ICDDR, B

BOARD OF TRUSTEES MEETING

NOVEMBER 2 – 4, 1996

PROGRAMME

OF THE

BOARD OF TRUSTEES MEETING

NOVEMBER 2 – 4, 1996

DRAFT
9/10/96

PROGRAMME

BOARD OF TRUSTEES MEETING

2-4 November 1996

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

Friday 1 November	Trustees arrive
Saturday 2 November	
8.30 a.m. - 10.15 a.m.	Personnel & Selection Committee Meeting (Executive Session)
10.15 a.m. - 10.45 a.m.	TEA/COFFEE
10.45 a.m. - 12.30 p.m.	Personnel & Selection Committee Meeting continues (closed)
12.30 p.m. - 2.15 p.m.	LUNCH at guest house with invited Centre staff
2.15 p.m. - 3.30 p.m.	Finance Committee Meeting
3.30 p.m. - 3.45 p.m.	TEA/COFFEE
3.45 p.m. - 5.00 p.m.	Finance Committee Meeting continues

Sunday 3 November

8.30 a.m. - 10.30 a.m.	Programme Committee Meeting
10.30 a.m. - 11.00 a.m.	TEA/COFFEE
11.00 a.m. - 12.30 p.m.	Programme Committee Meeting continues
12.30 p.m. - 1.30 p.m.	LUNCH (at Centre)
1.30 p.m. - 3.30 p.m.	Programme Committee Meeting continues
3.30 p.m. - 4.00 p.m.	TEA/COFFEE
4.00 p.m. - 5.00 p.m.	Programme Committee Meeting continues
6.30 p.m. - 8.30 p.m.	Reception at ICDDR,B Guest House

Monday 4 November	***DONORS' SUPPORT GROUP MEETING***
8.30 a.m. - 9.00 a.m.	TEA/COFFEE
9.00 a.m. - 9.30 a.m.	Inaugural Ceremony
9.30 a.m. - 9.35 a.m.	Election of Chair
9.35 a.m. - 9.50 a.m.	Resource Development: Summary Overview
9.50 a.m. - 10.20 a.m.	Financial Status and Proposed Budget for 1997
10.20 a.m. - 11.00 a.m.	TEA/COFFEE
11.00 a.m. - 12.00 noon	Donors' Round Table Forum (Trustees and donor representatives)
12.00 noon - 12.30 p.m.	Recommendations of the Report of the Integrated Institutional Review: Actions to be taken by donors
12.30 p.m. - 2.00 p.m.	LUNCH
2.00 p.m. - 5.00 p.m.	Visits to field sites in Dhaka

Monday 4 November (cont'd)

EXECUTIVE SESSION OF BOARD

2.30 p.m. - 2.45 p.m.	Approval of Agenda
2.45 p.m. - 3.00 p.m.	Approval of Draft Minutes of June 1996 Meeting
3.00 p.m. - 3.15 p.m.	Resolutions from Personnel & Selection Committee
3.15 p.m. - 3.30 p.m.	Resolutions from Finance Committee
3.30 p.m. - 3.45 p.m.	Resolutions and/or Recommendations from Programme Committee
3.45 p.m. - 4.15 p.m.	Resolutions from the Integrated Institutional Review Report
4.15 p.m. - 4.25 p.m.	Actions on Report from SWA
4.25 p.m. - 4.55 p.m.	Format of June Meetings
4.55 p.m. - 5.00 p.m.	Selection of Trustees
5.00 p.m. - 5.10 p.m.	Dates of Next Meeting
5.10 p.m. - 5.30 p.m.	Any Other Business
	Closure of Meeting

APPROVAL OF AGENDA

Draft
9/10/96

1/BT/Nov.96

FULL BOARD MEETING

Monday 4 November 1996

AGENDA

1. Approval of Agenda

2. Approval of Draft Minutes of Meeting held 1-3 June 1996

3. Resolutions from the Personnel & Selection Committee

4. Resolutions from the Finance Committee

5. Resolutions and/or Recommendations from the Programme Committee

6. Resolutions from the Integrated Institutional Review Report

7. Actions on Report from Staff Welfare Association (SWA)

8. Format of June Meetings

9. Selection of Trustees

10. Dates of Next Meeting

11. Any Other Business

2/BT/NOV.96

APPROVAL OF DRAFT MINUTES

OF THE MEETING

HELD ON 1-3 JUNE, 1996

DRAFT

14/7/96 2/BT/NOV.96

MINUTES OF THE MEETING OF THE BOARD OF TRUSTEES, ICDDR,B HELD IN DHAKA, BANGLADESH, ON MONDAY 3 JUNE 1996

Members Present

Mr. Md. Ali
Prof. Chen Chunming
Maj. Gen. (Ret'd) M.R. Choudhury
Prof. R.R. Colwell
Dr. D. Habte - Secretary
Dr. R.H. Henderson
Prof. F. Jalil
Dr. M. Law - Chairperson
Prof. P.F. McDonald
Mr. L. Majid
Prof. P.H. Makela
Mr. J.O. Martin
Prof. F.S. Mhalu
Dr. J. Rohde
Dr. Y. Takeda
Prof. C.G. Victora

Apology

Dr. T.A.M. Khoja

Senior Management (Agenda 1-6)

Mr. S.S. Ahsan
Dr. G. Fuchs
Mr. K. Tipping
Mr. G. Wright
Dr. M.J. Albert
Mr. M.A. Mahbub
Prof. J.P. Vaughan

Invited

Ms J. Banfield (Minute Secretary)

Observers - Donor Representatives (Agenda 1-6)

Dr. J. Barzelatto	Dr. M. Bentley
Ms J. Bratich-Cherif	Mr. D. Piet
Ms G. Ross	Ms Y. Yoshimoto

Dr. M. Law, Chairperson of the Board of Trustees, opened the 34th meeting of the Board at 8.30 a.m. on Monday 3 June 1996. She welcomed the Trustees, Donor Representatives, the Director, and staff, to the meeting, and offered a special word of welcome to the new Trustees, Mr. Mohammed Ali and Professor Cesar Victora.

She said that an apology had been received from Dr. Tawfik Khoja.

Agenda 1: Approval of Agenda

The agenda was adopted as presented.

Agenda 2: Approval of Draft Minutes of Meeting held on 5 November 1995

The draft minutes of the Board of Trustees meeting held on 5 November 1995 were approved.

Agenda 3: Director's Report

On behalf of the Centre, the Director, Dr. Demissie Habte, welcomed Board members and representatives of the donor community to the meeting. He extended a special welcome to Professor Cesar Victora and Mr. Mohammed Ali. He informed the Board that Mr. Mohammed Ali has replaced Mr. Syed Ahmed as Secretary of the Ministry of Health and Family Welfare of the Government of Bangladesh.

Dr. Habte advised that the Director's Report (document 3/BT/Jun.1996) had been circulated to the Board and to the donor community and said that the report to this meeting will consist of

- A brief overview of the activities of the Centre over the last six months by himself, and
- A brief exposition and update on resource development by Mr. G. Wright, Associate Director, External Relations & Institutional Development.

In addition, he brought to the notice of the meeting the 1995 Annual Report that had recently been distributed to Board members.

After introducing new senior staff to the Board, he presented his overview of the Centre's activities.

3.1 Overview of the Activities of the Centre

The six months of this reporting period started in an excellent note with Professor Patrick Vaughan joining as Division Director of the Community Health Division and Mr. Shamim Ahsan as Division Director of the Health and Population Extension Division. Two other senior scientists also joined, namely Dr. Jeroen van Ginneken, a distinguished demographer, and Dr. Jozef Bogaerts, a microbiologist with considerable experience in sexually transmitted diseases.

As intimated at the November 1995 Board of Trustees meeting, the management proceeded with some restructuring of the Community Health Division and Population and Family Planning Division. All major activities of the Centre that have considerable extension components (i.e. action oriented research) have been grouped under the newly named Health and Population Extension Division. This Division now consists of the Rural and Urban MCH-FP Extension Projects, the Environmental Health Programme and the Epidemic Control and Preparedness Programme.

The Community Health Division consolidated its hold on Matlab gaining the DSS and Population Studies Centre (PSC). It now has the Matlab Health Research Centre, the Matlab MCH-FP Programme, the Social and Behavioural Science Programme and the Health and Demographic Surveillance System (DSS and PSC). The imminent recruitment of a health economist, the expected growth of the

Social and Behavioural Science Programme, and a restructuring of Matlab will better prepare the Division for the challenges of the next five years.

The Laboratory Sciences Division is expanding its facilities to accommodate a reproductive health laboratory required to support the field research activities in this growing field. The internal structure of LSD will undergo a reorganization based in part on the recommendations of the external review conducted in late May.

The financial health of the Centre has improved since last November. The cash deficit at the end of 1995 turned out to be less than determined in November, thanks to a late receipt of promised funds. A number of large grants are expected in 1997, including from Japan, NIH, WHO, European Union, etc. and the campaign for the two endowment funds continues to yield satisfactory results. However, factors such as delayed release of USAID/W funds and uncertainties in the receipt of expected grants may pose potential problems for the 1996 budget year.

The political climate in the country during the past six months resulted in frequent hartals. There were 22 days of hartals during this period. Inevitably this negatively affected the Centre's research, training and service activities despite attempts to make up for the lost time. The situation further deteriorated with the enforced non-cooperation movement from March 9 to March 30. This potentially disruptive action was largely averted by the mobilization of the Centre's staff to come to work using available means of transport. Over 90% of the staff responded to the call keeping the Dhaka office open throughout March. Nevertheless, patient attendance at the hospital, and consequently patient recruitment, was severely curtailed. In addition, most of the field activities in Matlab and extension sites could not be conducted because of the movement.

3.1.1 Research Highlights

Research constitutes the Centre's primary function and during the last six months the Centre's staff have continued to work prodigiously and productively. Highlights are as follows:

Child Survival:

a. Significant urinary loss of vitamin A was observed during shigellosis in young children, and the loss was associated with malnutrition, fever, and abnormal renal function. Serum retinol was transiently and markedly depressed during the acute stage (admission) but spontaneously improved without supplemental vitamin A during recovery. This provided an explanation for the association of vitamin A deficiency with infections.

b. New activities over the past six months in the Physiology Laboratory (PL) of the Clinical Sciences Division included the successful establishment of the Griess reaction which quantified metabolites (nitrate and nitrite) of nitric oxide species (NOS). The total radical antioxidative parameters (TRAP) assay which measured antioxidative activity had also been recently established as an additional and complementary assay to the thiobarbituric acid reacting substances (TBARS) assay. The TRAP and TBARS assays reflected reactive oxidative species generation. Both NOS and ROS are postulated to be important mediators of intestinal inflammation. Additional human and animal studies are planned to further define the role of NOS and ROS in shigellosis, and to design potential treatment strategies for further study.

Ussing chamber facilities have been installed in the PL for the study of ion transport across intestinal epithelium. The body composition laboratory with the PL has also undergone further development with new uses of BIA to assess gastric acid output and hydration status under validation.

c. The physicochemical properties of water, and plankton and *V. cholerae* populations, have been monitored regularly in 4 ponds in Matlab. As with *V. cholerae* 01, we have shown for the first time *V. cholerae* 0139 to exist in association with planktons in a viable, but non-culturable state in a large number of samples.

d. Mannose-sensitive haemagglutinin (MSHA) is a putative adhesin of *V. cholerae* 01 El Tor biotype. It is believed that MSHA could be a protective antigen. To increase the efficacy of Holmgren's killed oral 01 cholera vaccine, addition of MSHA to the vaccine formulation is being contemplated. Antibody response to MSHA studied in *V. cholerae* 01 and *V. cholerae* 0139-infected patients showed that both groups of patients excreted antibodies to MSHA in the stool suggesting that MSHA is an immunogenic component of *V. cholerae* and might be a protective antigen.

e. A maternal immunization trial with pneumococcal polysaccharide vaccine given during pregnancy demonstrated that protective levels of antibodies are transferred to newborns and persist for as long as 20 weeks (half-life 35 days). Publication of this finding elicited considerable publicity in the international media. Follow-up studies on the clinical efficacy of such an intervention as well as possible effect on active immunization of infants will be started shortly.

In addition, the Centre is submitting an application to WHO for funds to conduct a large pneumococcal vaccine trial in infants in Matlab.

f. The reactogenicity and immunogenicity of a killed oral bivalent vaccine against both 01 and 0139 cholera are being studied in adult Bangladeshi volunteers.

g. Implementation of a newly developed nutrition education strategy showed significant increase in proportion and frequency of intake of ß-carotene rich food by children aged 6-59 months in Matlab. This is potentially a replicable strategy for the control of vitamin A deficiency.

h. A follow-up of children now 3 years old, who took part in the study of effects of vitamin A supplementation in infants, examined children at their homes for development using the Denver Developmental Screening Test (DDST). The groups of children who had received vaccines with either vitamin A or placebo did not differ significantly in developmental scores or mean anthropometric values, and there were no abnormalities in the neurological examination in any of the groups, including those who had bulging fontanelles.

i. Antimicrobial trials in cholera and shigellosis continue to result in simplified regimens as well as new treatment options. Azithromycin was found to be as effective as ciprofloxacin in the treatment of shigellosis. On the other hand 5-amino-salicylic acid was found to be therapeutically ineffective in acute shigellosis.

j. A new method to evaluate hydration status has been developed utilizing bioelectrical impedance analysis (BIA). Findings using this technique in a study comparing cholera and non-cholera diarrhoea indicate differential changes between intra- and extra-cellular water compartments. Extracellular water depletion is common in both cholera- and noncholera-associated dehydration. Unlike noncholera dehydration, dehydration due to cholera additionally has a marked depletion of intracellular water. BIA is an inexpensive, easy bedside method to assess hydration status.

k. A polymerase chain reaction (PCR) assay has been developed for *V. cholerae* O139 Bengal. This PCR assay should prove useful in clinical and environmental studies for detection of *V. cholerae* O139 especially when present in small numbers.

l. Several phages belonging to *Podoviridae* were isolated from the stools of *V. cholerae* O139-infected patients. These phages lysed wild capsulated *V. cholerae* O139 strains; non-capsulated variants of *V. cholerae* O139 and other unrelated bacteria were not lysed. Thus these phages are

useful for confirmatory diagnosis of *V. cholerae* O139 and differentiation of variants that lack the capsule.

m. Two ELISA tests - one for pathogenic amoeba (Entamoeba histolytica Test) and the other for both pathogenic and non-pathogenic amoeba (Entamoeba Test), were developed for commercial use by Tech Lab and University of Virginia in the USA with the assistance of the Centre's parasitology laboratory. These commercial tests have now been evaluated using over 2000 stool specimens from individuals with and without diarrhoea. The Entamoeba Test showed a sensitivity and specificity of both 94%, and the *E. histolytica* test showed a sensitivity of 86% and a specificity of 98% compared to culture and zymodeme analysis.

n. Surveillance of cholera has been set up in three sentinel posts in Sunamganj, Rangpur and in Jhalokathi Districts in collaboration with the Government of Bangladesh.

o. Two different models of water and sanitation programme interventions are being tested in rural Singair under the Action Research and Impact Studies on Community Water, Sanitation and Hygiene Education Interventions in Rural Areas. Both models are showing encouraging results. An evaluation will be completed in June.

Reproductive Health and Family Planning:

a. Preliminary observations on the study of reproductive tract infections in Matlab indicated a greater disease burden and a more enlightened health seeking behaviour among the inhabitants. Clinics for females and males have started to function in all subcentres.

b. A monitoring tool, known as the FPI Diary, developed by the MCH-FP Rural Extension Project to improve the performance of FP field workers and the quality of service data is under review by the Government for nation-wide implementation.

A manual on performance planning and monitoring for Thana managers has been developed which is under review by the Government for possible introduction in the national programme.

An HA register developed by the project has been introduced in the Extension Project laboratory Thanas in Abhoynagar and Mirsarai for field testing.

c. Training to improve referral of complicated obstetric cases and linkages between service providers has been completed in the two intervention unions in Mirsarai to strengthen maternal and neonatal health.

d. A baseline study on care seeking behaviour of women with complications of pregnancy and childbirth has been completed.

e. Preliminary findings from the rural MCH-FP Extension Project of the on-going "Cluster Visitations" intervention show that (a) MCH-FP service delivery from cluster spots has increased, and delivery at the homes of clients has decreased; (b) one-third of the users and more than one-tenth of the non-users visit cluster spots; and (c) there is a need for special IEC involving the house owners of the cluster spots.

Similarly preliminary findings of the on-going intervention of combined satellite clinic (SC) with EPI show that there is at least a three-fold increase at Abhoynagar and a five-fold increase at Mirsarai in attendance of clients at these satellite clinic sessions.

A set of cost-effectiveness analysis instruments has been developed to study the alternative service delivery approaches being field-tested at Mirsarai and Abhoynagar.

f. Planning and Coordination of Services (PCS) in the MCH-FP Urban Extension Project has resulted in the Government's decision to introduce similar committees in all cities and municipalities of the country.

An Urban Field Information System has been designed to improve the record-keeping and reporting system used by urban field workers while a Clinic Information System (CIS) has been designed to enable easy identification of clients' needs for greater continuity and improved services in fixed health facilities.

Also, an Urban Health Forum has been convened that brings together a group of 40 people with research and programme experience to discuss urban health issues.

g. Cost analyses of MCH-FP services at CWFP facilities in Zone 3 have been completed which identify areas for cost reduction and the capacity for the development of cost recovery schemes.

h. An inventory of urban health facilities has been completed and is being used to facilitate local planning and transfer of Zone 3 and Zone 1 lessons in other zones.

3.1.2 Training:

Dr. Habte acknowledged the busy training activities at the Centre of the Training and Education Department (formerly the Training Coordination Bureau). The Department has been busy providing seven short courses, running six fellowship programmes and a number of other activities.

A new feature has been the international workshop on Emergency Response to Cholera and *Shigella* Epidemics sponsored by the Office of Foreign Disaster Assistance in USAID/Washington and held in October 1995.

The international character of the training programme is reflected in the diverse origin of participants: thirteen countries in Asia, four in Africa, three from Europe, etc. During the period under review the courses and workshops organized included:

i. one research methodology workshop;

ii. one international workshop on "Emergency Response to Cholera and Shigella Epidemics";

iii. one international workshop on "Improving Family Planning Programme Effectiveness and Quality of Care through Operations Research";

iv. one international workshop on "Clinical Management of Diarrhoeal Diseases and Management of DTUs and ORT corners";

v. one national training course on "Clinical Management of Diarrhoeal Diseases for DCH students";

vi. two national training courses on"Clinical Management of Diarrhoeal Diseases for the physicians from Bangladesh College of General Practitioners".

3.1.3 Service:

The number of patients to visit the Dhaka hospital in 1995 continued at a high rate and once again reached a total of 114,729, which was more than that of 1994 and is the second highest number of patients treated at the CRSC since its establishment in 1962. The number of patients to visit the hospital during the six months of the report period was 42,835. *Vibrio cholerae* 01 continued to remain the predominant pathogen of epidemic cholera in Dhaka, with relatively few cases of 0139 relegating it to a comparatively minor role. This contrasted with the findings by the ECPP team of a much greater prevalence of 0139 in epidemic areas in the North and South of Bangladesh.

A total of 4,639 patients were seen at the Matlab Diarrhoea Treatment Centre during this period. Compared to the last two reporting periods, this number is considerably less. Routine provision of MCH-FP services continued to be provided to the inhabitants of the intervention area through community health workers, assistants, nurses, midwives, and medical doctors. Eighty-eight patients were seen by the MCH-FP service in Matlab at the sub-centres and in the Matlab hospital.

3.1.4 Staff:

Several new international level staff were appointed:

Mr. Syed Shamim Ahsan (Bangladesh), as Senior Advisor and Director, Health & Population Extension Division; Dr. Jeroen S. van Ginneken (The Netherlands) joined as Head of the Health and Demographic Surveillance Programme; Dr. Thomas T. Kane (USA) as Operations Research Scientist in the Rural MCH-FP Extension Project; Dr. Jozef Bogaerts (Belgium) joined the Centre as Senior Scientist in the Laboratory Sciences Division.

3.2 Resource Development

Mr. G. Wright, Associate Director, External Relations and Institutional Development, presented an updated report on resource development activities in Bangladesh and North America over the last six months which are summarized as follows (and attached to document 3/BT/Jun.96 previously circulated to the Board members):

Fund Raising Activities in Bangladesh:

3.2.1 Despite the difficult task in raising funds in the current environment, the Centre's total revenue has increased by 27% since 1992 ($9.527 million in 1992 to $12.115 million in 1995).

3.2.2 Several large project proposals had been prepared and submitted for funding: a proposal to the European Union for $18 million over 5 years; USAID/Washington proposal and cooperative agreement for $5.8 million over five years; SAREC proposal and research components; ODA core grant for $275,000 and computer systems project ($465,000); 3 proposals for 1995 of $100,000 each to the Arab Gulf Fund.

Mr. Wright paid tribute to the Centre scientists' ability and

willingness to prepare project proposals and to market their protocols.

3.2.3 He reported that efforts are continuing in order to diversify the Centre's funding base and to liaise with SAARC, ASEAN and countries involved in the establishment of the Centre in 1978.

3.2.4 Experts are being identified and recruited in collaboration with British Executive Services Overseas.

3.2.5 He reported that a series of committees have been organized to continue the Hospital Endowment Fund efforts and that Major General M.R. Choudhury and Mr. M.A. Mahbub were leading the fund-raising efforts.

Fund Raising Activities in North America:

Since October 1995, the Centre Fund campaign made great progress and has had a number of successes. The priorities for the Centre Fund Campaign staff in the U.S. during the past six months have been to obtain a leadership gift from USAID; cultivate foundations, corporate and individuals for support; maintain and build linkages with U.S. institutions; and identify and solicit donors for project support.

To date, the following progress has been made:

3.2.6 The Centre Fund ManagementCommittee has been formed to select a fund manager for the USAID $1 million, and subsequent, contributions.

3.2.7 The endowment agreement with USAID for an initial gift of $1 million was signed on 1 April 1996.

3.2.8 Morgan Stanley have been appointed as investment fund managers for the Centre Fund.

3.2.9 The Ford Foundation Board approved a gift of $1 million to the Centre Fund during their meeting in March 1996.

3.2.10 A contribution of $150,000 was received from The Rockefeller Foundation for the Centre Fund. The Centre plans to approach them again for additional funds.

3.2.11 Contact was made with a number of foundations and individuals in an effort to identify contributors to the Centre Fund.

3.2.12 For the first time, the Conrad Hilton Foundation initiated an award of $1 million to one organization that had done the most to alleviate human suffering in the past year, and the Centre was nominated by three organizations. However, a visit to the Centre by a representative of theHilton Foundation was cancelled due to the political situation.

3.2.13 With leadership gifts from USAID and the Ford Foundation, a move was made towards a programme of foundation/corporate solicitation.

Following both Dr. Habte's presentation and that of Mr. Wright, Dr. Law invited comments and questions from the Trustees and donors.

It was agreed to accept the Director's Report and the 1995 Annual Report.

Agenda 4: Programme Committee Report

The Chairperson of the Programme Committee, Professor P. Helena Makela, presented to the Board of Trustees a verbal report and a draft of the conclusions of the Programme Committee meeting held on Saturday 1 June 1996.

The Committee had heard reports from the four scientific divisions and the training and education department and each report was followed by discussion.

The Committee also received the report of the Programme Committee's Review of the Laboratory Sciences Division, and the Centre's response to the report of the Programme Committee's Review of the Clinical Sciences Division held in October/November 1995 (and presented to the November 1995 Board of Trustees Meeting).

Highlights from the Programme Committee report are as follows:

4.1 The research and other training activities of the four divisions and the Training and Education Department were of high quality and were responding to important public health needs of the country in accordance with the Strategic Plan of the Centre. Further development of interaction and collaboration between the divisions resulting in larger research programmes was seen as a means to have an even higher impact of the research.

4.2 The Committee appreciated the response from the Clinical Sciences Division to the External Review held in November 1995 which included renovations in the hospital premises, improvements in the nursing service, and reformulation of its research programme along thematic lines.

4.3 The Committee noted that an External Review of the Laboratory Sciences Division was held prior to the meeting and that a response from the Centre will be presented to the November 1996 Board Meeting.

4.4 Following extensive exchange of views with participation of donors, staff and Board members, the Committee agreed to recommend to the Board the acceptance of the report by Dr. Barry Evans on HIV testing at ICDDR,B and to instruct the Centre to start its implementation. It furthermore requested a progress report of implementation at its next meeting.

Dr. Law, Chairperson of the Board, asked for comments from the meeting. Several questions were asked and information provided. Dr. Law thanked Professor Makela for the presentation of the report.

The following resolution was passed:

1/BT/Jun.96 The Board resolved to accept the report of Dr. Barry Evans on HIV testing at ICDDR,B and to instruct the Centre to start its implementation. It furthermore requested a progress report on implementation at its next meeting in November 1996.

The meeting approved the Programme Committee Report.

Agenda 5: Integrated Institutional Review Update

The Director advised the meeting that after considerable delays due to a number of unforeseen obstacles, the review team has now been constituted and the dates for the review set for 1-14 September 1996. The team will be composed as follows:

Dr. David Sencer (USA) - Team Leader
Dr. Halida Akhter (Bangladesh) - Reproductive Health/Family Planning
Dr. Mary Amuyunzu (Kenya) - Social Science
Dr. M. Jegathasen (Malaysia) - Child Survival
Mr. Derek Reynolds (UK) - Management
Prof. Stig Wall (Sweden) - Epidemiology/Demography

Agenda 6: Finance Committee Report

Dr. J. Rohde, Chairperson of the Finance Committee, presented the report of the Finance Committee meeting held on Sunday 2 June 1996 to the Board of Trustees.

6.1 Audited Financial Statements for 1995

It was noted from the Financial Statements that the total income increased by $1,647,000 (15.7%) from $10,468,000 to $12,115,000, and the expenditure increased by $1,436,000 (12.35) from $11,712,000 to $13,148,000. The net operating deficit increased by $211,000 (17.0%), from $1,244,000 to $1,033,000. The cash operating deficit, after adjusting for profit on sale of fixed assets of $Nil (1994 - $20,000), decreased by $312,000 (61.9%), from $504,000 to $192,000.

The Committee recommended to the Board that the audited Financial Statements for 1995 be accepted.

6.2 1996 Forecast

It was reported to the Board that the total income for 1996 was budgeted at $13,208,000, but is now forecast at $12,805,000, a decrease of $403,000. Total expenditure was budgeted at $13,190,000, and is now anticipated to decrease by $441,000 (3.3%), to $12,749,000.

The net operating deficit after depreciation was budgeted at $811,000. This is anticipated to decrease by $1,000 (0.1%) to $810,000 because of the net effect of changes in income and expenditure.

The net cash surplus before depreciation was budgeted at $18,000. This is now anticipated to increase by $38,000 to give a surplus of $56,000.

The Board resolved that Centre management be urged to reduce the proportion of expenditure on personnel costs while renewing talent and maintaining the institution as a cost effective centre of excellence by a mixture of the following measures:

1. Stringent use of performance appraisals to assess staff capability and potential in order to reward and encourage quality staff to stay and encourage low performing staff to leave.

2. Reducing numbers of staff performing functions considered redundant or non-essential, or that could be reallocated to or amongst other staff members. This could include:

   a. re-training and re-orienting high quality staff with demonstrated capabilities and commitment to the Centre for re-deployment in line with the Centre's priorities, and

   b. achieving efficiencies and reducing selected activities with a lower overall priority while maintaining the Centre's infrastructure which contributes to its uniqueness and strengths.

   c. establishing mechanisms for securing staff participation in the development of strategies for increasing efficiency and reducing overall expenditure.

6.3 Appointment of Auditors for 1996

On the advice of the Centre's management, the Committee agreed to recommend to the Board that ACNABIN & Co. be reappointed for the year 1996 and that Deloitte Haskins & Sells be replaced by Price Waterhouse & Co. This follows advice that external auditors should be changed not less frequently than five to seven years.

6.4 Information Technology Update

A detailed written report on the background, what the Centre is doing, the cost of upgrading, funding to date and additional funding on the information technology strategy was presented.

Hope was expressed that these new systems could help the Centre in establishing a modern MIS, taking advantage of the computers being placed under the responsibility of the Finance Division.

6.5 Fixed Asset Acquisition and Replacement Fund

It was reported to the Board that capital expenditure committed to the end of March 1996 totalled $185,004. The balance remaining in the fund at 31 March 1996 totalled $520,838.

6.6 ICDDR,B Hospital Endowment Fund

It was reported to the Board that the balance of the Hospital Endowment Fund at 31 December 1995 was $3,369,350. Receipts for the first four months of 1996 were $69,121 giving a balance at 30 april 1996 of $3,438,471. No hospital expenditure has been charged to the Fund since its inception.

Dr. Rohde made a few comments at the conclusion of his presentation of the Finance Committee report, including reference to the likely curtailment of UNICEF contributions. It was noted that efforts are being made requesting reconsideration of this action.

Comments were invited from the meeting on the Finance Committee Report. A few comments were made and responded to.

Dr. Law, Chairperson of the Board, asked for comments from the donors present in the meeting. Dr. Jose Barzelatto, Vice President of the Ford Foundation, New York, Ms Yoshimoto from the Japanese Embassy in Dhaka, and Mr. David Piet from USAID Dhaka, addressed the meeting.

It was agreed to accept the report of the Finance Committee.

The following resolutions were passed:

2/BT/Jun.96 The Board resolved to accept the audited Financial Statements for the 1995 year.

3/BT/Jun.96 The Board resolved that the Centre management be urged to reduce the proportion of expenditure on personnel cost while renewing talent and maintaining the institution as a cost effective centre of excellence by a mixture of the following measures:

1. Stringent use of performance appraisals to assess staff capability and potential in order to reward and encourage quality staff to stay and encourage low performing staff to leave.

2. Reducing numbers of staff performing functions considered redundant or non-essential, or that could be reallocated to or amongst other staff members. This could include:

   a. re-training and re-orienting high quality staff with demonstrated capabilities and commitment to the Centre for re-deployment in line with the Centre's priorities, and

   b. achieving efficiencies and reducing selected activities with a lower overall priority while maintaining the Centre's infrastructure which contributes to its uniqueness and strengths.

   c. establishing mechanisms for securing staff participation in the development of strategies for increasing efficiency and reducing overall expenditure.

4/BT/Jun.96 The Board resolved to appoint ACNABIN & Co. and Price Waterhouse & Co. as joint auditors for the year 1996 at a fee not to exceed $14,000.

5/BT/Jun.96 The Board resolved to approve expenditure of $318,613 from the Fixed Asset Acquisition and Replacement Fund for 1995.

6/BT/Jun.96 The Board resolved to authorize the Centre to borrow money as and when required from the ICDDR,B Hospital Endowment Fund at an interest rate mid way between the American Express overdraft rate and the Fund's one month term deposit rate. Such borrowings will be limited to a one month duration with rollover by mutual consent and shall not exceed $750,000 at any point in time.

7/BT/Jun.96 The Board resolved to ask the management to pursue its efforts to attract donations to the Hospital Endowment Fund (HEF) as part of the overall resource mobilization.

Agenda 7: Personnel & Selection Committee Report (closed session)

Dr. R.H. Henderson, Chairperson of the Personnel & Selection Committee, presented the report of the Personnel & Selection Committee meeting held on Saturday 1 June 1996, to the Board of Trustees.

7.1 Staffing

7.1.1 Overview of the Staffing Situation

Attention was drawn to Tables 1-9 of the report to the Personnel & Selection Committee. It was noted that the Board's instructions on recruitment have continued to be followed although there has been a net increase in staff of 17, all of whom were in projects. At 31 March 1996 the total staff numbered 1002 compared to 985 at 30 September 1995. However, core staff has gone down from 603 to 591.

It was reported that the sex ratio of staff was 56% male and 44% female. When disaggregated 32% and 49% females belonged to the professional and support group categories respectively. The staff came from ten countries and from five continents.

The Committee complimented the Centre's management on their continued actions to reduce staff and recommended a continuation of the current policy (see Finance Committee resolution 3/BT/Jun.96).

7.1.2 Contract Renewal - Associate Director ER&ID

The meeting noted that Mr. Graham A.N. Wright, Associate Director, ER&ID, will complete his three years employment contract with the Centre on 31 December 1996.

It was agreed that Mr. Wright's current contract be extended by another term of three years effective 1 January 1997. The Committee also confirmed that Mr. Graham Wright be given a personal promotion to P5 as requested by the Director.

7.1.3 Status of Recruitment of International Staff

a. MCH-FP Physician

The meeting noted that the position of MCH-FP Physician was advertised in a national daily and the Lancet (UK) in March 1996. The advertisement was also circulated to some selected universities and to all Board of Trustees members.

It was noted that the management's efforts to identify a suitable person have not yet succeeded. It was agreed that Dr. Andres de Francisco be reappointed to the position for another term of three years effective from 6 November 1996.

7.1.4 Information on Seconded Staff

a. Demographer and Head, Health & DSS

It was reported to the meeting that Dr. J.K.S. van Ginneken joined the Centre on 1 November 1995, for three years as Demographer and Head, Health and Demographic Surveillance System, Community Health Division,

14/BT/Jun.96 The Board resolved that there be no change in the remuneration of staff.

15/BT/Jun.96 The Board resolved that a Search Committee for the position of Director be formed. Committee members to be Dr. R.H. Henderson (chairman), Major General (Ret'd) M.R. Choudhury, Professor F. Jalil, and Mr. J. Martin. Two non-Board persons familiar with the Centre will also be included.

Agenda 8: Selection of Trustees

a. It was noted that Mr. Mohammed Ali has replaced Mr. Syed Ahmed as a member of the Board.

b. It was agreed that Professor Cesar G. Victora (Brazil) be reappointed as a Board Trustee for another period of three years from 1 July 1996.

c. It was agreed that Professor Marian Jacobs (Republic of South Africa) be invited to join the Board of Trustees effective from 1 July 1996 representing a developing country in the African region.

d. The Board agreed to extend its thanks to Professor Fred. S. Mhalu for his outstanding contribution to the Centre as a member of the Board of Trustees from 1990 to 1996.

e. The Board agreed to extend its thanks to Mr. Syed Ahmed for his outstanding contribution to the Centre as a member of the Board of Trustees from 1994 to 1996.

The following resolutions were passed:

16/BT/Jun.96 The Board resolved that Professor Cesar Victora (Brazil) be reappointed as a Trustee for another period of three years from 1 July 1996.

17/BT/Jun.96 The Board resolved that Professor Marian Jacobs (RSA) be appointed as a Trustee for a period of three years from 1 July 1996.

18/BT/Jun.96 The Board resolved to extend its thanks to Professor Fred S. Mhalu for his outstanding contribution to the Centre as a member of the Board of Trustees from 1990 to 1996.

19/BT/Jun.96 The Board resolved to extend its thanks to Mr. Syed Ahmed for his outstanding contribution to the Centre as a member of the Board of Trustees from 1994 to 1996.

Agenda 9: Election of Chairperson of the Board

It was agreed that Dr. Maureen Law be appointed Chairperson of the Board of Trustees for one year from 1 July 1996.

a. Appointments to Committees

Dr. R.H. Henderson was re-elected as the Chairman of the Personnel and Selection Committee, Dr. J. Rohde as the Chairman of the Finance Committee, and Professor Helena Makela as the Chairperson of the Programme Committee.

The following resolutions were passed:

20/BT/Jun.96 The Board resolved that Dr. Maureen Law be appointed Chairperson of the Board of Trustees for one year from 1 July 1996.

under a secondment agreement between the Ministry of Foreign Affairs, Government of the Netherlands and the Centre.

b. Operations Research Scientist, MCH-FP (Rural), HPED

It was reported to the meeting that Dr. Thomas T. Kane, Operations Research Scientist, MCH-FP (Rural), HPED, joined the Centre on 1 January 1996 for a period of two years, on secondment from the Population Council.

c. Senior Scientist, LSD

Dr. Jozef Bogaerts joined the Centre on 1 January 1996 for two years as a Senior Scientist in the Laboratory Sciences Division, on secondment from BADC to ICDDR,B. Dr. Bogaerts is the sixth Belgian staff member under the existing BADC-ICDDR,B agreement.

d. Health Economist, CHD

The meeting noted that Dr. Mahmud Khan has been selected for the position of Health Economist in the Community Health Division. He is expected to join shortly.

e. Epidemiologist, CHD

The meeting noted that Dr. David Ross has been selected for the position of Epidemiologist in the Community Health Division. He is expected to join in January 1997.

7.1.5 Comparative Salary Survey

The Board of Trustees received the "Report on Salary and Benefits Survey" prepared by MRK Consultants, Dhaka, at the request of the Board. The survey was a comparative study of national staff at NO and GS level with institutions based in Bangladesh. These included national research institutions,

international NGOs and private corporations. The data was carefully compiled and the Centre commended on the excellent report.

The following resolutions were passed:

8/BT/Jun.96 The Board resolved to accept the report of the Personnel and Selection Committee.

9/BT/Jun.96 The Board resolved that the current contract of Mr. Graham A.N. Wright, Associate Director ER&ID, be extended by another term of three years effective 1 January 1997 and that he be given a personal promotion to P5.

10/BT/Jun.96 The Board resolved that the position of MCH-FP Physician be filled by Dr. Andres de Francisco for a period of three years effective 6 November 1996.

11/BT/Jun.96 The Board resolved to accept the appointment of Dr. Jeroen K.S. van Ginneken as Demographer and Head, Health & Demographic Surveillance Programme, Community Health Division, effective 1 November 1995, on secondment from the Ministry of Foreign Affairs, Government of the Netherlands.

12/BT/Jun.96 The Board resolved to accept the appointment of Dr. Thomas T. Kane as Operations Research Scientist, MCH-FP (Rural) Extension Project, HPED, effective 1 January 1996, on secondment from the Population Council.

13/BT/Jun.96 The Board resolved to accept the appointment of Dr. Jozef Bogaerts as a senior Scientist in the Laboratory Sciences Division, effective from 1 January 1996, on secondment from BADC.

21/BT/Jun.96 The Board resolved that the following members be appointed to the Personnel & Selection Committee for a one year term effective 1 July 1996:

Dr. R.H. Henderson (Chairman)
Mr. Md. Ali
Dr. Y. Takeda
Prof. F. Jalil

The Chairperson of the Board and the Centre Director are ex officio members.

22/BT/Jun.96 The Board resolved that the following members be appointed to the Finance Committee for a one year term effective 1 July 1996:

Dr. J. Rohde (Chairman)
Mr. Md. L. Majid
Mr. J.O. Martin
Dr. T.A.M. Khoja

The Chairperson of the Board and the Centre Director are ex officio members.

23/BT/Jun.96 The Board resolved that the following members be appointed to the Programme Committee for a one year term effective 1 July 1996:

Prof. P.H. Makela (Chairperson)
Prof. Chen Chunming
Maj. Gen. (Ret'd) M.R. Choudhury
Prof. R.R. Colwell
Prof. P.F. McDonald
Prof. C.G. Victora

The Chairperson of the Board and the Centre Director are ex officio members.

Agenda 10: Dates for 1996/1997 Meetings

It was agreed to confirm an earlier decision of the Board that meetings should be held in Dhaka on the first Saturday, Sunday, and Monday of June and November each year.

Accordingly the programme for 1996 and 1997 is as follows:

INTEGRATED INSTITUTIONAL REVIEW OF ICDDR,B

Sunday 1st September to Saturday 14th September	External Review Team led by Dr. David Sencer

BOARD OF TRUSTEES MEETING - NOVEMBER 1996

Friday 1st November	Trustees arrive
Saturday 2nd November	Personnel & Selection Committee Meeting Finance Committee Meeting
Sunday 3rd November	Programme Committee Meeting
Monday 4th November	Donors' Support Group Meeting Executive Session of Full Board

PROGRAMME COMMITTEE REVIEW OF CHD - JUNE 1997

Tuesday 3rd June	Reviewers arrive
Wednesday 4th June to Friday 6th June	Review of Community Health Division and write-up of report

BOARD OF TRUSTEES MEETING - JUNE 1997

Friday 6th June	Trustees arrive
Saturday 7th June to Monday 9th June	Committee Meetings and Full Board Meeting

PROGRAMME COMMITTEE REVIEW OF HPED - NOVEMBER 1997

Tuesday 28th October	Reviewers arrive
Wednesday 29th October to Friday 31st October	Review of the Health & Population Extension Division and write-up of report

BOARD OF TRUSTEES MEETING - NOVEMBER 1997

Friday 31st October	Trustees arrive
Saturday 1st November to Monday 3rd November	Committee Meetings, DSG Meeting and Full Board Meeting

Agenda 11: Report from the Staff Welfare Association

As part of its agenda, the Board met with the Staff Welfare Association (SWA) Executive Committee at 12.30 p.m. on Monday 3rd June 1996 and received the report of the President of SWA. A useful exchange of views ensued. The Board expressed appreciation for the services of the staff but regretted that the Centre's financial status will not allow salary increments as requested by SWA.

Agenda 12: Any Other Business

a. Format of the November Board and Donor Support Group Meetings

The Director reported to the meeting the responses received from donor representatives who were asked for views on improvements to the Donor Support Group Meeting which is currently held on the day following the November Board of Trustees Meeting.

The following suggestion for the programme for the November Board of Trustees meeting was agreed upon:

Day 1 a.m. Personnel & Selection Committee meeting (executive session)
p.m. Finance Committee meeting (open)

Day 2 Programme Committee meeting (open and to include donors)
Trustees' Forum or other matters of interest (open)

Day 3 a.m. Donors' Support Group Meeting
p.m. Executive session of Full Board

b. Ford Foundation

Dr. Jose Barzelatto, Vice President of the Ford Foundation, presented a report to the meeting indicating the extent of the present and future support to the Centre by the Ford Foundation. This consists of one million dollars to the Centre's Capital Endowment Fund; use of the balance of the Foundation's grant for HIV/AIDS work; the remaining funds in the Foundation's grant of $253,000 to the London School of Hygiene and Tropical Medicine for technical assistance to the Centre's Social and Behavioural Science Programme; an in principle additional tie-off grant of $1 million dollars for the Social and Behavioural Sciences Programme; a second and final grant of $300,000 has been made to support the second phase of the ICDDR,B/BRAC Joint Research project in Matlab.

The following resolution was passed:

24/BT/Jun.96 The Board agreed that the chairperson of the Board convey to the Ford Foundation the appreciation of the Centre's Board, management, and staff, for their continuing excellent support of the work of ICDDR,B.

The meeting closed at 1.30 p.m.

RESOLUTIONS FROM THE PERSONNEL & SELECTION COMMITTEE

DRAFT

REPORT OF THE PERSONNEL AND SELECTION COMMITTEE MEETING SATURDAY 2 NOVEMBER 1996

The Personnel and Selection Committee met in Dhaka at 8.30 a.m. on Saturday 2 November 1996.

Present

A list of those present is appended as Annex A.

Dr. R.H. Henderson, Chairperson of the Committee, welcomed the members of the Board of Trustees and called the meeting to order.

1. APPROVAL OF AGENDA

The agenda was approved.

2. APPROVAL OF MINUTES OF LAST MEETING

The minutes of the Personnel and Selection Committee meeting held on 1 June 1996 were approved.

3. STAFFING

3.1 Overview of the Staffing Situation

Attention was drawn to Tables 1-8. It was noted that the Board's instructions on recruitment have continued to be followed although there has been a net increase in staff of 15 (14 in projects, 1 in core). At 30 September 1996 the total staff numbered 1017 compared to 1002 as at 31 March 1996. However, core staff have remained the same at 591.

Concern was expressed by the Committee at the continuing high level of staff numbers and the major expenditure involved. The Committee expressed its concern to the Director that expenditures, particularly on staff, be reduced in line with revenue, while continuing current recruitment policies.

3.2 Status of Recruitment of Director

The Chairperson reported that the Search Committee will meet during the next two days and will present a report to the Full Board Meeting on 4th November.

3.3 Recruitment of Other International Staff

a. Division Director Finance, D1

It was reported to the meeting that the Division Director of Finance, Mr. Kenneth J. J. Tipping, will be completing his six years employment contract on October 15, 1997.

As per the rules of the Centre the position needs to be advertised both locally and internationally and a suitable candidate recruited as per the Centre's recruitment procedure.

b. Division Director LSD, D1

It was reported to the meeting that the position of Director of the Laboratory Sciences Division fell vacant with the departure of Dr. Bradley Sack in June 1994. Since then Dr. John Albert has been acting as the Division Director, LSD.

The management's earlier efforts to identify a suitable scientist with research, fund raising, and administrative capabilities have not produced any substantial result.

This subject was also discussed in earlier Board meetings and it was agreed that the search process will continue.

The Committee agreed to recommend to the Board that the Director be given the authority to formally recognise Dr. Albert's functions with a change of title if desired.

It was also suggested by the Committee that Board members actively assist in identifying a suitable candidate for this position.

c. Senior Scientist, Social & Behavioural Sciences, P5

The meeting noted that Dr. James L. Ross, Senior Scientist, Social & Behavioural Sciences, who was initially on a reimbursable secondment by LSHTM since January 15, 1994 was given a fixed term contract for three years with effect from January 1, 1996. Dr. Ross voluntarily terminated his contract effective June 11, 1996.

It was reported to the meeting that advertisements for the position have been placed in the Economist, Guardian Weekly, and the Bangladesh Observer.

Copies of the advertisement have been sent to all donor agencies, collaborating institutions, UN agencies, former trustees, alumni, and The Ford Foundation.

Professor Patrick Vaughan presented a report on the applications received and indicated that a short list of three candidates had been prepared.

d. Senior Epidemiologist (CHD), P5

The meeting noted that the position of Epidemiologist, CHD was advertised on July 7, 1995 both locally and internationally. Copies of the advertisement were sent to universities in the U.K. and the U.S.A., BOT members, donors, and UN agencies. Twenty applications were received and Dr. David Ross was selected for the post. However he declined to accept the position.

A further advertisement has been placed in the Lancet and British Medical Journal. Copies of the advertisement have been sent to all collaborating institutions and BOT members.

Professor Patrick Vaughan, Director of the Community Health Division, reported to the meeting on the applications received and that a short-list is being prepared.

The Committee agreed to recommend to the Board that approval be given for the appointment by the Centre of a suitable person for the position.

e. MCH-FP Physician

The meeting noted that Dr. L. A. de Francisco Sherpa's appointment was approved by the Board at its June meeting. Dr. Andres de Francisco was offered the job and has accepted the appointment.

f. Associate Director, ER&ID, P5

It was reported to the meeting that Mr. Graham Wright, Associate Director, ER&ID submitted his resignation effective November 7, 1996 to assume a new position in the Philippines.

It was noted that interim arrangements will be made to use the Centre's Senior Development Officer currently with the Centre Fund in the USA to partially fill the vacancy created. In the long term the post of ER&ID needs to be filled through the normal recruitment process.

3.4 New Positions

a. Epidemiologist (HPED) P4

It was reported to the meeting that the Centre won an NIH grant to study the epidemiology & ecology of cholera in Bangladesh. The proposal incorporated a position of an Epidemiologist and Dr. A.K.M. Siddique, who is a co-principal investigator of the study, was offered the position at pay level P4.

b. Head of Training P4

It was reported to the meeting that the Centre is embarking on an expanding training programme in the fields of Reproductive Health and Child Survival. In order to implement this, an international level staff member will be required.

A post classification exercise justified the position at pay level P4.

The Committee agreed to recommend to the Board that it approve opening a position of Head of the Training and Education Department noting that the actual grade and functions may be modified in the light of consideration of the Centre's future. It was noted that recruitment will depend on identification of funds from willing donors.

3.5 Information on Seconded Staff

a. Health Economist CHD, P4

It was reported to the meeting that the Centre received an ODA grant for the development of research capability in health economics within CHD.

An advertisement was published in the Lancet, Economist, and Daily Star (Bangladesh) and copies of the advertisement were sent to all donor agencies, Trustees, former Trustees and collaborating agencies.

Dr. Mahmud Khan, an Associate Professor at the University of Tulane, was selected as the most suitable candidate and was offered the position of Health Economist at pay level P4 on a reimbursable secondment from the Tulane University. He has accepted the position and will join the Centre in January 1997.

4. SELECTION OF TRUSTEES

a. It was reported to the meeting that Dr. Maureen Law concludes her second term of service as a Board Trustee in June 1997.

The Personnel and Selection Committee requested the Director to obtain as many nominations as possible for potential candidates for a Board of Trustees position from a developed country in North America effective from 1 July 1997.

b. It was reported to the meeting that Mr. Jacques O. Martin's first term as a Trustee concludes on 30 June 1997.

It was agreed to recommend to the Board that Mr. Jacques O. Martin (Switzerland) be reappointed as a Board Trustee for another period of three years from 1 July 1997.

c. It was reported to the meeting that Dr. Yoshifumi Takeda's first term as a Trustee concludes on 30 June 1997.

It was agreed to recommend to the Board that Dr. Yoshifumi Takeda (Japan) be reappointed as a Board Trustee for another period of three years from 1 July 1997.

5. STAFF SALARIES

5.1 International Professional Category

It was agreed to recommend to the Board that no change in remuneration be authorised.

5.2 NO & GS Category

It was agreed to recommend to the Board that no change in remuneration be authorised.

It was agreed to recommend to the Board that consideration be given to protecting staff salaries following the recent devaluation of the Bangladesh taka.

The meeting closed at 12.10 p.m.

DRAFT RESOLUTIONS

1/BT/Nov.96 The Board resolved that the position of Division Director Finance be advertised locally and internationally and a suitable candidate recruited as per the Centre's recruitment procedure.

2/BT/Nov.96 The Board resolved that the Director be given authority to change the title of Dr. John Albert's position.

3/BT/Nov.96 The Board resolved that the Centre appoint a suitable person to the position of Senior Epidemiologist, CHD, (P5).

4/BT/Nov.96 The Board resolved to approve the opening of a position for "Head, Training and Education Department", noting that the actual grade and functions may be modified in the light of consideration of the Centre's future, and subject to the availability of funds from donors.

5/BT/Nov.96 The Board resolved that Mr. Jacques O. Martin (Switzerland) be reappointed as a Trustee for another period of three years from 1 July 1997.

6/BT/Nov.96 The Board resolved that Dr. Yoshifumi Takeda (Japan) be reappointed as a Trustee for another period of three years from 1 July 1997.

Annex A

Personnel and Selection Committee Meeting, Saturday 2 November 1996

Members Present

Dr. R.H. Henderson (chairperson)
Mr. Md. Ali
Prof. F. Jalil
Dr. Y. Takeda
Dr. M. Law
Dr. D. Habte

Invited Trustees

Major General (Ret'd) M.R. Choudhury
Prof. R.R. Colwell
Prof. M.E. Jacobs
Prof. P.F. McDonald
Mr. J.O. Martin
Dr. J. Rohde

Invited Staff

Mr. W.Z. Ahmed
Mr. S.S. Ahsan
Dr. J. Albert
Ms J. Banfield (Minute Secretary)
Dr. G. Fuchs
Mr. M.A. Mahbub
Mr. K. Tipping
Prof. P. Vaughan
Mr. G. Wright

RESOLUTIONS FROM THE FINANCE COMMITTEE

REPORT OF THE MEETING OF THE FINANCE COMMITTEE

HELD ON NOVEMBER 2 1996 AT ICDDR,B.

PRESENT

Finance Committee Members

Dr. M. Law - Chairman of the Board
Dr. J.E. Rohde - Chairman
Mr. J.O. Martin
Prof. D. Habte - Director - ex-officio member

Board Members

Prof. R.R. Colwell
Maj. Gen. M.R. Choudhury (Retd.)
Dr. R.H. Henderson
Prof. F. Jalil
Prof. M. Jacobs
Prof. P.H. Makela
Prof. P.F. McDonald
Dr. A.K.M. Masihur Rahman
Dr. Y. Takeda

Division Directors, ICDDR,B and invited staff

The Committee convened at 2.15 a.m. on November 2 in Sasakawa Training Room number 1

1. APPROVAL OF THE AGENDA

The draft agenda was approved with the addition of Bylaws of the Endowment Fund Management Committee of International Centre for Diarrhoeal Research, Bangladesh under agenda item 6 - Any Other Business.

2. 1996 FORECAST

INCOME

Donor Contributions (Table 2 for summary and Tables 3 and 3A for individual donor amounts) which were budgeted at $13,208,000 are expected to decrease to $12,121,000. This decrease of $1,087,000 (8.2%) is explained by the following table.

	1996 BUDGET	1996 FORECAST	DIFF.
Restricted			
Projects/Programs	7,444,000	6,740,000	704,000
Fixed Assets	256,000	459,000	(203,000)
	7,700,000	7,199,000	501,000
Project Overhead	1,407,000	1,356,000	51,000
Total Restricted	9,107,000	8,555,000	552,000
Unrestricted	4,101,000	3,566,000	535,000
Total Contributions	$13,208,000	$12,121,000	$1,087,000

Restricted contributions have fallen in line with expenditure and are commented on under expenditure below.

The causes of the expected decrease in unrestricted contributions are:

a) Unanticipated Loss of Income - over $50,000 individually reported

UNICEF		175,000	
UNFPA		100,000	
All Others - net		274,000	
		549,000	
Moved to Restricted Income			
Australia (AusAID)	58,000		
United Kingdom (ODA)	137,000	195,000	744,000

b) Unanticipated Income - over $50,000 individually reported

Bangladesh	99,000	
Sweden (SAREC)	93,000	192,000
		$552,000

EXPENDITURE

Operating Cash Cost (Tables 2 and 4) which was budgeted at $13,190,000 is forecast to decrease by $705,000 (5.3%) to $12,485,000. This decrease is explained by the following table.

	1996 BUDGET	1996 FORECAST	DIFF.
Restricted			
Projects/Programs	7,444,000	6,740,000	704,000
Fixed Assets	256,000	459,000	(203,000)
Total Restricted	7,700,000	7,199,000	501,000
Unrestricted			
Programs	3,689,000	3,591,000	98,000
Management	1,801,000	1,695,000	106,000
Total Unrestricted	5,490,000	5,286,000	204,000
Total Operating Cash Cost	$13,190,000	$12,485,000	$705,000

Restricted costs will decrease because of the underspending and late start of protocols (e.g. Ford Foundation and USAID) and non realization of projects (mainly EU). USAID approval for 4 of the 6 targeted projects was not given until August 1996. This is partially offset by increased spending on existing or new projects (mainly Netherlands, the Population Council, Rand Corporation and the Johns Hopkins University through USAID). Details of all variations are shown in Table 3. A major contributing factor to underspending and late starts was the reduction in activities caused by the political turmoil in the early part of the year.

Unrestricted costs will decrease mainly as a result of more Central staff being charged to projects and the effect of staff and cost reductions. Stringent cost control and subcontracting of security and cleaning services will reduce management costs by $106,000 (5.9%). Details of unrestricted costs by area of activity are shown in Table 4.

Depreciation, which was budgeted at $829,000, is forecast to increase by $23,000 (2.8%) to $852,000. The increase results from depreciation on fixed asset acquisitions.

Total Expenditure including depreciation was budgeted at $14,019,000 and is anticipated to decrease by $682,000 (4.9%) to $13,337,000.

BALANCE

Net Operating Deficit after depreciation was budgeted at $811,000. This is anticipated to increase by $405,000 (49.9%) to $1,216,000 because of the net effect of changes in income and expenditure.

Net Cash Surplus before depreciation was budgeted at $18,000. This is now anticipated to decrease by $382,000 to a deficit of $364,000. Success in the effort to convince the EU to contribute to the costs of the early onset of the regular epidemic will reduce this deficit.

COMMENTARY

Management appreciates that **Deficits** of this magnitude are **unsustainable**. However sudden and unexpected curtailment of contributions, reduction of promised contributions and delays in disbursements make it exceedingly difficult for the Centre to avoid such deficits, particularly when these occur towards the end of the year.

In addition, the political unrest in the country negatively affected the Centre's income by reducing income generally from the Clinical Laboratories and by delaying implementation of project activities resulting in collection of lower overhead.

Discussion

The Committee was disappointed that 1996 would again show both a cash and operating deficit. However it was recognised that with unexpected curtailment of contributions, reductions in promised contributions and the political turmoil it would be almost impossible for the Centre to make cash surplus in 1996.

During discussion it was confirmed that less than budgeted expenditure on restricted activities could be carried over to the subsequent year providing it would still be spent within the agreed time scale of the project.

3. 1997 BUDGET

INCOME

Donor Contributions (Tables 2 for summary and Tables 3 and 3A for individual donor amounts) are budgeted at $12,772,000 (1996 $12,121,000) of which $3,319,000 is unconfirmed. This increase of $651,000 (5.4%) is explained by the following table.

	1997 BUDGET	1996 FORECAST	DIFF.
Restricted			
Projects/Programs	7,992,000	6,740,000	1,252,000
Fixed Assets	288,000	459,000	(171,000)
	8,280,000	7,199,000	1,081,000
Project Overhead	1,465,000	1,356,000	109,000
Total Restricted	9,745,000	8,555,000	1,190,000
Unrestricted	3,027,000	3,566,000	(539,000)
Total Contributions	$12,772,000	$12,121,000	$651,000

Restricted contributions have risen in line with expenditure and are commented on under expenditure below.

Unrestricted contributions are anticipated to drop by $539,000 which is explained by the following table.

Reduced Contributions		
Bangladesh	482,000	
Switzerland - SDC	84,000	
Sweden - SAREC	73,000	639,000
New Contribution		
France		100,000
Net Reduction		$539,000

EXPENDITURE

Operating Cash Cost (Table 2) is expected to be $12,739,000 (1996 $12,485,000). This increase of $254,000 (2.0%) comprises:

	1997 BUDGET	1996 FORECAST	DIFF.
Restricted			
Projects/Programs	7,992,000	6,740,000	1,252,000
Fixed Assets	288,000	459,000	(171,000)
Total Restricted	8,280,000	7,199,000	1,081,000
Unrestricted			
Programs	2,947,000	3,591,000	(644,000)
Management	1,516,000	1,695,000	(179,000)
Total Unrestricted	4,463,000	5,286,000	(823,000)
Total Operating Cash Cost	$12,743,000	$12,485,000	$258,000

Restricted costs will increase in line with higher expenditure mainly on European Union, Ford Foundation, SDC and USAID and the commencement of proposed new projects (e.g. European Union and USAID Washington). Management realizes that the increase of $1,252,000 in the non fixed asset component of restricted projects/programs is a high target but believes it is attainable if the new projects commence on the anticipated start dates (the trend over the last few years indicates this).

Unrestricted costs will decrease as staff are moved into new projects and cost cutting measures continue. Management costs will be reduced by $179,000 (11.8%) which, coupled with 1996 reductions will result in savings of $285,000 over the 2 years. In formulating the budget the patient load at the Dhaka hospital was based on 110,000 (1996 110,000) patients and if this number is exceeded it will increase unrestricted costs. Details of unrestricted costs by area of activity are shown in Table 4.

Depreciation is expected to be $875,000 (1996 $852,000) which is an increase of $23,000.

Total Expenditure including depreciation is budgeted at $13,618,000 (1996 $13,337,000). This is an increase of $281,000 (2.1%).

BALANCE

Net Operating Deficit is expected to be $846,000 (1996 $1,216,000) which is a decrease of $370,000 (30.4%).

Net Cash Surplus before depreciation is expected to be $29,000 compared to the forecast deficit of $364,000 for 1996.

COMMENTARY

The 1997 budget has several notable features. A fairly dramatic shift has occurred in the balance between unrestricted and restricted (project) funding, viz. from a nearly 1:1 in 1995 to a nearly 1:2 ratio in 1997. This has resulted from a simultaneous occurrence of a decrease in the level of unrestricted funds and an increase in the level of restricted funds.

These changes have forced the Centre to undertake significant measures to reduce expenditure on programs and management during 1997. Net costs will go down by 15.6% and 22.6% compared to 1995 and 1996 respectively, and will constitute reductions in personnel and other costs (including health care, administration, etc.). In non-project areas such measures are likely to reduce the quality of services and bring about dissatisfaction of staff as well as recipients of our services. While vigorous attempts are being pursued to raise revenue, it is likely that financial problems will continue to plague the Centre. Serious considerations are therefore being given to reduce or curtail activities that have to date been considered essential but remain unable to attract funds.

Discussion

The Committee recognised that the Centre had done all possible to reduce costs and was running very lean. As a deficit is not acceptable the 1997 budget had been framed to cut into or reduce programs which the Centre deemed as essential. These cuts were outlined by the Director and each of the scientific Directors.

The Committee appreciated the efforts of the staff to balance the budget but expressed concern that such drastic cuts may, as well as causing staff and Government consternation, provoke Donor dissatisfaction and urged the Centre to do whatever possible to sustain its essential services even though they may be reduced in overall activity. Concern was also expressed that such cuts may adversely affect ICDDR,B's reputation as a Centre of Excellence. It was noted that unrestricted contributions will reduce by a million dollars for the 2 years to 1997 and the magnitude of such cuts places a tremendous strain on the Centre's funding for essential programs.

Draft Resolution FIN:01

The Committee resolved to present the following draft resolution to the Board for it's approval:

The Board resolved to approve the 1997 Budget.

4. STAFF SALARIES AND ALLOWANCES

The Finance Committee met jointly with the Personnel and Selection Committee to consider any revision to the emoluments of National and International Staff.

NATIONAL STAFF

Salaries and allowances were last increased on January 1 1996 and the Centre is now paying salaries at the following percentages against UN rates:

National Officers	68.2%
General Service Staff - 5/6	68.9%
General Service Staff - 1/4	67.4%

To raise salaries to full UN rates would necessitate the following percentage increases:

National Officers	46.6%
General Service Staff - 5/6	45.1%
General Service Staff - 1/4	48.9%

and would cost the Centre $2,671,875:

	Central	Project	Total
National Officers	630,638	321,354	951,992
General Service Staff - 5/6	330,132	276,102	606,234
General Service Staff - 1/4	684,649	429,000	1,113,649
Total	$1,645,419	$1,026,456	$2,671,875

Implementation of each 1% increment would cost $56,645:

	Central	Project	Total
National Officers	13,533	6,896	20,429
General Service - 5/6	7,320	6,122	13,442
General Service - 1/4	14,001	8,773	22,774
Total	$34,854	$21,791	$56,645

The generally accepted target is for National Officers and General Service 5/6 to be at 85% of local UN rates and General Service 1/4 to be at 75%. To implement this would necessitate the following percentages raises:

National Officers	24.6%
General Service - 5/6	23.3%
General Service - 1/4	11.7%

and would cost $1,082,209

	Central	Project	Total
National Officers	332,912	169,642	502,554
General Service - 5/6	170,556	142,643	313,199
General Service - 1/4	163,812	102,644	266,456
Total	$667,280	$414,929	$1,082,209

Over the last three years salaries for National employees have been adjusted on January 1 1994, January 1 1995 and January 1 1996.

INTERNATIONAL STAFF

International staff salaries and allowances were adjusted to 95% of UN levels effective January 1 1995 which was the only adjustment after July 1 1992. Upward adjustments to UN scales since that date has resulted in the following differentials:

Salaries	9.7%	
Allowances	24.2%	
Total	15.7%	
Home Leave	100.0%	(UN leave every year, Centre every second year except for contract renewal)

For the period July 1 1992 to December 31 1996, a P/6 will, excluding lost home leave, earn $37,993 less than a comparable UN employee.

Full implementation of UN scales for salary and allowances on planned staff at December 31, 1996 would cost:

	Central	Project	Total
Salaries	35,338	56,449	91,787
Allowances	59,965	95,788	155,753
Total	$95,303	152,237	247,540

Implementation to 95% of UN scales would cost:

	Central	Project	Total
Salaries	15,027	24,284	39,311
Allowances	44,370	71,699	116,069
Total	$59,397	95,983	155,380

Discussion

This agenda item was included as part of the Personnel Selection Committee meeting.

The continuing erosion of remuneration compared to both national and international United Nations scales and its effect on retention and recruitment of staff was discussed and the reasoning behind the difference in the generally accepted percentage levels for GS1/4 and GS5 and above was explained.

As there is likely to be a cash deficit for 1996 and an insignificant cash surplus for 1997 no change to staff remuneration and allowances was recommended.

5. REPORT ON

a). ICDDR,B HOSPITAL ENDOWMENT FUND

General

The balance of the Hospital Endowment Fund at December 31, 1995 was $3,369,350. Receipts for the first nine months of 1996 were $209,268 giving a balance at September 30, 1996 of $3,578,618. No hospital expenditure has been charged to the fund since inception.

Investment of the funds of the ICDDR,B Hospital Endowment Fund was a major activity with Tk.15,668,700 (US$371,340) being invested in securities listed or to be listed on the Dhaka Stock Exchange.

Bye-laws

The Fund has been determined to be a Trust and will need to be registered as such. To comply with the Trust Act it will be necessary to amend the bye-laws. Our advisors are now looking at the bye-laws and will advise any changes required prior to trust registration.

The Board of Governors of the Fund have recognised the constraints that section 7 a) of the Funds bye-laws imposes on distribution of capital gains (net of any capital losses) and have recommended that up to 50% of the net capital gains in any one year should be available to meet the running cost of the hospital if required.

As all changes to the bye-laws must be approved by the Board of Trustees it is suggested that the following resolutions should be presented to the Board for its consideration.

Discussion

The Division Director, Finance advised that the current Trust Act was about one hundred years old and that a new Trust Act would probably come into law in 1997. The amended bye-laws would incorporate any requirements of the new Trust Act.

He also advised that realized profits on sale of shares had exceeded $112,000 and more realized profits are expected as the Fund divests itself of shares which are considered to be fully valued. The current bye-laws prevent any of these profits being available for hospital running costs and suggested a portion of such profits be available for the hospital.

Draft Resolution FIN:02

The Committee resolved to present the following draft resolution to the Board for it's approval:

The Board of Trustees authorises the ICDDR,B Hospital Endowment Fund to amend the bye-laws to the extent necessary to clarify wording and to comply with the Trust Act.

Draft Resolution FIN:03

The Committee resolved to present the following draft resolution to the Board for it's approval:

The Board of Trustees authorises the ICDDR,B Hospital Endowment Fund to add the following sentences to bye-law 7 c) reading - "However, should the Board of Governors deem it necessary, after deducting any realized capital losses and after protecting the real capital value of the Fund, up to fifty per cent of the realized capital profits in any one year may be disbursed to the ICDDR,B hospital budget. The total distributed amount shall however not exceed seven and one half percent of the capital value of the Fund at the beginning of the year under consideration. The balance of net realized capital profits will accrue to the Investment Capital Account".

Investment with Morgan Stanley

The Fund has approximately $3 million in cash which is currently invested in term deposits. The Fund considers that a more satisfactory return could be generated by investing $2 million in Morgan Stanley's Total Fund Management portfolio. As this is a major investment the Fund considers it prudent to ask the Board for its approval prior to embarking on this investment. Accordingly it is suggested that a resolution should be presented to the Board for its consideration.

Discussion

The committee commented that other items on the agenda mentioned investment with Morgan Stanley and asked if it was wise to put "all our eggs in one basket" and how strong Morgan Stanley was. As Mr. Brent Berwager from the North American office was present and was knowledgeable of Morgan Stanley and its Total Fund Management he was asked to brief the Committee. Mr. Berwager commented on Morgan Stanley, explained the operations of its Total Fund Management plan and how the plan could be geared to balance the exposure required.

It was recognised that a higher return on surplus funds may well be generated by investing in such plans but the Committee urged that the Centre should, in the future, not limit itself to one provider and should discuss with Morgan Stanley whether the management of all three of the Centre's separate investments is with one Morgan Stanley manager or would it be spread with different managers and what was the management fee difference. It was also suggested that should income performance not meet expectations other fund managers should be considered.

Draft Resolution FIN:04

The Committee resolved to present the following draft resolutions to the Board for it's approval:

The Board of Trustees authorises the ICDDR,B Hospital Endowment Fund to invest $2 million in a moderate exposure portfolio of the Morgan Stanley "Total Fund Management" program.

b). CENTRE FUND

To date the Centre Fund has raised $2.15 million which is invested in Morgan Stanley's "Total Fund Management Portfolio and being monitored by the Centre Fund Finance Committee. Other prospects have or are being approached as noted in the Director's report.

c). CENTRE FUND WASHINGTON OFFICE

At the November 1995 Board meeting it was resolved to use $221,000 as a loan from the Reserve Fund to finance the Centre Fund activities in 1996. While no funds were found for the campaign itself, around $2,150,000 has been added to the Centre Fund since inception. On the basis of this success, the Centre proposes to continue its North American based operations in 1997 with a budget of $155,000. In past years the office has been funded by using the interest on the Reserve Fund term deposits however this will only possible in 1997 to the extent of about $100,000 with the balance of $55,000 coming from the Centre's 1997 operating budget.

As no funding was found for the 1996 activities the amount of $221,000 advanced by the Reserve Fund will (subject to Board approval) be written of against that Fund in the 1996 annual accounts.

Discussion

The Committee recognised the importance of a North American base and it was suggested that, in addition to seeking monetary contributions, in kind benefits need to be pursued with used/surplus equipment form NIH being cited as an example. Members were urged to increase their efforts to raise money for the Centre and its various funds

In the long run it was suggested that the Board should consider the possibility for the cost of the campaign to be borne by the Centre's operating expenditure budget.

Draft Resolution FIN:05

The Committee resolved to present the following draft resolution to the Board for it's approval:

The Board resolved to approve that the amount of $221,000 advanced to the International Child Health Foundation to cover the 1996 costs of the Centre's North American based operations be paid for from the interest income of the Reserve Fund.

Draft Resolution FIN:06

The Committee resolved to present the following draft resolution to the Board for it's approval:

The Board directs the Centre to continue to explore avenues to find funding for the Centre Fund campaign. However, in recognition of the importance of this campaign, should no funds be found for this campaign the Board resolved that the Centre use up to a maximum of $155,000 to finance the 1997 campaign activities of which $100,000 would be allocated from the Reserve Fund interest income and the remaining $55,000 included in the 1997 operating expenditure budget of ICDDR,B.

Draft Resolution FIN:07

The Committee resolved to present the following draft resolution to the Board for it's approval:

The Board urges Management to incorporate the cost of fund raising into the Centre's operating budget from January 1 1998.

d). FIXED ASSET ACQUISITION AND REPLACEMENT FUND

Capital expenditure committed up to the end of August 1996 totalled $367,342 comprising:

Laboratory and Hospital Equipment	16,072
Hospital Building	22,955
Information Technology Upgrade	328,315
	$367,342

The balance remaining in the fund at August 31 1996 totalled $338,500 is reserved for Hospital Buildings and the Information Technology Update and comprises:

Balance January 1 1996	267,072
Contribution - ODA	438,770
	705,842
Less Committed Expenditure	367,342
Balance August 31 1996	338,500

6. OTHER BUSINESS

a). RESERVE FUND

The Reserve Fund has approximately $2 million in cash which is currently invested in term deposits. The cash deposits are the collateral for the Centre's overdraft facility with the American Express Bank (AMEX). The Centre considers that a more satisfactory return could be generated by investing $2 million in Morgan Stanley's Total Fund Management portfolio in the moderate exposure fund. Such investment would need the consent of AMEX. As this is a major change in investment policy Management considers it essential to ask the Board for its approval prior to embarking on this investment. Accordingly it is suggested that the following resolution should be presented to the Board for its consideration.

Subject to the collateral requirements of the American Express Bank being met, the Board of Trustees authorises the Centre to invest $2 million in the moderate exposure portfolio of the Morgan Stanley "Total Fund Management" program.

Discussion

This proposed investment was discussed in conjunction with a similar investment for the ICDDR,B Hospital Endowment Fund and in commented under item 5.

Draft Resolution FIN:08

The Committee resolved to present the following draft resolutions to the Board for it's approval:

Subject to the bank overdraft collateral requirements of the American Express Banking Corporation being met, the Board of Trustees authorises ICDDR,B to invest $2 million of the Reserve Fund in a moderate exposure portfolio of the Morgan Stanley "Total Fund Management" program.

b). CENTRE FUND MANAGEMENT COMMITTEE

The Centre Fund has formed a management committee named "The Endowment Management Committee of the International Centre for Diarrhoeal Research, Bangladesh". This committee will perform tasks relating to the endowment funds managed by a United States of America based asset manager. To give legal status to this committees it is recommended that bylaws be issued.

Discussion

The committee pointed out that insufficient time was given to study the by-laws but nevertheless considered that by-laws need to be in place.

Draft Resolution FIN:09

The Committee resolved to present the following draft resolutions to the Board for it's approval:

The Board of Trustees authorises the preparation and issuance of the bylaws of The Endowment Management Committee of the International Centre for Diarrhoeal Research, Bangladesh.

c). ACCEPTANCE OF GRANTS

It was pointed out that the minutes of the meeting of the Finance Committee held on June 2 1996 included a request under Resource Mobilization for a review of the Centre's existing policy on accepting grants from corporations be included in the November 1996 meeting but this was not presented. The Centre commented that this was still being worked on and a draft policy would be prepared for discussion.

The Finance Committee resolved to present the following draft resolutions to the Board for it's approval:

Draft Resolution FIN:01

The Board resolved to approve the 1997 Budget.

Draft Resolution FIN:02

The Board of Trustees authorises the ICDDR,B Hospital Endowment Fund to amend the bye-laws to the extent necessary to clarify wording and to comply with the Trust Act.

Draft Resolution FIN:03

The Board of Trustees authorises the ICDDR,B Hospital Endowment Fund to add the following sentences to bye-law 7 c) reading - "However, should the Board of Governors deem it necessary, after deducting any realized capital losses and after protecting the real capital value of the Fund, up to fifty per cent of the realized capital profits in any one year may be disbursed to the ICDDR,B hospital budget. The total distributed amount shall however not exceed seven and one half percent of the capital value of the Fund at the beginning of the year under consideration. The balance of net realized capital profits will accrue to the Investment Capital Account".

Draft Resolution FIN:04

The Board of Trustees authorises the ICDDR,B Hospital Endowment Fund to invest $2 million in the moderate exposure portfolio of the Morgan Stanley "Total Fund Management" program.

Draft Resolution FIN:05

The Board resolved to approve that the amount of $221,000 advanced to the International Child Health Foundation to cover the 1996 costs of the Centre's North American based operations be deducted from the interest income of the Reserve Fund (thus technically written off).

Draft Resolution FIN:06

The Board directs the Centre to continue to explore avenues to find funding for the Centre Fund campaign. However, in recognition of the importance of this campaign, should no funds be found for this campaign the Board resolved that the Centre use up to a maximum of $155,000 to finance the 1997 campaign activities of which $100,000 would be allocated from the Reserve Fund interest income and the remaining $55,000 included in the 1997 operating expenditure budget of ICDDR,B.

Draft Resolution FIN:07

Subject to the bank overdraft collateral requirements of the American Express Banking Corporation being met, the Board of Trustees authorises ICDDR,B to invest $2 million of the Reserve Fund in the moderate exposure portfolio of the Morgan Stanley "Total Fund Management" program.

Draft Resolution FIN:08

The Board of Trustees authorises the preparation and issuance of the bylaws of The Endowment Management Committee of the International Centre for Diarrhoeal Research, Bangladesh.

BYLAWS
OF
THE ENDOWMENT FUND MANAGEMENT COMMITTEE OF
INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

1. NAME: Fund Management Committee (Committee) of the International Center for Diarrhoeal Disease Research, Bangladesh (ICDDR,B).

2. PURPOSE: The Fund Management Committee was established by the Board of Trustees of ICDDR,B in November 1995 to perform certain tasks as specified below related to the ICDDR,B's Endowment funds managed by a U.S.-based asset manager. The Committee is a volunteer entity, which acts on behalf of and reports to the Trustees of ICDDR,B.

3. COMMITTEE MEMBERS:

01. - Classes: There shall be only one class of Committee members.

02. - Number/Composition: Although the specific number of Committee members shall be determined from time to time by ICDDR,B's Board of Trustees, the Committee shall be composed of no more than nine (9) and no less than five (5) persons, as follows:

(a) the Chair of the ICDDR,B Board of Trustees;
(b) the Director of ICDDR,B;
(c) the Chair of the Finance Committee of the ICDDR,B Board of Trustees;
(d) the Division Director of the ICDDR,B Finance Division; and
(e) one to five at-large members approved by the ICDDR,B Board of Trustees.

The at-large members shall be individuals qualified to serve by reason of experience in the areas of health and population research, finance, law, administration and endowment management.

03. - Appointment: At the Autumn meeting of ICDDR,B's Board of Trustees, the members of the Fund Management Committee to serve terms in the ensuing fiscal year will be approved by the Trustees.

04. - Term: Each Committee member shall hold a term of two (2) years or until a successor is appointed by the Board of Trustees

05. - Voting: All members have one vote.

06. - Vote by Proxy: Proxy votes are not permitted.

07. - Responsibilities:

To develop general guidelines for the investment of the Endowment funds to be managed by a U.S.-based asset manager and to submit those guidelines to the Board of Trustees for its approval;

To select a U.S.- based asset manager and to submit its choice to the Board of Trustees for its approval;

To receive and review at least on a quarterly basis, the asset manager's reports on the performance of the Endowment fund; and

To report on the performance of the Endowment fund to the ICDDR,B's Board of Trustees.

08.- Reimbursements: All reasonable expenses incurred by the Committee members in the conduct of their duties will be reimbursed by ICDDR,B. Reimbursable expenses include: travel to Committee meetings, long-distance phone calls and facsimile charges related to Committee business.

4. OFFICERS:

01. - Election: The officers shall consist of a Chairman of the Fund Management Committee and such additional officers as created from time to time by ICDDR,B's Board of Trustees.

02. - Vacancies: Any vacancy occurring in any office, for whatever reason, shall be filled by ICDDR,B's Board of Trustees and any Committee member so elected shall fill the term of his/her predecessor.

03. - Removal: An officer may be removed, without cause, as determined by ICDDR,B's Board of Trustees at any meeting where there is a quorum.

04. - Resignation: An officer may resign only by submitting a written resignation to the Chair of ICDDR,B's Board of Directors.

05. - The Officers shall have the authority and responsibility delegated by the Board and as stated in these Bylaws.

The Chairman shall: prepare the agenda for, preside at and conduct all meetings of the Fund Management Committee; cause to be delivered all notices of meetings to those persons entitled to vote as such meeting; communicate fund management performance information to the Committee members, serve as liaison with the Asset Manager; communicate the general investment recommendations of the Fund Management Committee to the Asset Manager; and normally serve as the representative of both the Committee and ICDDR,B's Board of Trustees with the Asset Manager.

Other Officers shall: perform such duties as may be specified by the Committee Member, the Board or officer given authority over them.

5. MEETINGS

01. - Regular Committee Meetings: Regular meetings of the Fund Management Committee shall be held at least twice-yearly and may be scheduled more often by the Committee Chairman or by the Chairman of the Centre's Board of Trustees. The regular meetings will be in October and April, to coincide with receipt of the Asset Manager's performance reports for the past six months.

02. - Special Meetings: Special meetings of the Committee shall be held at any time and at any place within the Washington, D.C. - New York City corridor when called by the Committee Chairman or the Centre Chairman of the Board of Trustees or by at least three (3) Committee members.

03. - Notice of Meetings: Notices of regular Committee meetings shall be in writing and delivered at least 10 days and no more that 30 days before the day of the meeting. Notices of special meetings shall state that it is a special meeting being called and may be given orally or in writing at least 24 hours prior to the meeting time. All persons entitled to vote at the meeting must receive proper notice of the meeting.

04. - Quorum: At any meeting, a majority of those persons entitled to vote being present in person or through use of conference telephone or similar communications equipment shall constitute a quorum. Voting by proxy is not permissible. A majority vote shall consist of 50 percent of those present in person or by conference telephone or similar communications equipment and entitled to vote.

05. - Participation in Meeting by Conference Telephone: Members of the Committee may participate in a meeting through use of conference telephone or similar communications equipment, so long as all members participating in such meeting can hear one another.

06. - Action without a Meeting: Any action required or permitted to be taken at a meeting of the Committee (including amendment of these Bylaws) may be taken without a meeting if all the members of the Committee consent in writing to taking the action without a meeting and to approving the specific action. Such consents shall have the same force and effect as a unanimous vote of the Committee as the case may be.

6. INDEMNIFICATION: Every member of the Committee shall be indemnified by the Corporation against all expenses and liabilities, including counsel fees, reasonably incurred or imposed upon such member in connection with any threatened, pending, or completed action, suit or proceeding to which she/he may become involved by reason of her/his being or having been a member of the Committee, or any settlement thereof, unless adjudged therein to be liable for negligence or misconduct in the performance of her/his duties. At the discretion of the ICDDR,B Board of Trustees, and subject to a finding that such indemnification would be in the best interests of ICDDR,B, members of the committee may be similarly indemnified if adjudged liable for negligence but not willful misconduct. Provided, however, that in the event of a settlement the indemnification herein shall apply only when the Board approves such settlement and reimbursement as being in the best interest of ICDDR,B. The foregoing right of indemnification shall be in addition and not exclusive of all other rights to which such member of the Committee is entitled.

7. FISCAL YEAR: The fiscal year of the Fund Management Committee will coincide with that of the International Centre for Diarrhoeal Diseases Research, Bangladesh (January 1 to December 31).

8. AMENDMENTS: These Bylaws may be amended by a major vote of the Centre's Board of Trustees provided the proposed amendment(s) has (have) been submitted to the Trustees for consideration at its regular meeting.

We, the undersigned, being Chairperson of the Board of Trustees and Director of the International Centre for Diarrhoeal Disease Research, Bangladesh, respectively, hereby certify that the above is a true, complete, and accurate copy of the Bylaws of the Endowment Fund Management Committee as adopted by the Board of Trustees on November , 1996.

Dr. Maureen Law, Chairperson

Dr. Demissie Habte, Director

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September 13, 1996

Attorney-Client Communication
Privileged and Confidential

Brent Berwager
Child Health Foundation
10630 Little Patuxent Parkway
Century Plaza, Suite 325
Columbia, MD 21044

Dear Brent:

As you requested, I have reviewed the draft bylaws for the ICDDR,B Fund Management Committee, particularly with an eye to establishing protection against potential liability for volunteers serving on this committee.

Attached to this letter is a suggested indemnification provision. I have drafted it to provide maximum protection to committee members. It requires the corporation to indemnify members against legal expenses related to their service on the committee unless they are found to have been negligent or engaged in willful misconduct, and permits the corporation to provide indemnification even when there is a finding of negligence. I must reiterate that I have no knowledge of the law of Bangladesh, which will govern whether this indemnification provision is legally binding on the corporation, and whether such payments are permitted to ICDDR,B. I therefore suggest that you ask the Center (or its board) to provide a statement that the provision is, indeed, appropriate under the laws applicable to the corporation. The bylaws should be adopted by the Center's board, and signed by an officer to verify that they were duly adopted.

As for your other liability concerns, I think the documents you have drafted do a good job of making clear the responsibilities of the committee, and establishing that ultimate responsibility lies with the Center's Board of Trustees. You indicated that the your insurance carrier would be willing to provide Directors' and Officers' insurance for the committee at a reasonable rate; I encourage you to secure such insurance coverage, both as an additional protection for the committee members and to provide some protection for the organization against large liabilities under its indemnification obligations. As we discussed, with these provisions in place I believe the committee members will be well protected against any potential liability. In general, legal principles applicable to volunteer directors of nonprofit organizations make it unlikely that a director could be found personally liable except in a

case of gross misconduct. In addition, in this particular situation, there is little worry of a third party lawsuit as the only person likely to be hurt by errors of judgment on the part of the committee is the organization itself.

I do have a few other comments on the bylaws, which I will go through in order. First, I was wondering whether it is correct to say in 3.02 that committee members serve in their individual capacity. Rather, they seem to serve by virtue of other positions held, which seems equivalent to serving in their official capacity as, for example, ICDDR,B Board Chair. Unless you have a particular reason for including the phrase, "who shall serve in their individual capacity," I would simply delete it to avoid confusion.

It would also be a good idea to provide for meetings to be held by teleconference, and for individual directors to participate by telephone if they cannot attend in person. You may also wish to permit action by unanimous written consent. This procedure can be useful for relatively minor, noncontroversial points, especially when the members are in geographically disparate locations. Sample such provisions are included in the enclosure with this letter.

On the other hand, I would advise against including a provision permitting voting by proxy. Of course, I do not know whether this is permitted under Bangladeshi law, but it generally is not in any U.S. jurisdiction, and the ICDDR,B ordinance contains no such provision. Even were it legally permissible, however, directors (or committee members) voting by proxy suggests that they have not fully carried out their responsibilities. Directors must give substantive consideration to all issues presented before assenting to action. At the very least, voting by written proxy should be limited to situations where there has been a detailed discussion or written presentation of the issues beforehand. In no event should a committee member delegate their voting authority to another person; members are responsible for the exercise of that authority, and for undertaking it in an informed manner. The inconvenience of this requirement of attendance and participation would be mitigated by adding the provisions for telephone participation and action by unanimous written consent.

Finally, the description of the committee's responsibilities should probably contain a reference to the USAID agreement, which limits their power with respect to a portion of the endowment.

Other than these few points, everything looks good. Please give me a call if any other questions come up.

Sincerely,

Elizabeth J. Kingsley

5/BT/NOV.96

RESOLUTIONS AND/OR RECOMMENDATIONS FROM THE PROGRAMME COMMITTEE

Draft
1/10/96

PROGRAMME COMMITTEE MEETING - SUNDAY 3 NOVEMBER 1996
(for Trustees and the Donor Community)

PROGRAMME

8.30 a.m. - 8.45 a.m.	Approval of Agenda
	Reports on Activities of 1996 and Plans for 1997:
8.45 a.m. - 9.00 a.m.	Overview - Director
9.00 a.m. - 9.30 a.m.	Clinical Sciences Division
9.30 a.m. - 10.00 a.m.	Laboratory Sciences Division
10.00 a.m. - 10.30 a.m.	Community Health Division
10.30 a.m. - 11.00 a.m.	Morning Tea/Coffee
11.00 a.m. - 11.30 a.m.	Health & Population Extension Division
11.30 a.m. - 12.00 noon	Training and Education Department
12.00 noon - 12.30 p.m.	Centre's Response to the June 1996 Review of the Laboratory Sciences Division
12.30 p.m. - 1.30 p.m.	Lunch (at Centre)
1.30 p.m. - 2.30 p.m.	Report on the Integrated Institutional Review - Dr. D. Sencer
	Selected Presentations on Achievements with Potential Programmatic Impact:
2.30 p.m. - 3.30 p.m.	Developing the Components of the Reproductive Health Package
3.30 p.m. - 4.00 p.m.	Afternoon Tea/Coffee
4.00 p.m. - 4.30 p.m.	Coping with Reproductive Tract and Sexually Transmitted Infections - Etiologic Spectrum and Management
4.30 p.m. - 5.00 p.m.	Matlab Reborn: Modernising Matlab to Face New Challenges

Draft
1/10/96

PROGRAMME COMMITTEE MEETING - SUNDAY 3 NOVEMBER 1996
(for Trustees and the Donor Community)

AGENDA

1. Report on activities of 1996 and plans for 1997:

   Overview

   Clinical Sciences Division

   Laboratory Sciences Division

   Community Health Division

   Health & Population Extension Division

   Training and Education Department

2. Centre's response to the June 1996 review of the Laboratory Sciences Division

3. Report on the Integrated Institutional Review

4. Selected presentations on achievements with potential programmatic impact

CENTRE
For Health and
Population Research

Developing and disseminating solutions
to major health and population problems facing the world

Director's Report

TO

THE BOARD OF TRUSTEES MEETING

2-4 NOVEMBER 1996
[Period: 1st April to 30 September 1996]

International Centre for Diarrhoeal Disease Research, Bangladesh

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1.0 OVERVIEW

The financial health of the Centre provided the major pre-occupation of the senior management during this period. Declining interest of many donor agencies in development assistance in general and in the health sector in particular is affecting the level and type of support that the Centre is receiving. The action taken by UNICEF to reduce its assistance to 30% is a case in point. Other donors have also reduced their contribution although not as severely. In addition, there is a growing trend in shifting from unrestricted to project funding.

Efforts to attract new sources of funds have continued.

The European Union remains a potential donor and we are pursuing development of the progress in the project submitted some years back.

The Centre has also been exploring areas of possible partnership with the World Bank and the Asian Development Bank whereby the Centre will undertake to become the apex of the operation research component of their health and population programme in Bangladesh.

The two endowment campaigns - the Centre Fund and the Hospital Endowment Fund - are being pursued with vigour. The dinner in Baltimore, Maryland, to launch the Centre Fund campaign, enabled the gathering of potential contributors and provided much needed publicity. The campaign for the Hospital Endowment Fund is soon to start now that the necessary preparatory steps have been completed.

The Centre's scientific staff have also redoubled efforts to secure competitive grants.

The chronic ill-health of the Centre's finances is due in part to the existence of partially or completely unfunded "essential" components of the Centre. These include the hospitals, the Matlab MCH-FP programme (including DSS), library, training activities and senior scientific and management staff. Unless the Centre's income increases, it is clear that some of the "essential" activities of the Centre may have to be sacrificed.

Financial headaches notwithstanding, the Centre's staff continued to pursue the research, training, and service functions, many of which are documented in the following pages of this report. One task that was undertaken with some speed was the setting up of an HIV testing laboratory and screening for HIV and HB of all blood used for transfusions at the Dhaka and Matlab health facilities. Unlinked, anonymous surveillance for HIV on selected population groups has also started.

An independent review of the Matlab field facility was undertaken which could well have far reaching consequences in the future. The various scientific working groups developed around themes that transcend divisional boundaries have been reactivated and are expected to maximize the Centre's research potential in the near future.

2.0 RESEARCH AND RELATED ACTIVITIES

2.1 RESEARCH OUTPUT

Table 1 shows the number of publications and ongoing research protocols for this reporting period. Appendices A-D list the relevant details.

Table 1: Research Output

Papers/Protocols	CHD	CSD	LSD	HPED	Total
Papers Published:					
1 Oct 94 - 31 Mar 95	6	8	21	4	39
1 Apr 95 - 30 Sep 95	6	14	18	3	41
1 Oct 95 - 31 Mar 96	7	19	19	2	47
1 Apr 96 - 30 Sep 96	10	11	18	5	44
Papers in Press:					
1 Oct 94 - 31 Mar 95	9	26	10	6	51
1 Apr 95 - 30 Sep 95	10	19	19	4	52
1 Oct 95 - 31 Mar 96	12	18	11	6*	47
1 Apr 96 - 30 Sep 96	5	17	12	3*	37
Total Papers Published and in Press:					
1 Oct 94 - 31 Mar 95	15	34	31	10	90
1 Apr 95 - 30 Sep 95	16	33	37	7	93
1 Oct 95 - 31 Mar 96	19	37	30	8*	94
1 Apr 96 - 30 Sep 96	15	28	30	8*	81
Research Protocols/Programmes in Progress:					
1 Oct 94 - 31 Mar 95	35	23	19	7	84
1 Apr 95 - 30 Sep 95	35	25	16	5	81
1 Oct 95 - 31 Mar 96	32	21	14	13	80
1 Apr 96 - 30 Sep 96	31	25	18	11	85

For details of these see Appendix A.

* Does not include published working papers.

2.2 CLINICAL SCIENCES DIVISION

The number of patients to visit the hospital continued at a high rate, 64,894 during the six months of the reporting period (compared to 70,648 patients during the same six months period of the previous year). Of these, 7,615 patients (mean, 1,269 per mo) required admission to one of the inpatient units (Short Stay Ward, General Ward, ICU, Research Wards) of the hospital for more intensive treatment. Data for the first eight months of 1996 enable a projection that there will be approximately ten percent fewer visits in 1996 than the previous year, although it will still be one of the busier years for the hospital. After a review of the surveillance system, the system was revised in 1996 to collect comprehensive data on a two rather than four percent subsample of all patients visiting the hospital, and to add testing of stool for ETEC, EPEC, and EAEC. The more comprehensive testing resulted in the identification of a pathogen in 78% of all patients during the reporting period, with one of the pathogenic *E. coli* isolated from nearly 50% of all patients. As in the previous year, *Vibrio cholerae* 01 has so far remained the predominant pathogen of epidemic cholera in Dhaka with comparatively very few cases of 0139. Research, training, and dissemination activities have continued at their customary level.

Achievements/New Developments

A. Research Highlights

- Zinc supplementation during acute diarrhoea in children is associated with a clinically worthwhile reduction in the rate of prolonged diarrhoea and with a modest decrease in duration of diarrhoea episodes. Other trials indicate beneficial effects of zinc supplementation during persistent diarrhoea, especially among particular subgroups of children. Supplementation of hospitalized children with acute or persistent diarrhoea reduces growth faltering and morbidity during the subsequent three months following hospitalization.

- Antimicrobial trials in cholera and shigellosis continue to result in simplified regimens as well as new treatment options. Single dose ciprofloxacin is found to be effective in the treatment of cholera. In a separate study, Azithromycin is as effective as ciprofloxacin in the treatment of shigellosis.

- The effect of inter-relationship between infection and vitamin A nutriture continues to be defined. In one study vitamin A (VA) supplementation of young infants has no effect on the incidence of diarrhoea or acute respiratory infection (ARI), however the duration (days per child-year) of ARI was significantly less in the VA than placebo group. Further, several infants remained VA deficient even after supplementation because of frequent respiratory infections, particularly those accompanied by fever. In another study, young children with shigellosis have substantial urinary loss of VA, and the loss is associated with malnutrition, fever, and abnormal renal function.

- Short chain fatty acids reduce fluid and electrolyte loss due to cholera toxin in an experimental animal model, with butyrate exhibiting the greatest effect of the SCFA's studied. SCFA's also significantly reduce the severity of inflammation of shigellosis in a rabbit model. Initial clinical studies in children with acute and persistent diarrhoea are in progress.

B. Updates on Selected Activities

Physiology Laboratory (PL)
Activities continue to be developed in the PL. The Griess reaction to measure metabolites of nitric oxide (NO) as well as assays of reactive oxidative species (ROS) including thiobarbituric acid reacting substances (TBARS), peroxynitrite, glutathione reductase, and the total radical antioxidant parameters (TRAP) have been successfully established. Animal studies and clinical trials are planned or in progress to assess the relationship of intestinal disease activity with these two central mediators of inflammation and tissue damage (oxidative stress, nitric oxide activity), and the effect of antioxidants as therapeutic strategies. The Ussing chamber method has also recently been established and will be used to study epithelial ion transport and to assess the therapeutic potential of pharmacologic agents in the pathogenesis and therapy of diarrhoea, especially shigellosis and cholera.

Nursing
Substantial progress has been made towards improvement of nursing in the CSD. The beneficial results of revision of nursing administration and of in-house nursing training activities are becoming visible in the form of improved nursing morale, patient care, infection control, among others. Training activities for nurses are ongoing.

2.3 LABORATORY SCIENCES DIVISION

Major activities of the Division revolved around studies on etiology and pathogenesis of diarrhoeal diseases as well as in the development of diagnostic tools against a few enteropathogens.

Achievements/New Developments

1. *Aeromonas* spp. organisms are putative agents of diarrhoea. They are isolated from patients with diarrhoea, apparently healthy subjects and surface water. A collection of isolates from all three sources were analyzed by hybridization groups (HGs) and biochemical phenotypes (PhP types); some selected virulence properties, such as haemolysin and cytotoxin production were also studied. The diversity by PhP typing was limited among patient isolates than among environmental isolates; moreover, human isolates produced higher amounts of cytotoxin. These data seem to suggest that there are clones of *Aeromonas* spp. pathogenic to humans.

2. Two monoclonal antibodies produced by us against the surface polysaccharide of *Vibrio cholerae* O139 Bengal have been used by the Universal Health Watch Company in Columbia, MD, USA, to produce a rapid dip-stick test. This test is currently being evaluated.

3. The two monoclonal antibody based ELISAs for amoebic parasites evaluated by us - Entamoeba test (for *Entamoeba histolytica* and *E. dispar*) and *E. histolytica* test (for *E. histolytica*) have been applied to assess the prevalence of pathogenic (*E. histolytica*) and nonpathogenic (*E. dispar*) amoebic infections in Bangladesh. In a rural area, among apparently healthy children, 7% were colonized with *E. dispar* and 1% by *E. histolytica*. At the ICDDR,B hospital in Dhaka, among children with diarrhoea, 6.5% were colonized by *E. dispar* and 4.2% by *E. histolytica*. A higher prevalence (7.5%) of *E. histolytica* infection was seen in children with diarrhoea who were older than 2 years.

4. G and P typing of rotavirus isolates from Matlab and Dhaka isolated during August 1994 to April 1996 was carried out. Most strains belonged to serotypes G4P8 and G2P4. There appears to be no differences in the distribution of serotypes between Matlab and Dhaka. Some strains with universal G and P types, i.e. G9P6, and a possible hybrid of bovine and human neonatal strain have been found.

5. The importance of calicivirus in the causation of diarrhoea in children less than 5 years of age was studied. Stool specimens from 130 children with diarrhoea and 50 apparently healthy children were studied by a specific ELISA. No child had infection with calicivirus.

6. Previous studies have shown that *V. cholerae* O1 strains remain viable for a period of up to 11 months in association with cyanobacteria. Similar results were found with *V. cholerae* O139 strains in laboratory-based microcosm studies. This may suggest that the ecology of *V. cholerae* O139 is similar to that of *V. cholerae* O1.

7. In 1993, in Dhaka and other parts of Bangladesh, the isolation rate of *V. cholerae* O139 was higher than that of *V. cholerae* O1 El Tor. Subsequently, the latter became the predominant strain. Ribotyping of *V. cholerae* strains indicate that the post-*V. cholerae* O139 epidemic *V. cholerae* O1 El Tor strains constitute a new clone compared to the pre-*V. cholerae* O139 epidemic *V. cholerae* O1 El Tor strains. This suggests that currently a new clone of El Tor vibrios has displaced *V. cholerae* O139 as the predominant strain.

8. The killed bivalent oral cholera vaccine has been found to be safe and immunogenic in adult Bangladeshi volunteers. The vaccines responded with vibriocidal antibodies and antibody secreting cells (ASCs).

The reproductive tract infections (RTIs) laboratory has been functioning in Dhaka since June of this year. A study on the prevalence of RTIs in women attending the Bangladesh Women's Health Coalition Clinic in Mirpur is under way. In addition, the Laboratory Sciences Division supports "A prevalence study of selected sexually transmitted diseases and associated risk factors in urban slum dwellers" of the Health and Population Extension Division. In both of these studies cases of gonorrhoea and syphilis have been detected.

The clinical laboratories have started screening blood for HIV for safe blood transfusion. In this connection, two laboratory personnel had been trained in HIV diagnostics at the CMC Hospital, Vellore, India.

The routine surveillance of resistance to pneumococci from isolates obtained from Shishu Hospital and ICDDR,B has continued.

2.4 HEALTH AND POPULATION EXTENSION DIVISION

In the last six months, the Division has gone through a productive period of transformation, consolidation and forward planning about the future of the Division. Aside from the research activities of the Division, a notable development includes the USAID's agreement to continue to support the operations research projects of the Division for the next seven years beyond the completion of the current agreement in July 1997.

Achievements and New Developments

- With USAID's formal decision, the Division has embarked on an intensive planning exercise in close coordination with the Government and USAID to formulate the basic parameters of the Division's operations research (OR) for the next seven years. Both of the Extension Projects' new funding proposal will be in place upon completion of the current agreement in July 1997.

- The Urban Project provided technical assistance in the development of the Asian Development Bank's (ADB) urban project. The possibility of allocating the operations research component of the ADB's urban project to the Centre was discussed and is being pursued.

- Both the Rural and Urban Extension Projects have assisted the Government and the World Bank to develop and field test the basic health and family planning service package for possible replication in the Government's 5th Health and Population Project.

- The visiting World Bank Mission was briefed about the operations research activities of the Centre with particular focus on the Rural Project's activities. Detailed discussions were held with the World Bank about the possible role of the Centre in operations research aspects of the 5th Health and Population Project.

- The Division's operations research and extension activities have gained significant interest and support of the Government and the Government's commitment in the work of the Extension Projects has been considerable as demonstrated by visits to the Project sites by the senior MOHFW officials.

- The Division has initiated a review process within the Division on a quarterly basis to ensure the scientific productivity and management efficiency of the Division.

A. Epidemic Control Preparedness Programme (ECPP)

- Between April and September 1996, the ECPP responded to the call from the Director General of Health Services, Government of Bangladesh (GoB) to provide technical assistance in the interventions and investigations of diarrhoea epidemics in Bhola, Jhalokathi, Noakhali, Laxmipur, Sylhet, Sunamganj, Maulavibazar, Hobiganj, Sirajganj, Pabna, Chapinawabganj and Rajshahi.

- Only *V cholerae* O1 biotype El Tor was isolated from all the districts except from the coastal districts of Noakhali and Jhalokathi where *V cholerae* O139 was also found. Both El Tor and O139 strains were sensitive to tetracycline.

- Results from Chhatak sentinel sites, where the ECPP has conducted cholera surveillance for a year, showed that watery diarrhoea was the most frequent (47.4%) cause of hospitalisation in Chhatak health complex. Positive isolation of *V cholerae* at the health centre co-related with the period of higher hospital admission due to watery diarrhoea.

- The health centre utilisation rate analysis in Chhatak *thana* revealed that people from only 5 unions having 35% of the total thana population, utilised the health centre facilities more frequently than the other 8 unions. The heath centre utilisation rate by the people from the 5 unions were 367/1000 persons/year compared to the over all utilisation rate of 127/1000 person/year by the thana population. This finding suggests that the present strategy of defined population based health care service delivery at rural settings which is focused on thana health complex may not be conducive to optimum utilisation of allocated health resources.

B. MCH-FP Extension Project (Urban)

Mid-term evaluations of the following interventions have been completed.

- **Basic Service Package (BSP):** Project has developed and adapted protocols for the delivery of essential health services. Management support systems for supervision, monitoring, record keeping and logistics are being introduced. A methodology has been developed and tested in two zones of DCC to assist local service providers in reorganizing health and family planning facilities to improve access to essential health services.

- **Alternative Service Delivery Strategies (ASDS):** This intervention has introduced several alternatives to the unsustainable doorstep distribution of contraceptives in urban areas. The results so far show that contraceptive prevalence rates are not affected when doorstep distribution is discontinued.

- **Planning and Coordination of Services (PCS):** This intervention established a structure of regular coordination committees for health and family planning activities at ward level with elected representatives, at zonal level with service providers and at city and inter-ministerial level with senior managers and policy makers. The committees are working well in Dhaka and already 55 municipalities outside Dhaka have reported similar activities to the Local Government Division.

- **Urban Field information System (UFI):** This intervention is intended to strengthen field operations and the use of data to improve work planning so that under-served and high risk groups receive special attention.

- Clinic Information System (CIS): This intervention introduced a card-based clinic system to enable easy identification of clients needs and ensure greater continuity and quality of care. The system reduces paper work for clinic staff and also assists managers in the identification of coverage problems and enables them to formulate local solutions. The mid-term evaluation has led to a simplification of the system.

The following interventions have been implemented:

- Quality Improvement (QI): This intervention is being tested in NGO and government clinics in Dhaka. Assessments of local quality related problems have been made by staff in the clinics involved and action plans for improvements have been formulated. Support Groups have been formed at higher management levels to support quality improvement activities at clinic level.

- **Development of Cost Management Strategies at the Unit level (CMI):** As part of this intervention, the project has developed instruments for costing services; provided training on cost analyses to CWFP managers from six units in urban areas of the country; assisted them in the analysis of unit cost information and the identification of areas for savings. Planned stages involve the design and implementation of savings strategies and monitoring the effect on cost recovery.

The following studies have been completed:

- **Factors associated with participation at NIDs in urban area:** A household survey was conducted to analyze the level of coverage of the second set of national immunization days in Dhaka and to identify communication issues affecting the involvement of slum dwellers in these events.

- **Review of prices of MCH-FP services in Zone 3:** The current trends and factors in payment for contraceptive methods were examined and their implications analyzed for developing effective pricing strategies for MCH-FP services.

- **Assessment of quality of immunization services in zone 3:** The study identified three major areas for quality improvement: 1) reducing the frequency of missed opportunities for promotion or provision of immunizations by MCH-FP providers, 2) improving the coordination and utilization of immunization services, and 3) stronger overall promotion of maternal TT immunizations.

- **Training Needs Assessments of Key DCC Staff:** Managers and health staff at zonal level were interviewed to assess experience, practices and training needs to improve their role in coordination of health activities.

- **Participation of Coordination Committee Members at Zonal Level in DCC:** A survey of members of coordination committees in all zones of Dhaka City to identify level of participation, understanding of issues involved and priorities in committee activity was undertaken as part of the PCS intervention.

- **Distribution of PHC facilities in DCC:** Information from the inventory of Urban Health Facilities was utilized to analyse the distribution of primary health care services and clinics in the subsidised sector in relation to population groups in DCC.

- **Determinants of birth weight, gestational age and perinatal mortality among the urban poor in Dhaka, Bangladesh** has been completed.

C. Environmental Health Programme (EHP)

- Developed training materials for trainers/promoters. NGO and local people participated in this development process.

- **Training Manual:** The training manual on basic environmental health issues has been designed to present the information in action terms under existing situations. The trainers of various GO and NGO agencies and/or promoters of these agencies and/or promoters of these agencies will use it.

- **Message Card:** The message cards show basic environmental health practices in pictures. This may be used by both literate and illiterate promoters.

- Asian Development Bank and Dhaka City Corporation (DCC) revised their Sanitation and Water Supply Components under Dhaka Integrated Flood Protection Project based on the Project's findings and recommendations.

- Provided technical assistance in the formation of Ward Committees for water and sanitation activities. The action plans of study ward committees have been completed. Art competitions among slum women and children on environmental health topics was organized by the ward committees. The committees also coordinated water and sanitation (WS) promotional activities through clubs and volunteers.

D. MCH-FP Extension Project (Rural)

Several activities and interventions have made progress during this six months of reporting period of the MCH-FP Rural Extension Project (Rural), under the three major areas of Quality of Care, Management Improvement, and Sustainability:

- The Needs Assessment Studies, jointly conducted by the Project and MOHFW, have enabled the district and thana level managers of the Chittagong district to identify the strengths and weaknesses of their programmes. In the Sixth District Approach Workshop held in Chittagong in August, a plan of action was developed to: 1) improve client-worker contact, and ii) increase the utilisation of fixed site service centres.

- Concerted efforts to **Strengthen Maternal and Neonatal Health: Improving Linkages** at all levels have continued to improve the quality and range of maternal and neonatal services at the thana level and below. In the reporting period, the Mirsarai Thana Health Complex has been upgraded to provide Comprehensive Emergency Obstetric Care (EOC), and the first caesarean section in rural Bangladesh was successfully performed at the Mirsarai THC in June 1996. With the approval of MOHFW in July, the Abhoynagar THC is now being upgraded to provide comprehensive EOC. Based on the initial positive outcomes of this intervention, the Government has adopted a policy of comprehensive EOC at all thanas of the country in a phased-in manner.

- Contraceptive Pricing has been introduced for field testing in two intervention areas in August and September 1996 respectively. The objective of charging for services and supplies is to increase cost recovery and sustainability of the programme, and to reduce dependence on external funding in the long run. The specific objectives are to get clients accustomed to paying user fees for MCH-FP services, to increase client use of fixed service delivery points rather than having services delivered at homes, and to increase the quality of services at the service delivery outlets.

- **Strengthening the role of FPI: an intervention to increase male involvement** in family planning has been introduced for field testing at Abhoynagar thana in September. The overall objective of this intervention is to identify how the FPI, as the front line supervisor of grass roots level family planning workers, can be used to: i) implement the supervision tools effectively; ii) organise community meetings to involve males in family planning effectively; iii) disseminate information about male family planning methods and STD preventions for men; and iv) identify key issues to design larger scale intervention.

- An intervention on varying the **Family Welfare Centre's (FWC) hours of operation** has begun at Abhoynagar in August. The objective is to facilitate FWC services to the working population and the people in the union, who are otherwise busy during morning hours when the FWC usually operates, by scheduling alternative and convenient hours for them.

- The **Basic Health Service Delivery Package** began in July in Chittagong and Jessore to address family planning, child survival, and other critical reproductive and basic health needs under the systems approach at different levels, e.g., at the community through cluster spots, Satellite Clinics combined with the EPI, and Family Welfare Centre. The Basic Service package proposes an alternative approach of service delivery, involving a constellation of services and strengthening linkages.

- Following the MOHFW's earlier acceptance of the **FWA Register** as a useful tool in improving field worker's performance, the nation-wide distribution of the third edition of FWA register has been completed.

- The implementation of **HA Register** at Abhoynagar, Mirsarai, and Sirajganj thana began in early 1996, and is still being field-tested for nation-wide implementation. A training curriculum and training materials have been developed, and training was provided to Health Assistants and thana managers in nine batches from October 1995 to February 1996. A checklist to follow-up the implementation process has also been prepared.

- Thana and Union level forums of several GO family welfare service providing agencies were formed in two thanas under the **Networking** intervention. The agencies are, Family Planning, Health, Education, Social Welfare, Agriculture, Cooperatives, and

Ansar, and Village Development Party (VDP). Their workers, as members of the Family Welfare Network Forum, hold monthly meetings at a common venue to plan Family Welfare service delivery and IEC activities. Thus far, Family Planning, Health, Agriculture, and BRDB are delivering information and services from a common place. The initial findings suggest that service providers feel encouraged by the activities undertaken collectively through the networking mechanism.

- Interventions on Supervision and Monitoring of activities have been implemented in 12 thanas of Chittagong district, where the Project provides technical assistance.

- The Local Level Planning intervention to improve the performance review process is continuing at Abhoynagar and Mirsarai. The evaluation is expected to be completed in November 1996.

- The following interventions have been scaled up in five thanas:

  a. Monitoring tools for front line health and family planning supervisors, namely, the FPI and AHI. Also, the FPI and AHI diaries have been introduced to enhance supervision of grassroots health and family planning workers.

  b. Satellite Clinics combined with EPI Spots are being replicated.

2.5 COMMUNITY HEALTH DIVISION

The Division has continued with a critical self-appraisal while maintaining implementation of its research programmes, clinical services and training activities. The most significant achievement of this period has been the review conducted on "Matlab" by Dr. David Ross. This is likely to have a long lasting imprint on the Centre. The review concluded with the following:

> "The Matlab field research station has been one of the most productive field research centres which has ever been established in a developing country, especially within the field of large scale trials of the efficacy of population-based health interventions. However, many of the systems currently in use at Matlab are now old. They urgently need to be modernized if Matlab is to remain a centre of excellence for population-based epidemiological and demographic studies over the next decade, let alone maintain the pre-eminent international status it has had in the past. Achieving this should be one of the top priorities of ICDDR,B over the next 3 years."

Achievements/New Developments

A. Matlab MCH-FP Programme

The Reproductive Tract Infections study entered its last phase. Preliminary results indicate the following:

(a) aetiologic: there are moderate levels of Reproductive Tract Infections which cause symptoms that can be difficult to distinguish from Sexually Transmitted Infections. There are low to moderate levels of most bacterial, viral and protozoal STIs in the population-based samples. A moderate level of syphilis in all population groups was found, most importantly in pregnant women. There is a moderate incidence of ophthalmia neonatorum.

(b) syndromic management: The assessment of the validity of syndromic management flow charts indicate that these are sensitive and specific for the management of certain syndromes, namely genital ulcer disease, inguinal buboes and urethra discharge in men. In females the most common presenting syndrome (vaginal discharge) has the lowest predictive value. Risk screening is of little value in this population. The usefulness of the flow charts can be potentially improved if staff are trained in clinical skills alongside theoretical training, posing a limitation for its widespread use.

A follow-up study of a historical cohort of women in Matlab to examine nutritional status, fertility and mortality has been completed. The study intends to examine changes in nutritional status, socio-economic status and demographic indicators in a cohort of women seen during 1975-78.

Geographic Information System Laboratory: The following activities have taken place:

1. The GIS files were updated in the field with accurate information on the presence and type of tubewells and latrines. Another file was created with all health care providers working in Matlab (N=1500).

2. Analysis was started on the data on hospitalised patients in the Dhaka Treatment Centre (DTC). A geographic file of Dhaka city was updated with 200 landmarks that allows linking the patients to their residential area.

B. Social and Behavioural Sciences Programme

The Head of the SBS Programme, Dr. Jim Ross, left ICDDR,B in June 1996 and Professor Vaughan has taken charge of the programme for the interim period.

Dr. Margaret E. Bentley, Dept of International Health, Johns Hopkins University was invited to review the programme during May 26-June 4. She recommended that although the SBS Programme is based within CHD, which is appropriate given their research and population-based focus, there is a need for reaching out to other divisions of the Centre. Accordingly arrangements have been made for each of the 7 research officers at SBS to be assigned to different collaborative studies.

Professor Pertti Pelto, an international reputed anthropologist, was invited for two week consultancy and he visited the Centre during 3-22 August, 1996, and Professor Nurul Alam, Anthropologist, Jahangir Nagar University, has been hired as a part time consultant for 6 months from July 1996.

To further strengthen the SBS programme, a Ford Foundation grant to the London School of Hygiene and Tropical Medicine will be used to train 3 national research officers at the London School of Health and Tropical Medicine for one year. (They left on 23rd September 1996.)

(a) BRAC-ICDDR,B joint research project in Matlab: Impact of socio-economic development interventions on human well-being

A number of working papers based on small scale qualitative studies have been published. Data collected during the quarterly surveys are being analyzed.

(b) Self-help for Health: Chakoria Community Health Project

Report of the baseline survey has been published. A small scale qualitative study on reproductive health problems has been conducted.

C. Health and Demographic Surveillance Programme

Demographic Surveillance System

The DSS 1993 Annual Report has been published and the 1994 Annual Report made ready for publication. The DSS Matlab Early Indicator for 1995 has been published.

The 1993 Census Report has been finalized. All the necessary preparations such as finalization of the questionnaire (after field testing), budget preparation, work plan, recruitment of interviewers have been completed for 1996 Census and Socioeconomic Survey in the Matlab DSS area.

Population Studies Centre

The Population Studies Centre (PSC) is the nucleus of population studies of ICDDR,B. The following studies were completed during this reporting period.

Is son preference for children an obstacle to fertility transition in Bangladesh?

The study reveals that gender preference had effects on contraceptive use, abortion and fertility in each area during this period. But what would happen if there were no gender preference? It is estimated that there would be no more than an 8% increase in contraceptive prevalence rate (CPR), but fertility might decline by more than 12% in the complete absence of gender preference.

Levels, Trends and Determinants of Child Mortality in Matlab, Bangladesh, 1966-94

Mother's education, birth interval, birth order, mother's age and sex of children have been significant determinants of under-5 mortality all through, although the importance of some of these variables changed with the passage of time. Matlab MCH-FP programme was highly successful in reducing infant and child mortality in the area. However, except for tetanus in infancy and measles for 1-4 year age group, the proportion of deaths due to other causes did not have any substantial decline during the study period. Matlab results differ in several ways from the national results obtained from national surveys data collected retrospectively.

Fertility and Its Proximate Determinants in Bangladesh: Evidence from DHS 1993-94

The study suggests that the increase in the use of contraception is the main factor for fertility decline in this country.

Reproductive Preferences and Subsequent Fertility in the Treatment and Comparison Areas of Matlab, Bangladesh

Age Pattern of Siblings' Mortality in Bangladesh

D. Child Health Programme

- ### Epidemiology of Diarrhoea and ARI in a Cohort of Newborn in Rural Bangladesh

The study on epidemiology of diarrhoea and acute respiratory infection in a cohort of new born children is nearing completion. Birth weight was recorded from 280 children of which 72% were recorded within 48 hours of delivery. About 42% children had birth weight less than 2500 gm. Colostrum was given to 29.2% of the newborn babies. Breast-feeding was continued to more than 88% of the children up to 18 months of age. Incidence of ALRI was 0.35 per child per year. Sixty-seven percent of pneumonia occurred during first six months

of life. Infant death rate was 86.8 per 1000. Of all deaths among the infants 64% died during first 28 days of life. Birth asphyxia was the major cause of death in this neonatal period.

E. Health Economics Programme

Analysis of the data is continuing on health care use patterns of slum and non slum residents in Dhaka. Simultaneously the write-up of papers and reports is ongoing. A paper " Health care seeking and spending in the urban slums of Dhaka" was presented at the dissemination seminar " Health care reform: user-provider-policy maker dialogue: a regional perspective.

3.0 TRAINING AND EDUCATION DEPARTMENT

3.1 Table 2 shows a listing of the many activities of the Training and Education Department made up primarily of short courses and of long term fellowship programmes. The quality of the training programme has steadily improved over the last few years. Participants came from thirteen developing countries.

3.2 STAFF DEVELOPMENT

Eighteen staff members returned after completion of training of which one received a Ph.D. and another a Masters degree. Twenty-four left for training during this period. Staff continued to participate in international conferences as well as the in-house academic activities.

Detailed information is included in the appendices.

4.0 HEALTH CARE SERVICES

The Centre has continued to provide health care services through the Dhaka "cholera" hospital, the Matlab hospital, the Matlab clinic sub-centres together with the doorstep health service by community health workers (Tables 3-5).

A persistent trend continued of the steady increase in the number of patients seen in the Dhaka hospital, and of a larger percentage of patients from outside the DSS areas attending the Matlab health facilities.

Table 2: ICDDR,B Training Activities during 01 April to 30 September 1996

Particulars of activities/courses/programmes	Numbers	
	Courses	Participants
1. Health Research Training Programme:		
1.1 Health Research Training Fellowship*		01
1.2 Introductory course on Epidemiology and Biostatistics	2	34
1.3 Post-graduate Students (M.Sc.-12, M.Phil -1 & Ph.D-1)		14*
2. Clinical Fellowship Programme***		
2.1 Clinical Fellows 13*		
2.3 Nursing Fellows 10		
2.4 Research Trainees 07		30
3. Short International Training Courses		
3.1 Workshop on Emergency Response to Cholera and Shigella Epidemics	1	10
3.2 Laboratory Diagnosis of Common Diarrhoeal Disease Agents	1	11
3.3 Clinical Management of Diarrhoeal Diseases	1	12
3.4.Clinical Management of Diarrhoeal Disease for WHO fellows	1	06
4. Training for Instructors's Course	1	10
5. Others		
5.1. Students from Dhaka University Library Sciences Department		08
5.2. Orientation Training		155
5.3. Seminars:		
- Weekly Seminars - 04		
- Inter-divisional Scientific Meeting - 22		
- Clinical Seminars - 10		
Total	7	291

NOTE:

* New recruitment during the period:

1.1. - none
1.2. - 3
1.3. - 1

Home countries of participants:

a) Asia : Bangladesh, Cambodia, Indonesia, Iran, Maldives, Pakiistan and Vietnam.
b) Africa : Angola, Ethiopia, Ghana, Kenya, Sudan and Tanzania.
c) Australia: Australia
d) Europe : None
e) North America: U.S.A. and Canada

Table 3: Patients Attendance

Clinical Research and Service Centre, Dhaka

Month	Nos. of Total patient visits (a+b+c)	Nos. of patient in ORT (a)	Nos. of Patient treated in											
			Short Stay Ward				General Ward+ICU+Research Ward							
			Duration of stay				Duration of stay				Stay in SSW before admission into GW+ICU+RW			
			Total (b)	<12 hrs.	12-24 hrs.	≥ 24 hrs.	Total (c)	<1 day	1-7 days	≥ 7 days	Total	<1 day	1-7 days	≥ 7 days
April '96	12,111	5,526	5,800	2,895	1,334	1,571	785	16	625	144	474	215	245	14
May '96	11,908	4,988	6,213	2,975	1,586	1,652	707	11	538	158	533	297	225	11
June '96	9,510	3,860	4,992	2,648	1,018	1,326	658	10	504	144	483	242	228	13
July ,96	9,500	4,152	4,782	1,960	1,334	1,488	566	8	441	117	410	203	194	13
August '96	10,392	3,600	6,151	2,819	1,646	1,686	641	6	494	141	476	241	223	12
September '96	11,473	3,862	7,010	3,370	1,791	1,849	601	14	463	124	414	188	204	22
Total	64,894													
Mean	10,816													

ORT = Oral Rehydration Triage.
SSW = Short Stay Ward.
ICU = Intensive Care Unit.
RW = Research Ward.

Table 4: Patients Attendance: Matlab Diarrhoea Treatment Centre

Number of patients visit with duration of stay at Matlab Diarrhoea Treatment Centre, April 1996 to September 1996

Month	< 1 Day	1 Day	2-6 Days	≥7 Days	Total
April	462	382	349	38	1231
May	407	347	360	24	1138
June	243	283	307	15	848
July	257	211	259	8	735
August	211	198	217	14	640
Sept	282	266	241	9	798
Total	**1862**	**1687**	**1733**	**108**	**5390**

Table 5: Patients Attendance: Matlab MCH-FP service

Month	1	2	3	4
April	2776	14	60	11
May	2970	6	44	19
June	2576	12	62	16
July	2701	14	88	21
August	2985	21	107	17
September	3203	4	79	26
Total	**17211**	71	440	110

1 = Outpatients MCH-FP subcentres and OPD Matlab Clinic
2 = Inpatient overnight
3 = Inpatient 2-7 days
4 = Inpatient over one week

5.0 TECHNICAL SERVICES

5.1 COMPUTER INFORMATION SERVICE

The Asian Institute of Technology (AIT), Bangkok, as Project Manager, is working to replace the aged Mainframe System to fulfil the target of Phase I of Information Technology (IT) Strategy of the Centre.

CIS's present e-mail system has been found as one of the cheapest and fastest communication facilities at the Centre. To reduce the cost of e-mail more, to increase the frequency of mail transactions and to derive a maximum performance from the system, it has been decided to move the routing station of e-mail system from AIT Bangkok to a local Internet Service Provider in Dhaka in October 1996.

5.2 DISSEMINATION AND INFORMATION SERVICES CENTRE (DISC)

During the reporting period DISC performed the following activities:

a. **Publications:** Two issues of **Glimpse**, two issues of **Shasthya Sanglap**, three issues of the bilingual **ICDDR,B News**, two issues of the **Journal of Diarrhoeal Diseases Research**, and the **1995 Annual Report** have been published and distributed.

   The format and design of Glimpse has been changed to make it more appealing to its users. Beginning the March-April 1996 issue, Dr. Aye Aye Thwin replaced Mr. N. Paljor as the Editor-in-Chief. The frequency of the newsletter has been changed from 6 issues to 4 issues a year, and the total page number per issue has increased from 8 to 12. The frequency of Shasthya Sanglap has also been changed to 3 issues a year.

   Five special publications (1) Programme Response of the Social and Behavioral Sciences to the ICPD-POA by J.L. Ross et al., (2) Training Manual on Domestic Water Use, Sanitation and Hygiene Education (a multi-coloured production in Bangla by EHP), (3) Health, Gender, Sexuality: Bangladesh Country Report by J.L. Ross, et al., (4) Teaching Health Social Science: Bangladesh Case Study by S.M. Nurul Alam, (5) Health Knowledge and Behaviour in Five Unions of Chakaria, have been published.

   The Proceedings of the Donors' Support Group Meeting has been mimeographed and bound with a printed cover.

b. **Library:** More than 450 of the Centre's staff members and 7,500 outside researchers, physicians, and students from universities, medical institutions, and other organizations, used the library facilities.

c. **Database and bibliographic service:** The library maintained the Medline, Popline, AIDS Compact Library databases on CD-ROMs, and the Current Contents: Life Sciences on diskettes.

Twelve issues of the **DISC Bulletin** were produced during the reporting period. Information on 1231 relevant articles, documents, books, and monographs were disseminated through the Bulletin.

d. **National collaboration:** Under the collaborative activities with the national institutions, the library continued to donate duplicate issues of journals to different libraries of the country. The library organized a one-month training programme for 6 students of the 3rd year BA Honours Course, Department of Library and Information Science, University of Dhaka. Besides, two MA-passed students of the same department undertook a 3-month practical training at DISC.

e. The head of DISC attended the Asian Health, Environmental and Allied Databases Board of Director's meeting held in Penang, Malaysia, on 19-22 July 1996. He also visited IDRC, Singapore, from 23-25 July 1996 to set up Web pages for the Centre under the IDRC's Pan Pacific Networking Programme. IDRC has been assisting in setting up these Web pages. Several files have been created to disseminate relevant information on and about the Centre and its research and fund-raising activities, including the strategic plan. Users can now access the ICDDR,B website by clicking http://www.icddrb.org.sg.

5.3 AUDIO-VISUAL UNIT

The unit continued to assist staff of different divisions with relevant support. Layout, illustrations and photographs were provided for publication of Glimpse, ICDDR,B News, and Partnership in Progress.

Photo albums and commendation plaques were prepared for departing heads of donor agencies.

5.4 BIO-ENGINEERING CELL

The Bio-Engineering Cell installed twelve pieces of new equipment in the LSD laboratory and other areas during the said period.

One of the bio-medical engineering staff participated in a training programme by the National Electromedical Equipment Maintenance Workshop and Training Centre, Dhaka, as a guest lecturer during July 1996.

6.0 ADMINISTRATION AND PERSONNEL

6.1 PERSONNEL OFFICE

The Centre's staffing status as at September 30, 1996, is detailed below and shows a net addition of 15 staff members:

Additions		Separations	
NO & GS		NO & GS	
a. Conversion from contractual service agreement	15	a. Retirement/abolition of post/released/death	7
b. New appointments	19	b. Resignations	6
		c. Separation by mutual agreement	6
International Professional			
a. Converted to fixed term	1	a. Resignation	1
Total	35		20

Net additions: 15

Dr. A.K.M. Siddique (Bangladesh), a former National Officer category staff member has been offered an International Professional Fixed-Term position as Epidemiologist in his capacity as co-investigator of the NIH grant entitled "Epidemiology and Ecology of V. cholerae in Bangladesh", (from 1 July 1996, for a period of 3 years).

Dr. James L. Ross, Senior Scientist in the Social & Behavioural Sciences Programme, left the Centre on 10 June 1996.

STAFF CLINIC

A total of 8,415 patients attended the Staff Clinic during this period. Continuing with the Health Education Programme, 4 seminars were organized by the Staff Clinic for staff members and their dependents.

6.2 ENGINEERING AND MAINTENANCE OFFICE

6.2.1 Construction and maintenance: The following constructions were completed during the reporting period:

- Around 700 rft of boundary wall with barbed wire.
- A new gatehouse (nearly completed).
- New drop ceiling for the OPD pavilion of the hospital.
- New carparking area.
- Part of the second floor of the hospital building is under construction for additional space for CSD.

6.2.2 General Services Branch: The General Services Branch continued to provide services for the safety and security, cleaning, mail, and conference management of the Centre.

6.2.3 Transport Office: During the period this office has maintained smooth operations on land and water.

6.3 ADMINISTRATION

6.3.1 Travel Office: During the period the Travel Office provided travel assistance to staff members, consultants, visitors and trainees, conference and workshop participants. In addition, the Travel Office maintained and supervised the guest house of the Centre.

6.3.2 Estate Office: During this period, 12 new digital telephone connections were obtained from T&T.

6.4 PROCUREMENT BRANCH

The branch continued to procure scientific and other materials for the Centre through local and overseas purchase. This resulted in timely procurement and placement of orders worth US$1.21 million.

7.0 FINANCE

Investment of the funds of the ICDDR,B Hospital Endowment Fund was a major activity with Tk.15,668,700 (US$371,340) being invested in securities listed or to be listed on the Dhaka Stock Exchange. Realized profits of Tk.830,500 US$19,682) were made on investments costing Tk.437;500 (US$10,369) which is a return of 189.8%. Unrealized profits stand at Tk.7,415,082 (US$175,734) for a return of 65.9%. Purchased securities in yet to be listed companies total Tk.12,000,000 (US$284,394) which, on listing, are expected to result in significant profits.

Disallowances in the USAID final report on the 1994 audit of the cooperative agreements totalled $246,076. We challenged all items but were required to repay $421.

The implementation of the Information Technology strategy by computer Information Services (CIS) is proceeding slowly pending resolution of certain issues with ODA. It is most likely that the target date of March 31, 1997, for the new IBM AS/400 and UNIX platforms and the decommissioning of the IBM 4361 will not be met and June 1997 is a more likely date.

The Ford Foundation, which is closing its office in Bangladesh during the second half of 1997, has signed an agreement with the Centre to transfer all of its movable fixed assets to us for free. The value of these assets exceeds $170,000 and will be used within the Centre or sold off.

8.0 EXTERNAL RELATIONS AND INSTITUTIONAL DEVELOPMENT OFFICE

The External Relations and Institutional Development (ER&ID) Office continued to implement the planned activities for 1996:

8.1 DHAKA OFFICE

Preparation of Project Proposals

The office continued to push the on-going "process" to develop the "Bangladesh Health Action Research Project" with the **European Union**. Progress has been slow, and the Centre awaits a "finalization mission". With the assistance of Dr. Khoja, additional effort was given to liaising with and responding to the needs of the **Arab Gulf Fund** and **UNDP** to try to overcome the backlog of proposals pending in Riyadh.

ER&ID also continued to coordinate the negotiation and revisions to the **SIDA/SAREC** proposal, and prepared proposals for **the Nippon Foundation** and **KOICA**.

Finally, more expert volunteers are being identified and recruited in collaboration with British Executive Services Overseas (BESO). The second expert, Ms Gillian Duffy, has arrived to help the Centre with the preparation of "Scientific Achievements 1979-95" and the strengthening of the publications section of DISC.

Visiting Key Donors

The ERID Associate Director joined the Director in trips to visit and discuss the Centre and new proposals with KOICA, Government of Japan, the Nippon Foundation, USAID/Washington, ODA and others. These visits were then followed up with proposals for work on hospital supplies, emerging and re-emerging infectious diseases and the Japan Matlab Family Planning Training Centre.

Planning for the Future

The office completed its plans for 1997/98 and the transition process with the departure of the Associate Director, External Relations and Institutional Development. Finally, substantial progress has been made towards finalizing the establishment of the UK-based Charitable Trust, and this process is expected to be completed by the end of 1996.

Hospital Endowment Fund Campaign

The Council of Investment Advisors received legal opinion that the Hospital Endowment Fund is a Trust Fund that can invest in shares and debentures. Furthermore, it has been deemed to be both a foreign and local investor, which has given it great opportunities to subscribe to initial public offerings prior to their coming onto the open market. To date, the fund's investments have made a gain of 41% over cost.

The External Relations Committee produced a colourful brochure and an appeal poster which have been extensively distributed. The Committee has also spearheaded a media blitz and accordingly all the leading national dailies, radio, and television were routinely fed with news on the endowment campaign. The Committee produced information packs for visitors and had put together special folders to introduce the campaign to potential members of the Council of Goodwill Ambassadors. It also worked with the American International School, Dhaka (AIS/D) to organize a concert to raise funds. A total of Tk.62,500 was raised from that concert and the entire sale proceeds from the tickets went to the endowment fund. The Committee is also liaising with Beximco Pharma's Multimedia Division to produce a video to be shown on television to promote the hospital's successes. Currently, work is under way to finalize the script, the footage, and leading personalities to volunteer as the Centre's spokespersons. Beximco would finance the costs of the video production. The Committee is also at work to erect "Honour Boards" to recognize large contributions to the campaign. These Honour Boards would record the contributions made by donors (individuals or corporations) in several categories.

The Events Committee is organizing the Annual Dinner Dance on 21 November at the Sheraton Hotel. This annual event is a way of involving individuals and corporations in the campaign and so that they can then be approached to provide larger contributions.

Communication

The ERID Office has been closely involved in the production of the 1995 Annual Report, and has recently completed the preparation and printing of the new edition of "Partnership in Progress - The Centre's Collaboration and Cooperation with the Government of Bangladesh".

Institutional Development

ER&ID took a lead role in coordinating the initial organization and implementation of the Board of Trustees' decision on HIV/AIDS work at the Centre, including the re-programming of the Ford Foundation HIV grant.

ER&ID has also been active in the coordination of the development of the Biennial Workplan.

8.2 NORTH AMERICAN OFFICE

The Centre's U.S. office has been successful in obtaining leadership level gifts from USAID, and the Ford Foundation. It has also established the endowment by selecting a fund manager and developed procedures for the management of the Centre's endowment funds. We've also been working on a number of other fronts, including cultivation of other foundations, corporations and individuals, building linkages with U.S. institutions, and identifying and soliciting donors for project support. In the past six months, we have achieved the following:

USAID

Following nearly a year of negotiations between the Centre and USAID, the endowment agreement was signed in April 1996. The $1 million endowment gift was transferred to the Centre's account at Morgan Stanley, the investment manager chosen by the Centre Fund Management Committee earlier this year. Quarterly statements are being sent to USAID for their review.

The Centre Tribute Dinner

To celebrate USAID's endowment gift, as well as the accomplishments of the Centre, a dinner in honor of the Centre was organized in conjunction with USAID's Lessons Without Borders Conference (LWOB) in Baltimore. LWOB celebrates achievements in foreign assistance programmes and applies lessons learned to programmes in the U.S. As an example of one such successful foreign aid programme, the Centre was honored for its contributions to global health. The U.S. office solicited Discovery Communications Inc. to underwrite the dinner. The dinner was attended by about 150 people from an array of fields, including philanthropy, public health and various governments. Speakers for the evening were Brian Atwood (USAID Administrator), Al Sommer (Dean of Johns Hopkins School of Hygiene and Public Health), Barry Gaberman (Senior Vice President of Ford), Mayor Kurt Schmoke of Baltimore City, Dr. Demissie Habte, as well as a video presentation by Mrs. Hillary Clinton. The evening was a great success and helped to increase the profile of the Centre. USAID has expressed interest in possibly hosting a similar event next year. Planning the tribute absorbed the majority of the U.S. office's time from June through mid-September.

FORD FOUNDATION

Following months of discussions with Ford, the U.S. Office submitted a proposal for $1 million for the Centre endowment in March. It was subsequently approved by the Ford Board in April. The gift has been transferred to the Centre's account at Morgan Stanley and is being invested in the same manner as the AID money. A decision on a second $1 million ("wasting grant") for the Behavioral & Social Sciences, which can be counted towards the endowment, has been deferred until later.

THE ROCKEFELLER FOUNDATION

The $150,000 gift for the endowment has also been transferred to the endowment account at Morgan Stanley and is being similarly invested.

OTHER FOUNDATIONS

Mellon: In June, the U.S. office arranged for Dr. Habte and Brent Berwager to meet with Carolyn Makinson, head of Mellon's Population Programmes. This was Mellon's first introduction to the Centre. There may be some funding opportunity for the Centre to host an international review of Demographic Surveillance Systems around the world. Further follow-up is planned.

Carnegie: The U.S. office opened a door at Carnegie. Dr. Patricia Rosenfield, head of Strengthening Human Resources in Developing Countries, indicated an interest in programmes that teach people in Africa about turning research into policy. Further follow-up is planned.

CORPORATE PROSPECTS

We have been cultivating corporations, particularly those with a major presence in Asia. Since most do not have a relationship with the Centre, thus possibly precluding a gift for the endowment at this early stage, we are working to initially appeal to them with smaller projects.

Discovery Communications, Inc.: The CEO of Discovery, John Hendricks, has taken a keen interest in the Centre. Discovery is an international cable network based in Maryland. Earlier in the year, US office representatives had met with Hendricks as well as the head of the Asia office and they were interested in doing a documentary on the Centre with a focus on emerging & re-emerging infectious diseases. However, more immediately, they were interested in funding the Lessons Without Borders dinner in honor of the Centre. It is hoped that John Hendricks will visit the Centre in the near future and to play a role in the campaign, as Discovery's involvement will be helpful in attracting other corporate donors.

Merck: The U.S. office has discussed possible funding opportunities for Merck with Gordon Douglas, President of Merck Vaccines. They may be interested in supporting a fellowship programme.

Levi Strauss: The U.S. office has been in contact with the Community Affairs Manager for Asia, Ms. Toni Costantino, regarding possible support for projects. The US office submitted

a concept paper written by George Fuchs, "Enhancing Iron Status of Women Garment Workers." We will be following up on this.

Chase Manhattan: The US office submitted a proposal for the Child Health Programme to Chase for $75,000 over a 3 year period. Unfortunately they will not be able to fund the programme as they are not yet involved in community projects in Bangladesh.

OTHER ACTIVITIES

Fund Management Committee: The Committee, which was formed earlier in the year, consists of: Dr. William Greenough, Dr. Demissie Habte, Dr. Maureen Law, Dr. Jon Rohde, Ken Tipping, Robert Smith, Norman D'Cruz (formerly with AmEx Bank) and Robert Stoll (AmEx Bank). The Committee unanimously voted to use the services of Morgan Stanley. As the US office are in the initial stages of the endowment investment, they are keeping an especially close eye on the way the monies are being invested, making sure USAID and the Committee chair, Dr. Greenough, are fully updated on its performance. Furthermore, By-laws for the fund management committee have been drafted by the US office and a U.S. law firm in D.C. for approval by the Board in November.

National Institutes of Health: The office has also developed good relations with a number of key staff at NIH including Dr. Ruth Kirschstein, Deputy Director of NIH, and other staff at the Fogarty International Center. They are interested in research opportunities at the Centre. The US office think Dr. Harold Varmus will be interested in visiting the Centre and hope to invite him along with others.

Japan/Korea Trip: The U.S. office also assisted in developing opportunities for Dr. Habte's and Graham Wright's trip to Japan and Korea. They consulted with Peter Geithner and Junko Chano at Ford to connect the Centre with some of their contacts in Japan.

Visits by Centre Staff: In addition to organizing visits by Dr. Habte and Graham Wright, the US office also assisted in planning itineraries for other Centre visitors, including Shamim Ahsan and Ishtiaque Zaman. They arranged for Mr. Ahsan to be on the panel for a conference sponsored by the Carter Center on future roles for the Carter Center in population. Through this conference, Mr. Ahsan met a number of key population people including Steve Sinding, Peggy Curlin (CEDPA) and Malcolm Potts (Berkeley). The US office also arranged for him to have a working session with Sharon Camp (consultant and population specialist) to develop strategies for cultivating foundations in population.

The US office also arranged for Ishtiaque Zaman to attend a workshop sponsored by the Council for the Advancement and Support of Education (CASE) on fundraising to assist him in leading the hospital endowment campaign. They also arranged for him to meet with development staff from a number of local institutions, including a local hospital and the University of Maryland.

Presentation Pieces: The US office developed some published materials to be used to introduce the Centre to prospective donors. The pieces (a brief brochure and a more detailed spiral bound booklet) give a brief overview of the Centre's history and accomplishments.

8.3 COMMITTEES COORDINATION OFFICE

The Committees Coordination Officer continued to run the Centre's mandatory committees:

Research Review Committee (RRC)

During the reporting period, the RRC met 6 (six) times and considered 15 (fifteen) research proposals, including two umbrella projects. The Committee approved twelve research proposals, one proposal was disapproved.

Ethical Review Committee (ERC)

During this period, the ERC met 7 (seven) times and considered 15 (fifteen) protocols, including one PCC-collaborative protocol. The Committee gave ethical clearance to thirteen research proposals, and consideration of two proposals are pending.

Programme Coordination Committee (PCC)

During the period under report, a joint meeting of the Standing Committee of PCC and the BOT, was held on 2nd June, 1996 which noted the various ongoing collaborative activities with the national institutions, in the fields of training, research and other areas.

As a follow up of PCC recommendations, the Centre has organized thirteen courses on "Epidemiological methods in public health" since August 1991. Recently, the course has been renamed as "Introductory Course on Epidemiology and Biostatiscs". These courses were attended by 229 Bangladeshi professionals from the Government and Non-governmental organizations.

Currently, three PCC protocols are in progress:

a) "Purification and characterization of anti-shigella active principles from herbs (E. hirta)". PI: Prof. Kamaluddin Ahmad, Bangladesh Institute of Herbal Medicine, Dhaka.

b) "Interrelationship between anthropometric indices, morbidity, Vitamin A and iron status in adolescent girls". PI: Dr. Faruk Ahmed, Associate Professor, Institute of Nutrition & Food Science, Dhaka University.

c) "Impact of zinc and Vitamin A supplementation in malnourished children with persistent diarrhoea". PI: Dr. Farida Khatun, Associate Professor of Child Health, Dhaka Medical College Hospital.

Appendix A

CLINICAL SCIENCES DIVISION
PUBLICATIONS 1 APRIL - 30 SEPTEMBER 1996

Papers Published:

1. Faruque ASG, Mahalanabis D, Hamadani JD, Zetterstrom R. Reduced Osmolarity Oral Rehydration Salt in Cholera. Scand J Infect Dis 1996, 28:87-90.

2. Faruque ASG, Fuchs GJ, Albert MJ. Changing epidemiology of cholera due to Vibrio cholerae 01 and 0139 Bengal in Dhaka, Bangladesh. Epidemiol Infect 1996;116(3):275-278.

3. Haider R, Islam A, Kabir I, Habte D. Early complementary feeding is associated with low nutritional status of young infants recovering from diarrhoea. J Trop Pediatrics 1996;42-170-72.

4. Haider R, Islam A, Hamadani J, Amin NJ, Malek MA, Mahalanabis D, Habte D. Breast-feeding counselling in a diarrhoeal disease hospital. Bulletin of the World Health Organization, 1996, 74(2):173-179.

5. Khan AM, Rabbani GH, Fuchs GJ. Feucal leucocytes in cholera due to Vibrio Cholerae 0139 Bengal J Diar Dis Res 1996 14(1):46-47.

6. Khan WA, Bennish ML, Seas Carlos, Khan EH, Ronan A, Dhar U, Busch W, Salam MA. Randomised controlled comparison of single-dose ciprofloxacin and doxycycline for cholera caused by Vibrio cholerae 01 or 0139. Lancet 1996;348:296-300.

7. Mahalanabis D, Faruque ASG, Islam A, Hoque SS. Maternal education and family income as determinants of severe disease following acute diarrhoea in children: a case control study. J Biosoc Sci, 1996;28:129-139.

8. Majumder RN, Kabir I, Rahman MM, Khatun M, Mahalanabis D. Absorption of macronutrients from a calorie dense diet in malnourished children during acute shigellosis. J Pediatric Gastroenterol Nutr 1996;23:24-28.

9. Rabbani GH. Mechanism and treatment of diarrhoea due to Vibrio cholerae and E.coli: roles of drugs and prostaglandins. Danish Med Bull, 1996, 43:173-185.

10. Shoda R, Mahalanabis D, Islam KN, Wahed MA, Albert MJ. Vitamin A supplementation on lectin-induced diarrhoea and bacterial translocation in rats. Nutrition Research,1996,Vol.15 459-465.

11. van Loon FPL, Banik AK, Nath SK, Patra FC, Wahed MA, Darmaun D, Desjeux J-F, Mahalanabis D. The effect of glutamine on salt and water absorption: a jejunal perfusion study on cholera in humans. European Journal of Gastroenterology & Hepatology 1996, 8:443-448.

Papers in Press:

1. Ahmed T, Sumazaki R, Nagai Y, Shibasaki M, Takita H. Immune response to food antigens: Kinetics of food-specific antibodies in the normal population. Acta Paediatrica.

2. Ahmed T, Kamota T, Sumazaki R, Shibasaki M, Takita H. Circulating antibodies to common food antigens in Japanese children with IDDM. Diabetes Care.

3. Ashraf H, Mitra AK, Mahalanabis D. Evaluation of an algorithm for the treatment of persistent diarrhoea - a multicentre study. Bulletin of WHO.

4. Bardhan PK, Fuchs GJ. Tropical Gastrointestinal and hepatic infections. Current Opinions in Infectious Diseases 1996.

5. Bhattacharya MK, Teka T, Faruque ASG, Fuchs GJ. Cryptosporidium infection in children in urban Bangladesh. Journal of Tropical Paediatrics.

6. Dhar U, Bennish ML, Khan WA, Ceas C, Khan EH, Albert MJ, Salam MA. Clinical features, antimicrobial susceptibility and in vitro toxin production in Vibrio cholerae 0139 infection: comparison with Vibrio cholerae 01 infection. Trans Roy Soc Trop Med Hyg.

7. Faruque ASG, Mahalanabis D, Hamadani J, Hoque SS. Hyposmolar sucrose ORS in acute diarrhoea.: A pilot study. Acta Paediatrica.

8. Islam MA. Oral rehydration fluids for use at home. Indian J Pediatr.

9. Islam MA, Rahman MM, Mahalanabis D, Rahman AKSM. Death in a diarrhoeal cohort of infants and young children soon after discharge from hospital: risk factors and causes of verbal autopsy. J Trop Paed.

10. Khaled MA, Kabir I, Goran MI, Mahalanabis D. Single, dual and multifrequency bioimpedence to determine human body composition. Indian Journal of Experimental Biology. 1996.

11. Khan AM, Bhattacharya ML, Albert MJ. Neonatal diarrhoea caused by Vibrio cholerae 0139 Bengal. J Diag Microbio Infect Dis.

12. Majumder RN, Hoque SS, Ashraf H, Kabir I, Wahed MA. Early feeding of an energy-dense diet prevents post shigella growth faltering in malnourished children. Journal of Nutrition.

13. Mahalanabis D, Rahman MM, Sarker SA, Bardhan PK, Hildebrand P, Beglinger C, Gyr K. Helicobacter pylori infection in infants and children in a poor community of Bangladesh: prevalence, socioeconomic and nutritional aspects. Int J Epidemiology.

14. Rahman MM, Mitra AK, Mahalanabis D, Wahed MA, Khatun M, Majid M. Absorption of macronutrients from an energy dense diet liquified with amylase from germinated wheat in infants with acute diarrhoea. J Pediatr Gastroenterol & Nutr.

15. Rahman MM, Mahalanabis D, Alvarez JO, Wahed MA, Ma Islam, Habte D. Effect of early vitamin A supplementation on cell-mediated immunity in infants under 6 months of age. Am J Clin Nutr.

16. Salam MA. Use of quinolones in pediatrics: Use in the developing countries. Chemotherapy (Review Article).

17 Teka T, Faruque ASG, Fuchs GJ. Risk factors for deaths in under-five children attending a diarrhoea treatment center. Acta Paediatrica.

Research Protocols in Progress:

Acute Watery Diarrhoea

1. Fiber (guar gum) in the treatment of acute non-cholera diarrhoea in children (N.H. Alam, SANDOZ, Nutrition, Switzerland)

2. Short chain fatty acids in the treatment of acute watery diarrhoea (G. Rabbani/G. Fuchs, USAID-PDF)

3. Multicentre clinical trial to evaluate the efficacy/safety of reduced osmolarity ORS solution in children with acute diarrhoea (R. Majumder/G. Fuchs,WHO/UNICEF/ADDR)

4. Multicentre clinical trial to evaluate the safety/efficacy of reduced osmolarity ORS solution in adult patients with cholera (N.H. Alam/G. Fuchs,WHO/UNICEF/ADDR)

5. Evaluation of hyperimmune bovine colostrum (HBC) in the treatment of E.Coli and rotavirus diarrhoea and H.pylori infection in children (S.A. Sarker, SAREC/Karolinska, Sweden)

6. Efficacy of tetracycline in the treatment of cholera in adults due to Vibrio cholerae 01 resistant to the drug in vitro. (U. von Gierke/AM Khan, PDF).

7. Assessment of water compartments during rehydration of patients with AWD (cholera and non-cholera) by dual frequency bioelectrical impedance analysis (BIA) (Iqbal Hossain, USAID PDF)

Persistent Diarrhoea

8. Effects of dietary fibers an short-chain acids in the management of children with persistent diarrhoea (G. Rabbani/G. Fuchs, (USAID PDF)

9. Evaluation of the effect of a soluble fiber (Sun Fibre) supplemented comminuted chicken diet in the treatment of persistent diarrhoea in children (N.H. Alam, Sandoz Nutrition, Switzerland).

10. Hypotonic ORS in children with persistent diarrhoea (S.A. Sarker, USAID-PDF)

11. H. pylori as a risk factor for acute diarrhoea and persistent diarrhoea (P.K. Bardhan, USAID)

12. Surveillance of HIV-seropositivity in Bangladeshi children with persistent diarrhoea and malnutrition (G. Fuchs/Sten Vermund (Univ. of Alabama collaborative).

Invasive Diarrhoea

13. The effect of anti-oxidative nutritional intervention on clinical outcome of acute shigelosis (M.A. Khaled et al., USAID/PDF)

14. Double-blind, randomized study of the safety and efficacy of ciprofloxacin in the treatment of childhood shigellosis (M.A. Salam, Bayer AG)

Nutrition

15. Vegetable protein sources for refeeding malnourished children with shigellosis (I. Kabir,Collaborative IAEC, SDC)

16. A study on the immunological effect of Vitamin A and Zinc in a placebo controlled 4-cell trial (S.K. Roy,USAID)

17. Impact of peer counsellors on feeding practices of mothers in the urban community (R. Haider, SDC)

18. Effect of dietary fat and infection on vitamin A status and dietary intake methodology (G. Fuchs, USAID OMNI)

19. Effect of Zinc supplementation during pregnancy on infant birthweight, growth, morbidity, and cell-mediated immune function (Saskia Osendarp/G. Fuchs, The Netherlands Government)

Others

20. Immune disruption caused by measles (S.M.Akramuzzaman, LSHTM)

21. Case control study to investigate factors associated with the severity of measles of delayed complications of measles. (S.M Akramuzzaman, LSHTM)

22. ICDDR,B Surveillance Programme, Clinical Research Centre (G. Fuchs/ASG Faruque, UNDP-WHO).

23. Nosocomial transmission of measles and diagnostic salivary IgM assay (S.M. Akramuzzaman, SDC)

24. Epidemiology and clinical feature of Acinetobacter bacteriaemia in diarrhoeal patients (Dr. Iqbal Hossain/G Fuchs, USAID PDF).

Appendix B

LABORATORY SCIENCES DIVISION PUBLICATIONS 1 APRIL TO 30 SEPTEMBER, 1996

Papers Published:

1. Albert MJ, Bhuiyan NA, Rahman A, Ghosh AN, Hultenby K, Weintraub A, Nahar S, Kibriya AKMG, Ansaruzzaman M, Shimda T. Phage specific for *Vibrio cholerae* O139 Bengal. J Clin Microbiol 1996; 34:1843-1845.

2. Albert MJ. Epidemiology and molecular biology of *Vibrio cholerae* O139 Bengal. Indian J Med Res 1996; 104:14-27.

3. Ansaruzzaman M, Albert MJ, Holme T, Jansson P-E, Rahman MM, Widmalm G. A *Klebsiella pneumoniae* strain that shares a type-specific antigen with *Shigella flexneri* serotype 6: characterization of the strain and structural studies of the O-antigenic polysaccharide. Eur J Biochem 1996; 237:786-791.

4. Hossain M, Wahed MA, Azhar ATM, Jahan F. Zinc concentration in breast milk and its diurnal variation in Bangladeshi mothers [Abstract]. FASEB J 1996; 3:A247.

5. Islam D, Wretlind B, Lindberg AA, Christensson B. Changes in the peripheral blood T cell receptor Vß repertoire *in vivo* and *in vitro* during shigellosis. Infect Immun 1996; 64:1391-1399.

6. Islam MS, Alam MJ, Begum A, Rahim Z, Felsenstein A, Albert MJ. Occurrence of culturable *Vibrio cholerae* O139 Bengal with *ctx* gene in various components of aquatic environment in Bangladesh. Tran R Soc Trop Med Hyg 1996; 90:128.

7. Islam MS, Rezwan FB, Khan SI. Survival of *Shigella flexneri* in artificial aquatic environment: effects of different physicochemical stress factors. J Diarrhoeal Dis Res 1996; 14:37-40.

8. Kilgore PE, Unicomb LE, Gentsch JR, Albert MJ, McElroy CA, Glass RI. Neonatal rotavirus infection in Bangladesh: Strain characterization and risk factors for nosocomial infection. Pediatr Infect Dis J 1996; 15:672-677.

9. Knirel Y, Senchenkeuva SN, Jansson P-E, Weintraub A, Ansaruzzaman M, Albert MJ. Structure of the O-specific polysaccharide of *Aeromonas trota* strain cross-reactive with *Vibrio cholerae* O139 Bengal. Eur J Biochem 1996; 238:160-165.

10. Lesmana M, Albert MJ, Subekti D, Richie E, Tjaniadi P, Waltz S, Lebron CI. Simple differentiation of *Vibrio cholerae* O139 from *V. cholerae* O1 and non-O1 and non-O139 by modified CAMP test. J Clin Microbiol 1996; 34:1038-1040.

11. Nakasone N, Iwanaga M, Yamashiro T, Nakashima K, Albert MJ. *Aeromonas trota* strains which agglutinate with *Vibrio cholerae* O139 Bengal antiserum, posseses a serologically distinct fimbrial colonization factor. Microbiology 1996; 142:309-313.

12. Qadri F, Mohi MG, Azim T, Faruque SM, Kabir AKMI, Albert MJ. Production, characterization and immunodiagnostic application of a monoclonal antibody to Shiga toxin. J Diarrhoeal Dis Res 1996; 14:95-100.

13. Qadri F, Mohi MG, Chowdhury A, Alam K, Azim T, Sack RB, Albert MJ. Monoclonal antibodies to the enterotoxin of *Bacteroides fragilis*: Production, characterization and immunodiagnostic application. Clin Diagn Lab Immunol 1996; 3:000-000.

14. Rahim Z, Aziz KMS. Factors affecting production of haemolysin by strains of *Vibrio fluvialis*. J Diarrhoeal Dis Res 1996; 14:113-116.

15. Raqib R, Ljungdahl A, Lindberg AA, Wretlind B, Andersson U, Andersson J. Dissociation between cytokine mRNA expression and protein production in shigellosis. Eur J Immunol 1996; 26:1130-1138.

16. Sack RB, Albert MJ, Siddique AK. The emergence of *Vibrio cholerae* O139. In: Remington JS, Swartz M, editors. Current Clinical Topics in Infectious Diseases. Boston: Blackwell Science, 1996: 172-193.

17. Unicomb LE, Faruque SM, Malek MA, Albert MJ. Demonstration of a lack of synergistic effect of rotavirus with other diarrheal pathogens in infants. J Clin Microbiol 1996; 34:1340-1342.

18. Unicomb LE, Jarecki-Khan K, Hall A, Podder G. Evidence that enteric adenovirus infection does not result in protection from subsequent symptomatic infection. Microbiol Immunol 1996: 40:000-000.

Papers in Press:

1. Albert MJ, Morris JG Jr. Cholera. In: Strickland GT, editor. Hunter's Tropical Medicine, 8th ed. Philadelphia: W.B. Saunders Company (in press).

2. Albert MJ. Epidemiology of enteropathogenic *Escherichia coli* infection in Bangladesh. Rev Microbiol Sao Paulo (in press).

3. Albert MJ. The role of food in the epidemiology of cholera and other diarrhoeal diseases. World Health Stat Quart (in press).

4. Azad AK, Ronan A, Bennish M, Rahman O, Philips R. Hyperglycemia during childhood diarrhea. J Pediatr (accepted).

5. Azim T, Sarker MS, Hamadani J, Wahed MA, Halder RC, Salam A. Effect of nutritional status on lymphocyte responses in children with *Shigella flexneri* infection. Immunol Infect Dis 1996; 00:000-000 (in press).

6. Azim T, Qadri F, Ahmed S, Sarker MS, Halder RC, Hamadani J, Chowdhury A, Wahed MA, Salam MA, Albert MJ. Lipopolysaccharide specific antibodies in plasma and stools of children with *Shigella*-associated leukemoid reaction and hemolytic uremic syndrome. Clin Diagn Lab Immunol 1996 (in press).

7. Falklind S, Stark M, Albert MJ, Uhlen M, Lindeberg J, Weintraub A. Cloning and sequencing of a region of *Vibrio cholerae* O139 Bengal and its use in PCR-based detection. J Clin Microbiol (in press).

8. Islam D, Wretlind B, Bardhan PK, Hammarstrom L, Christensson B, Lindberg AA. Semi-quantitative estimation of *Shigella* antigen specific antibodies: Correlation to disease severity during shigellosis. APMIS 1996 (in press).

9. Linnerborg M, Widmalm G, Rahman MM, Jansson P-E, Holme T, Qadri F, Albert MJ. Structural studies of the O-antigenic polysaccharide from *Aeromonas caviae* strain. Carbohydrate Res (in press).

10. Nandy RK, Albert MJ, Ghose AC. Serum antibacterial and antitoxin responses in clinical cholera caused by *Vibrio cholerae* O139 Bengal and evaluation of their importance in protection. Vaccine (in press).

11. Sack RB, Rahman M, Yunus M, Khan EH. Antimicrobial resistance in diarrhoeal diseases. Clin Infect Dis 1996 (in press).

12. Wahed MA, Alvarez JO, Rahman MM, Hussain M, Jahan F, Habte D. Subclinical vitamin A deficiency in young infants in Bangladesh. Nut Res 1996 (in press).

Research Protocols in Progress:

1. Biochemical fingerprinting in the epidemiological studies of bacterial diarrhoeal pathogens in Bangladesh. P.I.: Dr. M. John Albert. Starting date: September, 1992.

2. Production and characterization of monoclonal antibodies (MAbs) to the virulence-associated factors of enteropathogenic *Escherichia coli* (EPEC) for use as diagnostic reagents. P.I.: Dr. M. John Albert. Starting date: October, 1994.

3. Epidemiologic and ecologic study of *Vibrio cholerae*. P.I.: Dr. M.J. Albert. Starting date: July, 1996.

4. Characterization of epidemic strains of *Vibrio cholerae* O1 and non-O1 based on genetic and phenotypic strain. P.I.: Dr. Shah M. Faruque. Starting date: October, 1994.

5. Immune status of children who develop persistent diarrhoea. P.I.: Dr. Tasnim Azim. Starting date: January, 1992.

6. A study of immunological effect of vitamin A and zinc in a placebo controlled 4-cell trial. P.I.: Dr. S.K. Roy, Co-P.I.: Dr. Tasnim Azim. Starting date: December, 1994.

7. Study of immune disruption caused by measles and its association with clinical progress in Dhaka, Bangladesh. P.I. Dr. S.M. Akramuzzaman, Co-P.I.: Dr. Tasnim Azim. Starting date: January, 1995.

8. Local and systemic antibody response to a peroral inactivated ETEC vaccine. P.I.: Dr. P.K. Bardhan, Co-P.I: Dr. Firdausi Qadri. Starting date: August, 1993.

9. Safety and immunogenicity of an oral bivalent B subunit *Vibrio cholerae* O1/O139 whole cell (B-O1/O139 WC) vaccine in adult Bangladeshi volunteers. P.I.: Dr. Firdausi Qadri. Starting date: June, 1995.

10. Local and systemic immune response in patients in a diarrhoeal epidemic due to *Vibrio cholerae* O139. P.I.: Dr. Firdausi Qadri, Co-P.I.: Dr. P.K. Bardhan. Starting date: January, 1994.

11. Rapid diagnosis of pathogenic *Entamoeba histolytica* infection. P.I.: Dr. Rashidul Haque. Starting date: October, 1993.

12. Field evaluation and further characterization of an invasive-specific monoclonal antibody against *Entamoeba histolytica*. P.I.: Dr. Rashidul Haque. Starting date: April, 1994.

13. Field trial of beta-carotene supplementation and anti-helminthic therapy to improve micronutrient nutriture in children in Bangladesh. P.I.: Dr. Rashidul Haque. Starting date: September, 1996.

14. Role of various aquatic flora, fauna and physicochemical conditions of water in maintaining endemicity and seasonality of cholera in Bangladesh. P.I.: Dr. M. Sirajul Islam. Starting date: June, 1995.

15. Study of distribution of group A rotavirus P types in Bangladesh. P.I.: Leanne Unicomb. Starting date: September, 1996.

16. Further studies of systemic and local immune responses in shigellosis in order to formulate a protective vaccine. P.Is.: Dr. Dilara Islam and Dr. Rubhana Raqib. Starting date: September, 1996.

17. Prevalence of selected sexually transmitted diseases and associated risk factors in urban slum dwellers in Dhaka. P.Is.: Dr. Mahbubur Rahman and Dr. K. Sabin. Starting date: June, 1996.

18. The prevalence and aetiology of reproductive tract infections among women attending the Bangladesh Women's Health Coalition Clinic in Mirpur. P.I.: Dr. Joseph Bogaerts. Starting date: July, 1996.

Appendix C

HEALTH AND POPULATION EXTENSION DIVISION
PUBLICATIONS 1 April 1996 - 30 September 1996

Published papers:

1. Bilqis AH, Juncker T, Sack RB, Ali M, Aziz KMA (1996). Sustainability of a water, sanitation and hygiene education project in rural Bangladesh: a 5-year follow-up. Bulletin of the WHO: volume 74, No. 4:431-37.

2. Haaga J, Maru RM (1996). The Effect of Operations Research on Programme Changes in Bangladesh. Studies in Family Planning, Vol. 27, No. 2 (Mar/Apr 1996): 76-87.

3. Hossain MB, Phillips JF (1996). The Impact of Outreach on the Continuity of Contraceptive Use in Rural Bangladesh. Studies in Family Planning, Vol. 27, No. 2 (Mar/Apr 1996): 98-106.

4. Khan MA (1996). Factors Affecting Use of Contraception in Matlab, Bangladesh. Journal of Biosocial Science Vol. 28, 265-279.

5. Siddique AK, Akram K, Zaman K, et al. (1996). *Vibrio cholerae* O139: How great is the threat of a pandemic? Trop Med Int Hlth. 393-398.

Working Papers:

1. Ahmed S, Haque I, Barkat-e-Khuda, Hossain MB, Alam S (1996). Abortion in Rural Bangladesh: Evidence from the MCH-FP Extension Project. Dhaka: MCH-FP Extension Project (Rural) Working Paper No. 121, and ICDDR,B Working Paper No. 63.

2. Ashraf A, Dunston AG, Hasan Y, Barkat-e-Khuda, Maru R (1996). Strengthening Front-line Supervision to Improve Performance of Family Planning Field Workers in Bangladesh. Dhaka: MCH-FP Extension Project (Rural) Working Paper No. 110, and ICDDR,B Working Paper No. 47.

3. Barkat-e-Khuda, Hossain MB (1996). Fertility Decline in Bangladesh: An Investigation of the Major Factors. Dhaka: MCH-FP Extension Project (Rural) Working Paper No. 111, and ICDDR,B Working Paper No. 48.

4. Hossain, MB, Phillips JF (1996). The Impact of Outreach on the Continuity of Contraceptive Use in Rural Bangladesh. Dhaka: MCH-FP Extension Project (Rural) Working Paper No. 112, and ICDDR,B Working Paper No. 49.

5. Khan MMA, Rahman M (1996). Determinants of Contraceptive Method-Choice in Rural Bangladesh. Dhaka: MCH-FP Extension Project (Rural) Working Paper No. 117, and ICDDR,B Working Paper No. 54.

6. Khanum PA, Wirzba H, Haque I, Mirza T, Juncker T (1996). Service Delivery at The Union Health and Family Welfare Centers: The Clients' Perspective." Dhaka: MCH-FP Extension Project (Rural) Working Paper No. 118, and ICDDR,B Working Paper No. 55.

7. Mirza T, Ashraf A, Kabir H, Wazed A, Ahmed S (1996). Clinic Waste Disposal in the Rural Family Planning Programme of Bangladesh. Dhaka: MCH-FP Extension Project (Rural) Working Paper No. 119, and ICDDR,B Working Paper No. 56.

8. Mirza T, Ashraf A, Kabir H, Ahmed J (1996). Training Experience in Domiciliary Injectable Contraceptive Services in the National Family Planning Programme. Dhaka: MCH-FP Extension Project (Rural) Working Paper No. 120, and ICDDR,B Working Paper No. 57.

9. Mookherji S, Kane TT, Arifeen SE, Baqui AH (1996). The Role of Pharmacies in Providing Family Planning and Health Services to Residents of Dhaka, Bangladesh". MCH-FP Extension Project (Urban) Working Paper No. 21.

10. Mozumder, ABMKA, Sarker AH, Barkat-e-Khuda, Rahman MDM (1996). Gender Composition of Surviving Children and Contraceptive Use in Bangladesh. Dhaka: MCH-FP Extension Project (Rural) Working Paper No. 122, and ICDDR,B Working Paper No. 64.

11. Perry HB, Begum S, Begum A, Kane TT, Quaiyum MA, Baqui AH (1996). Assessment of Quality of the MCH/FP Services Provided by Field Workers in Zone 3 of Dhaka City and Strategies for Improvement. MCH-FP Extension Project (Urban) Working Paper No. 20.

12. Quaiyum MA, Tunon C, Baqui AH, Quayyum Z, Khatun J (1996). The Impact of National Immunization Days on Polio Related Knowledge and Practice of Women in Bangladesh. Urban MCH-FP Extension Project (Urban) Working Paper No. 19.

13. Rahman M (1996). Child Mortality and Fertility Regulation Behavior in Bangladesh: Implication for Family Planning Programmes. Dhaka: MCH-FP Extension Project (Rural) Working Paper No. 115, and ICDDR,B Working Paper No. 52.

14. Rahman MM, Hossain MB, Hossain A, Das SC (1996). Prevalence and Continuation of Injectable Contraceptives: Evidence from Extension Project Areas of ICDDR,B. Dhaka: MCH-FP Extension Project (Rural) Working Paper No. 116, and ICDDR,B Working Paper No. 53.

15. Roy NC (1996). Determinants of Child Malnutrition in Rural Bangladesh. Dhaka: MCH-FP Extension Project (Rural) Working Paper No. 114, and ICDDR,B Working Paper No. 51.

Special Publications:

1. Rahman M, Barkat-e-Khuda, Hossain (1996). An Assessment of Health and Family Planning Needs in Rural Chittagong. MCH-FP Extension Project (Rural), ICDDR,B. Special Publication No. 49.

2. Thwin AA, Islam MA, Baqui AH, Reinke WA and Black RE (1996). Health and Demographic Profile of the Urban Population of Bangladesh: An Analysis of Selected Indicators". MCH-FP Extension Project (Urban), ICDDR,B. Special Research Publication No. 47.

Papers In Press

1. Barkat-e-Khuda, Hossain MB (1996). Fertility Decline in Bangladesh: Toward an Understanding of Major Causes. Health Transition Review, The Australian National University, Canberra.

2. Bilqis AH, Sack RB, Chowdhury JTA, Ali M (1996). Domestic Water and Sanitation in Cyclone and Floods: Research Agenda. Journal of International Water Resources Association (IWRA).

3. Phillips JF, Hossain MB, Arends-Kuenning M(1996). The Long-Term Demographic Role of Community-Based Family Planning in Rural Bangladesh. Studies in Family Planning.

Research Protocols/Projects in Progress:

- MCH-FP Extension Project (Rural).
- MCH-FP Extension Project (Urban).
- Epidemic Control Preparedness Programme.
- Action Research and Impact Studies on Community Water, Sanitation and Hygiene Education Interventions in Rural Areas" (1995 -1999) in collaboration with DPHE, MLGRD&C, DHS, LGED, CWFP and JHU.
- Action Research and Impact Studies on Community Water, Sanitation and Hygiene Education Interventions in Urban Dhaka" (1995 - 1999) in collaboration with DCC, MLGRD&C, PROSHIKA and JHU.
- Environmental Health Intervention in Selected Poor Areas of Dhaka City (1996).
- The Impacts of a new technology on traditional resource management, social structure and the environment in rural Bangladesh (1996 - 1997).
- Household Treatment of Stored Drinking Water in an Urban Slum Community (1996).
- Effect of Zinc Supplementation During Pregnancy on Infant Birth Weight, Growth, Morbidity, Response to BCG
- Ethnographic and epidemiologic studies to improve care-seeking for child-hood illnesses, particularly pneumonia
- Study of prevalence and risk factors for Sexually transmitted diseases (STDs) in urban Bangladesh

Appendix D

COMMUNITY HEALTH DIVISION
PUBLICATIONS 1 APRIL - 30 SEPTEMBER 1996

Papers Published:

1. **Chowdhury AI**, Aziz KMA, de Francisco A. Infant and child mortality among high and low risk Bangladeshi mothers in relation to socioeconomic variables. Intl J Ind Anthropol Soc; 1996 June; 30(2).

2. **de Francisco A**, Baqui AH. Vitamin A and vaccines, the importance of side effects (Letter to the Editor). Europ J Clin Nutr 1996;50:122

3. **de Francisco A**, and Ahmed F. Measles vaccine failure not associated with vitamin A supplementation. Transactions of the Royal Society of Tropical Medicine and Hygiene 1996; 90:441

4. van Dillen J, **de Francisco A**, Overweg-Plandsoen WCG. Long-term effect of vitamin A given with vaccines (Letter). Lancet 1996 June;347:1705

5. Maine Deborah, Akalin MZ, **Chakraborty J**, de Francisco A, Strong M. Why did maternal mortality decline in Matlab? Studies in Family Planning. 1996; 27(4):179-87

6. **Khan SR**, Chowdhury AMR and Bhuiya A. Women's education and employment: Matlab experience. Asia-Pacific Pop J. 1996; 11(1):45-58

7. **Myaux J.A.**, Unicomb L., Uzma A., Islam A.M., Besser R.E., Modlin J.F., Santosham M. Effect of Diarrhoea on the Humoral Response to Oral Polio Vaccination. Pediatr Infect Dis J, 1996;15(3):204 - 9.

8. **Razzaque A** . "Reproductive preferences in Matlab, Bangladesh: levels, motivation and differentials." Asia-Pacific Pop J,1996; 11 (1):25-44.

9. **Shahid NS**, Greenough WB, Samadi AR, Huq MI, Rahman R. Hand washing with soap reduces diarrhoea and spread of bacterial pathogens in a Bangladesh village. J. Diarr Dis Res 1996;14(2):85-89

10. **Zaman K**. Baqui AH, Yunus M, Sack RB, Bateman OM, Chowdhury HR, Black RE. Association between nutritional status, cell-mediated immune status and acute lower respiratory infections in Bangladeshi children. Eur J. Clin Nutr 1996;50: 309-14

Papers in Press:

1. **Bairagi, R.**, S. Becker, A. Kantner, K.B. Allen, A.K. Dutta, and K. Purvis: Evaluation of the Bangladesh 1993-94 Demographic and Health Survey within the Matlab Demographic Surveillance System: Initial Findings. Demographic Publication Series, East-West Center .

2. Bhuiya A and Chowdhury M. Marital disruption due to divorce and child survival in a rural area of Bangladesh. Pop Stud

3. Chowdhury AI, Aziz KMA, de Francisco A, Khan MA. Difference of neonatal mortality by religion and socioeconomic covariates in rural Bangladesh. J Fam Welfare.

4. Myaux J., Iqbal A., Uzma A., Chakraborty J., Ali M., Hossain M. Environmental hazards as a leading cause of death in children from Bangladesh. Intl Child Health.

5. Sack RB, Rahman M, Yunus M, Khan EH. Antimicrobial resistance in diarrhoeal disease. Clinical Infect Dis

Research protocols in progress:

1. Development and implementation of nutrition education strategy for promotion of Beta carotene rich foods as a source of Vitamin A in children in Matlab communities.
PI- Dr K.M.A. Aziz

2. Contraceptive Failure in Matlab: Levels, Trends and Correlates.
PI- Dr R. Bairagi

3. Child Mortality in Matlab: Levels, Trends, Correlates and Cause of Death.
PI- Dr R. Bairagi

4. An Evaluation of the Bangladesh Demographic and Health Survey Data.
PI- Dr R. Bairagi

5. Proximate Determinants of Fertility
PI- Dr R. Bairagi

6. Improvement of health through community development oriented programme in rural Bangladesh
PI-Dr Abbas Bhuiya

7. The impact of social and economic development programmes on health and well-being: a BRAC-ICDDR,B collaborative project in Matlab
PI- Dr Abbas Bhuiya

8. Coordinating bilateral resources for health systems development: a policy analysis in Bangladesh
PI- Mr Kent Buse

9. Efficacy of Bismuth Subsalicylate in preventing acute diarrhoeal episodes from becoming persistent in rural Bangladesh children
PI- Dr Hafiz R. Chowdhury, Md Yunus

10. Health care use patterns of slum residents in Dhaka city, Bangladesh
PI- Dr Maarten Desmet

11. Health care use patterns of non-slum residents in Dhaka city,
PI- Dr Maarten Desmet

12. Risk factors for severe watery diarrhoeal disease in Matlab, Bangladesh: a medical geographic approach
PI- Michael Emch

13. Wheezing associated respiratory disorders (WARD) and hypoxemia in hospitalized children under five years of age in rural Bangladesh
PI- Dr Samuel Erny, Dr Andres de Francisco

14. Matlab Maternal and Child Health and Family Planning (MCH-FP) Programme and Record Keeping System (RKS)
PI- Dr Andrés de Francisco, Mr J. Chakraborty

15. Nutrition surveillance system
PI- Dr Andrés de Francisco, Mr J. Chakraborty

16. Safe Motherhood in Rural Bangladesh
PI- Dr Andrés de Francisco, Dr Anna-Maria Vanneste

17. Control of Acute Lower Respiratory Infections (ALRI) through case finding and management
PI- Dr Andrés de Francisco

18. Nutrition Rehabilitation in Matlab
PI- Dr Andrés de Francisco

19. Epidemiology of diarrhoea and ARI in a cohort of newborns in rural Bangladesh
PI- Dr Kh. Zahid Hasan

20. Reproductive Tract Infections in Matlab
PI- Dr Sarah Hawkes

21. Obstetric care in a district hospital in Bangladesh: an organizational ethnography
PI- Ms Margaret Leppard

22. Spatial analysis on migration in Matlab
PI- Dr Jacques Myaux

23. Spatial distribution of STD in Matlab
PI - Dr Jacques Myaux

24. Study on catchment area of the Dhaka DTC
PI- Dr Jacques Myaux

25. The effect of retinol and B carotene supplementation in lactatingm women on Breastmilk quality and Vit A status in infants
PI- Ms Amy Rice

26. Study of the immunogenicity of conjugate pneumococcal vaccine in infants of mothers who have and who not been immunized with polysaccharide vaccine
PI- Dr Nigar S. Shahid

27. Anemia during pregnancy in an urban community of Bangladesh: a study of prevalence, validation of simple screening methods and impact of iron folic acid supplementation
PI- Dr Anna-Maria Vanneste

28. Calcium supplementation in prevention of pregnancy induced proteinuric hypertension, low birth weight and prematurity.
PI- Dr Anna-Maria Vanneste

29. Does disease due to Vibrio cholerae 01 confer protection against subsequent diarrhoea due to Vibrio cholerae 0139? an analysis of the existing data
PI- Dr Md. Yunus

30. Children's fluid intake during diarrhoea: a comparison of questionnaire response with data from observations
PI - Dr K. Zaman and Mr J. Chakraborty

31. Evaluation of a packet rice ORS in cholera and cholera like illness in adults and children
PI - Dr K Zaman and Dr Md Yunus

Appendix E

LIST OF STAFF MEMBERS WHO RETURNED AFTER COMPLETING TRAINING
01 April - 30 September 1996

Name, designation and division of staff	Outcome of the training	Institution and their countries
Dr. Tahmeed Ahmed Medical Officer Clinical Sciences Division	Ph.D. in Gastroenterology	Tsukuba University, Japan
Ms. Fazilatun Nessa Research Fellow MCH-FP Extension Project (Rural), HPED	Could not acquire Ph.D in Applied Population Research for lack of funds	University of Exeter, UK
Mrs. Manakhushi Mondal Senior Staff Nurse Clinical Research & Service Centre (CR&SC), CSD	Diploma in Paediatrics Nursing	College of Nursing, Christian Medical College & Hospital, Vellore, India,
Mr. Zahidul Quayyum Sr. Operations Researcher MCH-FP Extension Project HPED	Masters in Health Policy Planning and Financing.	London School of Hygiene & Tropical Medicine, UK
Mr. Md. Shahidul Alam Sr. Computer Programmer MCH-FP Extension Project (Rural) HPED	Training on computer software	Asian Institute of Technology, Thailand.
Mr. SAKM Mansur Acting Office Manager MCH-FP Extension Projet (Urban) HPED	Training on computer software	Asian Institute of Technology, Thailand
Dr. A. N. Alam Head, Training & Education Department Director's Bureau	Training on curriculum planning and programme evaluation in health professions' education	University of Illinois, Chicago, USA
Dr. Indrani Haque Analyst Programmer MCH-FP Extension Project (Rural), HPED	Training on development of computer software	Asian Institute of Technology, Thailand.
Mr. M. Yousuf Hasan Sr. Operations Researcher MCH-FP Extension Project (Rural), HPED	Training on managing health programmes in developing countries	Harvard School of Public Health, USA

Mr. Md. Hasanur Rahman Senior Research Officer Social & Behavioural Sciences Programme (SBS) Community Health Division	Training on reproductive health	London School of Hygiene & Tropical Medicin, UK
Ms. Papreen Nahar Senior Research Officer SBS Programme, CHD	Training on reproductive health	LSHTM, UK.
Dr. Sarah Hawkes Principal Investigator Reproductive Tract Infection Project, CHD	Training on epidemiology & medical statistics.	LSHTM, UK.
Dr. Ishtiaque A. Zaman Technical Cooperation Officer External Relations & Institutional Development Director's Bureau.	Training on fundraising	University of Maryland, USA.
Mr. Farid Ahmed Programmer Matlab MCH-FP Project CHD	Training on statistics in health	University of Reading, UK.
Mr. AKM Abdus Samad Payroll Manager Finance Division	Orientation training on payroll management & procedures	International Crops Research Institute for the Semi-Arid Tropics (ICRISAT), India
Mr. Abdul Ahad Budget & Cost Officer Finance Division	Orientation training on budget and cost procedures and reporting.	ICRISAT, India
Mr. SAA Abdul Matin Treasurer Finance Division	Orientation training on banking arrangement and cash management.	ICRISAT, India
Dr. Nigar S. Shahid Scientist, CHD	Training on epidemiological methods and enrolment for doctoral studies as an external candidate.	LSHTM, UK

Appendix F

LIST OF STAFF MEMBERS WHO LEFT FOR TRAINING
01 april- 30 september 1996

Name, designation and division of staff	Type of training	Institutions and their countries
Mr. SAKM Mansur Acting Office Manager MCH-FP Extension Project (Urban) Health & Population Extension Division (HPED)	Training on computer software	Asian Institute of Technology, Thailand
Dr. A. N. Alam Head, Training & Education Department Director's Bureau	Training on curriculum planning and programme evaluation in health professions' education	University of Illinois, Chicago, USA
Dr. Indrani Haque Analyst Programmer MCH-FP Extension Project (Rural), HPED	Training on development of computer software	Asian Institute of Technology, Thailand.
Mr. M. Yousuf Hasan Sr. Operations Researcher MCH-FP Extension Project (Rural), HPED	Training on managing health programme in developing countries	Harvard School of Public Health, USA
Mr. Md. Hasanur Rahman Senior Research Officer Social & Behavioral Sciences Programme (SBS) Community Health Division (CHD)	Training on reproductive health	London School of Hygiene & Tropical Medicine (LSHTM), UK.
Ms. Papreen Nahar Senior Research Officer SBS Programme, CHD	Training on reproductive health	LSHTM, UK.
Dr. Sarah Hawkes Principal Investigator Reproductive Tract Infection Project, CHD	Training on epidemiology & medical statistics	LSHTM, UK.
Dr. Ishtiaque A. Zaman Technical Cooperation Officer External Relations & Institutional Development Director's Bureau.	Training on fundraising	University of Maryland, USA.

Mr. Farid Ahmed Programmer Matlab MCH-FP Project, CHD	Training on statistics in health	University of Reading, UK.
Mr. AKM Abdus Samad Payroll Manager Finance Division	Orientation training on payroll management & procedures	International Crops Research Institute for the Semi-Arid Tropics (ICRISAT) India.
Mr. Abdul Ahad Budget & Cost Officer Finance Division	Orientation training on budget and cost procedures and reporting	ICRISAT, India.
Mr. SAA Abdul Matin Treasurer Finance Division	Orientation training on banking arrangement and cash management	ICRISAT, India.
Mr. Mohammad Ali Analyst Programmer BADC/GIS Activities	Training on spatial analysis	Institute for Social & Economic Geography, University of Leuven (KUL), Belgium.
Dr. P. K. Bardhan Associate Scientist Clinical Sciences Division (CSD)	Doctoral study in Gastro-enterology	Faculty of Health Sciences, University of Basel, Switzerland.
Dr. Aminul Islam Associate Scientist CSD	Doctoral study in Nutrition	University of Alabama at Birmingham, USA.
Ms. Jahanara Khatun Research Investigator MCH-FP Extension Project (Urban), HPED	Master's in Health Development	Royal Tropical Institute, Amsterdam, Netherlands
Mr. Ansaruzzaman Assistant Scientist Laboratory Sciences Division	Training on laboratory methods and working for the research protocol on "characterization of v. cholera strains from Bangladesh"	Karolinska Institutet, Sweden.
Mr. Mian Bazle Hossain Assistant Scientist MCH-FP Extension Project (Rural), HPED	Doctoral study in Population Dynamics	The Johns Hopkins University, USA.
Mr ABM Khorshed A. Mazumder Sr. Demographer MCH-FP Extension Project (Rural), HPED	Training course on financing health care in developing countries	Centre for International Health, Boston University School of Public Health, USA
Dr. Nigar S. Shahid Scientist, CHD	Training on epidemiological methods and enrolment for doctoral studies as an external candidate	LSHTM, UK

Mr. Gazi Nazrul Islam Faisal Sr. Field Research Officer SBS Programme, CHD	Study for a Master's degree in Public Health in Developing Countries	LSHTM, UK.
Ms. Lazeena Muna SBS Programme CHD	Study for a Master's degree in Health Promotion Sciences	LSHTM, UK
Ms. Kamrun Nahar Senior Research Officer SBS Programme, CHD	Study for a Master's degree in Health Policy, Planning and Financing	LSHTM, UK
Dr. Shafiqul A. Sarker Associate Scientist CSD	Training in clinical gastroenterology (to learn endoscopy)	Faculty of Health Sciences University of Basel, Switzerland.

NB: In addition, Drs. S.M. Akramuzzaman and Rukhana Haider of the Clinical Sciences Division are working for their dissertation research for PhD degree at the London School of Hygiene & Tropical Medicine, UK as external candidates. Further, Dr. Nigar S. Shahid of Community Health Division on return after completing enrolment formalities will begin work for her dissertation for a PhD degree at the LSHTM, UK.

INTERNATIONAL CONFERENCES/WORKSHOPS ATTENDED BY ICDDR,B STAFF
1 April - 30 September 1996

Sl. No.	Title, venue, and duration of the conference/workshop	Staff members attended		
		Sl	Name and designation	Division
1.	Experimental Biology (FASEB) Meeting held in Washington, USA 14-17 April.	01.	Mr. M. A. Wahed Head, Biochemistry & Nutrition	LSD
		02.	Dr. R. N. Mazumder Assistant Scientist	CSD
		03.	Dr. George Fuchs Division Director	CSD
2.	Population Association of America (PAA) Meeting held in New Orleans, USA 9-11 May.	04.	Dr. Jeroen van Ginneken Project Director, DSS	CHD
		05.	Dr. R. Bairagi Senior Scientist	CHD
		06.	Prof. Barkat-e-Khuda Project Director MCH-FP Extension Project (Rural)	HPED
		07.	Dr. Shameem Ahmed Health Scientist MCH-FP Extension Project (Rural)	HPED
		08.	Dr. Thomas Kane Operations Research Scientist MCH-FP Extension Project (Rural)	HPED
		09.	Mr. Mehrab Ali Khan Assistant Scientist/Demographer MCH-FP Extension Project (Rural)	HPED
		10.	Mr. Mian Bazle Hossain Assistant Scientist/Demographer MCH-FP Extension Project (Rural)	HPED
3.	American Gastroenterology Meeting (AGA) held in San Francisco, USA 19-22 May	11.	Dr. G. H. Rabbani Scientist	CSD
		12.	Dr. P. K. Bardhan Associate Scientist	CSD
		13.	Dr. S. A. Sarker Associate Scientist	CSD

Sl. No.	Title, venue, and duration of the conference/workshop	Staff members attended		
		Sl	Name and designation	Division
4.	Paediatric Diarrhoea Workshop held in Hong Kong on June 9.	14.	Dr. M. A. Salam Chief Physician	CSD
		15.	Dr. George Fuchs Division Director	CSD
		16.	Dr. ASG Faruque Associate Scientist	CSD
		17.	Dr. Mahbubur Rahman Head, Dept. of Laboratory Services	LSD
5.	Paediatic Diarrhoea Workshop held in Hong Kong and organized by Smithkline Becham Pharmaceuticals on June 9.	18.	Dr. A. S. G. Faruque Associate Scientist	CSD
6.	Seventh International Congress of Infectious Diseases (International Society for Infectious Diseases - ISID) held in Hong Kong 10-13 June.	19.	Dr. M. A. Salam Chief Physician	CSD
		20.	Dr. Mahbubur Rahman Head, Dept. of Laboratory Services	LSD
7.	Expert Committee Meeting at the Institute of Trace Element Research for UNESCO held in Lyon, France 10-13 June.	21.	Dr. S. K. Roy Scientist	CSD
8.	Ninth Conference of the International Association of Health Policy held in Montreal, Canada 13-16 June.	22.	Mr. Md. Mafizur Rahman Senior Operations Researcher MCH-FP Extension Project (Rural)	HPED
9.	Council of International Health (NCIH) held in Washington 9-12 June.	23.	Mr. Syed Shamim Ahsan Sr. Advisor & Division Director	HPED
		24.	Dr. Abdullah-Hel Baqui Project Director MCH-FP Extension Project (Urban)	HPED
		25.	Dr. Aye Aye Thwin Operation Research Scientist MCH-FP Extension Project (Urban)	HPED
10.	Aga Khan Foundation's Regional Network Planning Workshop held Workshop, held on June 15.	26.	Dr. Maarten Desmet Visiting Scientist	CHD

Sl. No.	Title, venue, and duration of the conference/workshop	Staff members attended		
		Sl	Name and designation	Division
11.	Attended WHO meeting held in Geneva on June 17.	27.	Dr. Andres de Francisco MCH-FP Physician	CHD
12.	Destructive Water Conference held in California, USA 24-28 June.	28.	Dr. Bilqis A. Hoque Senior Scientist Environmental Health Programme	HPED
13.	Joint Congress of International Union of Anthropological and Ethnological Sciences at Linkopin, Sweden and Urban Dynamics Multicultural and Environmental Issues at London, UK 26-28 August.	29.	Dr. KMA Aziz Senior Scientist	CHD
14.	XIVth International Conference on the Social Sciences and Medicine held in Scotland 2-6 September.	30.	Dr. Abbas Bhuiya Social Scientist	CHD
15.	AOAC International Meeting held in Florida, USA 8-12 September.	31.	Mr. Mujibur Rahman Scientific Officer	LSD
16.	Twenty-second WEDC Conference held in New Delhi, India 8-13 September	32.	Mr. Shafiul A. Ahmed Environmental/Sanitary Engineer Environmental Health Program	HPED
		33.	Mr. Abdullah Al-Mahmud Research Officer Environmental Health Program	HPED
		34.	Mr. Hasnat Iftkhar Hossain Research Officer Environmental Health Program	PPED
17.	SIDA Health Equity Network Meeting held in Boston, USA on 18 September & Planning meeting with ICRW in Washington, USA	35.	Dr. Abbas Bhuiya Social Scientist	CHD
18.	Annual Conference of the Infectious Diseases Society of America (IDSA) held in New Orleans, USA 18-20 September	36.	Dr. Ujjwal Dhar Medical Officer	CSD
19.	Sixth International Conference on Applied and Business Demography held at Ohio,USA 19-21 September	37.	Dr. Mohsin Uddin Ahmed Senior Medical Officer MCH-FP Extension Project (Rural)	HPED

Sl. No.	Title, venue, and duration of the conference/workshop	Staff members attended		
		Sl	Name and designation	Division
		38.	Ms. Parveen A. Khanum Operations Researcher MCH-FP Extension Project (Rural)	HPED
20.	Annual Fundraising Workshop 1996 organised by the South Asian Fund Raising Group in Kathmundu, Nepal 22-25 September	39.	Dr. Ishtiaque A. Zaman Technical Cooperation Officer External Relations & Institutional Development (ERID)	Director's Bureau
		40.	Mr. Md. Sirajul Islam Molla Office Manager, ERID	Director's Bureau
21.	Meeting of the Collaborative Council Working Group held in New Delhi, India 23-27 September	41.	Dr. Bilqis Amin Hoque Senior Scientist Environmental Health Program	HPED

Appendix H

INTER-DIVISIONAL SCIENTIFIC MEETING
01 April - 30 September 1996

Sl. No.	Date	Division	Speakers	Titles of topics
1.	01.04.96	CSD	Dr. S. K. Roy	Efficacy of antibiotics in paediatric cholera.
2.	08.04.96	CHD	Ms. Amy Rice	Preliminary results from the retibeta study: babies, breastmilk and vitamin A.
3.	15.04.96	HPED	Dr. A.K.M. Siddique	Health care response of rural families during cholera epidemics in Bangladesh.
4.	22.04.96	LSD	Dr. M. Sirajul Islam	Study of association between a blue-green alga, *anabena sp.* and *vibrio cholerae* 01 in microcosms by culture, FA, PCR, and immunoelectron microscopy.
5.	06.05.96	CSD	Dr. M. R. Islam	Therapeutic efficacy of 5-aminosalicyclic acid in acute shigellosis.
6.	13.05.96	CHD	Mr. Victor Gomes Ms. Kamrun Nahar	Reproductive health in rural Bangladesh: perspectives of women and health providers.
7.	20.05.96	HPED	Dr. Cris Tunon	Planning urban health services and improving coordination among service providers: preliminary findings.
8.	27.05.96	LSD	Dr. S.M. Faruque	Characterization of epidemic strains of toxigenic *vibrio cholerae*.
9.	10.06.96	CSD	Dr. T. Ahmed	Food allergy in children: food antigens, food-specific antibodies and their clinical relevance.
10.	17.06.96	CHD	Dr. M. Desmet	Differentials in direct and indirect health care expenditure.
11.	24.06.96	HPED	Dr. Tariq Azim Ms. S. Mookherjee	Preliminary findings from the clinic information system intervention.
12.	01.07.96	LSD	Dr. Rubhana Raqib	Involvement of cytokines in the pathogenesis of shigellosis.
13.	08.07.96	CSD	Dr. Hasan Ashraf	Assessment of artificial fat malabsorption by the ^{13}C-hiolein breath test in healthy volunteers.
14.	15.07.96	CHD	Dr. K.Z. Hasan	Epidemiology of diarrhoea and ARI in a cohort of new borns in rural Bangladesh.
15.	22.07.96	HPED	Dr. S. Ahmed	Abortion in Bangladesh: Evidence from two rural areas.

16. 05.08.96	CSD	Dr. A. Ries CDC, Atlanta WHO Office, Harare, Zimbabwe Dr. M. Rollins University of Natal, Durban, South Africa Dr. M. Wellington Health Department Harare, Zimbabwe Dr. M.A. Salam ICDDR,B	Death and morbidity from epidemic dysentery - perspec-tives from Africa and Asia.
17. 12.08.96	CHD	Dr. Khalequzzaman	Malnutrition, cell mediated immune deficiency and acute upper respiratory infections in rural Bangladeshi children.
18. 26.08.96	LSD	Dr. Dilara Islam	Cellular and humoral immune responses in shigellosis.
19. 02.09.96	CSD	Dr. Iqbal Kabir	Dietary supplementation of mal-nourished children recovering from shigellosis: Effect on body composition, linear growth and morbidity during 6-month follow-up.
20. 16.09.96	HPED	Dr. Bilqis A.Hoque	Effects of a water and sani-tation project by DPHE and UNICEF.

CENTRE'S RESPONSE TO THE SCIENTIFIC REVIEW OF THE LABORATORY SCIENCES DIVISION HELD IN MAY 1996

The Review Committee made a number of recommendations, and the responses to these recommendations are given below item by item.

RECOMMENDATION 1

The Board and Centre management should take urgent steps to appoint a Search Committee to identify and recruit a Division Director. This recruitment has been identified as the highest priority.

RESPONSE

The post has been recently advertised internationally, and applications are awaited.

RECOMMENDATION 2

Additional laboratory space and reorganization of existing facilities are essential for the continued high quality performance and growth of the Division.

RESPONSE

To relieve overcrowding, additional laboratory space of 8,700 sq. ft. will be required. The estimated cost of building this space is approximately US$270,000. The Centre will attempt to raise these funds.

RECOMMENDATION 3

We identify the provision of the following equipment to

the Biomedical Engineering Section as of the highest priority: 100 hz digital oscilloscope, logic analyzer, precision digital multimeter, and precision digital thermometer.

RESPONSE

The items have already been ordered from the Centre's depreciation fund at a cost of approximately US$34,000.

RECOMMENDATION 4

A flow cytometer and a hematology autoanalyzer would considerably enhance the output of the Immunology Section and allow it to fully benefit from the expertise of its staff. This would also help the clinical pathology laboratory.

RESPONSE

Depending upon the brand, the cost of a flow cytometer is between US$130,000 to 300,000, and that of a haematology autoanalyzer is approximately US$65,000. The Centre will attempt to raise money to buy these equipment.

RECOMMENDATION 5

Replacement of existing fluorescent microscope and shaking environmental incubators are essential for the Environmental Microbiology section.

RESPONSE

The combined cost of a fluorescent microscope and environmental shaker is approximately US$23,000. Again the Centre has to raise funds to buy these items.

RECOMMENDATION 6

A prioritized list of equipment requested by the Division is appended (Annexure 3). The Review Committee has not evaluated or prioritized all of these.

RESPONSE

A list of equipment in three priorities had been submitted. To procure all these would cost the Centre more than US$ 0.5 million.

RECOMMENDATION 7

The high quality innovative research of the Centre depends on the unique possibility it offers for a combination of research in the laboratory, in patient care, in the community and in the environment. It was the definite impression of the Review Committee that these collaborative possibilities are not fully utilized at the moment. Noting the very successful record of the recently established Nutrition Working Group, the Committee recommends the establishment of active cross-Divisional Working Groups, with an active input of all partners, in areas of strategic importance

and potential for collaboration, such as ARI, reproductive health, and vaccine research. Potential problems of costing and funding of collaborative studies and of ascribing credit to all partners should be solved in a creative way.

RESPONSE

Realizing the importance of cross-divisional collaboration, the Centre management has recently reactivated different working groups. It is expected that this will improve inter-divisional collaboration.

RECOMMENDATION 8

Provision of additional laboratory safety features especially fire fighting equipment is necessary.

RESPONSE

Installation of a full fire fighting system will cost the Centre approximately US$31,000. To ease the financial burden, it has been decided that the firefighting system will be installed in phases. This will be further reviewed in light of the recommendations of the Integrated Institutional Review.

RECOMMENDATION 9

The Environmental Microbiology Programme will need to be expanded to include global epidemiological studies as well as to provide an ecological underpinning for the major initiatives of the Strategic Plan of the

Centre, e.g., diarrhoeal disease, ARI, RTI, STD, etc. Computer-based molecular microbial ecology, coupled with the advanced technology of remote sensing, will require an up-shift, in the future, to more sophisticated field and laboratory programmes in environmental microbiology. Therefore planning for this shift should begin now.

RESPONSE

With the Centre becoming a partner in an NIH funded collaborative study on the ecology and epidemiology of *V. cholerae*, most of these activities will be initiated. We plan to expand into these areas considerably in the future.

RECOMMENDATION 10

The Division laboratory in Matlab needs attention. Collaboration with other units working at Matlab, development of quality control and microbiology laboratory services at Matlab need the urgent attention of the Division Director.

RESPONSE

To strengthen quality assurance, we have introduced frequent quality control tests. To have better supervision, more senior staff members are now visiting the laboratory on a monthly basis.

RECOMMENDATION 11

Technology transfer and intellectual property policies need to be established. These should be designed to facilitate research and development, as well as enhance international cooperation, not impede these activities, which are essential to the Centre.

RESPONSE

Steps are being taken to address this issue.

RECOMMENDATION 12

A new Animal House with modern facilities is needed for biomedical research of the Division and the Centre. This will continue to be a national resource.

RESPONSE

The estimated cost of building an animal house with modern facilities is approximately US$4 million. We anticipate that it may be very difficult to raise money for this. Perhaps renovations at a much reduced cost may be considered.

CONCLUSIONS

1. The financial cost of implementing all recommendations amounts to approximately US$ 4.3 million for the animal house and additional laboratory space, and approximately US$ 1 million for equipment, thus a total of approximately US$ 5.3 million. While efforts will

be made to implement the recommendations, the financial burden involved cannot be underestimated.

2. The other recommendations which do not require financial obligations are being implemented.

J12B:RESPCR.LSD

Report from HIV Working Group - October 1996

Members of the Working Group are:

Dr. Mohsin Uddin Ahmed, HPED
Dr. Tasnim Azim, LSD
Dr. Jos Bogaerts, LSD
Dr. Sarah Hawkes, CHD, (Chair)
Dr. Tajul Islam, Training
Dr. Tom Kane, HPED
Dr. Mahbubur Rahman, LSD
Dr. M.A. Salam, CSD
Dr. Md. Yunus, CHD

HIV Working Group Report

Following the decision of the Board of Trustees in June 1996 to adopt in full the recommendations outlined in the report of Dr. Barry Evans (visiting consultant to ICDDR,B and Head of the Division of AIDS and STD surveillance in the Public Health Laboratory Service, UK), an inter-Divisional HIV Working Group was established in the same month to work towards the implementation of the recommendations.

The Working Group has met monthly since June and the following points outline the progress made by the Group's members in meeting the objectives outlined both in Dr. Evans' report and the subsequent BOT meeting.

(1) Safe Blood Transfusion

A system for ensuring the safety of the blood supply through pre-transfusion screening is now in place. Since August all blood transfused in the Dhaka hospital has been screened for HIV, syphilis and hepatitis B. Blood is purchased from commercial sources outside, thus no named patient (directed donation) testing of blood is currently undertaken.

If blood is required on a non-urgent basis in Matlab then screened blood is now transported from Dhaka for that purpose. Since emergency blood transfusions usually require directed donations (most often from relatives), testing of these donations will be undertaken as soon as staff on site in Matlab have been trained in HIV counselling (see below).

(2) Staff training and education programme

Two separate requirements for staff training were identified by the Working group: (i) a training programme to develop counsellors specialising in HIV/behaviour change; (ii) an HIV/AIDS education and information programme for ALL members of staff in ICDDR,B.

(i) Training programme for counsellors

Following a visit to Calcutta by Dr. Hawkes, it was arranged for two training experts (Dr. Raphael Baltes from SDC and Ms. Veena Lakhumalani from the British Council in Calcutta) to visit ICDDR,B and speak to the HIV Working Group in September. Subsequent to their visit, the HIV Working Group decided upon the following plan of action for training: Ms. Lakhumalani (and one colleague from Calcutta) and Dr. Baltes will be asked to come back to Dhaka to run a training course in ICDDR,B on sexual health, counselling and communication skills. This will be for a small number of ICDDR,B staff (probably 20). Some of these staff will then be sent to Calcutta for further training in HIV counselling. The rest of these trained staff will be invited to be trainers for the Centre-wide programme of education/information which will be run in collaboration with CARE-Bangladesh (see below).

(ii) Centre-wide staff education programme

Using some of the staff trained in communication skills, CARE-Bangladesh will be asked to run a 'training of trainers programme' within ICDDR,B. A Memorandum of Understanding has been signed with CARE to then undertake a Centre-wide staff training/education programme using these trainers. This education programme will be for ALL staff in ICDDR,B.

(3) Programme of Unlinked Anonymous Surveillance

Protocols for carrying out unlinked anonymous testing of blood samples (for HIV and hepatitis B) collected in the urban and rural RTI/STI studies have been passed by the RRC and ERC. All the HIV test kits required by the 2 studies have been obtained free of charge from Wellcome Diagnostics, and we hope to start testing within the next one month.

It is hoped that the collection and testing methodologies developed in these two protocols may serve as models for future unlinked anonymous screening programmes in the country.

(4) Laboratory Science Work

Laboratory Sciences has set up two separate testing protocols for dealing with HIV-related work. Testing for blood transfusion purposes is under the supervision of Dr. Mahbubur Rahman. Testing for research purposes is being carried out by Dr. Tasnim Azim and Dr. Jos Bogaerts. Procurement of testing and laboratory equipment is ongoing.

Two members of staff from Laboratory Sciences Division (Dr. Anowar Hossain and Mr. Zahirul Islam Bhuiya) have received training in HIV testing techniques in Vellore, India. Dr. Tasnim Azim has also received a training programme in Vellore in laboratory aspects of HIV.

6/BT/NOV.96

RESOLUTIONS FROM THE INTEGRATED INSTITUTIONAL REVIEW REPORT

6/BT/NOV '96

REPORT OF THE INSTITUTIONAL REVIEW OF THE INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

SEPTEMBER 1996

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INTRODUCTION

The Donor Community is to be congratulated on its continued support of the International Centre for Diarrhoeal Disease Research, Bangladesh (Centre). The funds that the donors have provided over the years have allowed the continuation of high quality research in subject matters that are essential to the healthy development of populations in the developing world. The Centre in turn is to be congratulated on its continued ability to attract scientists and staff who are not only outstanding investigators, but dedicated human beings. The Government of Bangladesh has been an irreplaceable partner in these endeavors, and in spite of the many competing demands for its scarce resources has not just continued its support but actually increased it.

The Centre is an unique asset to the health of the world and its continued support will continue to provide answers to key problems in health and population at the highest benefit to cost ratio. The Centre has earned its reputation and continues to add to it. The recent activities in support of national program operations will continue to enhance the benefits that the world derives from the Centre's work.

While the Centre is not dependent upon any one individual, the Director during his tenure has provided outstanding leadership, and the Review Team knows that the donor community will provide whatever help it can to the Board of Trustees in their search for a new Director.

ISSUES RAISED IN THE TERMS OF REFERENCE

1. SCIENTIFIC ISSUES

How are research priorities set Centre-wide?
To what extent is targeted research driven by the Centre, by donors? Are there repercussions as a result?

The first step in setting priorities by the Centre has been accomplished. The Centre has established a research agenda in its Strategic Plan that sets the priorities to the Year 2000. This Plan was the work of the scientific staff of the Centre, calling upon outside consultation and advice, and approved by the Board of Trustees

The Strategic Plan envisions the work in three broad areas:

Child Survival

Population and Reproductive Health

Application and Policy

Within each of these areas a Goal and Research Objectives are elucidated. These of necessity are broad, allowing the Centre to take advantage of opportunities, both programmatic and funding.

The next step in setting priorities is to find support for the research that has been identified. This is accomplished in a variety of ways.

The Centre does receive about 30% of its budget in core (undesignated) funds. These funds, however, must pay for many administrative services as well as much of the patient costs of the Clinical Research and Services Centre and the Demographic Surveillance System. Those funds left after these costs are covered can be used for research that is in keeping with the Strategic Plan and has a high priority with the Centre in contrast to those driven by external sources, both donors and funds from competitive grants/contracts.

Divisions within the Centre then compete for these discretionary funds by developing proposals that are submitted to the Director for decision on funding.

Research priorities are also established by donors. For the most part the research that donors support through the project mechanism (in contrast to core funding) falls within the framework of the Strategic Plan, but reflect particular concerns of

individual donors. Usually, there is no conflict in priorities, but on occasion when there is a third party (e.g. academic institution), differences in importance arise. These are usually negotiated, but valuable time may be lost in such reconciliation of interests.

The research staff are aware of these forces and make logical decisions. The review process that exists at the Centre with its process of clearance protects the Centre from entering into areas that it is not equipped to deal with or are outside the priorities. This review process involves the Research Review Committee and Ethical Review Committee. they consider research quality, methodology, duplication and ethical aspects of human subjects as well as appropriateness of research area.

In most instances the interest of donors and the Centre are the same, but the Centre is put in the position of being a less than equal partner in decision making, which has an adverse effect on the professional staff. There is danger that if the trend continues, the Centre could turn into a "hotel" housing and servicing work of others.

Research priorities are also established by the availability of competitive awards. The Centre has limited ability to compete for some such awards that fall within its priorities and within its capabilities to successfully compete. This is due to regulations that limit foreign institutions from competing for awards from certain national governments. In at least one instance the funding agency will not pay overhead to foriegn institutions, but will pay full overhead to its own national institutions. In some cases the Centre has formed partnerships with national institutions in which the Centre is a secondary partner. This limits the Centre from obtaining its full share of overhead costs which could be applied to the core funds.

In recent years an increasing factor in determining priorities has been the needs of the Government of Bangladesh. More funds Have become available to the Centre through bilateral donor agencies and these, of course, are made available to the GOB. This is a healthy situation for without the cooperation of the GOB, the Centre would not function. It is appropriate that the needs of the GOB assume greater priority. As long as the research component is maintained this is an excellent arrangement, since the disease patterns and demographic situation of Bangladesh are common in many countries of the world and lessons learned in Bangladesh should be applicable to other countries. Documentation and evaluation as a research tool will be necessary if this is to happen.

The RT found no instances in which the research of the Centre was not in keeping with the priorities set forth in the Strategic Plan.

How does the range of activities utilize optimally the Centre's comparative advantage?

The Centre's comparative advantage includes the research environment with its access to a full spectrum of maternal and child health problems, particularly diarrhoeal diseases, reproductive tract disease and acute respiratory disease. It is a world class laboratory with state of the art technology for infectious disease diagnosis. The DSS is a globally unique, high quality demographic database. The Centre has access to field areas : extension projects in the rural areas as well as the urban slums, which allow lessons learned at the hospital and at MATLAB to be field tested.

The center has the infrastructure and expertise to accept fellows and to conduct training courses (to date some 870 from about 40 countries candidates have been trained). The Centre's hospital is a superb training location for the clinical aspects of case management of diarrhea at all times of the year. An excellent relationship with the host government exists, which facilitates many aspects of the center's needs.

While the activities of the Centre benefit from all of these advantages, there is one major area in which they are not capitalized upon. That is in collaboration with other developing countries. There is very meaningful collaboration with institutions and individuals in the developed world, because as Willy Sutton said, "That's where the money is." Indirectly this collaboration benefits other developing countries, but much stronger ties should exist with the developing countries. The Centre does not have funds of its own to support such collaboration, countries who could benefit do not have their own funds to initiate such collaboration and where training for nationals of other countries is funded, they need the academic degree that they can obtain in the developed countries. If the Centre is to serve the world as best it can, this situation should be remedied.

How is the quality of the research assured, monitored, and measured?

The research management process is well documented. The entire spectrum of activities related to this have been well thought out. Procedures are in place that organize and manage the process through the stages of priority setting, development of work plans, and protocol development, Writing applications for grants, peer review through the Research Review Committee, ethical review and supervision of projects are all covered, as are evaluation of the research and the researchers, dissemination of research results, and the incorporation of research results into methodologies, policies and programs. A guideline entitled "Procedures Being Followed For Review Of Research Protocols" has been prepared and made available to all researchers.

The Centre publishes some 120-150 papers annually, most of them in peer reviewed journals. The quality of the science is judged by the fact that a sizable proportion of the papers published have gained acceptance by high impact journals. For example, in the Laboratory Services Division, of 150 papers published over the last three years nearly half were in high impact international journals.

There are also a significant number of reports such as training manuals, guidelines and reviews, which are published and are used by other institutions, programme managers and policy makers.

Research from the center continues to have international impact and some examples will illustrate the point:

Vibrio cholera 0139 was discovered within 3 months of its appearance in Bangladesh and a diagnostic reagent quickly produced. This has been patented in the US as 'Bengal SMART'.

A new rabbit model for shigellosis;

A new diagnostic for Entamoeba histolytica which is due to be commercialized soon;

Clinical algorithms for persistent diarrhea;

Elucidation of the role of Vitamin A in infection and health;

Demonstration that giving pneumococcal vaccine to pregnant mothers protects the baby.

It is not enough for the work to be in accordance with plans and of high quality. It must be put to use. The findings from studies in MATLAB and the CSRC are now being put to field use in the extension projects particularly in the areas of family planning. Findings from the laboratory sciences division have been converted to laboratory methodologies, diagnostic kits and potential vaccine components. The epidemic control program has come up with a novel 'emergency treatment center.'

How is on-going research monitored to assure quality, ethical considerations, timely completion and publication?

Procedures for monitoring ongoing projects are documented in "Procedures Being Followed For Review of Research Protocols." The progress is monitored regularly by the programme leader and semiannual reports are submitted to the scientific committee with copies to the RRC and the Grants Administrator.

Is the balance of research, training and service appropriate given the Centre's mandate and comparative advantage?

There has been a major swing in the past five years in the relative balance of research, training and service. The service element has grown with the addition and expansion of the extension projects. This is both good and bad. It is good in that it is showing how the research can be translated, but it is bad in that the drive for production may limit the operational research that is necessary for evaluation and documentation. (See Conclusions and Recommendations) To date, however, the additional emphasis being placed on application of research findings is a highly desirable outcome of earlier work.

The issue of collaboration (training) of scientists from developing countries has been discussed.

One of the mandated activities of the Centre is to provide facilities for training Bangladeshi and other nationals in areas of the Centre's competence in collaboration with national and international institutions. This training is designed to disseminate knowledge and information generated by the Centre to the health practitioners and researchers throughout the world, and to improve the knowledge and skills of the health professionals, managers and researchers.

An evaluation of the training activities of the Centre was conducted in October 1993. After in-depth review of the training activity the evaluation made many recommendations which are essential to strengthen the Training Coordination Bureau's activities.

Progress has been made since the review of the training program in 1993 in terms of improving it's capacity to provide training to nationals. The quality of in-house management of training has improved in general but further improvement could be seen by the adoption of more modern techniques in training. Better utilization of staff senior researchers in the research methodology courses could be made, rather than reliance on outside lecturers.

To what extent is research involving multiple disciplines and across division lines encouraged and implemented? How?

Although it is expected that the research activities of the Centre should be multidisciplinary and cross divisional this has not always been the case and remains less than optimal. This is due in part to lack of specific competencies, but also is a result of the divisional structure. There exists good collaboration and interdependence between Clinical Services Division (CSD) and the Laboratory Sciences Division (LSD). Community Health Division (CHD)has also now moved to conducting reproductive health research including sexual health and child health and

has developed some connection with the LSD. There is some natural rivalry between the CHD and the HPED. The HPED, being well funded by the donors through bilateral funds, is looked upon by the CHD as an extended arm of the government for implementation purposes. At the same time CHD feels that they have to struggle for research money in the international arena while being burdened by the DSS which has always seemed to be in danger in spite of its value. (See Conclusions and Recommendations)

The Centre has instituted mechanisms that will lead to better interdivisional and interdisciplinary relations, but they have to be accepted in spirit as well as letter. The Working Groups, the Council of Directors and the Forums are all examples of such mechanisms and work with a varying degree of success. This needs continuing encouragement from the Director's Bureau as well as from the Divisional leadership. The Director's Bureau by being even more open in its dealings can assist in this manner.

An important issue examined by the RT was the role of the interdisciplanry workings in the social sciences. Although it is recognised that social scientific in-put in research is important, the Centre, like all biomedically oriented institutions, has not implemented its active integration. It is worth noting that all health problems have a socio-economic and cultural dimension and implications. Diarrhoea and nutrition, for instance, are largely influenced by a community's behaviour. Thus, for sustainable solutions to such health problems, the social scientists have to be an integral part of the research and implementation process. Emphasis on the social scientific in-put should be based on the methodology applied in the formulation, implementation and evaluation of research and intervention programmes. By virtue of most diseases being socially related, a stronger socio-economic component at the Centre is called for. Sociology is represented by one junior scientist only, which is an imbalance relative to 3 anthropologists and 11 demographers.

The formation of the SBS programme is commendable but the departure of the leader, Dr. Ross, calls for an urgent replacement.

Have external oversight/monitoring groups such as the Board of Trustees, Donor Support Groups and scientific Programme Review Committees been effective? Do they have clear and appropriate TORs? Is there overlap between the groups? Gaps? Do these groups assure adequate accountability? Is the compositions of the groups appropriate given TOR?

The Board of Trustees has matured since the previous review. At that time the Centre had been experiencing managerial and fiscal problems, and the BOT had inserted itself to help in the correction of those problems. With management of the Centre now on a more even keel, the BOT has been able to revert to the functions outlined in the Ordinance. That function is broad oversight and not micromanagement. The BOT functions are clearly spelled out. While the functions

are clear, the Board should be more active in the most essential role of a Board - fund raising. A usual procedure is for a Board member with a particular contact or interest to accompany the Director or other members of the senior staff in visiting potential donors.The Programme Committee Reviews conducted for the Board prior to their meeting are an essential part of the overview and governance of the Centre. These are now conducted by outside experts in the subject matter being reviewed with participation of a Board member with technical expertise in the subject under review. This has improved the review process.

The Donor Support Group is discussed below. It does not have a clear TOR and if it is going to accept the recommendations of this review, it will need to develop such.

2. INFORMATION DISSEMINATION/COMMUNICATION/PUBLIC RELATIONS

Does the Centre have an effective strategy for communicating the results of its activities to a variety of external audiences (donors, scientific community, GOB, etc.?)

The Strategic Plan of the Centre outlines in some detail a strategy for the dissemination of information about its activities. In the strategic plan the Centre proposes to target information dissemination to the following audiences:

a) Donors and international organizations

The Centre provides to donors and international organizations many of its publications and reports. The Centre should undertake to assure that all donors receive at least a complete listing of publications and reports. For the most part it communicates satisfactorily with individual donors at their request. The donors are invited to attend the November Board of Trustees meeting. Both the donor community and the Centre benefit from a forum in which matters of common interest could be aired and coordinated. The RT recognizes that donors have restrictions placed upon them that sometimes appear to be at cross purposes with the Centre's goals, but open communication is the best prevention of misunderstandings.

b) Health and family planning professionals.

Communication with this group is for the most part traditional scientific communications and the Citation Index would indicate that it is effective. The Centre utilizes well the standard methods of scientific communication. It has an enviable record of publication in so-called high impact journals and other peer reviewed publications. The Centre publishes the Journal of Diarrhoeal Diseases Research which fills a unique niche in the scientific literature. The circulation is approximately 500. Other publications for specialized audiences are also produced.

c) Government and NGO policy makers

Since the last review, the Centre has made significant progress in communicating meaningfully with these audiences. This has been brought about by the funding of the Extension Projects with the Government of Bangladesh and local NGOs. The functioning of these projects offers a basis for future impact on Health Policy in other developing countries. As accomplishments are seen in these projects, it will be important that the results be communicated more broadly to health policy makers throughout the region and the rest of the developing world.

These activities are organizationally combined with the training activities of the Centre. This linkage should be capitalized upon as the results of the Extension Projects become available and can be integrated with the research activities.

While the Centre is obviously communicating better than before with the GOB, it is important that the Centre begin to provide some feed-back to the community who participate. This is not only ethically justified but is a way to ensure continued participation.

Are funds allocated for dissemination and public relations adequate? Effectively utilized?

The allocation of funds for dissemination does not reflect the effectiveness of the efforts. The successful solving of the V. cholera 0139 epidemic and the development of a diagnostic kit was the result of rapidly disseminated information, but can not be related to funds set aside for dissemination. Evaluation of information and education is more than counting the number of papers published and number of people trained. The use of scarce resources from the core budget for such an evaluation could lead to a savings in the long run.

If the development strategy as it relates to the Endowment Funds is included in this question the funds are adequate and being well used. The return on investment for the Centre Fund endowment to date has been ten fold and as long as that continues, the funds for development should continue to be allocated in the manner that they are at present. It should be noted that this represents only three donors and the productivity of this cost centre should be closely monitored.

How does the Centre encourage and accomplish communication internally?

Since the last review the Centre has made a serious effort to improve internal communication and it is succeeding. The Inter-Divisional Scientific Forum is a major step in improving internal communication. There are still barriers, deeply imbedded in the educational culture of the region, to openly challenging findings and opinions. Senior staff works at improving this, but there is a way to go.

The Annual ASCOM is another mechanism for internal communication which draws from both the staff and fellow workers in Bangladesh.

The revised methods of performance evaluation are intended to be used as means of improving communications but that is dependent upon better training of supervisors. (See Conclusions and Recommendations)

At some point in time, when the computer systems are upgraded, another opportunity for improved communications will exist. While this can be a mixed blessing if used appropriately it will help.

The staff in the field, particularly Matlab, need to be considered in developing overall plans for communication. At the present time they feel cut off from the main Centre of activity.

3. ORGANIZATIONAL/HUMAN RESOURCE MANAGEMENT

How effective is the current organizational structure, managerial and financial, in fulfilling the mandate and objectives of the strategic plan? How could it be improved?

The recent changes in Divisional structures reflect a logical grouping of like and complementary units. This reorganization will make it easier to follow progress towards achieving the Strategic Goals, and to monitor accomplishments. It also provides appropriate supervision of scientific activities.

How can staff recruitment, development and incentives be improved and issues of international vs. national salaries be resolved?

This is a complex issue made more so by the fact that the Centre is still trying to reduce the permanent staff. It is impossible to discuss recruitment and incentives without also examining the issues of redundancy.

Considerable progress has been made in this area since the 1990 review. Approximately 100 core (i.e. permanent) posts have been lost. Every vacancy is scrutinized and a case has to be made for filling it rather than abandoning it.

Staff must now retire at 60 and efforts to reduce that have not been successful.

No permanent employment contracts are issued.

Before a contract is issued the Finance Department determines the funding and contracts are limited to the period that funding is guaranteed. More use is made of short-term contracts; contract service agreements. Permanent staff wishing to fill a project post on promotion have to give up their contract status. The Personnel Office has worked hard to ensure comparability.

The percentage of permanent and fixed-term core staff have dropped from 69% to 58% since the last review, a conversion of 100 posts. Efforts will be made to continue this trend. By 1998 about 50 permanent staff will reach retirement age and the Personnel Office estimates that a further 100 will go for other reasons. Nevertheless, it is estimated that there will still be about 350 staff on permanent contracts remaining by the year 2000.

Performance evaluation reports have been introduced that are in two parts. The first part sets out agreed objectives between the staff member and his/her immediate supervisor. These are measurable and are used to assess performance during the report period, usually annually. This is in line with modern practice elsewhere.

The second part is an old-fashioned subjective opinion of the qualities of the staff member. These are usually not measurable. If this system is open, as it is here, there is a danger that the reporting officer will be inhibited in expressing his opinion in front of the employee. If it is a closed system, the staff member does not know what is being said of him and has no opportunity to change it. In most other places this part of the reporting procedure has been dropped and replaced by the use of quantifiable objectives.

It is understood that there is a system of personal promotion for holders of scientific posts. This is found elsewhere, but it is not used for general service and administrative type posts. The Centre should not widen its use but should instead consider a system of performance-related pay based on the agreed performance rating of the annual targets for all types of staff.

In some places an addition of between 1% and 5% of basic pay is awarded for exceeding the performance targets. This then forms part of basic pay for assessing the performance related pay in year 2 et seq.

The problem of recruiting staff from other countries to fill international positions remains a major problem. There has been some improvement, but the basic problems still exist. Professionals from developed countries who would welcome the

opportunity to work at the Centre are for the most part in universities. Sabbatical leaves seldom exceed one year. Leave of absence for more than two years are even rarer. Therefore, a potential employee would lose their tenure, and have no guarantee of employment upon return to their native country. This is a powerful disincentive. Secondment by governmental agencies is much more limited than in the past.

Schooling for older children is also a reason given for reluctance to accept employment in Dhaka.

Do financial management practices assure appropriate use of funds?

The financial management practices assure the appropriate use of funds, although there are a variety of steps that the Centre could take to make the use of the funds more flexible, and thereby maximize their effect.

The budget process:

> Each September Division Directors and Principal Investigators (budget holders) are asked to complete budget preparation forms showing line by line their budget estimates for the coming year. These are returned to the Finance department and after a period of time the Divisions and PIs are told what their allocations are. In recent years there has been no negotiation process and no general and open management discussion leading to "corporate" agreement, or at least, acceptance. This is an important issue and a source of concern to several of the top managers who have no sense of ownership of the budget and may not have an understanding of the overall financial situation.
>
> A more usual process is for the budget holders to be given an idea of the financial situation ahead so that they can tailor their bids accordingly. There is then a detailed discussion between the budget holder and Finance (and sometimes Personnel) to refine the estimates. Any bids for new money are then assembled by the Finance Department and discussed at the top executive management group. The debate may become vigorous and finally the chief executive may have to decide but at least there is transparency. The participants should leave the meeting feeling that they understand the overall position; that they have presented their cases and there should be corporate loyalty to the decisions. The same process is often followed for capital bids, e.g. for equipment.

Written procedures:

> There are some current written procedures. There is a folder with various Board of Trustees resolutions made over the years and some Staff Rules are

available but there are no Standing Orders; Standing Financial Instructions or detailed Financial Procedures. This is a weakness as these documents should be part of a framework for financial control, viz.:

Ordinance

Standing Orders

Standing Financial Instructions

Detailed Financial Procedures

If there were comprehensive written controls available for donors to see they might be less inclined to impose their own monitoring or audit procedures which are such a burden on the Centre at present.

External audits:

The annual audit is carried out by Price Waterhouse and a local firm. It usually lasts 20 weeks. For some donors this is accepted but others send in their own auditors.

Agency	Number of Audits	Type of Audit
USAID	requires 4 audits	Yearly audit Indirect costs audit "Close out" (i.e. final accounts) audit "Non-expendable property audit"
SDC		annual audit
NORAD		annual audit
IDRC/BRAC		annual audit

These donor-specific audits are conducted by local firms or a combination of local and foreign firms (so they are not cheap). Altogether they add up to a further 20 weeks of auditors on site. This not only throws a burden on the staff having to find office accommodation; answer questions and find documents but it could also create real problems of filing and storage as some donors think that documents supporting payments from their funds should be filed separately which is clearly impracticable. Accounts departments cannot function efficiently like that.

4. RESEARCH MANAGEMENT

To what extent are core funds vs. targeted research funds used for research activities? Does the Centre have the flexibility to fund high priority research which has not been designated by donors as targeted research?

The core funded fixed term staff is 590. Of this 32% are devoted to finance and administration. The remainder are identified as research administration (26%) and research (42%) None of the project funded staff are identified as administrative. There is only minimal flexibility for innovative research since most of the core designated research staff are involved in fixed operations such as DSS. This issue is addressed in other areas of the report as well.

How is external peer review accomplished? Is the roster of consultants adequate to assure access to external experts appropriate for the breadth of research undertaken by the Centre? To what extent does proposed research undergo review both by the Centre and the donor? Are there conflicts and how are these resolved?

The peer review process has been described and discussed above. The roster of consultants is extensive and represents the highest caliber of research scientists in the areas of the Centre's work. This issue of dual review has been discussed above. There are seldom conflicts, but the time consumed and correspondence necessary is a hindrance to the conduct of research. A recommendation is made to this effect.

Does the Centre provide assistance in proposal development? Could this assistance be expanded?

The External Relations and Institutional Development Office (ERID) of the Centre provides assistance in identifying sources of grant proposals, but not in the technical preparation of specific protocols. The ERID is also the central point for proposals that will increase the core support to the Centre. The ERID also provides logistical support in terms of notifying investigators of reports due, etc. The size of the Office is appropriate to its function.

How is compliance with international standards for human and animal use as well as biosafety assured? Is the composition and role of the Institutional Review Board appropriate?

The Research Review Committee and the Ethical Review Committee are both active committees with external representation as well as internal. All research projects are reviewed by the RRC and those that involve human subjects by the ERC. Minutes of both committees are kept and were made available to the RT. One member of the RT currently serves on the ERC. From the minutes as well as discussions with her, it is obvious that there is a high level of concern for the rights of patients, with many projects being sent back for revision. Site visits during the conduct of review are also conducted. The membership of the committee is an appropriate mix of internal and external, lay and professional and it functions in conformance with WHO Standards.

Is the research review and selection process both effective and timely? Are there identifiable obstacles?

The review process is effective, but is time consuming. There is frequently dual review by the Centre and donors. A recommendation to alleviate this is made.

Is the research at the Centre competitive (quality and cost)? If not, reasons should be identified and solutions proposed.

There is little question that the Centre is competitive in terms of quality. An obstacle does exist here, however. Some agencies that make competitive grants limit the recipient to their nationals. If the Centre bids on these, it must be a subbidder to a national institution. This detracts from the initiative of the Centre and also deprives it of overhead funds that could augment the core funds.

Cost is an issue which makes the Centre less competitive. The Centre has attempted to address this by reducing core costs. However. until the endowment funds are sizable enough to give the Centre the degree of independence that academic institutions with large endowments have, further reduction in core personnel will only be cosmetic. This does not say that the effort should not continue to reduce this cost.

Has an organizational culture evolved which is constructive, forward looking, positive? If not, what could done to assist in developing such?

The organizational culture derives from the top down. The current Director has greatly improved staff morale by his accessibility and his obviously successful efforts to put the Centre on a sound financial footing. Filling senior staff positions has also improved, an indication to the Centre personnel that it is a good place to work. The

inter-divisional forums, the Council of Directors and ASCON are all ways of improving morale. As mentioned above, cultural changes take time. The prompt recruitment of a highly respected and qualified director is the most important action in continuing movement toward an even stronger organization.

CONCLUSIONS AND RECOMMENDATIONS

1. Maintain the Strategic Plan As a Dynamic not Static Instrument

The Centre uses its Strategic Plan as a guide for establishing its priorities in research. The Strategic Plan should not, however, be considered a fixed plan, but one that needs continuing discussion and modification as circumstances change. The biennial work plans are an excellent means of initiating these discussions and modifications.

The RT **recommends** that the leadership of the Centre continue its encouragement of the planning process through interdivisional groups and at all levels of the research and support staff to assure that there is full understanding of the Plan and that it remains a dynamic document.

2. Establish Global Priorities for Research in Child Health

The Centre's Strategic Plan is purposely broad. It is able to accommodate not only the Centre's self-determined priorities, but can adjust to donor priorities and to the needs of others who collaborate in competitively funded projects. This can detract from the Centre's control of its own research agenda. If a global set of priorities existed it could give guidance so that the limited resources available are best used.

The RT **recommends** that a neutral party such as a foundation convene a meeting to propose priorities in child health research for the developing countries. Such priorities could guide funding agencies, WHO, the Centre and other research institutions in the use of their resources.

3. Improve Collaboration with Developing Countries

Among the comparative advantages of the Centre is its location in a developing country with the health, social and economic problems of other developing countries. Unfortunately, but understandably, most of the meaningful collaboration of the Centre is with scientists and institutions of the developed countries. Developing countries do not have the resources to fund scientists and/or institutions to work in other developing countries. Scientists from developing countries are reluctant to spend time at institutions that do not have the ability to grant degrees, since such are often necessary for advancement in their own country.

The Review Team (RT) **recommends** that the Centre and the donor community give priority to collaborative efforts that would link investigators from the developing countries to institutions in the developed countries for their academic experience. Then the investigators could be linked to the Centre for opportunities to conduct research in a meaningful environment with excellent supervision. The Centre should also enhance its role in strengthening regional and national research capability.

4. Strengthen The Social Science Component In The Centre.

The social dimension is a crucial and relevant part of most health research, with special application in developing countries. It is important for the Centre to strengthen its competence in the social science field, especially as it broadens its scope of research. Such strengthening, both qualitative and quantitative, will require that skills and perspectives in anthropology, sociology and statistics be sufficiently represented at the Centre.

The RT **recommends** that the social science unit within CHD be strengthened. The first order of business should be the recruitment of a senior scientist to head the unit. This would enable the development of research proposals specifically addressing socio-medical issues of relevance to the Centre's mandate. The RT further **recommends** strengthening of the links between CHD and HPED on social science and epidemiological methods. Such skills should be used throughout the divisions when applicable.

5. Maintain Research Integrity in Bilaterally Funded Projects

New pressures are put on the Centre in the conduct of projects using bilateral funds. Since these projects are viewed by some as "technical assistance" rather than research there are understandable demands put upon the Centre to meet goals. In doing this there are often less time and resources to assure that the activities are designed in a manner that will allow needed operational research questions to be answered. If the projects are going to be of value in replication in Bangladesh as well as other regions, there must be careful attention to the operations research as well as the operations..

The RT **recommends** that the Council of Directors constitute a scientific advisory board to review the design and make recommendations for changes to strengthen the design of projects by assuring that evaluation tools are built in from the onset. This would increase general applicability of the findings, improve regional collaborations and stimulate comparative evaluation and implementation research.

6. Improve Data Management

The Centre recognizes that its data management capabilities have long been inadequate. A study by the Asian Institute of Technology was done two years ago and recommendations for upgrading were made. To date funding has not been available to implement the recommendations. The RT is concerned that if funding is not soon found the technological advances since the last report may force another study with the subsequent delays. The needs are not just for the normal computer operations of the Centre but especially for the DSS.

The RT **recommends** that special appeals be made to the donors for the capital investment needed to match that already pledged to bring the electronic data management system up to contemporary standards.

7. Better Utilize Matlab and the DSS

The RT recognizes that Matlab and DSS are not one and the same, but it is difficult to separate consideration of the two. The RT further recognizes that an evaluation in depth of DSS is scheduled in the near future, but the RT will make recommendations based on this current review.

The 1990 Review stated: "The unique qualities of the Matlab field station and the DSS must be given high priority for budgetary support and continuity. Not only should these be protected from the budgetary standpoint, but no efforts should be spared to further open access to the data so that more investigators can test their hypotheses on existing data and propose plans for additional prospective research projects."

The current RT heartily concurs with that recommendation.

In spite of major public health contributions that have come from Matlab, there continues to be skepticism over its future value. Since the previous Institutional Review, major changes in the programmes of the Centre have come about as a result of the research conducted in Matlab. The Rural and Urban Extension Programmes are demonstrating the practical applications of the lessons learned in Matlab. The question remains, can Matlab continue to remain a cost effective research area?

The RT believes that it can and should remain a keystone in the research programmes of the Centre. Just as the hospital is essential to the clinical studies research, so Matlab is essential to field research. This is not to say that the activity should remain unchanged. The body of this Review raises questions of a technical nature that need to be addressed, and the Divisional Reviews also address these matters.

The RT is concerned, however, that more use has not been made of the data by non-Centre scientists. In part this is due to the necessity for investigators to bring their financial support, since the Centre is in no position to furnish others funds. But to a large measure this is also due to the ability to access the data. The databases are not user friendly.

The RT **recommends** that

a) priority be given to upgrading the data systems so that the data is more readily available to other investigators. Allowing this access would do much to alleviate the criticism from without;

b) a long-term plan for the DSS be developed;

c) Matlab be utilized as a site for international training courses on field research methodology.

8. Assess Possible Changes in Training Methods and Content

The Training Coordination Bureau has done an admirable job in developing training courses for clinicians and public health workers. Most of these courses are targeted towards leaders as befits a research institution. It is difficult to measure the full impact of the training. Counting numbers and anecdotes from past trainees gives only a measure of process, not accomplishment.

Training methods throughout the world are constantly changing in response to evaluations of training activities. Some training does not require hands-on experience. In such cases the Centre should look to the burgeoning technology that supports distance learning. Internet connections are opening with more and more of the developing world. This in turn opens opportunities for an expanded communication technology applied to training methods.

The RT **recommends** that the Centre, in collaboration with other training centres and international organizations, explore ways in which training methods could be brought up to date. Training methods, dealing particularly with policy and planning, could be expanded through use of electronic media.

9. Improve Donor Coordination

At the present time it appears that the donor community acts more as individuals than as a community. There is one formal meeting at the time of the Board of Trustees meeting in November, but other contacts are on an individual basis. Duplication of effort is not so much a problem as is the perceived lack of focus on key issues. The preceding recommendation, if adopted, would aid in this regard, but there are other steps that can be taken. Multiple peer review (by the Centre and by donors) continues.

The RT **recommends** that

a) There should be an annual meeting of the Donor Support Group, the key Centre staff and the Executive Committee of the BOT for discussions of matters of mutual interest. This meeting should be structured with a prepared agenda that is circulated in advance. This would allow for productive exchange of viewpoints. It would be helpful if representation from the various donor headquarters could also participate on a regular basis in this meeting.

b) To the greatest extent possible the donor community agree on a single auditing requirement: (See Recommendation 24)

c) The Donor Support Group and the Centre should develop a plan for external review of proposals that will be unitary and satisfy the requirements of both.

10. Maintaining Leadership

The Director in six years has brought about major improvements in programme direction and in the external relations of the Centre. As it become more difficult to obtain resources, the latter function increases in importance and will take an ever increasing amount of time. As donor bilateral funds become a more important part of the Centre's budget, maintaining close liaison with the Government of Bangladesh and NGOs in Bangladesh will become another major role for the Director. The Director must also carry the responsibility and accountability for management policies of the Centre Success in these activities dictates that the Director must be assured of the excellence of science base of the Centre. It is expecting too much of one person to fill all these responsibilities.

The RT **recommends** that the Director consider strengthening the Director's Bureau by establishing a post within it for a senior scientist. Under the overall guidance and supervision of the Director, the scientist would be responsible for, inter alia, science policy, interdivisional coordination of scientific matters,

chairing Scientific Review Committees and Ethics Committee and acting as Director in the absence of the Director. The RT recognizes that this position should not detract from the leadership and responsibilities of the Division Directors but should assist with the many responsibilities of the Director's position. The RT further **recommends** that the BOT allow for the establishment of the post, but that the Director decides the best division of labor. It is important that both the Director and the senior scientist agree on the division of labors.

11. Strengthen External Governance

The Centre is unique in that it has no institutional "home." It is not part of an international organization, an academic institution or a national government. Therefore, it must be its own governing body, its own fund raising organization as well as its own operating agency. It is dependent upon the donors for its financial well being, yet the donor community is not part of the governing body, the Board of Trustees.

Generically, a board has two major functions: first to assure the proper management of an institution and second to assist in improving the financial health of the institution. A board exercises the first function by employing the director of the institution. The second is achieved through individual efforts of members of a board to identify sources for and assist in accessing funds. In the case of the Centre's Board of Trustees, they have fulfilled the first function admirably. There is little evidence to indicate that the Board has been too effective in the latter function. The Director has greatly strengthened the scientific efforts of the Centre and has maintained its financial health in spite of the world wide problems involved in support for international activities. In particular, the Director has instituted two Endowment Funds that hold the promise of stabilizing the financial picture. However, the goals of those Endowment Funds have not been reached.

If the BOT is to further assist the Centre in its search for new sources of funds from new sectors, it will be necessary to add to the Board representatives of private sector leadership .

a) The RT **recommends** that the BOT seek members that have the ability to identify sources of funds from the private sector. If this recommendation is adopted choices must be made so that new members do not represent any conflict of interest.

If the BOT is to concentrate its efforts on improving the fiscal situation and overall management issues, it may be that the Board should delegate some of its concerns about scientific matters to another body. A Scientific Council

could provide for the technical oversight. If such were to be formed it should be structured so that it could function for both the BOT and the donors.

b) The RT **recommends** that the Director work with the BOT and the donor community to see if such an arrangement is feasible. Such a Council would have to take the place of some of the various review functions currently carried out, and should not be an additional review body.

12. Maintaining Core Services

The Centre has made remarkable progress in reducing the size of the core staff. As funds for maintaining the core activities become more difficult to obtain, further efforts are necessary.

The RT **recommends** that:

a) The Centre continue its aggressive policy of examining each core position to determine its necessity.

b) Donors work to direct as many funds as possible to maintaining those positions which would lower the costs of project research and increase the competitiveness of international grant proposals from the Centre.

c) The Centre work with donors who are unable to fund core activities to attempt to incorporate into projects support for certain core positions from the above roster which have relevance to the project.

13. Improve Managerial Efficiency

At the present time the administrative management and finance activities of the Centre are organized as Divisions and appear on a line with the scientific divisions. The management functions are activities that service the entire Centre and should be recognized as such. They are an integral part of the Director's Bureau, and should not be perceived as Divisions that may have to compete for resources with the scientific divisions.

The RT **recommends** that the current Administration and Personnel and Finance Divisions be shown as functions of the Director's Bureau. This should be done in a manner that does not imply loss of status, but actually status gained.

14. Allow More Budget Flexibility

The Divisions have no control over their budgets, and must obtain approval on all deviations from budget lines. This lack of authority detracts from the Division Directors ability to be managers, and does not stimulate innovation. It also inhibits timely reprogramming of funds to meet changing circumstances.

In many countries there is a movement towards devolving budgets to departmental budget holders who have power to move funds between expenditure heads within rules contained in a budget manual.

The RT **recommends** that the Centre should introduce systems of devolved budgets. Budget holders should be trained and a budget holder's manual should be written and issued to every budget holder, along with copies of Standing Orders and Standing Financial Instructions. The manual should set out the limits of the budget holders powers. It should also provide some motivators. As a policy, for example, the Centre should try to accept that savings or extra income generated by positive management action should be retained by the department responsible. However, fortuitous savings or surpluses may not automatically be used within the department and may have to go into central funds to help the corporate position.

15. Divisions Should Have Discretionary Funds

In the 1990 Review it was recommended that the Director should have a small discretionary account to take advantage of opportunities. This has transpired and the next step should be to allow the Division Directors a similar flexibility. At the present time some funds are made available to Divisions at the beginning of a fiscal year. The Division Directors make requests which are either granted or denied.

The RT **recommends** that there be discussions of the various proposals in the Council of Directors and that priority be given to those that foster interdivisional collaboration. Such funds could be used as planning grants and for pilot activities, which would foster more international grant proposals.

16. Consolidate Audits

At the present time there are five external audits conducted. This is expensive, time consuming and there have not appeared to be major discrepancies found. While it is realized that some of these audits may be mandated and cannot be altered, some simplification should be sought.

This might be more easily accomplished if there were more written procedures in place.

The RT **recommends** that donors consider whether sending in their own contracted auditors on such a scale is a cost-effective use of their own resources or whether their requirements could be met by a joint audit or the Centre audit currently conducted by Price Waterhouse.

The RT **recommends** that technical assistance be sought to write Standing Orders and Standing Financial Instructions for the Centre.

17. Contain Costs at the Clinical Research & Service Centre (CRSC)

The CRSC remains a major drain on core funds. The number of patients continues to rise and they can not be turned away. The Endowment Fund will, of course, help in this area but there are other measures that can be taken to reduce costs of hospitalization. But this alone will not solve the continuing escalation of patient costs. One way to achieve this would be to lessen patient demand by assisting in the upgrading of alternative facilities in the Dhaka area.

The RT **recommends** that the Director convene an interdivisional group to work with the GOB and the Municipality of Dhaka to study ways of improving services that could lead to lighten the case load at CRSC, For example, the Clinical Sciences Division and the Training Coordination Bureau could work with the HPED to help the GOB and the Municipality of Dhaka to establish patient-friendly diarrhea treatment centres in key locales in Dhaka that would be identified as part of "The Cholera Hospital." Since the residents of Dhaka identify with "The Cholera Hospital" attempts could be made to transfer the hospital's identity to the treatment centres.

18. Improve Commercial Potential of Research Findings

The Centre's Laboratory Sciences Division has succeeded in commercializing its SMART test for the rapid diagnosis of V. cholera 0139 and receives a royalty for it. This is encouraging. Other potential leads should be vigorously pursued to generate more income and to convince donors of the Centre's resolve to reach a measure of self reliance in funding. Some scientific contributions from the Centre have been incorporated in products that have been commercialized by collaborating institutes, Efforts must be made to see that the Centre realizes it share of income generated by joint efforts.

The RT **recommends** that the Centre continually monitor its findings to determine their commercial potentials. The Centre should explore the

feasibility of allowing individual researchers and their staff to share in any royalties that may ensue. This could act to motivate recognition of commercial potential as an initiative to recognizing commercial potential.

19. Continue to Seek Endowment Funds

The Centre has been remarkably successful in attracting endowment funds for the Hospital. This is an indication that the hospital is important to Bangladesh, and that individuals and corporations are willing to support it. There has been a broad base of support for the Hospital Endowment Fund which is more meaningful than a very few large donations.

The Centre Fund likewise has an impressive start with two commitments of $1 million and one of $150,000. This establishes a basis that the fund raisers can then use as examples of success as they approach other potential donors. This success is important in the light of continuing shrinkage of resources for international health activities.

The Development Office has a well crafted "Case Statement" to use in approaching donors.

The RT **recommends** that the Centre continue its present relationship with the Child Health Foundation, but carefully monitor the success or lack thereof of fund raising.

The RT further **recommends** that members of the Board be encouraged to assist in the identification and solicitation of potential donors.

20. Conduct a Strategic Review of Human Resource Policies

The problems outlined above are not amenable to a simple solutions. The Centre must try to reduce its fixed commitments because its guaranteed unrestricted funding is being reduced. It should, therefore try to reduce its permanent staff so that the Centre is more flexible and can be adjusted more readily to match funding. The hard reality is that this means changing the employment status or cutting jobs of some staff who have served the Centre well and loyally over the years. Finding the right human resource policies to deal with this is one of the most challenging tasks facing the Centre.

The RT **recommends** that there should be a major review of the human resource issues. This review should cover the following:

whether it is appropriate to continue the UN pay relationship formula;

if it is, then to define it more clearly;

whether using the UN pay formula also means that the WHO "other personnel" policies should continue to be used;

a review of the pay structure, should the length of pay scales be altered;

should efficiency bars be introduced;

performance evaluation systems including some form of management by objective;

performance related pay;

strategies for reducing the numbers of permanent posts in a manner least hurtful to effective long-service staff.

21. Improve Supervisory and Managerial Skills

Training of supervisors in their responsibilities and improving their skills as managers is an important aspect of any organization. It should be a function of the management of an institution. At the present time this function is managed by the Training Coordination Bureau. In the past year 2 employees received short term training in management. While this benefits those few, there are advantages to training supervisors as a group. It develops a sense of teamwork and makes the training seem more relevant to the workplace.

The RT **recommends** that the managerial aspects of career development be transferred to Administration and Personnel and a plan of management training be developed.

22. Improve External Communications to the Public

The Centre has made successful efforts to improve its communication to the non-scientific world, particularly in Bangladesh. However, many higher level policy makers and the public do not know about the work of the Centre. The Centre continues to communicate for the most part through written materials understandable to the scientific community, but that do not project the magnitude of its accomplishments to the lay public.

The RT **recommends** that the Centre seek a short term consultant to assist in drawing up a communication strategy. On the basis of that strategy, the

consultant should determine the level of resources necessary to meet strategic goals.

23. Continue to Improve Internal Communication

There has been an obvious improvement in internal communication since the last Review. The Inter-Division Scientific Forum, the Working Groups, the Council of Directors are all methods of communication. The RT recognizes the long term difficulties in moving from a traditional hierarchical work environment towards one that is more collegial. It applauds the efforts of the Director and the Senior Staff to move in that direction. The increasing number of younger staff should be encouraged to discuss and question scientific and programmatic matters in seminars.

The RT **recommends** that continued efforts be made by senior staff to encourage participation by junior staff in scientific discussions and meetings.

24. Explore New Ways of Information Dissemination

The Centre has an enviable record of publishing scientific papers in high impact journals as well as in its own publication, the Journal of Diarrhoea Disease Research. There are a variety of other publications for special audiences (Glimpse, ICDDR,B News, and Dialog in Health). While Glimpse and Dialog in Health have a large distribution, little is known of their impact.

The RT **recommends** that the Centre begin moving towards use of the Internet as a major method of communication with both the research and practicing public health community. "Home pages" and "mailing lists" are now part of the main stream of communication and the Centre should move rapidly to participate. The Centre should consider the cost-effectiveness of electronic publication of JDDR. If sufficient numbers of the readers can access the Internet, the cost of mailing and printing could be recovered for other activities

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MATERIALS REVIEWED

1989 External Review Report and Response

External and Programme Reviews of Scientific Divisions and Responses 1990-96

Division Achievements 1991-1995

ICDDR,B Ordinance

Board of Trustee Membership and Cvs

Resource Development Strategy

Strategic Plan

Financial Reports 1990-1995

Annual Reports 1990-1995

ASCON I-V Programmes

Special Reports

DONORS INTERVIEWED IN BANGLADESH

Board of Trustee Minutes 1993-95
Dr. Wit Harjotanojo
WHO Representative

Rolf Carriere
Dr. Monica Sharma.
UNICEF Representatives

David Piet
USAID

Walter Meyer
Swiss Development Cooperation

David Chiel
Ford Foundation

Dr. Mehtab Currey
ODA

Maj. Gen. (Ret'd) M.R. Choudhury
Board Member

Lutfullahil Majid
Board Member

Mr. Mohammed Ali (Health Secretary)
Board Member

Dr. Alain Mouchiroud.
UNFPA Representative

DRAFT REPORT OF MANAGEMENT CONSULTANT 14.9.96

Introduction

1. The visit took place between 31st August and 13th September 1996. When I left the UK on 30th August I had understood the visit to be for these two weeks. I was surprised therefore to learn on arrival that the Review mission has been shortened to one week. After some discussion with the ICDDR,B and ODA it was agreed that I should stay on after the first week and complete the terms of reference covering the institutional, finance and human resources aspects of the Mission with two additions. These were to look more closely at the Finance division and also to recommend to ODA how it might focus what is now its unrestricted core funding with maximum benefit to the ICDDR,B.

Format of the consultancy

Most of the first week was taken up with formal presentations to the Review Team (RT) by the Director and by each of the 6 Divisional Directors including Finance and Adminstration & Personnel. Other presentations were given by the heads of departments of Training and External Relations and by representative of WHO and Unicef. There was also a one day visit to Matlab by bus and boat. Together with the RT leader, Dr. David Sencer, I visited the local ODA representative, Dr. Methab Curry at the British High Commission.

In the second week I had long discussions with each of the Divisional Directors and other senior managers in Finance and in Personnel. I reviewed in depth many of the systems in Finance and in particular the financial coding system. At the end of the week I had another meeting with Dr. Curry at the BHC.

Achievement of the Terms of Reference

2. The original terms of reference were very extensive and it has not been possible to cover them all to my own satisfaction. This is no fault of the ICDDR,B whose staff could not have been more helpful and kind. For example, I have not been able to cover in depth all the human resource issues. These are key to the success of the organisation and I shall recommend that a strategic review of human resources be carried out with technical assistance. This suggestion has received support throughtout the Centre and from the resident ODA representative.

3. I have not been able to review the procurement practices in detail. The work I have done leads me to believe that there are tight centralised controls which can

sometimes frustrate the clients elsewhere in the Centre who see them as slow and beauracratic especially for overseas purchases. Inventory control looks sound.

4. The maintenance of scientific equipment is carried out internally to what is reported to be high standards. I did not have time to look at facility plans or safety programmes or the printing and publication management.

Review of the Financial Management System

2. The FinanceDivision has a typical structure in three parts

* Financial accounting including Paymaster services; Treasury management; general accounting; fixed asset accounting and central stores - (but not Supplies which comes under Administration).

* Budgeting and Costing.

* Computerised Information System (CIS)

As the computer arrangements are undergoing major change at present I did not review that section - see below.

Staffing

Div. Directors Office	1
Financial Accounts	23
Budget Section	8
CIS	12
Total	44

9. Staffing Resources

The Controllers stated that they had adequate staff for normal circumstances but they have to engage temporary staff or work overtime at times of pressure - e.g. when overwhelmed by auditors or when they have to pay large numbers of temporary clinical staff to manage epidemics. Although paid overtime is limited to a maximum of 15 hours a month per person staff actually work more. In 1995 aggregated overtime equivalent to 25 weeks was paid @ time-and-a-half. Total payments worth $2000 were made - only junior grade staff are paid at all. A lot more unpaid overtime is performed by staff at all levels.

Activity

The staff report that they are busier now than in the past but where there are some readily available figures this is not reflected e.g.

	1993	1995
Project Vouchers	1264	1020
Payment Vouchers	9911	9484

Although the number of staff on the payroll has not changed much the balance has swung from permanent staff to fixed-term contract staff. This means there is more movement on and off the payroll which is a time consuming process for the Payroll department as the work is detailed and has to be correct.

The activity of any Finance department is affected by the efficiency of other parts of the organisation. For example, if managers fail to give adequate notice of new joiners and leavers or of staff travelling who need travellers cheques etc. the Finance department is put under last minute pressure to produce the goods in the time available. This is not measured but it happens in most organisations. It happens here too and I get the impression that the staff will pull out the stops to help their colleagues.

Working Conditions

Although the offices of the Finance Division are in an area where optimum use of space could be better they are well organised with the cashier near the entrance so that people do not need to wander in for payments. Some rooms appear cramped. They could all do with some redecoration and general smartening-up but overall they appear to be satisfactory and they are reasonably clean and tidy.

Payment of Staff Wages and Allowances

All staff apart from very short-term contract staff and Daily Paid staff are paid by bank transfer. International staff can chose where to have their pay credited, either within Bangladesh or elsewhere. They may have it divided and have some paid locally and some credited overseas. All other staff must open accounts at the on-site branch of the Agrani bank, a state-owned bank. 1625 staff are paid monthly.

Daily Paid staff are paid in cash or at bank weekly; two weekly or monthly depending upon how long they are working. 200 staff are Daily Paid of which 160 are paid in cash.

Short-term contract staff are paid by crossed cheque.

Similar arrangements apply at Matlab but all the calculations are done at HQ.

There is a monthly exception staff return submitted by Divisional directors. The Centre should consider whether a positive staff return would give better control. (A negative staff return is a return which infers that everything is as before and only exceptions or variations are reported. A positive staff return is one where the manager has to affirm in writing that staff attended as required and where there are exceptions, variations or adjustments these are highlighted.)

4. Banking

The Centre has two local bank accounts. The main account is held in US dollars at the Amex Bank. Cash is transferred by cheque to the Agrani bank account as required for local payments of staff pay and creditors. The Centre also operates two overseas bank accounts, in London and New York.

5. Written Procedures

There are some current written procedures. There is a folder with various Board of Trustees resolutions made over the years and some Staff Rules are available but there are no Standing Orders; Standing Financial Instructions or detailed Financial Procedures. This is a weakness as these documents should be part of a framework for financial control, viz:

Ordinance

Standing Orders

Standing Financial Instructions

Detailed Financial Procedures

I am surprised that the auditors have not commented as without such written directions there is no reference point. Furthermore, if there were comprehensive written controls available for donors to see they might be less inclined to impose their own monitoring or audit procedures which are such a burden on the Centre at present - see External Audit below.

I provided some model SOs and SFIs used elsewhere but they would need substantial rewriting to suit the ICDDR,B and I recommend that technical assistance be provided for this. The first re-write could be done off-site and ideally the consultant would then need to spend time on-site to complete them.

6. Staff Training

New staff receive no general induction training within the division or from central Personnel. There is no core staff training budget. There is a Staff Development Fund financed by the Swiss Development Corporation (SDC). It is administered by the Director's office and Divisional Directors make annual bids.

In 1993 the two Controllers went to the International Rice Research Institute, Manila for 7 days to observe the financial processes there.
In 1996 they attended the Centre for Public Management in Washington for 3 days for a course which focused on the rules and compliances of the USAID.
The Treasurer; Payroll Manager and Budget Officer went to the International Crops Research Institute for the Semi-Arid Tropics, Hydrabad, India for 7 days in August, 1996 to gain experience of its financial systems.
One staff member in the Finance Division had his training paid for leading to the award of the International Diploma in Computer Studies from NCC UK - the training being provided locally by IBCS, Primax Ltd.
In July, 1996 there was an IBM local course for 2 1/2 weeks for 4 staff members.

7. Computerised financial systems.

The computer strategy is to acquire new hardware and transfer the existing financial systems to it. This is because the systems do what is required of them and the staff are familiar with them. ODA is paying for the hardware and project management. The latter is being provided by the Asian Institute of Technology, Bangkok at a cost of $159,000.

8. External Audit

The annual audit is carried out by Price Waterhouse and a local firm. It usually last 20 weeks. For some donors this is accepted but others send in their own auditors.

*USAID	requires 4 audits	Yearly audit Indirect costs audit "Close out" (i.e. final accounts) audit "Non-expendable property audit" - in plain English this is an audit of fixed assets and it is not carried out every year.
*SDC		annual audit
*NORAD		annual audit
*IDRC/BRAC		annual audit

These donor-specific audits are conducted by local firms or a combination of local and foreign firms (so they are not cheap). Altogether they add up to a further 20 weeks of auditors on site. This not only throws a burden on the staff having to find office accommodation; answer questions and find documents but it could also create real problems of filing and storage as some donors think that documents supporting payments from their funds should be filed separately which is clearly impracticable. Accounts departments cannot function efficiently like that. Donors should consider whether sending in their own contracted auditors on such a scale is a cost-effective use of their own resources or whether their requirements could be met by a joint audit or the Centre audit currently conducted by Price Waterhouse.

There is no Internal Audit function and the Centre should consider the disadvantages of this.

Budgetary Systems

a. the Chart of Accounts

b. the budget coding system (which identifies cost centres)

c. the budgetary reporting system and timetable.

d. the budget preparation process being used now for the 1997 budget-setting exercise

a. Chart of Accounts

I was provided with a copy of the Chart of Accounts (a document that sets out the accounts codes - which are the key to successful accounting systems). The account codes are in groups made up of two double digits e.g.

40 00 Training, Workshop and Seminar
40 01 Allowances for ayas & volunteers (while on training workshops or seminars)

Each 4 digit group is unique which allows for ease of aggregation for summary reports or other purposes. This is an important feature as non-unique codes (i.e.codes where the same number means different things depending on which budget it is found) cause inordinate amounts of work whenever any analysis of income and expenditure is required.

b. Budget Codes

The budget codes comprise 6 digits 0/0/ 00/ 0/0

1st digit	denotes Division
2nd digit	denotes Protocol or Department (0=Protocol; 1-9 = Department)
3rd & 4th digits	denote Branch
5th digit	denotes Unit
6th digit	denotes type of funding (0=Core; 1=Project)

The above two coding structures appear to give the Centre what it wants and the staff are happy with it. The decision has been taken to stick with this system for the foreseeable future and I would endorse it. It is an enormous exercise to change to a new coding structure and one that is only justified if the new one can provide significant advantages over the old one.

c. The Budgetary Reporting System And Timetable

The aim is to run the monthly cost reports off the computer by the 8th of the month and - after checking in the Budget department - to pass on to the Principal Investigators (PIs)and other budget holders by 12th. Thus there is always an intensely busy period of checking before the reports are released. Each budget report is supported by detailed listings of salaries and non-salary payments. This amlunt of supporting detail is impressive and not usually found elsewhere.
In addition to the monthly cost reports other reports are produced:

Summary reports by account code and budget code by Project and Core funding to Divisional Directors

Quarterly reports of project funding position issued to Divisional Directors (wef 3/96)

Also being considered are Inception Reports, i.e. reports detailing project expenditure over the life of the project (which may run for several years).

d. Budget Setting Process

Each September budget holders are asked to complete budget preparation forms showing line by line their budget estimates for the coming year. These are returned

to the Finance department and after a period of time the budget holders are told what their allocations are. In recent years there has been no negotiation process and no general and open management discussion leading to coporate agreement, or at least, acceptance. This is an important issue and a source of concern to several of the top managers who have no sense of ownership of the budget and may not have an understanding of the overall financial situation.

A more usual process is for the budget holders to be given an idea of the financial situation ahead so that they can tailor their bids accordingly. There is then a detailed discussion between the budget holder and Finance (and sometimes Personnel) to refine the estimates. Any bids for new money are then assembled by the Finance Department and discussed at the top executive management group. The debate may become vigorous and finally the chief executive may have to decide but at least there is transparency. The participants should leave the meeting feeling that they understand the overall position; that they have presented their cases and there should be corporate loyalty to the decisions. The same process is often followed for capital bids, e.g. for equipment.

The Director said that this process was followed some years ago but it led to a great deal of bitterness and destructive behaviour so he abandoned it. He thinks that it failed because of the personalities of one or two individuals at that time. He agrees that it should be reintroduced and said he would do it this year.

Relationship Between The Finance Department And The Rest Of The Organisation

I was impressed by both the Controllers in Finance who appear to be keen to improve
services to the rest of the organisation. The cehtral services such as Finance and Personnel have several roles. One is to safeguard the integrity of the organisation by the operation of control systems. A second is to ensure consistency across the organisation in the intepretation and application of policies. But they should not merely be policemen. A major role is of facilitator. The Centre exists to deliver top quality research; teaching and patient services and the Finance department should be proactive in contributing to those goals. It should not be viewed as a constraint by reasonable people. A balance has to be struck between the different roles. My impression is that currently the balance is slightly in favour of policing. The Finance department should explore ways of integrating itself more with the divisions.

Improved openess in the budget setting process discussed above should help. The Centre should also consider more devolution of budgetary control especially of the core budgets held by Divisional Directors. One Director said the PIs within his division had more powers than he has in managing budgets. Indeed he did not feel that he was managing a budget, rather that he was custodian of an allocation.

Although Finance was often receptive to suggestions about virement of budget sums the budget holder was essentially asking for permission rather than making financial management decisions. Similar thoughts were expressed by other senior managers. There was also resentment that any savings or surpluses were invariably lost to central funds rather than enjoyed in the departments which produced them.

In time of financial insecurity there is often a tendency to tighten central control but it is not always the best way of achieving success and it can cause enormous resentment within the organisation especially in those departments which run tight ships as they suffer along with the fat cats - if there are any. Control is not about top management signing every piece of papar and making every detailed decision. Control can also be achieved by setting policies and procedures; training managers to operate them and then by monitoring performance. These systems of control make middle managers feel more involved and empowered and since they are closest to the service they can often exercise imagination and creativity to obtain better value for money and can carry their staff with them. Top managers are left with more time to do what top managers should do, which is operate at the strategic levels.

It is suggested that the Centre should introduce systems of devolved budgets. Budget holders should be trained and a budget holder's manual should be written and issued to every budget holder, along with copies of Standing Orders and Standing Financial Instructions. The manual should set out the limits of the budget holders powers. It should also provide some motivators. As a policy the Centre should try to accept that savings or extra income generated by positive management action should be retained with the department responsible. Fortuitious savings or surpluses may not automatically be used within the department and may have to go into central funds to help the corporate position.

General Stores

The general stores looked fairly neat and tidy - even the engineering stores which in some other places are little more than scruffy boxes of things known only to backstreet mechanics. I was told that the local Safety Committee had made some recommendations which explained the building works taking place. Other recommendations had been implemented or were being implemented as funds allowed. Again the whole area would benefit from redecoration and painting.

Review Of The Human Resources Management System

Section 14 of the 1978 Ordinance which established the Centre states

1) Persons including Bangladeshi nationals appointed to the international level positions of the Centre by the Board shall receive the same privileges and salarries for equivalent positions; restrictions on pay and allowances imposed by the Government upon its nationals shall not be applicable.

2) Salaries and emoluments of non-international level positions should be comparable to those paid by the United Nations organizations (sic) in Bangladesh.

There are mixed views as to whether this is a good thing or a bad thing. The interpretation of "comparable to those paid by the United Nations....." appears to have changed over the years and I was informed that some local salaries have slipped compared with those paid by the UN because of the unstable financial position of the Centre. However, this part of the Ordinance is why the Centre uses the WHO manuals on Personnel policies and procedures. It is managerially convenient to be able to rely on these but they were not designed for a Centre like this and it may be time to re-examine their appropriateness.

Some of the pay scales are far too long, over 20 years with no efficiency bars. They do not encourage the good and they do not punish the less than good. There are systems of personal promotion with grade for scientific staff but such opportunities are not avaliable to general staff and this is resented.

The Centre should consider adopting a system of Performance Related Pay for all grades whereby staff are rewarded for above-average performance - see below.

Performance evaluation reports have been introduced which are in two parts. The first part sets out agreed objectives between the staff member and his/her immediate supervisor. These are measurable are and used to assess performance during the report period, usually annually. This is in line with modern practice elsewhere.

The second part is an old-fashioned subjective opinion of the qualities of the staff member. These are usually not measurable. If this system is open, as it is here, there is a danger than the reporting officer will be inhibited from expressing his opinion. If it is a closed system then the staff member does not know what is being said of him and has no opportunity of challenging it. In other places this part of the reporting procedure has been dropped and replaced by the use of quantifiable objectives. It is suggested that the Centre should do likewise.

Furthermore it should consider a system of performance related pay based on the agreed performance rating of the annual targets for all types of staff. Typically an addition of between 1% and 5% of basic pay is awarded for exceeding the performance targets. This then forms part of basic pay for assessing the performance related pay in year 2 et seq.

At the same time, the system should be used to measure poor performance and enable the Centre to act accordingly, including terminating employment if necessary.

Establishment Control

Considerable progress has been made in this area since the 1990 review. Approx. 100 core (i.e.permanent) posts have been lost. Every vacancy is scrutinised and a case has to be made for filling it rather than scrapping it.

Staff must retire at 60.

No permanent contracts are issued any more.

Before a contract is issued the Finance Dept. determines the funding and contracts are limited to the period that funding is guaranteed. More use is made of short-term contracts; contract service agreements (CSAs - i.e. payment for a job of work) and Daily Paid. The latter is no longer a term solely associated with labourers as all types of workers including doctors are being employed for very short periods as Daily Paid.

Permanent staff wishing to fill a project post on promotion have to give up their permanent status.

This diversity can in itself cause problems as there may be staff performing what may be regarded as similar roles on different rates of pay depending on their contract status. Personnel has to work hard to ensure comparability.

The figures for 1990 and 1995 are as follows:

	1990	1995
International	11	17
National	149	163
General staff	857	816
Total	1017	996

The % of permanent and fixed-term (i.e.those with rolling two-years contracts) core staff has dropped from 69% in 1990 to 58% in 1996 a conversion of 100 posts. Efforts should be made to continue this trend. By 1998 about 50 permanent staff will reach retirement age and Personnel estimates that a further 100 will go for other reasons. Nevertheless, it is estimated that there will still be about 350 staff on permanent contracts remaining by the year 2000.

This is a difficult problem. The Centre must try to reduce its fixed commitments because its guaranteed unrestricted funding is reducing. It should, therefore, try to reduce its permanent staff so that the establishment is more flexible and can be adjusted more readily to match funding. In reality, this means changing the employment status or cutting jobs of some staff who have served the Centre well and loyally over the years. Trying to find the right human resource policies to deal with this is one of the most challenging tasks which lies ahead for the Centre.

A Strategic Review Of Human Resource Policies And Procedures

For the reasons described above it is recommended that there should be a major review of the human resource issues. It should cover the following:

- whether it is appropriate to continue to follow the UN pay relationship formula

- if it is, then to define it more clearly

- whether using the UN pay formula also means that the WHO other personnel policies should continue to be used

- a review of the pay structure, should the length of pay scales be altered, should efficiency bars be introduced?

- performance evaluation systems including some form of management by objective

- performance related pay

- strategies for reducing the numbers of permanent posts in a manner least hurtful to effective long-service staff

Endowment Fund

Established in 1994 with a donation of $3M from the Swiss Development Corporation. Managed by Board of Governors chaired by Director and with other directors as members. There is a Council of Investment Advisers made up of interested business people. 50% held in $funds. 50% invested in blue chip securities in Bangladesh.
DKR

FORMAT OF JUNE MEETINGS

Suggestions for Changing the Format of June BOT Meetings

1. Meetings of the Board have been held regularly twice a year. In the past the question has been raised by some Trustees and staff of the advisability of continuing this practice.

2. Preparation for the BOT meetings consumes a considerable amount of time of staff and senior management. On some occasions, it distracts staff from carrying out their research, training and service functions. BOT meetings also cost money, on an average over $40,000.

3. The necessity of the November meeting is justified because of the Donors' Support Group Meeting that is held around the same time. The recent modification of the format of the meeting enables a better dialogue and interaction amongst Trustees, donors and senior staff. This leaves the June meeting as the only option for change.

4. The Ordinance stipulates that "at least two meetings should be held in one calendar year".

   Although the Ordinance makes provisions for the designation of an Executive Committee to act for the Board in the interim between Board Meetings on all matters which are delegated to it by the Board, such a committee cannot substitute for a regular meeting of the Board.

5. A majority of the sitting membership constitutes a quorum. This means that 9 persons are required to form a quorum for a regular meeting with 17 members.

6. Taking all the above into consideration, it is suggested that the June Board Meeting be modified as follows:

   Attendance:

   a. The number of Trustees be limited to nine, consisting of the Chair of the Board, subcommittee chairs, Director of the Centre, three Bangladeshi Trustees and one other.

   Duration:

   b. The meeting be shortened to 1-2 days.

   Agenda:

   c. The agenda to be restricted to the following items and others delegated to it in November:

      - Annual Audit Report
      - Update on Budget
      - Appointment of staff at division director level

   (This new format will result in a saving of approximately $30,000.)

SELECTION OF TRUSTEES

9/10/96

9/BT/Nov. 1996

SELECTION OF TRUSTEES

A. At its June 1995 meeting the Board of Trustees:

recognized that the Board of Trustees is under-represented in the area of demography and population sciences and that this needs to be a priority for the Board to address as soon as possible.

B. According to Ordinance Section 8(3) "At any given time, the Board shall be so composed that, not counting the members nominated by the World Health Organization and a member to be nominated by a United Nations Agency ...., more than 50% must come from the developing countries, including the members nominated by Bangladesh, and not less than one-third from developed countries. The Director shall be counted as coming from a developed or developing country depending upon nationality".

Lists of current Trustees with country and discipline, and current Trustees with their terms, are attached.

Action Required

1. Initiate nominations for a replacement for Dr. Maureen Law (develop~~ing~~ed country - North America) for 3 years from 1 July 1997.

2. Decide whether or not to extend the term of Mr. Jacques O. Martin for a second term of 3 years from 1 July 1997.

3. Decide whether or not to extend the term of Dr. Yoshifumi Takeda for a second term of 3 years from 1 July 1997.

LIST OF MEMBERS (AS AT OCT. 1996) WITH TERMS

Name	Joined Board	End of Term
Mr. Muhammed Ali	18 April 1996	17 April 1999
Prof. Chen Chunming	1 July 1992	30 June 1998 *
Maj. Gen. (Retd) M.R. Choudhury	11 June 1994	10 June 1997
Prof. R.R. Colwell	1 July 1995	30 June 1998
Dr. D. Habte	1 Aug. 1989	31 July 1998
Dr. R.H. Henderson	25 May 1990	24 May 1999
Dr. M.E. Jacobs	1 July 1996	30 June 1999
Prof. Fehmida Jalil	1 July 1993	30 June 1999 *
Dr. T.A.M. Khoja	1 July 1995	30 June 1998
Dr. M. Law	1 July 1991	30 June 1997 *
Prof. P.F. McDonald	1 July 1995	30 June 1998
Prof. P.H. Makela	1 July 1993	30 June 1999 *
Mr. J.O. Martin	1 July 1994	30 June 1997
Dr. J. Rohde	18 June 1990	17 June 1999
Dr. Y. Takeda	1 July 1994	30 June 1997
Prof. C.G. Victora	1 July 1993	30 June 1999 *

* Unable to serve another term without a break

LIST OF MEMBERS (AS AT OCT. 1996)
WITH NATIONALITY, DISCIPLINE, JOINING AND ENDING DATES

Name	Country	Discipline	Joined Bd/ end date
Mr. Muhammed Ali	Bangladesh	Civil Servant	1996/1999
Prof. Chen Chunming	China	Public Health	1992/1998 *
Maj. Gen. (Retd) M.R. Choudhury	Bangladesh	Pathology	1994/1997
Prof. R.R. Colwell	U.S.A.	Microbiology	1995/1998
Dr. D. Habte	Ethiopia	Child Health	1989/1998
Dr. R.H. Henderson	WHO	Scientific Admin.	1990/1999
Dr. M.E. Jacobs	South Africa	Child Health	1996/1999
Prof. F. Jalil	Pakistan	Child Health	1993/1999 *
Dr. T.A.M. Khoja	Saudi Arabia	Public Health	1995/1998
Dr. M. Law	Canada	Int. Health/Hlth. Policy & Admin.	1991/1997 *
Prof. P.F. McDonald	Australia	Demography	1995/1998
Prof. P.H. Makela	Finland	Microbiology/ Vaccine dev.	1993/1999 *
Mr. J.O. Martin	Switzerland	Finance/manage-ment	1994/1997
Dr. J. Rohde	UNICEF	Public Health/ Paediatrics	1990/1999
Dr. Y. Takeda	Japan	Microbiology	1994/1997
Prof. C.G. Victora	Brazil	Epidemiology	1993/1999 *

* Unable to serve another term without a break.

DATES OF NEXT MEETING

9/10/96

10/BT/Nov.96

Dates for 1997 Meetings

It was agreed to confirm an earlier decision of the Board that meetings should be held in Dhaka on the first Saturday, Sunday, and Monday of June and November each year.

Accordingly the programme for 1997 is as follows:

PROGRAMME COMMITTEE REVIEW OF CHD - JUNE 1997

Tuesday 3rd June	Reviewers arrive
Wednesday 4th June to Friday 6th June	Review of Community Health Division and write-up of report

BOARD OF TRUSTEES MEETING - JUNE 1997

Friday 6th June	Trustees arrive
Saturday 7th June	Personnel & Selection Committee Meeting Finance Committee Meeting
Sunday 8th June	Programme Committee Meeting
Monday 9th June	Executive Session of Full Board

PROGRAMME COMMITTEE REVIEW OF HPED - NOVEMBER 1997

Tuesday 28th October	Reviewers arrive
Wednesday 29th October to Friday 31st October	Review of the Health & Population Extension Division and write-up of report

BOARD OF TRUSTEES MEETING - NOVEMBER 1997

Friday 31st October	Trustees arrive
Saturday 1st November	Personnel & Selection Committee Meeting Finance Committee Meeting
Sunday 2nd November	Programme Committee Meeting
Monday 3rd November	Donors' Support Group Meeting Executive Session of Full Board

Action Required:

1. Confirm dates of Board Meetings for June 1997 and November 1997.

2. Confirm dates of Programme Committee Reviews of the Community Health Division in June 1997 and the Health and Population Extension Division in November 1997.