ICDDR,B

BOARD OF TRUSTEES MEETING

9-11 November 2001

PROGRAMME OF THE

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PROGRAMME
BOARD OF TRUSTEES MEETINGS
9-11 November 2001

Executive Committee
Friday 09 November 2001
Venue: Director's Conference Room

Preliminary meetings for Prof Marian Jacobs and Prof Azad Khan with selected Centre staff

09:30 – 11:00 am	with Director
11:00 – 11:45 am	with Prof Barkat-e-Khuda
11:45 – 12:30 pm	with Dr MA Salam/Prof LA Persson
12:30 – 13:15 pm	with Dr Rob Breiman/Dr GB Nair
13:15 – 14:15 pm	Break
14:15 – 15:00 pm	with Mr Peter Thorpe
15:00 – 16:00 pm	with Finance/ERID

Evening, dinner at the Centre with Self-Help Promotion Conference at the Roof Top Pavilion

Executive Committee Members of the Board
Saturday 10 November 2001
Venue: CSD Conference Room

Prof Marian Jacobs, Prof Azad Khan, Mr Rolf Carriere, Dr David Sack

08:00 – 08:30 am	Director's Report	NOC staff
08:30 – 08:55 am	Division Reports - CSD	"
08:55 – 09:20 am	LSD	"
09:20 – 09:45 am	ISD	"
09:45 – 10:00 am	Tea Break	"
10:00 – 10:25 am	HSID	"
10:25 – 10:50 am	PHSD	"
10:50 – 11:15 am	Director's Division and General Administration	"
11:15 – 12:30 pm	Discussion	"
12:30 – 13:30 pm	Lunch with Scientific Council	Scientific Council
13:30 – 14:30 pm	Finance Committee	Scientific Council
14:30 – 15:15 pm	Personnel and Selection Committee	Division Heads/HHR CFO
15:15 – 15:30 pm	Closed session of the Board	Board only
15:30 – 15:45 pm	Tea Break	
15:45 – 17:00 pm	Strategic Planning	Scientific Council
17:00 – 17:30 pm	Closed meeting	Board only
19:30 – 21:00 pm	Supper at Roof-top Pavilion	SC and spouses

Executive Committee Members of the Board
Sunday 11 November 2001
Venue: CSD Conference Room

08:00 – 09:00 am	Revise resolutions	Board only
09:00 – 09:30 am	Staff Welfare Association	SWA and Board
09:30 – 10:00 am	Consider resolutions	Board plus AC
10:00 – 12:00 pm	Any Other Business (Board only as needed)	Board plus AC
12:00 – 14:00 pm	Donor's Support Group (with lunch)	DSG/SC/Board
14:00 -	Self-Help Promotion Conference as time allows	

1/BT/NOV 2001

APPROVAL OF THE AGENDA

2/BT/NOV 2001

APPROVAL OF THE DRAFT MINUTES

OF THE MEETING

HELD ON 1-3 JUNE 2001

MINUTES OF THE MEETING OF THE BOARD OF TRUSTEES, ICDDR,B

HELD IN WASHINGTON, USA,1-3 JUNE 2001

OPENING SESSION OF THE BOARD OF TRUSTEES MEETING
1 June 2001

PRESENT:

Board Members:		**Absent (with regrets):**
Prof Marian Jacobs	Chair of the Board	Prof Carol Vlassoff
Dr David Sack	Director	Dr Masihur Rahman
Prof Peter McDonald		Mr Mohammad Moniurazzaman
Prof Rita Colwell		Dr Nobukatsu Ishikawa
Dr Tawfik A M Khoja		
Dr Tikki Pang		
Prof A K Azad Khan		
Mr Rolf Carriere		
Dr Marcel Tanner		
Prof N K Ganguly		
Prof Jane A Kusin		
Dr Claudio Lanata		

Invited: Associate and Acting Associate Directors, Head HR, CFO, Ag CFO, Mrs Vanessa Brooks and Dr Ishtiaque Zaman.

Minute Secretary: Mrs Judith Bennett Henry

The Board of Trustees meeting was scheduled to be held in Dhaka; however, owing to the award to ICDDR,B by the Gates Foundation, the meeting was moved to Washington to coincide with the awards ceremony which was held on 31 May.

The first day's meeting was held at the Churchill Hotel with the following two (2) days at the Omni Shoreham.

Prof Marian Jacobs, Chair of the BoT, opened the first day of the Board's meetings with a welcome to all the Board Members and CAD members. She stated that she could not proceed with the Board's meetings without first mentioning the Gates Award and the past evening's ceremony. She noted that the award pointed to the commitment and hard work of all the staff, alumni, and BOT members of ICDDR,B, and offered congratulations to Prof Sack and staff on receiving the Gates Award. She also thanked the staff of ICDDR,B for organizing and coordinating the meetings.

Prof Jacobs welcomed new Trustees, Dr Marcel Tanner and Dr Claudio Lanata and the new CFO, Stephen Sage; Dr Abbas Bhuiya who was acting for Prof Lars Ake Persson, Assoc Dir PHSD; and Dr A Salam who was present to make the transition after Prof G Fuchs' departure from the Centre. She further asked that the assembled members make individual introductions.

Prof Jacobs declared the meetings open. She then introduced Prof Peter McDonald, Chair of the Programme Committee.

Minutes of the Programme Committee meeting
1 June 2001

PRESENT:		**Absent (with regrets)**
Prof Marian Jacobs	Chair of the Board	Prof Carol Vlassoff
Prof Peter McDonald	Chair, Programme Committee	Dr Masihur Rahman
Dr David Sack	Director	Mr Mohammad Moniurazzaman
Prof Rita Colwell		Dr Nobukatsu Ishikawa
Dr Tawfik A M Khoja		
Dr Tikki Pang		
Prof A K Azad Khan		
Mr Rolf Carriere		
Dr Marcel Tanner		
Prof N K Ganguly		
Prof Jane A Kusin		
Dr Claudio Lanata		

Invited: Associate and Acting Associate Directors, Head HR, CFO, Ag CFO, Mrs Vanessa Brooks and Dr Ishtiaque Zaman.

Minute Secretary: Mrs Judith Bennett Henry

The Programme Committee Meeting was held on 1 June 2001 to hear the report of the Director, Dr David A Sack, as well as the presentations of the Associate Directors.

The Committee convened at 8:30am in the conference room of the Churchill Hotel in Washington DC.

Prof McDonald, Chair of the Programme Committee, thanked Prof Jacobs and asked Dr David Sack to start the proceedings with his presentation of the Director's Report. He also welcomed Drs Tanner and Lanata to the Board of Trustees.

Dr Sack thanked the assembly and welcomed the two new Trustees. He stated that his report will summarise issues that the Board should give consideration during their deliberations. The report will also include highlights from each Division, and as a separate entity, the draft strategic plan which will be the core of the meeting's focus.

He pointed out that for those who were not present at the awards ceremony, he was happy to report the commitment made by the government of Bangladesh to match the amount of the Gates award. He then reported on the changes in international positions at the Centre. Dr Balakrish Nair is acting Assoc Director following the departure of Prof Mathan and pending the nomination of a new Head LSD. Dr Salam is acting Assoc Director CSD following the departure of Prof Fuchs – the search for a suitable candidate continues.

John Winkelmann left the Centre on May 17, Mr Stephen Sage will join the Centre as Chief Finance Officer in August until which time Mrs Shamima Moin will continue as Ag CFO. Dr Cris Tunon completed his contract with left the Centre in November 2000 and took up a post with WHO Vietnam. New staff: Peter Thorpe was selected as Head Information Sciences and Dr Shams El Arifeen as Head, Child Health Programme.

He highlighted the issues for the Board's consideration:

- The Centre ended with a positive financial balance last year and anticipated the same for the current year. However, the cumulative deficit of about US$3.3m continues to be a factor as well as uncertainties envisioned for some projects without definite donors. He stated that the Dutch Government had recently made a significant gesture through the commitment of US$1 million annually for 3 years for institutional support. He expressed the hope that the Dutch would lead the way for similar commitments from other donors. He also pointed out that in this regard, the Centre should do more to better acknowledge the core donors of the Centre, because while project funding is routinely acknowledged, core donors tend to be ignored in the Centre's reports.

- The strategic planning process is advancing with input from each Division and Programme. The Board would need to assess the documents and evaluate whether major changes in direction are needed or whether the Centre's priorities should take another direction.

- Donors: USAID/Dhaka and Washington – significant amendments are being made in the respective Cooperative Agreements (CA). Significant negotiations with DfID, EU, GoB (BINP and NNP) are ongoing. UNICEF is no longer funding core; and Canadian CIDA's core funding is uncertain. Dr Sack noted that the Dutch contribution came several days before the Gates Award; the Dutch offcials in Dhaka were pleased since this seemed to validate their own contribution and commitment. Agreements with World Bank and JSI will be ending soon.

- The Centre's management and scientists are seeking Board endorsement for initiated and/or planned activities in neo-natal health, severe malnutrition, zinc deficiency, low birthweight, pneumonia, tuberculosis, dengue, enteric and respiratory vaccine testing, and HIV-AIDS.

- A question for consideration was whether the Centre's activities in the extension areas should be included in the same category as the Dhaka and Matlab hospitals and field areas as "essential activities". Traditionally they have not been considered "essential" and risked closing if project funding stopped, and with the current change in donor commitments to those areas, the question arises as outlined above.

- The Centre is seeking Board instructions about extending the range of the Centre's training programmes to include technical assistance and research projects in the Asia region or to develop training courses that could be given outside Bangladesh.

    - There were 88 peer-reviewed publications in 2000.
    - JHPN is on schedule and is available online through the Centre's website.
    - The Annual Report has been published and is available for BOT members.
    - Over 300 trainees from 33 countries attended courses at the Centre.

- Regarding the future of the Hospital, the status of the Hospital Endowment Fund, and the issue of franchising; while the HEF is growing, the amount is far less than what is needed to sustain the Hospital. The HEF currently provides 13% of the total cost of the Hospital. Hospital costs are a major issue for the Strategic Plan. The Endowment was boosted by a US

$1m by the govt of Japan in 2000 and 200,000 in 2001. The annual HEF Ball and other fundraising events raised approx US $50,000 a year.

- Franchising through NGO clinics is providing more comprehensive care but the clinics treat mostly the mild (and inexpensive cases) while the Hospital gets the bulk of the severe (and expensive cases). The Centre needs to expand the franchise plan, adding more clinics which will also include facilities for treating severely ill patients. The new PSKP clinic is under construction and is expected to be a two-storey building but there is the likelihood of it being a four-storey.

- A question is whether the Hospital should include a ward for patients with diseases that fall within the Centre's research agenda, e.g. dengue and pneumonia.

- The Hospital continues to be a stable resource for the Centre in that it focuses the scientists work on research on health problems and gives a hands-on view of health and disease in Bangladesh.

- The implementation of an administration incorporating both Divisions and Programmes. The Centre needs an administrative structure for clear lines of authority; and at the same time, needs a structure with cross-divisional thematic programmes.

Divisions	**Programmes**
CSD	Child Health
ISD	Reproductive Health
HSRD	Infectious Diseases & Vaccines
LSD	Nutrition
PHSD	ESP support
	Population

Divisions will be led by Division Heads with assistance from Division staff and administrative units to manage budgets, supervise staff, manage protocols, encourage innovative projects, and seek funding.

Programmes will be thematic and cross-divisional and will be led by Programme Heads with assistance from a small secretariat to seek broad-based funding, and be champions of the field.

Common features: Both Division and Programme Heads will be members of the Scientific Council who will make strategic decisions, help to establish priorities for the Centre, seek funding, partnerships and collaborations.

Issues: Administrative powers and responsibilities; overlapping interests; priority areas outside the current programmes such as arsenic, environmental health. We may need to add environmental health as well as HIV-AIDS but limit the number of programmes without inhibiting the work of the Centre. Working groups can be added for special activities.

Issues for the Board:

- What defines the core activities of the Centre? Administration, Matlab and Dhaka hospitals, HDSS, laboratories, training, extension areas?
- How to restore balance among the Divisions regarding international positions? (Most international positions are in PHSD)
- Major restructuring of HSRD
- Enhancement of the ER&ID office
- Promotion of national scientists to P-level rank (incl 6-year rule and retirement age)
- Capital development
- Core funding to be acknowledged in Centre's publications underlining that funding would not be possible without the infrastructure in place.
- Medical ethics: Centre should make contributions to global dialogue on this issue. Discussion biased from the developed countries but experience with the ethical conduct of research at the Centre can assist developing countries in establishing viable strategies to promote ethical research. The Centre can play a stronger role for the region.
  Re: HIV-AIDS in Bangladesh. The conduct of enquiry relating to the disease should be a headline in the Centre's deliberations.

Dr Sack ended his report. Discussion followed on certain key areas of the report which it was agreed would be elaborated on in the meetings relating to the Strategic Plan.

Prof McDonald thanked Dr Sack for his report and invited Dr Abbas Bhuiya to make his presentation for Public Health Sciences Division (PHSD).

Public Health Sciences Division:
Dr Abbas Bhuiya began his report by outlining the goal of the Division: The PHSD brings the population basis to the Centre's mission and focuses on the development and evaluation of population-based interventions to address major health problems.

Highlights of the Division:

- Priority given to long-term collaborative research in major areas of public health such as projects on safe motherhood and combined interventions against maternal depletion and intrauterine growth retardation.
- There are currently 31 protocols
- Equity and health: rural development programmes reduce the gap in infant survival
- Infant growth in the slums of Dhaka
- During the PHSD retreat last year: top research priorities were identified on major disease burden for Bangladesh and the world.

Two international scientists joined the PHSD namely Dr Lauren Blum (medical anthropologist) in the Social and Behavioural Sciences Programme (SBSP) and Dr Carel Van Mels (demographer) in the Health and Demographic Surveillance Programme (HDSP). The Epidemic Control and Preparedness Programme (ECPP) was moved to PHSD from the then-HPED. Dr Rob Breiman joined the Centre to head the Programme on Infectious Diseases and Vaccine Sciences (PIDVS). Dr Abdullah Brooks, formerly with Clinical Sciences Division joined the PIDVS in November.

In 2000, the PHSD's staff comprised public health professionals, epidemiologists, social scientists, population specialists, and health economists. International staff – 12; national officers – 58; other categories – 531; community health workers – 131.

4 staff members successfully defended their theses in 2000: Dr Zahid Hasan, Dr Kapil Ahmed, Dr Nurul Alam, and Mr Mohammad Ali.

Dr Abdullah Baqui who formerly headed the Child Health Programme left the Centre for the post as Associate Professor at the Johns Hopkins University School of Public Health. Dr Shams El Arifeen was selected as the new Head of the Programme.

The Division's research programmes contribute to an understanding of how health and diseases are generated throughout the community, with emphasis on the disadvantaged groups and on cost-effective methods that could be applied widely to ensure an equitable distribution of health. The Division provides primary health care in rural Matlab and in Chakaria. The HDSS in Matlab regularly updates demographic information on about 210,000 people. The Division's broad range of research projects address epidemiological patterns of ill health, transmission of infectious agents, effects of micronutrients, public health nutrition, delivery of health care, prevention of illness through education, modification of risk behaviours, vaccine trials, and community development.

Dr Bhuiya enumerated several major issues:

- Maternal mortality still at a high level
- Cost effective models of skilled attendance at delivery needed
- Reducing neonatal mortality in the community
- Breaking the cycle of malnutrition and foetal growth
- Finding ways of reducing the burden of tuberculosis
- Matlab: an opportunity for studies on arsenic and health
- Poverty, equity and health. Dr Bhuiya drew attention to a new publication edited by himself and others entitled "Challenging inequities in Health"
- Centre needs second success story and health equity may be such an opportunity

Dr Abbas Bhuiya ended his report for PHSD. Members discussed the report in more detail. They congratulated Dr Bhuiya on the new publication, the launch of which was being held that day.

Prof Mc Donald thanked Dr Bhuiya and invited Prof Fuchs to make his presentation for Clinical Sciences Division (CSD).

Clinical Sciences Division

Prof Fuchs reported that the CSD continued its research, patient care and training activities with a staff support of 202 fixed-term employees – 133 (core) and 69 (project). The Division was also supported by 64 health workers, 129 CSAs, 15 trainee doctors, 15 trainee nurses and an international child survival Fellow. Training of the staff and clinical fellows was conducted by 2 paediatricians and a consultant radiologist.

Prof Fuchs outlined several activities of the Division.

Division highlights:

Franchising of the hospital services began in 2000 with the Urban Family Health Partnership (UFHP). The Partnership's designated local NGO PKSP clinic has been operational on the grounds of the Centre campus since November 2000. This resulted in reduced patient load and financial burden on the Centre's Dhaka Hospital and provided a new infrastructure for operations research and surveillance.

The Division, with assistance from the Centre's Training Department, organized and hosted the WHO Workshop on Management of Severe Malnutrition in Hospitals to field-test the WHO training modules prior to global implementation. Participants at the workshop were health professionals from Bangladesh, Bhutan, India, Indonesia and Myanmar. The Division in conjunction with the Training Dept conducted additional training workshops on the treatment of severe malnutrition for health care providers in Bangladesh. The Centre is exploring the possibility of becoming the WHO training site for severe malnutrition management to include studies on follow-up effectiveness and operations research.

Two new groups were added to the Division in 2000:

Child Development Group: To add research capacity to measure cognitive and psychomotor development in infants and children. Dr Jena Hamadani responsible for the group.

Drug Trials Group: To ensure quality in the implementation of trials on pharmaceuticals. Dr Wasif Ali Khan responsible for the group.

Prof Fuchs ended his report. Members discussed in further detail several key aspects of the report. Prof McDonald thanked Prof Fuchs for his presentation and invited Dr Balakrish Nair to make his presentation for Laboratory Sciences Division (LSD).

Laboratory Sciences Division:

Dr Nair began his report by outlining the mission of the Division: To adopt, develop and use the best scientific technology to address infectious diseases and related health problems of disadvantaged populations in partnership with other Divisions of the Centre and with national, regional and international institutions that share our commitment to maintaining healthy populations. The mandate: To apply science to alleviate diseases.

Dr Nair highlighted several major activities of the Division.

Dr Rashidul Haque was awarded the International Research Scholar Award of the Howard Hughes Medical Institute through its Infectious Disease and Parasitology Programme for a 5-year term from Sept 2000 to August 2005.

The Division recently opened the new Tuberculosis Laboratory, the first in Bangladesh, as well as the upgraded Nutritional Biochemistry Lab.

The Division is currently undertaking 46 projects, with strengths in diarrhoeal disease.

He outlined the priorities of the Division: HIV surveillance, dengue, TB, ARI, malaria, arsenic (service and training).

Dr Nair completed his report. Members discussed in further detail. Prof McDonald thanked Dr Nair for his presentation. Dr Sack was asked to present his report for the Health Systems Research Division (HSRD).

Health Systems Research Division:

The Division, formerly known as HPED is undergoing changes in its organization. The Centre is currently revising the CA with USAID who has traditionally been the main funding agency of the ORP. The Division expects changes in staffing and in other aspects to better reflect the thrust of its operations research programmes. The reorganization should be completed during 2001. The Epidemic Control Preparedness Programme (ECPP) was transferred from the PHSD to encourage closer collaboration with the epidemiologists in PHSD.

Dr Sack outlined the mission of the Division: To enhance the efficiency, effectiveness, cost-effectiveness, and sustainability of the national health and population programme through operations research. The Division's activities focus on the design and replication of simple, appropriate and accessible strategies and technologies, making optimal use of the available resources.

The activities of the Division comprise a multidisciplinary range of research issues addressed through both qualitative and quantitative methods.

The Division has a staff of 243 – 2 international, 42 national, 199 GS and field-level staff. Former Head of the Division Prof Barkat-e-Khuda was appointed as Associate Director, Policy and Planning and Prof David A Sack assumed the role of Acting Head of HSRD.

Included in the wide-ranging activities of the Division during 2000:

The ORP co-hosted an international seminar on Family Planning Programmes in the 21st Century in conjunction with the IUSSP-Brussels and PPD-Dhaka.

Drs Cris Tunon and Subrata Routh were integral players as Convenor and Member of the Centre's 9th Annual Scientific Conference (ASCON) on "Health Systems Research: Meeting the Needs of Populations in Transition".

Dr Cris Tunon left the Centre in November 2000 to take up a post with WHO/Vietnam.

Prof Sack completed his report. Prof McDonald thanked Prof Sack for his presentation. He noted that several key points would be taken up at the meeting related to the Strategic Plan. He then turned the meeting over to the Board Chair.

Minutes of the Finance Committee
1 June 2001pm

PRESENT:		**Absent (with regrets)**
Prof Marian Jacobs	Chair of the Board	Prof Carol Vlassoff
Prof Rita Colwell	Chair, Finance Committee	Dr Masihur Rahman
Dr David Sack	Director	Mr Mohammad Moniurazzaman
Prof Peter McDonald		Dr Nobukatsu Ishikawa
Dr Tawfik A M Khoja		
Dr Tikki Pang		
Prof A K Azad Khan		
Mr Rolf Carriere		
Dr Marcel Tanner		
Prof N K Ganguly		
Prof Jane A Kusin		
Dr Claudio Lanata		

Invited: Associate and Acting Associate Directors, Head HR, CFO, Ag CFO, Mrs Vanessa Brooks, Dr Ishtiaque Zaman.

Minute Secretary: Mrs Judith Bennett Henry

The agenda was approved.

Prof Rita Colwell opened the Finance Committee meeting. She noted that the Centre was being well managed over the past year as the cumulative deficit was being consistently reduced. The budget was balanced with a very slight balance. She further noted that the Centre would be very strong if some way could be found to significantly reduce or eliminate the deficit. On the upswing, due to good management and the ongoing down-sizing exercise, the Centre's financial planning would be completed this year.

She welcomed Mr Stephen Sage as the new CFO who will be taking up his position in August and commended Mrs Shamima Moin for the capable way in which she assumed the role of Ag CFO following the departure of Mr John Winkelmann.

Appointment of Auditors for 2001:

The Centre currently uses the firms of Price Waterhouse, Calcutta and Hoda Vasi Chowdhury & Co Dhaka as the Centre's auditors. The auditors have served the Centre for 5 years and 2 years respectively. The Centre practice is that auditors are retained for 5-7 years for continuity in the audits and to minimize audit costs. The Centre Management is requesting Board approval to reappointment both firms for the year 2001. Further, it recommends that the audit fees do not exceed the amount of US$15,500.

Discussion:

It was discussed that it was important to change auditors after 5 or 6 years to avoid lethargy and loss of committed interest in the Centre's concerns. It was suggested that on changing the

auditors in the future, the Centre bids out for auditing firms. For the present, it was agreed that with the arrival of a new CFO, it was important to retain the existing firms to ensure continuity.

The point was put forward that the auditing firms should be asked to take a more analytical approach from its traditional "numbers" approach. It was further suggested that the auditors establish a risk management framework and draw up an annual audit plan. It was agreed that the Financial Plan should include a Business Plan which would serve to engender confidence in donors.

Hospital Endowment Fund:
Prof Colwell reported that Dr W B Greenough III would join the meeting during the discussion on the Strategic Plan to give a short report on the investment of the Hospital Endowment Fund.

At end 2000, the balance of the HEF was US$5,246,080. The Fund was given a boost by the contribution by the Govt of Japan of US$1m and US$45,000 plus from other donations and fundraising activities. During 2000, US$200,000 was withdrawn from the Fund to pay for the Hospital's operating costs.

Centre's Endowment Fund:
As at December 2000, the Centre's Endowment Fund including USAID Endowment Fund stood at US$3,926,617. The entire Fund is currently invested with Morgan Stanley's Total Fund Management Portfolio and monitored by the Centre Fund Finance Committee. No contributions in 2000 but a withdrawal of US$140,000 approved by the Board was expended for developing research programmes and fundraising activities (US$66,000); the remaining amount of US$47,000 will be used during 2001.

Reserve Fund:
As at end December 2000, the Fund stood at US$2,167,147 – interest accrued was US$102,296. The Fund is held at the American Express Bank to cover the Centre's overdraft. In 1999, the Board approved the transfer of US$300,000 to the Centre's Operating Fund in January 2000 to reduce the cumulative operating deficit. A transfer of US$100,000 was approved by the Board in 2001 to further reduce the aforementioned deficit.

Fixed Assets Acquisition and Replacement Fund:
As at end December 2001, the Fund balance of US$78,107 was contributed by the Japanese govt for the Matlab International Training Centre for the installation of a communication link between Matlab and Dhaka.

Bank Overdraft:
The Centre's current overdraft facility of US$2m with the AmexBank is due to expire on 13 July 2001. Due to the Centre's large cumulative deficit, there is an ongoing overdraft requirement to cover operating costs. The management is requesting Board approval to renew the overdraft facility to 13 July 2002.

Mrs Shamima Moin presented the tables detailing the 2001 budget.

Prof Colwell thanked Mrs Moin and declared the Finance Committee meeting closed.

Resolutions of the Finance Committee

The Committee resolved to present the following draft resolutions to the Board for its approval:

1/BT/JUNE/01

The Board accepts the Audited Financial Statements of the Centre for the year ended December 31 2001.

2/BT/JUNE/01

The Board appoints Hoda Vasi Chowdhury & Co Dhaka and Price Waterhouse, Calcutta, as joint auditors for the year 2001 at a fee not to exceed US$15,500.

3/BT/JUNE/01

The Board authorizes the continuation of the overdraft facility of up to US$2 million with the American Express Bank for the year to July 13 2002.

4/BT/JUNE/01

The Board recommends to management that future surpluses be used, as much as possible, to retire the cumulative deficit.

Minutes of the Personnel and Selection Committee
1 June 2001pm

PRESENT:		**Absent (with regrets)**
Prof Marian Jacobs	Chair of the Board	Prof Carol Vlassoff
Mr Rolf Carriere	Chair, Personnel & Selection Committee	Dr Masihur Rahman
Dr David Sack	Director	Mr Mohammad Moniurazzaman
Prof Rita Colwell		Dr Nobukatsu Ishikawa
Dr Tawfik A M Khoja		
Dr Tikki Pang		
Prof A K Azad Khan		
Prof Peter McDonald		
Dr Marcel Tanner		
Prof N K Ganguly		
Prof Jane A Kusin		
Dr Claudio Lanata		

Invited: Associate and Acting Associate Directors, Head HR, CFO, Ag CFO, Mrs Vanessa Brooks, Dr Ishtiaque Zaman.

Minute Secretary: Mrs Judith Bennett Henry

Mr Rolf Carriere opened the P&S Committee meeting and requested Head HR to make the presentation.

Mrs Diann Hill presented an overview of the staffing status. She reported that during the reporting period 1 Oct 2001 to 31 March 2001, there were 28 separations and 188 additions, the significant increase as a result of the conversion of 117 community health workers (CHWs) in Matlab to regular staff. The total number of staff of all categories increased by 160, 117 (73%) of which were CHW conversions to fixed-term positions; 43 (27%) for project positions. The Centre continues the policy of restricting external recruitment of fixed-term staff.

Recruitment of international professional staff:
Chief Finance Officer: Mr Stephen Sage was selected as the CFO at P5 Level in the Director's Division to replace Mr John Winkelmann who completed his contract with the Centre on 31 May 2001. Mr Sage will join the Centre in August and Mrs Shamima Moin will continue as Ag CFO until his arrival.

Head, Information Sciences: Mr Peter Thorpe was selected as Head, ISD at P5 Level in the Director's Division. He is expected to join the Centre in August 2001.

Associate Director: Two (2) candidates have been shortlisted for the post at D1 Level in the Laboratory Sciences Division: Dr Antoine Andremont and Dr Andre Weintraub. Dr Andremont visited the Centre in May for his interviews and gave a presentation to the CAD. Dr Weintraub is expected to visit the Centre for the same purpose in late June. A decision will be made following his visit. Meanwhile, Dr Balakrish Nair has assumed the role of Ag Associate Director, LSD.

Associate Director: The search continues for candidates for the post at D1 Level in the Clinical Sciences Division. Prof Fuchs completes his contract following this June BOT meeting. Dr Abdus Salam will take up the role of Ag Associate Director until a suitable person is selected.

Renewal of Contract:
The contract of Prof Lars Ake Persson is up for renewal in February 2002. The Centre is recommending that the Board approve the extension of Prof Persson's contract for another term of three (3) years effective 1 March 2002.

The contract of Dr Abbas U Bhuiya will expire on 31 December 2001 following service of 7.5 years as an international scientist. The Centre is recommending that the Board approve the extension of Dr Bhuiya's contract under the Bangladeshi Scientists to International Level Policy.

New international professional staff:
Dr Shams El Arifeen, a national of Bangladesh, was selected for the post of Epidemiologist and Head, Child Health Programme at P3 Level in the Public Health Sciences Division. He replaces Dr Abdullah Baqui who left the Centre to take up a post with the Johns Hopkins University School of Public Health.

New seconded staff:
Dr Greet Dieltiens, a Belgian national, joined the Centre on 9 January 2001 as a Technical Advisor in the Reproductive Health Programme in PHSD. This appointment is under the collaborative agreement between the Belgian Technical Cooperation (BTC) and ICDDR,B.

Dr Abdullah Brooks, Health and Child Survival Scientist, was seconded to the Centre under the Child Survival Fellowship Program through Johns Hopkins University since July 1997. Until recently, he was in the Clinical Sciences Division but was transferred to PHSD in November 2000. The Centre anticipates that Dr Brooks will remain with the Centre for another two (2) years under secondment agreement with Johns Hopkins University.

Dr Abdullah Baqui will continue at the Centre as an Adjunct Scientist in PHSD following his departure from the Centre in July 2000 to join the Johns Hopkins University faculty.

Completion of tenure at international professional posts:
Mr John Winkelmann left the Centre in May 2001 following the end of his 3.5 years at the Centre. He previously served for 3 years from 1988-91.

Prof George J Fuchs, Associate Director CSD, completed his tenure of 6 years, 8 months with the Centre and will leave the Centre at the end of June 2001. The Centre commends Prof Fuchs on his services during his tenure and especially during his term as Interim Director.

Dr R Bairagi, Senior Scientist, P5, PHSD, is expected to leave the Centre on 14 June 2001 on completion of his current extended part-time contract. He served the Centre for many years including 6 years as a full-time international professional staff at P5 level and for 3.5 years as part-time at the same level. Depending on adoption of the promotions policy for Bangladeshi scientists, he may continue at the Centre under the Bangladeshi Scientists to International Level Policy.

Discussion: The six-year rule: It was discussed that there should be flexibility in the rule to reward and retain the scientists who have consistently exhibited excellence and commitment to the Centre's vision. It was important to maximize the talents of the scientists and encourage creativity. It was agreed that the rule should be coupled with a process of periodic performance evaluation.

The P&S Sub-Committee is mandated to review the Centre's performance evaluation system and gender equity.

Prof Sack stated that he needs help from the Board with gender policies and with international recruitment.

The Chair of the P&S Committee then declared the meeting closed and requested CAD members to recess. The Board continued in closed session with discussion on individual staff and regarding new Board members.

Resolutions of the Personnel and Selection Committee

4/BT/JUNE/01

The Board approves the Bangladeshi Scientists to International Level Policy as presented to the Personnel and Selection Committee. The extension of contracts will be subject to the satisfactory performance appraisal of the staff members, and contracts will be renewed for three (3) years. **Annex 1.**

5/BT/JUNE/01

The Board puts on record its appreciation for the services rendered by Dr George J Fuchs during his tenure with the Centre, especially for the period he served as its Interim Director.

6/BT/JUNE/01

The Board resolves that the current employment contract of Prof Lars Ake Persson with the Centre be extended by another term of three (3) years effective 1 March 2002 under the same terms and conditions.

7/BT/JUNE/01

The Board resolves that the current employment contract of Dr Abbas U Bhuiya with the Centre be extended for a period of three (3) years renewable, subject to satisfactory performance, under the policy of promotion of Bangladeshi Scientists to International Level.

8/BT/JUNE/01

The Board approves re-categorising Dr Sirajul Islam as an international staff member at the Centre, under the policy of promotion of Bangladeshi Scientists to International Level.

9/BT/JUNE/01

The Board notes its appreciation of the invaluable contributions made by Prof Rita Colwell, Prof Peter McDonald and Dr Tawfik AM Khoja during their tenure on the Board of Trustees.

10/BT/JUNE/01

The Board endorses the selection of Mr Peter Thorpe, Head, Information Sciences and Mr Stephen E Sage, Chief Finance Officer, each at P5 at the appropriate step level. The Board also gave its approval to extend an offer of employment to one of the two short-listed candidates for the Associate Director, Laboratory Sciences Division at D1. The short-listed candidates are Prof Antoine Andremont and Dr Andrej Weintraub.

11/BT/JUNE/01

The Board notes the completion of tenure of appointment of Mr John Winkelmann, Chief Finance Officer, Prof George Fuchs, Associate Director CSD and Dr R Bairagi, Senior Scientist PHSD.

12/BT/JUNE/01

The Board approves the Personnel and Selection Committee's recommendation regarding the end-of-service grant as presented by the Committee. **Annex 2.**

13/BT/JUNE/01

The Board selects the following candidates to be invited to become members of the Board of Trustees:

Dr I Kaye Wachsmuth
Dr Terry Hull
Dr Maimuh Bte Abdul Hamid

The Board agrees to appoint Prof Carol Vlassoff to the Board of Trustees pending clarification of her status.

14/BT/JUNE/01

The Board appoints Prof AK Azad Khan as Chair of the Finance Committee and Dr Ricardo Uauy Dagach as Chair of the Programme Committee.

15/BT/JUNE/01

The Personnel and Selection Committee will work with the Director on reviewing the six-year rule for the Centre; and renewal of the contract for the Associate Director and Head, Policy and Planning.

16/BT/JUNE/01

The Board approves the Adjunct Scientists Policy as presented by the Director. **Annex 3.**

Minutes of the Strategic Plan meeting
2 June 2001

PRESENT:

Prof Marian Jacobs	Chair of the Board	
Dr David Sack	Director	
Prof Peter McDonald		
Prof Rita Colwell		
Dr Tawfik A M Khoja		
Dr Tikki Pang		
Prof A K Azad Khan		
Mr Rolf Carriere		
Dr Marcel Tanner		
Prof N K Ganguly		
Prof Jane A Kusin		
Dr Claudio Lanata		

Absent (with regrets)
Prof Carol Vlassoff
Dr Masihur Rahman
Mr Mohammad Moniurazzaman
Dr Nobukatsu Ishikawa

Invited: Associate and Acting Associate Directors, Head HR, CFO, Ag CFO, Mrs Vanessa Brooks, Dr Ishtiaque Zaman.

Minute Secretary: Mrs Judith Bennett Henry

At 8:30am on 2 June 2001, the BOT met in closed session to continue discussions on the Personnel and Selection Committee:

At 9:30am, the BOT meeting opened to hear updates on relevant issues from:

- Mrs Mary de Kuyper who was invited to do a follow-up session on the November 1999 BOT retreat.

- Dr W B Greenough III on the status of the Hospital Endowment Fund and CHF.

Mrs de Kuyper revisited the discussions held in November and projected to the Board the next steps to be taken to strengthen their functions, expectations, and performance. The members discussed further critical aspects of the Board's duties in the areas of fundraising; networking esp within southeast Asia; assisting in the recruitment of international staff; supporting the work of the Centre and the Director; evaluating its performance with a view to the wider issue of the stakeholders.

Dr Greenough reported on the status of the HEF. He advised the Board of the need to review the existing investment plan that he believed to be falling short of expectations. It was discussed that the Board should look into working with an investment house which would give better returns as well as exhibits in its corporate policy, social and moral global responsibilities.

Strategic Plan Meeting

The Strategic Plan meeting got underway and was introduced by Prof Barkat-e-Khuda. He noted that the Plan was based on input from the staff. He drew attention to the motto which he stated is open for discussion and review: "To contribute to healthy life in Bangladesh, and be a partner in global efforts to promote health of the people around the world". The Plan comprised 3 all encompassing components – Science, Human Resources, Business Plan.

Mission/Vision: Dr Barkat reported that a review of the existing mission statement revealed a number of issues to be addressed to adequately reflect the Centre's raison d'etre.

Proposed Mission Statement: Prof Barkat presented 2 options for a new mission statement for the Board's consideration.

The Centre does not currently have a vision statement which is necessary to project the Centre's expectations for the next 10-15 years.

Prof Barkat presented 2 options for a proposed vision statement for the Board's consideration.

Priorities: Prof Barkat stressed that the Strategic Plan should reflect research priority topics as being Centre priorities and not programme priorities. Personnel responsibilities should be determined in the work plans. Priorities should be done by the programmes not the divisions, with interaction between the two. A committee should be established for feedback to senior management for final decision on where activities should fall.

Overlap of the Programmes and Divisions is a positive to the Centre as it recognises the resources in the Divisions as well as the research interests of the Programmes. However, priority topics of Divisions which are not identified as priority within the Programmes would need to be incorporated into a programme. If a topic is not a research interest of the Centre, the investigator would need to be steered toward a topic of higher priority within the programme.

The Centre needs to take into account several factors in setting its priorities: cost-effectiveness of research; feasibility of implementation; emerging new research subjects such as arsenic; current and future national/regional/global needs; marketability.

Policy and Action: A strategy should be devised to strengthen the Centre's capacity to implement policy action which would result in increased interest and participation by donors and GoB.

Internationalisation: One of the major aspects for discussion is the name change of the Centre. It was agreed that a name change was necessary and as importantly, that the word "International" be included in the new name.

The Centre should strengthen collaborative efforts with institutions rather than countries and establish linkages with UN agencies such as WHO, UNICEF, UNDP, UNFPA. The Centre should exploit its strengths in training and consulting services to other countries to further internationalise its image.

Dhaka Hospital:
Dr Salam presented an update of the Dhaka Hospital. Patient visits have been increasing annually and patient visits currently stand at about 115,000 a year. This increase is due to the high standard of care at a very low fee of 10 taka; the lack of alternate facilities; as well as the increasing population in Dhaka. Providing care to such a large number of patients is causing serious strain on the Centres's financial and personnel resources.

Support from John Snow International (JSI) which in 1998 provided a 3-year funding for the patient care at the Short Stay Ward, will end in March 2002. The Centre needs to urgently address an effective strategy to deal with the issue of increasing patient numbers and funding

requirements. Dr Salam pointed out that with developing future strategies for the Hospital, an appropriate modeling exercise should be initiated to make projections of patient visits for the next 10-20 years.

Dr Salam reported on two approaches currently being put forward in discussions on the future of the Hospital: revolutionary and evolutionary. He pointed out that the revolutionary approach denoted radical changes to the system that may cause misunderstanding and confusion and is more applicable to developed country systems whereas the evolutionary approach supported gradual change over a longer period and is at present better suited to the Bangladesh experience. He noted that the evolutionary approach had its weaknesses but stressed that changes to the system must be done with a well-thought-out, controlled and deliberate approach and with input from all the relevant stakeholders.

Managing patient load: An option to reducing the strain of patient load on the Dhaka Hospital could be to look to the public and/or private medical facilities. The existing Diarrhoea Treatment Units (DTUs) are poorly appointed and inadequately staffed. The government-assisted ESP clinics, if they become effective, would further reduce the efficiency of the DTUs. Dhaka Shishu Hospital has scaled down its DTU and can no longer be considered a viable alternative. The

Centre may look into a collaborative agreement with IMCH as an alternative though mainly inhabitants from outside the city would benefit. The GoB have recently expressed support to improve the DTU at the Salimullah Medical College Hospital which if implemented, could be another alternative.

Franchising: These activities began last year with the view to reducing patient load at the Hospital. The first such clinic, opened by the NGO PSKP on the Centre's campus is currently functioning well. Dr Salam noted that it would be important to weigh the effectiveness of franchising at a clinic operating in a more distantly-located area.

Other options:

Patient referral: This should effectively costs but past experience showed a very low success rate for referrals to other hospitals.

Fixed number policy: This would effectively reduce patient visits. The policy would be to treat a fixed number of patients per day with considerations for epidemic periods. Because of the Centre's uniqueness as being traditionally free service and the regard in which it is held, this may cause some negative reaction, not least from the GoB.

Purchase of services by GoB: The Centre may need to negotiate with the GoB to purchase the services for management of non-diarrhoea critically-ill patients. It may be difficult to request additional support from the GoB while looking into the possibility of establishing a fixed number policy.

Dr Salam outlined several other options which would result in reducing costs/generating income at the Hospital: utilization of patients for funded research; increasing core funding; increasing the 10 taka registration fee; strengthening the HEF.

Training and Education:

Prof Sack presented the report for the Training and Education Department (TED). He outlined the proposed objectives, strategy and priorities of the Training Programme. He noted that by

developing collaboration with recognized universities to offer degree programmes, the Centre could attract more trainees from the countries of the South, esp in Africa. Donors would be interested in funding these collaborative training programmes as the costs for training would be far lower than in the North. The training will serve to enhance skills development and capacity building in Bangladesh and other South countries.

The Centre will continue priority training programmes in:

Management of Severe Malnutrition in Children
Health and Population Studies
Reproductive Health
Health Systems Research

It is planning to join programmes in distance learning available at universities in developed countries.

The TED needs to upgrade the following resources in order to reach its stated objectives – space; equipment; personnel.

The Centre would continue to offer courses and workshops as well as opportunities for undergraduate and postgraduate students to use the Centre's facilities for training and dissertation work. The future priority is to develop the TED into a Regional Training Centre for South-South collaboration.

DISC: This unit has been constrained due to lack of financial support needed for establishing and maintaining effective programmes. It needs to expand its facilities, update and upgrade its reading materials, upgrade its IT component to transform the Library into an electronic information Centre; develop its personnel base to prepare them to meet changes in library and information technology. DISC is lacking in space, and professional and support staff. The budget projected to meet the needs of DISC for its present and proposed activities is US$ 650,000 per year. It is expected that by 2005, DISC would be an modern electronic information Centre that can play an effective role in national/regional/global outreach efforts of the Centre.

CIS: Planned activities: Upgrading the UMIS to include modules of finance and accounting; human resources; procurement system; maintenance, security and logistics; ERID; TED; project information system; miscellaneous management reports. Implementing of a centre-wide Office Automation System for requisition forms, inter-office correspondence; maintenance service systems etc. Web enabling; upgrading Centre's computer hardware including anti-virus security system and anti-hacking system. Training needs for CIS have been identified as follows: system support, database development, Internet Web application development, advance system administration and integration. CIS plans to offer courses on relevant applications to end-users.

Master Plan:

The Centre's infrastructure is in need of upgrading and expansion. Urgent considerations need to be given to developing the physical facilities, esp the laboratories to support the growing number of projects.

The Centre is in the process of employing a consultant to develop a 10-year Master Plan. The priority focus is on the space housing the Transport Unit, Canteen, Creche etc. In addition, work

is being implemented to upgrade the PABX system, the electrical system (generator), telecommunication system; and developing an integrated radio communication system.

Discussion: The Board discussed in further detail aspects of the reports presented . It was agreed that urgent for consideration was organizational structure and incremental planning. It was further agreed that service and how to manage it should be included as an integral part of the Centre's activities.

The Board agreed to form sub-groups to discuss among themselves :

- The future of the Hospital (group leader : Dr Lanata)
- Organisational and administrative structure (group leader: Prof McDonald)
- Research priorities (group leader: Dr Pang)

Each of the groups is preparing brief reports outlining their discussions.

Research priorities: Those proposed in the draft Strategic Plan need to be further prioritized, keeping into consideration the national/regional/global context as well as donor priorities. Research questions for each priority area should be formulated, and performance indicators for each question identified. The comparable advantage of the Centre in respect of each priority area should be outlined. Also, for each priority area, there should be incremental or phased-in plan (up to 2005, 2010, 2020). In addition, resource needs (human, financial and physical) for each priority area should be determined.

Policy/programmes: The impact of ongoing and proposed activities should be identified.

Motto/mission/vision: These statements should be more focused. Also, statements embodying the culture and values of the Centre should be developed.

Centre decisions: Review resource balance in terms of research, service, training and technical assistance; review organizational structure.

Management component: This part of the SP should be developed to include an analysis of the existing human resource profile as well as a human resource plan for the future, including appropriate human resource policies and procedures. Additionally, the management component will assess the existing use of physical infrastructure and logistical support, and develop plan for optimum use of physical infrastructure and logistical support.

Business Plan: This should be further developed to include a review of funding over the last five years and projections into the following five years, resource mobilization, and acquisition plan.

Approval of draft SP: Monitoring implementation of the draft Strategic Plan, once approved by the BoT in November 2001, should be given high priority by the Centre.

Minutes of the Full Board
3 June 2001am

PRESENT:		**Absent (with regrets)**
Prof Marian Jacobs	Chair of the Board	Prof Carol Vlassoff
Dr David Sack	Director	Dr Masihur Rahman
Prof Peter McDonald		Mr Mohammad Moniurazzaman
Prof Rita Colwell		Dr Nobukatsu Ishikawa
Dr Tawfik A M Khoja		
Dr Tikki Pang		
Prof A K Azad Khan		
Mr Rolf Carriere		
Dr Marcel Tanner		
Prof N K Ganguly		
Prof Jane A Kusin		
Dr Claudio Lanata		

Invited: Associate and Acting Associate Directors, Head HR, CFO, Ag CFO, Mrs Vanessa Brooks, Dr Ishtiaque Zaman.

Minute Secretary: Mrs Judith Bennett Henry

At 8:30am on 3 June 2001, the BOT met in closed session to continue discussions on the Strategic Plan.

Prof Marian Jacobs opened the session of the Full Board. She stated that on behalf of the Board, she wanted to congratulate Dr Abbas Bhuiya on the publication of his new book; Dr Ishtiaque Zaman for his efforts, along with Dr Masihur Rahman, which resulted in the magnanimous donation from the Government of Bangladesh; Judith Bennett Henry on her recent marriage and Prof Sack on the recent marriage of his son.

She further stated that the Board should make a formal acknowledgement in appreciation of the PM's gesture.

Prof Jacobs reported that sadly, the wife of Prof Takeda (a recent Board member) passed away following a long illness; Prof Ramalingaswami, former member of the Board, and advisor to UNICEF, among other roles, also recently passed away. Condolences to be conveyed to their families.

Thank yous to the Centre's Executive, Secretariat and Administrative staff for organizing the relocation of the meeting. Prof Sack to convey thanks to: Johns Hopkins for the loan of the a/v equipment; Mrs Deb Clark for her assistance throughout the meeting's proceedings; Dr Greenough for his support; the Gates Foundation for the Award; the nominators; and the Global Health Council for their support.

Interaction with donors: The Centre should maintain the momentum of the Gates Award and keep the current high public profile to maintain and explore funding opportunities. To retain global interest, the Centre would need an aggressive PR and resource mobilization strategy and should review donors' interest and monies committed to the Centre.

Prof Jacobs stated that the meeting's distance from Dhaka meant not seeing the Hospital's children, the staff and the Donors Support Group. She pointed to the commitment of the staff to the Centre and the level of their productivity and expertise which allows them to compete internationally. The commitment of the Board is to see the process of the Strategic Plan through. The Board should seize the opportunity to harness the passion that still exists among Board and staff members and try to keep people – alumni, friends of the Centre – connected with the Centre.

Approval of the Draft Minutes of November 2000:

The minutes were approved with the following amendments:

Page 1: **"Absent (with regrets)"** should replace **"Absent"** in all instances.
Page 1: Include the names of Prof A K Azad Khan and Dr Masihur Rahman as **"Absent".**
Page 2: amend spelling of name of Dr **Tamanna** Sarmin.
Page 5: **Include "Head, Policy and Planning"** in the sentence "The **Scientific Council** comprises Heads of Scientific Divisions, Programme Leaders .....".

Adoption of minutes moved by Prof Peter McDonald and adopted by Dr Ricardo Uauy Dagach.

Prof Jacobs enumerated the future challenges for the Director in several areas:

The need to define priorities, establish a more efficient organizational and administrative structure – possibility of a merger of HSRD; extension of coverage and content of training beyond Bangladesh.

- Operational issues: programmes, hospital and its reorganization, scientific issues such as research medical ethics.
- HR: international positions, staff development and promotion, six-year rule, retirement age
- Admin: Location, leadership and expanded role of ERID.
- Funding: Hospital costs, increase donor base, where best to use Gates money

She pointed to the relevant themes to be addressed:

- The place of the Centre and its responsibility as an international research centre
- staff issues: equity in the areas of personnel, staff distribution and salaries
- links between research and other aspects of the Centre
- Issue of focus and emphasis and advantage of our strategic niche
- Staff development and support
- Board and how it works, policy and guidelines; improving effectiveness and efficiency

Decisions:

Role and Functions of the Board: To improve the board operations, several needs exist:

- The need to consolidate the induction and orientation process and package (more information about Bangladesh, its health and policies and research institutions; new Board members visits to the Centre; Ordinance, relevant Centre rules and policies)
- Code and Conduct to be developed and adopted by all Board members
- Executive Committee to attend to all issues as discussed by Mary de Kuyper

General Discussion:

Fundraising: how can the Board help? International scientists to raise visibility of the Centre. Slides on Centre activity to be sent to all Board members which would give them relevant information to discuss in international fora.

Strategic Plan: The old SP and Mummert Report to be sent to new BOT members for induction and orientation. Prof Barkat to redraft and make amendments and additions to new SP.

Reports from the Strategic Planning sub-groups (from 2 June) should be sent to the Director.

Prof Jacobs and Dr Tanner should visit the Centre before next BOT to help complete draft of SP.

As part of the Strategic Planning, a review is needed given the major events which developed over the last two years, especially the World Health Report 2000, the genome project, and research ethics conduct. It was agreed that the Centre needs a high-level visionary review of how the Centre relates to the global picture. It was suggested that someone with the expertise such as Amartya Sen is needed to review this.

Prof Ganguly pointed to the need for BOT members while in Dhaka to spend time in the units and departments to interact with the staff and so be better able to give input to the Director.

Prof Dagach stated that the BOT should familiarize themselves with the topics to see challenges ahead and provide a vision for the future. Members should submit relevant documents for future discussion on mode of review. Prof Ganguly to send several documents.

It was agreed that the Board should advise on BOT materials and send relevant materials to David. It was agreed that BOT should establish accounts with Yahoo Instant Messenger for online discussions.

Prof McDonald stated the need to stress the population component of the SP. Prof Ganguly advised the use of modern technologies such as the COHRED methodologies and should be adopted in the SP. Ms Brooks pointed out the SP afforded a longer window of opportunity critical to the fundraising component. Prof Colwell advised that the first 18 pages of the SP be translated into a promotional brochure for potential donors. It was suggested that a manual be developed for new BOT members which should include: the history of the Centre; of Bangladesh; role of the Board; Code of Conduct; Robert's Rules.

Approval of resolutions:

P&S Committee: Mr Rolf Carriere, Chair of the P&S Committee, presented the draft resolutions of the P&S Committee. They were approved as presented.

Finance Committee: Prof Rita Colwell, Chair of the Finance Committee, presented the draft resolutions of the Finance Committee. They were approved as presented.

Change of ICDDR,B name: Members discussed the need for a name change. It was suggested that the point should be noted in the redraft of the SP. Legal and other implications need to be looked into. It was suggested that an advertising agency be contracted to review and advise re fundraising etc. Mr Carriere suggested that there are some agencies who may want to donate their services for such a venture.

Inter alia: Prof Jacobs suggested that the term "ex" to denote past BOT members, staff, etc be omitted from future texts to be replaced with "friend of the Centre".

It was suggested that information about BOT members be posted on the Centre's website. BOT should send short bio-pics minus contact information to avoid inappropriate contact from staff and external site visitors.

Dr Sack reported to the Board the changes and upgrading being made to the Guest House rooms and outer-rooms.

Appreciation for the efforts of all the members of CHF was noted.

Centre thanks to the Ministry of Health, Bangladesh to be recorded.

Welcome to incoming Chief Finance Officer, Mr Stephen Sage. Appreciation to Shamima Moin as Ag CFO following departure of John Winkelmann and pending arrival of Mr Sage.

Goodbyes to Dr Tawfik Khoja, Prof Peter McDonald and Prof Rita Colwell.

Committee Chair appointments: Programme Committee: Dr Ricardo Uauy Dagach to replace Prof McDonald; Finance Committee: Prof AK Azad Khan to replace Prof Colwell.

Date of next BOT meeting: 2-5 November 2001.

Chair of the BOT, Prof Marian Jacobs declared the BOT meetings closed at 12:00noon. BOT members and staff participated in a "chill-out" lunch following the meetings.

Resolution of the Full Board

17/BT/JUNE/01

The Board appreciated the efforts of the Director, Associate Directors and Head, Policy and Planning as well as the staff members for producing the first draft of the Strategic Plan. The Board also approved continuing the discussion and revisions to the Plan and to reconsider the Plan at the meeting in November.

3/BT/NOV 2001

PROGRAMME COMMITTEE

BOARD OF TRUSTEES MEETING
NOVEMBER 2001

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

PROGRAMME COMMITTEE MEETING

PROGRAMME COMMITTEE

November 2001

1. Director's Report

2. SWA Report

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

Director's Report

Prepared for the

BOARD OF TRUSTEES MEETING
November 2001

Director's Report to the Board of Trustees
November 2001

Transitions at the Centre

The Centre has clearly been proceeding a time of transition this year, including changes in senior staff; in major grants; and in procedures.

Changes in senior staff

Some major changes in the senior staff include:

- Dr M Abdus Salam is now the acting division head for the Clinical Sciences Division following the departure of Dr. George Fuchs in June 2001.
- Dr Rob Breiman was appointed acting head of the head of the Health Systems Research Division (HSRD, formerly HPED). The management will propose his appointment as head of this Division.
- Mr Peter Thorpe joined the Centre in August as head of the Information Sciences Division.
- Mr Stephen Sage joined the Centre in August as Chief Financial Officer.
- Prof Marian Jacobs will be attending her last Board meeting in June, and the Board will need to identify a new trustee and a new Board Chair.

The P and S committee will consider the positions for the LSD, CSD, and HSRD divisions.

Other transitions

Several of the major grants are ending and new grants are beginning, and the transition between the old and new is not always smooth. Additional new projects are scheduled to start after finalization of the grant documents. The Scientific Council has become active in formulating issues of scientific priorities and in fulfilling their coordination role. The Strategic Plan is nearing finalization with the input from the Programmes which are beginning to take shape. In the HR arena, the reclassification process is moving forward. In each of these areas, I believe the Centre has been adapting well to the changes and is focussing on its important mission.

Outside the Centre, the country has also been making a transition to a new government, with the national elections returning the BNP to power. The tragic events of September 11 and the global reaction following these events has added an extra level of stress to the Centre as it has for all people around the world.

The Director's report will use the same format as used during the June meeting, starting with a summary of some of the issues the Board should consider and some highlights from each Division. Most importantly, the new draft of the Strategic Plan is included as a separate document.

Overview of the financial situation

Financially, the Centre expects to finish the year 2001 with a positive balance (for the third year in a row). The final balance will await the audit report, but we anticipate a positive balance for the current year of about US$150,000. Furthermore, we will be able to decrease the cumulative deficit by about $350,000 by transferring an additional amount from the interested earned in the reserve fund. This will bring the cumulative operating fund deficit to less than $3 million. This improved financial situation was possible of some key donations, and because of the continued cost containment by the management. It was also possible because of the excellent effort made by many of the scientists who continually develop new projects that receive funding. Clearly, the coordinated efforts to increase core funding to build capacity, and simultaneously to develop scientifically sound, relevant projects is the way the Centre can be productive and also work its way out of the financial difficulty we had in the past.

Not counted in the operating fund above was the amazing prize of $1 million to the Centre from the Bill and Melinda Gates Foundation of the first ever Gates Award for Global Health, nor was the matching gift from the Government of Bangladesh. The Gates funds were transferred to the Centre's account shortly after the award ceremony in June 2001, and we expect to receive the funds from the GOB by the end of October. The plans for budgeting these award monies will be a topic for the board meeting. Currently the Gates Award is in a money market account.

Major donors
The Finance report will provide more detail about the financial situation; however, we should note several major grants during the year.

Bangladesh
The Government of Bangladesh continues to provide core support to the Centre at a level of about 200,000 annually. As mentioned above, this was increased by the one-off contribution to match that of the Gates Award.

Netherlands
The Government of the Netherlands awarded an annual grant of about $1 million (depending on exchange rates) for three years starting this year. The importance of this award is hard to overestimate in terms of providing substantial stability to the work of the Centre.

Switzerland
The Swiss government had been giving the Centre a substantial award each year to various projects at the Centre from its Embassy in Dhaka. This year, they

decided to change to the mechanism to provision of a grant of about $500,000 from its headquarters.

Japan
The Government of Japan granted an award of $980,000 and this is divided into some different portions, $200,000 of which was designated for the hospital endowment.

USA, Washington
The Government of the USA through USAID had been providing funding through its central office in Washington through a cooperative agreement for Child Health Research. This agreement helps the Centre, not only in providing core and project funding, but also in being an administrative mechanism by which other government agencies can add funds to the Centre's programme. An extension to the Cooperative Agreement was signed in June 2001 for another three years. The amount of the award is expected to be in excess of $900,000 annually depending on availability of funding and the nature of the project work.

USA, Dhaka
The USAID mission has been providing a considerable amount of funding to the Centre primarily through a Cooperative Agreement for the Operations Research Project. In late September, an agreement was reached for a major change in this project, and it is now called the Family Health Research Project (FHRP). Under this amendment to the Cooperative Agreement, the Project was extended for another five years for a total budget of $15.5 million over this time period. The funds will be used primarily by targeted research protocols that will be developed by scientists in any of the divisions (formerly, only the HPED was involved). The transition of the ORP to FHRP requires many financial and personnel adjustments that are difficult this year, but we anticipate that the revised project will be more productive and will benefit more directly the effectiveness of the Essential Services Package in Bangladesh.

United Kingdom
In consultation with representatives from DfiD, the Centre prepared an application to DfiD for a five-year project on Poverty and Health at a funding level of one million pounds annually. At the time of this report, this was not officially awarded, but unofficially, it seems this new project will begin within a month.

Sweden
We are nearing completion of a new three-year agreement with SIDA-SAREC for continuation of work in collaboration with Swedish scientists. In addition, the Swedish government has provided additional funds for a project on health effects of arsenic contamination.

Australia
The Australian government has been a consistent donor throughout the history of the Centre; however, there was a major concern that they would no longer be able to continue this practice. The Director made a trip to Canberra in August, and through the efforts of our Board members, the decision was made to continue the contributions at about the same level (Au$ 500,000 annually). A portion (Au$200,000 annually) of the donation will, however, be designated for use in HIV-AIDS research.

Other grants
There are many other grants and awards that deserve attention, and it is not my intent to ignore any. I trust the Board will read the Finance report that gives more detail. However, the ones mentioned above are larger and support the infrastructure of the Centre that is critical to the financial and scientific health of the Centre. They are also important because these are multi-year agreements that allow for planning in a more realistic fashion.

Competitive Grants
Of note is the increase in receiving grants based on competition with granting agencies like NIH, Thrasher Foundation, NVPO, private companies, and others. The finance report formerly combined the NIH grants with USAID since both of these come from the US government. They are however different in their implications, and we are now showing them separately.

Decrease in support
Not all the grant news is good. Two major grants are coming to a close with out any logical replacement. The first is the Nutrition Centre of Excellence Grant from the World Bank, amounting to $900,000 annually over the last three years. Unfortunately, this particular grant cannot be extended beyond three years, and the Centre is looking for other sources to maintain the momentum in nutrition research that was stimulated by the NCOE / World Bank grant.

The other disappointment was a major (exceeding $600,000) shortfall in a grant from the European Union, caused primarily by currency devaluation along with some additional administrative problems. The EU was funding major projects in reproductive health and studies on contraceptive use dynamics, and these projects have had to reprogramme their activities severely.

Prospects
While there are many potential prospective grants, two should be highlighted because of their strategic importance. Both of these agreements will be finalized soon, and both are in cooperation with the Government of Bangladesh and the World Bank.

Under the first project, expected to start by years end, the Centre will assist the National HIV-AIDS Programme by continuing to conduct the national sero-

surveillance. This has proved to be a model project within Asia for which Bangladesh has received considerable credit. However much more needs to be done in HIV-AIDS research and control, and the Centre can play increasingly important roles.

The second is with the National Nutrition Programme (NNP) in which the Centre expects to conduct take a leadership role for the Operations Research aspect of this multi-year, multi-million dollar World Bank project. This is expected to start within a few months.

Strategic Planning
Led by Dr. Barkat-e-Khuda, the strategic planning process has moved forward and is an important issue for the Board to consider. Since the last board meeting, the programmes have continued to prepare their inputs into the plan, the primary outcome of these programme inputs are in the tables that reflect the priorities that each of the programmes is recommending as priorities for the Centre. This last convoluted sentence is only to clarify that there are potential overlapping interests between programmes, and one way to encourage cooperation rather than competition is to ensure that the priorities are Centre priorities and are not "owned" by any one programme.

Some crucial points I would ask the Board to consider about the strategic plan includes:

Name change for the Centre
Two names are suggested for consideration. International Centre for Health and Population (ICHAP) and International Health and Population Institute (IHAPI)

Mission / values / vision statements.
These statements are always difficult, but hopefully they capture the Centre's spirit. The Board should reflect on these to ensure that they are clearly understood, and do indeed give the right message. Consider that they are a way that we communicate our message to the outside and to our own staff.

Reorganization
There has been much discussion about "reorganization" during the last few board meetings, and the Board requested that it be given a copy of the Mummert Report developed in 1998 that described recommendations on reorganizing the Centre. This was included in the packet of materials. The organization described in the Strategic Plan has attempted to use some of the lessons from the Mummert Report, especially concerning the emphasis on cross-divisional thematic programmes as defining our priorities and our way of developing our "marketable ideas" to donors and to our staff. The Centre has not, however, adopted the administrative changes recommended since these did not seem to be practical for the organization. We did however create the **Information Sciences Division**, lead by the new Division Head, Peter Thorpe. This Division

brings together the DISC (library and publications), Computer Information Services (CIS), and the Training Extension Unit (TEU) into a coordinated division.

Divisions and Programmes

The discussion concerning relations between Divisions and Programmes has been settled (for now) by agreeing that Programmes are indeed cross-divisional and thematic, but that they are housed within the Division. The Division Heads are charged with the responsibility to insure that the Programmes act on behalf for the Centre and not just acting for the benefit of the Division. Currently there are six programmes, but we see the need for two others -- "HIV-AIDS" and; "Safe Water." The latter was thought to be a programme for environmental health, but the concept of safe water, including chemical and microbial safety, is more realistic since the Centre has considerable expertise in this area, but perhaps does not have so much expertise in the full range of issues it would take to claim an environmental health programme.

An aspect of emphasizing the cross-divisional activities is the formation of the Scientific Council (SC) that meets twice monthly, the Centre's Scientific Forum (CSF) held each Monday. The SC discusses the priorities and new projects of the Centre, and the CSF presents cross-divisional topics to inform the community about the research themes at the Centre. An informal mechanism of cross-division interaction is the new Corridor Café which is somewhat more conducive for lunch time discussions than the canteen which continues to function.

Priority Setting

In preparing the Plan, the Programmes spent considerable time discussing the methods for setting priorities, as well as creating tables of higher and lower priority issues. When each of the Programmes brought their priorities to the table, it was clear that there were many overlapping priorities and there was a potential conflict about which Programme was to "own" a given priority. However, the discussion revealed that in fact each of these priority areas were recommendations as Centre priorities, and should not be viewed as overlapping. The fact that multiple programmes recommended them, only added to their importance for the Centre.

Hospital Plans

The plan also presents a vision for the Hospital as evolving into a self-supporting model "Urgent Care Facility" for patients with certain diseases that fit the criteria of being "common, potentially fatal, and easy to treat." As Melinda Gates indicated in her award banquet speech, no child should die from an easily prevented or easily treated disease. Our interpretation of this remark is that we need to characterize these "easily prevented deaths" and build a treatment centre around this concept. In Bangladesh, the common and easily-treated diseases are diarrhoea, pneumonia, severe malnutrition, and perhaps dengue. Unfortunately, the primary care system is not equipped to deal with these

diseases, at least not those of sufficient severity as to be potentially lethal; however, the experience with the ICDDR,B hospital has shown that inexpensive care for diarrhoea or severe malnutrition, if given on an urgent basis, can save many lives at a very low cost. We feel the same is true for pneumonia and dengue, but the model for this new type of urgent care facility must be developed and be sustainable economically. It also must evolve into this new model... it is not something that can happen overnight.

Geographic interests for the Centre

In Bangladesh
Where should we carry out our work? Currently the Centre is based in Dhaka and has several field areas. New protocols have tended to add additional field areas to the Centre's range, and there is increasing realization that the Centre should concentrate in only a few field areas and not expand to further areas for intensive studies. That is, the Centre has invested heavily in the field areas already in place and we should use them to the maximum extent. This does not prevent surveys in any part of the country that is appropriate, but we should not be starting new field areas with each new protocol.

Outside Bangladesh
Outside Bangladesh, the Centre is conducting a major collaborative project with Nepal. This project to assist with improving the microbiology laboratory services has been going well and could lead to additional projects there. The Centre is interested in developing projects outside Bangladesh, especially in the region, but these will require project and long term funding.

Also outside Bangladesh, there is need for **consultants** from the Centre to assist with important work. Recently, the Centre has provided consultants to UNICEF, International Vaccine Institute, and to UNAIDS. We have also been in contact with WHO regarding collaboration for outbreak investigations of emerging diseases in the region. We anticipate that the Centre will need to increase its capacity to carry out these regional consultancies.

Management changes
In contrast to rather modest changes in the organigram, the Centre is working toward making changes in management systems to improve efficiency. One change is to decentralize the financial responsibilities, and from a financial perspective, our goal is for each unit of the Centre to become self-supporting, or nearly so. For example, administrative units such as the transport pool, maintenance, travel office, etc. receive core funding, and these costs have been included in the indirect cost pool. In principal, these units are functioning in order to carry out specific tasks and provide resources to the projects, and appropriate charges are made to budget codes using these services. However, the charges have not been sufficient to cover the costs of operating the units. In the future, the units will be run more like small businesses, and they must at least break

even in order to stay in business. If they require subsidies from the core, an evaluation will be made to determine if the amount of subsidy is warranted, or if there are ways to economize, or to outsource the service. Our current system monitors costs very accurately, but there is limited ability to make management decisions based on this information since the management decisions were made centrally, by persons not having direct knowledge of the unit. Decentralization will require greater responsibility upon those having the most knowledge of the unit.

Ethical Reviews
The ERC (Ethical Review Committee) continues to function well but there are some changing requirements for Assurances. The Centre has a Multiple Project Assurance with the USAID, but a new requirement will be to obtain a Federal Wide Assurance with the US government. (Currently there are no mechanisms for international assurances.) The requirement for the Federal Wide Assurance will require (very appropriately) increased training for scientists, ERC members and ERC staff.

Major Scientific Activities
The Division Heads will update the Board on the major new initiatives, some major findings from recent studies, and future directions. Many of these are ones that the Board learned about last June, but they include studies on neonatal health, severe malnutrition, zinc deficiency, low birth-weight, pneumonia, tuberculosis, dengue, enteric and respiratory vaccine testing, and HIV-AIDS. Of course, each of these depends on project funding, but the management and the scientists would like endorsement from the Board that these are appropriate and are in keeping with our mission.

Planned Changes in Medical Practice
As a result of some of the Centre's studies, as well as studies carried out in other centres, we will want to follow-up with the consensus to change the standard ORS to one containing 70 meq of sodium. We will also be advising the national authorities about this anticipated change.

We plan to begin treating diarrhoea patients with zinc. Research from the Centre has shown that zinc treatment decreases the severity and duration of diarrhoea and that children who receive zinc for 14 days have a decreased mortality rate. Operations research is now needed to determine the optimal methods for implementing these findings in our hospital, in clinics and in the community. We will likely need to find an industrial partner to produce the needed dissolvable tablets.

Physical Changes and Capital Investments
The campus has been changing its appearance in several respects.

- A master plan is under development with input from the Division Heads,

- A roof-top pavilion is nearing completion on the library / PHSD building. This will be used mainly to augment the training facilities by providing space for meals and receptions for guests attending sessions at Sasakawa auditorium,
- A space was renovated in the main building for a "corridor café" for snacks and lunch,
- The new clinic building is nearing completion close to the entrance of the campus. This will house the PSKP clinic in the first two floors and ICDDR,B projects in the upper two floors,
- Rooms are being re-configured in the director's wing of the main building to accommodate the HR. The Clnical Sciences Division will shift to the former personnel area,
- Shifting the CSD offices will allow for renovation of additional lab space on the top floor of the main building,
- The space known as the "travelers clinic" is being renovated into a "diagnostic centre." This space on the ground floor, close to the hospital, will have a separate entrance and will provide improved facilities for taking clinical specimens on a payment basis. We anticipate that this space will attract more patients, since it will be more user-friendly and will offer a wider range of services, and it will also limit patients to the ground floor, thus improving security in the building.
- The microwave link with Matlab is nearing completion. This will allow for voice and data transfer between Dhaka and Matlab and will allow the staff in Matlab to access the internet, via our V-sat.

Publications

The Journal of Health Population and Nutrition continues to be published on schedule. We are finding increasing interest in publication of summaries of important meetings. For example, the March issue reported on the findings of a meeting on community-based IMCI, and the December issue will publish the consensus of a WHO meeting on zinc. We expect these reviews and policy statements will increase the interest in the journal and increase its scores.

The Centre's web site is also changing to make it more user-friendly and to provide increased information to the users. We anticipate that this will continue to evolve with the additional staff who are being recruited for this.

Representation of the ICDDR,B Staff Welfare Association (SWA) to The Board of Trustee's meeting, 2-4 Nov. 2001

Welcome !

Hon'ble Chairperson of the ICDDR, B Board of Trustees Prof. Marian Jacobs, respected Trustees , representatives of the Government of Bangladesh Patron-in-Chief of the Staff Welfare Association, and SWA Executive Committee Members, welcome and *Assalamo-alaikum* .

It is my privilege to share the views of the staff of the Centre with the members of the Board of Trustees. I would like to thank the Board, on behalf of the staff of the Centre, for allowing us to discuss matters of mutual interests aimed their busy time schedule. I hope the issues that I am going to raise would receive favorable consideration .

1. Staff Salary :

On behalf of the staff of the Centre, I am pleased to express our gratitude to the Board members and the Patron-in–Chief , SWA , for considering two salary adjustments during the last two years consecutively. This helped the employees to overcome their frustration and lack of confidence on the Centre's policy, the salary adjustment helped them financially and increased their level of confidence and moral. They would remain ever grateful to you all .

However, there are still wide gaps in the salary structure, whether it is determined by UN scale (as prescribed in the ICDDR,B Ordinance) or by the market forces. By any standard, the staff of the Centre are grossly underpaid . Despite the fact, they have been continuing their efforts to accomplish the Centre's goals in promoting health and human welfare world wide. For example the Gate's Global Public Health Award which has been given to the ICDDR,B reflects the contribution of the staff at all levels.

It should be emphasized that the Centre's best strength is its skilled employees, their morale and interest must be protected judiciously against all odds. This will ensure an uninterrupted growth and development of the Centre. Moreover we are pleased to hear from the Director that the financial situation of the Centre is relatively better then it was previously .

I would therefore, strongly urge upon the Board and the management that the centre should target a defined time period to fulfill U.N 100% salary for its staffs.
However, the interest of the centre should also be considered while identifying the best possible way to resolve the salary gap.

2. Establishment of promotion criteria for non-scientific staff :

Introduction of the **scientific ranking system** has contributed much towards boosting up the morale of the scientific staff of the centre. But such system is yet to be introduced for non-scientific staff though these categories of staff of the centre work equally hard to perform their assigned duties and responsibilities with the entire satisfaction of their supervisors. There are many staff who have been working in the same Grade for years even for more than 25 years. These staff are so deprived and frustrated. The centre should establish some promotion criteria for this category of staff to encourage them. In view of the ongoing reclassification, we are pleased to see that this process has been started with

the new H.R. personnel but unfortunately the process has been slow and as yet unproductive.

Other pending issues :

There are some important and specific issue that have been brought repeatedly to the notice of the Board for many years now, but little has been done. They are briefly summarized below.

- Introduction of a uniform recruitment policy.
- Review of salary of national versus international staff.
- Review of working hours of employees in GS level I & II.
- Dependent facilities.
  (a) To increase the allowance .
  (b) Extension of age limit for dependent children up-to 25 years if study is not complete. (It may be mentioned that due to session jam in universities nowadays it tales about 25 years of age to complete the Masters degree)
- Increase of Annual Holidays from 11 to 14 days.
- Three months leave pay at the time of retirement.

It is good to hear that some of these issues are being considered by the current Head of Human Resources. However, we would solicit a fast action in these respects, since little major steps have been taken so far.

In conclusion, we believe that the relationship among SWA, BOT, and the management is becoming increasingly important, recognizable, and productive. We hope, this would continue in the future and lead to a highly productive centre with satisfied dedicated and committed staff.

Thank you.

G.H. Rabbani .MD, PhD, FACG

President, ICDDR, B Staff Welfare Association

4/BT/NOV 2001

FINANCE COMMITTEE

WELCOME TO FINANCE COMMITTEE

ICDDR,B: CENTRE FOR HEALTH & POPULATION RESEARCH

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

BOARD OF TRUSTEES MEETING
FINANCE COMMITTEE

November 03, 2001

ICDDR,B BOARD OF TRUSTEES MEETING

FINANCE COMMITTEE - NOVEMBER 03, 2001 MEETING

AGENDA

1. Approval of Agenda.

2. 2001 Forecast.

3. 2002 Budget

4. Staff Salaries and Allowances

   a) National
   b) International

5. Report on:
   a) Hospital Endowment Fund
   b) Centre Endowment Fund
   c) Reserve Fund
   d) Gates Foundation Award Reserve Fund
   e) Fixed Assets Acquisition and Replacement Fund
   f) Operating Fund

6. Miscellaneous.
   a) Bank Overdraft Facility / Line of Credit
   b) Exchange Rates
   c) Strategic Plan Issues

Attachments:

Table 1/1A. Contributions from Donors 1999 to 2002
Table 2. Income by Sources and Expenditure by Categories 1999 to 2002
Table 3. Unrestricted and Restricted Income and Expenditure 1999 to 2002
Table 4/4A . Donor Contributions by Unrestricted and Restricted Funds 1999 to 2002
Table 5. Unrestricted Program and Management Expenditure 1999 to 2002

Annexure –A Report of the Finance Committee of June 01, 2001

2001 FORECAST

INCOME

Donor and Endowment Funds Contributions (Tables 1 and 3 for summary and Tables 4 & 4A for individual donor amounts) which were budgeted at $14,501,000 are expected to decrease to $14,136,000. This decrease of $365,000 (2.5%) comprises:

	2001 BUDGET	2001 FORECAST	DIFF. INC/(DEC)
Restricted			
Projects/Programs	10,292,000	9,328,000	(964,000)
Fixed Assets	562,000	626,000	64,000
Endowment Funds	285,000	74,000	(211,000)
	11,139,000	10,028,000	(1,111,000)
Project Overhead	1,552,000	1,370,000	(182,000)
Total Restricted	12,691,000	11,398,000	(1,293,000)
Unrestricted	1,810,000	2,738,000	928,000
Total Contributions	14,501,000	14,136,000	(365,000)

Restricted Income will decrease in line with expenditures and are commented on under expenditures. The Forecast includes $74,000 from the Centre Endowment Fund.

Unrestricted Income is expected to increase by $928,000 (51.3%) primarily due to the increased contributions from Netherlands (from $191,000 to $1,004,000) and Swiss Development Co-operation (from $224,000 to $524,000). Former donor has agreed and latter donor has indicated to continue funding at the same level up to 2003.

The Budget includes $100,000 from UNICEF, a long standing donor to the Centre, which has not to date been confirmed, hence not considered in Forecast.

The Forecast income of $14,136,000 reflects an overall decrease of $365,000 (2.5%) over the budget $14,501,000.

2001 FORECAST

EXPENDITURE

Operating Expenditure (Tables 3 & 5) which was budgeted at $14,391,000 is forecast to decrease by $435,000 (3%) to $13,956,000. This decrease comprises:

	2001 BUDGET	2001 FORECAST	DIFF. INC/(DEC)
Restricted			
Projects/Programs	10,292,000	9,328,000	(964,000)
Fixed Assets	562,000	626,000	64,000
Endowment Funds	285,000	74,000	(211,000)
	11,139,000	10,028,000	(1,111,000)
Unrestricted			
Programs	1,679,000	2,216,000	537,000
Management	1,573,000	1,712,000	139,000
Total Unrestricted	3,252,000	3,928,000	676,000
Total Operating Expenditure	14,391,000	13,956,000	(435,000)

Restricted Expenditures are expected to decrease mainly due to change over of activities in projects funded by USAID/Dhaka and not implementation of further funding by EU.

Unrestricted Expenditures are expected to increase primarily due to not considering contributions from the Hospital Endowment Fund and adding expenses which fall back from funded activity of EU, salary increase, holding June BoT 2001 in Washington, funding capital expenditure for partial supporting to construction of PKSP building, laboratory equipment and renovation at Guest House, shifting and renovation of office space at the main building.

Depreciation which was budgeted at $880,000 is expected to increase by $80,000 (9.1%) to $960,000.

Total Expenditures including Depreciation was budgeted at $15,271,000 and is expected to decrease by $349,000 (2.3%) to $14,916,000.

BALANCE

The Net Operating Surplus excluding depreciation was budgeted at $110,000. This is expected to increase by $70,000 (63.6%) to $180,000.

Net Operating Deficit including depreciation was budgeted at $770,000. This is anticipated to increase by $10,000 (1.3%) to $780,000.

2002 BUDGET

INCOME

A revised set of tables including 2002 budget with its analysis will be sent separately.

2002 BUDGET

EXPENDITURE

A revised set of tables including 2002 budget with its analysis will be sent separately.

NATIONAL STAFF SALARIES AND ALLOWANCES

Materials for this Agenda item will be sent separately.

Agenda - 4 b)

INTERNATIONAL STAFF SALARIES AND ALLOWANCES

Materials for this Agenda item will be sent separately.

a). HOSPITAL ENDOWMENT FUND

	Market Value
Balance – January 01, 2001	$ 5,247,607
Earnings, net	22,975
Contributions	252,112
Withdrawals	-
Realized loss when transferred to TIAA-CREF on September 07, 2001	(419,394)
Unrealized gain	6,314
Balance September 30, 2001	$5,109,614

As of September 30, 2001 this fund was invested in the following :

TIAA-CREF money market	66.6%
AMEX- Singapore Time Deposit	26.6%
Bangladesh Government Debentures	4.3%
Equities and Debentures on Dhaka Stock Exchange	1.9%
Cash	0.6%

Management is recommending a withdrawal of up to $200,000 but not to exceed a maximum of 5% of the Fund balance as of December 31, 2001 for operating costs of the hospitals in 2002.

b). CENTRE ENDOWMENT FUND

	Market Value
Balance – January 01, 2001	$ 4,016,397
Contributions	-
Withdrawals	-
Realized loss when transferred to TIAA-CREF on 07 September 2001	(512,410)
Unrealized gain	6,511
Balance September 30, 2001	$3,510,498

This fund is invested with TIAA-CREF and currently held in money market account.

c). RESERVE FUND

	Market Value
Balance – January 01, 2001	$ 2,162,147
Interest Earnings average 4.6%	75,081
Withdrawals	-
Balance September 30, 2001	$2,237,228

The Fund is invested in time deposits at American Express Bank earning interest at short term investment yields which is currently 1.8% per annum. At this rate, the fund would earn approximately $36,000 in interest annually.

A minimum of $2,000,000 must remain in the Fund as security collateral for the overdraft line of credit facility with American Express Bank.

Management recommends that in the year 2001, the amount in excess of $2,000,000 be withdrawn from the Reserve Fund to further reduce the cumulative historical operating deficit.

d). GATES FOUNDATION AWARD RESERVE FUND

	Market Value
Balance – January 01, 2001	$ -
Award Contributions	1,000,000
Balance September 30, 2001	$1,000,000

The Fund is invested in short term time deposits and is projected to earn approximately $14,000 in 2001. These earnings will be transferred in 2001 to operating expenditures to partially offset the unbudgeted costs associated with receiving the award.

The matching contribution announced by the Government of Bangladesh is expected to be forthcoming in 2001.

The award monies are being held pending instruction and approval of the Board of Trustees.

e). FIXED ASSETS ACQUISITION AND REPLACEMENT FUND

Balance – January 01, 2001	$	78,107
Capital expenditures		40,559
Balance September 30, 2001	$	38,338
Projected additional expenditures in 2001		(38,338)
Projected balance – December 31, 2001	$	-

This fund was provided by the Government of Japan for the Matlab International Training Centre. The expenditures were used to establish system intranet communications between Matlab and the Centre in Dhaka.

f). OPERATING FUND

Balance (Deficit) January 01, 2001	$	(3,356,244)
Anticipated transfer from Reserve Fund		250,000
Projected Net Cash Surplus for 2001		180,000
Total Projected decrease in deficit		430,000
Projected Balance (Deficit)- December 31, 2001		(2,926,244)

With the projection, the cumulative deficit will have decreased by $995,162 (25%) from its peak of $3,921,406 at the end of 1998.

6. MISCELLANEOUS

a) BANK OVERDRAFT FACILITY / LINE OF CREDIT

The facility is authorized through July 13, 2002 and is expected to be renewed on an annual basis consistent with past practice.

Interest expense is projected to be approximately $5,000 or less for year 2001. This compares favorably to interest expense of $28,000 for year 2000. The decrease is due to lower interest rates this year and improved cash flow from a dvance funding.

b) EXCHANGE RATES

The local currency of Bangladesh was devalued by 4.8% in May 2001 resulting with significant foreign exchange gain to the Centre.

During 2001, the Centre incurred a significant impact in foreign currency exchange loss from funding provided by the European Unions. Such funding were required to be held in Euro currency which weakened against the dollar during 2001. The Centre offset this decline by adjusting the scope of projects.

c) STRATEGIC PLAN ISSUES:

1) Common Operating Costs
   - identify in all projects
   - indicate portions contributed by project
   - indicate portion contributed by core funds
   - allow tracking to inform core donors of projects funded by their contributions

2) MIS Review
   - test capabilities of finance MIS
   - identify capabilities of current system
   - identify improvement needed

3) Audit of indirect costs for USAID reimbursement
   - required periodically to maintain ongoing funding
   - will effect future funding of common operating costs

4) Service units on a business basis
   - identify service support units
   - develop business operating model
   - implement with specific support services e.g. transport pool, hospital lab.

TABLE - 1

ICDDR,B: CENTRE FOR HEALTH AND POPULATION RESEARCH

CONTRIBUTIONS FROM DONORS 1999 - 2002

(IN US$'000)

DONORS	1999 ACTUAL		2000 ACTUAL		2001 BUDGET		2001 FORECAST		2002 BUDGET	2002-STATUS FIRM	ESTI.
Revenue Contributions :											
AUSTRALIA - AusAID	209	1.6%	357	2.6%	274	1.9%	145	1.0%			
BANGLADESH	677	5.0%	497	3.6%	678	4.7%	782	5.5%			
BELGIUM - BADC/ BTC	210	1.6%	158	1.1%	169	1.2%	264	1.9%			
CANADA - CIDA	205	1.5%	204	1.5%	201	1.4%	192	1.4%			
EUROPEAN UNION	573	4.3%	910	6.6%	1,221	8.4%	769	5.4%			
FORD FOUNDATION	256	1.9%	309	2.2%	336	2.3%	290	2.1%			
JAPAN	658	4.9%	658	4.8%	820	5.7%	908	6.4%			
NETHERLANDS	237	1.8%	238	1.7%	193	1.3%	1,005	7.1%			
NORWAY - NORAD	113	0.8%	4	0.0%							
SWEDEN - SIDA	425	3.2%	444	3.2%	417	2.9%	453	3.2%			
SWITZERLAND - SDC	513	3.8%	836	6.0%	420	2.9%	762	5.4%			
SWISS RED CROSS	477	3.5%	243	1.8%	190	1.3%	173	1.2%			
UNICEF	136	1.0%	3	0.0%	106	0.7%	195	1.4%			
UNITED KINGDOM - DfID	596	4.4%	759	5.5%	753	5.2%	749	5.3%			
USAID/Dhaka	3,387	25.2%	2,762	20.0%	3,693	25.5%	2,148	15.2%			
USAID Washington	1,803	13.4%	2,192	15.8%	2,235	15.4%	2,292	16.0%			
USA - NIH	735	5.5%	888	6.4%	753	5.2%	744	5.1%			
USA - Other Sources	159	1.2%	185	1.3%	148	1.0%	158	0.9%			
WORLD BANK - NCOE	885	6.6%	973	7.0%	814	5.6%	758	5.4%			
WHO	128	1.0%	242	1.7%	167	1.2%	149	1.1%			
HOSPITAL ENDOWMENT FUND	200	1.5%	200	1.4%	200	1.4%					
CENTRE ENDOWMENT FUND			66	0.5%	85	0.6%	74	0.5%			
OTHERS	883	6.6%	702	5.1%	628	4.3%	1,126	8.0%			
GRAND TOTAL	**13,465**	**100.0%**	**13,830**	**100.0%**	**14,501**	**100.0%**	**14,136**	**100.0%**			

TABLE - 1 A

ICDDR,B: CENTRE FOR HEALTH AND POPULATION RESEARCH

CONTRIBUTIONS FROM DONORS 1999 - 2002

(IN US$'000)

	1999 ACTUAL		2000 ACTUAL		2001 BUDGET		2001 FORECAST		2002 BUDGET	2002-STATUS FIRM ESTI.
OTHERS :										
ARAB GULF FUND			(18)	-2.6%	(11)	-1.8%				
SAUDI ARABIA	9	0.1%	52	0.4%	50	0.3%	50	0.4%		
SRI LANKA	4	0.0%	4	0.0%			4			
ABT Associates	2	0.0%								
AMEX. FOUNDATION							10	0.1%		
BGS ARGOSS	6	0.0%	10	0.1%						
BDG/DGHS/ARI			3	0.0%						
CANADA/CHC-ASCON VI/IX			15	0.1%						
CDC - ATLANTA										
CIRCLE AROUND THE CENTRE							25	0.2%		
CYTOS PHARMACEUTICAL	33	0.2%	49	0.4%	23	0.2%	28	0.2%		
DUNCAN BROTHERS			10	0.1%			9	0.1%		
FUTURES GROUP	42	0.3%	67	0.5%	38	0.3%				
G. MASON FOUNDATION	8	0.1%			4	0.0%	7			
ICRW/USA : BRAC-ICDDR,B	47	0.3%								
IDRC	4	0.0%								
INT'L. ATOMIC ENERGY	3	0.0%								
INTL. VACCINE INSTT.(S.KOREA)							95	0.7%		
JAPAN - JICWELS	4	0.0%	50	0.4%	35	0.2%	78	0.6%		
JAPAN - EMBASSY							41	0.3%		
JAPAN - UNIVERSITY OF TOKYO							78	0.6%		
MACRO INTERNATIOAL INC.			(1)	0.0%						
MEDICAL RESEARCH COUNCIL	2	0.0%								
NEW ENGLAND MEDI. CENTRE	117	0.9%	66	0.5%	148	1.0%	120	0.8%		
NESTLE RES. FOUNDATION			20	0.1%	12	0.1%	30	0.2%		

TABLE - 1 A

ICDDR,B: CENTRE FOR HEALTH AND POPULATION RESEARCH

CONTRIBUTIONS FROM DONORS 1999 - 2002

(IN US$'000)

	1999 ACTUAL		2000 ACTUAL		2001 BUDGET		2001 FORECAST		2002 BUDGET	2002-STATUS FIRM	ESTI.
NORTHFIELD LABORATORIES	3	0.0%	18	0.1%	2	0.0%					
NOVARTIS	24	0.2%	12	0.1%	11	0.1%	31	0.2%			
NEWCASTLE UNIVERSITY	75	0.6%	63	0.5%	112	0.8%	87	0.6%			
PRAXIS			(4)	0.0%							
SAVE THE CHILDREN			(4)	0.0%							
PLAN INTERNATIONAL			13	0.1%							
PROCTOR & GAMBLE	1	0.0%	1	0.0%							
ROCKEFELLER FOUNDATION			6	0.0%			73	0.5%			
SAIDNET	5	0.0%									
SMITHKLINE BEECHAM			49	0.4%			85	0.6%			
THE INDEPTH NETWORK							14	0.1%			
THRASHER	20	0.1%	(51)	-0.4%			101	0.7%			
THRASHER (207731)	63	0.5%									
TOMEN CORPORATION					15	0.1%	29	0.2%			
UCB-OSMOTIC/SIDAC	48	0.4%	38	0.3%							
UNAIDS	59	0.4%	4	0.0%			10	0.1%			
UNIVERSITY OF BASEL											
UNIVERSITY OF PENNSYLVANIA	10	0.1%	12	0.1%	9	0.1%	10	0.1%			
UNOCAL			35	0.3%	50	0.3%	70	0.5%			
UFHP-633841	(8)	-0.1%									
DISASTER / EPIDEMIC :											
USAID/CARE	15	0.1%									
DfID-DHAKA	45	0.3%									
AusAID			13	0.1%							
UNOCAL, Cairn, Shell & OXY	169	1.3%	79	0.6%	116	0.8%	10	0.1%			
SDC	29	0.2%					7				
OTHERS (SS)	44	0.3%	91	0.7%	14	0.1%	24	0.2%			
TOTAL OTHERS	**883**	**6.6%**	**702**	**5.1%**	**628**	**4.3%**	**1,126**	**8.0%**			

TABLE - 2

ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH

INCOME BY SOURCES AND EXPENDITURE BY CATEGORIES - 1999 TO 2002

(IN US$'000)

	ACTUAL 1999		ACTUAL 2000		BUDGET 2001		FORECAST 2001		BUDGET 2002	INC/(DEC) BUDGET 2002 FORECAST 2001
INCOME:										
CONTRIBUTIONS BY DONORS										
UNRESTRICTED FUNDS	2,109	16%	1,732	13%	1,810	12%	2,738	19%		
RESTRICTED - OVERHEADS	1,441	11%	1,404	10%	1,552	11%	1,370	10%		
RESTRICTED - PROJECTS / PROGRAMS	9,915	73%	10,694	77%	11,139	77%	10,028	71%		
TOTAL DONOR INCOME	**13,465**	**100%**	**13,830**	**100%**	**14,501**	**100%**	**14,136**	**100%**		
EXPENDITURE:										
LOCAL SALARIES \ WAGES	5,971	45%	6,166	45%	6,472	44%	6,766	49%		
INTERNATIONAL SALARIES	1,953	15%	2,451	18%	2,900	20%	2,231	16%		
CONSULTANTS	162	1%	323	2%	278	2%	256	2%		
MANDATORY COMMITTEES	95	1%	81	1%	104	1%	143	1%		
TRAVEL	489	4%	583	4%	670	5%	607	4%		
SUPPLIES AND MATERIALS	1,503	11%	1,890	14%	1,975	14%	1,851	13%		
REPAIR AND MAINTENANCE	122	1%	199	1%	141	1%	182	1%		
RENT, COMMUNICATION AND UTILITIES	460	3%	454	3%	445	3%	440	3%		
PRINTING AND PUBLICATION	421	3%	270	2%	282	2%	266	2%		
TRAINING AND FELLOWSHIP	268	2%	224	2%	230	2%	181	1%		
STAFF DEVELOPMENT	135	1%	143	1%	119	1%	125	1%		
VOLUNTARY SEVERANCE PROGRAM	288	2%	288	2%						
OTHER EXPENSES	903	7%	869	6%	903	6%	770	6%		
OTHER RECEIPTS	(778)	-6%	(833)	-6%	(765)	-5%	(706)	-5%		
TOTAL INTERNAL CASH EXPENDITURE	11,992	90%	13,108	95%	13,754	96%	13,112	94%		
DONOR CAPITAL EXPENDITURE	1,271	10%	659	5%	637	4%	844	6%		
TOTAL OPERATING CASH EXPENDITURE	**13,263**	**100%**	**13,767**	**100%**	**14,391**	**100%**	**13,956**	**100%**		
NET CASH SURPLUS/(DEFICIT)	**202**		**63**		**110**		**180**			
DEPRECIATION	899		920		880		960			
NET OPERATING SURPLUS/(DEFICIT)	**(697)**		**(857)**		**(770)**		**(780)**			

Note: Where necessary 1999 to 2000 figures have been regrouped to conform with 2001 forecast and 2002 budget preparation.

TABLE - 3

ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH

UNRESTRICTED AND RESTRICTED INCOME AND EXPENDITURE 1999 TO 2002

(IN US$'000)

	ACTUAL 1999			ACTUAL 2000			BUDGET 2001			FORECAST 2001			BUDGET 2002		
	UNRESTR.	RESTRI.	TOTAL	UNRESTR.	RESTRI.	TOTAL	UNRESTR.	RESTRI.	TOTAL	UNRESTR.	RESTRI.	TOTAL	UNRESTR.	RESTRI.	TOTAL
INCOME:															
CONTRIBUTIONS BY DONORS:															
UNRESTRICTED FUNDS	2,109		2,109	1,732		1,732	1,810		1,810	2,738		2,738			
RESTRICTED - OVERHEADS	1,441		1,441	1,404		1,404	1,552		1,552	1,370		1,370			
RESTRICTED - PROJECTS / PROGRAMS		9,915	9,915		10,694	10,694		11,139	11,139		10,028	10,028			
TOTAL INCOME	**3,550**	**9,915**	**13,465**	**3,136**	**10,694**	**13,830**	**3,362**	**11,139**	**14,501**	**4,108**	**10,028**	**14,136**			
EXPENDITURE:															
LOCAL SALARIES \ WAGES	2,145	3,826	5,971	1,795	4,371	6,166	2,076	4,396	6,472	2,354	4,412	6,766			
INTERNATIONAL SALARIES	772	1,181	1,953	927	1,524	2,451	1,165	1,735	2,900	1,150	1,081	2,231			
CONSULTANTS	2	160	162	45	278	323	11	267	278	12	244	256			
MANDATORY COMMITTEES	92	3	95	81		81	104		104	143		143			
TRAVEL	58	431	489	28	555	583	38	632	670	44	563	607			
SUPPLIES AND MATERIALS	621	882	1,503	732	1,158	1,890	672	1,303	1,975	729	1,122	1,851			
REPAIR AND MAINTENANCE	56	66	122	48	151	199	31	110	141	75	107	182			
RENT, COMMUNICATION AND UTILITIES	217	243	460	220	234	454	238	207	445	273	167	440			
PRINTING AND PUBLICATION	138	283	421	132	138	270	145	137	282	170	96	266			
TRAINING AND FELLOWSHIP	18	250	268	20	204	224	10	220	230	8	173	181			
STAFF DEVELOPMENT		135	135		143	143	1	118	119	51	74	125			
VOLUNTARY SEVERANCE PROGRAM	288		288	288		288									
OTHER EXPENSES	315	588	903	309	560	869	285	618	903	198	572	770			
INTERDEPARTMENTAL SERVICES	(679)	679		(773)	773		(851)	851		(801)	801				
OTHER RECEIPTS	(756)	(22)	(778)	(827)	(6)	(833)	(748)	(17)	(765)	(696)	(10)	(706)			
TOTAL INTERNAL CASH EXPENDITURE	3,287	8,705	11,992	3,025	10,083	13,108	3,177	10,577	13,754	3,710	9,402	13,112			
DONOR CAPITAL EXPENDITURE	61	1,210	1,271	48	611	659	75	562	637	218	626	844			
TOTAL OPERATING CASH EXPENDITURE	**3,348**	**9,915**	**13,263**	**3,073**	**10,694**	**13,767**	**3,252**	**11,139**	**14,391**	**3,928**	**10,028**	**13,956**			
NET CASH SURPLUS/(DEFICIT)	**202**		**202**	**63**		**63**	**110**		**110**	**180**		**180**			
DEPRECIATION	899	0	899	920	0	920	880		880	960		960			
NET OPERATING SURPLUS/(DEFICIT)	**(697)**	**(0)**	**(697)**	**(857)**	**(0)**	**(857)**	**(770)**		**(770)**	**(780)**		**(780)**			

Note: Where necessary 1999 to 2000 figures have been regrouped to conform with 2001 forecast and 2002 budget preparation.

TABLE - 4

ICDDR,B: CENTRE FOR HEALTH AND POPULATION RESEARCH

MAJOR DONOR CONTRIBUTIONS BY UNRESTRICTED AND RESTRICTED FUNDS 1999 - 2002

(IN US$'000)

	1999 - ACTUAL		2000 - ACTUAL				2001 - BUDGET				2001 - FORECAST				2002 - BUDGET				2002 - STATUS	
	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	FIRM	ESTIM.
UNRESTRICTED FUNDS:																				
AUSTRALIA - AusAID	209	1.6%	297		297	2.1%	274		274	1.9%	145		145	1.0%						
BANGLADESH	384	2.9%	191		191	1.4%	186		186	1.3%	186		186	1.3%						
BELGIUM - BADC / BTC	66	0.5%	(11)		(11)	-0.1%	63		63	0.4%	65		65	0.5%						
CANADA - CIDA	205	1.5%	204		204	1.5%	201		201	1.4%	192		192	1.4%						
NETHERLANDS	232	1.7%	214		214	1.5%	191		191	1.3%	1,004		1,004	7.1%						
SWEDEN - SIDA	301	2.2%	272		272	2.0%	257		257	1.8%	230		230	1.6%						
SWITZERLAND - SDC	324	2.4%	252		252	1.8%	224		224	1.5%	524		524	3.7%						
UNITED STATES - USAID	275	2.0%	275		275	2.0%	275		275	1.9%	338		338	2.4%						
UNICEF	100	0.7%					100		100	0.7%										
OTHERS	13	0.1%	38		38	0.3%	39		39	0.3%	54		54	0.4%						
TOTAL UNRESTRICTED	2,109	15.7%	1,732		1,732	12.5%	1,810		1,810	12.5%	2,738		2,738	19.4%						
RESTRICTED PROJECTS/PROGRAMS FUNDS:																				
AUSTRALIA - AusAID			3	57	60	0.4%														
BANGLADESH	293	2.2%	35	271	306	2.2%	68	424	492	3.4%	80	516	596	4.2%						
BELGIUM - BADC/ BTC	144	1.1%		169	169	1.2%		106	106	0.7%		199	199	1.4%						
EUROPEAN UNION - BHARP	573	4.3%		910	910	6.6%		1,221	1,221	8.4%		769	769	5.4%						
FORD FOUNDATION	256	1.9%	37	272	309	2.2%	44	292	336	2.3%	38	252	290	2.1%						
JAPAN	580	4.3%	54	560	614	4.4%	80	740	820	5.7%	102	754	856	6.1%						
NETHERLANDS	5	0.0%	5	19	24	0.2%		2	2	0.0%		1	1	0.0%						
NORWAY - NORAD	113	0.8%		4	4	0.0%														
SWEDEN - SIDA/SAREC	124	0.9%	15	157	172	1.2%	13	147	160	1.1%	28	195	223	1.6%						
SWITZERLAND - SDC	189	1.4%	57	527	584	4.2%	24	172	196	1.4%	20	218	238	1.7%						
SWISS RED CROSS	477	3.5%	32	211	243	1.8%	25	165	190	1.3%	23	150	173	1.2%						
UNITED KINGDOM - DfID	596	4.4%	96	663	759	5.5%	93	660	753	5.2%	90	659	749	5.3%						
UNDP - Japan	78	0.6%	(5)	49	44	0.3%						52	52	0.4%						
UNICEF	36	0.3%		3	3	0.0%		6	6	0.0%	17	178	195	1.4%						
USAID/Dhaka	3,387	25.2%	503	2,259	2,762	20.0%	653	3,040	3,693	25.5%	374	1,774	2,148	15.2%						
USAID/Washington	1,528	11.3%	348	1,569	1,917	13.9%	362	1,598	1,960	13.5%	369	1,585	1,954	13.8%						
USA - NIH	735	5.5%	3	885	888	6.4%	1	752	753	5.2%	1	743	744	5.3%						
USA - Other Sources	159	1.2%	27	158	185	1.3%	8	140	148	1.0%	19	139	158	1.1%						
WORLD BANK - NCoE	885	6.6%	127	846	973	7.0%	106	708	814	5.6%	99	659	758	5.4%						
WHO	128	1.0%	(1)	243	242	1.7%		167	167	1.2%	1	148	149	1.1%						
HOSPITAL ENDOWMENT FUND	200	1.5%		200	200	1.4%		200	200	1.4%										
CENTRE ENDOWMENT FUND				66	66	0.5%		85	85	0.6%		74	74	0.5%						
OTHERS	870	6.5%	68	596	664	4.8%	75	514	589	4.1%	109	963	1,072	7.6%						
TOTAL RESTRICTED	11,356	84.3%	1,404	10,694	12,098	87.5%	1,552	11,139	12,691	87.5%	1,370	10,028	11,398	80.6%						
GRAND TOTAL	13,465	100%	3,136	10,694	13,830	100%	3,362	11,139	14,501	100%	4,108	10,028	14,136	100%						

Note: Where necessary 1999 to 2000 figures have been regrouped to conform with 2001 forecast and 2002 budget preparation.

TABLE - 4 A

ICDDR,B - CENTRE FOR HEALTH AND POPULATION RESEARCH

MAJOR DONOR CONTRIBUTIONS BY UNRESTRICTED AND RESTRICTED FUNDS 1999 - 2002

(IN US$'000)

	1999 - ACTUAL		2000 - ACTUAL				2001 - BUDGET				2001 - FORECAST				2002 - BUDGEET				2002 - STATUS	
	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	FIRM	ESTIM.
UNRESTRICTED FUNDS: - OTHERS																				
ARAB GULF FUND			(18)		(18)	-0.1%	(11)		(11)	-0.1%										
SAUDI ARABIA	9	0.1%	52		52	0.4%	50		50	0.3%	50		50	0.5%						
SRI LANKA	4	0.0%	4		4	0.0%	-				4		4	0.0%						
TOTAL UNRESTRICTED - OTHERS	13	0.1%	38		38	0.3%	39		39	0.3%	54		54	0.4%						
RESTRICTED FUNDS:																				
UNITED KINGDOM - DfID:																				
- DfID / T.Well / HIV	52	0.4%	40	128	168	1.2%	37	131	168	1.2%	28	89	117	0.8%						
- DfID / HE	188	1.4%	11	83	94	0.7%	11	75	86	0.6%	18	130	148	1.0%						
- DfID / Interim fund for HDSP/DSS	38	0.3%																		
- DfID / Modernization of Matlab DSS	318	2.4%	45	452	497	3.6%	45	454	499	3.4%	44	440	484	3.4%						
Sub-total	596	4.4%	96	663	759	5.5%	93	660	753	5.2%	90	659	749	5.3%						
UNITED STATES:																				
- USAID/Dhaka																				
- ORP/FHRP	3,228	24.0%	503	2,025	2,528	18.3%	653	2,775	3,428	23.6%	374	1,545	1,919	13.6%						
- JSI	159	1.2%		234	234	1.7%		265	265	1.8%		229	229	1.6%						
Sub-total	3,387	25.2%	503	2,259	2,762	20.0%	653	3,040	3,693	25.5%	374	1,774	2,148	15.2%						
- USAID/Washington																				
- Research and Others	1,257	9.3%	328	1,490	1,818	13.1%	323	1,444	1,767	12.2%	331	1,431	1,762	12.5%						
- Nepal	150	1.1%	20	79	99	0.7%	39	154	193	1.3%	38	154	192	1.4%						
- HKI	121	0.9%																		
Sub-total	1,528	11.3%	348	1,569	1,917	13.8%	362	1,598	1,960	13.5%	369	1,585	1,954	13.8%						
- USA - NIH																				
- NIH-Surveillance	436	3.2%		542	542	3.9%		406	406	2.8%		391	391	2.8%						
- UMBI				176	176	1.3%		272	272	1.9%		142	142	1.0%						
- GEN.HOSPITAL - MGH				6	6	0.0%						122	122	0.9%						
- NIH/RAND CORPORATION	165	1.2%		24	24	0.2%														
- STANDFORD UNIVERSITY												11	11	0.1%						
- UC - Davis	65	0.5%	6	49	55	0.4%	1	8	9	0.1%	1	8	9	0.1%						
- UNIVERSITY OF ALABAMA	7	0.1%		5	5	0.0%		2	2	0.0%		2	2	0.0%						
- UNIVERSITY OF VIRGINIA	62	0.5%	(3)	83	80	0.6%		64	64	0.4%		67	67	0.5%						
Sub-total	735	5.5%	3	885	888	6.4%	1	752	753	5.2%	1	743	744	5.3%						
- US other Sources:																				
- OMNI-HNI,HMMI				3	3	0.0%	4	42	46	0.3%	5	44	49	0.3%						
- OFDA	33	0.2%		43	43	0.3%		83	83	0.6%		37	37	0.3%						
- JHU	126	0.9%	27	112	139	1.0%	4	15	19	0.1%	14	58	72	0.5%						
Sub-total	159	1.2%	27	158	185	1.3%	8	140	148	1.0%	19	139	158	1.1%						
RESTRICTED FUNDS: - OTHERS																				
ABT Associates	2	0.0%																		
AMEX. FOUNDATION											2	8	10	0.1%						
BGS ARGOSS	6	0.0%	2	8	10	0.1%														
BDG/DGHS/ARI				3	3	0.0%														
CANADA/CHC-ASCON VI/IX				15	15	0.1%														
CDC - ATLANTA																				
CIRCLE AROUND THE CENTRE												25	25	0.2%						
CYTOS PHARMACEUTICAL	33	0.2%		49	49	0.4%		23	23	0.2%		28	28	0.2%						

TABLE - 4 A

ICDDR,B - CENTRE FOR HEALTH AND POPULATION RESEARCH

MAJOR DONOR CONTRIBUTIONS BY UNRESTRICTED AND RESTRICTED FUNDS 1999 - 2002

(IN US$'000)

	1999 - ACTUAL		2000 - ACTUAL				2001 - BUDGET				2001 - FORECAST				2002 - BUDGEET				2002 - STATUS	
	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	FIRM	ESTIM.
DUNCAN BROTHERS			2	8	10	0.1%					2	7	9	0.1%						
FUTURES GROUP	42	0.3%	12	55	67	0.5%	8	30	38	0.3%										
G. MASON FOUNDATION	8	0.1%						4	4	0.0%		7	7	0.0%						
ICRW/USA : BRAC-ICDDR,B	47	0.3%																		
IDRC	4	0.0%																		
INT'L. ATOMIC ENERGY	3	0.0%																		
INTL. VACCINE INSTT.(S.KOREA)											10	85	95	0.7%						
JAPAN - JICWELS	4	0.0%		50	50	0.4%		35	35	0.2%		78	78	0.6%						
JAPAN - EMBASSY											8	33	41	0.3%						
JAPAN - UNIVERSITY OF TOKYO												78	78	0.6%						
MACRO INTERNATIOAL INC.				(1)	(1)	0.0%														
MEDICAL RESEARCH COUNCIL	2	0.0%																		
NEW ENGLAND MEDI. CENTRE	117	0.9%	16	50	66	0.5%	35	113	148	1.0%	28	92	120	0.8%						
NESTLE RES. FOUNDATION				20	20	0.1%		12	12	0.1%		30	30	0.2%						
NORTHFIELD LABORATORIES	3	0.0%	4	14	18	0.1%		2	2	0.0%										
NOVARTIS	24	0.2%	3	9	12	0.1%	3	8	11	0.1%	7	24	31	0.2%						
NEWCASTLE UNIVERSITY	75	0.6%	15	48	63	0.5%	26	86	112	0.8%	20	67	87	0.6%						
PRAXIS				(4)	(4)	0.0%														
SAVE THE CHILDREN				(4)	(4)	0.0%														
PLAN INTERNATIONAL				13	13	0.1%														
PROCTOR & GAMBLE	1	0.0%		1	1	0.0%														
ROCKEFELLER FOUNDATION				6	6	0.0%					3	70	73	0.5%						
SAIDNET	5	0.0%																		
SMITHKLINE BEECHAM			10	39	49	0.4%					17	68	85	0.6%						
THE INDEPTH NETWORK												14	14	0.1%						
THRASHER	20	0.1%	(3)	(48)	(51)	-0.4%					6	95	101	0.7%						
THRASHER (207731)	63	0.5%																		
TOMEN CORPORATION							3	12	15	0.1%	6	23	29	0.2%						
UCB-OSMOTIC/SIDAC	48	0.4%	7	31	38	0.3%														
UNAIDS	59	0.4%		4	4	0.0%						10	10	0.1%						
UNIVERSITY OF BASEL																				
UNIVERSITY OF PENNSYLVANIA	10	0.1%		12	12	0.1%		9	9	0.1%		10	10	0.1%						
UNOCAL				35	35	0.3%		50	50	0.3%		70	70	0.5%						
UFHP-633841	(8)	-0.1%																		
DISASTER / EPIDEMIC :																				
USAID/CARE	15	0.1%																		
DfID-DHAKA	45	0.3%																		
AusAID				13	13	0.1%														
UNOCAL, Ca.m, Shell & OXY	169	1.3%		79	79	0.6%		116	116	0.8%		10	10	0.1%						
SDC	29	0.2%						-				7	7	0.0%						
OTHERS (SS)	44	0.3%		91	91	0.7%		14	14	0.1%		24	24	0.2%						
TOTAL RESTRICTED - OTHER	870	6.5%	68	596	664	4.8%	75	514	589	4.1%	109	963	1,072	7.6%						

TABLE - 5

ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH

UNRESTRICTED PROGRAM AND MANAGEMENT EXPENDITURE 1999 TO 2002

(IN US$ '000)

	ACTUAL 1999		ACTUAL 2000				BUDGET 2001				FORECAST 2001				BUDGET 2002			
	NET COSTS	%	GROSS COSTS	RECOVERY	NET COSTS	%	GROSS COSTS	RECOVERY	NET COSTS	%	GROSS COSTS	RECOVERY	NET COSTS	%	GROSS COSTS	RECOVERY	NET COSTS	%
PROGRAMS																		
CLINICAL SCIENCES:																		
DHAKA HOSPITAL	656	4.9%	1,223	(622)	601	4.4%	879	(104)	775	5.4%	1,413	(434)	979	7.0%				
DIVISIONAL	87	0.7%	140	(44)	96	0.7%	266	(140)	126	0.9%	87	(46)	41	0.3%				
PUBLIC HEALTH SCIENCES:																		
MATLAB CLINICAL RESEARCH	272	2.1%	334	(140)	194	1.4%	377	(142)	235	1.6%	378	(138)	240	1.7%				
MATLAB ADMINISTRATION	184	1.4%	331	(128)	203	1.5%	314	(139)	175	1.2%	307	(116)	191	1.4%				
MATLAB COMMUNITY RESEARCH	129	1.0%	95	(1)	94	0.7%	91		91	0.6%	152		152	1.1%				
DIVISIONAL	145	1.1%	173		173	1.3%	67		67	0.5%	286		286	2.0%				
HEALTH & DEMOGRAPHIC SURVEILL.	118	0.9%	43		43	0.3%	13		13	0.1%	69		69	0.5%				
LABORATORY SCIENCES:																		
LABORATORY SERVICES	(185)	-1.4%	1,010	(1,189)	(179)	-1.3%	1,077	(1,218)	(141)	-1.0%	967	(1,127)	(160)	-1.1%				
DIVISIONAL	86	0.6%	120	(120)			130	(120)	10	0.1%	120	(120)						
HEALTH & POPULATION EXTENSION:/HSRD																		
DIVISIONAL	98	0.7%									65		65	0.5%				
INFORMATION SCIENCES:																		
DISC	167	1.3%	206	(25)	181	1.3%	288	(39)	249	1.7%	292	(23)	269	1.9%				
TRAINING & DISSEMINATION	7	0.1%	147	(137)	10	0.1%	183	(188)	(5)	0.0%	175	(152)	23	0.2%				
COMPUTER SERVICES	42	0.3%	94	(76)	18	0.1%	147	(63)	84	0.6%	156	(95)	61	0.4%				
TOTAL PROGRAMS	1,806	13.6%	3,916	(2,482)	1,434	10.4%	3,832	(2,153)	1,679	11.7%	4,467	(2,251)	2,216	15.9%				
MANAGEMENT																		
DIRECTOR'S BUREAU	176	1.3%	336		336	2.4%	336		336	2.3%	282		282	2.0%				
EXTERNAL RELATIONS & INSTI.. DEV.	67	0.5%	75		75	0.5%	156		156	1.1%	85		85	0.6%				
POLICY AND PLANNING			37		37	0.3%	135		135	0.9%	149		149	1.1%				
BOT & COMMITTEES	110	0.8%	100		100	0.7%	127		127	0.9%	157		157	1.1%				
ADMINISTRATION & PERSONNEL	486	3.7%	856	(336)	520	3.8%	837	(341)	496	3.4%	909	(312)	597	4.3%				
FINANCE	303	2.3%	334	(15)	319	2.3%	348	(4)	344	2.4%	387	(38)	349	2.5%				
VOLUNTARY SEVERANCE PACKAGE	288	2.2%	288		288	2.1%												
OTHER	112	0.8%	302	(338)	(36)	-0.3%	264	(285)	(21)	-0.1%	326	(233)	93	0.7%				
TOTAL MANAGEMENT	1,542	11.6%	2,328	(689)	1,639	11.9%	2,203	(630)	1,573	10.9%	2,295	(583)	1,712	12.3%				
TOTAL PROGRAMS AND MANAGEMENT	3,348	25.2%	6,244	(3,171)	3,073	22.3%	6,035	(2,783)	3,252	22.6%	6,762	(2,834)	3,928	28.1%				
UNRESTRICTED FUNDS	3,348	25.2%			3,073	22.3%			3,252	22.6%			3,928	28.1%				
RESTRICTED FUNDS	9,915	74.8%			10,694	77.7%			11,139	77.4%			10,028	71.9%				
TOTAL	13,263	100%			13,767	100%			14,391	100%			13,956	100%				

Note: Where necessary 1999 to 2000 figures have been regrouped to conform with 2001 forecast and 2002 budget preparation.

Minutes of the Finance Committee
1 June 2001pm

PRESENT:

Prof Marian Jacobs	Chair of the Board
Prof Rita Colwell	Chair, Finance Committee
Dr David Sack	Director
Prof Peter McDonald	
Dr Tawfik A M Khoja	
Dr Tikki Pang	
Prof A K Azad Khan	
Mr Rolf Carriere	
Dr Marcel Tanner	
Prof N K Ganguly	
Prof Jane A Kusin	
Dr Claudio Lanata	

Absent (with regrets)

Prof Carol Vlassoff
Dr Masihur Rahman
Mr Mohammad Moniurazzaman
Dr Nobukatsu Ishikawa

Invited: Associate and Acting Associate Directors, Head HR, CFO, Ag CFO, Mrs. Vanessa Brooks, Dr. Ishtiaque Zaman.

Minute Secretary: Mrs. Judith Bennett Henry

The agenda was approved.

Prof Rita Colwell opened the Finance Committee meeting. She noted that the Centre was being well managed over the past year as the cumulative deficit was being consistently reduced. The budget was balanced with a very slight balance. She further noted that the Centre would be very strong if some way could be found to significantly reduce or eliminate the deficit. On the upswing, due to good management and the ongoing down-sizing exercise, the Centre's financial planning would be completed this year.

She welcomed Mr Stephen Sage as the new CFO who will be taking up his position in August and commended Mrs Shamima Moin for the capable way in which she assumed the role of Ag CFO following the departure of Mr John Winkelmann.

Appointment of Auditors for 2001:

The Centre currently uses the firms of Price Waterhouse, Calcutta and Hoda Vasi Chowdhury & Co Dhaka as the Centre's auditors. The auditors have served the Centre for 5 years and 2 years respectively. The Centre practice is that auditors are retained for 5-7 years for continuity in the audits and to minimize audit costs. The Centre Management is requesting Board approval to reappointment both firms for the year 2001. Further, it recommends that the audit fees do not exceed the amount of US$15,500.

Discussion:

It was discussed that it was important to change auditors after 5 or 6 years to avoid lethargy and loss of committed interest in the Centre's concerns. It was suggested that on changing the auditors in the future, the Centre bids out for auditing firms. For the present, it was agreed that with the arrival of a new CFO, it was important to retain the existing firms to ensure continuity.

The point was put forward that the auditing firms should be asked to take a more analytical approach from its traditional "numbers" approach. It was further suggested that the auditors establish a risk management framework and draw up an annual audit plan. It was agreed that the Financial Plan should include a Business Plan which would serve to engender confidence in donors.

Hospital Endowment Fund:

Prof Colwell reported that Dr W B Greenough III would join the meeting during the discussion on the Strategic Plan to give a short report on the investment of the Hospital Endowment Fund.

At end 2000, the balance of the HEF was US$5,246,080. The Fund was given a boost by the contribution by the Govt of Japan of US$1m and US$45,000 plus from other donations and fundraising activities. During 2000, US$200,000 was withdrawn from the Fund to pay for the Hospital's operating costs.

Centre's Endowment Fund:

As at December 2000, the Centre's Endowment Fund including USAID Endowment Fund stood at US$3,926,617. The entire Fund is currently invested with Morgan Stanley's Total Fund Management Portfolio and monitored by the Centre Fund Finance Committee. No contributions in 2000 but a withdrawal of US$140,000 approved by the Board was expended for developing research programmes and fundraising activities (US$66,000); the remaining amount of US$47,000 will be used during 2001.

Reserve Fund:

As at end December 2000, the Fund stood at US$2,167,147 – interest accrued was US$102,296. The Fund is held at the American Express Bank to cover the Centre's overdraft. In 1999, the Board approved the transfer of US$300,000 to the Centre's Operating Fund in January 2000 to reduce the cumulative operating deficit. A transfer of US$100,000 was approved by the Board in 2001 to further reduce the aforementioned deficit.

Fixed Assets Acquisition and Replacement Fund:

As at end December 2001, the Fund balance of US$78,107 was contributed by the Japanese govt for the Matlab International Training Centre for the installation of a communication link between Matlab and Dhaka.

Bank Overdraft:

The Centre's current overdraft facility of US$2m with the AmexBank is due to expire on 13 July 2001. Due to the Centre's large cumulative deficit, there is an ongoing overdraft requirement to cover operating costs. The management is requesting Board approval to renew the overdraft facility to 13 July 2002.

Mrs. Shamima Moin presented the tables detailing the 2001 budget.

Prof Colwell thanked Mrs. Moin and declared the Finance Committee meeting closed.

Resolutions of the Finance Committee

The Committee resolved to present the following draft resolutions to the Board for its approval:

1/BT/JUNE/01

The Board accepts the Audited Financial Statements of the Centre for the year ended December 31 2001.

2/BT/JUNE/01

The Board appoints Hoda Vasi Chowdhury & Co Dhaka and Price Waterhouse, Calcutta, as joint auditors for the year 2001 at a fee not to exceed US$15,500.

3/BT/JUNE/01

The Board authorizes the continuation of the overdraft facility of up to US$2 million with the American Express Bank for the year to July 13 2002.

4/BT/JUNE/01

The Board recommends to management that future surpluses be used, as much as possible, to retire the cumulative deficit.

5/BT/NOV 2001

PERSONNEL AND SELECTION COMMITTEE

BOARD OF TRUSTEES MEETING
November 2001

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

PERSONNEL AND SELECTION COMMITTEE MEETING

PERSONNEL AND SELECTION COMMITTEE MEETING
Saturday, 3 November 2001

Agenda

1. Approval of agenda

2. Approval of the minutes of June 2001 meeting

3. Staffing:

   3.1 Overview of the staffing status and total numbers by categories

   3.2 Status of recruitment of international professional staff:

   a. Associate Director, D1, Laboratory Sciences Division
   b. Associate Director, D1, Clinical Sciences Division

   3.3 Renewal of contract

   a. Associate Director, D1, Policy & Planning
   b. Head, Health & Demographic Surveillance Programme, P5, PHSD

   3.4 Information on new international professional staff

   a. Head, Information Sciences, P5, Information Sciences Division
   b. Chief Finance Officer, P5, Director's Division

   3.5 Status of seconded staff contracts

   a. Director, ADG
   b. Senior Scientist, P5, Laboratory Sciences Division
   c. Medical Epidemiologist & Acting Head, Health Systems Research Division, P5
   d. Demographic Researcher, HDSP, P4, Public Health Sciences Division
   e. Scientist, ECPP, P4, Public Health Sciences Division

   3.6 Information on new seconded and adjunct staff

   a. Scientist, P4, Public Health Sciences Division

   3.7 Completion of tenure at international professional post

   a. Epidemiologist and Head, ECPP, P4, Public Health Sciences Division
   b. Senior Scientist, P5, Public Health Sciences Division

   3.8 Establishment of new international professional posts

   a. Head, Nutrition Research Programme, P4/P5, Clinical Sciences Division
   b. Programme Officer, ER&ID, P2, Director's Division

   3.9 List of established international professional posts

4. Staff salaries

   4.1 International professional category
   4.2 NO & GS categories

5. Selection of members of the Board of Trustees

6. Any other business

   6.1 International Promotion Applications
   6.2 Scientific Promotions Update
   6.3 Update on ongoing HR agenda
   6.4 Revision of Staff Rules

Minutes of the Personnel and Selection Committee
1 June 2001pm

PRESENT:		**Absent (with regrets)**
Prof Marian Jacobs	Chair of the Board	Prof Carol Vlassoff
Mr Rolf Carriere	Chair, Personnel & Selection Committee	Dr Masihur Rahman
Dr David Sack	Director	Mr Mohammad Moniurazzaman
Prof Rita Colwell		Dr Nobukatsu Ishikawa
Dr Tawfik A M Khoja		
Dr Tikki Pang		
Prof A K Azad Khan		
Prof Peter McDonald		
Dr Marcel Tanner		
Prof N K Ganguly		
Prof Jane A Kusin		
Dr Claudio Lanata		

Invited: Associate and Acting Associate Directors, Head HR, CFO, Ag CFO, Mrs Vanessa Brooks, Dr Ishtiaque Zaman.

Minute Secretary: Mrs Judith Bennett Henry

Mr Rolf Carriere opened the P&S Committee meeting and requested Head HR to make the presentation.

Mrs Diann Hill presented an overview of the staffing status. She reported that during the reporting period 1 Oct 2001 to 31 March 2001, there were 28 separations and 188 additions, the significant increase as a result of the conversion of 117 community health workers (CHWs) in Matlab to regular staff. The total number of staff of all categories increased by 160, 117 (73%) of which were CHW conversions to fixed-term positions; 43 (27%) for project positions. The Centre continues the policy of restricting external recruitment of fixed-term staff.

Recruitment of international professional staff:
Chief Finance Officer: Mr Stephen Sage was selected as the CFO at P5 Level in the Director's Division to replace Mr John Winkelmann who completed his contract with the Centre on 31 May 2001. Mr Sage will join the Centre in August and Mrs Shamima Moin will continue as Ag CFO until his arrival.

Head, Information Sciences: Mr Peter Thorpe was selected as Head, ISD at P5 Level in the Director's Division. He is expected to join the Centre in August 2001.

Associate Director: Two (2) candidates have been shortlisted for the post at D1 Level in the Laboratory Sciences Division: Dr Antoine Andremont and Dr Andre Weintraub. Dr Andremont visited the Centre in May for his interviews and gave a presentation to the CAD. Dr Weintraub is expected to visit the Centre for the same purpose in late June. A decision will be made following his visit. Meanwhile, Dr Balakrish Nair has assumed the role of Ag Associate Director, LSD.

Associate Director: The search continues for candidates for the post at D1 Level in the Clinical Sciences Division. Prof Fuchs completes his contract following this June BOT meeting. Dr Abdus Salam will take up the role of Ag Associate Director until a suitable person is selected.

Renewal of Contract:
The contract of Prof Lars Ake Persson is up for renewal in February 2002. The Centre is recommending that the Board approve the extension of Prof Persson's contract for another term of three (3) years effective 1 March 2002.

The contract of Dr Abbas U Bhuiya will expire on 31 December 2001 following service of 7.5 years as an international scientist. The Centre is recommending that the Board approve the extension of Dr Bhuiya's contract under the Bangladeshi Scientists to International Level Policy.

New international professional staff:
Dr Shams El Arifeen, a national of Bangladesh, was selected for the post of Epidemiologist and Head, Child Health Programme at P3 Level in the Public Health Sciences Division. He replaces Dr Abdullah Baqui who left the Centre to take up a post with the Johns Hopkins University School of Public Health.

New seconded staff:
Dr Greet Dieltiens, a Belgian national, joined the Centre on 9 January 2001 as a Technical Advisor in the Reproductive Health Programme in PHSD. This appointment is under the collaborative agreement between the Belgian Technical Cooperation (BTC) and ICDDR,B.

Dr Abdullah Brooks, Health and Child Survival Scientist, was seconded to the Centre under the Child Survival Fellowship Program through Johns Hopkins University since July 1997. Until recently, he was in the Clinical Sciences Division but was transferred to PHSD in November 2000. The Centre anticipates that Dr Brooks will remain with the Centre for another two (2) years under secondment agreement with Johns Hopkins University.

Dr Abdullah Baqui will continue at the Centre as an Adjunct Scientist in PHSD following his departure from the Centre in July 2000 to join the Johns Hopkins University faculty.

Completion of tenure at international professional posts:
Mr John Winkelmann left the Centre in May 2001 following the end of his 3.5 years at the Centre. He previously served for 3 years from 1988-91.

Prof George J Fuchs, Associate Director CSD, completed his tenure of 6 years, 8 months with the Centre and will leave the Centre at the end of June 2001. The Centre commends Prof Fuchs on his services during his tenure and especially during his term as Interim Director.

Dr R Bairagi, Senior Scientist, P5, PHSD, is expected to leave the Centre on 14 June 2001 on completion of his current extended part-time contract. He served the Centre for many years including 6 years as a full-time international professional staff at P5 level and for 3.5 years as part-time at the same level. Depending on adoption of the promotions policy for Bangladeshi scientists, he may continue at the Centre under the Bangladeshi Scientists to International Level Policy.

Discussion: The six-year rule: It was discussed that there should be flexibility in the rule to reward and retain the scientists who have consistently exhibited excellence and commitment to the Centre's vision. It was important to maximize the talents of the scientists and encourage creativity. It was agreed that the rule should be coupled with a process of periodic performance evaluation.

The P&S Sub-Committee is mandated to review the Centre's performance evaluation system and gender equity.

Prof Sack stated that he needs help from the Board with gender policies and with international recruitment.

The Chair of the P&S Committee then declared the meeting closed and requested CAD members to recess. The Board continued in closed session with discussion on individual staff and regarding new Board members.

Resolutions of the Personnel and Selection Committee

4/BT/JUNE/01

The Board approves the Bangladeshi Scientists to International Level Policy as presented to the Personnel and Selection Committee. The extension of contracts will be subject to the satisfactory performance appraisal of the staff members, and contracts will be renewed for three (3) years. **Annex 1.**

5/BT/JUNE/01

The Board puts on record its appreciation for the services rendered by Dr George J Fuchs during his tenure with the Centre, especially for the period he served as its Interim Director.

6/BT/JUNE/01

The Board resolves that the current employment contract of Prof Lars Ake Persson with the Centre be extended by another term of three (3) years effective 1 March 2002 under the same terms and conditions.

7/BT/JUNE/01

The Board resolves that the current employment contract of Dr Abbas U Bhuiya with the Centre be extended for a period of three (3) years renewable, subject to satisfactory performance, under the policy of promotion of Bangladeshi Scientists to International Level.

8/BT/JUNE/01

The Board approves re-categorising Dr Sirajul Islam as an international staff member at the Centre, under the policy of promotion of Bangladeshi Scientists to International Level.

9/BT/JUNE/01

The Board notes its appreciation of the invaluable contributions made by Prof Rita Colwell, Prof Peter McDonald and Dr Tawfik AM Khoja during their tenure on the Board of Trustees.

10/BT/JUNE/01

The Board endorses the selection of Mr Peter Thorpe, Head, Information Sciences and Mr Stephen E Sage, Chief Finance Officer, each at P5 at the appropriate step level. The Board also gave its approval to extend an offer of employment to one of the two short-listed candidates for the Associate Director, Laboratory Sciences Division at D1. The short-listed candidates are Prof Antoine Andremont and Dr Andrej Weintraub.

11/BT/JUNE/01

The Board notes the completion of tenure of appointment of Mr John Winkelmann, Chief Finance Officer, Prof George Fuchs, Associate Director CSD and Dr R Bairagi, Senior Scientist PHSD.

12/BT/JUNE/01

The Board approves the Personnel and Selection Committee's recommendation regarding the end-of-service grant as presented by the Committee. **Annex 2.**

13/BT/JUNE/01

The Board selects the following candidates to be invited to become members of the Board of Trustees:

Dr I Kaye Wachsmuth
Dr Terry Hull
Dr Maimuh Bte Abdul Hamid

The Board agrees to appoint Prof Carol Vlassoff to the Board of Trustees pending clarification of her status.

14/BT/JUNE/01

The Board appoints Prof AK Azad Khan as Chair of the Finance Committee and Dr Ricardo Uauy Dagach as Chair of the Programme Committee.

15/BT/JUNE/01

The Personnel and Selection Committee will work with the Director on reviewing the six-year rule for the Centre; and renewal of the contract for the Associate Director and Head, Policy and Planning.

16/BT/JUNE/01

The Board approves the Adjunct Scientists Policy as presented by the Director. **Annex 3.**

3.1 Overview of the staffing status and total number by categories

There were 45 separations and 57 additions during this reporting period (April 01, 2001 – September 30, 2001). The total number of Centre fixed-term staff belonging to all categories thus increased by 12 as shown in Table 1 below. The net additions of 12 were hired mostly for project positions. The Centre however, continues to follow the policy of restricting external recruitment of fixed-term staff.

Table 1

OVERVIEW OF STAFFING SITUATION
April 2001 – September 2001

Separations/Additions of Staff

	Restricted		Unrestricted		**Total**		**Net Change**
	Sep	Add	Sep	Add	**Sep**	**Add**	
International	--	+1	(1)	+2	**(1)**	**+3**	**+2**
Research (Scientific Support & Field)	(22)	+29	(8)	+11	**(30)**	**+40**	**+10**
Research (Administration)	(6)	+6	--	+7	**(6)**	**+13**	**+7**
Administration & Personnel	--	--	--	--	--	--	--
Finance	--	--	(8)	+1	**(8)**	**+1**	**-7**
	(28)	+36	(17)	+21	**(45)**	**+57**	**+12**

Net addition : 12

3.2 Status of Recruitment of International Professional Staff

Agenda 3.2a Associate Director, D1, Laboratory Sciences Division

The position was advertised in Lancet, ASM News, the New England Journal of Medicine and ICDDR,B website. Out of the five (5) CVs received, two (2) (Dr. Andrej Weintraub, a Swedish national and Prof. Antoine Andremont, a French national) were short-listed. In the June 2001 meeting, the Board gave its approval to extend an offer to one of the two short-listed candidates. Offers were made to both candidates but due to personal and institutional difficulties, the offers were not accepted. Therefore, the position was sent for re-advertisement in October 2001.

An update on this recruitment shall be provided during the meeting.

Agenda 3.2b Associate Director, D1, Clinical Sciences Division

In response to the advertisement, fifteen (15) applications were received and after scrutiny, only one candidate (Dr. Peray Ogra, a US citizen) was short-listed. But since he is not available, the position is being re-advertised in October 2001.

3.3 Renewal of Contracts

Agenda 3.3a **Associate Director, D1, Policy & Planning**

The current contract of employment of Dr. Barkat-e-Khuda, Associate Director, Policy & Planning at pay level D1 will expire on June 19, 2002. He will complete almost five (5) years of service as international professional staff. Dr. Khuda has contributed tremendously to the growth of ORP and in developing ICDDR,B 2001 strategic plan. His performance is rated as excellent.

The Centre recommends to the Board that the current employment contract of Dr. Khuda be extended by the period to complete his six (6) years term.

Draft resolution:

The Board resolves that the current employment contract of Dr. Barkat-e-Khuda with the Centre, be extended for the period from June 20, 2002 to July 31, 2003 under the same terms and conditions.

3.3 Renewal of Contracts

Agenda 3.3b **Head, Health & Demographic Surveillance Programme, P5, PHSD**

The current contract of employment of Dr. Peter Kim Streatfield, Head, Health & Demographic Surveillance Programme, PHSD at pay level P5 will expire on July 17, 2002. Dr. Streatfield during this tenure of contract has contributed enormously to the growth of the programme that he heads as well as to the overall growth of the division, PHSD. His performance is rated as excellent.

The Centre recommends to the Board that the current employment contract of Dr. Streatfiled be extended by another full term of three (3) years effective July 18, 2002 under the existing terms and conditions.

Draft resolution:

The Board resolves that the current employment contract of Dr. Peter Kim Streatfield with the Centre, be extended by another term of three (3) years effective July 18, 2002 under the same terms and conditions.

3.4 Information on new International Professional Staff

Agenda 3.4a Head, Information Sciences, P5, Information Sciences Division

Mr. Peter Thorpe, a British national, was selected for the position of Head, Information Sciences. Mr. Thorpe joined the Centre on August 01, 2001 as the Head, Information Sciences at pay level P5. He is heading the newly established Information Sciences Division.

This is for the information of the Board.

Agenda 3.4b Chief Finance Officer, P5, Director's Division

Mr. Stephen E. Sage, a US national, was selected for the position of Chief Finance Officer under Director's Division at pay level P5. Mr. Sage joined the Centre on August 21, 2001.

This is for the information of the Board.

3.5 Status of seconded staff contracts

Agenda 3.5a **Director, ADG**

The current three years secondment employment contract of Dr. David A. Sack, Director of the Centre, expires on September 30, 2002. His services have been seconded to the Center by the Johns Hopkins University.

Clause 13.1 of the ICDDR,B ordinance 1978 (Ordinance No. LI of 1978) stipulates 'a Director who shall be selected and appointed by the Board for a term of three years which may be renewable for another term'.

This is submitted for the kind perusal of the Board.

3.5 Status of seconded staff contracts

Agenda 3.5b **Senior Scientist, P5, Laboratory Sciences Division**

On completion of the secondment employment, Dr. Jozef Bogaerts, Senior Scientist, Laboratory Sciences Division at pay level P5, will leave the Centre on December 21, 2001. Dr. Bogaerts has been working at the Centre on secondment from the Belgian Technical Cooperation.

This is for the information of the Board.

Agenda 3.5c **Medical Epidemiologist and Acting Head, Health Systems Research Division, P4**

The current secondment contract of Dr. Robert F. Breiman, Medical Epidemiologist and Acting Head, Health Systems Research Division at pay level P4 will expire on July 21, 2002. Dr. Breiman has been working at the Centre on secondment from CDC, Atlanta and the US Embassy, Dhaka.

Agenda 3.5d **Demographic Researcher Health & Demographic Surveillance Programme, P4, PHSD**

The current contract of employment of Mr. Carel T. Van Mels, Demographic Researcher, Health & Demographic Surveillance Programme, PHSD at pay level P4 will expire on December 28, 2001. Mr. Van Mels has been working at the Centre on secondment from the Ministry of Foreign Affairs, Government of the Netherlands.

This is for the information of the Board.

Agenda 3.5e **Scientist, Epidemic Control Preparedness Programme, P4, PHSD**

The current contract of employment of Dr. Yukiko Wagatsuma, Scientist, Epidemic Control Preparedness Programme, PHSD at pay level P4 will expire on January 16, 2002. Dr. Wagatsuma has been working at the Centre on secondment from the Johns Hopkins University, USA.

This is for the information of the Board.

3.6 Information on new seconded staff

Agenda 3.6a **Dr. Abdullah Brooks, Scientist, P4, PHSD**

Dr. Abdullah Brooks who completed his assignment as the Child Survival Fellow on May 31, 2001 has commenced his new tenure as a Scientist at the Centre on secondment from the Johns Hopkins University effective July 01, 2001. His appointment is for a period of two years.

This is for the information of the Board.

3.7 Completion of Tenure at International Professional Post

Agenda 3.7a **Epidemiologist and Head, Epidemic Control Preparedness Programme, P4, PHSD**

Dr. A. K. M. Siddique, Epidemiologist & Head, Epidemic Control Preparedness Programme, Public Health Sciences Division will complete six (6) years of tenure at international professional post on June 30, 2002. He may however, continue as 'a Bangladeshi Scientist to international level' under the policy of promotion of Bangladeshi Scientists to international levels. His extension may be for a period of one year at a time since he has already attained the age of 60 years and can continue on a yearly renewal basis till the age of 65 years under the provisions of the Staff Rules.

Agenda 3.7b **Senior Scientist, P5, Public Health Sciences Division (part-time)**

The part-time contract of Dr. Radheshyam Bairagi, Senior Scientist, P5, PHSD expired on June 14, 2001. He has however been given a contract for one year effective June 15, 2001 as 'a Bangladeshi Scientist to international level' under the policy of promotion of Bangladeshi Scientists to international levels. His contract may be renewed on a yearly basis based on both satisfactory performance and availability of funds however, not exceeding 65 years of his age, as per rule.

3.8 Establishment of new international professional posts

Agenda 3.8a **Head, Nutrition Research Programme, P4/P5, CSD**

To provide effective leadership to the ongoing and highly expanding Centre's nutrition research, training and service activities; it is strongly felt that a new position of Head, Nutrition Research Programme at an international professional level at P4/P5 be urgently established to carry out these activities. Facilitation of nutrition research, dissemination of research findings, development of the Centre's nutrition research agenda and mobilization of funds for nutrition research will be the primary functions of the newly created post.

Thus, it is recommended to the Board that it consider establishment of this new post for which funds are available.

A brief job description of the post is attached for the perusal of the Board.

ICDDR,B

JOB DESCRIPTION

Position : Head, Nutrition Research Programme

Pay level : P4/P5

1. SUMMARY OF THE POSITION

Under the overall supervision of the Director and reporting to the Associate Director, Clinical Sciences Division or his delegated authority, the incumbent performs the assigned duties and provides leadership to the Centre's nutrition research, training and service activities. The incumbent also will be responsible for facilitating nutrition research, disseminating research findings, assisting in the development of Centre's nutrition research agenda and mobilizing funds for nutrition research.

2. DESCRIPTION OF FUNCTIONS

a. Plans and coordinates activities related to nutrition research at the Centre.

b. Provides research and management leadership for selected ongoing projects.

c. Develops new research initiatives and implements the research agenda

d. Supervises the secretariat established for the Nutrition Research Programme.

e. Develops and coordinates research priorities of the Centre and works with donors, international institutions and government agencies for meeting those.

f. Performs any other duties as assigned by the Director

3. REQUIREMENTS FOR THE POSITION

An M.D., Ph.D or equivalent with training in nutrition, clinical or epidemiological research are required. S/he will have at least 5 years experience of working in a nutrition related field and a good record of related publications in peer reviewed journals. Applicants should have demonstrated abilities to develop research proposals, obtain research funding, lead and manage scientists in research as well as to foster interactions with researchers of various disciplines (clinical, epidemiological, operations, and/or laboratory research). Fluency in English is essential. Experience in South Asia a plus.

3.8 Establishment of new international professional posts

Agenda 3.8b **Programme Officer, ER&ID, P2, Director's Division**

A post of Head, External Relations & Institutional Development (ER&ID) at pay level P2, was established at the November 1998 Board of Trustees Meeting. Accordingly, announcements were made and a number of applications received. However, as per a later management decision, the process of recruitment was postponed pending the joining of the Director (Dr. David A. Sack) to enable him to assess the needs of the planned post, further.

Now, since the Director himself is looking after this office, it is felt that in order to streamline its activities, the already established and currently vacant post of the Head, ER&ID be renamed as Programme Officer at the same pay level (P2) and an early recruitment made.

A revised job description of the post is being made to suit the various needs based on the restructuring.

This is submitted for the approval of the Board.

3.9 List of established international professional posts

Director's Division

Sl.	Job Title	Grade	Post establishment date	Remarks
01	Director	ADG	January 1982	
02	Associate Director, P&P	D1	July 2000	
03	Head, Human Resources	P5	April 2000	
04	Chief Finance Officer	P5	September 1988	
05	Head, ER&ID	P2	November 1998	Vacant
06	Executive Assistant to Director	P1	January 1982	
07	Internal Auditor	P1	November 1998	Vacant
08	Grants Administrator, ER&ID (ST)	P4	October 1997	
09	Associate Director, ER&ID	P4	May 1978	Vacant

Public Health Sciences Division

Sl.	Job Title	Grade	Post establishment date	Remarks
01	Associate Director, PHSD	D1	January 1982	
02	Head, HDSP	P5	November 1995	
03	Head, Reproductive Health	P5	July 1997	
04	Senior Scientist	P5	January 1989	
05	Scientist	P4	January 2000	
06	Scientist	P4	July 2001	
07	Epidemiologist & Head, ECPP	P4	July 1996	
08	Social Scientist	P4	January 2000	
09	Social Scientist, Head, SBSP	P4	July 1994	
10	Epidemiologist & Head, CHP	P3	November 2000	
11	Environmental Specialist	P4	June 1997	Vacant
12	Health Economist	P4	January 1997	Vacant
13	Demographer	P4	April 1995	Vacant
14	Maternal Health Specialist	P3	October 1994	Vacant

Clinical Sciences Division

Sl.	Job Title	Grade	Post establishment date	Remarks
01	Associate Director, CSD	D1	January 1982	Vacant
02	Health & Child Survival Fellow		July 1997	Vacant
03	International Fellow		November 1995	Vacant

3.9 List of established international professional posts

Laboratory Sciences Division

Sl.	Job Title	Grade	Post establishment date	Remarks
01	Associate Director, LSD	D1	January 1982	Vacant
02	Senior Scientist	P5	January 1996	
03	Research Microbiologist	P4	July 1982	
04	Environmental Microbiologist	P4	July 2001	

Health System Research Division

01	Epidemiologist & Head, HSRD	P4	August 2000	
02	Management Scientist	P4	December 1994	Vacant
03	Health Scientist	P4	October 1994	Vacant
04	Administrative Director	P5	November 1994	Vacant
05	Sr. Advisor & Head, HPED	D1	December 1995	Vacant
06	Operations Research Scientist	P4	February 1989	Vacant
07	Visiting Scientist	P4	July 1990	Vacant

Information Sciences Division

01	Head, ISD	P5	August 2001	
02	Head, Training & Edu. Dept. (ST)	P4	May 1996	

Staff salaries

Agenda 4.1 International professional category

The Finance Committee will provide the required information on this agenda item.

Staff salaries

Agenda 4.2 **NO & GS categories**

The Finance Committee will provide the required information on this agenda item.

Agenda 5 **BOT/P&S/Nov 2001**

Selection of members of the Board of Trustees

No action required at this meeting.

Any other business

Agenda 6.1 International Promotion Applications

Any other business

Agenda 6.2 **Scientific Promotions Update**

Any other business

Agenda 6.3 **Update on ongoing HR agenda**

Any other business

Agenda 6.4.a **Revision of Staff Rules**

HOME LEAVE POLICY

Revised effective: 1 November 2001

Purpose:

Home leave is provided so that a non-Bangladeshi staff member of the international professional category who is serving outside the country of his recognized place of residence may spend a reasonable period of annual leave in his home country or recognized place of residence with a view to maintaining effective association with his culture, family, national, professional or other interests.

Guidelines:

1. The date of eligibility for home leave shall be the date on which the staff member has completed 18 months of qualifying service
2. An international staff member is eligible for home leave when:
   a. His duty station is outside the country of his recognized place of residence as established under Rule 640.
   b. His service is expected to continue at least six (6) months beyond the date of return from home leave or six (6) months beyond the date of eligible for home leave, whichever is later, unless otherwise approved by the Director in writing.
   c. He is not locally recruited under Rule 1310, is not appointed on a short-term basis under Rule 1320 and is not appointed as a consultant under Rule 1330.
   d. He has met the requirements for qualifying service under Rule 640.4.
3. Eligible staff members will be entitled to one home leave every eighteen months of their contract. See example below:

Date of hire: April 30, 2000

Home Leave Entitlement	*Date of Entitlement*	*Contract Term*
Joined Centre	April 30, 2000	Start of 3-year contract
1st Home Leave	October 30, 2001	
2nd Home Leave	April 30, 2003	If renewed 3-year contract
3rd Home Leave	October 30, 2005	
Repatriation	April 30, 2006	At end of second 3-year contract

Any other business

4. In exceptional circumstances, home leave may be advanced with the approval of the Director, provided there has been a minimum period of qualifying service.

Procedure:

The administration of the revised home leave policy will be carried out as per relevant provisions under Staff Rule 640 and the Centre's current practices.

Any other business

Agenda 6.4.b Revision of Staff Rules

CLARIFICATION/RIVISION IN EDUCATION GRANT POLICY

Revised effective: 1 November 2001

Purpose:

This is to clarify our current Education Grant under Staff Rule 350.3.2, which states that an education grant shall not be paid for the attendance of kindergarten or nursery school at the pre-primary level.

Background:

Since there are several different education systems in use in Dhaka, which are not altogether easily reconciled between the curriculums as to which are and are not qualifying under the existing Staff Rules, we are making the following recommendations to clarify and streamline the guidelines of what education will be eligible for the Education Grant.

Recommendations:

A child will be eligible for an Education Grant under Staff Rule 350.3.2 for the first full school term that begins after the date of the child's fifth (5^{th}) birthday. By using age as a qualifier for the Education Grant, any variations in curriculum and differences in interpretation as to what is consider pre-primary between schools are eliminated, and the policy will become more straightforward and consistent to administer.

It is recommended that the policy be retroactive to August 01, 2001, to include the beginning of the current school year in Dhaka.

All other portions of the Education Grant Policy under Staff Rule 350 will remain unchanged.

ADDITIONAL BACKGROUND DOCUMENTS

Table-2
BOT/P&S/Nov 2001

NUMBER OF FIXED-TERM UNRESTRICTED, RESTRICTED & INTERNATIONAL PROFESSIONAL STAFF

Functional Area	**2000 (Sept 30)**	**2001 (March 31)**	**2001 (Sept 30)**
Unrestricted	459	465	468
Restricted	476	630	637
International Professional	13	13	15
Total	**948**	**1108**	**1120**

Table-3
BOT/P&S/Nov 2001

STAFFING STATUS
FIXED-TERM

As of September 30, 2001

Sl. No.	Location	International Professional			NO	GS	Total
		Fixed Term	Short Term	Seconded			
1.	Director's Division	4	1	1	16	121	143
	-Director's Office	2	-	1	-	2	5
	-Human Resources	1	-	-	3	9	13
	-Finance	1	-	-	7	24	32
	-ER&ID	-	1	-	2	1	4
	-Support Services	-	-	-	4	84	88
	-SWA	-	-	-	-	1	1
2.	Public Health Sciences Division	8	-	4	58	362	432
3.	Clinical Sciences Division	-	-	-	31	167	198
4.	Laboratory Sciences Division	2	-	1	26	112	141
5.	Health Services Research Division	-	-	1	34	152	187
6.	Information Sciences Division	1	1	-	8	18	28
	Total	**15**	**2**	**7**	**173**	**932**	**1129**

Table-4
BOT/P&S/Nov 2001

STAFFING STATUS
(SECONDED, SHORT-TERM, CHWs & HEALTH WORKERS)

As of September 30, 2001

Sl. No.	Location	Seconded Staff (Int'l)	Short-term			CHWs	Total	HW
			Int'l	NO	GS			
1.	Director's Division	1	1	-	-	-	2	-
2.	Public Health Sciences Division	4	-	-	-	19	23	-
3.	Clinical Sciences Division	-	-	-	-	-	1	72
4.	Laboratory Sciences Division	1	-	-	-	-	1	-
5.	Health Systems Research Division	1	-	-	-	-	-	-
6.	Information Sciences Division	-	1	-	-	-	1	-
	Total	**7**	**2**	**-**	**-**	**19**	**28**	**72**

NO : National Officer
GS : General Services
CHW : Community Health Worker
HW : Health Worker

Table-5
BOT/P&S/Nov 2001

LIST OF INTERNATIONAL PROFESSIONAL STAFF
As of September 30, 2001

FIXED-TERM

Sl. No.	Name	Country	Job Title	Pay Level	Contract Start Date	Contract End Date
1.	ARIFEEN, Dr. Shams El	Bangladesh	Epidemiologist & Head, CHP	P3	21.11.2000	20.11.2003
2.	BAIRAGI, Dr. Radheshyam	Bangladesh	Senior Scientist	P5	15.01.1998	14.06.2002 *
3.	BENNETT HENRY, Ms Judith G.	Trinidad & Tobago	Executive Assistant to Director	P1	01.10.1999	30.09.2002
4.	BHUIYA, Dr. Abbas Uddin	Bangladesh	Social Scientist & Head, SBSP	P4	01.07.1994	31.12.2004 *
5.	BLUM, Dr. Lauren S.	USA	Anthropologist, SBSP, PHSD	P4	23.01.2000	22.01.2003
6.	HILL, Ms. Diann M.	USA	Head, Human Resources	P5	30.04.2000	29.04.2003
7.	ISLAM, Dr. Sirajul	Bangladesh	Environmental Microbiologist	P4	01.07.2001	30.06.2004
8.	KHUDA, Dr. Barkat-e-	Bangladesh	Associate Director, Policy & Planning	D1	01.08.1997	19.06.2002
9.	KILLEWO, Prof. Japhet Z. J.	Tanzania	Head, Reproductive Health Programme, PHSD	P5	27.10.1999	26.10.2002
10.	NAIR, Dr. Gopinath Balakrish	India	Research Microbiologist	P4	09.04.2000	08.04.2003
11.	PERSSON, Prof. Lars Åke	Sweden	Associate Director, PHSD	D1	01.03.1999	28.02.2005
12.	SIDDIQUE, Dr. A. K. M	Bangladesh	Epidemiologist, ECPP, PHSD	P4	01.07.1996	30.06.2002
13.	STREATFIELD, Dr. Peter K.	Australia	Head, Health & Demographic Surveillance Programme, PHSD	P5	18.07.1999	17.07.2002

* per Policy of promotion of Bangladeshi Scientists to International Level

contd.....

Table-5
BOT/P&S/Nov 2001

LIST OF INTERNATIONAL PROFESSIONAL STAFF
As of September 30, 2001

FIXED-TERM

Sl. No.	Name	Country	Job Title	Pay Level	Contract Start Date	Contract End Date
14.	SAGE, Mr. Stephen E.	USA	Chief Finance Officer, DD	P5	21.08.2001	20.08.2004
15.	THORPE, Mr. Peter	UK	Head, Information Sciences	P5	01.08.2001	31.07.2004

Table-6
BOT/P&S/Nov 2001

SHORT-TERM

Sl. No.	Name	Country	Job Title	Pay Level	Contract Start Date	Contract End Date
1.	ALAM, Dr. A. N.	Bangladesh	Head, Training & Education Dept.	P4	01.05.96	30.04.2002
2.	BROOKS, Ms. Vanessa J.	USA	Grants Administrator, ER&ID	P4	01.10.97	30.09.2001

Table-7
BOT/P&S/Nov 2001

LIST OF SECONDED STAFF
As of September 30, 2001

Sl. No.	Name	Country	Job Title	Pay Level	Contract Start Date	Contract End Date	Seconding Institution
1.	BOGAERTS, Dr. Jozef	Belgium	Senior Scientist, LSD	P5	01.01.1996	21.12.2001	BTC
2.	BREIMAN, Dr. Robert F.	USA	Medical Epidemiologist, PHSD	P4	01.08.2000	31.07.2002	CDC/US Embassy
3.	BROOKS, Dr. W. Abdullah	USA	Scientist, PHSD	P4	01.07.2001	30.06.2003	JHU
4.	MELS, Mr. Carel T. van	Netherlands	Demographic Researcher, HDSP	P4	29.12.1999	28.12.2001	NFA
5.	SACK, Dr. David A.	USA	Director, ICDDR,B	ADG	01.10.1999	30.09.2002	JHU
6.	WAGATSUMA, Dr. Yukiko	Japan	Scientist, ECPP	P4	17.01.2000	16.01.2002	JHU
7.	DIELTIENS, Dr. Greet	Belgium	Technical Advisor, RHP	P4	09.01.2001	08.01.2004	BTC

BTC : Belgian Technical Cooperation
CDC : Centre for Disease Control
JHU : The Johns Hopkins University
NFA : The Netherlands Ministry of Foreign Affairs

ICDDR,B

OVERVIEW OF THE STAFFING STATUS

CF - Core funded
PF - Project funded

Functional Area	2000 (Sep 30)		2001 (Mar 31)		2001 (Sep 30)	
-International Professional staff	13		13		15	
-Research (Scientific, Support & Field)	571	CF 197 PF 374	604	CF 196 PF 408	614	CF 199 PF 415
-Research (Administration)	230	CF 128 PF 102	353	CF 131 PF 222	360	CF 138 PF 222
-Support Services & Personnel	96	CF 96 PF 0	100	CF 100 PF 0	100	CF 100 PF 0
-Finance	38	CF 38 PF 0	38	CF 38 PF 0	31	CF 31 PF 0
Sub Total	**948**		**1108**		**1120**	
-International Seconded Staff	6		8		7	
-Short term staff (Int'l, NO & GS)	10		2		2	
-Community Health Worker	132		20		19	
Sub Total	**148**		**30**		**28**	
Health Worker	**67**		**69**		**72**	
Fellows	**33**		**27**		**27**	
Contractual Service Holder	**405**		**376**		**379**	
Daily Wagers	**235**		**158**		**274**	
GRAND TOTAL	**1836**		**1768**		**1900**	

ICDDR,B
STAFFING STATUS
SEPTEMBER 2001

Functional Area	2000 September 30		2001 September 30	
-International Professional Staff	13		15	
-Research (Scientific, Support & Field)	571	U 197 R 374	614	U 199 R 415
-Research (Administration)	230	U 128 R 102	360	U 138 R 222
-Administration & Personnel	96	U 96 R 0	100	U 100 R 0
-Finance	38	U 38 R 0	31	U 31 R 0
Sub Total	**948**		**1120**	
-International Seconded Staff	6		7	
-Short-term staff (Int'l, NO & GS)	10		2	
-Community Health Worker	132		19	
Sub Total	148		28	
Health Worker	67		72	
Sub Total	1163		1220	
Others				
-Trainees	33		27	
-CSA Holders	405		379	
-Daily Wagers	235		274	
GRAND TOTAL	**1836**		**1900**	

ICDDR,B
International Professional Staff
Staffing by Region

		Staff No.
AFRICA		1
Tanzania	1	
ASIA		9
Bangladesh	7	
India	1	
Japan	1	
AUSTRALIA & THE PACIFIC		1
Australia	1	
EUROPE		5
Belgium	2	
The Netherlands	1	
Sweden	1	
UK	1	
NORTH AMERICA		7
U.S.A.	7	
SOUTH AMERICA (The Caribbean)		1
Trinidad & Tobago	1	
Total:		**24**

ICDDR,B

STAFFING STATUS BY GENDER
(As of September 30, 2001)

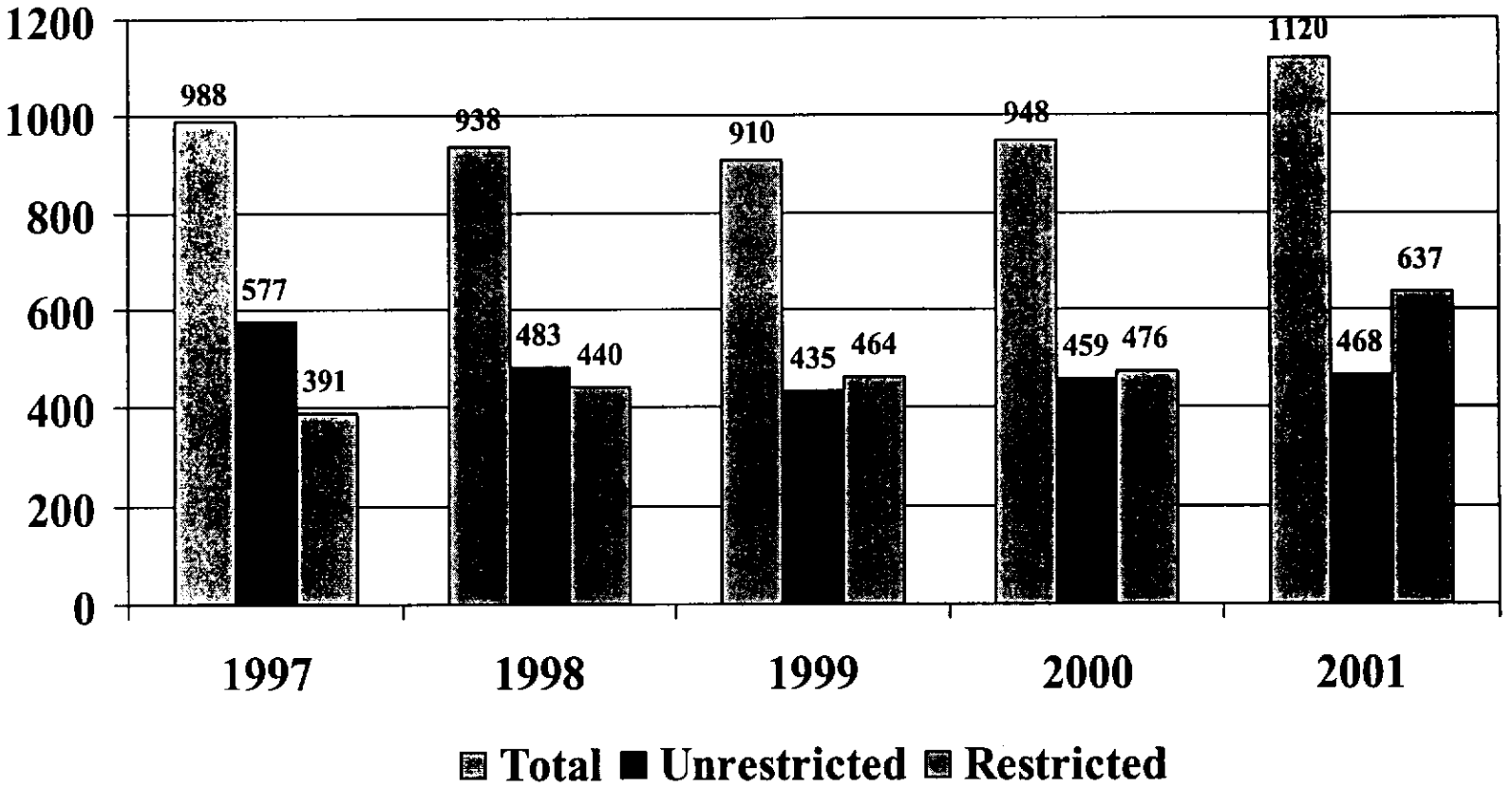
Category	Total # of Employee	# Male	# Female	% Male	% Female
Int'l Professional (FT/ST/Seconded)	24	18	6	75%	25%
National Officer (FT/ST)	173	133	40	77%	23%
General Services (FT/ST)	932	546	386	59%	41%
Community Health Workers	19	6	13	32%	68%
Volunteers	72	1	71	1%	99%
Trainees	27	18	9	67%	33%
Contractuals (CSA)	379	120	259	32%	68%
Grand Total	**1626**	**842**	**784**	**52%**	**48%**

Note: (Includes all staff except daily wagers)

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

BOT/P&S/Nov 2001

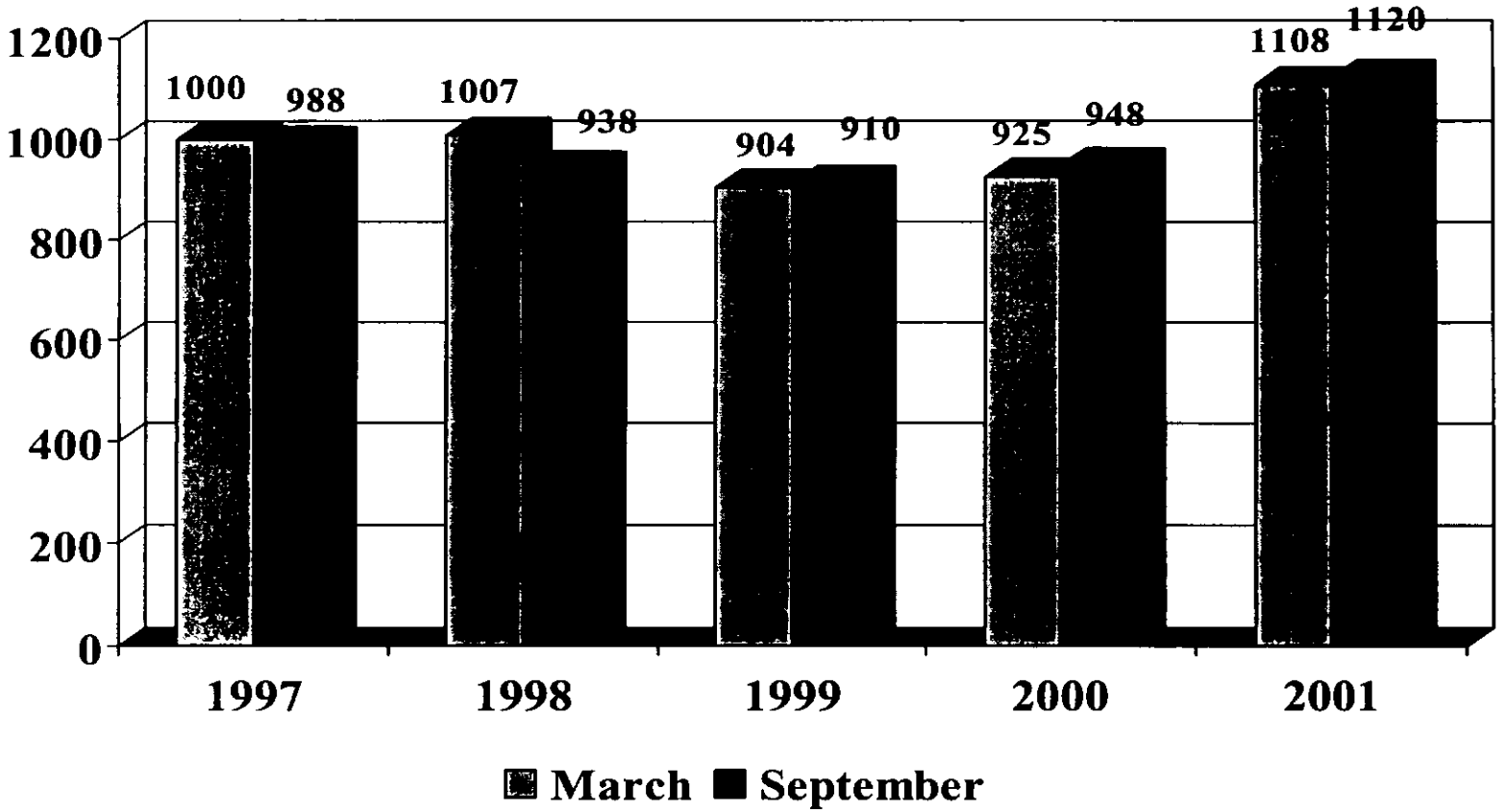
ICDDR,B
FIXED-TERM STAFFING STATUS
1997 – 2001
(As of September 30)



CENTRE
FOR HEALTH AND
POPULATION RESEARCH

BOT/P&S/Nov 2001

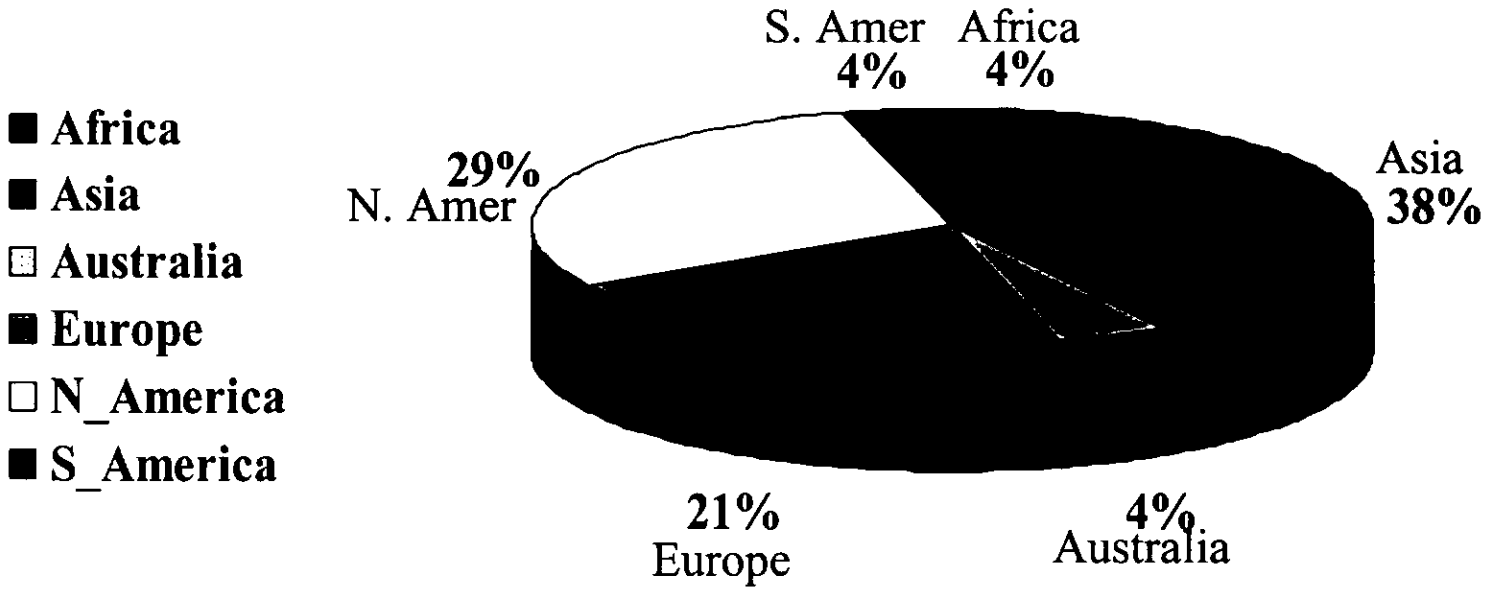
ICDDR,B
FIXED-TERM STAFFING STATUS
1997 – 2001



CENTRE
FOR HEALTH AND
POPULATION RESEARCH

BOT/P&S/Nov 2001

ICDDR,B
Int'l Professional Staff
By Continent
(As of September 30, 2001)

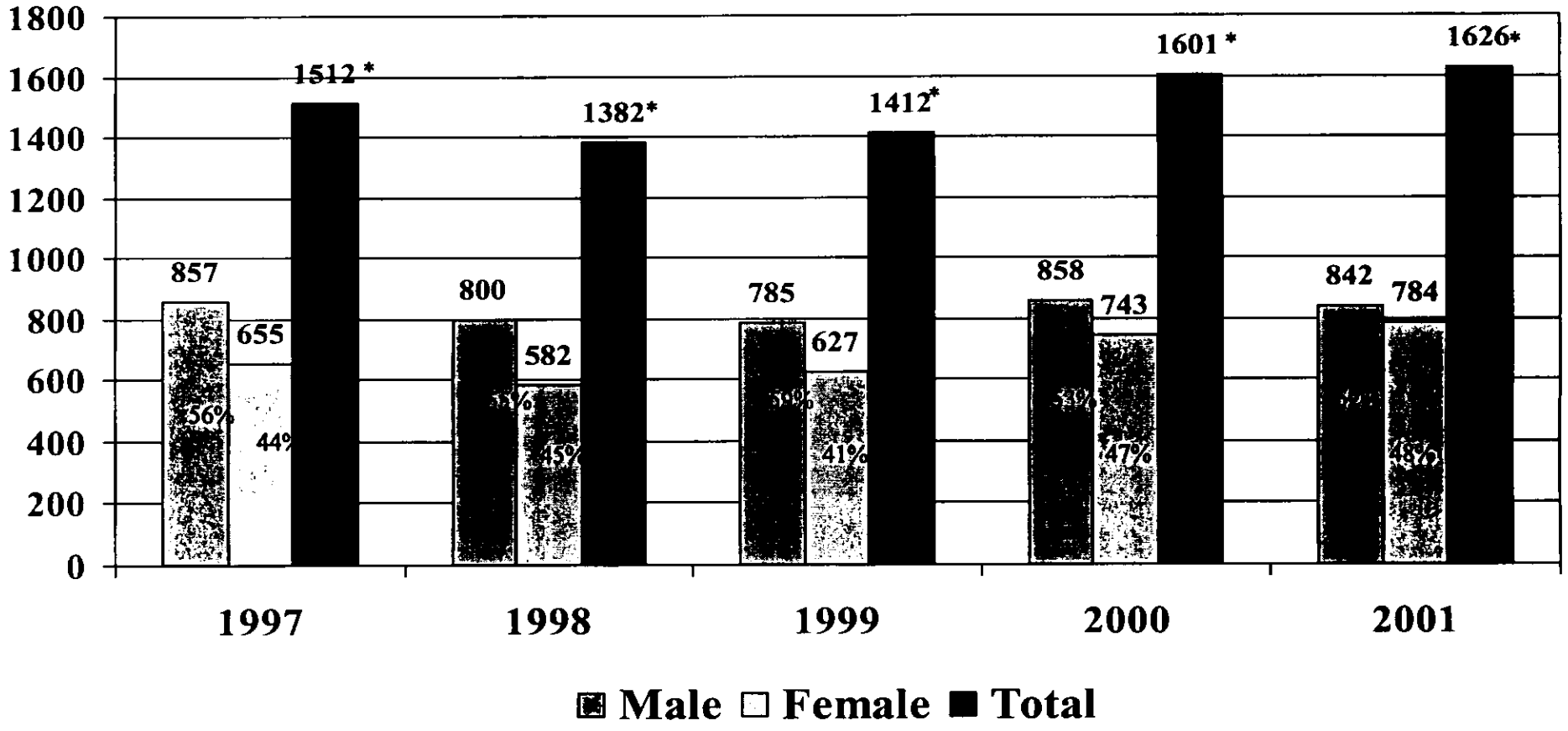


Note: (Includes Fixed-term, Seconded & Short-term staff)

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

BOT/P&S/Nov 2001

ICDDR,B
GENDER RATIO
1997 – 2001
(As of September 30)



* Does not include the daily wagers

6/BT/NOV 2001

STRATEGIC PLAN
TO THE YEAR 2005

BOARD OF TRUSTEES MEETING
NOVEMBER 2001

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

STRATEGIC PLAN

STRATEGIC PLAN REPORT

November 2001

1. Draft Strategic Plan

2. Strategic Plan (1994-2000)

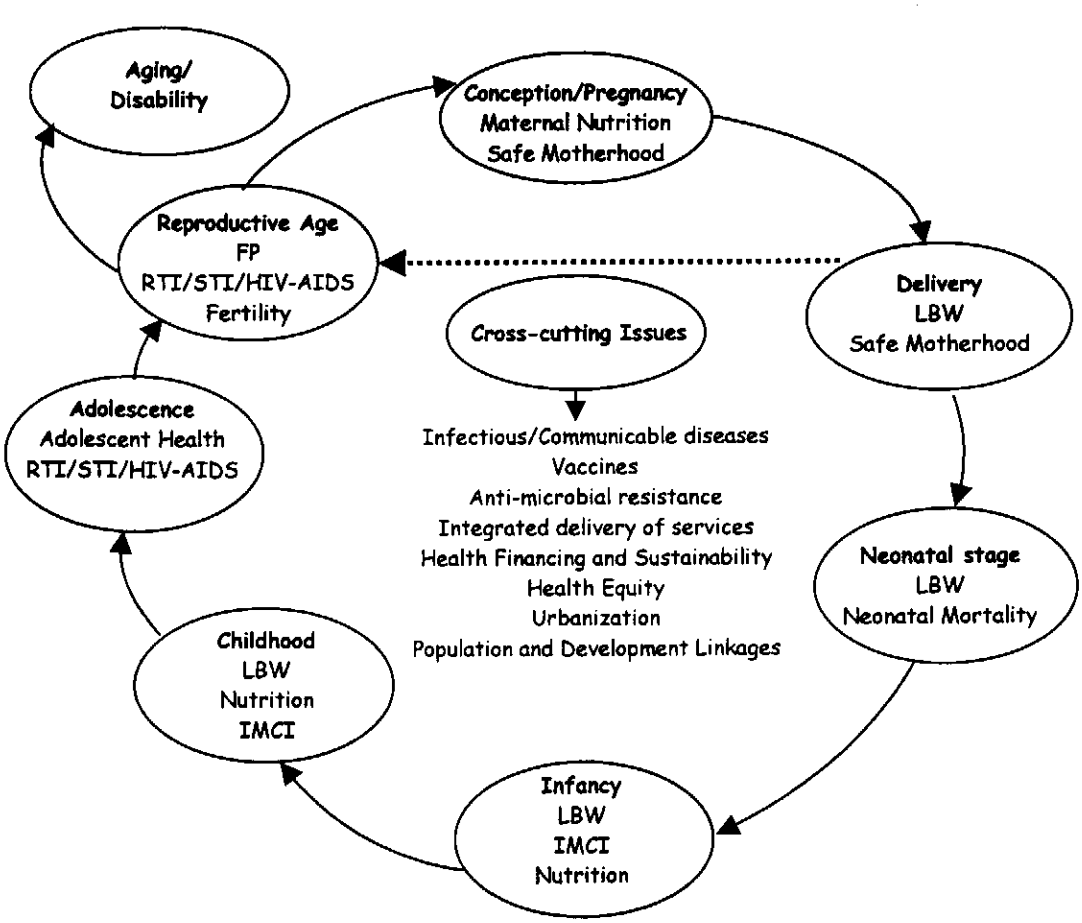
Draft
16 October 2001

Centre for Health and Population Research

STRATEGIC PLAN -to the year 2006

Improving health in Bangladesh and across the globe

Life Cycle Approach to Prioritization of ICDDR,B Research



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Acknowledgements

This Strategic Plan represents the collective work of the scientists and staff of the ICDDRB: Centre for Health and Population Research along with the members of the Board of Trustees, and with input from donors. Many of the contributors may not be aware of their input in the Plan since many of the concepts were formulated during unofficial as well as official discussions relating to the Centre. We appreciate all of these contributions.

Mission, Values And Vision

Mission

The mission of the Centre is to improve the health of vulnerable people in Bangladesh and globally, by developing and disseminating feasible and cost-effective solutions for major problems of ill-health and malnutrition through health research, service, training, and communication, leading to policy and action.

Values

The Centre's guiding values are:

- Excellence and high ethical standards in science and service
- Fairness to and respect of staff, patients, communities and partners
- Responsible and efficient use of resources
- Responsive to emerging issues

Vision

The Centre's vision is to be a leader and a partner in national, regional and global efforts to improve the quality of life in developing countries, and to be an advocate, guiding scientific and health resources to benefit vulnerable populations.

Executive Summary

The ICDDR,B: Centre for Health and Population Research (The Centre) is a maturing health research and service institution based in Bangladesh but with a global sphere of influence. The Centre, founded in 1960, was originally focussed on cholera control through improving case management and testing cholera vaccines. These objectives required the establishment of a clinical research ward and laboratories in Dhaka, and a large, population-based field area in Matlab. These facilities have grown considerably since 1960, and the Centre has continued to evolve toward addressing a much-expanded agenda dealing with critical problems of health, population and nutrition that are common in poor countries.

As the Centre moves into its next phase, it retains many of the features of the original institution, i.e. importance of excellence in clinical research to improve treatment for patients with common and severe health conditions; modern laboratories to support the clinical research, while providing fundamental knowledge about these conditions; and population-based studies to understand the epidemiology of ill-health while devising interventions. The Centre has however progressed considerably in expanding its research agenda. Originally focused on cholera and diarrhoea, it now encompasses a full spectrum of issues related to child health, reproductive health, infectious disease and vaccine sciences, nutrition, population sciences, health systems research, safe water, and HIV-AIDS. Additionally, it has greatly expanded its research tools to include disciplines of anthropology, economics, medical geography, and other social sciences. In each of these "new" areas of research, the Centre took into consideration which aspects could best contribute to the overall improvement in health for vulnerable populations.

A tenet of the Centre's approach is the interdisciplinary and inter-divisional research in which the clinical and laboratory research interacts with epidemiologic, social sciences, and health systems research. Thus, findings from the clinical studies can quickly be applied to field situations and the lessons from these field studies can be "scaled-up" into programmes. Similarly, the observations from the field and programmes provide guidance for the clinical and laboratory studies. Mechanisms for facilitating this cross-disciplinary interchange include the Scientific Council, the inter-divisional Programmes, the weekly Centre Scientific Forum (CSF) and other seminars as well as working groups on specific topics.

Priority-setting at the Centre represents a complex interaction of numerous factors, but begins with the "life cycle" approach to define the different stages and the vulnerable periods in the life cycle when cost-effective interventions are most likely to improve the health of populations. Key factors in priority-setting includes the mission of the Centre, the relative strengths of the Centre in terms of its scientific/medical and logistic resources, global priorities by international agencies, interactions with the Government of Bangladesh (GoB), and funding opportunities. The Centre primarily attempts to carry out applied and downstream research but it does not shy away from using state-of-the-art tools to provide a better understanding of the issues it studies. For example, studies on cholera range from molecular studies of the bacterial genes, to clinical studies on new treatments, epidemiologic and vaccine studies, and economic analyses.

Some major new initiatives which have recently begun, include projects to a) evaluate the efficacy of the Integrated Management of Childhood Illness (IMCI), b) understand causes for low birth weight and evaluate strategies for decreasing rates of low birth weight and increasing survival, c) evaluate interventions for neonatal mortality, d) develop strategies for reducing maternal mortality, e) improve referral systems for maternity care, f) improve family planning services, g) characterize the problem of sexually-transmitted infections, h) improve health services at primary clinics for women with gynaecologic symptoms, i) surveillance for HIV-AIDS in high-risk groups, j) strategies for recognizing severe malnutrition in the community, k) development of programmes for zinc supplements to children, l) increase rates of exclusive breast feeding, m) evaluation of new vaccines for enteric infections (cholera, enterotoxigenic *E. coli*, and rotavirus), n) evaluation of new vaccines for respiratory infections (*H. influenzae* and *S pneumococcus*), o) understand population dynamics of Bangladesh, especially the slowing of fertility rate decline, p) improve health equity and improve understand relations between poverty and health, q) operations research to improve the Essential Services Package (ESP) in Bangladesh, r) control of tuberculosis, dengue, and acute respiratory disease.

The Centre is an international centre and is the only such health research centre based in a developing country. It is international in several respects. It is governed by an international Board of Trustees and is able to recruit professional staff from around the world. It is guided by global health priorities as well as national ones. It publishes its findings in internationally-recognized, peer-reviewed journals, and its results are of international quality. Its financial

accounting and its ethical standards meet or exceed international standards. Trainees come from around the world (over 20,000 trainees from 78 countries).

At the same time it is a local institution. About 95% of its scientific staff are Bangladeshi nationals. It provides medical services to over 120,000 local patients per year in its hospitals, and provides services to many others in the community. It provides technical assistance to the Government of Bangladesh and non-governmental agencies (NGOs) in Bangladesh. Thus, the Centre qualifies both as an international and a national organization.

The Centre is organized into five scientific Divisions and six cross-divisional Programmes. Each of the Divisions has responsibilities for certain aspects of the infrastructure of the Centre. They host the cross-divisional Programmes, and they foster the scientific and technical research of their scientists. They also, increasingly, take responsibility for the financial integrity of the Centre by promoting and marketing their key activities and research. Thus, the Divisions provide the administrative organization for the Centre. The cross-divisional Programmes however, better describe the scientific agenda by defining the scientific goals. These current Programmes include Child Health, Reproductive Health, Infectious Diseases and Vaccine Sciences, Nutrition, Population Sciences, and Health and Family Planning Systems. The Centre anticipates the formation of two additional programmes in Safe Water and HIV-AIDS. Each of these programmes have a "home" in one of the Divisions, but are clearly Centre-wide in their scope.

The administration of the Centre is managed through four offices of the Director's Division: Finance, Human Resources, External Resources & Institutional Development and General Administration. There was some consideration for a complete re-organization for the Centre's management system, but after careful examination of the options, a more evolutionary approach was applied. The changes in the former organizational chart include the following:

- Creation of the Division of Information Sciences bringing together DISC[1], the Computer Information Services (CIS) and the Training & Education Unit (TEU) into

[1] Dissemination and Information Services Centre includes the library, publications, and audio-visual unit.

a combined division to better coordinate the production, organization and dissemination of knowledge at the Centre.

- Establishment of defined programmes to foster cross-divisional collaboration.
- Increasing decentralization of responsibility for the scientific agenda to the Divisions and Programmes.
- Direct reporting of Finance, Human Resources, and General Administration to the Centre's Director rather than through a Head of Finance and Administration.

A theme of this reorganization structure has been a decentralization of authority, stimulating individual initiative while encouraging cooperation and cross-cutting activities. Good science and good programmes work together, and the Centre encourages this synergism. Decentralization implies that scientists and public health professionals become increasingly responsible for the defining the work of the Centre as well as generating the financial support for the Centre. The challenge is thus to encourage this decentralization, while still maintaining the coordination and cooperation needed for a coherent programme.

This Strategic Plan depends on adequate finances to carry out the research, service, and training. Traditionally, the Centre has relied on significant financial input from government donor agencies of the United States, the UK, Bangladesh, the Netherlands, Japan, Switzerland, Canada, Belgium, Sweden, Australia and others. Other funds have come from foundations such as Ford Foundation, Rockefeller, and more recently Gates Foundation. Project funds have come from other agencies, foundations, companies, and significant funding is now coming from grant support from the National Institutes of Health (NIH) and the World Health Organization (WHO). Recently, private companies such as UNOCAL have also provided significant funding.

Considerable changes have occurred in donor-funding at the Centre in recent years. Firstly, because of a shift in donor policy, core (unrestricted) funding has decreased dramatically in favor of project funding. For example, in 1994, about 50% (or US$ 4 million) of the total income was unrestricted, but this decreased to 13% (or US$ 2 million) in 1990. On the other hand, the total income increased from US$ 8 million in 1994 to over US$ 13 million in 1990, reflecting a marked increase in project funding. Some, but not all, of the project funding

included payment for common institutional costs[2], but many of the projects did not pay their full share to be completely funded. In the future, the Centre will have a clear policy regarding charges for these costs in order to adequately fund the projects. (Not all donors have moved to project funding; notably the governments of the Netherlands and Switzerland have increased their funding to core.) When the full level of the common institutional costs is not funded, the Centre must identify core funds to co-fund the project, and acknowledgement of this is given to the core donors.

Based on the projects being anticipated, the Centre will increase its activities by about US$ 1 to 2 million each year during the next five years. The increase is anticipated because of the defined projects that are underway as well as other projects that are likely to start soon. For many of the new projects, funding has already been identified. Thus, the annual budget for 2002 is expected to be about US$ 15 million and by the year 2005, is likely to be about US$ 20 to 22 million. We anticipate that the funding from government aid agencies will remain stable or will increase somewhat, but that the majority of the increase will be from research granting agencies (e.g. NIH), foundations, companies, and individual donors. The Centre initiated a programme called Circle Around the Centre, as a way to appeal to alumni and friends for specific contributions. Funds raised from this appeal have been designated for staff development at present.

In addition to the annual income to the Centre, endowments have been formed for the Centre as a whole, as well as specifically for the Dhaka Hospital. At present, the total value of the endowments is about US$ 9 million. There is currently a special drive on for contributions to the Hospital Endowment Fund (HEF), and with prudent investments, a goal of US$ 15 million by the year 2006 has been set.

During the last decade, the Centre accumulated a significant deficit of about US$ 4 million caused by the rapid shift of donors from core to project funding, along with the cost incurred by humane responsibility to maintain hospital services in Dhaka and Matlab. The Centre was not able to adapt to this rapid shift in donor funding as quickly as the donors were able to change their pattern of funding. The unfortunate accumulation of this deficit has had considerable negative impact on the creativity and flexibility of the Centre's programme.

[2] Common institutional costs are sometimes referred to as indirect costs.

Since 1999, the Centre has balanced its annual accounts and has been able to decrease the accumulated deficit by at least US$ 300,000 each year according to a plan adopted by the BoT that year. By the end of 2001, the deficit had decreased to less than US$ 3 million. By the year 2006, the plan is for the deficit to be eliminated. If possible, the deficit will be

eliminated even more quickly. However, the more critical concern is for the Centre to continue to carry out its life-saving and scientifically-creative mission while managing its resources in a responsible manner.

During the next five years, the Centre will upgrade its physical facilities in several ways as outlined in the Master Plan currently being developed. A new outpatient clinic building is nearing completion to house the PSKP[3] clinic, as well as follow-up clinics for the Centre's Clinical Sciences Division. The major projects however will be the completion of the

[3]Progati Samaj Kallyan Pratisthan (PSKP), an NGO supported by John Snow International (JSI).

Centre's main building in Mohakhali that will be extended to eight floors from its current three floors. This expansion will accommodate the overcrowded hospital inpatient wards, short-stay wards, and outpatient facilities. It will also house a new and expanded library, new laboratories, additional office space, expanded training and computer facilities, and dining and activity facilities. During a subsequent building phase, a second building, now housing the generator, will be expanded to accommodate maintenance, utilities, warehouse, on the lower floors and additional office space above. This new building will replace several temporary buildings that have already outlived their expected life by many years.

Some expansion will also be needed in Matlab to accommodate increased activity there. A decision will be made about whether office and guest house space will be built in the field areas of Mirsarai and Abhoynagar, or whether units will continue to be rented. The Centre also owns a large office and guesthouse in Chakaria as a base for its fieldwork in this region, and it continues to own facilities in Teknaf. The Teknaf property is currently leased to an NGO for a nominal fee, but could represent an additional resource for the Centre in the future.

Management of human resources will be changed during the next five years. Originally the system has used the system of the United Nations (UN) as the basis for a human resources system. This had the benefit of using an established and stable system with tested personnel rules. However, the UN system has had frequent changes in its pay scale, as well as its rules and procedures that are difficult for the Centre to adopt, and in some cases are inappropriate. Also, the UN system fits better with a civil service career structure rather than a research organization that must be more adaptable to rapid changes in scientific and funding opportunities. The Centre's new human resources management system will be a hybrid of that found in the private sector and a UN organization, but it will certainly be more merit-based, flexible, and market-driven. The Centre will attempt to hire and retain excellent staff and to be among the best paymasters in Bangladesh at about the 75 percentile of the market, but it can no longer use the UN system as its only benchmark.

Staff development has been a major part of the Centre's programme and this will continue in the future. A change in staff development policies will be to gear the staff development programme more toward the anticipated future scientific and technical needs of the Centre rather than viewing staff development as a benefit for long service at the Centre. The

numbers of scientists with advanced degrees have increased, and there will be a greater need for sabbaticals to maintain skills rather than doctoral training to develop junior researchers as has been the need in the past.

The Centre has recently adopted new policies regarding the status of the international level of Bangladeshi staff in an attempt to retain the highly valued senior scientific staff. Previously, international staff members were limited to six years of international service. The new policy allows such scientific staff to remain at the Centre at an international level, but with a salary that depends on the grants being raised by project donors. It is anticipated that this incentive system will stimulate productivity, will help the Centre retain key leaders, but will protect the Centre from financial risk.

Some of the changes in the Strategic Plan will require modifications to the ordinance. The major change needed is a change in the official name of the Centre. It was proposed that the name be changed to International Centre for Health and Population (ICHAP), or alternatively to the International Health and Population Institute (IHAPI), while keeping the same logo. It was felt that either name would better represent the mission of the Centre. The other major change is to release the Centre from the reference to HR policies and salaries comparable to the UN scale, since this is not an appropriate standard for a research institution such as ICDDR,B. Since the ordinance is an official document from the Government of Bangladesh, an amendment will require passage through Parliament.

Looking Forward

The Centre has matured over the last 40 years and it continues to look forward to a bright future. One might expect the job of the Centre to be finished within the next few years, that "health for all" will have been accomplished, and that there would be no need for the Centre to continue. Unfortunately, this is unlikely and the coming years will present even greater challenges than those of past years. In fact, the success of the Centre will depend, in great part, on the ability of the Centre's scientists to forecast problems of the future, and to adapt to the changing needs of Bangladesh and other developing countries. Some of the new challenges that will certainly be important will include:

- control of HIV-AIDS
- control of tuberculosis

- adapting to a rapidly increasing population, even if fertility rates decline
- problems of an aging population with increasing rates of disability
- health impacts related to urbanization and industrialization
- managing the long term effects from arsenic exposure
- continuing increase in antimicrobial resistance among infectious diseases
- managing the increasing utilization of community clinics and maternity centres
- creating a model for sustainable "urgent care centres" for common, but easily-treated, fatal diseases
- adapting to new systems for providing health care, likely to be increasingly based on self-sustaining, fee-for-service and insurance systems

The challenges of improving health in developing countries will continue throughout the next century, and we expect that the mission of the Centre will continue for a very long period.

Background

The Board of Trustees (BoT), at its June 2000 meeting, asked the Centre to develop a Strategic Plan for the next five years. In July 2000, the Centre Director set up a Strategic Planning Core Group (SPCG), headed by the Associate Director and Head, Policy and Planning, and comprising two representatives from each of the four scientific Divisions and four representatives from the Director's Division, to work under the overall guidance of the Centre Director. The SPCG had a number of meetings, and finalized two sets of questionnaires, one to be completed by the Principal Investigators and the other by the Associate Directors and Programme Heads. Subsequently, the SPCG developed checklists to generate additional information and reach consensus on some major issues such as the Centre's mission, vision, and priorities.

The basic approach adopted for the development of the Strategic Plan included three stages: (1) situation analysis; (2) formulation of vision statement and future directions; and (3) formulation of Strategic Plan/proposed actions. The Strategic Plan development process comprised: (i) major activities under each of the above three key aspects, (ii) methods and processes for accomplishment of the proposed activities, and (iii) timelines and responsibilities for the proposed activities.

With the finalization and approval of the Strategic Plan by the BoT, the process of developing a mechanism to assess the performance of the Strategic Plan would be initiated: (i) to examine whether the Centre is on the right track, (ii) to be responsive to major change(s) that could not be foreseen while preparing the Strategic Plan, and (iii) to assess how implementation of the Strategic Plan affects the institutional and financial sustainability of the Centre.

At the June 2001 BoT meeting, the draft Strategic Plan was presented. Useful discussion followed, and the draft plan was modified accordingly. Subsequently, the draft plan will be shared with the Government of Bangladesh (GoB) and the Donor Support Group (DSG). Based on inputs and suggestions from all concerned, the draft Strategic Plan will be finalized for adoption at the November 2001 BoT meeting. A salient feature of the Strategic Plan is its participatory nature, with the involvement of the Centre staff at different levels, the BoT, the GoB, and the donors.

Brief History

In 1960, the Cholera Research Laboratory (CRL) was created under the Pakistan-SEATO agreement to study the epidemiology, treatment and prevention of cholera. In 1963, a field site was opened in Matlab, rural Bangladesh, and a series of cholera vaccine trials was initiated. In 1966, the Demographic Surveillance System (DSS) was set up, and in 1968 the first successful clinical trials of Oral Rehydration Solution (ORS) were completed. Indeed, the CRL conducted research that now forms the core of the global knowledge on diarrhoeal diseases, and led to the development of ORS which is now used world-wide for the treatment of diarrhoeal diseases, and is estimated to save three million lives annually. The pioneering work of the Centre in the development of ORS has been acclaimed worldwide, and in June 2001 the Centre received the first Gates Award for Global Health.

In 1978, the Government of Bangladesh (GoB) passed an Ordinance, making the CRL an international institution, and renaming it the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), hereinafter referred to as the "Centre". Under the Ordinance, an international Board of Trustees (BoT) was set up to provide overall guidance to the activities of the Centre. With the internationalization of the Centre, its focus broadened to include not only cholera and diarrhoeal diseases but also family planning, fertility, and nutrition; and over time child health, reproductive health, health systems research, and environmental health. In addition to conducting basic and applied research, the Centre provides training to scientists from around the world. It also provides hospital and laboratory services. Furthermore, it provides valuable technical assistance to the GoB and NGOs. Thus, it has evolved from being primarily a research institution to one that also provides training, service and technical assistance (Annex I gives a brief history of the evolution of the Centre).

Over the years, the Centre has attracted scientists from all parts of the world, including Bangladesh. This has resulted in a powerful cross-fertilization of ideas and approaches, thereby contributing considerably to the high-quality research, training, service, and technical assistance activities of the Centre. The publication record of the Centre (over 2000 scientific publications in peer-reviewed journals and numerous working papers and other special publications since 1978) provides evidence of the level of research that is being carried out at the Centre. The Centre has trained over 20,000 health and family planning professionals from 78 countries in five continents across the globe, who have applied what they have

learned at the Centre in their own countries. At the same time, the Centre has earned the reputation of running the world's best diarrhoeal disease hospital at Dhaka, treating, on average, 120,000 patients per year. In addition, the Centre has provided valuable technical assistance to the GoB and NGOs in Bangladesh in the design of a number of important programme interventions. In short, the Centre, through its excellent research, training, service and technical assistance activities, has used science and technology to develop solutions to major health and population problems in Bangladesh, with global application. Indeed, the work of the Centre is often cited as the authority for important health and population-related decisions taken by governments and development agencies throughout the world. Also, the Centre takes pride in the fact that many of its alumni are influential policymakers in their respective agencies.

Organization and Management

Board of Trustees

The Centre is governed by a 17-member international Board of Trustees, comprising distinguished researchers, public health professionals, representatives of the GoB and the private sector. A majority of the members are nationals of developing countries including three from Bangladesh. The Board also includes one representative from the World Health Organization and one from another UN agency, currently UNICEF. The Board is a self-selecting body, and members serve for three-year terms, and they may serve for a maximum of two terms. While there is no specific geographic representation, the Board has traditionally represented different regions of the world. The Board appoints a Director and approves the selection of all staff at the rank of P5 and higher, including the Associate Directors who head the scientific Divisions.

Organizational Structure

There were 1,117 permanent staff as of July 2001 including 12 international staff. These staff work in one of five scientific/technical Divisions or in one of four administrative units within the Director's Division.

The Clinical Sciences Division (CSD), staffed with physician-scientists trained in gastroenterology, infectious diseases, nutrition, epidemiology, and general medicine, is engaged in clinical hospital and community-based research of enteric and respiratory diseases and nutrition; the provision of care to more than 120,000 patients annually at the Clinical Research and Service Centre (CRSC) in Dhaka; preventive health activities directed toward children and their mothers; and training in case management of diarrhoeal diseases and associated complications as well as in research methodology.

The Health Systems Research Division (HSRD), staffed with public health professionals, medical doctors, economists, demographers, statisticians, sociologists, and anthropologists, undertakes operations research in both rural and urban areas of the country in family planning, reproductive and child health, and provides technical assistance to the GoB and NGOs and the Social Marketing Company (SMC) in the application of the Centre's research findings to improve the national health and population programme in areas related to management, quality of care, and sustainability. There is a surveillance system, covering both rural and urban areas of the country where the Division conducts its research. The Division assists the Centre's training programmes, and takes the lead role in training courses on health systems research.

The Laboratory Sciences Division (LSD), staffed with bacteriologists, virologists, parasitologists, molecular biologists, immunologists, histopathologists, nutritionists, biochemists, and environmental microbiologists, conducts research in enteric and respiratory diseases, reproductive tract infections (including sexually-transmitted infections (STIs) and human immune deficiency virus diseases), environmental microbiology and nutritional biochemistry; provides laboratory support to other scientific Divisions as well as state-of-the-art diagnostic facilities for a variety of illnesses and disorders. Laboratory-based training programmes are also a priority of the Division.

The Public Health Sciences Division (PHSD), staffed with public health professionals, epidemiologists, social scientists, and economists, focuses on the evaluation and testing of community-based, cost-effective, sustainable interventions to improve the health of children, young adults, and women of child-bearing age. The Division is responsible for the primary health care services in rural Matlab, where there is a population of 210,000 people under demographic surveillance. The Division also provides several short training courses, and

assists in various training programmes carried out by the Centre's Training and Education Department.

The Information Sciences Division (ISD), staffed with IT experts, trainers, librarians and related staff, comprise the Training and Education Department (TED), the Dissemination and Information Services Centre (DISC), and the Computer Information Services (CIS). The Division is responsible for the Centre's overall training, library, publications, dissemination and computer services.

The Director's Division provides the administrative and infrastructural support essential for the efficient functioning of the research, service, training and technical assistance activities of the Centre. The Director's Division currently consists of offices for Policy and Planning, External Relations and Institutional Development, Human Resources, Finance, and General Administration. The Director's Division also houses the secretariat for the Ethical Review Committee (ERC) and the secretariat for Asian Scientific Conference on Diarrhoeal Diseases and Nutrition (ASCODD).

Programmes

With a view to better position the Centre to respond to the emerging priorities in the health and population sector as well as of the donor community and realizing the need for greater synergies and coordination among the activities of the scientific divisions, the Centre, over the last few years, has set up several cross-divisional Programmes. These are: Child Health, Reproductive Health, Nutrition, Infectious Diseases and Vaccines, Health and Family Planning Systems, and Population. These cross-cutting programmes are aimed at enabling the scientists from one Division to work closely with their colleagues in other Divisions and to move research findings from basic findings to their application in an efficient manner.

Child Health. The mandate is to contribute to the development of cost-effective child health and survival programmes by enhancing the understanding of the causes of childhood morbidity and mortality and by testing cost-effective public health interventions. Major emphasis is given to decreasing mortality during the neonatal period, and to implementation of the integrated management of childhood illnesses.

Reproductive Health. The mandate is to address issues related to reproductive health research with major emphasis on safe motherhood, family planning and prevention and treatment of sexually-transmitted infections.

Nutrition. The mandate is to improve the overall nutritional status and address other nutritional issues applicable to the population by conducting relevant research and translating the research results into meaningful action. Major emphasis is given to prevention of and treatment of severely-malnourished children, evaluation of micronutrients such as zinc, and reducing the adverse consequences from low birth weight.

Infectious Diseases and Vaccine Sciences. The mandate is to facilitate and focus on the Centre's expanding role in the prevention and control of infectious diseases relevant to Bangladesh and other impoverished settings globally, with particular emphasis on epidemiology, clinical and laboratory research, and vaccine evaluation. Major emphasis is given to evaluation of vaccines for enteric and respiratory infections and control of tuberculosis, dengue, HIV-AIDS, and malaria.

Health and Family Planning Systems. The mandate is to conduct research relevant to national health and family planning programmes through identification of priority problems; design, implementation, evaluation and replication of cost-effective and sustainable interventions; and provision of technical assistance that will deliver maximum health benefits to the community, making optimal use of available knowledge, solutions and resources. Major emphasis is given to supporting studies of practical value to improving the Essential Services Package (ESP), evaluation of government and NGO programmes, development of evaluation tools, providing technical assistance, and understanding issues of health equity.

Population. The mandate is to understand demographic trends in Bangladesh and to assist with development of policies and programmes that will decrease fertility and mortality while respecting individuals' desires and expections. Special emphasis is given to studies to understand the levelling of the fertility rates at a level above replacement rates.

New Programmes. The Centre expects to form at least two new programmes in the near future including one for safe water and another for HIV-AIDS. The Programme on safe water will coordinate those activities that are involved with provision of bacteriologically

safe water, arsenic contamination in water, and operations research related to provision of safe water. The HIV-AIDS Programme will greatly expand the ongoing activities already started to control the impending HIV epidemic in Bangladesh.

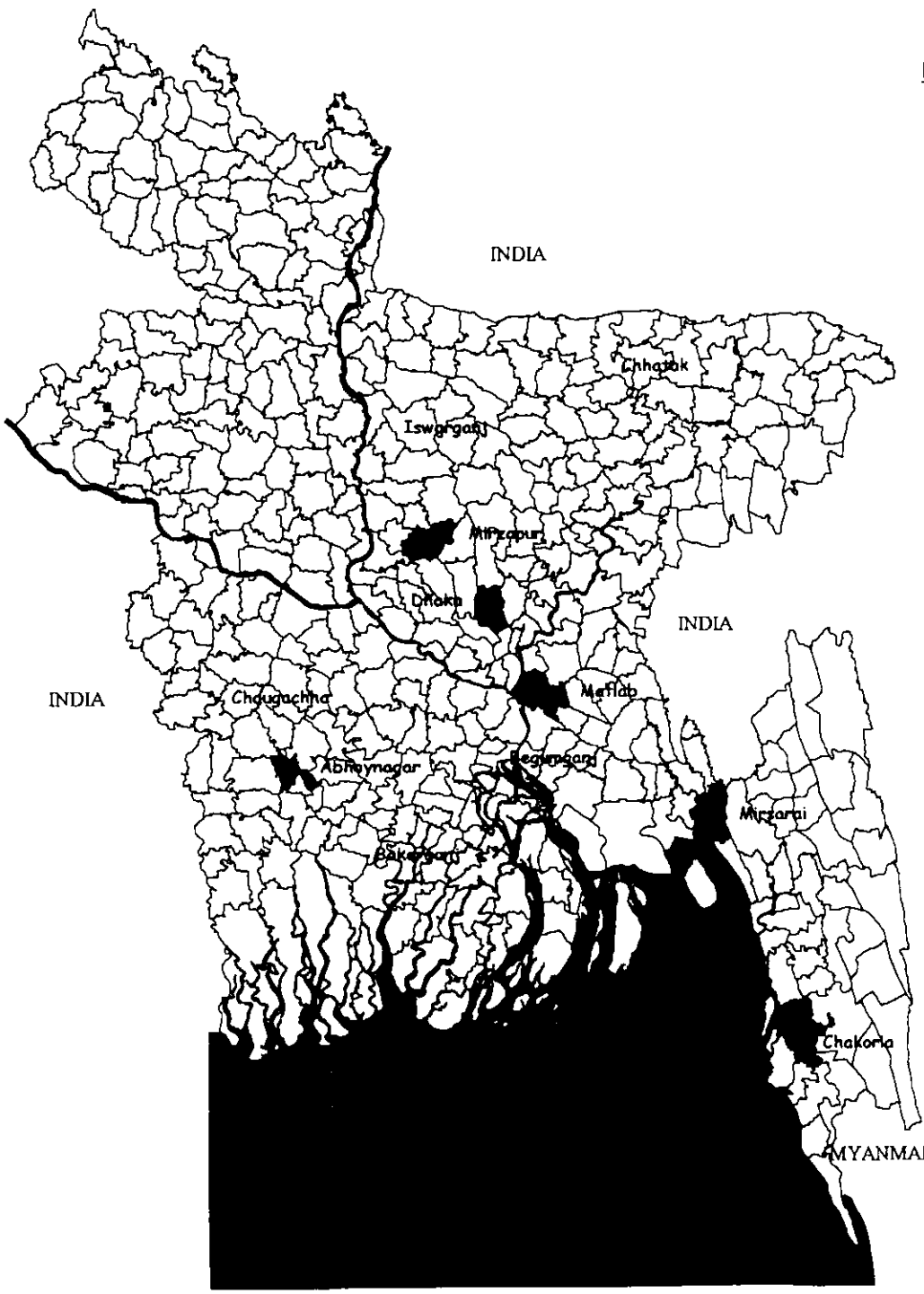
Existing Activities. The activities of the Centre fall in four broad categories: research, training, technical assistance and services.

As of early 2001, the Centre had a total of 85 ongoing research and technical assistance projects. These projects fall under nine themes: nutrition, child health, health systems, emerging and reemerging infectious diseases, clinical case management, reproductive health, social and behavioural sciences, vaccines, and population dynamics. The ongoing projects cover various topics, including, for example, prevention, pathogenesis and risk factors, treatment and management, molecular epidemiology, diagnostics, immune response, effectiveness and impact; and strengthening of knowledge, service delivery, support systems, and financial sustainability. The ongoing projects are divided into 12 major types of studies, with community-based trials/interventions being the most frequent type, followed by clinical trials, cohort or follow-up studies, surveillance/monitoring, and cross-sectional/descriptive studies.

The Centre has several field sites, spread across different parts of the country. The majority of the ongoing studies are carried out at the Dhaka Hospital, followed by Matlab, rural ORP sites (Abhoynagar and Mirsarai), selected urban sites, and a few in other specific areas. (See map).

Map of Bangladesh

Showing ICDDR,B Field Sites



DIVISIONWISE FIELD SITES

SYLHET DIVISION

Chhatak

DHAKA DIVISION

Iswarganj
Mirzapur
Dhaka

CHITTAGONJ DIVISION

Matlab
Begumganj
Mirsarai
Chakoria

BARISAL DIVISION

Bakerganj

KHULNA DIVISION

Abhoynagar
Chaugachha

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The Centre operates two hospitals that constitute the infrastructure for clinical research, patient care, and research and case management training. In addition to supporting research activities, the two hospitals provide patient services for the treatment of diarrhoeal diseases, malnutrition, and acute respiratory infections and, at the Matlab facility, reproductive health services including emergency obstetric care. The hospital-based clinical and laboratory facilities provide information to the GoB on trends and patterns in the epidemiology of diarrhoeal diseases through a hospital surveillance system.

At the Dhaka Hospital, about 120,000 patients are treated annually: 85 percent are children and 60 percent are under five. At Matlab, over 20,000 patients are treated annually of whom over 80 percent are children and 60 percent are under five. Children under five represent the most vulnerable population for mortality and morbidity from diarrhoeal diseases, vaccine preventable diseases, acute respiratory infections and related issues of malnutrition. Most of the Dhaka patient population live in the urban slum areas and most are the poorest of the poor.

Starting in March 2000, the Centre implemented the first phase of its plan to "franchise" its Dhaka hospital services with John Snow International (JSI) and Progati Samaj Kallyan Pratisthan (PSKP), a JSI-supported NGO[4]. The expected outcomes of this initiative include reduced patient load and financial pressure on the Centre's Dhaka hospital; improved health care delivery (decentralization, improved case management of diarrhoeal disease and malnutrition within a package of comprehensive health care services); and a new infrastructure for the Centre to undertake operations research and surveillance.

The clinical laboratory services unit provides diagnostic support to the Dhaka CRSC, Traveller's Clinic, Staff Clinic, and paying users; enables scientists to carry out research and provide research support to protocols of LSD and other divisions; and supports training programmes organized by the Centre. The clinical laboratories services were opened to private paying users in 1990, and since then the demand for its services has been constantly rising. The total amount of cash revenue earned from paying users from 1990 to 2000 was over US$ 3.0 million.

[4] Funded through USAID

The Centre's Training and Education Unit (TEU) provides training facilities to Bangladeshi and other nationals in areas in which the Centre has a comparative advantage. The TED offers short-term national and international training courses primarily on the clinical management and laboratory diagnosis of common diarrhoeal diseases, and health systems research.

Since 1978, nearly 20,000 scientists, physicians, laboratory personnel, programme managers, trainers and students from various countries have received training at the Centre. The Centre's Training Department has contributed towards the strengthening of national Control of Diarrhoeal Diseases (CDD) programmes in developing countries.

The Dissemination and Information Services Centre (DISC) disseminates research findings and manages information resources. To support this activity, DISC maintains one of the richest libraries in the country. DISC is composed of the Information Services Branch, Publications Services Branch, and Audiovisuals Unit.

The Library has a collection of over 45,000 books, journals, reprints, documents, and audiovisuals, and receives over 300 current journals. The library provides a full range of modern information services.

The Publications Services Branch produces the Centre's annual report, *Journal of Health, Population, and Nutrition* (*JHPN*), Glimpse, working papers, scientific reports and other documents.

The Audiovisual Unit supports the Centre's communication activities through visual aid development, graphics and artwork, photography, tape-slide preparation and projection, recording of tape-slide presentations and sound mixing, and video shooting.

The major tasks of the Computer Information Services (CIS) are to: (i) provide services on all host computers and Internet connections; (ii) provide IT services to all scientific and support division and units; (iii) maintain, administer and manage all LANs in the Centre as well as the backbone network of 450 network PCs and 10 servers; and (iv) maintain Internet services for e-mail, world wide web, and interoffice communications.

Collaboration

The Centre has wide-ranging collaboration with universities and research institutions, both in Bangladesh and abroad. Collaboration within Bangladesh is conducted through relevant government agencies, NGOs, universities and research institutions. The nature of collaboration includes material support, scientific and technical assistance, expert advice and exchange of ideas, technology transfer, and financial support.

The Centre's reputation for excellence in research, training, technical assistance and services and its well-reputed alumni have established the Centre as a world leader in health research. Over the years, the Centre has entered into collaborative agreements with the world's leading international health research institutions. These agreements provide the basis for international collaboration and partnership in health and population research activities.

Over the years, leading scientists from around the world have collaborated with the scientists working at the Centre, and have provided leadership and guidance to Centre staff. The commitment of the Centre to the development of its staff has established many of them as leaders in their field of expertise, and has given the Centre a dedicated team of internationally-recognized scientists. Through collaborative work, scientists from other countries have also been able to increase their research capacity.

Collaboration within the region is expanding and includes collaborative work in Nepal and India, and Thailand. An example of the regional collaboration includes the South Asian Association for Regional Co-operation (SAARC) fellows programme, the hosting of the ASCODD secretariat at the ICDDRB, joint protocols with the National Institute for Cholera and Enteric Diseases (NICED) in Kolkata, India, a technical assistance project in microbiology in Nepal, and joint research projects with scientists in Thailand. The Centre also has collaborative links with several UN agencies such as WHO, UNICEF, UNAIDS and UNFPA. Further, the Centre collaborated with the International Union for the Scientific Study of Population (IUSSP) and Partners in Population and Development (PPD) in hosting the International Seminar on Family Planning Programmes in the 21st Century.

Health Setting as a Context for the Centre

Global Setting

In 1998, the world's population was growing at 1.3 percent per year, or an annual net addition of 78 million people. Ninety seven percent of the world population increase takes place in the less developed countries. Sixty percent of the world population increase is contributed by only 10 countries, with 21 percent contributed by India and 15 percent by China. Every year, the population of Asia increases 50 million, the population of Africa by 17 million, and that of Latin America and the Caribbean by nearly 8 million. In 2000, the world population was 6.1 billion people. It is projected to increase to 7.2 billion in 2015, and further increase to 8.9 billion by 2050. Therefore, the developing countries still have a continuing need to pursue strong family planning programmes and research in issues relating to cost-effective and sustainable population strategies.

Financing of these important activities is a major problem. Expenditure on family planning in developing regions was US$ 9.9 billion in 1996, of which about 8.0 billion was contributed by national governments and US$ 2.0 billion by donors. Funding requirements will rise about three-fold to US$ 21.7 billion by the year 2015, as the number of eligible couples increases (Bulatao, 1999).

The global demography trends are exhibiting new challenges for both the developed and developing countries. For the developing countries, some of the key emerging issues relate to rapid urbanization, environment degradation, malnutrition, and notable increase of older people in the overall population structure. If not properly addressed, in combination with underdevelopment and limited resources, both human and financial, such problems can become almost insurmountable and tie countries down in vicious cycles of further poverty and violence.

The era of globalization is presumably opening many opportunities for millions of people around the world. Increased trade, new technologies, foreign investments, expanding media and internet connections are fuelling economic growth and human advance. All this offers enormous potential to eradicate poverty and create an enabling environment for people to enjoy long, healthy and creative lives. However, experience of the last two decades indicate that most of the low-income countries have failed to seize the opportunities of economic and

technological globalization. These countries are becoming even more marginal used. Inequality has been rising in many countries since the early 1980s. Globalization was predicted to result in convergence; in fact, disparities have been widening between the developing and developed economies. For instance, by the late 1990s, one-fifth of the world's population had 86 percent of the world's GDP, while the bottom one-fifth had only 1 percent. In 1993, just 10 countries accounted for 84 percent of global research and development expenditures and controlled 95 percent of the US patents of the past two decades (Overview: Globalization with a Human Face, Human Development Report 1999).

Since the 1978 Declaration of Alma Ata, which followed the promise of "Health for All by the Year 2000", there has been progressive physical and social deterioration of communities, countries, and the environment, with increasing polarization of wealth distribution. This has resulted in a decline in the health of the world's poor, characterized by a high burden of disease, death and disability associated with a number of new and re-emerging conditions including AIDS, drug-resistant malaria and tuberculosis. For the majority of people, this has been accompanied by lack of access to decent affordable health care.

The dismal state of the health of the poor takes place against a background of political uncertainty, social and economic upheavals and cultural change. At the same time, rapidly-increasing globalization, and the revolution in information and communications technology, has made this world a global village which means that what happens in one country potentially affects every other.

Nowhere is this clearer than in health where the rapid spread of communicable diseases has emphasized once again our interdependence – and vulnerability – in the face of these global threats. At the same time, major scientific development and breakthroughs, such as the human genome project, innovative technologies that have accelerated drug and vaccine development, and the crucial evaluative frameworks now available to appraise health reform efforts and the performance of national health systems (WHO, 2000) hold the promise of more effective prevention, management and treatment for an array of critical health problems. However, the inherent danger in the powerful and inexorable forces of globalization, and similarly with the revolutionary applications now arising from new genetic understanding, is their potential to accentuate inequality. While their fruits are enjoyed by those nations and

groups with the means of access, they are generally not available to the world's poor who, instead, progressively crowd the margins behind barriers that are ever more difficult to penetrate (International Conference on Health Research for Development – Conference Report, Bangkok, October 2000).

The resources devoted to health systems are very unequally distributed, and not at all in proportion to the distribution of health problems. Low- and middle-income countries account for only 18 percent of world income and 11 percent of global health spending (US$250 billion or 4 percent of GDP in those countries). Yet, 84 percent of the world's population live in these countries, and they bear 93 percent of the world's disease burden. These countries face many difficult challenges in meeting the health needs of their populations, mobilizing sufficient financing in an equitable and affordable manner, and securing value for scarce resources (The World Health Report 2000, WHO). Overall, the world macroeconomic situation appears to be quite dismal. Poor countries are becoming poorer, debt burdens are soaring, and it is becoming increasingly difficult for them to retire and service the debts. As a result, they are forced to slash their budgets and expenditure, and health and social services are the usual casualties in this exercise.

Added to the above are the issues of allocative inefficiency. Global spending on health research for both the public and private sectors amounts to about US$56 billion per year (1992 estimate). However, less than 10 percent of this is devoted to 90 percent of the world's health problems – a misallocation often referred to as "the 10/90 gap." It has been estimated that pneumonia, diarrhoea, tuberculosis and malaria, which together account for more than 20 percent of the global disease burden, receive less than 1 percent of the total public and private funds devoted to health research. The human and economic costs of such misallocation of resources are enormous (The 10/90 Report on Health Research 2000).

Understanding how countries finance their health care systems is of critical importance for developed and developing countries alike. The methods used to mobilize the resources that support basic public health programmes, provide access to basic health services, and configure health service delivery systems affect people's economic and political well-being.

In 1994, global spending on all health activities totalled US$2,330 billion, or about 9 percent of global income. Of this, high-income countries accounted for 89 percent of the total health

expenditure, while their populations accounted for just 16 percent of the global population. The extreme disparity between the amount of resources low- and middle-income countries and high-income countries devote to health care reflects the widely varying capacities of these country groups to provide health services.

Average per capita health expenditures range from US$16 in low-income countries to US$1,468 in the high-income countries – about a hundred-fold difference. Developed countries also spend more on health as a percentage of GDP. Low-income countries spend about 4 percent of GDP on health, while the high-income countries spend about 7 percent. South Asia spends the least on health as a percentage of GDP (3.7%).

To close the resource gap, developing countries will have to make sizeable investments in health services and increase spending at rates faster than those of high-income countries. Thus, policymakers will continue to face the perpetual challenge of raising sufficient revenue for the health sector in an equitable and efficient way. Although most countries recognize that health care is a right of all citizens – as embodied in the WHO goal of "Health for All by the Year 2000" – there are no clear guidelines on how this objective translates into health service delivery, and whether such services are affordable (Innovations in Health Care Financing, World Bank Discussion Paper No. 365, 1997).

The gap between rich and poor nations is even more dramatic, when the distribution of the global disease burden is considered. Of the estimated 1.4 trillion Disability Adjusted Life Years (DALYs) lost in 1990, industrial countries accounted for just 7 percent. Of these, 81 percent were attributable to non-communicable diseases. Developing countries, which accounted for 93 percent of the global disease burden, had a rather different disease profile. Except for countries in Europe and Central Asia, which have demographic and epidemiological profiles similar to those in industrial nations, nearly half of the DALYs lost in developing countries were caused by communicable diseases, mainly among children.

Aging populations and the rising incidence of non-communicable diseases will continue to raise the cost of patient care. In industrial countries, a large portion of health spending is used for a small percentage of patients in the final years of their lives. Most of these patients are suffering from some form of non-communicable disease. Over the next three decades, developing countries will undergo a major demographic and epidemiological transition, with

significant increases in the burden of injuries and non-communicable disease. Epidemics of non-communicable diseases such as cardiovascular diseases, neuro-psychiatric conditions, and chronic respiratory infections, as well as the growing burden of violence and injuries, are increasing in low-income countries (The 10/90 Report on Health Research 2000). These diseases are more expensive to treat and harder to prevent. This transition will reorient demand for health services, including research, and increase pressures for new investment in health care and health systems development.

Bangladesh Setting

Most developing countries, including Bangladesh, face difficult challenges caused by poverty, malnutrition, and poor health, poor performance of health systems, and inadequate and/or unsustainable health care financing. More detail of the Bangladesh setting is discussed in World Bank, Health Futures in Bangladesh: Some Key Issues and Options. (draft, June 2001) and the Demographic Health Survey, 1999-2000 released in 2001.

Bangladesh is the eighth most populous country in the world with a population of around 130 million. The country has the highest population density in the world. It is one of poorest countries in the world with a per capita income of around US$ 380. As a result of overcrowding, poverty, and poor access to health services, infectious diseases and malnutrition are common.

Cholera and all other known forms of diarrhoeal disease are endemic to Bangladesh. The Centre's two hospitals and its state-of-the-art laboratories, coupled with the existing surveillance systems and field sites, offer unique opportunities for research, training, services and technical assistance. Such opportunities enable scientists to carry out comprehensive studies on cholera and other enteric diseases, together with other public health concerns, in the environment in which they thrive, with access to both hosts and agents.

Seventy-five percent of total DALYs in Bangladesh is accounted for by seven conditions: respiratory diseases, perinatal conditions, diarrhoeal diseases, accidents, malnutrition, cardiovascular diseases, and child birth related complications. Although infant and under-five mortality rates have declined considerably, they are still high. The maternal mortality rate in Bangladesh is one of the highest in the world.

Malnutrition is a major cause of Years Lived with Disability in Bangladesh. Half of all babies born are of low birth weight, about half of children are moderately malnourished, and about 12 percent are severely malnourished. As a result, 1 in 40 deaths is due to poor nutritional status. In addition, half of all women are malnourished.

Childhood infections have declined considerably in Bangladesh in recent decades due to the widespread immunization programme. Communicable diseases now account for about 38 percent of DALYs. However, respiratory and diarrhoeal diseases are still the most common causes of death among children under five, accounting for about 40 percent of all Years of Life Lost. Tuberculosis is the second most common cause of death among adults. Tuberculosis causes about 70,000 deaths per year, with 300,000 new cases each year.

Non-communicable diseases are also major causes of death in Bangladesh, accounting for half of the Years of Life Lost. Deaths associated with complications of childbirth continue to be a major cause of concern.

There are marked health inequalities in Bangladesh. The probability of dying among infants in poor households is 1.7 times higher compared to that in richer households. Also, under-five mortality is higher in poor than rich households. Twice as many children in poor than in rich households suffer from stunted growth, and severe under-weight is five times as pronounced among poor children than among rich children. Communicable as well as non-communicable diseases are more prevalent in poor households.

Population growth is also a major development challenge in Bangladesh, and places a heavy burden on health care and social services. The current average fertility level in Bangladesh is over three children per woman of reproductive age, and has reached a plateau over the last several years. Although contraception has increased, the drop-out rate is quite high. Also, the relative share of longer-acting methods has declined.

With demographic transition taking place, the disease patterns of the past century are changing. An important point to note is that in the future, communicable, perinatal and pregnancy-related complications as causes of death will decline in Bangladesh from about

half of deaths to less than one-third of all deaths. By contrast, non-communicable diseases will account for over half of all deaths.

Thus, the Centre is located in a setting that provides itself with immense scope for research, training and services on diseases which not only affect Bangladesh but most of the developing world. In other words, the setting enables the Centre to bring science to where the problems exist.

Comparative Strengths

Infrastructure

The **hospitals and clinical resources** in Dhaka and Matlab provide a large patient population typical of those who will benefit from the advances in our research. Although only a small proporation participate in actual research protocols, those who do assure timely completion of studies on new drugs, vaccines, nutritional interventions, new rehydration solutions, and other new strategies for treating diarrhoeal disease, pneumonia and malnutrition. The hospitals' **Hospital Surveillance System** (HSS) in Dhaka records information on every 50th patient, and every patient coming from the **Health and Demographic Surveillance System** (HDSS) area in Matlab. The surveillance records data on etiologic agents, physical findings, anthropometrics, socioeconomic, demographic characteristics, feeding practices, and the use of drugs and fluid therapy at home. This system thus allows scientists and physicians to improve care and preventive measures, as well as to monitor changes in disease patterns, including drug sensitivity.

The **laboratories** provide opportunities and facilities to study health problems commonly encountered in developing countries, using state of the art equipment. Also, the Centre has excellent laboratory animal facilities, including provision for inbred strains, as well as larger animals for media reagents.

The Centre's extensive rural and urban **community-based health and family planning** interventions, together with its excellent working relationships with the GoB and NGOs, provide exciting opportunities for social, behavioural, and health systems research in a variety of settings. Years of experience and meticulous record-keeping have given the Centre an invaluable wealth of information and data sets, enabling scientists to undertake high-

quality research. Longitudinal data sets enable the scientists to examine changes over time. The longitudinal data is included in the HDSS data base. About 100 field workers collect this data from the 215,000 residents of the Matlab field area, and the data is computerized as a resource for the Centre's scientists as well as others who collaborate with the Centre. Previously, the demographic data was collected separately from the health information, but the two systems have now been merged into a single surveillance system.

In other urban and rural "extension areas", the Centre maintains demographic surveillance systems. These extension areas were funded by USAID through the Operations Research Project (ORP), but with the transition to the new Family Health Research Project (FHRP), these extension areas are funded more generally by ongoing research projects.

Modern computer systems, based on a 500+ user local area network, with a dedicated satellite link and microwave link to Matlab ensures rapid compilation and analysis of the extensive data collected by Centre researchers. The Centre's **library, data archives**, and **publication facilities** allow for rapid and effective exchange and dissemination of information.

The Centre's **training facilities** at Dhaka include a 192-seat auditorium and two large seminar rooms equipped with the latest audio-visual equipment. The Centre also has a residential training facility at Matlab where groups can stay for several days while participating in hands-on experience in this rural area.

The Centre operates a **Epidemic Control and Preparedness Programme (ECPP)** that enables the Centre to assist the Ministry of Health and Family Welfare (MOHFW) during outbreaks of diarrhoeal disease, and to characterize disease and drug resistance patterns throughout the country. This programme continues to yield useful nationwide information on existing diseases as well new, emerging pathogens.

Since 1998, a second generation **Surveillance system for HIV** has been conducted annually. So far, three rounds of serological surveillance have been conducted by the Centre. The total sample size is around 8,000, and includes sex workers, male-on-male sex partners, injecting drug users, STD patients and bridging populations such as truckers, rickshaw-pullers and dockworkers. The serological surveillance is coordinated with a behavioural surveillance, and

is jointly published in cooperation with the office of the Director General Health Services. This serological and behavioural data thus forms the basis for action programmes to control or prevent the expected HIV epidemic in Bangladesh.

Multi-Disciplinary Human Resources

The breadth of disciplines among the Centre's scientific staff allows the Centre to address health and population problems from a wide variety of complementary approaches. For example, laboratory scientists and epidemiologists help scientists identify pathogens and disease patterns affected by emerging and reemerging diseases such as dengue, TB, STD and malaria, while social scientists examine the changes in human behaviour and demographers analyze the effects on population. The results of their work are then fed into health care delivery systems, which are then refined and optimized by means of health systems research. The ability to draw on this diverse expertise allows researchers at the Centre to develop a comprehensive understanding of health and population problems and their potential solutions for Bangladesh in particular and developing countries in general.

Review Mechanisms

The Centre is committed to ensure that its research agenda is relevant and is at the forefront of international health. Furthermore, to ensure its scientific excellence and relevance and that the research agenda falls within the Centre's strategic areas of interest and competence, each **research protocol is subjected to internal and external peer reviews**. In addition, to maintain the highest standards of propriety, the Centre's **Ethical Review Committee** (ERC) critically examines the ethics of any proposed protocol.

The **Programme Committee** of the Board of Trustees meets biannually to review the scientific activities of the Centre; review implementation of these activities, review and approve programmes formulated by the Centre, and develop and implement a mechanism of auditing on-going and completed programmes. In addition, the BoT commissions external reviews of the divisions on a regular basis.

With these mechanisms, the Centre ensures that its activities are well-organized and directed to the major health and population issues within its expertise, while maintaining the

flexibility to respond to the changing needs and new discoveries that characterize health and population research.

Financial systems

The finance system provides a completely computerized accounting of all income and expenditure that allows the Centre to generate financial reports as needed for each donor. The Centre's accounts are audited annually jointly by a reputable multi-national audit firm (currently Price Waterhouse Cooper) in association with a well-recognized local audit firm. In addition, special audits are conducted as needed for specific grants. Also as needed, audits are conducted to review specific financial actions within the centre (e.g interdepartment charges, risk management of the financial system, etc.)

Ethical Reviews

Each protocol involving human subjects is subjected to a review by the Ethical Review Committee (ERC). This Committee was established through provision in the Centre's Ordinance which was signed by the country's president. The ERC reports to the Board of Trustees, but its members serve in their individual capacity with the exception that the Bangladesh Medical Research Council (BMRC) must be represented on the ERC. Approximately one-third of the members of the ERC are scientists of the Centre, but the others are respected members of the local community, including both scientists and non-scientists. The membership includes women, members of the religious community, and legal professionals. The ERC has a Multiple Project Assurance (MPA) with USAID, and has applied for an Assurance with the Federal Wide Program of the United States. It uses the Helsinki Accord as its standard, and has formed its own set of procedures. The Committee meets monthly, but may hold extraordinary meetings if needed. Its meetings are recorded in official minutes.

Future Directions

Revision of mission statement

A review of the previous mission statement identified a few issues that needed to be addressed to ensure that the statement(s) adequately reflected the purpose of the Centre's existence, outlined its "business", and provided a statement of values that guide the

accomplishment of the Centre's mission. Thus, the statement has been re-formulated into three sections: a mission statement, a values statement and a vision statement.

Mission

The mission of the Centre is to improve the health of vulnerable people in Bangladesh and globally, by developing and disseminating feasible and cost-effective solutions for major problems of ill-health and malnutrition through health research, service, training, and communication, leading to policy and action.

Values

The Centre's guiding values are:

- Excellence and high ethical standards in science and service
- Fairness to and respect of staff, patients, communities and partners
- Responsible and efficient use of resources
- Responsive to emerging issues

Vision

The Centre's vision is to be a leader and a partner in national, regional and global efforts to improve the quality of life in developing countries, and to be an advocate, guiding scientific and health resources to benefit vulnerable populations.

Priority Setting

The basis for setting priorities is provided by the Centre's broad mission statement, a well-defined vision for the future, a multi-disciplinary skills pool, a long-standing evidence-based research experience, patient and field populations, and funding prospects. These aspects are combined with an evaluation of the cost-effectiveness of the activity, the feasibility of potential resulting interventions, and emerging new problems.

In setting its priorities, the Centre's guiding principles are: Global Health by the year 2020, the regional burden of disease/DALYs, and the local burden of disease.

"Life Cycle" Approach

In general, the "life cycle" approach conceptualizes the health, development, and research issues of individuals and families, and suggests intervention points where significant

improvements can be implemented. The Centre places a great deal of emphasis on the periods immediately prior to pregnancy, the pregnancy itself, the delivery of the newborn infant and the period during infancy. In addition, the Centre places emphasis on critical periods of vulnerability, especially from common illness that are preventable or treatable using cost-effective methods. This is not, however, to exclude other periods of life (later childhood, adolescence, later adult years), but it does focus the Centre's resources on these particularly vulnerable periods. It seems that interventions during the defined vulnerable periods will have the greatest payoff in terms of cost-effective and long-term improvements in health and development. The "life cycle" approach also suggests that the rewards of intervening at these crucial periods are likely to have payoffs in future generations.

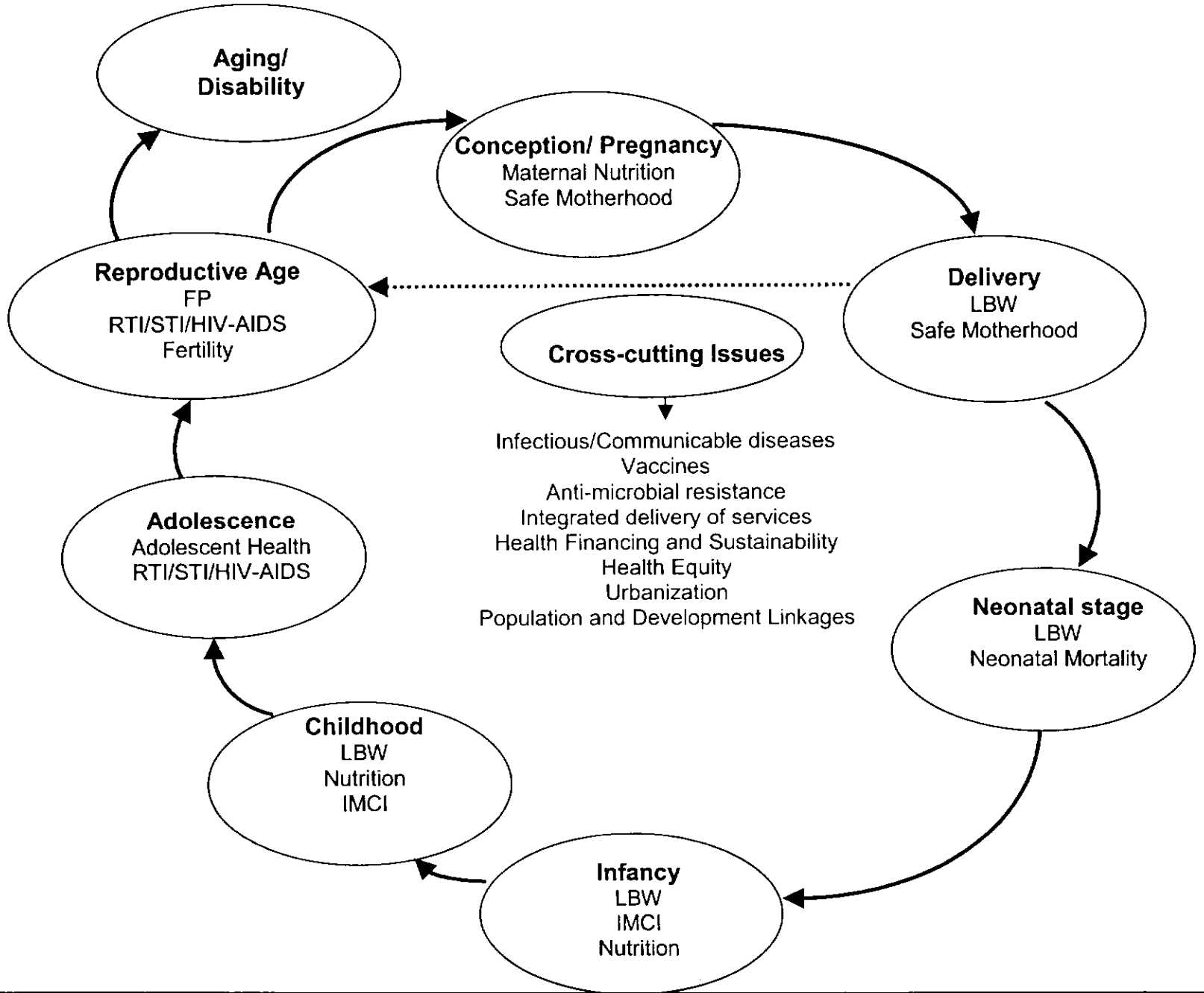
The major challenges for the health research in the developing regions include population growth, emerging and re-emerging infectious diseases resulting from globalization and ecological changes, and non-communicable diseases with the rapid growth of medical technology and their implications on the costs of the health systems. The Centre's research priorities cover six major programmatic/thematic areas, namely, child health, reproductive health, nutrition, infectious diseases and vaccine sciences, health and family planning systems, and population. The major research priorities of the Centre, at different stages of the life cycle, include (see Figure 1):

maternal nutrition	safe motherhood	low birth weight
neonatal mortality	childhood nutrition	integrated management of childhood illness
adolescent health	RTI/STI/HIV-AIDS	family planning and fertility

The major cross-cutting research issues are:

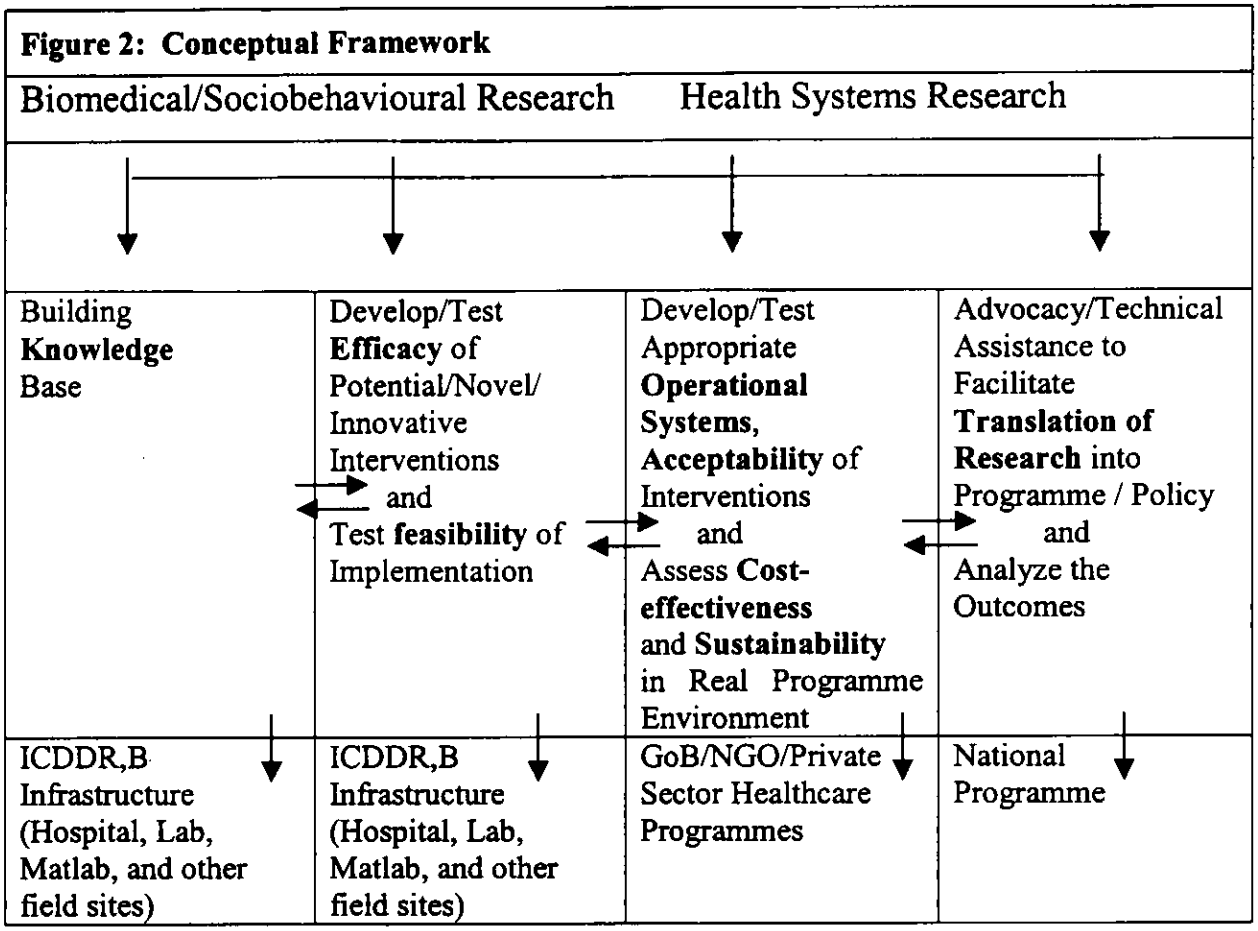
infectious / communicable diseases	vaccines
anti-microbial resistance	safe water
integrated delivery of services	health financing and sustainability
health equity	urbanization
population and development linkages	research findings to policy and action

Figure 1: "Life Cycle" Approach to Prioritization of ICDDR,B Research



In conducting this priority research, the Centre will follow the conceptual framework, as outlined in Figure 2.

Figure 2: Conceptual Framework



Programme Priorities

Annex II gives the key research priorities by their current strengths, comparative advantages and time frame. The research questions, performance indicators, resource needs, benefits to the Centre, and expected policy/programmatic impact are described in Annex III. These priorities and directions for research are grouped according to the programme area; however, it should be clear that these are Centre priorities that have been recommended by the different Programmes. Therefore, the specific activities may, or may not be actually carried out through that Programme.

The priorities for child health include surveillance and management for common childhood illnesses, improving neonatal health, strengthening immunization programmes, strengthening health systems for delivery of health systems for children, and responding to emerging childhood health problems. These priorities are in keeping with the major new initiatives for

IMCI, EPI, and the realization that neonatal mortality has been extremely resistant to decreases seen in other age groups. The latter priority is seen as very much complementary with the priority on emergency obstetric care of the reproductive health programme. It is also complementary to the new concepts of improving the management of the common, lethal diseases being developed for the hospital.

The priorities for reproductive health include safe motherhood and emergency obstetric care, improving family planning services, meeting the needs of adolescents reproductive health, prevention and treatment of STI/RTI/HIV-AIDS, minimizing the need for and improving post-abortion care, new born care, violence against women, and increasing appropriate breast feeding.

The priorities for nutrition include improving maternal nutrition and decreasing rates of low birth weight, prevention and management of severe and moderate malnutrition, improving child feeding, monitoring the interaction of nutrition and child development, provision of micronutrients, and building the knowledge of the interaction between infectious diseases and nutrition.

The priorities for infectious diseases and vaccine sciences include evaluating promising new vaccines for enteric and respiratory infections, defining disease burdens of selected infectious diseases, defining the risk factors for selected infectious diseases such as cholera, pneumonia, dengue, tuberculosis, malaria, improving management of selected infectious diseases such as dengue and tuberculosis, enhancing the capacity to investigate study and manage outbreaks in the region, and containing the impending epidemic of HIV-AIDS in Bangladesh.

Priorities for health and family planning systems include defining service strategies, economic analysis of various delivery options, measurement of health equity at the local level, private and public partnerships, translation of research findings into policy and programmes, improving medical information systems to make them useful for local health authorities.

The priorities for population include investigations of the fertility decline in Bangladesh and understanding why it has not continued in recent years, understanding contraceptive use

dynamics, understanding the relation between contraception and abortion to minimize the latter, beginning to characterize patterns of adults ill health especially related to disabilities, unederstanding the relation between poverty, equity, and health especially as this relates to rapid population growth, understanding how to reduce fertility rates to replacement levels and characterizing the consequences of higher fertility rates.

Translation of Research Findings into Policy and Action

The Centre is principally involved in research leading to new knowledge to promote health; however, it has limited scope and resources to implement policy actions without the direct involvement of the government, NGOs, or a relevant regulatory body. Efforts are underway to develop a strategy to make this possible. Translation of research findings is an important task, and will lead to increasing GoB and donor interest and attention. To achieve this, the Centre will identify its products and services that would lead to health promotion, and try to attract the attention of relevant bodies for practical implementation. Special efforts will be made by the Centre to develop communication with policy makers, NGO officials, donors, and UN agencies. The Centre will have a strong policy and advocacy unit to undertake these activities.

The Centre will provide support and due recognition to the scientists (in terms of salary and other support) for the time that is required for such translation, and appropriate funding will be allocated to research projects which involve activities which are aimed at translating research findings into policies.

Although the Centre's future research will be policy-oriented, basic research will not be discouraged. Not every research finding is translatable, and there would be no move to do so.

Internationalization

The Centre currently has major collaborations with institutions globally, but has limited project activities outside Bangladesh. As an international centre, it has the capability to expand its activities beyond the boundaries of Bangladesh but this depends on the willingness of other governments to accept our assistance and funding mechanisms to support such projects. The Centre plans to actively seek opportunities for projects within the region. Such activities might include training and technical assistance, joint research projects with

universities or other research organizations, subcontracting with primary health care projects who need our expertise, and development of expertise for investigating outbreaks in the region in collaboration with the World Health Organization. The Centre feels that these activities can be carried out in the spirit of South-South collaboration and will benefit both institutions.

Marketing products and services in Bangladesh and the region. In addition to the collaborative projects identified, the Centre also plans to generate income through marketing its products through appropriate channels. These might include, for example the rice-based oral rehydration solutions, new vaccines under development, as well as surveillance systems. It will also provide consultation services to agencies who need such expert assistance in the region.

A new name for the Centre

The name International Centre for Diarrhoeal Disease Research, Bangladesh no longer describes the mission or activities of the Centre and a new name has been strongly suggested by many stakeholders. Two names that have been suggested include the International Centre for Health and Population (ICHAP) and International Health and Population Institute (IHAPI). A decision will be made soon, but the official change will require approval by the Bangladesh Parliament. The Board emphasized that the word International should remain in whichever name that is eventually decided on.

Further Strengthening of the Centre is Infrastructure and Services

Dhaka Hospital

The Dhaka Hospital was originally established as a clinical research centre where clinical studies involving patients with cholera and other diarrhoeal diseases could be conducted. Over the years, it became increasingly popular because of the high quality and dependable service with low case fatality rates, with no hidden charges. Meals and medicines are provided free of charge. The cost per patient has remained extremely low (about $10 per patient treated), and the number of patients whose lives were saved has been incredibly high – estimated to be about 10 to 15,000 patients per year. Thus, the treatment is very cost-effective; however, because of the high patient volume, the total costs have been high – about US$1.5 million per year. Unfortunately, in spite of the excellent, low cost, and life-saving

care provided, donors have not shown much interest in supporting the costs of the Hospital since they believe that the costs of running such a facility should be absorbed by the host government. The Government of Bangladesh provides some support, but not nearly enough to support the Hospital; hence, other strategies must be employed to either reduce the costs of the Hospital by decreasing the quantity of services, identifying other donors, or developing another strategy to bring the Hospital costs in balance.

A recent analysis of the patients coming to the Dhaka Hospital suggests a division into two major groups: adults and children who have severe illness coming from the entire Dhaka metropolitan area, and children with mild illness who come from the immediate adjacent areas of the city. The lives saved are those of the first group, but the others with mild illness should ideally be going to primary health care centres rather than to the Dhaka Hospital.

New role for the Hospital

The Dhaka Hospital is a key part of the health care system in Dhaka. One of the lessons learned from the Hospital is that there are certain illnesses (e.g. severe diarrhoea) that are common, life- threatening, but are easily and inexpensively treated once the appropriate case management system has been developed. Other illnesses, however, also fit these criteria of being common, potentially fatal, easily treated, and having low cost for case management. The other illnesses include pneumonia, severe malnutrition, and dengue[5]. A concept espoused by Melinda Gates in her speech awarding ICDDR,B the Gates Award for Global Health was that no child should die of an easily treatable disease, and it would be the intent of the Centre to take this message and put into practice. Thus, we intend that the Hospital should develop a model for treating with much less cost these common, potentially-fatal diseases. At the same time, the Hospital is unable to take responsibility for additional patient care unless the actual treatment is provided by the Government and the NGO providers. The Hospital can, however, develop the treatment model for these illnesses.

This new role implies that the Hospital will evolve from being a "diarrhoea hospital" to a new form of treatment centre that provides a level of care between that of a primary health care facility and that of a full service hospital, perhaps more like a specialized urgent care facility.

[5] Maternity care could be added to this list, but is not included here to avoid confusion with regard to focus on child health.

Complex cases that require extensive or prolonged care, surgical and maternity facilities, etc. would need to be referred to other area hospitals, but a large number of patients with life-threatening illness could be treated at low cost.

This model of an urgent care facility fits well with the model being developed for emergency maternity care; that is, there is planned to have one Emergency Obstetric Care (EOC) facility to serve as a referral centre for several primary health care centres.

In order for the Centre's diarrhoea hospital to evolve into an "urgent care" facility, several pre-requisites have to be considered. These include:

- provision of proper physical facilities to manage patients with ALRI and severe malnutrition
- a decrease in the number of diarrhoea patients to make room for the patients with other conditions
- a patient reimbursement scheme that will make the new facility more self-sustaining
- training of providers to this new strategy for care
- franchising the treatment for diarrhoea, ALRI and severe malnutrition to other NGO clinics in Dhaka
- referral system which allows the new ICCDR,B "urgent care" facility to send patients needing hospital care to other hospitals
- marketing of the new treatment facility to inform the potential clients of the changes in services provided
- clear statement of goals of the new facility as a research and model clinic, such that the Ministry of Health understands that the ICDDR,B will be unable to assume responsibility for the care of all patients in Dhaka who may choose to come
- a strategy for converting from the current hospital to the new urgent care facility

Financial plan for an Urgent Care Facility (UCF)

The new facility will need to plan for efficient conduct of research, minimum costs, maximum cost-effectiveness, cost recovery, and logistics. These are needed, not only to make it sustainable for the ICDDR,B, but also to make it adaptable to the MOHFW and NGOs. Thus, when developing the facility, a business manager will be need to be recruited

to assist in the design and to monitor personnel, medical records, quality assurance, costing, and efficiency. It is planned that the budget for the facility will not exceed US$ 1 million annually for patient care activities. Research costs will be in addition to this amount, but will be covered by specific research projects.

To cover the costs of the patient care, we anticipate the following income[6]:

Income from Hospital Endowment Fund	**200,000**
Income from the Diagnostic Centre	**300,000**
Income from surcharge on research studies	**100,000**
Income from patient recovery	**50,000**
Income from Government of Bangladesh	**300,000**
Total	**1,000,000**

This facility requires a separation of budgets from those of the current Clinical Sciences Division (CSD) and those of the Hospital. There are no plans however for an administrative separation. To explain, the Head CSD will remain in charge of the Hospital, but will supervise a manager of the Hospital. In addition, the Head CSD will be in charge of the clinical research activities of the Division. As the Hospital requires physician time, this will be "purchased" from the physicians in the Division. However, the Hospital will only pay for the actual physician requirements. As is the present case, nurses and paramedics can carry out much of the work of the Hospital, and the provider mix will be determined in order to maximize the cost-effectiveness of the re-designed hospital. This may result in an assessment that the Centre currently has more physicians than it requires for the Hospital. If not justified by the patient care requirements, the physicians will need to have research protocols, consulting, or technical assistance projects to cover their salaries.

It is anticipated that the MOHFW will more actively purchase medical services for its citizens through contract mechanisms. Most certainly, the contracts will require the services to be low cost. The Centre will position itself to successfully obtain these contracts and should then be able to obtain significant funding to provide the care administered through the Hospital.

[6] To adjust for inflation, the hospital endowment will need to increase to 10,000,000 USD, providing up to 400,000 per year

In March 2000, the Centre introduced a patient registration fee of 10 Taka. There are no other charges, either for food or medicine, and this registration fee only pays a token amount toward the real cost of the treatment given. It is planned to increase this fee, as well as to determine whether specific fees should be introduced to cover the costs of medicine and food more adequately.

Referrals to other hospitals

This plan will only be successful if there are other hospitals to which the excess patients can be referred. This referral system must be developed with the MOHFW. However, this would seem to be no different than the problems that the NGO primary clinics have now when dealing with patients, other than the patient expectations may be different when coming to the ICDDR,B.

The most logical plan is to assist organizations to start similar urgent care facilities based on the lessons learned from the ICDDR,B. To assist with the development of these other urgent care facilities, the ICDDR,B will have to carry out operations research into the way in which to make these facilities function using minimal resources. The NGOs may not have the same financial resources as ICDDR,B (e.g. from the Endowment and the Diagnostic Centre), and thus, will need to have solid economic data that will convince the MOHFW to invest in these facilities.

The urgent care model is not intended to be an alternative to the primary care clinic but rather as a facility where many patients with life-threatening illnesses can find care when they need an alternative to a hospital. Currently, there are no like facilities as ICDDR,B other than general hospitals, but it is widely agreed that these hospitals are unable to manage the large number of patients who need treatment, added to which, their patient care treatment is very costly.

Other clinical services that interact with the urgent care facility

Currently, the Centre operates a clinical laboratory facility that carries out routine tests. These tests are provided on a fee-for-service basis for research protocols as well as to paying clients who choose to use the laboratory at the Centre because of its high reputation. The Centre has decided to improve these facilities into a "diagnostic centre," to make it more

user-friendly, and to expand the range of diagnostic tests being performed. It is expected that the diagnostic facility can subsidize the hospital costs to some extent, while continuing to provide an increase its range of tests.

There have been suggestions that the Centre have private cabins with an enhanced level of personal services for patients who are able to pay the necessary cost. Preliminary evaluations have found that such a system would be unlikely to be cost-beneficial for the Centre unless a large number of such beds were available. Further, it may distract from the stated mission of the Centre. This suggestion for private paying beds will therefore need further review and evaluation.

Another suggestion is to provide clinical services for employees of other companies. The Centre's staff clinic has developed an excellent reputation for providing excellent preventive care and general medical care for the staff and immediate families of the Centre at minimal cost. Furthermore, the system that has been put into place for more complex care, using a pre-paid medical plan model, has been successfully established. Other companies have expressed interest in purchasing this service from our staff clinic. The Centre could decide to offer employee health services to other companies, embassies, etc., and this would provide additional income that would subsidize the Hospital. Additionally, it would direct some of the laboratory specimens to our laboratory and increase this activity as well.

Thus, using the Centre's experience in clinical research and its expertise, within its overall mission, the Hospital would have the ability to earn significant income in order to subsidize its costs. During the next year, a decision will be reached on which of these is more appropriate.

Interaction of Hospital with Clinical Research

A central mission of the Hospital is to conduct clinical research. Thus, the patients coming to the Hospital must be the types of patients needed for the Centre's mission. Currently, a very small proportion of the patients (less than 1%) is included in research protocols. This represents a mismatch between the patients served and the research needs of the protocols that have been developed. Either the patients need to change or the protocols need to change to match the patients that are available. It is assumed that both are needed and in fact it is

possible to learn of the true research needs by studying the characteristics of the patients being treated.

Adapting the research to the patients has two advantages. Firstly, the research will be more relevant to the needs of Bangladesh and to the poor in general and secondly, it will be financially beneficial to the Centre since the research protocols will increasingly benefit the Centre's financial situation.

Laboratory Services

Clinical Laboratory and Diagnostic Unit (CLDU)

The clinical laboratory tests specimens for research studies, specimens from the Hospital for clinical care, and specimens for patients who come to the Centre on a fee-for-service basis. In the near future, the clinical laboratories will be incorporated into a new Clinical Laboratory and Diagnostic Unit (CLDU) that will include the resources for the current tests, but it will be expanded to include sonography, radiology, endoscopy, histopathology and cytopathology, as well as testing of purity of water and food samples for arsenic and pathogenic bacteria. The range of clinical tests will continue to expand depending on the demand for such tests (e.g. serum lead levels for children). The concept of the Centre is to provide services to the greater Dhaka area and to generate some revenue to subsidize the Hospital.

The clinical laboratory is one unit of the Centre that is currently profitable. There is general agreement that there is much more demand for these services. Therefore, if the Centre were to provide additional services, patients will be eager to use them, and to pay for them. The reason for the popularity of the Centre's laboratory is the reliability of the results and the reasonably good service.

The Centre is renovating space on the ground floor where the services can be expanded. It is expected that the new space will be more user-friendly, and will allow for faster service. If there continues to be increased demand, additional neighborhood centres for specimen collection may be needed in Gulshan, Dhanmondhi and Mirpur. Specimens will still be sent to the Centre's main clinical laboratory, but the results will be faxed or sent by modem to the neighborhood centre.

The CLDU will likely require a full-time pathologist to head of the unit. Consultant specialists will need to be recruited for sonography, ECG, and radiology. The new CLDU will need to continue to upgrade its equipment, and the new equipment will be justified on the basis of a business-like approach in terms of "return on investment."

A specific additional requirement will be to anticipate the laboratory requirements for managing the patients with HIV-AIDS. Currently, the Centre's laboratory is one of the few laboratories with reliable HIV serology (including confirmatory western blot tests), and it will likely need to establish polymerase chain reaction assays and flow cytometry. The latter equipment has been ordered and will be operational during early 2002.

Research Laboratories

The laboratory conducts studies in a variety of fields including enteric and respiratory microbiology, STI/RTI, environmental microbiology, immunology, parasitology, bacterial genetics, and nutritional biochemistry. These laboratories have been extremely productive, but some capabilities need to be added, especially in the areas of additional molecular biology, arsenic, and serology laboratories where GCP methods can be carried out for vaccine trials. Key for this is a modern serum bank with computerized and well-characterized specimens.

The research laboratories require more space to accommodate the additional protocols under way and being planned. Some space (six units) will be renovated on the second floor to provide this extension, but even more space will be needed when added floors are built. The laboratories also need additional equipment that is quite expensive. A flow-cytometer is being added currently, but additional big-ticket items are needed (e.g. electron microscope, and sequencer).

Urban and Rural Field areas

Matlab

Matlab remains as the major rural field area of the Centre. The station boasts over 35 years of history and data collection on a current population, and it remains a major resource for the Centre and for research on health issues of developing countries. Many of the questions of crucial importance to public health can only be answered definitively in Matlab, and these

issues are ones that were never anticipated five years ago. The Centre has recently embarked on a major study on low birth weight, testing nutritional interventions in an attempt to reduce low birth weight and improve survival. Other interventions are reproductive health, including subcentre-based emergency obstetric care and male involvement, community-based IMCI, a water filtration to prevent cholera, as well as determining the epidemiology of tuberculosis in rural Bangladesh. Additional research projects include characterization of family planning successes and constraints, contraceptive use dynamics, defining the relationship of abortion and family planning, and understanding why fertility rates have not declined in recent years in spite of increasing contraceptive prevalence rates. Anticipated studies include vaccine efficacy trials for cholera, enterotoxigenic *E. coli*, and rotavirus. An unanticipated opportunity was the need for a population database on which to evaluate the safety of routinely administered vaccines. There is no other site like Matlab for conducting this evaluation in terms of its large sample size, long-term follow-up, and data quality.

A major effort went into combining the demographic surveillance system (DSS) and the record keeping system (RKS). The first records demographic data while the latter records illness events, especially related to health of children and mothers. These two systems are now combined and ongoing data are collected and organized within one HDSS database.

Matlab is only 35 miles away from Dhaka, but has felt separated from Dhaka by the 3-hour trip required to travel by car and speedboat. This distance has been effectively made closer by the microwave link that was established during 2001 allowing data and voice transmission between Dhaka and Matlab. It is anticipated that this will allow access to the Internet for Matlab users and will provide video-conferencing between Dhaka and Matlab.

Plans for Matlab include completing some needed expansion to the hospital building, completing the EOC facilities in cooperation with the Government of Bangladesh, and continuing to plan and implement new interventions that can then be scaled up for implementation in other parts of the country.

Other Rural Field Areas

The Centre works in several other field areas in addition to Matlab and each of these adds such-needed capabilities and resources. The largest of these are the rural extension areas that were part of the Operations Research Project currently the Family Health Research Project

(FHRP), but other areas include Chakaria, the Epidemic Control and Preparedness Project sentinel surveillance sites, and other areas. At all of these sites, the Centre works in collaboration with the Ministry of Health and Family Welfare and / or NGOs.

The newly designed FHRP provides some resources for the extension area, but these sites will need to identify other donors to continue their operations. They are expected to be sufficiently useful for other projects that will make them sustainable based on this project support.

Urban Field Areas

The Centre's urban major community projects are located in Kamalapur and Mirpur. The first is located close to the train station in a slum area. It has been extremely useful for studies on pneumonia, and is now the site for studies on shigellosis, and for a study on a new influenza vaccine. In cooperation with the Urban Family Health Project, this area will be used for studies on urban health, including how best to provide health services, how best to set up referral systems, and how to finance urban health programmes. The Kamalapur area will also be used for studies on new vaccines when a large urban field area is needed.

The other urban area in Mirpur has been used for smaller but intensive studies of cohorts of children. For example, studies on the epidemiology of amebiasis using molecular techniques, Phase I/II studies of new vaccines for enterotoxigenic *E. coli* and rotavirus, and community based interventions for malnutrition are currently ongoing. It is anticipated that this field area will continue as the site for other intensive community-based studies.

Information Sciences Division (ISD)

The Division was formed in 2001 as a way to bring together the Computer Information Services (CIS), the Dissemination and Information Services Unit (DISC) and the Training and Education Unit (TEU) as well as to upgrade the information services to the Centre, e.g data archiving, data management, etc. Each of these units remains as units within the Centre but it is anticipated that they will act increasingly as a coordinated division.

Training and Education Unit (TEU)

The TEU plays a key role in the Centre's strategy to disseminate its research findings to health professionals in developing countries. Since 1978, the TEU has been offering short-term training courses, usually lasting two weeks, in the clinical management and laboratory diagnosis of diarrhoeal diseases, nutrition, family planning and reproductive health, biostatistics, epidemiology and research methods. Short-term fellowship programmes are also coordinated by this unit. To date, over 20,000 researchers, physicians, laboratory personnel, managers, trainers and students from 78 countries have received training at the Centre. Most come from the developing world, but trainees from North America, Europe and Japan have also participated.

The objectives of the training programme are to promote human resources development by strengthening capacity in:

- research techniques
- management of diarrhoeal diseases and family planning services
- responding to new and emerging issues in health and population.

The TEU's strategy for development over the next five years focusses on:

- the development of tools and techniques for making the Centre's courses available by distance learning to trainees around the world. This will initially concentrate on producing printed training modules, and then making these available on the Internet and on CD-ROM. Additional reference materials to assist trainees will also be added.
- collaboration with national and regional universities to enable participants at the Centre's courses to gain credits for degree-level qualifications. The courses offered are in great demand and highly valued by trainees and their employers and the additional benefit of degree-level credits would make them even more attractive. The contacts established with the universities concerned will also have the ancillary effect of enlarging the number of resource persons available to participate in the courses.
- developing new training courses in areas in which the Centre has world-class expertise, such as demographic surveillance and severe infant malnutrition. The training programme must keep pace with changes and developments in the Centre's

research programmes, as well as with requests from potential participants, collaborating institutions and donors.

- the re-introduction of a training fellowship scheme, enabling trainees to participate in Centre projects and so gain first-hand experience of the Centre's methods and techniques. There is a continued demand from the region for more long-term training in the methods and techniques used at the Centre. In the past, the Centre has provided scholarships for training fellows to be attached to a particular project or unit to work with Centre staff and so gain first-hand experience and hands-on training. At present, there are few funds available for this type of training. The training programme will endeavour to identify funding to support the re-introduction of such a scheme.
- making the training programme self-sufficient, by promoting and marketing the training courses to donors and potential participants around the world.

Dissemination and Information Services Centre (DISC)

DISC is the central gateway to the Centre for the two-way flow of information, both incoming and outgoing. It includes sub-units concerned with information provision (library), publications and audiovisuals.

The mission of DISC is to diffuse the results of global health, nutrition and population research to solve common problems, especially in the context of the developing world. It aims to achieve this by:

- serving as an effective information management and dissemination centre in the fields of health, population, nutrition and related subjects
- optimizing the application of improved practices of information storage, retrieval, publication and dissemination
- encouraging the free flow of information, so helping to avoid duplication of research efforts
- preparing and publishing the Centre's periodicals and reports
- providing audiovisual and photographic services
- developing and maintaining computerized databases on publications and contacts.

During the next five years, DISC's strategy is to:

- evolve into an electronic information store by creating digitized archives of the Centre's publications, selected papers published by Centre authors elsewhere, research project proposals and related materials, and training materials in support of the distance learning programme. These archives will be searchable both within the Centre and on the Internet. Digitisation serves two purposes – preservation and accessibility. The older printed material relating to the establishment and history of the Centre are in danger of deterioration beyond repair. Digitisation will preserve them for the future. At present, the material can only be consulted by users in the library--digitisation enables copies of these materials to be held in several different locations and even to be purchased and used by individuals and institutions around the world.
- provide increasing access for Centre staff to periodicals and external reports in electronic format via the Internet and CD-ROM. At present, 70 percent of the periodicals subscribed to by the library are available in electronic form on the Internet, and this percentage will only increase. By subscribing to more electronic versions, DISC will overcome the problem of printed versions being lost in the mail in transit. Access to electronic journals and the acquisition of site licenses for campus-wide access, will ensure better and appropriate use.
- develop additional bibliographic databases, such as a bibliography of Centre authors' external publications and a bibliography of material on Bangladesh related to health, population and nutrition, and make these available on the Internet. There is a decreasing need for the detailed databases, containing abstracts of material selected from incoming journals and reports, once maintained by libraries. This information is now generally readily available on the Internet. Effort is better expended on developing more specialized databases in which the Centre has a comparative advantage.
- rearrange the layout in the library to provide programme information areas in which the main books and journals will be grouped together. There are indications that several programmes will be employing librarians or information officers in the near future. By rearranging the library stock in this way, this project will be facilitated and service to users improved.

- provide upgraded computer facilities for library users, enabling them to access DISC resources and the Internet. Library users can find the answer to most, if not all of their, queries by consulting material on CD-ROMs and in the various databases developed by DISC. Some users may also be allowed access to the Internet in the library. In view of these developments, up-to-date computers would need to be installed in the library to assist users in their search for information.

Computer Information Services (CIS)

CIS is responsible for the provision of modern IT services, including e-mail and Internet, to all scientific and support divisions in the Centre. This includes maintenance and management of the local area network (nearly 500 PCs connected), development and maintenance support for applications used in the Centre, training and assistance to users.

The broad objectives of CIS are to:

- develop a fully integrated IT infrastructure, based on existing and recognized technology standards and which is capable of managing and delivering information throughout the Centre in accordance with defined requirements;
- provide end-users with a seamless interface and connectivity to all applications; and
- provide direction and strategy in fulfilling these requirements.

CIS' future plans over the next five years focus on:

- the development of an integrated management information system to provide the Centre's managers with predefined reports to assist in decision-making, monitoring and control.
- the introduction of a data warehouse, an Internet application that will allow registered users to access and download special datasets derived from the Centre's demographic surveillance work. In addition, a donor area in the warehouse would provide access for donors to specific reports and audit requirements. This facility will facilitate access to data held in the Centre by our collaborators and donors.
- enhancement of the Centre's Internet presence by providing features such as forms, database interfaces and distance learning modules on the Centre web pages. This will

involve working closely with other Divisions in the Centre to enable web interfaces to existing systems to be developed. In this way, information from the Centre will be made more easily available to users around the world.

- standardization of the software and hardware used by Centre staff for common office automation tasks and the provision of regular training courses, in cooperation with TED. The limited resources available in CIS to support and maintain both software and hardware and the desire for standardization within the Centre necessitate this decision.

Human Resources Management

The Centre's ordinance specifies that the personnel system be similar to that of the United Nations. Over the years, it has become clear that the UN system is not ideally suited to the needs of a large research and health service provider like the ICDDR,B. Unlike the UN, there is no guaranteed revenue each year, the work is primarily academic / research and not administrative, and the market place does not allow for a civil service system like that of the UN. Also, for international posts, the UN assumes a career structure while the Centre does not have a career structure for international professional officers (IPOs).

The Board of Trustees asked the management to evolve toward a personnel system that is based on merit, and increasingly based on the market. The Centre is now proceeding to identify a rational HR system and has started a process of reclassification of all jobs at the Centre. The new system will adapt some components of a merit system, but will not completely abandon the UN system. For positions that are in high demand, however, the newer system will be more adaptable to market forces. For Bangladeshi scientists who are highly productive, the Centre has instituted a plan that allows them to have international salaries in proportion to the external grants they secure.

The HR agenda also aims to increase emphasis on internal training, cross-training, development of career tracks, and staff development to allow professionals and skilled workers to reach their full potential. At the same time, the agenda encourages economy of human resources so that more productive work is accomplished with fewer staff. This can be accomplished by cross-training, out-sourcing, increasing automation, and selection of highly qualified staff.

Certain financial aspects of the human resources are also under review. Specifically, the costs for a benefit package available to staff must be included in the personnel costs charged to the projects. The cost for medical coverage is currently included in the personnel costs and placed in a medical reserve account. Similarly, the costs for indemnity and end of service payments will also be placed in similar reserve accounts.

The Centre formerly followed a six-year rule for international staff which was interpreted to mean that IPO staff may serve for a maximum of six years, at which point, they must leave the Centre or revert to a local staff salary. This rule has now been changed for Bangladeshi scientists and is now being reviewed for staff at international rank.

A major need in the HR agenda is an improved management information system (MIS) to record all HR data for each staff member. This will be developed during the next few years, and will be coordinated with the system in the Finance Section.

Financial management of the Centre

The financial health of the Centre will depend on the adequacy of the financial resources provided to the Centre by its donors (resource mobilization), the income from its Endowment, the efficiency of the Centre's management, and the Centre's productivity. The Centre has an excellent reputation for financially-sound management and transparent accounting practices, and it places great emphasis on maintaining this trust. The goals of the financial management of the Centre are to utilize the resources made available in a manner that is responsible, and to make full efficient use of these resources in keeping with the mission, values and vision of the Centre.

Resource Mobilization

The broad objectives of this Resource Mobilization Strategy are to expand the Centre's resources through the following mechanisms:

- strengthening institutional relationships between the Centre and its traditional donors
- expanding our base of non-traditional donors from public and private foundations, the corporate sector and the local business sector

- increasing support from Centre alumni
- expanding knowledge of the Centre through contacts nurtured by the Centre's Board of Trustees, alumni and supporters
- structuring our project budgets to ensure full recovery for the total costs of the project
- attracting new funds through better use of information technology that can publicize the Centre's programmes and skills to a much wider audience of professionals, researchers and practitioners in the global health community
- broadening the range of activities for our professional staff to include technical assistance, consultations, and evaluation projects
- increasing income from fee-for-service activities (e.g. clinical laboratory and patient fees)
- increasing support to the endowments
- ensuring that our senior management team, international scientists and senior-level national scientists know how to: (a) identify new resources, (b) utilize appropriate channels to secure new resources and, (c) present to the donor community a consistent and unified picture of the Centre's unique qualities such as its location, its state-of-the-art research capabilities, its wealth of human resources, and its scientific excellence.

This strategy will require additional resources for the office of External Relations and Institutional Development and training of the scientific staff to increasingly become responsible for the development of successful programmes.

Centre Endowment

The Centre's Endowments, raised during the last ten years, totals about US$ 9 million, but needs to grow to at least US$ 30 million. The goal for the next five years is to reach a goal of US$20 million by 2010. The additions to the Endowment will depend on gifts from organizations, foundations and individuals who share our goals, and believe that a strong and stable Centre will continue to meet the challenges of the future. The intent of the Endowment is to provide stability, flexibility and responsiveness, and to become less dependent on donors. Only with a strong financial base can the Centre respond quickly to new opportunities, and new emergencies.

The Endowment Funds are invested conservatively and only a modest amount (not exceeding 5% of the principal) of interest earned is taken into revenue. Thus, the Endowment is intended to grow over time. A fund management committee, appointed by the Board of Trustees, oversees the Fund which is currently managed by TIAA-CREF, one of the largest investment firms in the US.

Common Institutional Costs

Each activity at the Centre has a budget formulated at the time the project is defined, and this budget is designed to anticipate the actual costs of the project. All direct costs associated with the project are itemized, and the project director or principal investigator has authority and responsibility to manage this account within the rules of the Centre, and under the supervision of the Division Head and the Director. Some costs, however, are more difficult to itemize (e.g, the costs for the offices of finance or human resources, or procurement, the Director's Office, or costs for the Board of Trustees, etc.) These costs are, thus, categorized as the common institutional costs which are currently calculated to be about 32% in addition to the directly itemized cost, but can vary slightly from year to year. These rates are actually low when compared to similar rates for US universities, and are much lower than for-profit organizations.

The Centre receives income in the form of both project support and core support. The donations to core is available for the Centre to use in the most effective way possible. Project funds, however, are designated for specific projects and these costs are tracked to validate the appropriate use of the funds. Most donors who provide project funding pay the full cost of the project including the common institutional costs, but a few have rules which do not allow these common costs, or set a cap on the amount that can be included. When a project donor provides less than the full cost of the project, the additional expenses for these common costs must be subsidized by the core donors. Thus, in the future, the additional costs for these common costs will be acknowledged in publications, and will be reported to the core donors. Using this mechanism, the Centre will be able to track the value of the core donors. In fact, the Centre will show that the core donors make it possible to carry out the work of the Centre, and that many of the projects will not be possible without this core support.

Financial efficiency and reporting

The Centre's financial management is one of the Centre's great strengths as its computerized system accurately records each transaction and makes it possible to provide reports to donors as required. During the coming years, the Centre, however, will be adopting a new computerized financial package, coordinated with the HR section, to manage all of its financial and HR functions.

A critical feature of the financial system is to have information on which to base sound management decisions. As a part of the Strategic Plan, each of the units of the Centre will be reviewed to examine ways in which to cut costs and so make the Centre as cost-efficient as possible. The Centre underwent a downsizing process in 1998, resulting in a reduction of about 200 permanent positions, and the Centre continues to carefully monitor cost, and this cost efficiency has paid off in terms of balanced annual budgets during the last three years.

Monitoring Mechanisms for implementing the Strategic Plan

The Strategic Plan serves many functions including informing all the stakeholders, on the priorities, activities, and goals of the Centre. It is meant to be a dynamic instrument that allows for some changes when absolutely needed, but should ideally be a guide for the Centre. To operate effectively, the Plan will be monitored regularly to determine if the activities are on track. The tracking of activities will be done by means of logframe, showing means of verification for each performance indicator identified. Also, each Programme will develop annual workplans, which will serve as an additional basis for monitoring its activities. Further, each Programme will identify new areas of research, not included in the Strategic Plan, for consideration of the Scientific Council, as to which of the new activities should be included as additional priorities of the Centre. The monitoring activity will consist of a report of each protocol activity and matching this report with the Strategic Plan. These reports will be prepared every six months by each Principal Investigator and unit head, and reviewed at the Scientific Council. These reports will then form the basis for reporting to the donors, and the Board of Trustees. When the actual activities differ significantly from the Plan, these will be carefully evaluated to determine if they should be included in the Plan, or if they should be reconsidered for de-emphasis. Also, when there are problems in effective implementation of activities, the Scientific Council will provide guidance regarding the optimal solutions.

Annex I

A BRIEF HISTORY OF ICDDR,B

1960	*Pakistan-SEATO Cholera Research Laboratory established.*
1963	*Matlab field station started.*
	First of a series of cholera vaccine trials launched.
1966	*Demographic Surveillance System established.*
1968	*First successful clinical trials of Oral Rehydration Solution.*
1969	*Relationship between stopping breast-feeding and resumption of menstruation demonstrated.*
1971	*Independence of Bangladesh.*
1973	*Shift from Classical to El Tor cholera identified.*
1977	*Maternal Child Health and Family Planning interventions began in Matlab.*
1978	*Government of Bangladesh Ordinance establishing ICDDR,B signed.*
1981	*New Dhaka hospital built.*
	Urban Volunteer Programme initiated.
1982	*Classical cholera returned.*
	Field testing of cereal Oral Rehydration Solution began.
	MCH-FP Extension Project began.
1983	*First issue of the Journal of Diarrhoeal Disease Research published.*
	Epidemic Control preparedness Programme initiated.
1984	*ICDDR,B received UNICEF's Maurice Pate award.*
1985	*Full Expanded Programme of Immunization activities tested in Matlab.*
	WC/BS cholera vaccine trial launched.
1987	*ICDDR,B received USAID's "Science and Technology for Development" award.*
1988	*Treatment of and research into Acute Respiratory Infection began.*
1989	*The Matlab record-keeping system, specially adapted for government use, extended to the national family planning programme.*
1990	*The new Matlab Health and Research Centre opened*
1991	*ICDDR,B scientists assist in the response to the diarrhoeal disease epidemics after the cyclone in southern Bangladesh, and the cholera epidemic in South America.*
1992	*ICDDR,B-Bangladesh Rural Advancement Committee study commenced.*
	New Sasakawa International Training Centre built.
1993	*New laboratories built and equipped*
	New Vibrio cholerae 0139 – Bengal identified and characterized.

1994 *ICDDR,B celebrated the 25th anniversary of the first successful clinical trial of ORS.*

1997 *Operations Research Project (ORP), following the merger of the former MCH-FP Extension Project (Rural and Urban), was set up as the sole source for the entire National Integrated Population and Health Project (NIPHP), funded by USAID for 1997-2004.*

1998 *Nutrition Centre of Excellence (NCOE) was set up under a World Bank grant to undertake operations research in nutrition as part of Bangladesh Integrated Nutrition Programme (BINP).*

2000 *Major initiatives in infectious diseases began with studies/interventions on dengue, malaria and TB.*

Annex II

COLLABORATION OF THE CENTRE

	Within Centre	***Bangladesh***	***International***
CSD	- Two with LSD	- One with INFS/DU - One with Dhaka Medical College (DMC)	- One with JHU, USAID, SDC - One with Institute of Child Health, UCL - One with University of California, Davis
HSRD	- One with CSD - One with LSD	- MOHFW, DGHS, DFP, DCC - NIPHP Partners - IHE/DU	- Partners in Population and Development (PPD)
LSD	- 13 with CSD - 7 with PHSD - 1 with HSRD	- Three with DMC - One with Salimullah Medical College - One with Shishu Hospital - Three with NGOs, (BWHC, Concern) - One with GoB and NGOs	- Two with University of Leuven, Belgium - Seven with Karolinska Institute, Sweden - Two with National Institute of Child Health and Human Development, Maryland, and JHU - One with SMI, Stockholm, Sweden - One with National Institute of Cholera and Enteric Diseases, Calcutta, India and National Institute of Infectious Diseases, Tokyo, Japan - Two with CDC, Atlanta, and Emory University, USA - One with University of Edinburgh, UK
PHSD	- 8 with LSD - 3 with CSD	- MOHFW, DGHS, DFP, DHC, Universities, BIDS, Bangabandhu Medical Unviersity, Holy Family Red Crescent Hospital, NGOs	- Six with JHU, USA - One with PRISMA, Peru - One with University of Maryland - One with WHO - Three with LSHTM - One with INDEPTH - One with NIDI

- ***Centre-wide Collaboration:*** World Bank, UNICEF, WHO, UNAIDS, UNFPA, PPD

- ***Duration of Collaboration***

  CSD – 1- 10 years
  HSRD – 1-18 years
  LSD – 1-11 years
  PHSD – 1-2+ years (one project over 20 years)

- ***Nature of collaboration***
  - Material Support
  - Scientific
  - Technical Assistance
  - Expert advice
  - Exchange of ideas
  - Financial support
  - Technology transfer to the Centre

Annex III

KEY RESEARCH ISSUES BY CURRENT EXPERTISE, COMPARATIVE ADVANTAGES, AND PRIORITY

i) Child Health

Research Issues	Current Expertise[1]	Comparative Advantage[1]	Priority[2]			
			2000	2005	2010	2015
Surveillance and management of common childhood illnesses						
• Levels, trends and patterns of childhood illness and death	+++	+++	++	+++	++	++
• Management of childhood illnesses	+++	+++	++	+++	++	+
• Prevention and management of childhood illness in the community	+	+++	0	++	+	+
Improving perinatal and neonatal health						
• Levels, trends and causes of neonatal death	++	++	+	+++	+++	++
• Management of neonatal sepsis	+	++	0	++	+++	+++
• Newborn care	0	+++	0	+++	++	+
• Prevention and management of asphyxia	0	++	0	+++	++	+
• Pregnancy and delivery based interventions	+	++	+	++	+++	++
Strengthening and expansion of immunization programmes						
• Strengthen routine immunization programmes	++	+++	+	+++	++	++
• Disease burden and cost-effectiveness evaluation for new childhood vaccines	++	+++	+	++	+++	+++
• Disease control and reduction targets	++	++	0	+	++	+++
Childhood growth and development						
• Improving caring practices in the community	+	+	+	+++	++	+
• Incorporating nutritional interventions in child health services	++	++	+	+++	++	+
• Childhood development – interventions	+	+	+	++	+++	+
• Preventing and managing foetal growth retardation	+	+	+	+++	++	+
Strengthening health systems for the delivery of child health services						
• Improving child health services	+++	+++	++	+++	+	+
• Health service improvements in support of IMCI	+++	+++	++	+++	+	+
• Impact and cost-effectiveness of IMCI	++	+++	++	+++	+	+
• Alternative service delivery strategies	++	+++	++	+++	+++	+++
Understanding and responding to emerging childhood health problems						
• Prevalence, causes and prevention of childhood injuries	+	++	0	++	++	++
• Levels, trends, patterns and consequences of non-communicable morbidities in children	+	++	0	++	++	++

[1] + indicates some, ++ moderate, and +++ high level of current expertise/comparative advantage

[2] 0 indicates no, + low, ++ moderate, and +++ high level of priority

ii) Reproductive Health

Research Issues	Current Expertise	Comparative Advantage	Priority			
			2000	2005	2010	2015
Safe motherhood						
• Determine the most cost-effective, acceptable and affordable interventions to reduce maternal mortality	++	+++	+++	+++	+++	+++
• Develop strategies to train, deploy and sustain skilled attendants during delivery	++	+++	+	+++	+++	+++
• Measure progress towards improvement of maternal health	++	++	+	+++	+++	+++
Family Planning						
• Determine the most cost-effective, acceptable and affordable interventions to further reduce fertility to reach replacement levels	++	++	++	++	++	++
• Develop strategies to access them	+	++	++	++	++	++
Adolescent health						
• Determine factors responsible for health risk behaviour among adolescents	+	+	++	+	++	+
• Develop appropriate health indicators to measure behavioural change in unmarried adolescents	+	+	++	+	++	+
• Develop service delivery approaches for improving reproductive health services for adolescents	+	+	++	+	++	+
STI/RTI/HIV/AIDS						
• Determine impact of interventions on STI/RTI/HIV/AIDS/Sexual health in preventing further transmission	+	+	+	++	+	+
• Develop public health interventions to prevent/combat HIV/AIDS in a "virgin" country like Bangladesh	+	+	++	++	++	++
Maternal nutrition						
• Explore reasons leading to poor nutrition among women in general and particularly pregnant women	0	0	0	+	+	+
• Determine effect/impact of maternal nutrition/nutrition supplementation on maternal morbidity, pregnancy outcome and birth-weight	0	0	0	+	+	+
Abortion care						
• Develop strategies to reduce abortion-related mortality and morbidity	+	+	+	+	+	+
Violence against women						
• Assess magnitude, type and reasons for violence against women	+	+	++	++	+	+
• Develop strategies to reduce violence against women	+	+	+	++	++	++
Newborn health and breast feeding						
• Develop strategies to reduce neonatal mortality and to increase exclusive breastfeeding	+	+	+	+	+	+
• Determine barriers to appropriate breastfeeding	0	+	0	+	+	+

iii) Nutrition

Research Issues	Current expertise	Competitive advantage	Priority			
			2000	2005	2010	2015
Maternal Malnutrition and LBW						
• Strategies to improve Maternal Nutrition and Adolescent Nutrition	++	++	++	+++	+++	++
• Strategies to understand determinants of Maternal and Adolescent Nutrition	+	+	+	++	+++	++
• Strategies to improve and manage LBW	+	++	++	+++	+++	+++
Severe and Moderate Malnutrition						
• Understanding the determinants of moderate and severe malnutrition	+	++	++	++	++	+
• Strategies on prevention and management of severe and moderate malnutrition	++	++	++	+++	+++	+++
Infant and Child Feeding						
• Strategic studies to improve breast feeding practices	+++	+++	+	+++	+++	++
• Understanding and behavioral study on complementary feeding	+	++	++	+++	+++	++
• Improving complementary feeding and child growth	+	++	+	++	+++	++
Child Development						
• Studies on physiology, magnitude and determinants of development	++	++	+	+++	+++	+
• Studies on improving child development with malnutrition with different biological and social implications	+	++	+	+++	+++	+++
Micronutrient Research and Intervention						
• Impact and determinants of micronutrients deficiencies	+	++	++	++	++	+
• Strategies on assessment, intervention and improving micronutrient malnutrition	++	++	++	+++	+++	+++
Infectious Disease and Nutrition interaction						
• Impact, magnitude and determinant studies on infection-malnutrition	0	+	++	+++	+	+
• Strategic studies on prevention and curative measures of infection-malnutrition cycle.	+	++	+	+++	+++	+++

iv) Infectious Diseases and Vaccine Sciences

Research Issues	Current Expertise	Comparative Advantage	Priority			
			2000	2005	2010	2015
Evaluate promising vaccine candidates against key infectious diseases and disease syndromes						
• Diarrheal diseases	+++	+++	+++	+++	+++	++
• Respiratory diseases	++	+++	+	+++	+++	++
• Dengue and vector-borne	+	++	0	++	+++	+++
• TB	+	++	0	+	+++	+++
Define disease incidence and burden for major disease syndromes and key etiologies						
• Diarrheal diseases	+++	+++	++	+++	++	+
• Respiratory diseases	++	++	+	+++	++	+
• TB	+	++	+	+++	+++	++
• Vector-borne diseases	+	++	+	+++	+++	+++
• Sexually transmitted infections	++	++	+	++	+++	+++
Define risk factors, clinical, sociologic, nutritional, and other epidemiologic characteristics of priority diseases for use in developing cost-effective strategies for prevention and control						
• Diarrheal disease	+	+++	+++	++	+	+
• Respiratory diseases	+	++	+	+++	++	+
• Vector-borne diseases	+	++	+	+++	++	+
• Sexually transmitted infections	+	++	+	++	+++	+++
• Newly emerging diseases	0	+++	0	++	+++	+++
Identify, implement and evaluate treatment and prevention strategies effective for reducing morbidity and mortality from infectious diseases						
• Treatment regimens	+	++	+	+++	+++	++
• Community interventions/awareness	+++	+++	+	+++	+++	+++
• Improved management	++	++	+	++	+++	+++
Create or enhance Centre-wide focus on research of the following priority infectious diseases: Diarrheal diseases, respiratory infections, vector-borne diseases, TB, sexually transmitted diseases (including HIV)	+	+++	+	+++	+++	+++
Enhance capacity to investigate outbreaks of infectious diseases in Bangladesh and the region to use scientific methods to develop and implement strategies for outbreak control						
• Lab "surge potential"	+	+++	+	+++	+++	+++
• Epidemic response teams (national)	+ (cholera)	++	+	++	++	++
• Other out-breaks	+	++	+	+++	+++	+++
• Regional response team	+	++	+	+++	+++	+++

v) Health and Family Planning Systems

Research Issues	Current Expertise	Comparative Advantage	Priority			
			2000	2005	2010	2015
Service delivery systems for an integrated package of essential health and family planning services (ESP)						
• Cost-effective and sustainable strategies and operational sub-systems for ESP delivery through government, NGO and commercial programmes						
• Appropriate strategies for incorporating new/ efficacious interventions						
• Strengthening quality of services and strategies for meeting client satisfaction						
Economic analyses and financing of health and family planning systems						
• Demand, costing and cost-effectiveness analyses						
• Strategies for health financing and improved financial sustainability						
Health equity						
• Mechanisms to analyze/monitor types, extent and causes of inequities						
• Design and testing pro-equity intervention (s)						
Public-private partnership						
• Design and testing effective strategies for public-private partnership in ESP delivery						
Monitoring and evaluation of ESP systems						
• Simple and cost-effective methods/tools for monitoring/evaluation of process/output/outcome indicators						
• Strategies for use of monitoring/evaluation tools and results for local level planning of ESP programme						
Meeting additional (emerging) health and family planning needs of the communities						
• Appropriate methods/tools to identify additional needs by involving local communities						
• Design and testing additional health and FP needs identification methodologies						
TA for translation of research findings into policy and action						
• Communication/advocacy skills and appropriate steps for translation of research into policy and action						
• TA for cost-effective and sustainable replication of successful research findings						

vi) Population

Research Issues	Current Expertise	Comparative Advantage	Priority			
			2000	2005	2010	2015
Fertility decline in Bangladesh	+++	+++	+++	+++	+++	+
Contraceptive use dynamics	+++	+++	++	++	+	+
Interrelation between abortion and contraceptive use	+++	+++	+++	++	+	+
Health & Demographic Surveillance System	+++	+++	+++	+++	+++	+++
Ageing and adult health issues	++	++	+	+++	+++	+++
Education and family size	++	++	+++	++	+	+
Poverty and rapid population growth	++	++	+++	++	++	+
Urbanization and rural-urban migration	+	++	++	+++	+++	+++
Utilization of health and family planning services	++	++	++	++	+	+
Health equity, poverty and population	++	++	+++	+++	++	+

RESEARCH PRIORITIES, QUESTIONS, AND RELATED INFORMATION

i) Child Health

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
		Not same in every section	Not same in every section	Not same in every section	Not same in every section	
Surveillance and management of common childhood illnesses	- What are the levels, trends and patterns of childhood illness and cause of death? Can monitoring tools be improved? (5-10 years) - Can the recognition, assessment and management of childhood illnesses be improved? Can IMCI case management guidelines be improved and what impact do they have? (5 years) - What strategies can be used for the prevention and management of childhood illness in the community? How can we improve caring and care-seeking practices? What community-based nutrition/micronutrient programmes are effective and can be incorporated into programmes? (5-10 years)	- Number of projects developed, funded and implemented. - Collaborative links established. - Number of publications, dissemination activities, conferences and workshops. - Ongoing dialogue with policy-makers, stakeholders, government and non-governmental agencies, international agencies and scientific community to determine key research needs, interpret research findings and initiate policy change - Strategies, tools and protocols developed and evaluated	- Human resources having training and experience in public health, programme management, epidemiology, paediatrics, and social sciences. - Practical skills in health systems research, community-based observational and intervention studies, and clinical trials - Core expertise in data processing and management. - Computer, and other related office and communication equipment. - Access to communities and facilities with necessary research infrastructure. - Funding support	- Gain new knowledge and skills - Improved childhood illness management in ICDDR,B - Position ICDDR,B as a key player and resource - Provide ICDDR,B capacities to achieve its mission	- Expanded scientific knowledge and understanding - Contribute to the development of cost-effective and sustainable health interventions and strategies. - Improved family health, reduction in childhood mortality and morbidities, especially in socio-economically disadvantaged sub-populations.	- Extensive skills and experience in child health research - Access to study populations with high childhood morbidity and mortality levels - Centre's work in child health is well regarded

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Improving perinatal and neonatal health [Cross-cutting with Infectious Diseases and Vaccine Sciences (IDVS) Programme, and Reproductive Health (RH) Programme]	- What are the levels, trends and causes of neonatal deaths? Can verbal autopsy techniques be improved? What aetiological agents are associated with neonatal sepsis? (5-10 years) - What strategies can be used for the management of neonatal sepsis? (10 years) - What strategies can be used for routine newborn care? (5 years) - What strategies can be used for the prevention and management of asphyxia? (5 years) - What pregnancy and delivery based interventions will improve neonatal health? (5-10 years)	- Number of projects developed, funded and implemented. - Collaborative links established. - Number of publications, dissemination activities, conferences and workshops. - Ongoing dialogue with policy-makers, stakeholders, government and non-governmental agencies, international agencies and scientific community to determine key research needs, interpret research findings and initiate policy change - Strategies, tools and protocols developed and evaluated	- Human resources having training and experience in public health, programme management, epidemiology, paediatrics, obstetrics, laboratory and social sciences. - Practical skills in health systems research, community-based observational and intervention studies, and clinical trials - Core expertise in data processing and management. - Computer, and other related office and communication equipment, laboratory equipment. - Access to communities and facilities with necessary research infrastructure. - Funding support	- Gain new knowledge and skills - Improved community-based services by ICDDR,B - Position ICDDR,B as a key player and resource - Strengthen ICDDR,B laboratory capacities	- Expanded scientific knowledge and understanding - Contribute to the development of cost-effective and sustainable health interventions and strategies. - Improved family health, reduction in childhood mortality and morbidities, especially in socio-economically disadvantaged sub-populations.	- Access to study populations with high neonatal morbidity and mortality levels - History of success in building partnerships and collaborations with institutions with complementary skills and experience

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Strengthening and expansion of immunization programmes [Cross-cutting with IDVS]	- How can we strengthen routine immunization programmes, improve coverage and completion rates, reduce vaccine wastage, and integrate with other health services? What alternative vaccine delivery strategies can be adopted? (5 years) - What new vaccines can be incorporated in routine immunization programmes: assessment of disease burden and cost-effectiveness evaluation? (5-10 years) - How can we achieve disease control and reduction targets? What operational issues need to be investigated? (10 years)	- Number of projects developed, funded and implemented. - Collaborative links established. - Number of publications, dissemination activities, conferences and workshops. - Ongoing dialogue with policy-makers, stakeholders, government and non-governmental agencies, international agencies and scientific community to determine key research needs, interpret research findings and initiate policy change - Strategies, tools and protocols developed and evaluated	- Human resources having training and experience in public health, programme management, epidemiology, paediatrics, and social sciences. - Practical skills in health systems research, community-based observational and intervention studies, and clinical trials - Core expertise in data processing and management. - Computer, and other related office and communication equipment. - Access to communities and facilities with necessary research infrastructure. - Funding support	- Gain new knowledge and skills - Position ICDDR,B as a key player and resource - Provide ICDDR,B capacities to achieve its mission	- Expanded scientific knowledge and understanding - Contribute to the development of cost-effective and sustainable health interventions and strategies. - Improved family health, reduction in childhood mortality and morbidities, especially in socio-economically disadvantaged sub-populations.	- History of working closely with the government - Strong foundation in epidemiology, laboratory procedures and operational research

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Childhood growth and development [Cross-cutting with Nutrition Programme]	- How can we improve caring practices; and achieve better understanding of practices? What strategies can be used for improving practices in the home and the community (5 years) - How to incorporate nutritional interventions in child health services (development and evaluation) and address issues of integration? (5 years) - How to improving childhood development and measurement tools? What are the levels and determinants of development and what interventions are effective in improving the situation? (5-10 years) - How to prevent and manage foetal growth retardation? (10 years): • What are the levels, determinants and consequences of foetal growth retardation? • What interventions will be effective in reducing foetal growth retardation? • How to strengthen caring practices for a growth retarded newborn?	- Number of projects developed, funded and implemented. - Collaborative links established. - Number of publications, dissemination activities, conferences and workshops. - Ongoing dialogue with policy-makers, stakeholders, government and non-governmental agencies, international agencies and scientific community to determine key research needs, interpret research findings and initiate policy change - Strategies, tools and protocols developed and evaluated	- Human resources having training and experience in public health, programme management, epidemiology, paediatrics, obstetrics, nutrition and social sciences. - Practical skills in health systems research, community-based observational and intervention studies, and clinical trials - Core expertise in data processing and management. - Computer, and other related office and communication equipment. - Access to communities and facilities with necessary research infrastructure. - Funding support	- Gain new knowledge and skills - Help expand child development skills and activities in ICDDR,B - Help establish focus on "child care" in ICDDR,B - Improved community-based services by ICDDR,B - Position ICDDR,B as a key player and resource	- Expanded scientific knowledge and understanding - Contribute to the development of cost-effective and sustainable health interventions and strategies. - Improved family health, reduction in childhood mortality and morbidities, especially in socio-economically disadvantaged sub-populations.	- Centre of excellence in nutrition research - Developing skills in child development - Substantial experience in conducting community studies

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Strengthening health systems for the delivery of child health services [Cross-cutting with Health and Family Planning Systems (HFPS) Programme]	- What are the critical operational issues in implementing child health services: drug supply, recording and reporting systems, referral systems? (5 years) - How can we achieve health service improvements in support of IMCI? (5 years) - What is the impact and cost-effectiveness of IMCI and what implementation issues need to be addressed? (5 years) - What alternative service delivery strategies can be adopted? (10 years)	- Number of projects developed, funded and implemented. - Collaborative links established. - Number of publications, dissemination activities, conferences and workshops. - Ongoing dialogue with policy-makers, stakeholders, government and non-governmental agencies, international agencies and scientific community to determine key research needs, interpret research findings and initiate policy change - Strategies, tools and protocols developed and evaluated	- Human resources having training and experience in public health, programme management, epidemiology, paediatrics, and social sciences. - Practical skills in health systems research, community-based observational and intervention studies - Core expertise in data processing and management. - Computer, and other related office and communication equipment. - Access to communities and facilities with necessary research infrastructure. - Funding support	- Gain new knowledge and skills - Improved community-based services by ICDDR,B - Position ICDDR,B as a key player and resource - Provide ICDDR,B capacities to achieve its mission	- Expanded scientific knowledge and understanding - Contribute to the development of cost-effective and sustainable health interventions and strategies. - Improved family health, reduction in childhood mortality and morbidities, especially in socio-economically disadvantaged sub-populations.	- Capacity for health systems research is strong and versatile - History of working closely with the government

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Understanding and responding to emerging childhood health problems	- What is the prevalence and cause of childhood injuries and how can they be prevented? (10 years) - What are the levels, trends, patterns and consequences of non-communicable morbidities in children (e.g., lead exposure)? How can we prevent and manage them? (10 years)	- Number of projects developed, funded and implemented. - Collaborative links established. - Number of publications, dissemination activities, conferences and workshops. - Ongoing dialogue with policy-makers, stakeholders, government and non-governmental agencies, international agencies and scientific community to determine key research needs, interpret research findings and initiate policy change - Strategies, tools and protocols developed and evaluated	- Human resources having training and experience in public health, programme management, epidemiology, paediatrics, nutrition and social sciences. - Practical skills in health systems research, community-based observational and intervention studies, and clinical trials - Core expertise in data processing and management. - Computer, and other related office and communication equipment - Access to communities and facilities with necessary research infrastructure. - Funding support	- Gain new knowledge and skills - Define areas of emphasis for ICDDR,B - Position ICDDR,B as a key player and resource - Provide ICDDR,B capacities to achieve its mission	- Expanded scientific knowledge and understanding - Contribute to the development of cost-effective and sustainable health interventions and strategies. - Improved family health, reduction in childhood mortality and morbidities, especially in socio-economically disadvantaged sub-populations.	- Capacity for cross-disciplinary research - History of being responsive to health needs of the population - With declining infections, non-infectious morbidities are becoming increasingly prominent. Centre's credibility makes it ideal for it to expand into emerging problems.

ii) Reproductive Health

Priority Areas/ Categorization	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Safe motherhood	- What are the most cost-effective, acceptable and affordable interventions to reduce maternal mortality? (5-10 years) - What are the strategies to train, deploy and sustain skilled attendants during delivery? (5-10 years) - What are the ways to measure progress towards improvement of maternal health? (5-10 years)	Presence of functioning basic and comprehensive EOC services at H&FWC as well as at Upazila health complex Availability and acceptability of services assessed and documented. Cost-effectiveness of birthing strategies assessed. Validity of indicators of progress assessed. Service utilization increased. Number of community midwives trained and taking up private delivery work in the homes	Scientists as well as supporting staff. Government staff for carrying out the interventions. Transport, equipment, computers and stationery and other supplies. Researchers, administrative staff, fieldworkers, community midwives, safe delivery kits, training cost, stationery and other supplies	Increased research capacity to deal with safe motherhood issues Knowledge-base on safe motherhood expanded	Increased utilization of services by those in need and reduction of maternal mortality. Rational allocation of resources to meet the need Adoption and scaling up of strategy found to be cost-effective Increased utilization of services by those in need and reduction of maternal mortality Increased access to skilled delivery services at home and in health facilities	RHP has a multidisciplinary team of researchers and has collaborative arrangements that can provide required expertise. The existence of a well-established health and demographic surveillance system in Matlab, the first of its kind in the world. Data management officers already available to handle the large data-sets. Programme has previous experience with functioning community midwives.

Priority Areas/ Categorization	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Family planning [Cross-cutting with the HFPS]	- What are the most cost-effective, acceptable and affordable interventions to further reduce fertility to reach replacement levels? (5-10 years) - What are the strategies to access them? (5-15 years)	Increasing number of vasectomies, increasing number of condom users. increased number of patients attending male clinics with RH problems Indicators of progress available, documented in literature and used Strategies for accessing interventions available and documented	Project staff in various scientific disciplines as well as supporting staff.. Transport, equipment, computers and stationery and other supplies	Establishment of male clinics will improve the infrastructure of the Matlab sub-centres. There will be increased resources for dealing with male involvement issues. Knowledge-base expanded	To scale up the successful elements in other areas of Bangladesh.	RHP has a multidisciplinary team of researchers and has collaborative arrangements that can provide required expertise

Priority Areas/ Categorization	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Adolescent reproductive health [May be cross-cutting with the Nutrition Programme]	- What factors are responsible for health risk behaviour among adolescents? (5 years) - What are the most appropriate health indicators to measure behavioural change in unmarried adolescents (long and short term)? (5-10 years) - What service delivery approaches are best for improving reproductive health services for adolescents and how can they be improved? (5-10 years)	Identification of risk and protective factors to take health-risks Identification of appropriate reproductive health indicators to track behavioural changes among unmarried adolescents Appropriate service delivery approaches identified	Human resources having institutional as well as practical training in social science and public health research Computer and other related office equipment Field workers Transport	Increased research capacity for the centre to deal with adolescent reproductive health and hence creation of new knowledge.	The Centre's ongoing and planned activities on adolescent reproductive health will contribute to the development of appropriate strategies to improve reproductive health status of adolescents	Experience of ICDDR,B, as one of the leading organizations in conducting research in adolescent health Existing multi-disciplinary scientists in ICDDRB including social scientists, epidemiologists, demographer, anthropologist, statistician etc ICDDR,B has long experience in conducting collaborative research with national and NGO programmes
STI/RTI/HIV/AIDS/Sexual health [May be cross-cutting with the IDVS]	- What is the impact of interventions on STI/RTI/HIV/AIDS/Sexual health in preventing further transmission? (5-10 years) - What are the public health interventions to prevent/combat HIV/AIDS in a "virgin" country like Bangladesh? (5-15 years)	Rates of HIV infection and prevalence of STDs among population groups with high risk behaviour Public health interventions available	Scientists Lab staff Field staff Support staff Lab equipment and space	Increased research capacity for the centre to deal with STI/RTI/HIV/AIDS and hence creation of new knowledge.	The prevalence rates will be fed back into policy and provide guidelines for directing resources for prevention activities	Serological surveillance has been conducted successfully for three years so that the methodology is established The surveillance has been recognised internationally Competent and trained staff are available Potential for expanding to other areas of research and service e.g. establishing a VCT centre and cohorts of specific population groups for possible vaccine development.

Priority Areas/ Categorization	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Maternal nutrition [May be cross-cutting with the Nutrition Programme]	- What are the reasons leading to poor nutrition among women in general and particularly pregnant women? (5 years) - What is the effect/impact of maternal nutrition/nutrition supplementation on maternal morbidity, pregnancy outcome and birth-weight? (5-10 years)	Reasons obtained and documented Indicators of maternal depletion improved and proportion of low birth-weight decreased	Senior Medical Officer Medical officers Consultant Supporting staff Field workers Scientists to analyze data, Transport, Computers, Stationery		Improved maternal nutrition and neonatal health	Nutrition programme in place within ICDDRB. Collaboration of the two programmes will be advantageous.
Abortion care	- What are the strategies to reduce abortion-related mortality and morbidity? (5-10 years)	Reduction of abortion-related mortality (deaths)	Project staff including researchers and field workers. Also consultants, computers and stationery.	Increased research capacity to deal with safe motherhood issues	Increased resource allocation for abortion care	Programme is already working on ways to reduce maternal mortality in general, i.e. increasing access to skilled attendance at deliveries
Violence against women	- What are the magnitude, type and reasons for violence against women? (5 years) - What are the strategies to reduce violence against women? (5-15 years)	Reduction in incidence of violence against women	Project staff including researchers on gender issues and field workers able to collect sensitive information. Also consultants, computers and stationery.	Increased research capacity to deal with gender issues		
Newborn health and breastfeeding [May be cross-cutting with the CHP]	- What are the strategies to reduce neonatal mortality and to increase exclusive breastfeeding? (5-10 years) - What are the barriers to appropriate breastfeeding? (5-10 years)	Reduction in neonatal mortality and increased duration of exclusive breastfeeding	Project staff including researchers in neonatology and field workers. Also consultants, computers and stationery.	Increased research capacity to deal with child survival issues	Improved newborn and infant health	Programme is already working in related safe motherhood projects

iii) Nutrition

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Maternal Nutrition and Low Birth weight [Cross-cutting with RH and CHP]	- Can combined intervention with food, micronutrients and treatment of bacterial vaginasis reduce LBW? (5 years) - Can nutrition education and food demonstration improve adolescent nutrition, maternal nutrition and complementary feeding practices? (5 years) - Can simplification of therapeutic management of low birth weight and neonates improve neonatal outcome? (2-10 years) - What are the benefits of maternal dietary supplementation on immune status and growth of infants? (5 years) - Can community based nutrition programme (NNP) improve sustainable nutritional status of women and children population? (5-20 years)	Improved maternal nutrition is likely to reduce maternal morbidity and mortality, reduce low birth weight infants, reduce neonatal and infant mortality Management protocol developed Reduced morbidity and mortality of LBW and neonates New information generated to provide programme tools NNP outcomes of interventions on maternal health, birth weight, health of adolescent girls, food security	The Centre has expertise and credibility to undertake research in the aforementioned areas. Existence of trained, qualified clinical and community/public health nutritionists, epidemiologist, nutritional biochemists, immunologist and anthropologists. Need capacity building, funds Need training and funds, capacity	Gain new knowledge, develop expertise, develop laboratory capacity, equipment, gains in image internationally Develop expertise, draw attraction from national and international donors and policy makers Open scope for funds Improve case management at Centre's Hospital Centre helps GoB directly, new research gives credits and develops expertise for large scale nutrition programme	Research results from these studies will have immense impact to improve maternal mortality and reducing LBW. Indeed the GoB is looking forward to incorporate the findings in its national programme (NNP). As LBW is also a major public health problem in the whole of south Asia, results of this study will have regional programmatic implication.	The Centre had already been conducting many research in nutrition and produced some state-of art research in this area. The nutrition programme has evolved as a cross-cutting programme of the Centre, and started functioning for last five years. This programme has members and involvement from all the scientific divisions and many research had/are being undertaken using the multi-disciplinary approach. It has many qualified and experienced clinical, community nutritionists, epidemiologist, operation researcher, health economist, biochemist, immunologist, and behavioral scientists. Another comparative advantage is the field site in Matlab, and other rural and urban field sites of the Centre. Good collaboration with GoB, NGOs, national and international institutes, international agencies.

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Severe and moderate malnutrition [Cross-cutting with CHP, HFPS]	- What is the efficacy of therapeutic intervention with antibiotics and micronutrients in nutritional rehabilitation of severely and moderately malnourished children recovering from diarrhoea? (5-15 years) - What is most effective community-based management strategies and impact on body composition of the severely and moderately malnourished children? (5-15 years) - What are the pathophysiology and determinants of malnutrition and measures for programmes for preventive strategies of moderate and severe malnutrition? (10 years) - How can the management of severe malnutrition in Urban areas be strengthened? (10 years)	Improved management of severe malnutrition will have direct impact on infant and child mortality Results avilable to modify policy at centre or global considerations Projects are undertaken, Results available for application GoB policy and international use Social, clinical, and biochemical measures identified	Funding mobilization All avilable, funds needed Funds needed, training needed	Centre improves in capacity building, gains credit of new therapeutic development, helps fund flow to Centres clinical and nutrition Improves case management, enhances Global impact Centre gets credit of new strategies for PEM Management and prevention in community, likely to be most attractive to the GoB Centre may get additional (ADB) funding for the project Improves relationship with the GoB Improves capacity building, Improves clinical and social strategic ability	ICDDR,B has already taken the lead to reduce the mortality of severely malnourished children. Further research to improve management of severe malnutrition and operations research to incorporate these findings in health programme will improve child survival. The findings are expected to have national and regional policy and programmatic implications.	Same as previous section

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Infant and child feeding [Cross-cutting with CHP, RHP, HEPS]	- Can breastfeeding counseling by community counselors, and/or trained fieldworkers and establishment of community clinics improve infant feeding practices? (5 years) - How to develop of culturally acceptable, low cost, micronutrient-rich complementary foods? (5 years) - Does appropriate nutrition education with BCC reverse malnutrition in all communities? (5-15 years) - What the key determinants of child malnutrition and effective remedial strategies related to complementary feeding and beyond 2 years of age? (5-10 years)	Appropriate infant and child feeding practices are avialble Data on child growth, and infant feeding available. Formula and strategy available to apply BCC material and techniques are generated Results available for policy and programme for complementary feeding.	Maintaining the core and research infrastructure will be required to sustain these activities.	Improved knowledge base Training skill increased. More recognition in nutrion field , attarcts more fund and collaboration with WHO, UNICEF , WB etc. Centre improves in large scale BCC expertise, improved capacity for giving training internally and nationally More funds can be attracted Contribute in a high priority area for GoB and other developing countries	Appropriate breastfeeding practices is one of the key interventions for improved child survival. Previous studies from ICDDR,B have already shown that trained community counselors can improve infant feeding practices. Further research in this area will lead to programatic implementation and incorporation in the existing GoB health programme/system.	Same as in previous section

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Child Development [Cross-cutting with CHP.]	- What is the impact of psychosocial stimulation and parental counseling to malnourished children on cognitive functions in national programme? (2-5 years) - Does micronutrient supplementation improve cognitive function in malnourished children? (5-10 years) - What are the impact of malnutrition on academic and social development? (5-20 years)	Improved child growth, improved cognitive function, school performance, skilled human resource in future. Results available for evaluation Results available to make policies Data available for evaluation and consider for policy	Training and expansion of skills Need expertise, and training Expand lab capacity	Gains new knowledge and capacity building and expertise in child development, More recognition of Centre in this needed but scarce area Helps Centre for a major contribution in understanding and give weightage to Policy and programme New knowledge is generated, more credt is earned for child health and nutrition, funds move to Centre	Childhood malnutrition and poor cognitive function have been identified as an obstacle to development of skilled human resource. UNICEF and other international agencies have put lots of emphasis in this area. ICDDR,B with its expertise will undertake research in key issues in this area. The GoB national nutrition programme (NNP) has shown interest to incorporate some simplified interventions to their existing programme to improve child development.	Same as in previous section

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Micronutrient research and Intervention [Cross cutting with IDVS/ CHP, RHP, HFPS]	- What is the micronutrient status of different age groups? (2 years) - Can a cost-effective strategy of dietary diversification be identified and implemented to address micronutrient deficiencies? (5-10 years) - What are the acceptability, safety, and effectiveness of multi micronutrient pediatric supplementation? (5-10 years) - What are the strategies for use of different micronutrients to enhance health, economic and social outcome? (5-15 years)	Reduction of anemia, Vitamin A deficiency, reduction in iodine deficiency disorder, reduction in infant, child morbidity and mortality Availability of projects and reports on time frame, development of policy from research results Research results helps to formulate policy Results available for evaluation	Good collaboration with GoB (through BINP/NNP, Dhaka City corporation) Laboratory capacity, Need funds Funds needed Training need of food composition data base	Knowledge gain, Get recognition to contribute for policy formulation Knowledge gain, capacity development, more strength for new contracts , recognition in policy formulation, nationally and internationally, Gains recognition and invitation to work in this field, improves case management in Centre work Better case management in Centre, get more recognition from donors and policy makers	Micronutrient deficiencies such as iron, iodine, zinc and vitamin A are widely prevalent in Bangladesh as well as in South Asia. Positive impact of micronutrient supplementation to infant, children and women has already been shown in different studies worldwide and also at ICDDR, B. Further research and the findings from these studies will help GoB to improve overall micronutrient status of infant, children and women and morbidity related to these deficiencies.	Same as in previous section

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Infectious Disease and Nutrition interaction [Cross-cutting with IDVS, CHP]	- Does dietary management improve outcome of infectious diarrhea and ARI? (5- years) - What is the effect of micronutrient supplementation on diarrhea outcome and growth in children? (5 years) - What is the effect of micronutrient supplementation on vaccine efficacy? (10 years) - Have HIV and other infections during pregnancy any effect on birth outcome, breast-feeding, growth, and immunity? (10 years)	Improved management of diarrhea and ARI. Improved vaccine efficacy, improved child survival Trials are in place/ results available HIV subjects identified, projects in place /results available	Good collaboration with leading NGOs and their field sites Trials and resources needed	Impact of new knowledge in scientific world Saves money for hospital at Dhaka and Matlab Develop expertise and get impact from consultancy Image improves for new knowledge base, Laboratory capacity and human resources generated New knowledge on HIV Human resource developed Image of Centre improves	Research in this area will increase our understanding of malnutrition and infection interaction. An effective strategy to reduce infectious disease and its morbidity by nutritional intervention may have positive impact on child survival.	Same as in previous section

iv) Infectious Diseases and Vaccine Sciences

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Evaluate promising vaccine candidates against key infectious diseases and disease syndromes (Cross-cutting with Child Health Programme, and Health and Family Planning Systems Programme)	- Can a substantial proportion of diarrheal disease be prevented with a package (system) of vaccines against key etiologies for severe diarrheal disease? (5-10 years) - Can a substantial proportion of severe respiratory infection be prevented with a package (system) of vaccines against key etiologies for severe respiratory infection? (10 years) - Can dengue and dengue hemorrhagic fever be prevented through immunization? (5 years) - Can new vaccines for tuberculosis prevent pulmonary TB more effectively than BCG? (10 years)	Conduct efficacy studies, ethnographic and economic assessments integral to introducing new vaccines.	- Need core expertise for vaccine evaluations, including vaccinologists/epidemiologists, vaccinologists in training, data management team, data entry team, clinical research review team, economist, ethnographer/ anthropologist, policy specialist. - Funding for projects	Will contribute to development of cost-effective prevention strategies	Could lead to accelerated introduction of safe and effective vaccines to prevent priority diseases resulting in reduction in mortality.	Highly credible Centre with substantial experience with vaccine evaluation in field settings with high incidence of disease

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Define disease incidence and burden for major disease syndromes and key etiologies (Cross-cutting with Child Health Programme, and RH Programme)	- What are the incidence rates and burden of disease (key indicators) for principal causes of enteric disease including cholera, rotavirus, ETEC, Campylobacter, Shigella and typhoid? (3 years) - What are incidence rates and burden of disease (key indicators) for principal causes of respiratory disease, including *Streptococcus pneumoniae*, *Haemophilus influenzae*, respiratory syncytial virus, influenza, and *Mycoplasma pneumoniae?* (3 years) - What is incidence of disease for tuberculosis and multi-drug resistant tuberculosis in rural (3 years) and urban areas (5 years)? - What is incidence of priority vector-borne diseases including dengue (2 years), malaria (5 years), leishmaniasis (5 years), filariasis (5 years), and Japanese encephalitis (5 years)? - What is incidenc of key sexually transmitted infections (10 years)	Completed studies with data disseminated to Bangladesh government health authorities, NGOs and Development agencies, as well as globally through publications.	- Funding to carry out projects - Improved laboratory methodology for key indicators - More fully developed field sites	Will help to set priorities for research and use of resources so that they are based on magnitude of the public health problem; Centre will be a resource for global health organizations who need to set priorities and to optimally target resources.	Focused disease control and prevention activities of Ministry on diseases with highest incidence and mortality.	Centre's field settings and laboratory capacity and epidemiologic skills ideal for conducting burden of disease studies

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Define risk factors, clinical, sociologic, and other epidemiologic characteristics of priority diseases for use in developing cost-effective strategies for prevention and control [Cross-cutting with CHP and RHP]	- Define risk factors for disease and for poor outcome for disease for: a) Diarrheal diseases b) Respiratory diseases, including bacterial, viral and mycobacterial infections c) Vector-borne diseases d) Sexually transmitted diseases e) Newly emerging diseases, like Nipah (10 years)	Identify modifiable risk factors for key diseases. Define characteristics of at risk population for targeted intervention strategies? Data are used by global , regional or national public health authorities in developing or implementing prevention and control strategies	Funding to carry out specific projects. Training of laboratory and epidemiologic personnel to accomplish specific tasks.	Will contribute to development of cost-effective prevention strategies	Could lead to new algorithms for treatment and prevention. Could contribute to prevention and control strategies.	Disease incidence is high, making epidemiologic and clinical studies feasible Clinical, epidemiologic, and laboratory expertise foundations are strong resulting in optimal use of additional training to boost capacity Substantial experience in conducting similar studies
Identify, implement and evaluate treatment and prevention strategies effective for reducing morbidity and mortality from infectious diseases [Cross-cutting with CHP and HFPS]	- Can new antimicrobial regimens be identified which are practical, affordable and effective at reducing morbidity and mortality from key infectious diseases? (5 years) - Can we implement an effective risk factor reduction programme through community interventions to prevent key infectious diseases? (10 years) - Can we improve early diagnosis and appropriate treatment to reduce impact of priority diseases? (Through 2015)	Effective strategies identified and/or evaluated at the Centre are implemented nationally, regionally, or globally. There is a measurable reduction in morbidity and mortality as a result of this work.	Support for field sites capable of epidemiologic and translation (operational) research	Will contribute to development of cost-effective prevention strategies	Enhance existing approaches for reducing morbidity and mortality from infectious diseases and allied conditions.	Substantial experience in conducting operational research and following science from the bench to the field.

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Create or enhance Centre-wide focus on research of the following priority infectious diseases: Diarrheal diseases, respiratory infections, vector-borne diseases, TB, sexually transmitted diseases (including HIV)	- Can we utilize more optimally Centre-side staff and expertise to address Centre's mission? (ongoing) Form scientific teams for modest strategic planning (i.e. priority setting, key objectives, and identify donors for specific projects) and collaborative work for each priority infectious disease area. Teams have already been established for respiratory infections and TB. Among vector-borne diseases, teams have been established already for dengue and leishmaniasis.	Thriving set of highly focused activities cross-cutting through the Centre. Measurable through increased number of integrated projects which are coherent with overall programme priorities.	Increased staffing to organize and focus workgroups.	Ensure optimal use of Centre resources.	More efficient use of Centre resources	Centre needs coordination of vast areas of interest and expertise, especially as it expands its domain and mandate.

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Enhance capacity to investigate outbreaks of infectious diseases in Bangladesh and the region to use scientific methods to develop and implement strategies for outbreak control	- How can Laboratory Sciences Division contribute to capacity to investigate and respond to outbreaks? (2 years) - What is needed to develop capacity and to identify scientists and technicians who will be part of epidemic response team (depending upon likely etiology)? (1 year) - How can existing Epidemic Control Preparedness Programme within PHSD enhance capacity to address outbreaks? Is this adequate? Do we need to involve other Divisions and Units? (1 year) - How can ISD contribute, in particular can Training and Education Department disseminate methods for investigation and response to various regions/settings? (1 year)	Demand for our services for response to outbreaks from GoB and from scientists and authorities (like WHO) outside the country.	Increased laboratory and epidemiologist staffing to provide surge potential; Training for lab and epi staff on outbreak investigations. Pool of emergency funds which can be appropriated during emergency (outbreak) situations.	Centre will function as a global resource for investigating new and emerging problems. Centre will be in a position to recognize outbreaks in Bangladesh and assist authorities in prevention and control measures to reduce morbidity and mortality.	Improved perception of ICDDR,B by public and Ministry and internationally as a state-of-the-art centre which responds to emerging problems of local concern and global importance.	Given dense population, malnutrition, close interaction of animals and humans, wide range of diseases, the potential for outbreaks of new and emerging diseases in Bangladesh is substantial. Centre is most credible scientific facility for investigating outbreaks of new diseases.

v) Health and Family Planning Systems

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Expected Gain for Center	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Develop strategies/ operational sub-systems for efficient, cost-effective and sustainable delivery of an integrated package of essential health and family planning services (ESP). [Cross-cutting with CHP, RHP, IDVS, and Nutrition]	- What additional strategies/modifications are needed to further strengthen ESP provision within the national programme (government, NGO and commercial sector)? (Up to 2005) - What institutional/ programmatic arrangements are needed to incorporate the efficacious/new interventions on reproductive health, child health, RTI/ STD/HIV/AIDS and other communicable diseases, mother and child nutrition, and adolescent healthcare in the national programme? (Up to 2010) - What interventions/ activities are critical to further improve quality of health and family planning services within the various ESP programmes (government, NGO, etc)? (Up to 2010) - How to make the service-delivery systems more responsive to community needs and to better meet client satisfaction? (Up to 2010)	- Appropriate service delivery tiers defined; specific services to be provided from each of these tiers ascertained; guidelines/manuals on the service delivery strategies/systems and operational sub-systems such as management information, logistic and supplies, training, etc. developed/ modified/tested/ finalized and disseminated. - Feasible strategies and related operational sub-systems for integration of new interventions into the existing programmes developed/ tested/ finalized and disseminated; guidelines/manuals/ documentation and reports generated and disseminated. - Simple and cost-effective approaches for quality improvement of service(s) and appropriate/needed job-aids/ manuals developed/ tested/ finalized and disseminated. - Community perceptions on satisfactions with the service delivery strategies/systems assessed; manuals/ guidelines for providers to address client satisfaction issues developed/ tested/finalized and disseminated.	• Human resources having training in public health, medicine, demography, economics and other areas of social sciences and biomedicine. • Practical skills in operations research, health systems developed and good understanding of the national programme and ongoing health reform programmes in various countries. • Computer and other related office equipment and accessories. • Government and NGO programme sites with necessary research infrastructure and surveillance systems. • Additional funding.	• New solutions, strategies and appropriate technologies for sustainable, cost-effective and equitable delivery of an integrated package of essential health and family planning services developed and available with the Centre. • Centre's applied research capacity strengthened further. • Centre would be better positioned to address the practical issues in implementing an integrated package of essential health and family planning services.	• Documents on functional, cost-effective and sustainable strategies/ systems for the integrated delivery of essential health and family planning services made available for the national programme. • Increased coverage of essential health and family planning services. • Improved family health, reduction in fertility and mortality and morbidities, especially for women, children and socio-economically disadvantaged sub-populations. • Clear-cut policies on implementation of sustainable, cost-effective and equitable delivery of an integrated package of health and family planning services (ESP).	• Long-standing experience of ICDDR,B and the Programme on Health and Family Planning Systems in conducting operations/ health systems research of programmatic and policy relevance. • National and global recognition of ICDDR,B in conducting high-quality operations/ health systems research. • Multi-disciplinary skills experienced in operations research and field sites along with monitoring/evaluation facilities and other necessary infrastructure available with the Programme/ICDDR,B. • In response to the ICPD and the ongoing health sector reforms in various countries across the globe, practical issues relating to operationalization of cost-effective, sustainable and equitable strategies for an integrated delivery of a broader package of reproductive health (including family planning) and other essential family health services have evolved as important areas of research.

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Expected Gain for Center	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Undertake economic analyses and develop health financing mechanisms (e.g., user-fees, insurance schemes) for the integrated service delivery programmes.	- What are the cost and effectiveness implications of the various ESP interventions and programmes? (Up to 2015) - What health financing strategies/ schemes are viable to adopt to improve the financial sustainability of the service delivery systems, without adversely affecting utilization? (Up to 2015)	- Cost-effectiveness and cost benefit ratios worked out for the various intervention(s) on integrated service delivery strategies. - Viable health financing schemes and related manuals/ guidelines developed/ tested/ finalized and disseminated.	Same as in previous section	• Appropriate strategies and approaches for improved financial sustainability of the integrated health and family planning service delivery programmes developed and available with the Centre. • Centre's research capacity for economic analysis of health and family planning systems strengthened further. • Centre would be better positioned to address the practical issues of economic analysis and financial sustainability of the integrated health and family planning service delivery systems.	• Reports on cost, cost-effectiveness and other economic analyses (demand- and supply-side factors) of the service delivery programmes. • Appropriate approaches for cost recovery and improved financial sustainability of the programmes, with "safety net" measures for the poor. • Clear-cut policies on cost recovery and revenue utilization.	Same as in previous section

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Expected Gain for Center	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Conduct equity analyses of the integrated service delivery programmes. [Cross-cutting with CHP, RHP, IDVS, and Nutrition]	- What are the existing types and causes of inequities in health service utilization and how to measure/ monitor those effectively? (Up to 2005) - What effective strategies can be identified and implemented to redress inequities in the healthcare systems? (Up to 2015)	- Gender, socio-economic status and other variable-specific disparities assessed. - Pro-equity intervention(s)/ action(s) designed/ tested/finalized and disseminated.	Same as in previous section	• Appropriate strategies and approaches for equitable delivery of integrated health and family planning services developed and available with the Centre. • Centre's research capacity for equity analysis of health and family planning systems strengthened further. • Centre would be better positioned to address the practical issues of equity (monitoring equity effects and implementing pro-equity interventions) in the delivery of integrated health and family planning services.	• Report(s) on equity effects of the service delivery programmes. • Strategies/actions for an equitable delivery of health services.	Same as in previous section

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Expected Gain for Center	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Develop strategies for private-public partnership in the delivery of essential health and family planning services.	- What should be the optimal private-public mix in the provision of ESP? (Up to 2010) - What are the effective strategies for private-public partnership? (Up to 2015)	- Feasible strategies for private-public partnership ascertained. - Intervention(s) on private-public partnership piloted/ finalized and documented.	Same as in previous section	• Appropriate strategies and approaches for effective private-public partnership in the integrated delivery of health and family planning services developed and available with the Centre. • Centre's research capacity on improvement of financial sustainability of health and family planning systems through private-public partnership strengthened further. • Centre would be better positioned to address the practical issues of private-public partnership in the integrated delivery of health and family planning services.	• Appropriate approaches for an effective private-public partnership. • Policy guidelines for private-public partnership.	Same as in previous section

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Expected Gain for Center	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Develop simple and cost-effective evaluation methods/ techniques for the integrated service delivery programmes.	- What evaluation methods and rapid assessment techniques are feasible and cost-effective for periodic measurement of the process/output/outcome indicators of the integrated service delivery systems? (Up to 2005) - Can these tools and results be used effectively to enhance programme performance? (Up to 2010)	- Tools/techniques for simple/rapid evaluation/assessment developed and piloted. - Manuals/ guidelines to conduct programme evaluation/assessment by local managers/ communities developed and piloted. - Strategies/manual on use of evaluation/ assessment results for local level planning and monitoring of the health programmes by stakeholder developed/ tested and documented.	Same as in previous section	• Appropriate strategies and approaches for cost-effective and rapid evaluation techniques for integrated health and family planning service delivery systems developed and available with the Centre. • Centre's research capacity for programme evaluation strengthened further. • Centre would be better positioned to address the practical issues of cost-effective, reliable and rapid programme evaluation techniques.	• Simple and rapid monitoring/ evaluation methods/techniques for the programmes. • Guidelines on utilization of the monitoring/ evaluation results for local level planning and organization of health services.	Same as in previous section

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Expected Gain for Center	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Identify the additional (emerging) health and family planning needs of the communities. [Cross-cutting with CHP, RHP, IDVS, and Nutrition]	- What are the additional (emerging) health needs in the communities that require to be incorporated/ addressed within the programmes for essential family health services? (Up to 2015) - What are the effective ways of involving the local communities in this process? (Up to 2005)	- Additional (emerging/re-emerging) health needs in the ESP programme areas assessed. - Strategies/ guidelines on involvement of the stakeholders in assessing the additional health needs developed/tested and documented.	Same as in previous section	• Appropriate strategies and approaches for identification of additional health needs with the involvement of programme managers and local communities developed and available with the Centre. • Centre's research capacity on effective ways to identify the emerging additional health needs of local communities strengthened further. • Centre would be better positioned to address the practical issues in identification and implementation of new interventions for the additional health needs.	• Report(s) on additional (emerging) needs of the health and family planning programmes. • Guidelines on programmatic and policy actions to address the additional health and family planning needs.	Same as in previous section

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Expected Gain for Center	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Advocacy/TA in the translation of research findings into appropriate programmatic and policy changes. [Cross-cutting with CHP, RHP, IDVS, and Nutrition]	- What capacities and skills are critical in sensitizing/ involving policy-makers and programme managers for speedy translation of the successful research findings into policy and action? (Up to 2015) - What sort of technical assistance ensures cost-effectiveness and sustainability of this translation process? (Up to 2015)	- Practical ways of involvement/ ownership of the programme managers/ policy-makers in the design, implementation and dissemination of the research findings ascertained. - Limited and time-bound TA plan (manual/ guidelines) developed to facilitate the replication/ translation process and ensure its sustainability within the government and NGO programmes.	Same as in previous section	• Appropriate skills and approaches for translation of research findings into policy and action developed and available with the Centre. • Centre would be better positioned to address the practical issues in effecting programmatic and policy changes through its research.	• Adaptation/ replication of research findings into programmes and national policies.	Same as in previous section

vi) Population

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Fertility decline in Bangladesh	- Why has the fertility decline of the 1980s stalled at above 3 children per women? What is likely to happen in the future? What are implications for attaining replacement fertility by 2005? - Although expressed desired family size exceeds the level of replacement fertility, it is well below current fertility? Is that inevitable, or does it reflect inefficient FP use and FP failure? Time frame: 1.5 years	The major outcomes or outputs from the research should of course be a better understanding of the issues and the underlying factors contributing to the problem or issues being studies. Ideally this greater understanding should lead to new or modified and more efficient interventions, depending on the issue.	• Many of these studies require similar resources, namely skilled researchers with access to the necessary data. • Of course research infrastructure needs to be in place, but in an institution which has been doing this work for four decades, that is reasonably clear.	Issue of great national importance. Findings will receive widespread attention. Requires the application of research skills, and datasets for analysis, not widely available outside ICDDR,B Will highlight the high value of longitudinal demographic data which ICDDR,B has been collecting for several decades.	A better understanding of the causes of the stalling of the fertility decline, with guidance as to how this can be overcome.	Many of these current research issues are based on the needs of Bangladesh, viewed in conjunction with the information which is currently available through the ICDDR,Bs data collection systems. These include the various longitudinal surveillance systems which generate relatively unique data of a wide variety of health conditions and related behaviours, as well as providing settings for conducting well designed studies.
Contraceptive use dynamics	- Why does contraceptive discontinuation continue at such high levels? - What can be done about improving quality of services to ensure more satisfactory FP use? - What can be done to reduce contraceptive failure? Time: Continuing 2002 subject to availability of (EU) funds.	Same as in previous section	Same as in previous section	Findings should lead to greater cost efficiency in national FP Program. Will highlight the high value of longitudinal demographic data which ICDDR,B has been collecting for several decades.	Lead to improved contraceptive use rate.	Same as in previous section

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Interrelation between abortion and contraceptive use	- Does the provision of high quality, effective contraceptive services reduce the demand and use of abortion services? - Why did abortion rates rise in parallel with rising use of contraception? Is it that awareness of the capacity to control fertility produces an initial rise in all mechanisms to limit fertility, and only later do couples cease resorting to abortion as they become more efficient in using FP? Time: 1.5 years	Same as in previous section	Same as in previous section	Induced abortions contribute to maternal morbidity and mortality, so the issue of whether or not effective FP services can reduce demand for abortion is of great importance, for both health and ethical reasons.	Lead to improved services with reduced reliance on abortion.	Same as in previous section
Health and Demographic Surveillance System	- The maintenance of the HDSS, which forms the basis of many research studies, is a critical activity of the Centre. Time: Ongoing	Timely production of health & demographic data. Production of HDSS annual reports. Provision of datasets requested by other researchers.	Same as in previous section	The HDSS provides the platform of high quality longitudinal data essential for many of the studies undertaken by Centre research staff.	Better understanding of longitudinal demographic, health, and socio-economic processes. Outcomes of other studies based on HDSS.	Same as in previous section

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Ageing and adult health issues	- Are chronic diseases taking a growing proportion of the overall burden of disease, as a result of population ageing or other factors, with substantial implications for health service financing? - How much of the growing proportion of the population described as 'old age' is simply related to declining numbers of births, and how much is directly due to improved survival of older people? And, what are the implications in relation to changing family structures (towards more nuclear)? Time: Continuing subject to funding.	Same as in previous section	Same as in previous section	The Bangladesh health system needs to evolve to take account of changing patterns of disease, and previously neglected conditions which restrain the advancement of health. The current MOHFW surveillance systems are not well designed for producing the necessary information on morbidity and mortality which ICDDR,B can do.	A better understanding of the true nature and levels of adult diseases will assist the Government in designing future health services, and the associated needs for training, equipment, facilities, etc.	Same as in previous section
Education and family size	- How much is the rapidly increasing provision of education for girls and young women linked to reductions in desired and achieved family size? Time: Continuing till June 2002	Same as in previous section	Same as in previous section	The mission is to throw light on major social changes which affect population growth and poverty reduction in Bangladesh. Understanding changes in female education is part of that process.	A better understanding of how development interventions, such as increasing female education, can be expected to affect future marriage and childbearing patterns.	Same as in previous section

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Poverty and rapid population growth	- Does limitation of family size result in improved economic status for individual families, or does this proposed development effect only work at the community or national level? Time: 1.5 years	Same as in previous section	Same as in previous section	Nations can benefit from population policies which are promoted to individual families. These families do not always benefit individually. Policies need to take this into account.	Better understanding of how macro level changes in the national population affect individual families who adopt new family building strategies for the national good.	Same as in previous section
Urbanization and rural-urban migration	- What are the implications of urbanization for family support, both economic and in other areas, as well as how changing family structures, due to declining fertility and mortality, are playing a role in this movement? - What strategies do rural families use to decide who should migrate and when? - How do the aspirations of young people change as a result of various development interventions such as growing employment in the textile sector for young women, and how are marriage and childbearing behaviours influenced by these evolving expectations? Time: 2002-2003, subject to funding	Same as in previous section	Same as in previous section	The most important demographic process at present is not overall population growth but rapid urbanization. The nation needs to better understand what forces are driving this in order to predict future trends, and to plan services and policies to minimize the negative aspects of such a process.	Urban growth needs to be slowed, so a better understanding of the push factors driving such migration to the cities will hopefully lead to programmes which encourage rural dwellers to remain there.	Same as in previous section

Priority Areas	Key Research Questions/ Timeframes for Accomplishment	Performance Indicators	Resource Needs	Benefit to center/mission	Expected Policy/Programmatic Impact	Current Strengths and Comparative Advantages
Utilization of health and family planning services	- As modernization has proceeded, is there still a need for such high density, proximate services, and can the Ministry of Health reasonably expect that families will seek out preventive and curative services wherever and however they may be offered? - How has the provision of preventive and curative health services greatly reduced the gender disparities of mortality for male and female children? Time: Ongoing into 2002	Same as in previous section	Same as in previous section	Bangladesh has widely accessible health services, but they are not fully utilized. In order to maximize the benefits of such services, a better understanding of users motivations, needs and experiences is required.	Cost-effective provision of health and FP services to all who require them is a desirable goal of the national health and population sector programme. This work should contribute to achieving greater efficiency in this.	Same as in previous section
Health equity, poverty and population	- How major development and health interventions are differentially benefiting different sectors of the population?	Same as in previous section	Same as in previous section	Overall improvements in health can sometimes conceal disadvantaged groups, particularly the poorest. This work will extend recent approaches to measuring equity to ensure policies result in equitable services and health benefits.	The HPSP is explicitly pro-poor, but better refinement is needed to be certain that the programmes and interventions are actually reaching the poor, and poorest.	Same as in previous section