PROCEEDINGS

OF THE SUPPORT GROUP MEETING OF THE INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

Sasakawa International Training Centre Auditorium,
ICDDR,B

Dhaka, 30 November 1992

Special Publication No. 31

Support Group Meeting

November 30, 1992 – Sasakawa International Training Centre

AGENDA

9.00 am	**Opening Addresses** 1. Chairman of Donors' Support Group 2. Minister of Health and Family Welfare, Government of Bangladesh 3. Secretary, Economic Relations Division, Ministry of Finance 4. Chairman of the Board of Trustees
9.30 am	**Implementation of the Recommendations of the 1990 UNDP/Donors' Support Group External Review** Director, ICDDR,B
10.00 am	**Major Achievements in 1992** Chairman – Programme Sub – committee
10.45 am	**Coffee/tea break**
11.15 am	**New and Continuing Initiatives: 1993 and beyond** 1. A collaborative study of BRAC's rural development intervention in Matlab 2. The environmental health research programme 3. The micro – nutrients and health research programme 4. Contributions to the national family planning programme
12.30 pm	**Sandwich lunch**
1.15 pm	**Financial Statement 1992 and Budget 1993** Member – Finance Subcommittee
1.45 pm	**Special Needs in 1993** Associate Director, Finance, and Director, ICDDR,B
2.00 pm	**Revised Draft Resource Development Strategy** Assistant to the Director, ICDDR,B
2.15 pm	**Discussion** Donor representatives
3.30 pm	**Closing Address** Chairman, Donors' Support Group

List of Participants

Chairman	:	Mr. Timothy Rothermel Director, Division of Global and Interregional Projects, UNDP, New York
Representative of Host Country	:	The Honourable Mr. Chowdhury Kamal Ibne Yusuf Minister of Health & Family Welfare
Chairman of the Board	:	Dr. Deanna Ashley
Director	:	Prof. Demissie Habte

Trustees

Mr. Enam Ahmed Chowdhury
Mr. Syed Ahmed
Professor J.R. Hamilton
Dr. Maureen Law
Professor A.S. Muller
Professor J.C. Caldwell
Professor F.S. Mhalu
Professor Chen Chunming
Professor Dr. K.M. Fariduddin
Dr. Yagob Y. Al-Mazrou
Dr. R.H. Henderson
Professor V.I. Mathan
Dr. T. Wagatsuma
Professor A. Lindberg
Dr. Jon Rohde

Participants	**Organization**
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Dr. Amir Ali	Aga Khan Foundation, Dhaka
Dr. Christopher Kenna	Australian H/C, Dhaka
H.E. Mr. Xavier van Migem	Embassy of Belgium, Dhaka
Mr. R. Van Lerbeirghe	BADC, Dhaka
Mr. Albert Felsenstein	BADC, ICDDR,B
Mr. Brian Proskurniak	Canadian H/C, Dhaka
Mr. J.C.B. Dirkx	Dutch Embassy, Dhaka
Mr. J.P. Arroucau	Embassy of France, Dhaka
Dr. James Ross	Ford Foundation, Dhaka
Mr. M.I. Khan	GTZ, Dhaka
Mr. Kazumi Endo	Embassy of Japan, Dhaka
Dr. Reidar Kvam	NORAD, Dhaka
Mr. Stephen Chard	ODA, Dhaka
Dr. Mehtab Currey	ODA, Dhaka
Dr. Kim Streatfield	Population Council, Dhaka
Dr. Barbro Carlson	SAREC, Stockholm
Mr. Sigvard Schwartzman	SIDA, Dhaka
Mr. Albert Mehr	Embassy of Switzerland, Dhaka
Dr. Peter Arnold	SDC, Dhaka
Mr. S.A. Karim	SDC, Dhaka
Mr. Wolfgang Fischer	UNDP, Dhaka
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Mr. William R. Goldman	USAID, Dhaka
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Dr. Caryn Miller	USAID, Washington
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Prof. M.A. Matin	Chairman, PCC, ICDDR,B

Staff	Title
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Mr. Graham A.N. Wright	Assistant to the Director

OPENING ADDRESSES

Mr Timothy Rothermel (Chairman of the Support Group) welcomed the participants and noted that this was the first time that a meeting was taking place in the auditorium of the Sasakawa International Training Centre. The new facility was a very tangible demonstration of the extraordinary progress that had taken place since the meeting last year. He noted that there had also been a great deal of progress at ICDDR,B on perhaps less tangible, but equally important, fronts. Thanks to the efforts of Dr Habte and his colleagues 1992 had been a successful year in all aspects of the unique work of the Centre: research, training and the provision of health care. In addition, as exemplified by the excellencies seated at the table, the Minister of Health, the Secretary of Health, and the Secretary of the Economic Relations Division, the partnership at all levels between the Centre and the host country continued to flourish. In short, 1992 had been a year of exceptional progress and the participants would have an opportunity to learn more about this progress, as well as the future initiatives, in the meeting.

Participants would also have the opportunity to review progress on the implementation of the Donors' Support Group's own 1990 External Review which had had its origins in a somewhat less optimistic climate. Needless to say, the positive changes which had taken place at ICDDR,B had come about not only because of good management, skilled scientists, dedicated staff and the support of the host government, but also because the international donor community had provided the financial resources required to maintain ICDDR,B as a unique international centre of excellence. Further progress would require a continuation and indeed intensification of that financial support. The Centre still operated on a very modest budget with few reserves, so the importance of the international donor community could not be overstated. This annual meeting gave all participants the opportunity to review current activities and future ones that were planned for the Centre.

The Honourable Minister of Health and Family Welfare, Mr Chowdhury Kamal Ibne Yusuf noted that it was a pleasure to return to the International Centre for Diarrhoeal Disease Research, Bangladesh. The last time he had been at the Centre was to participate in the launch of a very important initiative, a quarterly newsletter entitled "Shasthya Sanglap". This Bangla language newsletter, was now being sent to 15,000 frontline health professionals operating in the government and non-government organizations' health programmes throughout the country. It was this type of initiative that had characterized the ICDDR,B of the early 1990's.

The Centre continued to identify needs in Bangladesh and abroad and to respond to these needs. The Matlab MCH-FP project offered unique opportunities both for Bangladesh and for the rest of the developing world to examine the health and family planning policy and implementation issues. The MCH-FP Extension project, which had been established at the request of the Government of Bangladesh (GOB), provided invaluable input into the national health and family planning programme. Indeed the record-keeping system first used by the ICDDR,B's community health workers in Matlab, and modified for use by the Government Family Welfare Assistants by the Centre's Extension Project was now being implemented throughout the government system.

ICDDR,B's Epidemic Control Preparedness Programme teams had been working throughout the country in response to diarrhoeal disease outbreaks. The two hospitals continued to treat nearly 100,000 patients each year and served as training centres for Bangladesh doctors, thus building national capacity. The new Sasakawa International Training Centre reminded the Minister of the intrinsic importance of training in the ICDDR,B's mandate and of the Centre's success in fulfilling this mandate.

Internationally the reputation of ICDDR,B as a centre of excellence had risen remarkably in the recent years. This was in line with the increased effectiveness and efficiency in the Centre's operations. In the last two years alone, Centre staff had responded to epidemics in Ecuador, Peru, Yemen, Iran, and Cambodia and had contributed to international health and population seminars across the globe.

The current government was proud that an institution of such global importance was based in Bangladesh. Its contribution to the country and to the rest of the world was highly valued. The GOB continued to support the Centre by making both cash and in-kind donations despite serious limitations in the country's own financial resources. This wa indicative of the importance that the government attached to ICDDR,B and its work. The GOB supported ICDDR,B wholeheartedly and asked the donor agencies to do the same.

The Minister noted that, despite the effects of inflation, some donors had not increased their contribution to ICDDR,B for some years. Indeed the current total contribution was significantly lower than in 1988. In view of the extremely important work and the extraordinarily high productivity of the Centre, he hoped very much that the contributions would rise in recognition of the great progress made by ICDDR,B over the last three years.

Mr Enam Ahmed Chaudhury, Secretary, Economic Relations Division stated that ICDDR,B was one of the few truly international health research institutions based in the Third World. The Centre's excellent laboratory and library facilities, its busy rural and urban health facilities, and its unique field study areas, had been specifically designed for intensive research programmes in the areas of health and fertility, diarrhoeal diseases, and all other related areas. The ICDDR,B had developed, over the last three decades, from a small research laboratory interested in one specific disease, to a busy cosmopolitan centre with a wide ranging interest and expertise in many different fields. Its scientific discoveries had earned it international recognition.

Since its inception, the ICDDR,B had brought incalculable benefits to the populations of developing countries. ICDDR,B was supported by countries and agencies which shared its concern for the health problems of the developing countries. The GOB wanted to see the Centre well funded and supported by the countries and organizations which could afford this, commonly known as the donor community. Regarding Bangladesh itself, as had been made clear by the Minister for Health, the GOB provided some core financing, and a number of other benefits in kind, and would continue to do so in the future. The government provided 4.1 acres of land to ICDDR,B to construct the physical facilities, hospital, library etc., together with facilities for duty free purchases for the Centre and its expatriate staff, telephone lines, and electricity free of cost. Until 1990, ICDDR,B's entire operations in Matlab hospital and offices were based at an area within the Thana health centre provided by the GOB. The government had been as generous as possible in supporting ICDDR,B over the years, and the donor community should see this as demonstration of the commitment of the government to this international endeavour.

In addition, a sum of US$ 1 million UNCDF programme assistance had also been given to ICDDR,B by the GOB in the form of assistance during 1986–90. In spite of financial problems, very recently the GOB, to demonstrate its profound commitment to ICDDR,B, had settled the long-standing loan of about $ 1.3 million extended by the GOB to ICDDR,B in 1983. He hoped that all this would encourage more generous donations and contributions to the Centre from other countries with greater resources available to them.

The Centre was managed by a Board of Trustees, which included very distinguished people from all over the globe . There were representatives from Australia, from North America, Europe, Africa, China, Asia, and the Middle East. These were people who had been selected for their commitment and contributions in their particular fields. He had been associated with a number of international institutions but had not seen and worked in a more balanced, well managed institution than ICDDR,B. He thought that the governments and organizations should become more interested in institutions of this nature. This was not because ICDDR,B was located in Bangladesh, but because he believed that such international endeavours do demand, deserve, and warrant recognition and patronage. In today's changed international climate, where the reasons and need for assistance and cooperation were becoming clearer by the day, the Centre should generate a great deal of interest among the donor community. So to them, he wanted to say only seven words: "Perhaps there could be no nobler cause".

Dr Deanna Ashley, (Chairperson of the Board of Trustees, ICDDR,B) said that 1992 had been a relatively good year and the Centre had had a fruitful Board meeting. Productivity had continued to rise significantly, it had risen in terms of papers published in the international scientific journals, and in terms of protocols in progress. The Centre had made significant strides in providing support in the international arena, especially to other Third World countries. ICDDR,B had provided technical support, shared its expertise, and also facilitated the training and development of research skills of people from Third World countries.

At the same time, costs had been contained after significant staff reductions in previous years. The budget for 1992 was the same as for 1988, despite inflation during the intervening period. Core expenditure was to be maintained at the same level in 1993 as it had been in 1992. However, project expenditures were to rise, reflecting the increased activity and productivity in the Centre. The announcement by the GOB

canceling the UNROB loan and converting it to a grant to the Centre had given greater financial health to the institution and boosted its spirits. On behalf of the Board of Trustees and the Management of the Centre, she thanked the government and in particular ICDDR,B's own Trustee, Mr Chaudhury, in his capacity as a Secretary of the Economic Relations Division, for coming to the Centre's assistance and pursuing this matter to its final conclusion. It was greatly welcomed and greatly appreciated, symbolizing the great spirit of cooperation and collaboration that presently existed between the GOB and the management and Board of the Centre.

This annual meeting was extremely important to the Centre. It allowed the Centre staff to present their plans, successes and indeed their problems to the donor community. This allowed for an exchange of views and an opportunity for the donors to further participate in the success of the Centre. The donors support group meeting allowed the donors to provide their input and to express their interests and priorities to the Centre management. This was particularly important this year since the Centre was starting the process which was to lead to the drawing up of the five year strategic plan for presentation to the Board of Trustees in June 1993. It was therefore very important this year that the donors were very forthcoming, not only with ideas and guidance, but also with support in terms of funding.

IMPLEMENTATION OF THE RECOMMENDATIONS OF THE 1990 UNDP/DONORS' SUPPORT GROUP EXTERNAL REVIEW (See Appendix 1).

Dr D. Habte (Director, ICDDR,B) warmly welcomed the participants on behalf of the staff and management of ICDDR,B, and then presented the document entitled: "***Progress and Transition 1990 – 92,* Implementation of the Recommendations of the External Review** of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B)".

In response to concerns of the donor community on the performance of the Centre, an external review had been conducted in early 1990 by the late Dr Gordon Smith and Dr David Spencer. The findings came out as a report in April 1990. The review addressed several important issues including management, personnel, finance, strategic planning, public relations, etc.

It concluded that despite its past accomplishments, the Centre could not remain viable with the serious impairment of its productivity and potential by over-staffing and the failure to recruit creative senior scientific staff. The report recommended a series of actions and further added that donors should seriously address the necessary difficult decisions to provide financial support. During the last two and a half years the Board and Centre staff had undertaken a series of measures to improve the Centre's performance.

One of the reviewers' major criticisms was that the Centre had no rational system of management, that it had no long term strategic plan, and that it was essentially an autocratic institution. Dr. Habte was happy to say that most of these criticisms had been addressed. The Centre now had a clear and direct research agenda which was evolving in response to findings, needs, capability and expert advice. The Centre had now instituted a broad-based participatory management system in which ideas flowed from the researchers and the staff. Through this process, communication within the Centre had also considerably improved. It was fair to say that, most of the staff of the Centre now knew what was going on and were therefore able to contribute appropriately.

In terms of the type of research activity the Centre was conducting, one of the recommendations was that research plans for the future should lay greater emphasis on applied and operational research. The Centre's research agenda continued to recognize the importance of operations research and had extended its capability from rural Matlab, to Maternal Child Health Family Planning in the MCH-Family Planning Extension Project, and to the new Urban Health Extension Project. Other components of the Community Health Division had been significantly strengthened and this reflected the Centre's increasing commitment to social science. The Centre's new Population Studies Centre was working with the Bangladesh Rural Advancement Committee and other national organizations to study and quantify the health impacts of the NGO's non-health interventions.

Another major concern of the report was the relationship that the Centre had with the GOB. It was now eminently clear that this had been addressed, and that there was no better reflection of this than the announcement of the cancellation of the UNROB loan.

Another major issue that had been of significant concern to many donors was the quantity of personnel employed at ICDDR,B. Not many people were aware that ICDDR,B was by far the largest international organization in Bangladesh, and indeed one of the largest international organizations anywhere in the world. There had been a progressive reduction in the size of the staff, and particularly in the core staff. During the last three years the Centre had been able to reduce the fixed term staff, (the staff for which the Centre has contractual obligations), by 171 or 15% of the 1989 number; and the total staff by 365, or 22% of the 1989 total staffing. This had been achieved through a process of natural attrition, by implementing a freeze on hire of new staff, a freeze on replacement of staff leaving as a result of resignation, ill-health or death, timely retirement, and closure of certain activities of the Centre. The Centre was adopting a system by which it entered into short-term contractual agreements with employees to undertake specific tasks so that the Centre made no long-term commitment to these staff. This had resulted in a reduction in the number of core staff and increased the flexibility of the Centre to respond to its changing circumstances.

This guided evolution of ICDDR,B's staffing was an on-going process, reflecting the changing priorities of the Centre and Dr. Habte wanted to make it very clear that the Centre would continue to address this issue because he believed that still more could be done. In so saying, one important fact could not be

overlooked, the Centre was located in a developing country with very high unemployment, with appalling poverty, and no state social security system, thus management was constrained by the context in which it worked.

A third important activity, related to the personnel, had been the finance. The Centre's budget was reduced by $2.65 million in the three years between 1989 and 1991. By 1992 the Centre had cut its expenditures, raised productivity, and completed its transition into a cost-efficient, international health research organization. To realize the potential of this unique resource, the international donors were requested to increase funding at the 1991 Support Group Meeting. The limitations of the 1993 budget had meant that some important research initiatives would not be implemented.

In 1992 the Centre was trying to broaden its source of funding including through application for competitive grants. Although the amount was not yet significant, the Centre had to compete with developed country institutions and the increasing number and value of competitive grants was testimony of the strength of its scientific set-up.

In 1991, the Centre had extinguished the accumulated cash deficit that had plagued its operations since 1981. In fact, the external review had predicted or forecast that this could not be done before 1996 and the Centre was justifiably very proud that this had already been achieved by 1991.

Having given this optimistic overview, Dr. Habte cautioned the participants that the accumulated operating deficit was still some $4 million, and this was due to lack of funding depreciation. Many centres of similar size had the same problem, but nevertheless, the long-term survival of the Centre depended on its ability to fund depreciation.

Financial, grant administration and resource development systems had been strengthened to give Centre management, mechanisms to monitor the Centre's activities, and information to optimize decision making. In particular the donor community would be pleased to note that the establishment of a grants administration office had greatly strengthened the Centre's capability to meet the frequent and various demands of the donor community. The Centre understood and accepted that these needs were necessitated by requirements of accountability to the donor governments, and was pleased to be able to respond through the grants administration office.

Increased intra- and inter-divisional meetings had improved communication and collaboration between divisions at all levels. This had enabled the Council of Associate Directors to follow a broad-based participatory approach to planning and management.

Another of the major concerns of the review was that the Centre did not have a sufficient batch of mid-level Bangladeshi scientific staff. Over the last three years, through an intensive programme of staff development, the Centre had been able to develop a very sound cadre of mid-level scientific staff, all of whom were Bangladeshis. This was not simply the Centre's own opinion, recent external reviews of the Clinical Sciences Division and the Laboratory Sciences Division had both highlighted this.

With regard to scientific leadership, the picture had been gloomy in the past, and the Centre had not been able to be competitive in the international market to attract international level staff. Fortunately, over the last three years, a positive change had taken place and the Centre now had more applicants for senior management staff.

The Board and staff of the Centre had worked hard to redress the many problems besetting the institution. The Centre had set a strategic plan of work for itself. It had significantly reduced the salary burden of staff without causing serious dislocation of morale and discipline. It had instituted, and continued to implement, a Centre-wide discipline of severe economic austerity. As a result, it had been able to extinguish the accumulated cash deficit that had been in existence for several years and had instituted a healthy financial climate. It had increased research productivity and contributed to global efforts to promote good health to the people of the developing world and of Bangladesh. The Centre was now poised to enter a new era, an era which was perhaps even more challenging than the one that had passed, and one that called for increased commitment and effort from all.

MAJOR ACHIEVEMENTS IN 1992

Professor J.R. Hamilton, Chairman, Programme Committee said that the number of publications showed that research productivity in the Centre (as measured by conventional means) was on the increase. Although publications in 1992 generally meant work completed in 1991 and 1990, this figure along with the rise in the acquisition of competitive grants, was a solid but very conventional measure of research productivity. But ICDDR,B was not really a conventional centre. It combined health care facilities with important teaching programmes, and with research. Though there was nothing that unique about this combination, what was particularly special, particularly unique, about the Centre was the remarkable scope of its research endeavours. There was no other place where the spectrum of the research carried out spanned from sophisticated, innovative, community-based work including the study of large populations with cutting edge methodology, to the most sophisticated laboratory-based basic research.

So, in contemplating research achievements in an institution like ICDDR,B, the world community had come to expect a lot from a relatively small group of exceptionally dedicated scientists, working with what was a very modest budget, and now seeing extraordinary achievement.

Studies that had been completed and/or were proposed ranged from work which was identifying not only the biological determinants of specific diarrhoeal disorders, but also the environmental factors, water contamination etc., and behavioural determinants of specific diarrhoeal illnesses, as well as the study of practical approaches to deal with these problems. These community-based studies extended to considerations of the health of the individual who was of central importance for the prevention of childhood diarrhoeal illness, namely the mother.

But these community-based studies did not just stop with specific issues within specific communities. They extended to considerations of much larger populations, for example the dynamics and determinants of contraceptive use and distribution in the community, and the programme so widely known across the world, so admired and so uniquely important to the demographic community, namely the demographic surveillance system.

Shifting to the other end of the research spectrum, there was the type of work that went on primarily in the laboratories. The recent review of the Laboratory Sciences Division provided the Trustees with an excellent glimpse of the tremendous improvement and development that was occurring in the Centre's microbiological laboratories where studies had focussed on the factors determining the virulence of the organisms that cause diarrhoeal illness. They had identified new pathogens and characterized them, they had developed more efficient and more extensive diagnostic technology, and with these basic advances they had shown potential for future advances in therapy. In this unique Centre it was possible to actually evaluate those advances in therapy in the hospital.

Efforts had begun to examine the mechanisms that lie behind diarrhoea and the transmission problems that determine diarrhoeal illness. With the new technology that was now available the Centre could better focus on the malnutrition that was such an important corollary to diarrhoea, particularly among children.

The Centre was particularly exciting since it could bring these two ends of the spectrum together. Perhaps the most famous of the therapeutic achievements attributed to the Centre was the use of rational effective oral rehydration therapy, and efforts continued to improve the solution and to determine what it was that makes people decide whether to utilize this therapy, how to deliver it effectively, and to examine what it is that causes people to seek health care.

In addition, new drug therapies had been developed in the past year or so for the treatment of specific infections. One particularly devastating disease was shigellosis, and the use of a specific antibiotic approach had proved to be very effective against this infection. A novel and interesting approach had been the use of antibodies from the colostrum portion of the cow's milk, hyper-immunized and used in the active treatment of certain enteric infections. Plans were underway to broaden the scope of this therapeutic concept.

Prevention of disease had to be a priority and studies continued with the evaluation of vaccines, indeed plans were in place for the trial of specific vaccines. Meanwhile, maternal milk was a preventive measure

that was being advocated with great success by the Centre, while at the same time, studies continued on ways to improve its acceptance and improve its effectiveness.

It was ironic that with all the progress and increased activity, and with the development of bright, young, innovative, enthusiastic people came new concerns and anxieties. This was because their efforts required support, they required money. It was of critical importance to maintain this momentum to develop a critical mass of young scientists, not just for the present, but for the years to come. And to do so would require a substantial investment and a long-term investment. Dr. Hamilton hoped that the Centre could convince the donor community that it was extremely worthwhile, not only for the health of this community, and this part of the world, but also for the health of individuals in the developing world, for ICDDR,B was an institution whose work had truly global impact.

NEW AND CONTINUING INITIATIVES: 1993 AND BEYOND

1. BRAC/ICDDR,B/Ford Foundation: A New Collaboration

Presented by: Dr. Michael Strong (Associate Director, Population Science and Extension Division)

It was increasingly clear that the alienation of women from the formal health care system was an important problem. Social, cultural, and economic barriers combined to ensure that women do not have access to the limited formal health facilities that were available. As a result, there was a high incidence of Reproductive Tract Infections, maternal mortality was 200 times higher than in developed countries, and there were few trained female health care professionals. To address this problem: women must be empowered to demand what was rightfully theirs, and accessibility and quality of health services must be improved.

Fortunately the Ford Foundation had recently initiated its reproductive health strategy, emphasizing the examination of the social, cultural, and economic factors which influence reproductive health. It was also fortunate that Bangladesh Rural Advancement Committee (BRAC), the largest NGO in Bangladesh, was moving into the Matlab area as part of the normal expansion of its rural development activities.

These activities included:

- group formation: raising the consciousness of poor rural women and men;
- non-formal primary education: aimed at children, especially girls, who had dropped out of school or who had never started;
- savings and credit activities;

and

- income generation assistance.

All of these were being started in Matlab, where ICDDR,B had been working for over 25 years.

Success with female workers, finding that giving them employment as health and family planning workers, had given them a professional status and social influence without reducing their prestige. ICDDR,B had also developed an extensive research infrastructure, including the hospital in Matlab bazaar, and detailed demographic and maternal, child health and family planning information data collection spanning over a quarter of a century.

To plan for the collaboration with BRAC in Matlab, an expert group had been formed with members from the new Reproductive Health Coalition - BIDS, BIRPERHT, and Pop Council - in addition to BRAC and the ICDDR,B, as well as other national and international experts. This group helped frame the research design and set the research agenda.

Work had already begun, field work for the baseline survey was being conducted and BRAC's intervention had already started.

Thus in Matlab there were areas which were:

- inside and outside of the MCH-FP programme;
- inside and outside of the Meghana Dhonagoda embankment, and
- inside and outside of the BRAC intervention area.

And ICDDR,B and the Reproductive Health Coalition were poised to undertake a number of qualitative and quantitative studies on the impact which rural development, education, empowerment, environmental change, and health and family planning activities - both separately and together - have on the health, fertility, and the well being of a rural population.

The Centre looked forward to several years of exciting research, and hoped that those donor agencies attending the meeting would join it.

2. The Environmental Health Research Programme

Presented by: Dr. Bilqis Amin Hoque (Senior Scientist, Community Health Division)

The Environmental Health Science working group was multi-disciplinary and cross-divisional . The objectives of this group were: to conduct research and to provide technical services and training to ICDDR,B programs, as well as other agencies at the national, regional and international levels.

Some of the on-going and planned activities were:

Major research: The major research activities of this working group included the examination of the environmental risk factors for child survival in rural areas (funded by IDRC), environmental risk factors for shigellosis in Dhaka city (funded by SDC), water quality impacts of the Meghna-Dhonagoda embankment (funded by BADC), efficacy of hygiene education through primary schools and volunteer women (funded by BADC), the sustainability of a rural water sanitation program (funded by BADC), development of appropriate hand-washing techniques (funded by WHO), and urban sanitation.

Major technical services: The working group provided advisory and laboratory services to ICDDR,B research projects and other external agencies during normal and disaster periods (e.g. testing the quality of both water and water purifying tablets), acting as advisory/resource persons (e.g for NGOs, UNICEF, ESCAP, WHO, GARNET), and assisting with the local networking of NGOs in water supply and sanitation.

Major training services: The working group had conducted a regional workshop entitled "Water and Sanitation Priorities for the 1990s", (sponsored by ICDDR,B-SDC-WASH) and a national workshop entitled "Mobilization of NGOs in Water Supply and Sanitation", (sponsored by ICDDR,B-UNICEF). The proceedings of these workshops had already been published. ICDDR,B had conducted 2 training workshops in Chittagong immediately following the cyclone in 1991, and these were extremely well received. The group had planned workshops on "urban sanitation" and "environmental preparedness during disasters", and these would take place in 1993. In addition, the working group continued to conduct lectures and presentations in courses and conferences organized by ICDDR,B as well as other national/international agencies, and was planning the establishment of a Regional Water Supply and Sanitation Applied Research Center, to be located at ICDDR,B.

3. Micro-nutrients and Health Research Programme

Presented by Dr. Dilip Mahalanabis (Associate Director, Clinical Sciences Division)

The term "micronutrients" was increasingly being used to indicate vitamins and minerals essential for human growth and functioning, i.e. nutrients needed in very small amounts. Micronutrients which had important implications for national intervention programmes included vitamin A, iodine and iron. Micronutrients which may in future become important from a public health point of view included zinc, vitamin C, B vitamins, selenium and others.

Vitamin A

Several recent studies had shown that vitamin A supplementation reduced child mortality substantially. Furthermore, one early study in the 1930s and two recent studies showed that vitamin A treatment for measles reduced case fatality by one half. An estimated 42 million children under 6 years of age suffered from mild to moderate xerophthalmia. Over a quarter of a million go blind, and 50-80% of those who go blind die within one year. Vitamin A deficiency was hyper-endemic in Bangladesh. However, a recent case control study at ICDDR,B identified the risk factors for vitamin A deficiency in Bangladesh; they included lack of breast-feeding (4 times higher risk), severe protein energy malnutrition, persistent diarrhoea, recent attack of measles, and lack of mothers' education.

An important and inexpensive source of vitamin A in Bangladesh was green leafy vegetables. So the question was, can infants and small children eat enough green leafy vegetables to meet their requirements ?

In a recent study at ICDDR,B it had been shown that infants and children aged 9 months to 2 years can consume their daily recommended amount from a single meal when offered in a traditionally cooked preparation in oil along with rice. In a community based study mothers had been supplemented with a large dose of vitamin A soon after the birth of an infant which increased vitamin A in the milk of mothers for up to 9 months; also it reduced morbidity from respiratory infections in those infants who were nursed by these mothers. Studies had been initiated to evaluate the feasibility of vitamin A administration in infants under 6 months at EPI contact; the results were not yet available.

Zinc

Zinc was an important micronutrient which was deficient in the diet of many developing country children. Zinc was a constituent of many metalloenzymes and was needed for the growth of the children and for immune functions. Earlier studies had shown that zinc supplementation in zinc deficient children leads to better gain in height and may reduce morbidity. In a randomized, controlled trial at ICDDR,B, zinc supplementation of under-nourished children with acute diarrhoea had reduced faecal output and diarrhoea duration. It had also reduced the attack rate and cumulative duration of diarrhoea during the three month follow-up. In addition, the zinc supplemented group grew taller during the three month follow up. In another randomized trial, under-nourished children with persistent diarrhoea supplemented with zinc had 30% reduced diarrhoea duration. Acute mortality among the supplemented group had been less, they grew taller by 30% during the three month follow up, and attack rate and cumulative duration of diarrhoea had been lower. A recent study evaluating the effect of zinc supplementation in children in the community on diarrhoea and ARI morbidity and on growth had just now been completed and the results were not yet available. In another study the effect of a micronutrient cocktail (zinc, selenium, folate, iron, and copper) on diarrhoea/ARI morbidity and on growth was being studied in 25 research clusters of 50 children each.

4. ICDDR,B's Contribution to the Bangladesh Family Planning Programme: Past and Future.

Presented by Dr. John Haaga (Project Director, MCH – FP Extension Project)

Family planning, along with immunization, had been one of the notable success stories in Bangladesh in the 1980s. No one familiar with international experience would have predicted the speed with which Bangladeshi couples have adopted contraception in the last decade, because no comparably poor country had ever started its demographic transition.

The nationwide contraceptive prevalence rate (CPR) had reached 40 percent of married women of reproductive age (Mitra, Lerman, and Islam, 1992). In small areas like Matlab, where the ICDDR,B's MCH – FP project operated, CPR above 60% had been achieved, even though the social and economic conditions have changed little (see Figure 1). The increase in contraceptive prevalence had been accompanied by a decrease in fertility rates, from about seven births per woman on average in the mid – 1970s, to well below five births per woman in the early 1990s. Bangladesh did not need to wait for profound social and economic transformation before the fertility decline began. Indeed, the fertility decline might be a pre – condition for the social and economic transformation the country needed.

However, the success achieved so far did not mean that effort could now be curtailed. Based on prior international experience, a CPR above 70% would be required to achieve replacement – level fertility. And even when that fertility level was reached, the nation's population would still be growing for years to come. The legacy of past high levels of fertility was a large proportion of the population in the youngest age groups, yet to begin their own child – bearing years.

On a personal, rather than national, level, there was consistent evidence of an unmet demand for control over fertility. In recent national surveys, well over half the women (and where they were interviewed, well over half the men) expressed a desire not to have any more children. Many of those who did want more children wanted to delay having their next child. But the majority of those expressing these views were not using safe, effective, and appropriate methods of birth control. A fifth of all contraceptive users relied on "traditional methods" including safe time, abstinence and withdrawal; many of these were likely to prefer, and use, more effectively, modern methods. Both limitation of family size and spacing of births produced desperately needed improvements in health for both women and their children. Morbidity and deaths related to pregnancy, abortion, and delivery were a real threat for most Bangladeshi women, and family planning was the most effective and feasible program to reduce the threat.

Early Years of the Family Planning Programme

A decade ago, there was no nationwide infrastructure, married women (and their husbands and older relatives) were unfamiliar with the idea of contraception, and women could not travel far on their own initiative to make contact with the health services. In these conditions, as the Matlab and the MCH – FP Extension Projects showed, home visits by respected local women, well trained and supervised, delivering effective but reversible methods including injectable contraceptives, could lead to rapid and sustained increases in contraceptive use. The program had to go to the women. Much of the first few years of Extension Project research focussed on how to make this possible in the government system, and technical assistance from the project helped in the process of expansion of the force of female outreach workers.

The MCH – FP Extension Project was a joint initiative of the government and ICDDR,B. Its original role was to test the feasibility of some of the interventions that had proven successful in Matlab in the ordinary government program. From the start, there was close collaboration with government colleagues, a strong focus on implementation problems, and constant contact with field realities.

The Extension project had made important contributions to solving "first – generation" issues for the family planning and MCH programs examining the effects of different worker – client ratios, helping to ensure adherence to standards in nationwide recruitment, solving implementation problems for satellite clinics, devising training plans, helping to establish record – keeping and reporting systems, and working on improved supervision and coordination in the field. The Project had also began to lay the groundwork for meeting challenges of the 1990s, for example, in the area of assessing and improving the quality of care.

Addressing Issues of the 1990s

In most rural areas the family planning program had now passed the initial stages. Field workers were in place and had received some degree of training. Nearly all women knew about modern contraceptives. Supplies of contraceptives to field workers and clinics were frequently interrupted, but a nationwide network of warehouses, clinics, and private outlets did exist. In these circumstances, the program had probably already reached most of the "easy adopters", those whose motivation was so strong that they managed to obtain supplies or services despite the gaps and deficiencies in the program. To reach the higher levels of CPR and reduce the level of unmet need, though, would require increases in both adoption and continuation rates. And to achieve the full impact on population growth, health, and personal freedom, the higher levels of CPR would have to be accompanied by efforts to improve the "use-effectiveness" of contraception. Both types of effort seemed to require improvements in the quality of services, not just expansion of existing services.

The challenge for the family planning program in areas where it was now well established was to improve the quality of the full package of services, including counselling, side-effects management, and follow-up care, for a full range of methods.

In other parts of the country, such as the far northeast and the southeast in Chittagong Division, the family planning program had not reached this stage of maturity. As Figure 2 showed, CPR and immunization indicators for that division lagged behind the rest of the country. The policy and program changes that had worked during the 1980s elsewhere in the country might need modification for the different social and physical environments of the current low-performing districts.

The rapid expansion had been achieved through an enormous effort and devotion of resources by international donors and the government. Partly as a penalty of its success, the program now had to be much more concerned with both financial and institutional sustainability.

Family planning was no longer deviant behavior: 40% of eligible women used contraception, and most knew someone who did even if they did not use contraception themselves. Contraception was a legitimate topic even for public discussion. Pills and condoms were available throughout the country in pharmacies or from government or NGO workers. Changes in women's jobs in most of the country had made women more mobile than they were even a few years ago.

The heavy reliance on house-to-house visits that had been necessary when the program was in its infancy might no longer be suitable for the mature program. Delivering services by field worker visits to the home met many of the privacy and transportation concerns of clients, but was not feasible for services requiring high levels of technical competence, close supervision, or bulky equipment. Even if current levels of aid could be kept up, the costs of alternate modes of service delivery had to be estimated and considered in making decisions. The satellite clinic program, to which the Extension project had made some useful contributions, represented one promising compromise between the extremes of excessive reliance on home visits and exclusive reliance on underused, fixed-site clinics.

But small-scale experimentation was needed before large-scale changes could be made. The crucial area of uncertainty was the effect of any change in service delivery on contraceptive use. The demand for contraceptives might still be very sensitive to "price" (the price paid by women in terms of embarrassment, violations of social norms, and inconvenience and travel time, as well as money prices). If so, then radical changes that required rural women to travel more, and make their own purchases could undo many of the gains of the last decade. These were not issues that could be resolved by consulting policy makers' preferences or by asking women hypothetical questions. Tests were needed in a variety of real field conditions to answer fundamental questions about the future of the program.

With the exception of immunization, MCH services had not had a breakthrough in the last decade. Reproductive health services for women, in particular, had made little progress. Most babies were born at home, attended by relatively untrained persons, and there was no easy access to emergency care when something went wrong with pregnancy or delivery. Though early abortions were legal and not proscribed by religion, large numbers of women suffered or died from incomplete, septic abortions. Both health and family planning field workers and paramedics were meant to screen and refer high-risk pregnancies, and provide some pre- and postnatal care. But there were few good services to which high-risk or emergency

cases could be referred. Basic questions about the feasibility, costs, and effectiveness of alternate arrangements for safe delivery services had to be answered.

There were good arguments for providing reproductive health services, and other components of MCH, along with family planning: convenience and acceptability to clients, convenience to field workers, sharing facilities and other fixed costs. But as with all public services, there were also arguments in favor of division of labor. The proper balance of family planning services delivered by "other health" workers, and other health services delivered by family planning workers, needed to be worked out empirically.
Changes had to be tested in the field, to see what worked for Bangladeshi women, and what the implications were for training, supply, and supervision.

Agenda for the MCH–FP Extension Project

Under a new agreement for 1993–97, the Extension Project would deal with these newly emerging issues. Based on considerations of its comparative advantage among the institutions and agencies working on family planning and health, it proposed a program of work grouped under three broad themes:

- Management Improvement
- Quality of Care, and
- Sustainability.

Under this new agreement, the mandate of the project would again be broadened, so that it could continue to work on the new issues facing policy makers. The project would continue to work on incremental improvements in the FP and MCH systems, with a concentration on implementation issues at field level. But it should also be a tool for policy makers to use in testing more pervasive changes in the MOH&FW system, designed to overcome some of the structural problems that emerged during the last decade. This would require working closely with the central, division, and district levels of management, as well as the thana and union.

A related project at the Centre, the Urban Health Extension Project (UHEP), would begin work on ways to improve the effectiveness and efficiency of both NGO and government family planning services in the urban areas.

Agenda for the Population Studies Centre and Demographic Surveillance System

Besides these applied research projects working directly on service design and implementation issues, much of the Centre's research would deal with underlying issues that would influence the design of population policy and family planning program in the next decade. Demographic research, using Matlab, Extension Project, UHEP and national data, would deal with issues of choice and continuation of contraception. Several studies had documented causes of death and morbidity related to pregnancy and delivery, and future work would concentrate on testing interventions to reduce the burden. More basic work on social determinants of high fertility and poor health included both research on women's status and gender preference in child rearing, and interventions designed to bring about change, such as the project with BRAC. Lastly, it was important to note the methodological contributions of current projects at the Centre. Examples included helping with field testing of Census instruments, examining indirect methods of estimating maternal mortality rates, and helping with the design of national morbidity surveys.

Family planning was a health intervention of great promise, the success of which could make progress possible in dealing with all the interrelated health problems of poor countries. The Centre was proud of its record in applied research on these issues and looked forward to more years of productive collaboration with its colleagues in government and other research institutions.

Figure – 1

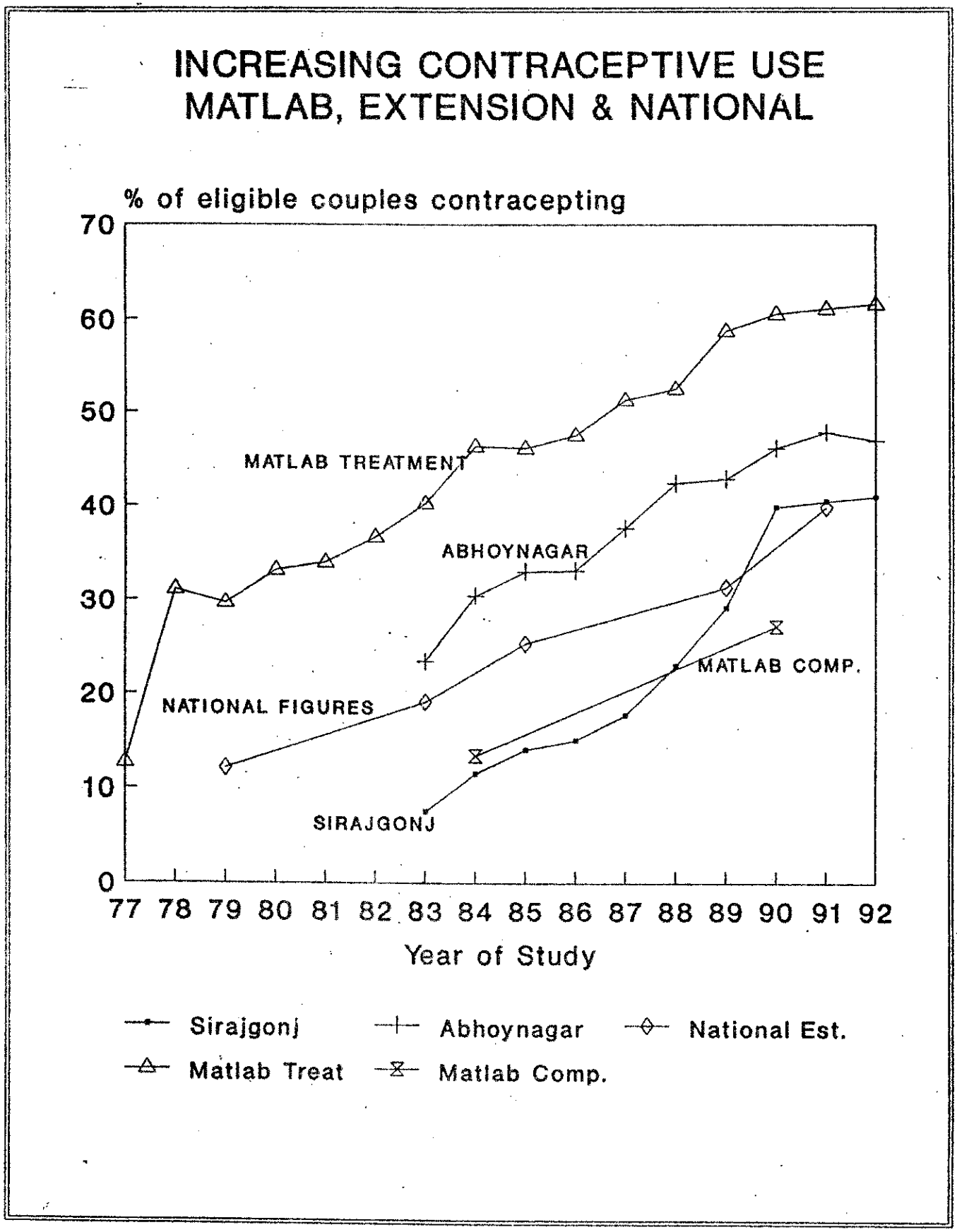
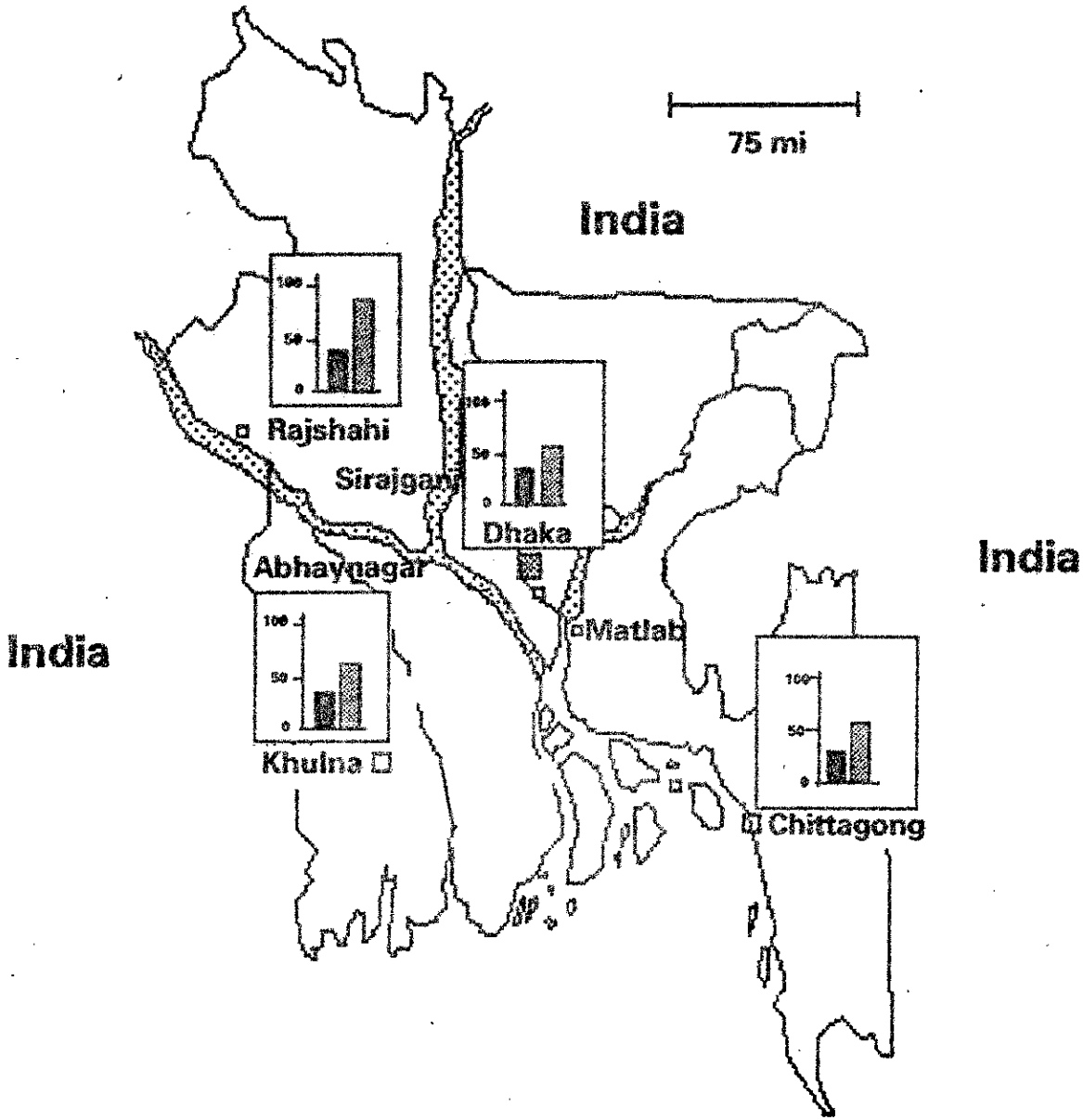

INCREASING CONTRACEPTIVE USE
MATLAB, EXTENSION & NATIONAL
% of eligible couples contracepting
70
60
50
40
30
20
10
0
MATLAB TREATMENT
ABHOYNAGAR
MATLAB COMP.
NATIONAL FIGURES
SIRAJGONJ
77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92
Year of Study
Sirajgonj
Abhoynagar
National Est.
Matlab Treat
Matlab Comp.

Figure - 2


Bangladesh
75 mi
India
India
India
Rajshahi
Sirajganj
Dhaka
Abhaynagar
Matlab
Khulna
Chittagong
Contraceptive Prevalence Rate, 1991
(Source=CPS)
1-Year-Olds Fully Immunized, 1991
(Source=WHO)

FINANCIAL STATEMENT 1992 AND BUDGET 1993

Dr Ralph Henderson, Member, Finance Committee (Dr Muller, Chairman of the Finance Committee, had to leave the day before) reminded the participants who were relatively new to the Centre, that it had emerged from a troubled past, both in terms of its internal management and its external financing.

In the morning, Dr Habte had told the meeting that the Centre was heading into a new era, in fact it was in a new era. It was in a new building, a very concrete demonstration of the change that had occurred; the resolution of the long standing loan by the GOB was another very substantial evidence of the new status of the Centre and last, but certainly not least, the donors were getting more science and better science which was the bottom line for the Centre's health in the future.

Nonetheless, the Board remained acutely conscious that the finances remain fragile and their task was to assure that the Centre continued to be austere and vigilant in its management of its resources. However, continued support from the international community and the GOB would be required. The Centre was showing that it was a uniquely valuable global scientific resource and that it continued to provide extraordinarily high value for money.

The current year had been a disappointing one in that a major donor was not able to provide the Centre as much resources as had been initially hoped. The 1992 ending would show a small cash surplus, but an operating deficit after depreciation. Thus the Centre had paid all the salaries, and had not gone into debt, but had been unable to contribute substantially towards the costs of maintaining its buildings, equipment and other essential assets that depreciated and lost their value over time. The Trustees were not happy with the amount that was going to fund depreciation and would continue to insist more money be set aside for this purpose in the future.

Given current pledges and expectations, the Centre would wind up at the end of 1993 with a substantial cash surplus, a surplus between US$ 200,000 and 220,000. Having ascertained this, the Board had had to confront an acute problem that the Centre was facing, which was one of adjusting staff salaries. The Centre paid a salary which is based upon, but not exactly equivalent to, UN salaries which were paid locally in Bangladesh. The Centre's salaries had been around 85% of the UN equivalent salaries in Bangladesh before the UN raised its salaries last April. After the UN raise, the General Service (GS) staff fell back a little bit, a couple of percentage points, but the National Officers (NO) went from a pre-raise where they had been at 86% of the UN salary rate down to 78%. The problem was that the National Officer staff were absolutely critical to the Centre's survival, and were its future. The Centre was committed to developing its good national staff who should then succeed to senior staff positions and go on to compete for international positions. There was no more death dealing blow to the Centre than to lose the opportunity to recruit, and even more importantly, retain the top level of the national staff.

So, the Board seeing that there would be a surplus in 1993, then debated what would be an appropriate response to this problem. The Board determined that the Centre could afford to (and indeed could not afford not to) raise those national staff salaries, and a few percentage points for the general services staff, so that they would both be 85% of current UN levels. This was a little less than what the National Officers were getting before the UN salary raise, but it seemed to be a reasonable figure, and the cost to the Centre would be some US$ 208,000. This would still leave a few thousand dollars cash surplus at the end of 1993.

Thus, one of the resolutions that the Finance Committee passed to the Board of Trustees, and the full Board then passed, was that, commencing as soon as the Centre found the additional money necessary to finance the increases, both the GS and NO salaries would be set at 85% of current UN levels. But secondly the Board had said to the Centre that they wanted two revised budgets for them to review the financial situation at the June 1993 meeting. The first budget would show money that the Centre had either got in the bank or as firm pledges for 1993, and also the adjustment of the Centre's activities so that incorporating this $ 208,000 salary increase, it would still wind up the year with a cash balance of $ 100,000. That cash balance would help to cover some of the depreciation. The Board and the participants understood that the Centre always worked on a combination of hopes and fears. This budget was the worst case scenario and would mean cutting back on some activities that were currently in the budget, if no new pledges came in during 1993.

The second budget would show how much was required to meet all of the Centre's priority activities, because, at present, there were a lot of activities and needs in 1993 that were not being funded. The Centre had many aspirations that it simply could not meet with the current pledges, and the Board wanted to examine these carefully. But it was clear that if no new pledges came in, the Centre would operate on the pessimistic budget and ensure a $ 100,000 cash surplus at the end of the year.

So, there had been one firm decision to increase the salaries to 85% of the UN levels, and a second to review a budget in June that would produce a cash surplus of $ 100,000 by the end of 1993.

The third major act of the Board was to make quite explicit the Centre's gratitude to the GOB for the considerable work that had been done to forgive the UNROB loan. This had been a major step forward in relationships between the government and the Centre, and had resolved a considerable uncertainty.

So the Board emerged from the debate feeling quite confident that 1993 was going to be a very productive and financially responsible year. But the Board recognized that the Centre had not yet resolved a more chronic problem that would take some years to address fully. This was the problem of "core" funding. There were a number of activities, including the demographic surveillance system that had been established in Bangladesh, which were essential for the full functioning of the Centre but which were difficult to fund through individual research projects. A Vitamin A study was not necessarily going to cover the full costs of the Centre's institutional overhead. And every institution faced this problem.

The Centre had been trying to balance project funding with the funding required to maintain the Centre's infra-structure as a whole. It was only the Centre as a whole that could conduct the full spectrum of health research, from the community studies to the basic research; and even more preciously, put those two ends of the spectrum together, in a way that no other place could really do. The chronic problem for the Centre was that it had to remain competitive on the project basis. If the Centre came with a project that had a huge overhead, to support these core activities, the project became so expensive that the international funders would go elsewhere.

The funding of the core needed to be addressed; there were two ways that the Centre was thinking about this. One was to be sure that the donor community was clear about the immense value of those core activities, because there was still quite a lot of room for direct funding of those core activities. They were essential and important in themselves. This meant either the GOB helping out with the costs of some of the services that were being provided in the hospitals, and/or other donors who were interested in some of the aspects of the family planning and the demographic surveillance system studies, (also core activities), giving direct support for that. But then secondly, in the longer term, the raising of two endowment funds to provide interest income and make contributions to the core.

SPECIAL NEEDS IN 1993

Dr Habte (Director, ICDDR,B) said that of the various activities that the Centre wished to conduct in 1993, there were a few that remained unfunded and it was considered important to bring these to the donor agencies' attention. The proposals for the three projects were included in the working papers that were circulated to the participants.

The first of the three in the folder was **Matlab MCH – FP project**. This was a core activity, and although the Centre would make every attempt to fund this activity, this sometimes meant that it might go into a deficit budget. As the participants had heard over and over again during the day, the Matlab MCH – FP activity of the Centre was an invaluable resource to Bangladesh and the world. Indeed it was an activity that made the Centre unique and provided one major comparative advantage over other health research institutions in the world. There were still many studies that could be conducted in Matlab, but which were not proceeding for want of funds. The BRAC – ICDDR,B joint venture on trying to assess the impact of non – health interventions on health was largely funded by Ford Foundation and BRAC, but there were areas that still required funding. In particular there was a need for an economist who would be part of the team to conduct this work. This was but one example of the type of activities planned for implementation within the Matlab infrastructure that still required additional support.

The second important activity was the diarrhoea surveillance programme in the **Epidemic Control Preparedness Programme**. Of all the activities that the Centre undertook, the most popular amongst the people of Bangladesh was the Centre's contribution during epidemics. The newspapers often reported that there was a major diarrhoea epidemic in a given part of the country, and there were some health workers working on it, and then highlighted that there were no staff from ICDDR,B working there. This was a sort of flag, and reflected the high value placed on ICDDR,B's contributions in times of epidemic.

The Centre wanted to develop a surveillance system through which it would be able to warn of impending epidemics, particularly of cholera. This would be done by establishing fixed or sentinel surveillance units which would also include a small diarrhoea treatment facility along the lines that ICDDR,B had developed. The Centre intended to have five such diarrhoea units, sentinel surveillance sites, one in the north, one in the south, one in the east and one in the west and one of course in Dhaka. The Centre had already established one in Dhaka, partially established one in the south, in Barisal, and during the epidemics that followed the cyclone, had set up one in Chittagong, and had made a study of another one in the north in Dinajpur. Besides establishing this sentinel surveillance system the Centre also intended to assist the GOB to evolve a diarrhoea epidemic response team, who would be trained over two to three years, and constitute part of the diarrhoeal disease control program of Bangladesh. This team would then be able to respond to epidemics as effectively as ICDDR,B's team. Of all the felt needs of the people and the GOB, it was interesting to note that this was the most important.

The third need had essentially come from the donors and was the Centre's **communication and dissemination** expertise. One of the major criticisms of almost all research that was going on around the world was the inability to communicate findings to policy – and decision – makers. The research community was inordinately successful at communicating amongst themselves, but dismally failed when it tried to communicate these findings to others. As a result there was a major lag between research findings and results, and the use of those results in implementation.The Centre wanted to address this. A consultant, supported by USAID, visited ICDDR,B about a year ago and evolved a strategy that the Centre could use. Donors were repeatedly exhorting the Centre to improve the dissemination of its results, but it needed help to do so. The project proposal included in the folder offered a chance to turn words into actions and Dr. Habte encouraged donors to come forward to finance it.

Finally, Dr. Habte introduced Professor Matin to say a few words on the Programme Coordination Committee (PCC). Professor Matin was a former Minister of Health and Deputy Prime Minister, he was attending the meeting in his capacity as Chairman of the PCC and would say a few words about the needs of that program.

Professor Matin introduced the Programme Coordination Committee (PCC) which was a mandatory committee of ICDDR,B. The Ordinance of the ICDDR,B, the charter on which the ICDDR,B is legally based, was formulated in 1978. Article 12 stated that ICDDR,B would not only support the development of

research in the field of diarrhoeal diseases with the help and collaboration of the world scientists, but also be supportive of the national institutions engaged in the research in the field of diarrhoeal diseases, fertility and nutrition. On the basis of this Article 12, the PCC was established.

The committee was very large, encompassing all the universities situated in Bangladesh, the Institute of Post Graduate Medicine and Research, the Institute of Child Health, Bangladesh College of Physicians and Surgeons, Bangladesh Medical Research Council, National Institute of Preventive and Social Medicine, some of the heads of the medical colleges and the scientists in their individual capacities. The committee was about 40 in number, and met twice in a year, but also had sub-committees. The Standing Committee of about 15 conducted the day-to-day activities of the committee, on behalf of the whole PCC. The Scientific Review Committee examined the research proposals coming from the national institutions for funding by ICDDR,B. After research proposals had been examined by the Research Review Committee they went to the Ethical Review Committee of the ICDDR,B and were then ready for funding.

So it was a very complicated procedure and initially did not meet with great success. To exemplify this, the initial $10,000 that was allocated to the committee by ICDDR,B remained unspent for a couple of years. But the situation very rapidly changed under the leadership of Dr Habte, when he took over as the Director of the Centre.

The PCC had funded eleven research proposals so far, and nine of them had been completed in 1992. In 1992 only $ 26,690 was given for these research projects and there were two projects which remained unfunded because of shortage of funds.

As Minister of Health, as well as the first Chairman of the Board of Trustees, Professor Matin had had the pain as well as the pleasure of seeing ICDDR,B go up and down hills during the last one decade. But today he was very happy, because everybody is happy when their dream comes true. As the first Chairman of the Board of Trustees, he had a dream that ICDDR,B would one day be established on its own land and functioning in its own building. This had come true. Today as Chairman of the PCC, he had a dream that through the PCC collaborative funds, the PCC would be able fund to all those Bangladeshi scientists doing research in the fields of diarrhoea, fertility and nutrition.

The name of the Centre signified its difference, the first letter of the acronym was for "international", but the last letter was for "Bangladesh". It meant that the objective was not only to develop research capabilities of world scientists but also those of Bangladeshi scientists. So for 1993, the PCC would need at least $150,000 to fund the projects or proposals coming from various institutions of Bangladesh in the field of diarrhoea, nutrition and fertility.

REVISED RESOURCE DEVELOPMENT STRATEGY (See Appendix 2)

Graham Wright (Assistant to the Director) stressed at the beginning of his presentation that the document was a "revised draft", which meant that he was presenting it to the meeting for input and suggestions, not as something that was "final" or set in concrete. The draft was the product of a significant amount of work this year during which Dr Habte and Mr. Wright had made visits throughout Europe and the North American continent as well as Australia and Japan, examining the ways to broaden and deepen the funding base for ICDDR,B.

Traditionally the vast majority, 80% to 90%, of ICDDR,B's funds had been derived from government and multi-lateral donors. This reflected the nature of the work of ICDDR,B and it was important to stress at this stage that it was unlikely that any medium term resources development strategy would be able to affect anything but a shift in emphasis from this pattern. The nature of ICDDR,B's work meant that it would require this government/multi-lateral support for an indefinite period.

This did not mean that ICDDR,B proposed to simply sit around and wait for the government and multi-lateral donors to come forward. The Centre had significantly increased competitive grant activity and was looking towards broadening the base of the resources of the Centre in several ways:

Foundations - to date ICDDR,B had had relationships with the Aga Khan Foundation, the Sasakawa Foundation and the Ford Foundation and a small amount with the Rockefeller Foundation. However, there were many other foundations, particularly in the U.S., which the Centre had yet to approach. The Centre had initiated a program of examining and identifying the foundations that support the type of work that ICDDR,B undertakes. These foundations were U.S. foundations, Japanese and U.K. foundations and many of the Japanese foundations now had representation in the U.S.

Corporations, both pharmaceutical industry and non-pharmaceutical industry were to be approached. However, the Centre recognized, particularly with the pharmaceutical industry, that strict guidelines were necessary to maintain its perceived and indeed actual independence. These guidelines had been drawn-up and were being used.

The diagram entitled "Resource Development Strategy" (Figure 1) showed that ICDDR,B had set-up and established two endowment funds with two very different focuses. The first was the institutional or reserve endowment fund. This was an endowment fund to allow forward planning of health research, to provide for bridging funding when cash-flows were variable; in short to develop and fund the institution. This would appeal to a very different type of donor than the other endowment, the hospital endowment fund, which was much more orientated towards donors who appreciated and wished to fund humanitarian services.

There was one element of ICDDR,B's activity that had not been effectively utilized to date, and which the Centre was aiming to utilize considerably more in the future. This was the Centre's alumni. In this context, "alumni" meant not only ex-employees and ex-Board of Trustee members but also consultants and other people who had come through the Centre and who recognized its full value. Near the top of almost every major international health organization in the U.S., were alumni of ICDDR,B. When the Centre submitted project proposals to foundations and governments, by using these alumni to network, and to endorse these proposals, the Centre could significantly increase its funding. ICDDR,B was working on the establishment of a data base of these alumni and would hold regular meetings with them when the Director and Associate Directors went to the U.S. and Europe. Mr. Wright hoped that in this way ICDDR,B would be able to strengthen its fund raising activities in these countries.

In 1985 the Centre had established the International Child Health Foundation (ICHF) to give it representation in the U.S. This had not worked as effectively as it might have done, primarily due to the problems the Centre was facing in the late 1980s. Some considerable time had been spent re-building that connection and communications with them, and in future, the Centre would be able to work much more closely with ICHF to coordinate its activities in the U.S.. Many of the fund raising experts consulted during the year had repeatedly advised that one has to have representation where the money is. Although there was money in Dhaka, there was also a great deal of money in the U.S. that the Centre was not addressing at the moment.

Turning to the endowment funds, Mr. Wright said that ICDDR,B had initiated activities to raise money for

both these funds. The institutional endowment fund stood at just over $2 million at the moment and Mr. Wright believed that the Centre should target a considerably higher amount than that. An issue with endowment funds that was not necessarily clear to everyone was that you cannot simply rake off the interest from the capital, since you have to preserve the real value of the fund's capital. Thus if you had an endowment fund giving 10% interest, and the rate of inflation was 7%, the amount that you could take out of that endowment fund would be 3%, not 10%. If you took the full 10%, the real value of the capital in the endowment fund would fall progressively over time.

The institutional or reserve endowment fund was designed to assist the Centre in preservation of core activities in the face of fluctuations in funding, and also in timing delays of funding. The Centre was not expecting the institutional endowment fund to pick-up the full cost of the Centre's core activities, but simply to assist with smoothing out those bumps and ensuring the continuity of research. If one was living from hand to mouth year to year one could not plan activities effectively. The institutional endowment fund would allow the Centre to plan research activities for a longer period of time and this would make them considerably more effective.

The hospital endowment fund offered the opportunity to appeal to a significantly different type of audience, an audience that did not necessarily understand the role or importance of international health research, but nonetheless wished to give to an extremely important humanitarian service cause. As a consequence, this was more likely to appeal to some of the non-health related corporations and to philanthropic individuals. However, it was important to recognize that to build up this fund to a level that was adequate to subsidize the hospital activities, a significant amount of money would be required. One of the optimal ways of doing this was to look at releasing blocked currency funds derived from the sale of fertilizer, wheat and the like. ICDDR,B's investigations had shown that this was not feasible in the short term, but the Centre hoped to work on it on the medium and long term. This would be an extremely long term process but the Centre, in consultation with USAID, would look at some of the potential mechanisms for doing this. The Centre was also working with an organization called "Debt for Development" to look at the possibility of debt swaps. However, there was a limited amount of commercial debt in Bangladesh so this was unlikely to provide much help.

To summarize the objectives of the resource development strategy:

The **first objective** was to increase annual flow of funds by at least 10% per annum through broadening of the funding base. This included increased project activity in particular through competitive grant work, work for foundations and with corporations as well.

The **second objective** was to maintain the current trend of long term core funding under multi-year agreements. Increasing numbers of donors had come to sign multi-year long term funding agreements with the Centre and this was extremely important to allow it to plan its health research effectively. Core was important to ICDDR,B and indeed to the project activities. The Centre could not run a contraceptive use dynamics investigation without the basic infrastructure that the core activities of the Centre provided. Almost all of the project activities required either the broad patient base that the hospital provided or the rural infrastructure that the Matlab and DSS systems provided. For that reason, it was extremely important to maintain the core funding.

The **third objective** was to secure GOB agreement for the use of bilateral funding for the provision of health care services on projects that assisted government policy formulation and implementation, as well as training. When this was discussed in the Finance Committee, the Secretary of Health had been extremely encouraging. The GOB increasingly recognized the significant role played by the ICDDR,B hospitals in the National health service provision infrastructure. It was important to note, however, that it was not feasible to ask the GOB to finance the whole of the hospital. It was feasible to ask them to finance the hospital up to the same level per patient day as they have in government hospitals. The Centre would try to proceed with this, but those at the meeting with experience in this issue would know that the Centre would have to proceed with care, sensitivity, and that it would take quite some time. However, it was quite clear that many donors were very keen to provide ICDDR,B with bilateral funding and the Centre would very much encourage the government to allow it to utilize this funding in the areas where the work that it was doing was of direct benefit to Bangladesh.

The fourth and fifth objectives were the establishment of endowment funds. These two endowment funds

were also addressing this core funding issue. The **fourth objective** was the institutional reserve endowment fund. Mr. Wright's calculations suggested that the Centre should aim for an institutional endowment fund of $30 million. This would allow it to fulfill the functions that he had talked about before, and to maintain the continuity of health research.

The **fifth objective** was the hospital endowment fund. The first phase of the hospital endowment fund had already been launched with the aim of raising $ 5 million. Mr. Wright believed that there should be a second phase to raise an additional $ 5 million. He asked the meeting to note that the total of $ 10 million for the hospital endowment fund would not cover all the costs of the hospital. It was once again designed to provide the differential between the basic cost of running the hospital, which the Centre hoped that the GOB would eventually come forward to fund, and the cost of providing the quality and standard of service that ICDDR,B provided in that hospital.

One of the suggestions that had been made was for cost recovery through charging patients to come into the hospital. ICDDR,B had looked into this, and knew that many NGO's had been encouraged to do this, and that a typical system was to charge a registration fee of Tk. 5. If the Centre were to do this, there are two potential problems. First, the revenue that the ICDDR,B would generate in this way would be extremely limited, and the Centre would finish up paying a significant proportion of it in administering the scheme. Secondly there was a very large risk of losing a critical element of the hospital population. By charging Tk. 5 to some of the urban slum dwellers the Centre would receive fewer patients from this population. This was quite clearly a critical component of the population that came to the hospital, and was the basis of much of the Centre's observational research. Mr. Wright noted that he had made this digression to impress upon the meeting that ICDDR,B was considering as many ways as possible to finance its activities.

Turning to the diagram entitled "Resource Development Strategy – Implementation Plan" (Figure 2), Mr. Wright said that it showed the extremely complex series of steps that the Centre had to undertake to implement the Resource Development Strategy. He stressed that most of these steps were learning activities. They were additional research that the Centre had to do, to identify additional foundations, examine the U.K., the potential of the U.K. market, to build alumni data bases and start alumni networking systems. This was all being initiated and was "in process" but clearly the Centre had a long way to go. The Centre proposed to report back on progress to the regular Board of Trustees meetings. One of the suggestions that had been made was to keep the Resource Development Strategy permanently in "draft" form, to reflect the changing circumstances, opportunities and needs of the Centre. As these changed, so the strategy for raising the funds and meeting those needs must change. Nonetheless, Mr. Wright hoped that by the May Board of Trustees meeting the Centre would have made some basic decisions on the establishment of the representation based in the U.S. under the umbrella of the International Child Health Foundation.

Over time, with the successful implementation of this resource development strategy ICDDR,B could not only increase the funding to meet the huge potential of the Centre, but also to effect the shift away to take some of the burden off government and multi-lateral organizations. As he had noted at the beginning, it was extremely important to note that it was unlikely that the Centre would be able to effect anything but a change in emphasis, but nonetheless it was trying very hard to affect that change in emphasis.

Turning to the diagram that had been adapted from Commission on Health Research (Figure 3), it showed the break-up of research funding on developing countries' health issues. The left hand column showed the world's health research in 1988, and the breakdown of the funding sources. The majority was from government and multi-lateral sources but there was a significant amount from corporations. Corporations offered some opportunity for ICDDR,B but it had to be recognized that this was limited by virtue of the nature of the Centre's work and by virtue of the fact that the commercial interests of corporations are not addressed in that work. The work that ICDDR,B was doing was not necessarily commercially exploitable, it was primarily for the benefit of developing countries as opposed to addressing the health problems of developed countries.

The middle column showed ICDDR,B's current funding mix and the final column showed where the Centre hoped to be by 1999. It was also important to note that this slide and the one headed "Funding sources over time" showed the transition to 1999 without reference to the endowment funds. Mr. Wright hoped that in the intervening period the Centre would be able to build up the endowment funds. Clearly the better the Centre did this, the less it would have to rely on or insist on government and multi-lateral donors funding

the core. Both those endowment funds were effectively funding core, either through the institutional reserve fund or through the hospital endowment fund.

The Centre's initial budgeting for the Resource Development Strategy appeared to be low in 1993, because it was not proposed to start the U.S. representation until mid-way through 1993. The Centre had a little more ground work to do with the International Child Health Foundation, but as soon as that had been completed and the alumni data base had been prepared, the Centre would move into the U.S. The Centre would report back to the Board of Trustees in June this year with a detailed plan of what it proposed to do in the U.S. and the Board would then, give permission to move forward and establish a desk officer part-time in the U.S. to coordinate our fund raising activities there.

Some part of the budget had been tentatively ear-marked for a U.K. office which would be responsible for generating funds from the whole of Europe. However, Mr. Wright considered that it might be more desirable to have a full-time representative in the U.S. and delay operations in the U.K. and Europe simply on the basis of the size of the market. The funds available from foundations and private individuals in the U.S. was ten times what was available in the U.K.

There was a case to appoint a consultant to undertake two important tasks for ICDDR,B in the U.K. One was to establish charitable status which would allow tax-free giving in the U.K. and the second was to carefully examine the market available in the U.K. and Europe. Clearly, raw numbers from "Giving U.S.A." and the Foundation Directory did not tell the whole story in that significant amounts of money given to charitable purposes were for highly domestic-oriented programs. It was important to fine tune marketing efforts and to examine from where funds could realistically be expected. When the Centre received a report on the potential of the U.K. and Europe, it could then make a decision as to whether it was worth investing in opening representation in the U.K. as well.

Mr Rothermel (Chairman of the Support Group) asked for questions.

Dr. Peter Arnold (SDC) wanted to know more about the endowment funds, how they would be managed, and how the money would be invested ?

Mr Ken Tipping (Associate Director, Finance) stated that at the moment the Centre did have some investment funds in its Reserve Fund, and these were currently invested in US dollar deposits in Dhaka. Obviously, if the magnitude of the Fund increased, the Centre would seek professional advice as to how to manage it. The Centre was too far away from where the financial markets were located to be able to manage such a Fund adequately from Dhaka given the vagaries of moving stock markets, money market rates and fluctuating currencies. So, if the Fund grew to a large extent, the Centre would seek professional advice on how it should invest.

Mr. Johan Dirkx (The Netherlands) thanked Mr. Wright for his explanation. He wondered what was the motive to go to England to establish another office.

Mr. Wright said that he thought that Great Britain had a larger tradition of foundations than most of the rest of European continent. However, he was open to other suggestions and indeed that was one of the issues that he expected the consultant to look at when the Centre appointed someone to examine the UK and the European market. If it transpired that in fact the opportunities in The Netherlands were significantly higher then the Centre would be delighted to establish an office in Amsterdam.

Dr. Caryn Miller (USAID, Washington) wanted to know whether the Centre actually envisioned two separate endowment funds ? or one with designations for each ?

Mr. Wright said that currently the Centre favoured two separate endowment funds, separately demarcated and separately handled. However, this was an issue that was still under consideration.

Professor Matin noted that in Figure 1 showing the flows of money under the Resource Development Strategy, the arrow showed that the hospital endowment fund money flowed to the core costs. Did the Centre think that it would be able to convince people to donate, if it was thought by them that the money would flow from the hospital endowment to the core cost of the Centre?

Mr Wright pointed out that the hospital was an intrinsic part of the core cost of the Centre, and so by definition money donated to the hospital flowed to the core.

Professor Matin said that the people whom the Centre would address for money for the hospital endowment fund were in a completely different category. They were the individuals who wanted the services to be delivered at the hospital. So, he felt that it would be very difficult to convince them to donate if the money flowed from the endowment fund to the core cost of the Centre.

Dr Habte suggested that he should explain. Professor Matin was considering research activities as a core. What the Centre considered as core actually included the hospitals providing free health service to the population in both Matlab and Dhaka. In fact most of the research activities were project funded.

Dr Henderson thought that Professor Matin was correct, that as a relations tool this money is not subsidizing core, it was much better to identify a health services component to which maybe the GOB would be happy to contribute and maybe these funds would be contributory.

Mr Wright said that the hospital endowment fund would be to finance the running of the hospital as a humanitarian service centre. ICDDR,B needed this wide patient base in order to conduct the clinical research activities and indeed some of the community-based studies, as well as training.

Mr Bill Goldman (USAID, Dhaka) noted that the work that the Centre had been doing in terms of developing this strategy and looking for resources was very good. However, he had a question. As the centre had objectives to obtain funding from different types of funding sources, especially private corporations, did it anticipate that there would be different demands made on it for the types of activities it was involved in ? Had it taken this into account or was that something that it would address during its strategic planning process over the next six, seven, eight months?

Mr Wright said that the answer to that was a little bit of both. The Centre was not going to start doing research outside its strategic plan simply because there happened to be a little bit of corporate money there. On the other hand, it was important in the strategic planning process to identify the key issues that the Centre was being asked to deal with, and if there was funding available from corporate sources to actively pursue that.

Dr Jim Ross (Ford Foundation) appreciated the work that had gone into developing the Resource Development Strategy. However, he wanted to make a couple of points or observations. It might be that the Centre's $30 million estimate for the reserve or institutional endowment fund was perhaps not adequate. Today, it would give the Centre probably a little less than $1 million as a contribution to the core operating costs of the Centre. This was about 10% of the total annual operating cost, so in effect to really have an impact, the Centre might want to be looking at something like $50-$70 million in order to be able to protect that corpus of investment and still have resources that would make a significant impact on sustaining the activities of the Centre. The Centre would need something on the order of a 5-10 year capital fund campaign with two endowments to be able to pull this together.

Obviously the best chance the Centre had in terms of making an immediate impact was in its negotiations with the GOB to recover the cost of hospital service delivery. There were two possibilities: either the government would pay the equivalent of what they would in any other hospital from their own resources, or it would permit the Centre to be included in the more general frame for bilateral/multilateral aid for this purpose in the health program. ' This might be a more immediate likelihood than a $ 50 million endowment fund, in terms of the immediate horizon at least. So Dr. Ross wanted to know where the Centre stood in its discussions with the government on this and its sense of the likelihood of that being considered.

Mr Wright said that 'Dr. Ross had been at the Finance Committee meeting in which the government participated, and stated that he was very encouraged by the apparent openness and receptiveness to that type of suggestion. It would be extremely helpful for the Centre if the donors were to repeatedly suggest this approach as well. The government recognizes the validity of the arguments for supporting the ICDDR,B hospitals, but it is not something that it would do easily. He hoped that the donors would assist the Centre in that process.

Dr. Reidar Kvam (Norway) wanted to support what Dr. Ross said about the importance of discussing this

with the government, and to question what Mr. Wright had just mentioned about the donors repeatedly suggesting to the government that they should do this. That was not a very practical solution for some donors had clear policy guidelines on not defining the governments' own priorities for them. NORAD would be open to a suggestion from the government to fund either towards core or specific project activities from its bilateral frame, but the initiative would have to come from the government.

There was one other important aspect of this type of bilateral funding which had not been mentioned, and that was not just as a funding channel but also as a means of integrating the activities of the Centre better into government policy. If the government regards it as a cost sharing activity the impact on their own activities and policies might be greater.

Mr. Brian Proskurniak (The Canadian High Commission/CIDA) wanted to know what was the value of the loan that was converted to a grant by the GOB.

Dr Habte said that it was about $1.2 million in 1982 and according to the donor agreement the Centre had signed, it would have been forced to pay interest on it since 1984, so the actual cost to the Centre would have been about $1.7 million.

Mr. Johan Dirkx (The Royal Netherlands Embassy) returned to what M. Kvam said about the bilateral frame. In a way The Netherlands was of the same opinion about this. But there was one other side: Did the Centre really want more involvement of the Bangladesh Government ? These were issues which would have to be considered.

DISCUSSION:

Dr Chris Kenna, (Australian High Commission/AIDAB) was not in a position to announce the likely level of support for the Centre in 1993, since it still had not been finalized. In addition to whatever may be forthcoming by way of funding AIDAB hoped to continue to provide some training opportunities for members of staff (who could compete along with others) for the scholarships to universities etc. in Australia.

He stated that the visit of Dr Habte and Graham Wright to Australia was very much appreciated and valuable in terms of giving many people, especially in AIDAB, an opportunity to hear about the Centre, and its plans for the future.

He also complimented the Centre on the Director's Report. It was clear that there were very significant improvements in the operations of the Centre. One was the re-orientation of the Training Bureau to focus on measures that contribute to building research capacity in the developing world. Another was the work on the development of the Resource Development Strategy and office. This was a significant step forward, demonstrating that ICDDR,B was looking creatively at ways of ensuring its financial support for the future. Once the Centre had all this in place it would be able to concentrate again on conducting and reporting on research which would make an impact on people.

AIDAB had a few questions on the budget, noting that a 15% increase was planned for 1993. It would interested to know what the implications of this were:

> whether other donors had pledged to cover this increase; whether there were any shifts in the ratio between core and project funding; and
> andwhat proportion had been allocated for running costs.

Finally, he commended the Centre on its work in the family planning area and noted that the Executive Director of UNFPA had praised the Centre for its work in Matlab. AIDAB had an interest in trying to urge the Centre to, wherever possible replicate its work, so that the research it did had an impact throughout the developing world. Although the Centre was producing an increasing number of publications, AIDAB still believed that the real question was what sort of impact this had in service delivery, in achieving improvements in some of the indicators that AIDAB was interested in. Though it was much harder to quantify this sort of indication of impact, he encouraged the Centre to develop tools to make this easier. So, in addition to producing papers, the Centre should, he urged, tell its donors when it saw key pieces of research being picked-up, implemented, and translated into service delivery.

Dr Habte answered Dr. Kenna's main questions and noted his suggestions. The budget for 1993 was based on a realistic estimate of revenue. There was no increase in core expenditure, in fact, there was a reduction in projected core revenue. And there was a significant increase in project expenditure. The running costs were essentially personnel and had increased very little in 1992 as a result of the increased number of community-based studies. The question posed on how to measure impact of health research was very important and very difficult, but the Centre would try to look into it.

Mr Brian Proskurniak, (Canadian High Commission/CIDA) said that CIDA recognized the quality of the management and the work being undertaken by ICDDR,B, and its wish to support these. This was evident from CIDA's move from project support in the past, to core funding.

What CIDA was interested in was the involvement of an active international Board (which the Centre had); in setting the overall direction of the organization; in overseeing financial matters; and assessing progress in achieving objectives over time. Participation at donor meetings and discussions with other major donors formed part of CIDA's assessment process and in this respect the open Board of Trustees' and Donors' Support Group Meetings were extremely useful.

The Centre's continued willingness to work with donors on the implementation of recommendations of the external review indicated its seriousness in identifying problem areas and taking appropriate action to improve its performance. Mr. Proskurniak had arrived in Dhaka over two and a half years ago, when ICDDR,B was at a particularly low ebb. It was very satisfying to see the improvements that had taken place from year to year over this time.

CIDA was moving more and more towards supporting linkages with Canadian institutions. There was an increasing demand for CIDA to show linkages between international institutions and Canadian organizations. In the case of the Centre, there were two Canadians on the Board, Dr. Hamilton of McGill University and Dr. Law of IDRC. For CIDA this was important because it helped to raise the profile of ICDDR,B in Canada. Studies of Canadian tax payers' views of development assistance and aid had not been very encouraging and it was the Canadian tax payer provided funding for overseas development assistance. One way CIDA was trying to address this was to encourage these linkages so that Canadians became more aware of what the institutions were doing and their importance.

CIDA was now in the process of emphasizing the importance of international NGO's. In the case of the Centre, CIDA recognized that ICDDR,B was clearly Bangladesh-based, and that most of the Centre's work was done here. What made ICDDR,B special was its relevance to work being done in other developing countries, the wide dissemination of information, and the international nature of the training and staffing. CIDA applauded the Centre's willingness and ability to move quickly to assist other countries in need.

Given CIDA's support for developing country based institutions, it was entirely appropriate that Bangladesh hosted a highly visible international organization such as ICDDR,B, derived benefits from its activities, and gained international prestige as well.

The CIDA grant 1991 was about 8.6% of the Centre's income of $US 10.3 million. This figure did not include payments that were made to now completed bilaterally funded projects. CIDA assumed that the percentage of total income in 1992 would be about the same. In 1993/94 CIDA would be commencing the third year of a three-year program of support for ICDDR,B, and during this next fiscal year it would be considering a new multi-year financing agreement with ICDDR,B.

CIDA hoped that other donors to the Centre would continue their financial contributions in the future and would give greater consideration to providing core support. CIDA hoped that the Centre would continue its efforts to expand its donor support base such that its dependency on a few donors is minimized. ICDDR,B should continue its prudent austerity program as economic conditions worldwide were not conducive to an increasing aid budget.

In summary, Mr. Proskurniak said that CIDA was pleased with the progress made by the Centre over the past years. They were pleased with the strengthening of management, the focussing of scientific programs, the strengthening of financial procedures, the improved relations with GOB and the regaining of the confidence of donors and others.

Dr Habte noted that the Centre was highly appreciative of CIDA contribution that is 100% core, and took this as a recognition of the importance of the Centre as an international resource.

Dr James Ross (The Ford Foundation) said that he would not repeat all the well-deserved accolades that the Board and the Director deserved for their accomplishments since 1989.

The Ford Foundation had identified the Centre as one of five core institutions with which it would be working closely, and supporting over the next decade. The Centre had a prominent role to play in the Foundation's programme on reproductive health in Bangladesh. This was reflected in their support for the BRAC-Matlab initiative. He believed that this was going to be one of the more interesting projects in which the Centre would be engaged over the next several years.

The Foundation's interests in the Centre were also in supporting institutional strengthening and human resource development in the social behavioural sciences, and the Foundation would hope to use its resources for this purpose.

Mr. Endo (Embassy of Japan) said that in spite of budgetary constraints, the Government of Japan this year had continued to maintain its contribution at the same level as 1991. In addition to its financial contribution, the Government of Japan was to send one medical researcher to the Centre by the end of the fiscal year 1993 to establish personal contacts between the Centre and Japanese researchers.

The Government of Japan appreciated continuing efforts by the Director, to streamline the budgetary

position of ICDDR,B. The recent visit to Japan by the Director and his meetings with officials of the Foreign Ministry, Health Ministry, and other private funding organizations, had contributed to the better understanding of the Centre's activities in Japan.

Among the activities of the Centre, Japan took special interest in the family planning service activities in Matlab. One of the Japanese Government's major contributions to the family planning service sector was made to the International Planned Parenthood Federation (IPPF) which had headquarters in London. In 1991 they contributed $US 15 million to IPPF. The International Organization Division of the Foreign Ministry, Tokyo, had suggested that ICDDR,B contact the South Asian Desk of IPPF to explore ways of establishing some collaboration with them.

It was regrettable that due to budgetary system constraints, the Government of Japan could not make multi-year commitments to the Centre, but Mr. Endo had been instructed to make clear Japan's readiness to continue its support to the Centre in the future.

Mr Johan Dirkx (The Royal Netherlands Embassy) was pleased with the continuation of the activities of ICDDR,B, which had been going in a really good direction, especially during the last few years, when the Centre had been playing a more forward role in Bangladesh.

He understood that the recent visit of Dr Habte to The Hague had been successful and that, most probably, the funding of DSS would be continued, and the Urban Health Extension Project was likely to be funded next year. The Netherlands was not providing core funding, but the project funding for these two projects would be quite substantial.

Regarding the future of ICDDR,B, Mr. Dirkx asked that ICDDR,B take a more active role in the IEM (Information, Education & Motivation) activities in Bangladesh, especially the IEM in the broader sense of health and education. Maybe there was also a role for ICDDR,B in the area of AIDS prevention in Bangladesh. The Centre could help with blood transfusions and blood screening, or perhaps also in IEM activities. There was a lot of experience within ICDDR,B and support in the donor community for initiatives on this. He hoped that the GOB would also be pleased with a combined effort to combat AIDS, which would be coming to Bangladesh.

Dr Habte said that the Board had spent no less than one hour discussing the HIV and AIDS problem, and what the Centre's role ought to be. The Centre had been instructed by the Board to look carefully into how it could contribute, and it will certainly do so.

Dr Kim Streatfield (The Population Council) said that The Population Council was not a donor in the conventional sense but had a long history of collaborating with the ICDDR,B. It had, with USAID support, seconded staff to the MCH-FP Extension Project since it began in 1982.

He hoped that the Council's profile would be higher in the future. The Council now had an office in Bangladesh and though collaboration would not be directly financial, it would be continued and expanded in terms of technical assistance in developing training and research methodology, particularly with the rapid increase of social science and its role in health in Bangladesh.

The Council was hoping to link up with some of its other offices in Africa and Latin America. With the new interest in low-cost longitudinal surveillance systems, the office network would be used to bring people to see how Matlab works as one model, to see how the MCH-FP Extension Project works as another, and to see the USS as a low cost urban surveillance system.

Dr. Reidar Kvam (NORAD) said that NORAD was a minor donor, and in the context of ICDDR,B, somewhat more minor than it would have liked to be. He was very impressed both with the quantity and the quality of the programs presented and discussed both at the Donor's Support Group Meeting and in the various reports he had received. NORAD was very happy with the direction the Centre seemed to be going, and recognized the importance both of basic and applied research, and how it linked up with extension activities, but these were also concerned with the impact of programs on the population, and the long term sustainability of these activities, especially in terms of the institutional sustainability.

NORAD was very happy to see the increased importance given to linkages and cooperation with other

institutions, both NGO's (particularly BRAC but also others) and government institutions. This was important not just because they might be convenient funding channels, for bilateral funds, but also because of the long-term sustainability of programs.

NORAD regarded its support to ICDDR,B as an integrated part of overall development cooperation with Bangladesh, which was primarily defined by the GOB and not by NORAD. There were a number of sectors of development cooperation of which health and family planning was a major one, but in the last couple of years NORAD had placed much greater demands on the GOB to formulate its own development priorities, and to take greater responsibility for implementation of programmes. This meant that NORAD no longer actively suggested to the government which programmes they ought to carry out.

NORAD operated with two separate channels, one bilateral, and the other a separate funding for NGO activities, out of which they had funded ICDDR,B. Some of the other donor agencies in the meeting had commented on the fact that NORAD's contribution to ICDDR,B for 1992 was less than previous years. Dr. Kvam assured the meeting that this was a result of NORAD's own budgetary restrictions, and was not any criticism of the work carried out by the Centre. On the contrary NORAD was very pleased with the direction it was going.

NORAD had been late in making its contribution for 1992 in the hope that this would allow it to find additional funds, and had recently signed an agreement for a contribution of just under US$ 100,000, Tk. 3.85 million. For next year, the contribution was not likely to be less, and might be more. If the government wanted bilateral funds channelled through ICDDR,B, NORAD would be interested in discussing this.

Dr. Barbro Carlson (SAREC) expressed her appreciation of the excellent presentations that she have heard throughout the day. It had helped to get a view of what was going on at the Centre and of the plans for the future. She complimented the management of the last years under the leadership of the Director. SAREC was also very happy to see the movement to find ways to supplement funding in the future.

SAREC, which was the agency for research cooperation with developing countries, had a very special mandate to find research cooperation and capacity building in these countries. That means that SAREC was very happy to see the activities going on at the Centre since they were in line with the type of work that SAREC wanted to support. There was both the excellent, top-class research going on, as well as training possibilities for young scientists, both from this country and from other developing countries.

SAREC had been supporting the Centre since the beginning of the 1980s, with a short break in the mid-80s. For the last two fiscal years, for 1991/92 and 1992/93, SAREC had given approximately US$ 600,000, as core funding. On top of that, SAREC was also funding collaborative projects with Swedish university departments. The money going into those projects was about the same as for the core funding.

Sweden was facing some financial problems, and the government had said they would have to cut funding to developing country programs everywhere. In about a month's time they would know how much this would affect SAREC. SAREC was hoping that this would not affect it too much, and so SAREC's intention was to maintain the current level of support being given to ICDDR,B in the future.

Dr. Peter Arnold (Embassy of Switzerland/SDC) thanked ICDDR,B for organizing the Donor Support Group meeting. It always offered an excellent opportunity for donors to keep themselves informed about ongoing activities and existing problems, and to exchange views on various subjects.

The documents, the presentations during the day, and discussions in the meeting had provided ample evidence that ICDDR,B has fully recovered its dynamism and its capacity to manage its own affairs in a sound way. In particular, SDC noted, to its great satisfaction, that income and expenditure for 1992 was congruent with the approved budget.

SDC wished to congratulate the Centre for designing an innovative Resource Development Strategy for exploring new avenues to raise funds from untapped sources. This document was in itself proof of the renewed dynamism of the Centre.

SDC acknowledged also with satisfaction the initiation of the international fellowship program to encourage

dissemination of knowledge to, and exchanges with, scientists from Asia, Africa and South America.

ICDDR,B had also significantly increased the community-based field studies and was making a growing contribution towards improving the environmental health situation. It was a move SDC had emphasized in the past, and so they were glad that it had materialized.

SDC had also noticed that the attendance in the two hospitals, especially in Matlab, had broken an all-time record with patients coming from farther and farther afield. This was viewed with mixed feelings. On the one hand it demonstrated the quality of the service delivered in the hospitals. On the other hand, it also implied that the situation in the health sector remained unsatisfactory. Much more combined effort, by all partners, would be needed in future to identify and change the unsanitary habits which are responsible, in part at least, for people becoming sick.

Therefore, SDC was very much in favour of the proposition to improve the linkages with the GOB programs and not least on the financial side. In addition, as a contributor to a nation-wide rural water supply and sanitation program executed by DPHE and UNICEF, and other similar efforts undertaken by NGO's, SDC wanted a closer link between its contribution to ICDDR,B and these programs. This should be in the field of research on water and sanitation, personal hygiene, collaborative efforts in monitoring, and in media communication to bring the message to the common man.

SDC was at the end of the first year of a three year agreement. So, SDC's financial contributions were fixed for another two years. These contributions placed emphasis on core funding, at the same time providing specific project- related funds to give the Centre the necessary flexibility to adjust to various needs.

Dr. Mehtab Currey, (ODA Aid Management Office, AMO) said that ICDDR,B was like the sick children in the hospital. On admission, they look as if they would certainly die, but after ORS had been given they revived very well. For the Centre, the "Habte Formula" with some generous assistance from the Board of Trustees, had worked tremendously well. She congratulated the Centre management on all that had been achieved.

The ODA had changed its approach, and the focus had shifted to more control or decision-making within the Dhaka office through the AMO. However, the ODA continued to have a section in London, called the Health and Population Division, headed by Dr David Nabarro. He had personally communicated his continued support to the Centre. He had been very impressed with his last visit here, and particularly following the meeting with the Director when he visited London.

ODA wished to assure the Centre of the UK's continued support, both to its core funding, which had been slightly increased this year, as well as a special agreement between the Health and Population Unit in London and ICDDR,B for additional funding for the DSS over a three year period beginning January 1, 1993 for about 450,000 pounds.

The AMO in Dhaka was very interested in three proposals looking at contraceptive use dynamics that they had received. The AMO was hoping that these proposals would be developed further and that this would mean continued support for another five years.

Dr. Currey said that one of the impressive things that she had seen was the Resource Development Strategy which had also been appreciated in London. In addition, she praised the Centre's strategic planning and the annual operational plans which the ODA followed very closely. She felt that these had been very important developments for the Centre.

ODA was looking forward to reviewing the implementation of the recommendations of the external review committee. There were two linkages that the ODA hoped would develop further. One was between research institutes within the UK and ICDDR,B for research collaboration, and the other was the ODA's agreement with, and contributions to, other international agencies like WHO, UNFPA and IPPF which have increased tremendously.

Dr Habte underlined the importance of the UK's contribution to the Centre, which had more than doubled for 1993 and beyond.

Mr Bill Goldman, (USAID, Dhaka) said that USAID provided assistance through three different mechanisms, two at the country level and one from its office in Washington. He would talk about a couple of issues in general and also about the assistance from the country program. Caryn Miller, who had come from USAID's Washington office, would talk about the Washington assisted activities in more detail.

USAID wished to laud the Centre for the work it had done to improve its financial situation, and particularly praiseworthy were the efforts to develop the Resources Development Strategy. It was a beginning, and there was a long way to go, but it was an excellent effort. It was USAID's feeling that there should be more of these kinds of efforts from other organizations with whom they were working in the sector.

USAID concurred with some of the comments of their colleagues: these are difficult economic times worldwide and there was a very strong interest in foreign assistance for the Eastern European countries and the new countries coming out of the old Soviet Union. Consequently there was lots of competition for resources which were becoming scarcer, so organizations like ICDDR,B, which were doing excellent work and were well-funded on an annual basis, need to look rigorously at the long term and long term security. The establishment of the endowment funds and the Resource Development Strategy put them ahead of other organizations with whom USAID were working in Bangladesh.

The United States had had a presidential election and a change of administration and there were lots of rumours and stories going around about what that meant for the US foreign aid program. What was clear was that a legislative bill had been passed this year which was extremely supportive of the activities in the health and population sector, and there were very large, the largest ever, funds earmarked for population, child survival and AIDS. So there was a very strong Congressional interest in those activities.

In Bangladesh last year the AID Mission, with Washington concurrence, authorized an extension of their family planning health services project which is USAID's main mechanism for providing assistance in the sector. That extension brought the total funding level to US$ 300 million, and extended USAID assistance to August 1997. This was the vehicle through which USAID, Dhaka would continue to provide assistance to ICDDR,B.

The main focus of that assistance was for strengthening the national population and MCH program. USAID's interest in assisting ICDDR,B would be a continuation of the MCH-FP Extension Project to support applied, practical research into the Bangladesh population program. This was research that could be used to test various models and be used to influence the government and NGO programs and policies.

USAID, Dhaka were also supporting the Urban Health Extension Project, and were in the process of negotiating with the Centre to redesign it to act in a similar way to the rural Extension Project. It would thus serve as a model for providing information, on an applied research basis, about the implementation of urban family planning and MCH programs.

The approval of the USAID family planning health services project would provide continued assistance to the ICDDR,B for these two activities. They would be financed to at least the level they have been historically. USAID felt that this was an excellent time to be negotiating as the Centre itself was going through a strategic planning process and USAID wanted that process to consider the relevance and importance of these activities.

USAID also provided and would continue to provide substantial assistance by funding Population Council and Johns Hopkins University for both short and long term technical assistance to these applied research activities. This would also be available to August 1997.

From the country perspective USAID were extremely interested in the utilization of research results, and whereas they agreed that the number and quality of publications were an extremely important product of the Centre, they also felt that another criteria for excellence should be local dissemination and impact on program and policies. USAID would encourage the Centre to give even greater consideration to achieving these goals. USAID could see that being done through training and workshops. Last year the Centre had its first Annual Scientific Conference, and USAID thought that this was an excellent mechanism and wanted to encourage more of that type of activity. Instead of writing formalized papers, short briefing papers to

the government, with translations into Bangla, visits to the field sites from key decision-makers, and technical assistance activities, could all play an important role in this process.

USAID also requested that, in the strategic planning process, the Centre look closely at this issue of co-ordination of donors. As more and more donors became involved in funding, especially of non-core activities where there were overlapping interests in funding for similar type activities, it was important that the money be used most effectively and not duplicate or conflict with other objectives that were not in the strategic plan. And there was the whole issue of opportunity cost in terms of limited talent doing one activity versus another.

Dr Caryn Miller, (USAID/Washington Bureau of Research and Development) said that the focus of her department's assistance had been in applied research in health, mainly diarrhoeal disease, but also more recently expanding into ARI, measles and related diseases.

USAID, Washington believed that it was very important to encourage the linkages not only between the donor country institutions and ICDDR,B, but particularly with other LDC institutions. She commended ICDDR,B for its recent efforts in this regard, not only for the exchange of fellows, but also for the technical assistance which ICDDR,B had been providing to Latin America and to Africa.

In the upcoming revision of the five year plan, USAID believed that there were a few issues that needed to be considered carefully. One was that there had been talk about expanding into new areas, for instance in ARI and HIV diagnostics, and ICDDR,B would have to consider where it was going to get the resources to do these. If the Centre was going to expand into new areas, it should not only look at what funds would be available, but also who else was already doing such activities, and how it all fit in with the national plan. For instance, the Centre might want to hold off going into HIV diagnostics until there was more of a national plan within which to operate.

An issue that was raised during the Board of Trustees meeting was the concern that the clinical services of the hospitals were to a great extent being subsidized by the research component, making the research component not as internationally competitive as it could be. This was of concern to USAID, and so it was happy to hear that as part of the Resource Development Strategy this is being taken into consideration. USAID hoped that this would relieve some of these problems because it believed that, in the long term, this could be very detrimental for the research component.

Another area which should be addressed in the upcoming strategic plan, was the whole issue of vaccine evaluation, particularly the efficacy of large scale testing of vaccines. These consumed enormous amounts of resources, not so much financial resources (which might even be more easily available in the future because of the children's vaccine initiative), but human resources. These trials were a tremendous burden for any one research centre, and Dr. Miller had experience of this since USAID, Washington had funded vaccine trials in other places. One or two trials was the maximum that any well-equipped, fully staffed centre could possibly manage and even then it was very difficult, and other activities could then suffer as a result. It was important to carefully reflect on what vaccines the Centre was going to consider testing, and why and how it would phase them in over time.

Several people had referred to the fact that with diminishing resources being available, and with donors funding multiple institutions for health research, they wanted to make sure that the programs were carefully coordinated to minimize the overlap. Dr. Miller commended ICDDR,B for participating in some of the coordination meetings that USAID had been holding. USAID funded ICDDR,B, the WHO/CDD program, and several US institutions to do very similar types of research, and was making efforts to meet every six months to make sure that this research was complimentary, not redundant, and therefore that it made the best use of everybody's resources.

Dr Habte said that the issue of duplication in research funding was an issue that is probably best addressed when the Centre evolves to a stage where donors would adopt the strategic plan or the work plan and then provide 100% core expenditure.

Mr W. Fischer, (UNDP) also congratulated Professor Habte and his staff for the excellence in the past and in the past year particularly. UNDP was happy to have been associated with ICDDR,B's resurrection. This was an association which had involved UNDP in chairing local Donor Support Group meetings, very

frequently at the time of crisis, and much less so nowadays. Together with WHO, UNDP had partially financed and coordinated the external review which paved the way toward the Centre's recovery.

UNDP would also support ICDDR,B in the future. For the period 1992–96 UNDP planned to make US$ 1.75 million or US$ 350,000 per year available through the Global Programme. At the request of the ICDDR,B and with the agreement of the government, UNDP could also provide funds from its Fifth Country Programme resources, from UNCDF, and with the agreement of countries of the region, also from regional program resources.

In addition, a US$ 350,000 one time Arab Gulf Fund grant, which was announced three years ago, but not paid, would be made available to ICDDR,B by the end of this year, with WHO having been involved in facilitating the administrative aspects of the transfer.

Mr Rolf Carriere, (UNICEF) said that ten years ago diarrhoeal disease was the single biggest killer of children in the world, claiming almost 4 million young lives each year. Most of the victims died of dehydration and although a simple and inexpensive method of preventing and treating dehydration had been available for many years, it was known only to a few people outside the scientific community. Today, thanks to a decade of promotion, some form of oral rehydration therapy was known and used by approximately one family in three in the developing world. This resulted in the saving of about one million lives each year and the demotion of diarrhoeal disease to second place among the causes of child death. It was ICDDR,B's pioneering work that had made this success possible and the world owed its dedicated and skillful researchers, trainers, programers, care providers and extension workers a great debt of gratitude for their unglamorous but most important public health contributions.

Success in the last decade had reshaped the challenge for this decade, and the much broader basic and operations research of the type ICDDR,B was currently engaged in would once again lead the way. ORT still needed to be strongly promoted. The majority of the developing world's families still did not use the technique and dehydration still caused 3 million deaths a year. Bangladesh faced a special challenge since over 90% of mothers were aware of ORT but only 1 in 4 actually applied it. Tragically this resulted in some 300,000 children dying unnecessarily each year, or 800 a day, not counting diarrhoea's impact on malnutrition growth. Therefore, converting current awareness and skills into timely and sustained use of the ORT was a new priority in social communications and social mobilization.

But beyond oral rehydration there was now a need for more proper diarrhoea management that increasingly addressed the issues of dysentery and persistent diarrhoeas as well as a whole range of preventive measures. Whereas these interventions needed to be scaled–up as soon as possible, they required the operations research back–up from agencies like ICDDR,B.

UNICEF was proud to be associated with ICDDR,B's work and had recently seen an increasingly close working relationship between the two agencies. They met regularly to review the status of research which ICDDR,B carried out for UNICEF, locally, regionally and globally. Mr. Carriere was happy to report that UNICEF would continue to provide core support to ICDDR,B at the same level as before. This would be over and above the contracts that would be signed with them on various new research protocols.

Mr. Carriere would not repeat all the support UNICEF had received from ICDDR,B in the form of research studies, training and laboratory services, but wanted to thank ICDDR,B for it, and for all the work that they had done on behalf of UNICEF regional office, country office and global office. He also wanted to express UNICEF's special appreciation that ICDDR,B had agreed to provide them an annual situation analysis on the state of health of women and children in Bangladesh. This would be a very useful tool for advocacy and in UNICEF's annual program reviews and would greatly facilitate program design and modification. To further strengthen the ICDDR,B–UNICEF cooperation he hoped that the organizations would be able to systematically review UNICEF Bangladesh's needs for assistance from ICDDR,B for the next three years of their country program. UNICEF planned to present a series of new research needs before the end of February 1993.

UNICEF believed that it could no longer be argued that the world lacked the resources to achieve the goals and objectives agreed upon at the World Summit for Children two years ago. Indeed, recent cost studies at UNICEF have shown that all 27 goals covering health, nutrition and population, water and sanitation, education and children in special difficult circumstances could be reached by the year 2000 at the

cost of about US$ 25 billion a year. This is on the order of the magnitude of the 1992 G-7 Western aid package to Russia alone.

It needed to be stressed that the global goals of reducing malnutrition by half, and child mortality by one-third, simply could not be achieved by the year 2000 without controlling diarrhoeal disease. There were just 2,500 days to go to the turn of the century. Unfortunately, the world was now seeing signs of donor fatigue, and a faltering in the growth of ODA at a time when new claimants had come to the fore to compete for the scarce aid resources. It was well to recall that only about 10% of ODA is currently spent on people's basic needs, on the priority concerns of human development. Therefore, if ODA had to decline in the near future, all agencies should do their utmost to guarantee that the vital investment in maternal and child survival and development were protected against indiscriminate cutbacks. He was sure the meeting would agree that ICDDR,B's work should not become the victim of any cutbacks, for it continued to play an essential role in achieving the global goal for the 1990's.

Dr R.H. Henderson, (WHO) said that WHO would warmly associate itself with the remarks of UNICEF, very much in the same spirit of support for the Centre.

WHO was a small dollar contributor to the Centre but considered itself a major intellectual and scientific partner. WHO had every confidence that the partnership with ICDDR,B would continue to grow in the future, and that the Centre would continue to play an absolutely critical role in leading the way in many of the fields that WHO was interested in. In the fields of both child and maternal health, as well as in environmental improvements, and in every other kind of way in which social development could contribute to human development.

Dr Ashley, Chairperson of the Board of Trustees, on behalf of the Board of Trustees, wanted to thank the Donor Support Group for their constructive and valuable comments, suggestions, support and the pledges. The Centre management would be following up with the donor representatives to ensure that there was further discussion of these suggestions and commitments. She thanked the Centre staff for the presentations that they made during the day to set the stage for the discussions, and the management team for the excellent job that they had been doing to provide the basis on which the Donor Support Group had been able to give such favourable comments and expressions of willingness to continue their support to the Centre. She thanked the Chairman, Mr. Tim Rothermel, wished the Centre a productive 1993, and looked forward to the donor representatives' participation in the formulation of the next five year strategic plan.

Dr Habte expressed the gratitude of the Centre's staff and management for the wonderful collaboration that they got from the donor community. He stressed that ICDDR,B always had its ears open to suggestions for improvement and would continue to pursue a vigorous program to rationalize the Centre's management, personnel, and finances while simultaneously trying to improve the research productivity.

CLOSING ADDRESS

Mr Timothy Rothermel, Chairman of the Support Group echoed some of the important things that had repeatedly been said about the Centre during the meeting. One was "sound management and dynamism" and a second was "a uniquely valuable scientific resource". The meeting had heard some very encouraging remarks about the relations and the partnership with the Government of Bangladesh. It had also heard comments about financial fragility, but at the same time had listened to the introduction to a very forward looking Resource Development Strategy.

Over the last eight years, beginning with a meeting during the UNDP Governing Council in New York, Mr. Rothermel had had the privilege of chairing this group in one form or another. He said in summary that this was the most encouraging, most positive, and most useful of the many meetings over those eight years.

He joined Dr Ashley and Dr Habte in thanking the donor representatives and reminded them that the Centre would not be where it was today without the people and the organizations that were represented around the table, who had done so much
to bring about its transformation.

Attachment – 1

International Centre for Diarrhoeal Disease Research, Bangladesh.

ICDDR,B

Resource Development Strategy
Revised Draft

October 1992

Executive Summary

Overview

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

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

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

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

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

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

ICDDR,B

Centre for Health And Population Studies

Institutional Needs

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

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

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

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

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

Objectives of ICDDR,B's Resource Development Strategy

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

Requirements to Meet Objectives

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

Immediate Options and Recommendation

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

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International Centre for Diarrhoeal Disease Research, Bangladesh.

ICDDR,B

Resource Development Strategy
Revised Draft

I. Overview

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

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

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

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

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

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

C. **Competitive Grants:** As the Cholera Research Laboratory, the Centre received funding and technical assistance through the National Institutes of Health (NIH). With the changes in emphasis by NIH, the Centre is no longer able to bid on the majority of the projects (cancer, HIV/AIDS etc.), but there

are some significant areas of common interest (ARI, shigella, population etc.) These must be developed further. IDRC and WHO already have an extensive competitive grant system, and the ODA is now also moving in this direction. Approaching foundations for funding is increasingly competitive in nature, and other donors, including corporations, are likely to follow. It is clear that the Centre will have to develop its expertise in submitting proposals for competitive grants. A planned programme of training and technical assistance in competitive grant proposal writing should be instituted. This could be given by senior scientific staff or visitors. At the same time, the Centre will have to develop an effective mechanism for monitoring the submission of competitive grant project proposals to ensure that these are properly coordinated.

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

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

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

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

F. **Alumni:** For resource development purposes, ICDDR,B's "alumni" are as follows:
1. Employees
2. Members of the Board of Trustees
3. Consultants
4. Trainees and fellows
5. Members of other Boards and Councils members
6. Influential visitors

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

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

H. **International Child Health Foundation:** The establishment of ICHF in 1985 was ICDDR,B's first attempt to develop resource development capability in the US, where most of the potential funds were located. Cooperation and collaboration between ICDDR,B and ICHF could significantly increase the yields from new funding sources. With fund-raising operations located only in Dhaka, the Centre is less able to develop and use its networks of supporters, or to approach new government agencies, private sector foundations and corporations etc..

I. **Institutional Collaboration:** In the current international economic and political climate, self-interest is one of the prime motivations of most Government donor agencies. The development of effective collaboration with key institutions in donor countries has several advantages:

1. It provides a constituency and advocacy in the countries from where funds are coming,
2. It improves chances of winning competitive grants,
3. It provides answers to the question "what's in it for us ?" that is increasingly prevalent in Government offices.

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

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

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

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

   The hospital endowment fund is the fund most likely to appeal for personal contributions to the Centre's alumni and other private individuals. Indeed, this fund has been marketed through the Centre's publications to the alumni and others interested in the Centre's work. Additional

attempts to raise funds for the hospital endowment fund have been centered in Bangladesh. A local group of trustees, drawn from Bangladeshi leaders, the foreign embassies and multilateral agencies, to head the hospital endowment fund appeal would assist the local fund-raising efforts.

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

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

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

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

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

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

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

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

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

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

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

ICDDR,B

Centre for Health And Population Studies

II. Institutional Needs

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

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

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

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

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

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

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

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

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

In 1992 Core funding came from:

1. Government multi and bilateral agencies
2. Multilateral agencies
3. Project overhead charges

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

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

In the future core funding should come from:

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

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

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

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

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

1. To provide a source of funds to permit the scientific work of the Centre to continue, pending the receipt of committed donor funds, without the necessity and expense of borrowing interim funding, (through temporary withdrawals from capital, up to a maximum of $ 1.2 million).

2. To provide a source of flexible funds for the Centre, through its scientists, to use in exploring new lines of research or training, or supplement funding in those projects where donors are not paying the full costs of important Centre work, (to a maximum of 75% of annual income).

3. To provide funds to meet unforeseen judiciary requirements, or for safeguarding the Centre's programmes against shortfalls in expected revenues, (to a maximum of 25% of annual income).

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

In 1992 project funding came from:

1. Government multi and bilateral agencies
2. Multilateral agencies
3. Foundations
4. Corporations

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

In future project funding should come from:

1. Government multi and bilateral agencies
2. Multilateral agencies
3. Foundations
4. Corporations
5. International Non – Government Organizations

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

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

A. To increase annual flow of funds by at least 10% per annum through the broadening of its funding base and tender in competitive bids. (See Appendix 1)

B. To maintain the current trend of long-term core funding under multi-year agreements.

C. To secure Government of Bangladesh agreement for the use of bilateral funding for the provision of health care services and projects assisting with GoB policy formulation and/or implementation.

D. To establish an Institutional Reserve Fund of $30 million in two $15 million or three $10 million phases.

E. To establish a Hospital Endowment Fund of $10 million in two $5 million phases.

IV. Requirements to Meet Objectives

A. Finalized Resource Development Strategic plan with which to work as an initial flexible framework.

B. Competent Resource Development Officer in Dhaka capable of coordinating resource development inside the Centre and its US and UK desks.

C. A part-time resource development officer who can work with ICHF to build the alumni network in the US and Canada, and research into new funding sources.

D. Charity-maker consultant to build the networks and establish the UK charitable trust that will allow tax-free giving in the UK (and possibly Europe depending on how the financial integration of the EEC progresses).

E. Increased public relations activities in Japan.

F. Finalized Case Statement that presents the Centre's history, strengths, plans and needs.

G. A review of the markets and opportunities prior to embarking on a major formal endowment fund(s) campaign.

H. A decision on the launch of formal endowment campaign(s).

I. A decision on the establishment of an ICDDR,B desk in the UK.

V. Activities to-Date

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

1. a clear understanding of the complexity of running large scale fund-raising campaigns and generating funds from the private sector,
2. an increased impetus in resource development activity,
3. the development of the revised draft ICDDR,B Resource Development Strategy.

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

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

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

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

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

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

VI. Immediate Options

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

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

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

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

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

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

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

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

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

VII. Recommendation

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

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

I. On-Going Activities

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

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

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

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

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

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

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

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

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

VI. **Launch of Endowment Campaign**

Appendix 1

Contributions in $'000

Contributions:

Inflation = 5.0%

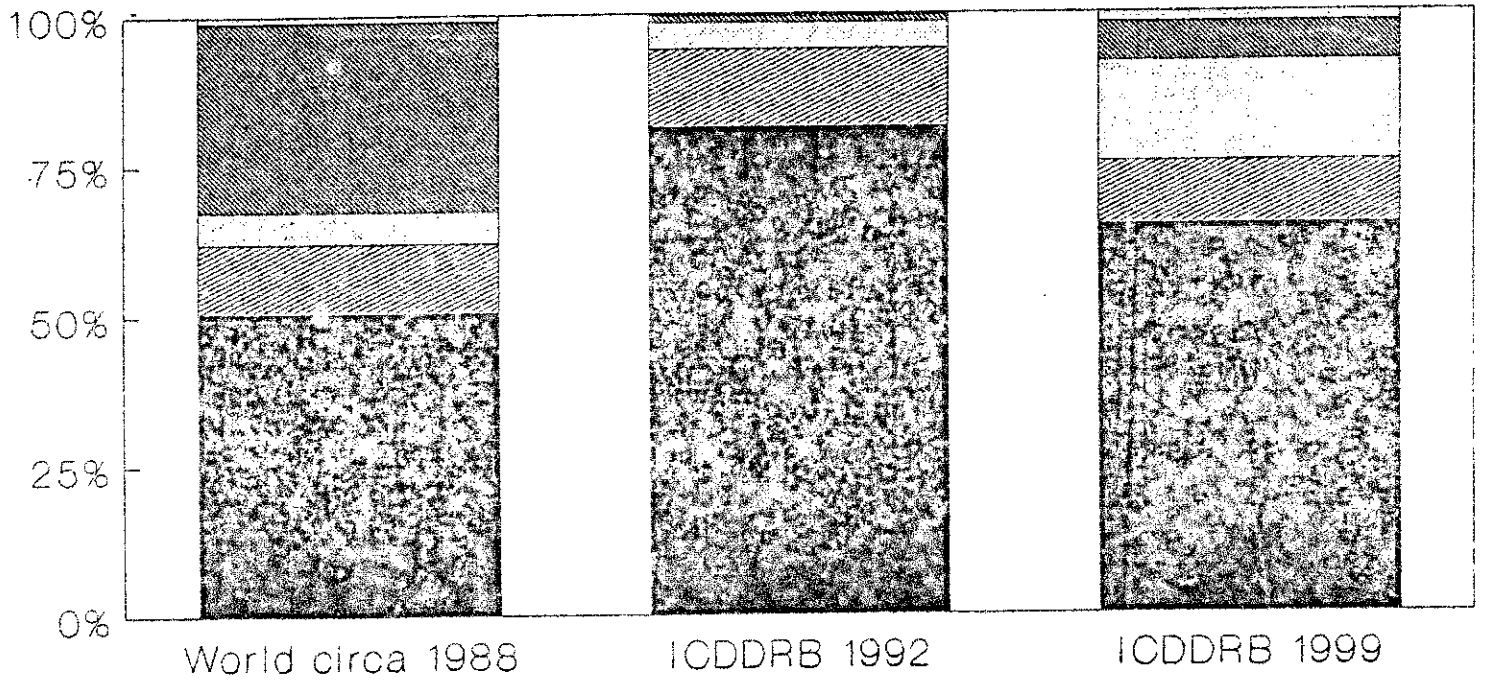
	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Core	1,765	3,048	3,374	3,176	3,494	3,843	4,227	4,650	5,115	5,626	6,189
Project	10,359	7,293	5,497	6,294	7,238	8,324	9,572	11,008	12,659	14,558	16,742
Capital	272	29	351	500	300			300	400	400	300
Total	12,396	10,370	9,222	9,970	11,032	12,167	13,800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

Nature/Source of contributions

Contributions:

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

Health Research Funding Source Mix For Developing Countries' Issues



Source: Commission on Health Research

ICDDR,B

GUIDELINES FOR THE ACCEPTABILITY OF DONATIONS/ FUNDS FROM COMMERCIAL ENTERPRISES

Background:

The activity of the ICDDR,B is supported by aid agencies of the Governments of different countries, international organizations, private foundations, and some commercial enterprises. In view of increasing activities of the Centre, and difficulties in obtaining such funds there is a need to diversify sources of support.

In many developmental areas involving current advanced technology, it may be important for the Centre to work with industrial/ pharmaceutical/commercial enterprises, especially in the areas of bio-technology. Possible areas of involvement include drug trials, scientific equipments, and diagnostics. This may also include gift of scientific and diagnostic equipments, either free or with the purpose of validation. Additionally, some activities of the Centre, such as development of new diagnostic tests for bacteria or viruses, development of vaccines, development of new formulation of ORT or food could have wide applicability and commercial potential. In accepting such funds or gifts, or undertaking such activities, a great care must be exercised in adhering to strict commercial and professional ethics.

As a non-profit, humanitarian, research organization, the ICDDR,B should exercise great care and prudence in all its dealings with industrial/ commercial enterprise, or their agents, and all such enterprises, or their agents should be treated equally. The objective of establishing "Guidelines for the Acceptability of Donations/Funds from Industrial/Commercial Enterprises" is to enable support from and collaboration with industry without compromising either research or conflict of interest.

Central Principles:

In this context, the two key issues are:

- **The researcher's or research organization's implied or stated responsibility to the funder regarding how a particular study is developed and the findings are presented.** For example, if research finds something that might hurt the corporate sponsor and its profit-making ability, what is the responsibility of the researcher (i.e. to downplay or slant the findings to meet the concerns of the funder) or conversely if research found something beneficial to the funder would the researcher feel pressure to promote more aggressively?

- **The perception that research funded by interested corporate sponsors is not objective.** Most of the pharmaceutical companies that have approached ICDDR,B in the past understand and appreciate the need for our work to be independent and free from their influence. However, the Centre's strength in advocating for better health and population programs and policies is built on our ability to withstand scrutiny of our findings by other researchers, the media and policy-makers. Even though most companies purposefully state that any contribution from them could be used at ICDDR,B's discretion and they relinquish control over how the research is conducted or presented, the perception that ICDDR,B's objectivity is being compromised in any way could have serious implications the Centre's entire program and effectiveness.

Guideline Proposals:

1. Fund should not be sought from such enterprise whose activities are not compatible with the objectives of ICDDR,B. Funds should only be sought/accepted for project/activities which fall clearly within the research priority/mandate of the ICDDR,B.

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

3. No staff members of ICDDR,B will be allowed to make any private dealings with such enterprises in any matter related to his/her work at the ICDDR,B.

4. Funds can be freely accepted from commercial enterprises if they are unearmarked for particular investigation/projects /meetings.

5. Direct funding for scientific research projects/drug trials may be accepted from industrial/commercial enterprises, however, such funding should be guided by the following principles:

   5.1. Such project/drug trial/activity should clearly fall in the study priority/mandate of the center.

   5.2. Such protocols/projects/activities must have enough scientific merits, follow the critical scientific review process by competent reviewer who will remain anonymous and should not have information on the possible funding source. It would also be mandatory to scrupulously adhere to ethical standards.

   5.3. Whenever possible, funds should be accepted as unearmarked contributions for research in a general area.

   5.4. In no case shall the scientific freedom of ICDDR,B be waived. This will include research direction, assurance of research quality, freedom to publish the results without hindrance and without influence/modification of the results by the funding agency. Results from such research project/protocols should be the subject for scrupulous scrutiny by the authorized person/body delegated by the Centre.

5.5. No reference may be made by the enterprise to its donation/grant in its promotional material. Donors should, however, be entitled to refer to the donation/grant in its internal official documents, such as documents submitted to board and shareholders' meetings, balance sheets, budgets & direction and auditor's reports.

5.6. Investigations should remain entirely under the control of the institutional personnel.

5.7. The results of research including raw data are the exclusive property of the Centre.

5.8. When publishing the results of projects funded by such agencies, sponsors support for the Centre may be acknowledged without acknowledging contribution for specific project.

6. Institution will hold title to all research data, code books, and equipments purchased, developed, or fabricated under any agreement.

7. Centre rules relating to contracts between such enterprises and the ICDDR,B, covering issues such as on payments, periodic reporting, auditing, patents, royalties, liabilities, etc. must be followed.

Definitions of some of the terms used in this paper are provided below:

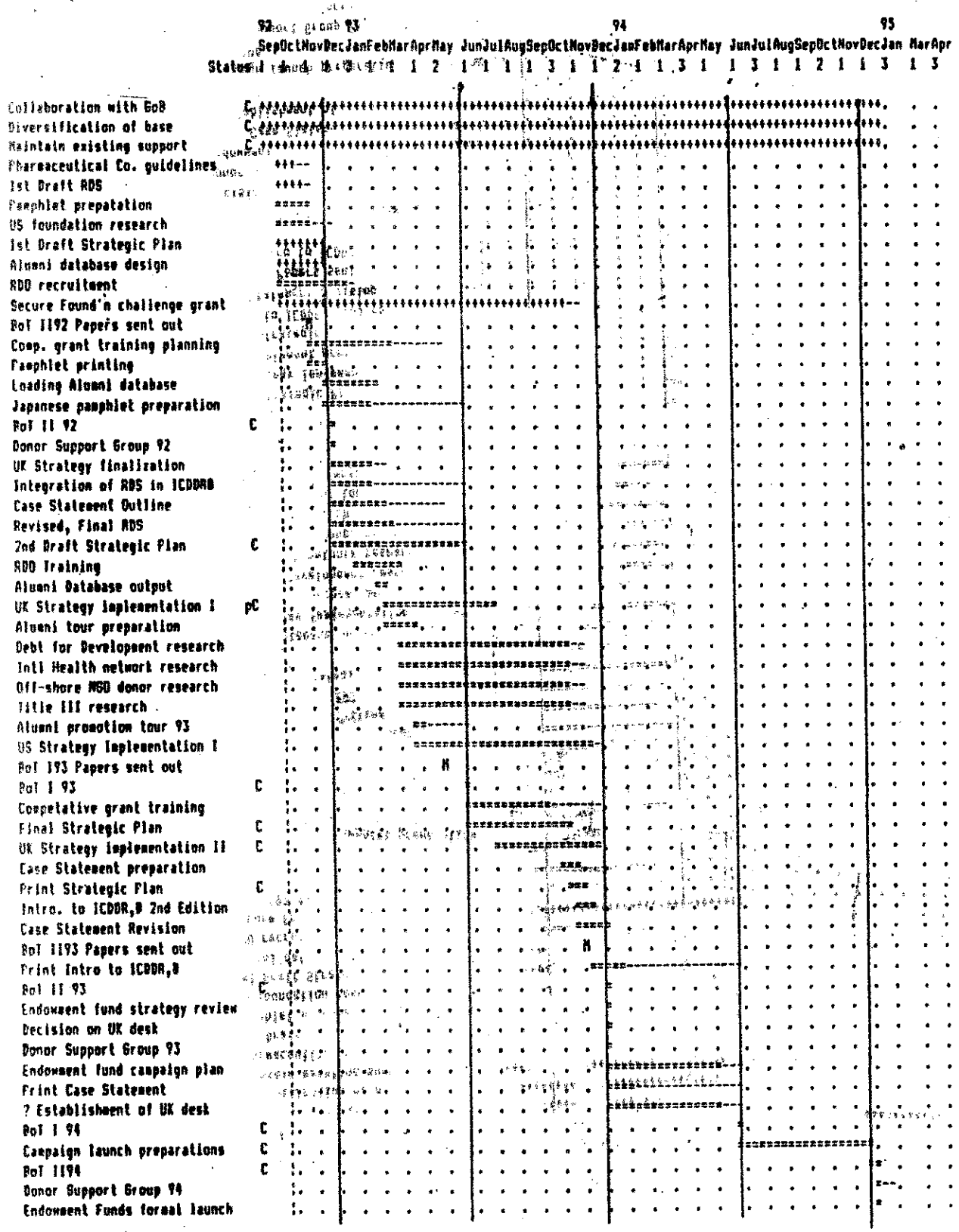
Drug: Drug is understood in its broadest sense, viz. any agent, irrespective of its route of administration, that has, or claimed to have, preventive, curative or other health-promoting activities. The definition thus includes, e.g., zinc and ORS. It is considered as an axiom that no drug can or should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

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

Drug trial: Any study involving humans used as experimental subjects to study whatever action of a "drug". Careful monitoring of persons receiving a drug as part of a well-established treatment schedule would not be considered a drug-trial. At ICDDR,B, it still might be considered as a protocol, subject to all usual processes.

Schedule Name:
Project Manager:
As of date: 27-Sep-92 2:36pm Schedule File: D:\FILES\ASS\PLAN\BOT1192

Appendix-4



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

=== Task
+++ Started task
M Milestone

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

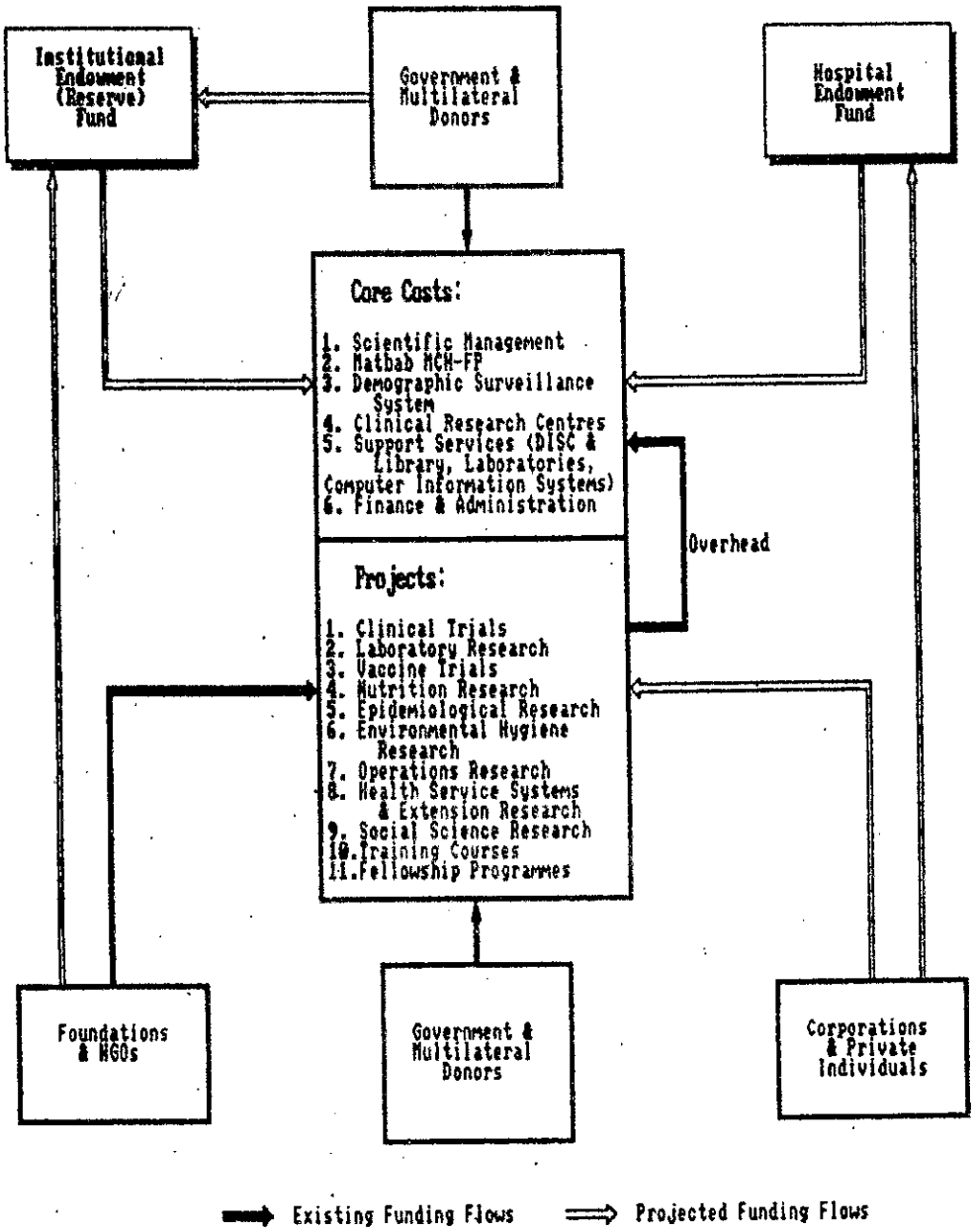
ICDDR,B Resource Development Strategy — Draft # 1

	1993	1994	1995	1996	1997	1998	1999
USA - In conjunction with ICHF	$	$	$	$	$	$	$
Fixed Costs							
Computer system	4,000				5,000		
Desk, chair etc.	750				1,000		
Initial Stationery etc.	750						
Total US based fixed costs	5,500	0	0	0	6,000	0	0
Recurring Costs							
Part-time adminstrator	18,000	37,800	39,690	41,675	43,758	45,946	48,243
Office Rental	1,800	3,780	3,969	4,167	4,376	4,595	4,824
Stationery etc.	500	1,050	1,103	1,158	1,216	1,276	1,340
Transport	1,500	3,150	3,308	3,473	3,647	3,829	4,020
Communications	1,200	2,520	2,646	2,778	2,917	3,063	3,216
Total US based recurring annual costs	23,000	48,300	50,715	53,251	55,913	58,709	61,644
UK - In conjunction with a consultant							
Fixed Costs							
Institutional establishment - consultant	37,500						
Computer system		5,000			7,000		
Desk, chair etc.		750			1,000		
Initial Stationery		750					
Total UK based fixed costs	37,500	6,500	0	0	8,000	0	0
Recurring Costs							
Consultant		13,860	11,435	6,289			
Part-time adminstrator		31,500	33,075	34,729	36,465	38,288	40,203
Office Rental		3,780	3,969	4,167	4,376	4,595	4,824
Stationery etc.		1,050	1,103	1,158	1,216	1,276	1,340
Transport		2,310	2,426	2,547	2,674	2,808	2,948
Communications		3,150	3,308	3,473	3,647	3,829	4,020
Total UK based recurring annual costs	0	55,650	55,314	52,362	48,377	50,796	53,336
Bangladesh based PR/RDO							
Recurring Costs							
RDO/PR salary	36,000	39,600	43,560	47,916	52,708	57,978	63,776
RDS Travel	20,000	22,000	24,200	26,620	29,282	32,210	35,431
Consultants	17,000	11,000	12,100	13,310	14,641	16,105	17,716
Printing and supplies	5,000	5,500	6,050	6,655	7,321	8,053	8,858
Communications	2,400	2,640	2,904	3,194	3,514	3,865	4,252
Total Bangladesh based recurring annual costs	80,400	80,740	88,814	97,695	107,466	118,211	130,033
Total Resource Development Strategy Costs	$146,400	$191,190	$194,843	$203,309	$225,755	$227,716	$245,013

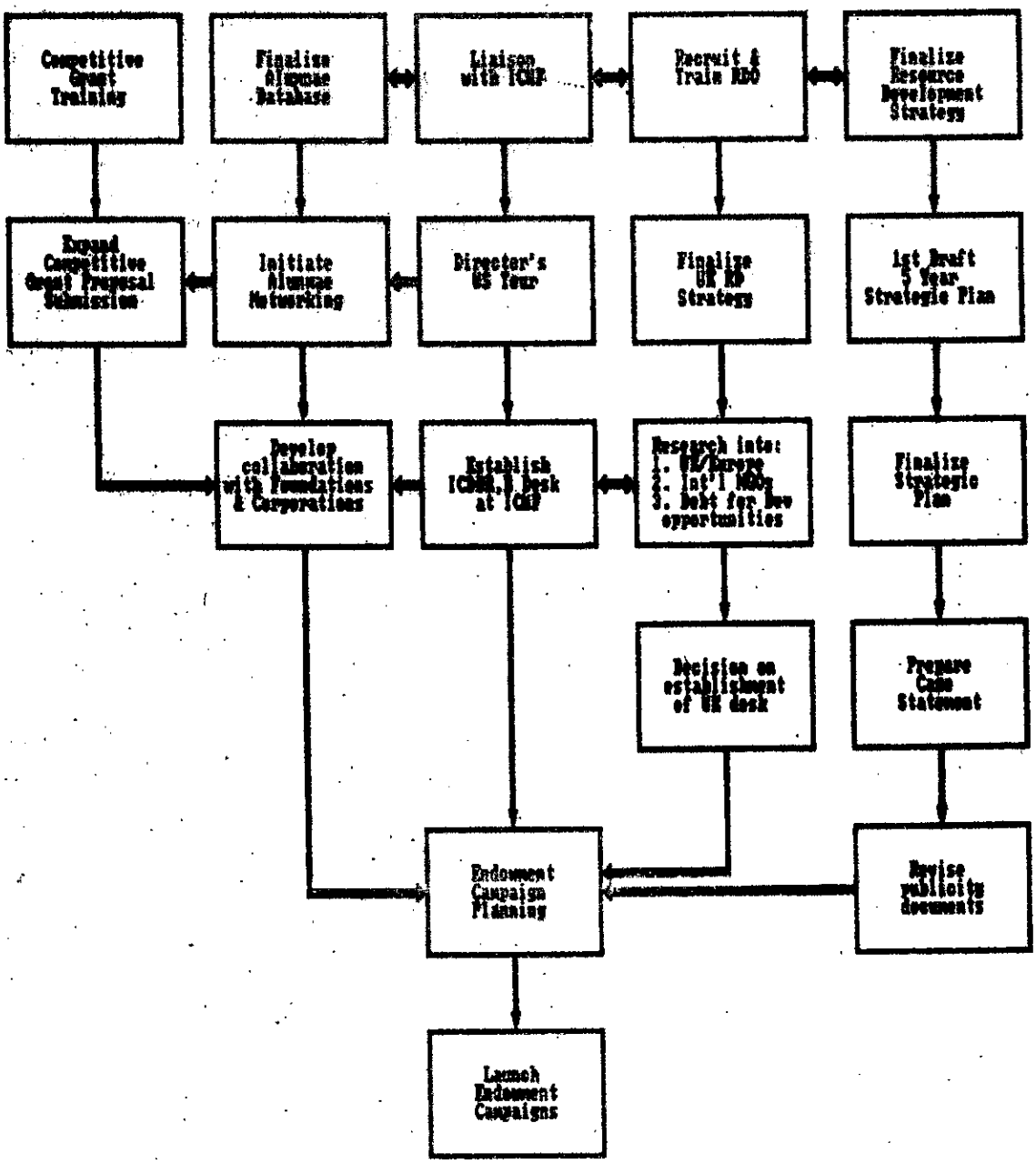
ICDDR,B

International Centre for Diarrhoeal Disease Research, Bangladesh

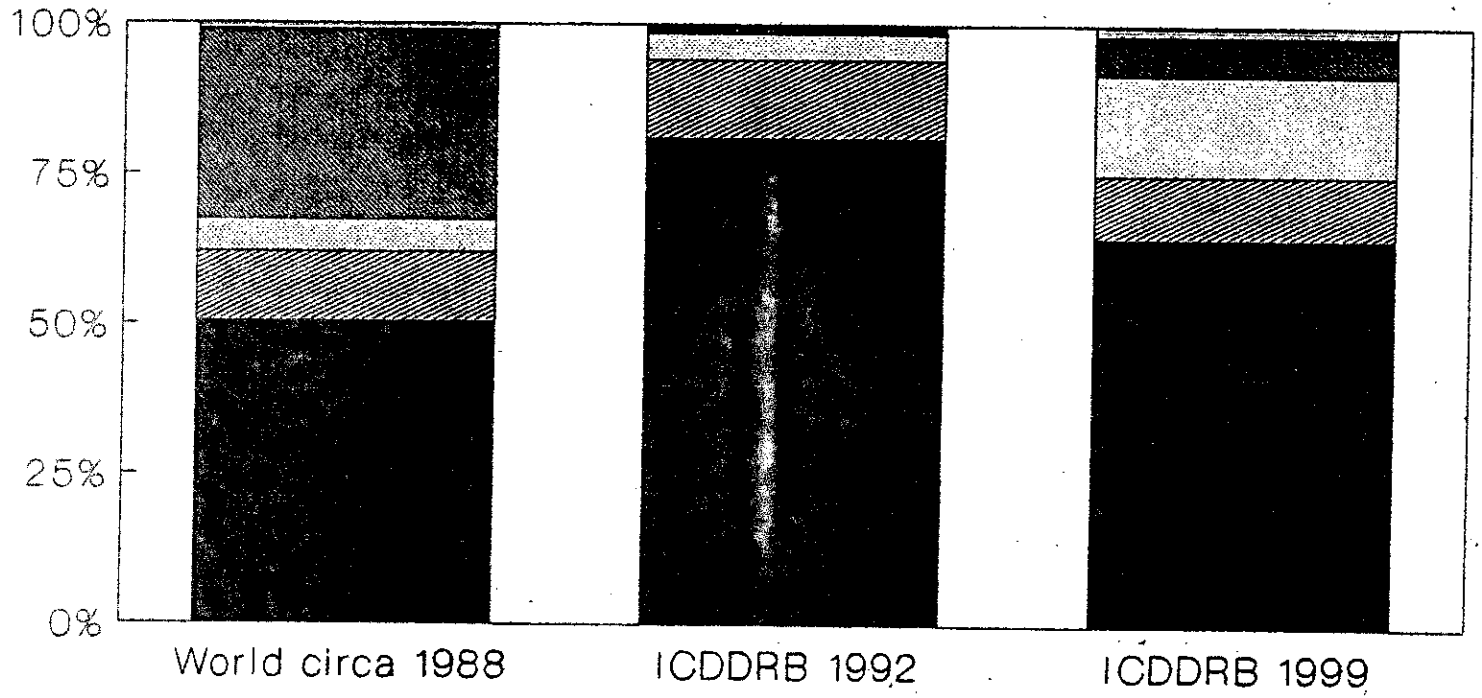
Resource Development Strategy



Resource Development Strategy
Implementation Plan



Health Research Funding Source Mix For Developing Countries' Issues



Source: Commission on Health Research

Attachment – 2

Progress and Transition 1990 – 92

Implementation of the Recommendations External Review of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B)

Background:

In 1989, recognizing the importance and potential of ICDDR,B, the Centre's donors financed an external review in order to assist attempts to strengthen the direction and management of this unique institution. In April 1990, Professors C.E. Gordon Smith and David J. Spencer submitted the report entitled "External Review of the International Centre for Diarrhoeal Disease Research, Bangladesh".

Since April 1990, ICDDR,B has not only made extraordinary progress, but has also affected the transition of the organization into a directed and dynamic international research institution ready to lead the search for solutions to the world's health problems.

This document highlights the key components in this transition in section 1., and reports on the progress made in implementing the recommendations of the External Review in section 2..

Section 1. – Components of a Transition

Planning:

ICDDR,B has initiated a sophisticated planning for both scientific and administrative divisions. This has resulted in a clear and directed research agenda which is evolving in response to findings, needs, capability and expert advice.

Work has already commenced on preparing the 1994 – 1999 strategic plan. Scientific advisory councils (for health and social sciences) composed of international experts meet regularly to work with Centre scientists to focus the research agenda on key issues. A new system of revolving reviews of the scientific divisions mean that each is reviewed by a panel of external experts every two years. These Program Sub-committee reviews report directly to the BoT, and trustees monitor implementation of recommendations during their regular visits to the Centre. An active and enthusiastic Programme Coordination Committee (PCC) has ensured coordination with the work of the national institutes in Bangladesh. Constant liaison and Support Group meetings with donor agencies ensure that the funder's interests are also considered. The Consultative Management Committee, with four representatives from each division meets 3–4 times a year, and the monthly divisional meetings have increased the participation of mid-level scientists in the planning of the Centre's activities. Within this framework of advice and guidance, annual workplans are prepared, implemented and monitored to ensure that the Centre's high standards of productivity are maintained.

An evolutionary transition is occurring in the Centre's research agenda. ICDDR,B continues to recognize the importance of operations research, and has extended its capability from the rural Matlab Maternal Child Health – Family Planning (MCH-FP), and the MCH-FP Extension projects to the new Urban Health Extension Project. Other components of the Community Health Division have been significantly strengthened and this reflects the Centre's increasing commitment to social science. The Centre's new Population Studies Centre is working with Bangladesh Rural Advancement Committee (BRAC) and other national research organizations to study the health impact of the NGO's non-health interventions.

Relations with the Board of Trustees (BoT) and the Government of Bangladesh (GOB):

As ICDDR,B has emerged from the problems it faced in the late 1980s and effected the transition, so the role of the BoT has evolved. Now there is an excellent and supportive relationship between ICDDR,B's management and its BoT. Board members have assisted in strategic planning, external reviews, international recruitment, and fund-raising efforts, and, recognizing the importance of the Centre, have spent considerable time and effort to assist and guide the Centre's management.

As a result of its increasing contributions to and collaboration with Bangladesh, ICDDR,B enjoys a very special relationship with GOB. Effective communications have been established between the Centre's staff and the Ministry of Health and Family Welfare, from the Minister and Secretary down to the unions where the MCH-FP Extension Project is helping the GOB Family Welfare Assistants optimize their work. There is increasing recognition of the role and importance of the Centre's research, training and health-care services in Bangladesh throughout the Government.

Personnel:

During the last three years the Centre has been able to reduce the fixed term staff size by 171 (15% of 1989 fixed term staffing levels), and total staff by 365 (22% of 1989 total staffing levels). This was achieved through natural attrition by implementing the following:

- a freeze on hire of new staff
- a freeze on replacement of staff leaving as a result of resignation, ill-health, death, etc.
- non-extension of retirement age
- termination of project staff on completion of project
- closure of Teknaf field station (31 December 1989).

Increasingly, ICDDR,B enters into short-term contractual agreements with employees to undertake specific tasks or projects. This has resulted in a reduction in the number of core staff, and greatly increased the flexibility of the Centre to respond to the changing circumstances.

This guided evolution of ICDDR,B's staffing is an on-going process, reflecting the changing priorities of the Centre.

Financial:

The Centre's budget was reduced by $2.65 million (21.48%) in the three years between 1989 and 1991. By 1992 the Centre had cut expenditures, raised productivity, and completed its transition into a cost-efficient, international health research organization. To realize the potential of this unique resource, the international donors were requested to increase funding at the 1991 Support Group meeting. However, the limitations of the 1993 budget has meant that some important research initiatives will not implemented.

In 1992, the Centre has extinguished the accumulated deficit that has plagued its operations since 1981. This was accomplished even more quickly than was envisaged by the External Review.

Management:

Financial, grant administration and resource development systems have been strengthened to give Centre management mechanisms to monitor the Centre's activities, and information to optimize decision making.

Increased intra- and inter-divisional meetings has improved communication and collaboration between divisions at all levels. This has enabled the Council of Directors to follow a broad-based participatory approach to planning and management.

Strong and directed management has resulted in a transition as remarkable as it has been quick.

Section 2. – Implementation of Recommendations

The External Review made a series of specific and far-reaching recommendations. ICDDR,B has carefully considered all of these recommendations, and has implemented almost all of them. Details are listed below.

1) The Director's continuing excellent efforts to develop the Strategic Plan and control personnel costs as a means of addressing the financial state of the Centre must be strongly supported by the Board of Trustees, the donors and the Government of Bangladesh.

The BOT, donors and GOB have expressed strong support for the Centre's Strategic Plan and the socially responsible manner in which personnel costs have been reduced. The 1990 – 94 Strategic Plan is now being implemented, and the 1994 – 1999 Strategic Plan is under preparation. The new Strategic Plan will emphasize social science and operations research.

2) Through the accountability review process (Recommendation 6) the Strategic Plan must be regularly revised to identify areas of lesser importance to the mandate of the Centre and areas of support service that can be reduced, contracted out or eliminated; and to better define essential areas of research support that cannot be a eliminated without destroying the scientific potential of the Centre.

The 1990 – 94 Strategic Plan is now being implemented, with guidance from the BoT Program Sub-committee reviews, and other internal and external review mechanisms (intra- and inter-divisional meetings, Scientific Advisory Committees, Programme Coordination Committee etc.). The input and advice from these experts has resulted in a dynamic research agenda that responds to the knowledge and needs of the international and national community. These mechanisms will also allow Centre management to prepare the 1994 – 1999 Strategic Plan with considerably more certainty and clarity than was available in 1990. The increased emphasis on social science and operations research in ICDDR,B demonstrates the evolution of the Centre's priorities.

In the three years to 1992, reviews of the laboratory, personnel, Diarrhoeal Diseases Information Services Centre (DISC), Computer Information Services (CIS), supply, and maintenance support service areas have been completed, and the recommendations are being implemented. Where possible, these support services have been scaled down, or contracted out. Efforts are being made to increase recovery of support service costs by offering these services to outside agencies to generate income. However, income from these services is only making marginal contributions to cost recovery.

3) Research plans for the future should lay greater emphasis on applied and operational research, for which the field areas offer such fertile opportunities.

As noted above, the Centre is already increasing the emphasis on applied and operational research, indeed over 90% of the Centre's research budget is spent on these. The Matlab MCH-FP, Matlab MCH-FP Extension, and the Urban Health Extension Projects are at the forefront of health service systems and operations research in Bangladesh, and indeed the world. The moves to strengthen the social science capability of the Centre and the increased importance of environmental health and population studies in the ICDDR,B research agenda all demonstrate the Centre's commitment to applied and operations research.

4) 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.

Both the Matlab field station and the Demographic Surveillance System (DSS) have been given high priority for budgetary support and continuity. Despite the intense financial pressure facing the Centre, the DSS was largely financed from unearmarked core funds in 1991 and 1992, and the Matlab field station was entirely financed from core funds in 1992. However, in the absence of significant increases in core funding, it is extremely important that donors are found for these central and irreplaceable projects as soon as possible.

Several important steps have been taken to further open access to the Matlab MCH-FP and DSS data. There are four levels of data support that ICDDR,B is currently offering. The simplest is to provide existing published data, for example from the DSS Annual Report, to a user. At the next level, the Centre provides

detailed data, for a fee where appropriate, but with very little involvement of ICDDR,B staff and resources. The Centre also responds to requests which require more complex data extraction from the database systems and files. This type of work is generally undertaken on a fee-paying basis. The highest level of support involves full collaboration, where ICDDR,B provides data and field support in return for major personal or institutional collaboration, such as training Centre staff, as well as financial support.

Users of data over the past three years include Bangladesh Bureau of the Census, Bangladesh Control of Diarrhoeal Disease programme, Bangladesh Bureau of Statistics, London School of Hygiene and Tropical Medicine, Georgetown University, Harvard University, ISPAN, Population Council, UNICEF, and USAID.

5(a) As vacancies occur on the Board of Trustees priority should be given to appointing members who are not only highly qualified as scientists and public health experts but we also have experience in managing research and public health programmes. We recommend that the Chairman should serve for 3 years; and that he/she should preferably be able to visit the Centre fairly frequently so as to develop a working relationship not only with the Director and his senior staff, but also with the Bangladeshi trustees and other members of the Dhaka scientific community.

In 1991, one of the USAID nominees, Dr. Maureen Law, became a member of the BoT, bringing a wealth of experience in health research programme management and public health policy formulation. The chairman selected at the time of the External Review, Dr. Peter Sumbung, served three years before retiring from the BoT in May 1992. This period was characterized by greater involvement of the BoT in the Centre's strategic planning, organizational and research agenda reviews, and resource development activities.

5(b) The Bangladeshi trustees should take more advantage of their proximity to the Centre in order to get to know its staff and understand its activities so as to play a fuller role at the Board.

Since the External Review, the trustees nominated by GOB have served on the BoT for longer periods than was previously the norm. Mr. Enam Ahmed Chaudhury, Secretary of Economic Relations Division of the Ministry of Finance, and Prof. Dr. K.M. Fariduddin have now both served on the BoT for two full years. This increased length of service has allowed the Bangladeshi trustees to ensure that the Centre continues to respond to Bangladesh's interests, and to make even more valuable contributions to the BoT meetings. The efforts of the Bangladeshi trustees have done a great deal to improve the relationship between ICDDR,B and its host country's Government. The Bangladeshi trustees have also been involved in efforts to improve the finances of ICDDR,B, including attempts to access UNDP regional funds for the Centre, and efforts to resolve the outstanding UNROB loan issue.

5(c) The Board should hold some of its meetings in circumstances which encourage more social interaction between the trustees.

In response to this recommendation, the 1991 BoT meeting was held in Jakarta, in conjunction with lecture tours and seminars conducted by the Centre's senior staff and trustees. While this was a great success, and led to improved understanding among the trustees, the BoT decided that it was more important to hold their meetings in Bangladesh, so that they could visit the Centre and effectively review its operations. Recognizing the importance of this recommendation however, ICDDR,B have made special efforts to maximize the social interaction not only between the trustees, but also among the trustees and senior staff at the Centre.

5(d) When appropriate, Bangladesh scientists should be involved in the work of the Programme Sub-committee and invited to attend appropriate sessions of meetings of the Board.

The sessions of the Programme Sub-committee, and indeed most of the BoT meetings are open to all Centre staff, donor agencies, and anyone interested to attend. Bangladeshi scientists are also regularly involved in presenting their projects to the BoT, both formally in meetings, and informally during the trustees' reviews of the Centre's activities.

6) There should be an annual Institutional Accountability Review conducted over two or three days by a Review Body composed of representatives of those donors who wish to participate (particularly those contributing substantially to core funding) and representatives of the Board of Trustees, chaired by the Chairman of the Board of Trustees. This review should be part of, and perhaps largely replace, one of the

two annual meetings of the Board of Trustees. Details are set out in Section III. Prior to the Institutional Reviews, each Division should be similarly reviewed in an internal accountability review by the Director in order to build up the integrated institutional report and plans.

After careful consideration the Centre has adopted the need for periodic accountability review, but does not believe that it should be implemented in the manner suggested. An alternative plan is being followed that does not erode the confidence of the management of the Centre, allows time for measurable change to take place, and is less expensive.

In November 1990, the Programme Committee of the Board, after discussion, "recommended, in accordance with the Director's suggestion, that the Programme Committee should take the responsibility to conduct the Institutional Accountability Review with the addition of one or more outside scientists with the desired expertise plus a representative of donors nominated by the Donor Support Group. It was recommended that this should be done for one division at a time during a one day meeting prior to the regular meeting of the BOT. The first such review will be held in November 1991. The detailed format of the review and the order in which the Divisions will be reviewed is to be determined in consultations between the Director and his senior staff and the Scientific Programme Committee".

The Population Science and Extension, Clinical Science, and Laboratory Science Divisions have already been subjected to intensive Programme Sub-committee reviews. The next Centre-wide institutional review is due to take place in 1994, by which time all of the scientific divisions will have been reviewed at least once, and in many cases twice, under this new system.

In addition, the Centre's management meet annually to conduct extensive accountability reviews, which examine the extent and effectiveness of the implementation of the annual workplans. These then provide invaluable feedback into the annual and strategic planning processes.

7) If permissible, consideration should be given to negotiating a "Headquarters Agreement" as a schedule to the Ordinance clearing up some current ambiguities and providing, among other matters, for visas along the lines of the Headquarters Agreement of the International Jute Organization.

The Ordinance already provides for these privileges, and the improved relations with the GOB has meant that this has ceased to be a problem.

8) The feasibility of alternative structures for ICDDR,B in the long term need to be examined: for example, the Centre could become a non-profit enterprise managed on business lines; or an organization sponsored by a group of international agencies.

Both the Centre management and the BoT considered this recommendation carefully, and consulted with the Centre's major donors before concluding that there was, at present, little scope to change the existing status quo. However, the ICDDR,B Resource Development Strategy, currently under preparation, describes a series of new initiatives and approaches to raising funds for the Centre's operation.

9) Performance evaluation must be firmly and consistently applied with the active support of higher level supervisors, the Director and the Board of Trustees. At the same time, better use should be made of performance evaluation to reward exceptional performance.

This recommendation has been implemented as far as is possible. In 1991/2, scientific ranking was successfully used to determine promotions among the senior research staff. New personnel evaluation forms have been prepared, and are to be introduced from 1993 after a series of Centre-wide meetings to explain their role and how to use them effectively. Step increases in salary, which previously were automatic, are now awarded on the basis of performance.

10) Probationary periods must be strictly observed with adequate documentation of performance throughout the period. Persons not meeting the performance standards must not be retained. Since probationary periods can be extended beyond one year, this option should be exercised where necessary. Employees hired for project work must understand that their term of employment will not necessarily exceed the duration of the project and that conversion to core staff will be rare, not usual.

This recommendation has been implemented in full.

11) Consideration should be given without delay to implementing retirement arrangements in line with Bangladesh Government policy i.e. 25 years service or age 57 whichever is earlier.

Both the Centre management and the BoT considered this recommendation carefully, before concluding that the negative effects were likely to outweigh the benefits of its implementation. However, the objective of the recommendation, to reduce personnel numbers and costs, has been achieved through natural attrition (see section 1. above) and the BoT decision to follow a version of the UN rules and salary structure modified to fully reflect the reality of the Bangladesh's labour market.

12) Donor support for the compensation of those required to retire before age 60 should be sought since it is in the interest of all to improve the over – all functioning of the Centre.

For reasons outlined in 11. above, it was not necessary to approach donors for funds for this activity. However, with the drop in funding since 1989, additional core funds are now necessary to support the Centre's central activities, in particular the Matlab MCH – FP and DSS programmes.

13) A Division by Division, unit by unit review should be conducted by either a small outside team to determine pattern (numbers and grades) to carry it out.

During the period 1990 – 1991, ICDDR,B carried out an extensive programme of divisional reorganization and restructuring. This has lead to the modified organograms presented in the 1991 Annual Report. This process, together with a series of external reviews (in particular those of the support service areas documented in 2. above) have led to increased efficiency and direction throughout the Centre.

14) We give very high priority to ensuring that the current severe difficulties in recruiting international scientific payment of a housing allowance. Attention is necessary not only to questions of salaries and allowances but also to further establishing a satisfactory working environment.

In May 1992, the BoT resolved to raise the international staff salaries to 100% of the UN scale, thereby addressing one of the most important barriers to effective international recruitment. The working environment inside the Centre, as well as its reputation in the international scientific community, has improved dramatically over the last three years. With the improvements in planning and management, ICDDR,B has been able to take its place at the fore – front of international health research once again, thus facilitating the recruitment of quality scientific leadership.

15) Following a stringent job review, the personnel structure should be rationalized with a view to ensuring that personnel costs from a lower proportion of total costs in order that ICDDR,B may respond to changes in the volume of project activities quickly and effectively.

Local salary costs have been reduced by 23 %, from $ 6.5 million in 1989 to $ 5.0 million in 1992, both as a function of reducing number of staff, and of increasing use of short term contract staff (see Section 2. above) While the salary costs as a proportion of the total costs of ICDDR,B are no higher than comparable organizations, this policy has meant that the Centre can respond more flexibly to the volume and nature of project activities.

16) The use of efficiency indicators should be extended wherever possible throughout the Centre.

Efficiency indicators are being used throughout the Centre, as part of health systems services research to ensure quantity and quality of care, and in the form of the personnel evaluation and scientific ranking systems. A health economist is to be hired to review the cost – efficiency of the two hospitals.

17) In order that ICDDR,B may analyze, control and monitor core expenditure more effectively and also make a strong case for donor support for such expenditure, core expenditure must be precisely and unambiguously defined, clearly specifying its constituent elements. Gross and net core expenditure (i.e. before and after recoveries) must be separately reported and monitored in order to ensure that core expenses do not increase in the years when project activities rise, only to become an unbearable burden when such activities conclude. Cost reduction and utilization controls are necessary if the support services are to be self-supporting from project reimbursements.

ICDDR,B has gone further than the External Review report suggests in that it has not only clearly defined the Centre's core activities, but also has moved to look more carefully at how these core activities contribute to the implementation individual projects in the Centre. Projects are being charged for the use of the data and expertise from these core activities. This policy is indicative of ICDDR,B's commitment to financing the key core components necessary for the effective functioning of the Centre as an international health research institution, and of the limited availability of core funding.

18) We recommend that consideration is urgently given to persuading the Bangladesh Government to ask donors to provide at least for the Dhaka hospital and associated diagnostic services from bilateral aid funds put at its disposal.

ICDDR,B welcomes this proposal, and the need for this is reflected in the Resource Development Strategy. The Centre would welcome donor assistance in making the case for the use of bilateral funds in several areas: the health services (including both the Matlab and Dhaka hospitals), national training programmes, and the Epidemic Control Preparedness Programme (ECPP).

19) Priority should be given to restoring the Director's ability to fund start-up or small projects from discretionary funds.

This has been implemented, and each year, $ 100,000 is set aside as Project Development Funds for use at the discretion of the Director and Scientific Associate Directors.

20) The Centre must develop long range plans for financial support from an expanded mix of funding bodies including foundations and trusts that support research.

In process - see the revised draft of the ICDDR,B Resource Development Strategy.

21) If a donor or donors can be found there would be considerable benefits to stability if an endowment fund could be created, sufficient to provide bridging finance for key operations in short term funding difficulty.

Endowment funds have been set up both for the institution, and for the hospitals and campaigns are being planned for both - see the revised draft of the ICDDR,B Resource Development Strategy.

22) A small investment in an institutional development specialist to assist in fund raising is recommended.

In process - see the revised draft of the ICDDR,B Resource Development Strategy.

23) The Director should be responsible to the Board and able to call on its members individually or collectively for advice or help. The Director's role should be defined as executive officer of the Board and it should be entirely clear that the Director is responsible for all the activities of the Centre, accountable for all its funds, that all staff working in the Centre are responsible to him; and that there will be no external interference in these success of the Director's role in creating an integrated research programme is critical for the future of the Centre. The Director, while retaining ultimate responsibility, must have the power to delegate his authority as he considers necessary; such delegation should be defined in writing.

This has been implemented with the full support and confidence of the BoT and the Centre's senior management staff.

24) The Director and Associate Directors need to ensure that appropriate policy decisions are widely disseminated and that there is adequate provision for staff views and reactions to be received and considered.

With the new broad-based participatory approach to management, a great deal of emphasis has been placed on implementing this recommendation. Communication with staff takes place through several complementary channels:

a) Inter-divisional scientific meetings are well attended by scientific staff, and each division presents papers weekly in rotation.
b) Two meetings (management and administration, and scientific) are held monthly in each division.
c) The Consultative Management Committee meets every six months.
d) Staff are also involved in the preparation of the annual workplans and budgets.
e) The Community Health Division has initiated annual retreats to ensure maximum input from staff at all levels of the division.
f) The Director's Office operates an open-door policy
g) The publication of a bi-monthly internal ICDDR,B newsletter in Bangla and English.

25) We emphasize the need to develop more meaningful communications with the Government of Bangladesh so that the work of the Centre can be better understood.

ICDDR,B is actively seeking to maximize the cooperation and collaboration with GOB, and has made significant progress towards this goal over the last three years. The booklet "Partnership in Progress - ICDDR,B's contribution to, and collaboration with Bangladesh" was published and widely distributed throughout Government offices and national institutions. The Government continues to rely on ICDDR,B's assistance to control epidemics and to train the doctors in the national CDD programme. The initiation of Annual Scientific Conferences and "Shasthya Sanglap" (see 26. below) has also done much to improve understanding of ICDDR,B and its work among Government officials.

26) The Centre should look to all forms of the media to improve its local and international recognition.

International recognition of ICDDR,B and its importance has grown as the Centre has improved its management and scientific productivity. Technical assistance has been provided to diarrhoeal disease affected countries throughout South America, Africa and Asia. ICDDR,B staff have contributed to, and on occasions arranged, international, regional, and national conferences and seminars. Attempts have been made to improve dissemination with the initiation of the ICDDR,B Annual Scientific Conference, and the publication and distribution of "Shasthya Sanglap" for front-line health service staff. 15,000 copies of the latter, highlighting and discussing current and relevant health issues in Bangla, are distributed every quarter. The format and presentation of the Centre's international dissemination newsletter, "Glimpse" has been improved. ICDDR,B has further extended both its national and international fellowship schemes and training courses. In the first nine moths of 1992 ICDDR,B trained nearly 500 people from 21 different countries and four continents.

However, the Centre still believes that it could further improve it communication and dissemination activities, and is looking for donor support to develop an effective dissemination office. The Centre is also examining the possibilities for developing its slide-tape and video-making capability.

27) The mechanism through the UN system for Associate Professional Officers should be explored as a possible source of a person skilled in public relations and population science writing.

This is in process, however, given the priority and immediacy of this need, the APO scheme was not considered appropriate. ICDDR,B has prepared a project proposal for the establishment and training of a Communication and Dissemination Office in the Centre. However, a donor has yet to be found for this.

28) There is a need to establish closer ties with other research institutions, national, regional and international,with importance as the Centre's activities expand beyond diarrhoeal disease.

ICDDR,B has made strenuous efforts to broaden and deepen its programmes of institutional collaboration, and is now seeking to maximize those with institutions in other developing countries. In Bangladesh, the

PCC has facilitated the strengthening of ties with national institutions. In 1992 eleven collaborative studies were completed or underway with six national institutions.

A listing of the major, active institutional collaborations is attached as Appendix 1. This represents a burgeoning of collaborative activity where the competitive advantage of ICDDR,B can be best used to work in conjunction with other research institutions across the globe.

However rewarding and productive these institutional collaborations are, they all cost money. For this reason, particularly in the context of under-funded research institutions in developing countries, the scope for further improving these activities are dependent on funds being made available by the international community.

29) There is need for broader involvement of the Bangladesh scientific community in the work of the Centre [see also Recommendation 5(d)].

The activities of the PCC has lead to increased numbers of training courses in areas of special interest to Bangladesh, and a significant rise in the number of graduate and post graduate research fellows working in the Centre. Project research fellowships provide young scientists and researchers with invaluable experience in project design and implementation, and contribute to the human resources available for the national development effort. ICDDR,B has been intimately involved in the fostering of the Essential National Health Research (ENHR) movement in Bangladesh. ICDDR,B also plays a central role in the Ford Foundation funded Reproductive Health Consortium. In the consortium, ICDDR,B's partners include leading national development and research organizations such as BRAC and the Bangladesh Institute for Development Studies (BIDS).

30) There is no need for additional external scientific reviews at least until the key international scientist vacancies have been filled and there has been sufficient time to evaluate the effectiveness of the Strategic Plan and the proposed accountability review process.

The Centre looks forward to its next management and institutional review in 1994.

Appendix 1.

Clinical Science Division

The collaborations in this division include those with the following organizations:

Dhaka Medical College, Bangladesh
All India Institute of Medical Sciences, New Delhi, India
National Institute of Cholera and Enteric Diseases (NICED), Calcutta, India
The University of Alabama (The Sparkman Centre), USA
The University of California, Davis (Department of Nutrition), USA
McGill University, Montreal, Canada
The Karolinska Institute, Sweden
The Institute of Child Health, London, UK
The Royal Children's Hospital, Melbourne, Australia

Laboratory Science Division

The collaborations in this division include those with the following organizations:

Johns Hopkins University, Baltimore, USA
Kyoto University, Japan
Karolinska Insitute, Sweden
Walter Reed Army Medical Institute, Washington DC, USA
University of Adelaide, Australia
The University of California, Davis, USA
Dhaka University, Bangladesh
IPGM&R, Dhaka, Bangladesh
Centres for Disease Control, Atlanta, USA
The University of Virginia, USA
The University of Maryland, USA
The London School of Hygiene and Tropical Medicine, UK

Community Health Division

The collaborations in this division include those with the following organizations:

Johns Hopkins University, School of Hygiene and Public Health, Baltimore, USA
The London School of Hygiene and Tropical Medicine, UK

Population Science and Extension Division

The collaborations in this division include those with the following organizations:

Bangladesh Rural Advancement Committee (BRAC)
Bangladesh Institute for Development Studies (BIDS)
Bangladesh Institute of Research for Promotion of Essential and Reproductive Health Technologies (BIRPERHT)
The Ford Foundation, New York, USA and Dhaka, Bangladesh
The Rand Corporation, California, USA
The Population Council, New York, USA
The University of Pennsylvania, USA
The University of Michigan, USA
The University of Wisconsin, USA
The London School of Hygiene and Tropical Medicine, UK
Georgetown University, USA
Pennsylvania State University, USA
The East West Population Institute, Hawaii, USA
Netherlands Inter – university Demographic Institute (NIDI)