1 July 1989	30 June 1995 *
Mr E.A. Chaudhury	7 Feb. 1991	6 Feb. 1994
Dr Chen Chunming	1 July 1992	30 June 1995
Prof. Dr K.M. Fariduddin	7 Feb. 1991	6 Feb. 1994
Prof. D. Habte	1 Aug. 1989	31 July 1995 *
Prof. J.R. Hamilton	1 July 1989	30 June 1995 *
Dr R.H. Henderson	25 May 1990	24 May 1996 *
Dr M. Law	1 July 1991	30 June 1994
Prof. A. Lindberg	1 July 1987	30 June 1993 *
Prof. V.I. Mathan	1 July 1987	30 June 1993 *
Prof. F.S. Mhalu	1 July 1990	30 June 1993
Prof. A.S. Muller (completed Prof. Feachem's term)	9 July 1990	30 June 1994 *
Dr J. Rohde	18 June 1990	17 June 1996 *
Prof. T. Wagatsuma (completed Dr Tanak's term)	December 1989	30 June 1994 *

* Unable to serve another term without a break

20.10.92

DATES OF NEXT MEETING.

DATES OF NEXT MEETING

In the May 1992 Meeting of the Board of Trustees it was agreed that the June 1993 Board Meeting should be held in Dhaka from 8-10 June, 1993.

Accordingly, the Programme for the June 1993 meetings will be as follows:

Monday, 7 June	Trustees arrive
Tuesday, 8 June	Programme Committee Meeting Personnel & Selection Committee Mtg
Wednesday, 9 June	Finance Committee Meeting Report writing, lectures, etc.
Thursday, 10 June	Full Board Meeting

A Programme Committee Review of the Training Coordination Bureau has been suggested for June 1993.

A list of meeting dates, circulated to Trustees in November 1991 suggests that the November 1993 meeting be held in Dhaka from 26-28 November, 1993 with the Support Group Meeting to be held on 29 November, 1993. There would be a Programme Committee Review of the Community Health Division from 23-25 November, 1993.

ACTION REQUIRED

1. Confirm dates of the June 1993 Board of Trustees meetings.

2. Decide on dates for the Programme Committee Review of the Training Coordination Bureau and names of reviewers - if not decided on by the Programme Committee.

3. Agree on dates for the November 1993 Board of Trustees meetings.

ANY OTHER BUSINESS.

REPORT FROM STAFF WELFARE ASSOCATION (SWA).

ADDRESS OF PRESIDENT, STAFF WELFARE ASSOCIATION, ICDDR,B AT THE BOARD OF TRUSTEES' MEETING TO BE HELD IN NOVEMBER 1992

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH
MOHAKHALI, DHAKA-1212, BANGLADESH

OCTOBER 16, 1992

ADDRESS OF PRESIDENT, STAFF WELFARE ASSOCIATION, ICDDR,B

Honourable Chairperson,Dr.Deanna Ashley and the distinguished Board Members from home and abroad:

First of all I, on behalf of the members of the Staff Welfare Association and my own behalf, would like to extend to you our warmest welcome and felicitation on this occasion. I am also taking this opportunity to congratulate Dr.Diana Ashley on being elected as the Chairperson of the Board of Trustees.

I am thankful to the Chairperson of Board of Trustees and the Director of ICDDR,B for allowing me the opportunity to place before you some important issues related to welfare of the staff of this Centre. It is my earnest hope that you will deliberate on these matters patiently despite your many preoccupations in this meeting.

Hon'ble Trustees:

During the last Board meeting held in May, 1992, I submitted certain issues for your consideration. We were given understanding that the Board would deliberate on these matters in its November meeting and give their decision. Therefore, my present discussion will be limited to emphasizing some of those issues.

a) The issue of salary raise of the local staff is a priority issue for us. In my last presentation, I discussed in detail about the rise in living cost (by 18%) and price hike of daily commodities (by 16%) during the year 1990-1991 (Annexe-1). I also mentioned that the Government of Bangladesh had raised the salary of its employees by about 75% in 1991 to alleviate their sufferings.

Between March 1990 and March 1992, there had been a devaluation of Bangladesh currency by more than 19%(Table-1). These factors have contributed to and aggravated the economic hardships of the local staff members by decreasing their purchasing capacities for daily neccessities.

b) It is expected that our salaries will be revised from time to time in pursuance of the revisions made in the UN Agencies in Bangladesh to make our salaries comparable to those of the local staff in the UN Agencies. Unfortunately, this has not happened. During our last discussion in May, we showed that ICDDR,B local staff were far below the UN salary level due to non-implementation of salary revisions made in '88 and '90.

c) A further salary revision (Revision 15 for GS employees, July-92, and Revision 8 for NO employees, July-92) in the UN agencies with retrospective effect from December '91 and January '92 for NO and GS category staff respectively. This latest revi-

sion of UN salaries for local staff has further aggravated the difference between the salaries of ICDDR,B staff and corresponding UN local staff. The current difference stands at 19% for GS level and 28% for NO level staff(Table-2).

d) We are happy to note that you have approved a salary raise for the International staff of ICDDR,B to 100% of latest salary revision of the UN agencies (Rev. for '92) in your last meeting in May, 1992, which has been effective July, 1992. So, I hope that the honourable Board Members will take similar decision for the local staff as well.

e) This year the local staff have helped the Centre to save approximately $ 70,000 by reducing the Centre's Income Tax liability through making investments, despite their hardship. We can reasonably claim that this savings should be used, in addition to other normal resources, to raise the salary of the local staff to the level of that of UN agencies in Bangladesh, as mandated.

f) In a recent issue of the Asiaweek, an international journal on the economic events in Asian countries, the inflation rate for the Consumer Price Index (CPI) has been shown to be 7.4% (Annexe-B). This further supports that the living cost in Bangladesh has substantially gone up since 1991. The salary revision with resultant rise in salary in the UN agencies in Bangladesh is the international acceptance of this fact.

Under these circumstances, we fervently urge upon the Honourable Trustees to consider salary raise for the local staff with all the seriousness and magnanimity, and to implement immediate salary raise at par with UN level scales with retroactive effect, to ensure that the staff are not deprived of their legitimate and due benefits.

Learned Trustees:

The other issue, as mentioned in my May memorandum, was local currency (Taka) devaluation during the last 2 years and its deleterious effect on our already existing high living cost and our retirement fund contributions. In that memorandum, it was discussed how an employee actually sustains a loss on his salary in local currency and how his retirement contributions (which is in US Dollars) decline due to devaluation.

To protect an employee against such losses, we suggested that the Centre can make salary payments by determining the US Dollar equivalent salary for each staff as of January 01, and pay the salary for each month on the basis of conversion to Taka as of the 1st of each month. This should be applicable in case of Centre's contribution to Retirement Fund also. We fervently request the Honourable Trustees to consider the feasibility of such arrangement or suggest alternative to protect the employees against losses occurring due to devaluation.

Distinguished Trustees:

We made a note on the Centre's policy of restricting dependent allowance to 2 children (effective October 1992), a policy which has not been adopted by the UN Agencies in Bangladesh. However, we agree in principle that everybody should aim for a small family. In this respect we suggest that, to make this policy encouraging to general staff, a positive approach can be incorporated by providing an incentive for employees who having family size to 2 children. At the same time, I suggest that the family planning component of the staff clinic be strengthened.

I am thankful to our Patron-in-chief and Director for taking some steps to formulate a promotion policy for the staff in general, which was one of the issues raised in the last Board Meeting. Therefore, it would be superfluous to discuss this matter further in the present forum.

Finally, the SWA expresses its deep gratitude and thanks to the Hon'ble Chairperson and the Members of the Board of Trustees once again for the opportunity given to the Staff Welfare Association for presenting its views before such a distinguished forum of representatives from various countries of the world.

We assure you our best cooperation in upholding and enhancing the Centre's prestige, reputation and scientific productivity.

Kindly accept our warmest regards,
Thank you all.

Dr. A. S. M.Mizanur Rahman
President,
Staff Welfare Association (SWA)
ICDDR,B

TABLE 1

Percent Devaluation Of TAKA Compared To US DOLLAR

Devaluation Date	Percent Devaluation
Mar - 04, 1990	5.00
Apr - 25, 1990	1.00
May - 10, 1990	1.96
Aug - 01, 1990	1.98
Sep - 06, 1990	0.22
Nov - 22, 1990	0.28
	10.44
Jun - 30, 1991	0.56
Jul - 06, 1991	1.39
Aug - 19, 1991	1.10
Sep - 12, 1991	2.17
Nov - 09, 1991	1.06
Dec - 01, 1991	0.39
Dec - 08, 1991	0.41
Dec - 21, 1991	0.47
	7.55
Jan - 01, 1992	0.60
Mar - 31, 1992	0.48
Total Devaluation In 2 Years:	19.07

TABLE 2

COMPARISON OF SALARY WITH UN ORGANIZATIONS
& ICDDR,B AS OF OCTOBER, 1992

UN Organization	ICDDR,B	Difference	% Less in ICDDR,B scale
Rev. #15 GS Level I Tk.67690/annum	Tk.56882/annum	Tk.10808	19
Rev. #8 NO Level A Tk.259000/annum	Tk.202528/annum	Tk.56472	28

Bangladesh Observer
dated 01 July 1991

ANNEXE - I

Cost of living rises by 18 p.c

Staff Correspondent

The cost of living recorded a rise by 18.32 per cent during the year 1990-91 while the prices of different commodities have risen by 15.77 per cent during the same period.

A survey conducted by Consumers Association of Bangladesh (CAB), revealed that the cost of living and prices of different commodities have shown an upward trend following increase in the expenditures of house rent, fuel, cloths and edible oil. The prices of rice, egg, tea, sugar, salt and soap were relatively less compared to other commodities during the last fiscal year, the CAB survey revealed further.

During the period the prices of vegetables and spices increased moderately while the prices of different essentials have marked a steady rise during the period of last July-December. Meanwhile, the prices have risen by 4.91 per cent during the month of January-June, the survey

(See Page 10 Col. 4)

Cost of living

(From Page 1 Col. 1)

disclosed.

The CAB survey unveiled that a section of profit mongers raised the prices of different commodities taking the advantage of Gulf crisis, democratic movement, increase in the price of fuel, Ramazan and cyclone, etc. The survey further revealed that there was no variation in the prices of various essentials at the peak of the democratic movement.

The following percentage of increase in the prices of various commodities mentioned against each items.

Fuel by 41.26 per cent, clothes by 30.48 per cent, house rent by 20.59 per cent, vegetables by 16.80 per cent, oil by 16.65 per cent, fish by 13.57 per cent, rice by 9.07 per cent, crushed wheat and flour by 8.49 per cent; milk by 13.44 per cent, spices by 13.42 per cent, meat by 12.73 per cent, pulse by 12.46 per cent, rice by 9.07 and other commodities by 7.14 per cent and egg by 4.61 per cent.

During the last financial year the prices of green chilli and sugar have registered a fall by 18.58 per cent and 16.21 per cent respectively.

"To report accurately and fairly the affairs of Asia in all spheres of human activity, to see the world from an Asian perspective, to be Asia's voice in the world"

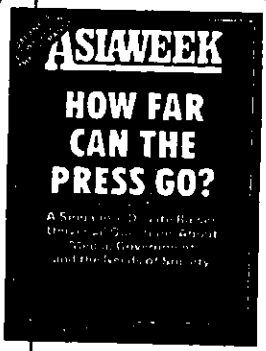
— MISSION STATEMENT, 1975

LETTERS & COMMENT

Tell Us Again About Press Freedom, Bruce

To the editors of Asiaweek from Geoffrey M. Gold of Richmond North, Victoria, Australia:

Roger Mitton's "What Role For the Press?" [THE LONG STORY, Sept. 25] has put into perspective here the Australian media's reporting of the raid on *Business Times* in Singapore.



I thought you might be interested in *Media Australia's* report on a police raid on a newspaper. In this case the newspaper was *The Canberra Times*, published in our nation's capital.

Surprisingly, the raid on *The Canberra Times* was not reported by other Australian newspapers — even those newspapers that had earlier reported the raid on *Business Times* in Singapore!

GEOFFREY M. GOLD

As far as yours

We are indebted both figuratively and literally to Mr. Gold, who is the Editor of the weekly *Media Australia*. Figuratively because we figure that his admirable journal's account of a raid on an Australian newspaper puts into perspective, in Asia, Western reporting of Asian media. Literally because Reader Gold naturally wins the $250 that we are obliged to pay under the terms of the policy* protecting this space. Here, with the permission of its editors, is a condensation of *Media Australia's* report:

Police officers front the reception desk of a major metropolitan newspaper. They flash a search warrant, then proceed

*"A surgical mask that has muffled the world for century upon maddening century is suddenly flapping loose . . . Send us the kind of letter that flips the mask and we will send you $250 for giving us the privilege of putting a name to a voice of Asia."

The Bottom Line

	GNP per cap.	GDP growth	Exports 12 mths	Surp/Def cur. a/c	Foreign debt	Inflation CPI
Switzerland	$35,020	–0.5%	$61.3b.	$6,941m.	0†	3.8%
Japan	$27,305	1.1%	$320.6b.	$90,080m.	0†	2.4%
U.S.	$22,550	1.5%	$430b.	–$34,240m.	$664b.	3.0%
Canada	$21,500	1.9%	$129b.	–$23,374m.	$149b.	1.7%
Germany	$21,475	1.2%	$403b.	–$20,480m.	0†	4.8%
France	$21,085	1.0%	$217b.	–$13,331m.	$9.6b.	3.2%
Italy	$18,685	2.0%	$169.9b.	–$12,733m.	$36.9b.	5.2%
Britain	$18,250	–0.7%	$188.3b.	–$7,769m.	0†	3.7%
Brunei	$17,000	3.5%	$1.9b.	$1,900m.	0†	3.0%
Australia	$16,180	1.6%	$41.9b.	–$9,050m.	$114b.	1.2%
Hongkong	$14,102	4.7%	$104.2b.	–$1,300m.	0†	8.3%
Singapore	$13,600	4.7%	$58.8b.	$3,823m.	0†	2.3%
New Zealand	$11,875	1.5%	$9.5b.	$67m.	$33.5b.	1.0%
Macau	$9,050	5.0%	$1.8b.	N.A.	$1.5b.	7.5%
Taiwan	$8,685	7.3%	$79.3b.	$12,014m.	0†	5.2%
South Korea	$6,489	6.7%	$74.0b.	–$6,251m.	$40.2b.	5.7%
Saudi Arabia	$5,838	9.5%	$44.3b.	–$4,107m.	$16.7b.	4.8%
Mexico	$3,200	3.6%	$28.8b.	–$7,487m.	$80.6b.	22.7%
South Africa	$2,810	–0.6%	$23.8b.	$2,685m.	$0.8b.	15.3%
Malaysia	$2,475	8.6%	$34.7b.	–$4,300m.	$14.8b.	5.0%
Brazil	$2,000	1.2%	$31.4b.	$6,580m.	$110b.	441%
Fiji	$1,712	0.4%	$0.46b.	–$4m.	$0.4b.	7.0%
Turkey	$1,670	1.5%	$13.7b.	$272m.	$41.4b.	56.3%
Thailand	$1,605	7.9%	$30.4b.	–$7,450m.	$27.3b.	4.7%
P.N.Guinea	$880	9.3%	$1.6b.	–$584m.	$2.4b.	5.3%
Egypt	$753	2.3%	$4.7b.	$237m.	$38.4b.	19.8%
Philippines	$725	–0.4%	$8.9b.	–$1,676m.	$29.6b.	8.9%
Indonesia	$605	6.4%	$29.4b.	–$4,837m.	$70.1b.	8.7%
Sri Lanka	$510	5.0%	$2.1b.	–$363m.	$6.1b.	12.0%
Maldives	$470	8.0%	$0.06b.	–$4m.	$0.09b.	8.0%*
Pakistan	$430	6.4%	$6.9b.	–$2,172m.	$22.3b.	12.7%
Bhutan	$415	3.5%	$0.08b.	–$58m.	$0.09b.	11.5%
Kenya	$346	4.0%	$1.01b.	–$477m.	$6.4b.	14.8%
Nigeria	$330	4.2%	$10.6b.	$3,500m.	$33b.	13.0%
China	$325	12.0%	$71.9b.	$13,300m.	$60.5b.	5.0%
India	$310	2.5%	$19.3b.	–$4,848m.	$73.5b.	11.8%
Burma	$250*	3.7%	$0.44b.	–$659m.	$4.8b	28.7%
Bangladesh	$208	3.3%	$1.7b.	–$306m.	$11.9b.	7.4%
Vietnam	$200	3.8%	$1.9b.	–$440m.	$15.3b.	78.9%
Laos	$180	4.0%	$0.08b.	–$65m.	$0.7b.	10.4%
Nepal	$180	4.0%	$0.24b.	–$279m.	$1.7b.	15.4%
Afghanistan	$150*	–2.2%	$0.25b.	–$142m.	$1.6b	56.7%
Cambodia	$150	5.0%*	$0.04b.	N.A.	$1.4b.	150%*
Mongolia	$100*	–18.0%	$0.44b.	–$100m.	$7.1b.	130%

Compiled from the latest available national and multilateral data. Gross Domestic Product (GDP) is the value of all goods and services produced in a country in one year. Gross National Product (GNP) per capita is GDP plus or minus the surplus or deficit in trade in goods & services (Current Account), divided by population. Consumer Price Index (CPI) measures one year's price changes in goods & services bought by a typical household. N.A. Not available. 0† Net creditor. * Best estimate. ASIAWEEK

 LETTERS TO THE EDITORS: Write Letters Department, Asiaweek, Vicwood Plaza 30/F. Hongkong, or fax your letter to Letters Department, (852) 815-5903. All letters intended for publication must include the writer's name and address. Please also include a telephone number if possible. Identities will be withheld when necessary. Letters are edited as clarity, space and accuracy of expression require, but our publishing a letter does not invariably mean we agree with everything or even anything in it.