

ICDDR,B

BOARD OF TRUSTEES MEETING

1-3 November 2002

**PROGRAMME OF THE
BOARD OF TRUSTEES MEETING**

1-3 November 2002

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PROGRAMME
BOARD OF TRUSTEES MEETINGS
1-3 November 2002

20 Oct 02

Executive Committee
Friday 01 November 2002
Venue: Seminar Room 1 & 2

Prof. Ricardo Uauy Dagach (Chair, BoT), Prof Carol Vlassoff (Chair, Programme Committee),
 Dr Claudio Lanata (Chair, Human Resources Committee), Prof Azad Khan (Chair, Finance Committee),
 Prof Barkat-e-Khuda (Acting Director, ICDDR,B)

09:30 – 11:00 am	Opening of the Art Auction and Tea	
	Programme Committee:	
11:00 – 11:30 am	Director's Report	NOC staff and above
11:30 – 11:45 am	Division Reports - CSD	"
11:45 – 12:00 am	LSD	"
12:00 – 12:15 pm	ISD	"
12:15 – 12:30 pm	HSID	"
12:30 – 12:45 pm	PHSD	"
12:45 – 14:00 pm	Lunch	BoT & SC
14:00 – 15:00 pm	Strategic Plan	BoT & SC
15:00 – 15:15 pm	Tea	
15:15 – 16:15 pm	Discussion	BoT & SC
16:15 – 16:45 pm	Closed meeting	BoT only
19:30 – 21:00 pm	Supper at the Roof-top Pavilion	BoT, SC & spouses

Saturday 02 November 2002
Venue: Seminar Room 1 & 2

08:30 – 09:30 am	Finance Committee	BoT & SC
09:30 – 10:30 am	Human Resources Committee	BoT, Div Heads, HHR & CFO
10:30 – 11:00 am	Tea	
11:00 – 12:00 pm	Staff Welfare Association	BoT & SWA
12:00 – 13:00 pm	Lunch	BoT, SC & SWA
13:00 – 15:30 pm	Closed session of the Board	BoT only
15:30 – 15:45 pm	Tea	
6:00 pm Dhaka time	Conference call (Director's Office)	BoT only

Sunday 03 November 2002
Venue: Seminar Room 1 & 2

08:30 – 10:00 am	Revise and consider resolutions	BoT only
	Any Other Business	
10:00 – 10:15 am	Tea	
10:15 – 11:15 am	DSG	BoT, SC & DSG
12:00 – 13:00 pm	Lunch	BoT & SC
13:30 pm	(Leave for Planning Commission)	
14:00 pm	Meeting at ERD	BoT & SC

BoT-Board of Trustees; DSG-Donor Support Group; AC -Administrative Council; SC-Scientific Council

1/BT/NOV 2002

APPROVAL OF THE AGENDA

2/BT/NOV 2002

APPROVAL OF THE DRAFT MINUTES

OF THE MEETING

HELD ON 6-9 JUNE 2002

OPENING SESSION OF THE BOARD OF TRUSTEES

Sasakawa Auditorium

Dhaka, Bangladesh

6 June 2002

The Board of Trustees held its meeting from 6 to 9 June 2002. The proceedings commenced at 8:30am on 6 June with a tour of the facilities by the Board members as an orientation exercise for the new Trustees.

Present:

Prof Marian Jacobs (Board Chair)	Prof David Sack
Dr Ricardo Uauy Dagach (Chair, Programme Committee)	Prof Jane Kusin
Dr I Kaye Wachsmuth	Prof AK Azad Khan
Mr Anisul Huq Chowdhury	Dr Claudio Lanata
Dr Maimunah Bte Abdul Hamid	Prof Terry Hull
Prof N K Ganguly	Dr Tikki Pang
Dr Nobukatsu Ishikawa	Prof Marcel Tanner
Mr M Fazlur Rahman	Prof Carol Vlassoff

Absent (with regrets): Mr Rolf Carriere

Invited: Scientific Council members, donor representatives, Centre scientific staff.

Minute Secretary: Mrs Judith Bennett Henry

Prof Marian Jacobs, Board Chair, opened the BOT meeting with a welcome to all and an introduction of the Board members to the assembly. She stated that it was her last meeting as a Trustee and as Chair and that the last six years had been an enriching experience. She welcomed the direction the Centre is taking and was confident that the Centre was sufficiently motivated to take on the challenges ahead.

She congratulated Dr Uauy on the award he recently received from his home country; Dr Balakrish Nair on his recent appointment as Foreign Associate to the National Academy of Sciences; PAHO on its centennial; Dr Tikki Pang on the publication of "Genomics and World Health"; Mrs Diann Hill on the new addition to her family.

She then invited Dr Uauy to open the proceedings of the Programme Committee.

Minutes of the Programme Committee

Sasakawa Auditorium

6 June 2002

At 10:00am, the Programme Committee convened at the Sasakawa Auditorium.

Present: Members of BOT

Absent (with regrets): Mr Rolf Carriere

Invited: Scientific Council members, donor representatives, Centre scientific staff

Minute Secretary: Judith Bennett Henry

Dr Uauy thanked the assembly for taking time out of their busy schedules to participate. The Committee will hear the Director's Report from Prof Sack and highlights of activities from the Division Heads.

Director's Report: Prof Sack welcomed all to the meeting. He noted that this was the first Board meeting to be held in Dhaka in 18 months. Many Board members are coming to Dhaka for the first time as members. All members but one have been able to attend. Many changes have occurred at the Centre since the last meeting in November 2000 and new and old BOT members were earlier shown some of the physical changes that took place and those which are underway. The LSD external review was successfully completed yesterday.

Highlights: Since the last Dhaka meeting, the Centre were announced the first-ever winner of the Gates Award for Global Health and awarded US\$1million; following this, the GoB made a matching award. The Centre extends once more its appreciation of both awards. Celebrations of the award were held in Washington and Dhaka and more recently, the Centre hosted two profile-raising events in Atlanta at the Carter Center and in New York at the United Nations HQ. The event in NY was headlined by the Centre's development of ORS which to date has saved 40 million lives. The event drew a host of representatives of corporate companies, UN agencies and NGOs. Keynote speaker was Nobel Prize winner Dr Joshua Lederberg. A press conference by Prof Sack was also held in New York with a coinciding press conference in Dhaka.

The Centre's Dhaka Hospital and Kamalapur site were highlighted in the February 2002 National Geographic magazine.

Staffing:

BOT. Prof Sack reported that Prof Rita Colwell, Dr Tawfik AM Khoja and Prof Peter McDonald completed their tenure on the Board. The Centre appreciated their support of and contribution to the Centre. Incoming Board members are Dr Maimunah Bte Abdul Hamid; Dr I Kaye Wachsmuth; Prof Terrence Hull; Mr M Fazlur Rahman and Mr Anisul Huq Chowdhury.

Centre staff (international). Prof George Fuchs; Mr John F Winkleman and Dr Jose Bogaerts completed their contracts with the Centre. Incoming staff are Dr Md Abdus Salam (Acting Head CSD), Dr Balakrish Nair (Head LSD), Dr Rob Breiman (Head, HSID), Mr Peter Thorpe (Head ISD), Mr Stephen Sage (CFO) and Dr Charles Larson (Operations Research Scientist).

Other changes: Major changes were implemented in the change-over from ORP to FHRP. Many new projects are starting. There has been little overall change in staff numbers but considerable turnover which would impact on the indirect costs to the Centre; on the morale of the Centre staff; and on the "core vs project" designation.

The Centre continues to strive to be a good employer. The HR agenda will be discussed at the HR Committee meeting. The job classification is nearing completion and the promotions system and job families have been developed. Project funding will unfortunately create jobs that are less secure than in the past, and it will be the responsibility of Centre scientists to coordinate their projects.

Physical changes: The Centre instituted a number of additions/renovations to the physical structure of the campus:

Renovation of the Animal House	Construction of the Corridor Café
False ceiling in the LSD corridor	Data Centre for LSD
Renovation of Director's wing	Rooftop Pavilion
Out-patient Building	Staff Clinic
Computer lab	Diagnostic Unit
CSD offices	STD lab
Parking area	PABX and Reception Area
Replacement of auto-transfer switch of standby generator	Power substation with new 800 KVA transformer
Microwave link to Matlab	

Prof Sack pointed to the Master Plan for the Centre that would facilitate library space, hospital space and laboratories.

Administrative and scientific activities: Meetings of the Administrative Council (AC) and Scientific Council (SC) are held on rotating Mondays; the Centre Scientific Forum every Monday at 12:30pm to review critical issues from each of the Programmes; Division and Programme conferences average of about 2 per week; Research Review Committee (RRC) and Ethical Review Committee (ERC) meet monthly with about 5 protocols for review each month; visitors average about 4 per week.

The ERC is an integral part of the Centre; is necessary for the Centre's functioning; and is on the cutting edge of medical ethics. The existence of the ERC is also a requirement from most donors and regulatory agencies. The Committee also maintains interaction with data safety monitoring boards.

Strategic Planning: Much of the planning was implemented informally as well as formally. The draft has been distributed to the Board and has been discussed with the Health Secretary and additional discussions are needed with key persons representing national interests as well as donors.

Factors in the Centre's success: Prof Sack pointed to the successful blending of service, research and training; a mix of national and international scientists; clinical, laboratory and field research; local initiatives and collaborations; administrative and financial controls; ethical standards; consistent and generous support from multiple donors; impressive list of alumni; staff development of local scientists; continually evolving scientific agenda; ability to carry research from concept to application; support from Bangladesh.

What makes the Centre international?: Prof Sack noted that the Centre's international character was highlighted by its international Ordinance; international Board of Trustees; international scientists; international standards; international relevance to research; potential for working in countries worldwide. The Centre continues, however, to address the needs of Bangladesh first.

Evolution of the Centre: The Centre evolved from its beginnings as being primarily focused on cholera which was then expanded to diarrhoeal diseases, to population and; to nutrition. The Centre now has Programmes on Child Health; Reproductive Health; Infectious Disease and Vaccine Sciences; Nutrition; Population and; Operations Research.

Strategic Plan

Prof Sack reported that the Centre has a Strategic Plan (SP) for the decade. It remains a knowledge-creating organization and uses the new knowledge to improve programmes, and create new technologies with global application. The SP provides a compass for the scientists and administrators and a yardstick to measure progress. It summarises the Centre to present and prospective donors. It therefore needs to be a useful tool year by year.

By the year 2010, Bangladesh will have a population of 154 million, 20 million of which will live in Dhaka. It seems unlikely that there will be major improvements in water and sanitation. Whether the recent improvements in health statistics will continue or will deteriorate will depend on policies and programmes to be implemented.

Prof Sack identified areas where the Centre will focus its efforts:

Neonatal Health, Nutrition during Pregnancy and Lactation; Super ORS; Control of the 8th Pandemic; New Vaccines for Immunisation Programmes; Oral Cholera Vaccine; Herd Immunity for Measles; Rotavirus Vaccine; Equity of Rotavirus Vaccine; Equity of Health Interventions; the "failing child"; IMCI; Enterotoxigenic *E.coli* vaccine; Easily preventable deaths; Child development; Exclusive breast feeding; Fertility reduction; Reducing STDs; Case management of dengue; Health cooperatives; Tuberculosis; Health consequences of Arsenic; HIV-AIDS; Training and Outreach; Micronutrients; Rapid diagnosis; gender equity; Medical ethics for developing countries; An International Institution; Future Leadership; Master Plan; Financial sustainability.

He outlined that by the year 2010, the Centre projects that it will know:

- the major causes of deaths during the first few days of life and will learn how to prevent them
- how to provide proper nutrition to pregnant and lactating mothers to improve the health and development of the children
- how to prepare the "super ORS" that reduces diarrhoea as well as rehydrates.
- Which new vaccines should be introduced into routine immunization programmes and understand how to make this recommendation
- How to use a low-cost, oral vaccine and will show others how and when to use it.
- How to improve the coverage for EPI vaccines, and especially improve the coverage for measles vaccine in order to achieve herd immunity

The Centre will:

- Establish the effectiveness of the new rotavirus vaccines, expecting that they will reduce diarrhoea admissions by 30%

- Monitor the equity benefit of rotavirus vaccines since the vaccine can be given to nearly all infants, even those who would not normally access treatment when they become ill.
- Know how to monitor health interventions for equity characteristics and will use this knowledge to prioritise new programmes.
- Know how to determine which infants and children are at high risk for an early death and will know what can be done to save them, and to improve their lives. The Centre can then introduce these strategies in its field areas and begin to inform others how this can be done.
- Know if the integrated management of childhood illness (IMCI) approach is useful and effective, and will use its evaluation of IMCI to simplify and improve its effectiveness in the treatment of sick children.
- Know if a vaccine for enterotoxigenic *E. coli* is effective in preventing severe *E. coli* diarrhoea. Assuming it does, the Centre will demonstrate its public health utility with the expectations that this will further reduce overall admissions for diarrhoea by 20% (above that provided by rotavirus vaccine).
- Know how to identify the common acute life-threatening illnesses of children and know what kind of facilities, skills and resources are needed to prevent these deaths. The Centre will have a model facility for treatment of these illnesses and will use these as a teaching facility.
- Know how to improve the mental and physical development of children through stimulation and better nutrition.
- Know how to influence families to practice exclusive breastfeeding for the first six months of their baby's life with the goal of implementing national programmes for breastfeeding promotion.
- Know why the reduction in fertility has leveled, and will learn what steps will be needed to reduce fertility to replacement levels. The Centre will use this knowledge to inform policies and programmes.
- Have identified effective strategies for minimizing spread of sexually-transmitted infections through behaviour change and treatment.
- Learn how to improve the case management of patients with severe dengue infection using oral rehydration solution. This improvement will have special importance to rural areas where IV fluids may not be available.
- Have gained experience with "health cooperatives" as a way to provide community-directed primary health services.
- Know the epidemiology of tuberculosis in Bangladesh and will know the magnitude of antibiotic resistance where and when multiple antibiotic resistance occurs.
- Know the relation between arsenic and illnesses and how to reduce arsenic consumption.
- Know how the HIV virus is spread within population groups and how to interrupt these routes to limit the HIV epidemic in Bangladesh.
- Use anti-retroviral drugs, in concert with voluntary counseling and testing to prevent the impending epidemic.
- Include in the Centre's training programme, an electronically-based curricula, including both face-to-face and distance learning, and will be integrated with outreach and consulting services. The training will be conducted in several sites in Bangladesh as well as some additional sites in the region.
- Know which micronutrients are needed and how to provide these through food fortification, supplements, and locally-available foods.
- Know how to diagnose important common illnesses (e.g. cholera, malaria, shigellosis) using rapid tests like dip sticks.

- Have a management information system in place with coordinated information from finance, human resources and projects in order to improve efficiency at the Centre.
- Have achieved gender equity at each level of the organization.
- Be advocates providing a voice for developing country institutions toward discourse on medical ethics.
- Continue to conduct scientific and medical projects in an ethical manner upholding international standards.
- Continue to be an international centre with international and Bangladeshi staff and scientists working side by side.
- Will attract and develop young national scientists through structured programmes to become future leaders for the Centre and the international scientific community.
- Complete construction on the main building and construction of the office tower will be underway. The main building will house new space for hospital patients, laboratories, library and training, and offices.
- Will be deficit free and will have a Centre endowment of US\$10 million and a Hospital endowment of US\$20 million.

Dr Uauy thanked Prof Sack for his presentation and noted that these were exciting times for the Centre.

Discussion:

Prof Sack was asked for his thoughts on the main constraints, internal and external, currently being felt at the Centre. He stated that the Centre's financial stability is always uncertain but it is hoped that the Centre can achieve financial stability during the decade.

It was discussed that the Centre is now far removed from its original focus and it was a timely move to consider changing the make up of the staff to include political and social scientists to implement knowledge to action. It was time for the Centre to look at sustainability and maintain research capability with service as a by-product. The Centre cannot solve all health problems and should decide on a focus.

It was agreed that the subject of gender equity would be addressed in the HR Committee meeting. Prof Jacobs pointed out that we should be speaking of gender "equality" rather than gender "equity".

Clinical Sciences Division

Dr Uauy invited Dr MA Salam to present the report of the Clinical Sciences Division (CSD), and Nutrition Programme.

Dr Salam outlined the major activities of CSD.

Research: diarrhoeal diseases, malnutrition and related areas such as ALRI, and other infectious diseases

Service: diarrhoeal disease and associated problems particularly ARI, malnutrition and other infectious diseases

Training: case management of diarrhoeal diseases, malnutrition and clinical research.

Staffing status:

Number of international/seconded staff = 0
Consultants = 4: 3 local, 1 international
National staff = 188: 31 National Officers; 157 General Service
Other = 245: 103 CSAs; 80 health workers

Staff development:

6 scientists completed degrees/courses; 6 currently undergoing advanced degrees at external institutions; 12 complete clinical training programmes at BIRDEM in Dhaka.

Research themes:

- Case management research: Nutrition therapy; fluid therapy; pharmacological therapy; other
- Pathophysiology research
- Preventive strategies / Maternal Child Health

Research productivity (Oct 2001-Mar 2002):

Peer reviewed publications	8
Original article	8
Abstract	1
In-press (original article)	3
Manuscript under preparation	18
Protocols	
Completed	11
In progress	25

Dr Salam also reported on significant research findings for the period Oct 2001-Mar 2002. Patient visits for the period were Short Stay Ward – 30,075; General Ward – 2,345; Special Care Unit – 882; Research Wards – 266; Nutrition Rehabilitation Unit – 148.

Diarrhoeal Disease Surveillance, Clinical Research and Service Centre

Monitoring changes:

- Epidemiology of diarrhoeal diseases
- Sociodemographic characteristics of the patients
- Aetiology
- Anti-microbial susceptibility of enteric bacterial pathogens
- Relate research findings to larger population
- Identify research topics and help design proposals
- Monitor impacts of health interventions

Training Activities at the CRSC: 15 Clinical Fellowships; 15 Nurse Fellowships; 9 Training of Trainers – International Course on Clinical Management of Diarrhoeal Disease.

Dr Salam reported on CSD scientists' participation at national and international conferences, workshops and seminars. He further listed other accomplishments of the Division:

- Development of Divisional Strategic and Action Plans
- Completion of Doctoral Programme by staff member
- Improvement of physical facilities
- Improvement of Special Procedure Clinic and plans for expansion of the range of its activities
- Renovation/restructuring of physical facilities in progress
- Establishment of Video Health Education / Behaviour Change Communication

He also outlined the Division's research work plan for the next 12-24 months for the Programmes on Nutrition and; Infectious Diseases. Other CSD priorities over the next 12 months include:

Research:

- Sustain and further strengthen institutional linkage
- Maintain and further strengthen inter-divisional collaboration
- Continue efforts for competitive grants
- Improve quality of research, and emphasise publication in high-impact journals

Case management

- Standardize management of acute lower respiratory tract infections and pneumonia.
- Standardize management of persistent diarrhoea

Staff development

- Train a number of Division staff on ORACLE to take part in Centre-wide MIS and maintenance of research and patient care database.
- Develop management skills
- Strengthen nurse management
- Develop skills on management of ARI
- Continue training of CRSC staff and fellows on Cardiopulmonary Resuscitation.

Training

- Strengthen fellowship (clinical, nurse and research) programmes
- Structure Elective Training at the Dhaka Hospital including development of various course curriculum in partnership with the Training and Education Unit

Hospital strategy

- Strengthen "Special Procedure Clinic" as part of strengthening of the Centre's "Diagnostic Laboratories".
- Work at extending franchise of ICDDR,B services to other ESP clinics operated by PKSP, which currently operates a clinic within the Centre premises.
- Continue efforts to increase GoB financial support for patient care activities at the Dhaka Hospital.

Dr Salam also reported that the Division maintains collaboration with a number of national, regional and international institutions.

Nutrition Programme

The Programme was headed by Prof George Fuchs from Jan-Jun 2001 and from Jul 2001 to the present by Acting Head Dr SK Roy.

The research themes are: Severe & moderate child malnutrition; Infant and child feeding; maternal nutrition/LBW; Child development; Micro-nutrient research; infection/nutrition inter-relation. The Programme coordinates with LSD, CSD, PHSD and HSRD on these themes. Theme leaders are: Dr T Ahmed (CSD), Dr I Kabir (CSD), Mr MA Wahed, Dr DS Alam (PHSD), Dr J Hamadani (CSD), Dr S El Arifeen (PHSD).

Nutrition Programme achievements:

- 18 research projects conducted under World Bank grant
- 16 research projects supported by other donors
- 15 research publications
- Development of Strategic Plan
- Operations Research Management and Capacity Development under BINP Operations Research
- Establishment of Programme Office at the new Clinic

Nutrition Programme requirements:

Recruitment of Programme Head
WB grant ended in September 2001
BINP activity will end in June 2001

Dr Uauy thanked Dr Salam for his presentation.

Discussion:

Prof Jacobs congratulated Dr Salam on holding over as Acting Head of the Division for the past 9 months. Dr Uauy noted that the Division needs to move beyond the World Bank support. Dr Salam pointed out that the Division does have support from recognized donors, USAID, Thrasher Foundation and NIH, among others, but needs to be more aggressive in pursuing funding opportunities. Funding for patient care remains a problem.

Information Sciences Division

Dr Uauy invited Mr Peter Thorpe to present the report of the Information Sciences Division.

Mr Thorpe reported that the Division was established at the same time he took up his position with the Centre in August 2001. The Division comprises Training and Education Unit, Dissemination and Information Services Centre (DISC), and Computer Information Services (CIS).

Training and Education Unit (TEU) promotes human resources development by strengthening research capacity in:

- Research techniques
- Management of diarrhoeal diseases and family planning services
- Responding to new and emerging issues.

The training courses offered by TEU contribute to human resources develop and research capacity building in Bangladesh, in the region and globally. The present range of courses concentrates on building research capacity in research methods, particularly epidemiology and biostatistics, in the clinical management and laboratory diagnosis of diarrhoeal diseases, in reproductive health and family planning, and in the response to new and emerging public health issues.

The Unit's objectives are to develop distance learning methods and tools; develop new training courses in areas in which the Centre has a comparative advantage; promote the Fellowship scheme; collaborate with national and regional universities for accreditation; make the unit self-sufficient.

These objectives represent an intensification of efforts to bring the Centre's technical skills and expertise to a growing number of trainees. This will be done by distance learning. ISD plans to capture well-established Centre training courses on CD-ROM and the Internet. New training courses will be developed in cooperation with the research units concerned. Examples are the Poverty and Health courses and a workshop with the LSD parasitology laboratory, also in the planning stages.

The Centre's expertise is in great demand and on-the-job training in the form of research fellowships are an excellent way of introducing trainees to the methods and tools developed and used in the Centre. ISD will promote this concept to donors so as to increase the resources available to offer fellowships over the coming years.

There will also be increased efforts to develop relationships with both national and regional universities who have an interest in the public health topics that concern the Centre. The aim is to increase the faculty available to the Centre and also enable participants on the training courses to gain credits towards higher degrees.

TEU aims to become self-sufficient by modifying the way in which training courses are funded. This will be a gradual step but which will ultimately enable the Centre to charge course fees from individual participants. It is anticipated that the participants will then be funded by a number of donors, rather than the course being supported by one donor.

In 2001, the Unit conducted workshops on:

- Emerging and Re-Emerging Pathogens – 12 trainees from Japan participated.
- Clinical Management of Diarrhoeal Diseases – 12 participants from Bangladesh, Bhutan, Cambodia, Indonesia, Lao Republic, Kenya, Pakistan
- Laboratory Diagnosis of Common Diarrhoeal Disease Agents – 11 participants from Bangladesh, Bhutan, Cambodia, India, Laos, Nepal, Sri Lanka, Vietnam
- Improving Effectiveness, Quality of Services and Sustainability in Reproductive Health Programmes through Health Research – 11 participants from Bangladesh, Indonesia, Kenya, Mexico, Pakistan, Philippines, Senegal, Tanzania, Zambia, Zimbabwe

National courses for 2001 included:

- Clinical Management of Diarrhoeal Diseases for FCGP students – 17 trainees from Bangladesh participated
- Feasible means to address moderately malnourished children – 30 from Bangladesh

- Orientation course on Arsenic Measurements (Chemists, Analysts and Engineers of DPHE) (X4) – 25 from Bangladesh.

Health Research Training:

- Course on Epidemiology and Biostatistics (x2) – 30 participants from Bangladesh.
- International workshop on Health and Demographic Surveillance System and Longitudinal Data Analysis – 16 from Bangladesh, Japan, Kenya, Mali, Nicaragua, Tanzania and Vietnam
- Postgraduate fellowship – 2 from Bangladesh

Fellowship Programme 2001:

- International Fellowship (elective training and training for postgraduate degree and diploma – 29 from Australia, Bangladesh, Canada, India, Japan, Malaysia, Netherlands, Singapore, Sweden, UK, USA
- Training of Fellows from SAARC countries – 10 from Bangladesh, Bhutan, Maldives, Nepal, Pakistan, Sri Lanka
- DGIC Fellowship programme – 6 from Lao DR and Cambodia
- Clinical Fellowship – 13 from Bangladesh
- Nurse Fellowship -- 15 from Bangladesh.

DFID Poverty and Health Project

The Centre began a major new Project on Poverty and Health funded by DFID in November 2001. This 5-year Project as well as being Centre-wide, also included a considerable amount of funding to support areas of the Centre's activities which are often over looked by other projects – training, communications, human resources development.

Internships and Research Associate

This is another form of Centre Fellowship. The Unit plans to employ 2 Bangladeshi interns – new Master's level graduates as well as Research Associates – who can contribute their experience to the project.

Research Training Courses

Two training courses are currently being planned in cooperation with the poverty and health researchers in the Centre and in collaboration with external organizations. The first course, scheduled for Sept/Oct this year, is a week-long national course on methodologies for measuring poverty and health arranged in cooperation with an ex-Centre staff member now at the Tulane University in the US. The second course is a month-long workshop planned for next January. This is being organised in cooperation with Bangladesh Health Equity Watch, a group of 4 organisations active in this area (including the Centre).

IT/Web-Based Training Activities

This part of the DFID project enables the Unit to develop a capacity for distance learning, and the preparation of training courses on CD-Rom and on the Internet. A new Computer Training Laboratory has just been equipped and completed – this will be used for training our own staff in the use of the usual office software, plus more specialized courses for individual units and divisions in particular software packages. It will also be invaluable for the Centre's

national and international courses on subjects such as epidemiology and the surveillance system. The Unit will also use the computer lab to test training courses on CDs.

Improved Human Resource Base

This will be extremely useful both to the Division and the Centre as a whole to facilitate training the Centre's trainers in modern methods of teaching. The Unit has been conducting courses for some time and the training staff have had very little opportunity to catch up in both technical areas such as advanced PowerPoint presentations and in methodological areas such as participatory training methods.

Dissemination and Information Services Centre (DISC). 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. DISC contains one of the best bio-medical libraries in the world. It fulfils its role in the Centre by serving as an effective information storage and dissemination unit, using up-to-date methods of information storage and retrieval. DISC contributes enormously to the research activity within the Centre by providing this access and also to making the Centre's work known to others through the publication of the Centre's periodicals (JHPN, Glimpse and Shastha Sanglap) and other publications.

Audio-visual support is provided for all aspects of the Centre's work from contributions to conferences as presentations or posters to the design and production of illustrated publications such as the Annual Report and promotional leaflets for the Hospital Endowment Fund.

DISC's objectives are to produce and make digitized archives of Centre materials; provide increasing access to materials in electronic format on CD and the Internet; develop additional specialized databases; provide resource areas in the library for Centre programme areas; upgrade computer facilities for library users.

DFID Poverty & Health Project: Development of a resource unit for effective dissemination and communication with focus on poverty and health equity; production of newsletters and health policy analyses of research results on poverty and health. These two areas are included in the communications component of the DFID project.

Poverty & Health Resource Unit: A DISC staff member has been assigned to this project and additional computer equipment has been provided for access to both the Internet and internal databases for visitors to the Centre. A start has been made on upgrading the Audio-Visual Unit to enable computer editing of video material. This will contribute not only to the Centre's general awareness presentations but also to the development of distance learning materials on CD.

Newsletters and Bulletins: A further component of the DFID project foresees the production and dissemination of newsletters and research papers on Poverty and Health. DISC is in the process of recruiting an Editor for this area. Materials will be disseminated by email, on the Internet, as well as on hard copy by ordinary mail.

Computer Information Services (CIS) – responsible for the provision of modern IT services to all scientific and support divisions in the Centre. Its objectives are to develop a fully integrated IT infrastructure throughout the Centre; provide end-users with a seamless interface to all applications; provide direction and strategy to fulfil these requirements. CIS' strategic plans are to introduce a data warehouse on the Internet; enhance the Centre's web

pages; standardize the software and hardware used in the Centre; convert CIS to a self-supporting business.

DFID Poverty & Health Project: Further development of web page and IT-based communication of new knowledge. A further part of the communications component of the DFID project involves the further development of the Centre's website.

Web Page and IT-based Communication: Considerable progress has been made but is not yet visible. By the end of the summer, it is expected that the website will be revitalized, faster and able to supply much more up-to-date information.

Dr Uauy thanked Mr Thorpe for his presentation.

Discussion:

It was discussed that a Business Plan should be implemented for the Division. Mr Thorpe reported that the Division is looking into charging a monthly fee for individual users for network connection.

The Board also touched on licensing, accreditation and funding for training courses. It was discussed that course topics are influenced by the donors. The Division would prefer that candidates for the courses seek funding from different donors rather than the course itself be funded by one single donor. It was suggested that the Division should set up a separate project for training programmes.

Laboratory Sciences Division

Dr Uauy invited Dr Balakrish Nair to present the report of the Laboratory Sciences Division.

Dr Nair presented the highlights of the Laboratory Sciences Division. He began by describing the functional components of the Division and elaborated on the 10 research units. He described the theme-wise spread of the 33 on-going protocols. Based on these, he showed that the emphasis of LSD is still on enteric diseases but there are projects in other areas like ARI, RTI, HIV, TB and Peptic Ulcer Diseases and this was in keeping with the expanding mandate of the Division.

He then went on to present technical highlights of work accomplished by the Division in the past six months. He laid emphasis on a new technique to isolate bacterial enteropathogen from environmental samples using specific phages. The prevalence of ETEC and its incidence in comparison with incidence of cholera was also highlighted. Several new variants of *Shigella species* were identified in the past 6 months and the molecular characterization of these were described. The technical highlights included recent findings on the *Helicobacter pylori* and their comparison with isolates from different parts of the world in a population genetics study.

Dr Nair also presented recent findings on the polymorphosis in the serine rich *Entamoeba histolytica* protein gene and elaborated on its usefulness in typing isolates.

He further elaborated on drug resistance in the mycobacterium TB isolates and the use of molecular techniques to distinguish whether the Mycobacterium isolates belonged to Bovine TB type.

The highlights of the Virology Laboratory include Rotavirus G type specific distribution of rotavirus and introduction of a voluntary counseling and testing centre for HIV.

The epidemiology and etiology of sexually-transmitted infections of the RTI/STI laboratory was also highlighted. The work of the Environmental Laboratory over the past few years was summarized.

Dr Nair then outlined the infrastructure developed in the Laboratory Sciences Division over the past six months. He also listed the recognition of some of the LSD scientists in their research and other activities. The scientific achievement in terms of papers published and staff development activities was also presented.

Discussion:

Dr Nair stated that the Division is enjoying a community atmosphere in its cross-collaboration efforts with the other Divisions. He noted that the Division just completed an external review and findings, interim report and Centre response would be looked at in a separate session on the review.

Health Systems and Infectious Diseases Division (HSID)

Dr Uauy invited Dr Rob Breiman to present the report of the Health Systems and Infectious Diseases Division.

Dr Breiman reported that new opportunities of the Division are to provide a focused infrastructure for moving research findings into action and policy; and to be the home base for research into new priority research in emerging infectious diseases.

HSID's provisional mission is to strengthen national health systems through support of operations research; design, test and facilitate extension of cost-effective and sustainable research outcomes for rural and urban settings with emphasis on prevention and control of infectious diseases.

What HSID does: The Division provides infrastructure/expertise for operations research with adaptation and implementation of the benefits of interventions identified in "research world" into "real world" applications. It also provides a Division-level epidemiologic and operational focal point for emerging infectious disease research.

HSID staffing: Total number of staff = 220; 45 national; 5 international and 171 field level and general services staff.

Programmes and Units: The Division houses the following Centre-wide cross-divisional activities:

- Programme on Infectious Diseases and Vaccine Sciences (PIDVS)
- Programme on Health and Family Planning Systems (PHFPS)
- Family Health Research Project (FHRP)

The functional Units include Rural Interventions Unit, Urban Intervention Unit, Infectious Disease Unit, Health and Economics Policy Unit and Data Resources Unit.

Plans are underway for the launch of a new Centre newsletter, the Bangladesh Health and Science Bulletin, which will deliver late-breaking surveillance and research data with

interpretation to the Ministry of Health leadership; government and private community clinics; NGOs; donors; and others in the region who are focused on health and disease prevention.

The Division has well-developed field sites for addressing rural health issues and the rapidly-growing area of urban health. Rural field sites are in Abhoynagar and Mirsarai; urban field site is in Kamalapur.

Issues in urban health include rapid urbanization, inadequate housing and overcrowding, poor sanitation, unsafe water, indoor and outdoor air pollution and waste removal. The demographic surveillance activities in Kamalapur are mapping/enumeration; active surveillance for disease; field-site-based clinical management; training; monitoring and evaluation. The principal areas of focus in Kamalapur are pneumonia, diarrhoeal diseases, tuberculosis, dengue and vaccine-preventable diseases

Ongoing activities in Kamalapur:

- Morbidity surveillance for:
 - pneumonia (USAID)
 - diarrhoeal/dysentery (International Vaccine Institute)
 - dengue Fever (USAID, National Institutes of Health, AFRIMS)
 - other febrile illnesses (CDC)
- Influenza vaccine trial (Wyeth Lederle)

Dengue incidence study in Kamalapur:

- Hospital surveillance shows increased mortality from dengue among the poorest of the poor.
- Active surveillance among 20,000 people
- 1000 febrile episodes
- 11 cases of dengue identified
- risk factor study pending
- fever etiology studies slated for this year
- NIH-funded surveillance study about to begin
- Vector studies to be done in tandem

Upcoming projects in Kamalapur:

- Burden of disease studies
 - Respiratory pathogens (CDC, Gates-CVP/PATH)
 - Encephalitis (CDC)
 - Typhoid fever (CDC, IVI)
 - Tuberculosis (+ therapy) (DFID/USAID)
- Asthma risk factor study (University of Tokyo)
- Influenza Vaccine Trial (Wyeth Lederle)
- Pneumococcal Vaccine Trial (PATH, Johns Hopkins Univ)

PIDVS

The Programme's objective is to facilitate and focus ICDDR,B's expanding role in the prevention and control of infectious diseases important to Bangladesh and other impoverished settings.

The Programme's strategic plan:

- Evaluate promising vaccine candidates against key infectious diseases and disease syndromes
- Define disease incidence and burden for major disease syndromes and key aetiologies
Define risk factors and clinical and epidemiologic characteristics of priority infectious diseases for use in cost-effective strategies for prevention and control
- Evaluate treatment and prevention strategies for reducing burden of infectious diseases.
- Enhance capacity to investigate outbreaks in Bangladesh

PIDVS' cross-divisional scientific teams conduct studies on dengue, shigella burden of disease, ARI (influenza, pneumococcus, Hib), tuberculosis, new vaccines (rotavirus, cholera), kala azar, malaria, outbreak investigations.

Partners/Collaborators: Ministry of Health (Bangladesh), Dhaka City Corporation, Bangladesh hospitals, WHO, IVI, JHU, CDC, AFRIMS, pharmaceutical companies

Donors: USAID, DFID, JICA, NIH, NVPO, WHO, IVI, CDC, AFRIMS, Gates/PATH, GAVI, pharmaceutical companies

HSP

The Programme's objectives are

To facilitate, focus and make coherent Centre-wide operations research and activities relevant to national health and family planning programmes through identification of priority problems; design implementation, evaluation and replication of cost-effective and sustainable interventions; provision of technical assistance

To deliver maximum health benefits to the community, making optimal use of available knowledge, solutions and resources.

FHRP

The USAID/Dhaka-supported Operations Research Project (ORP) has been restructured and renamed FHRP. The restructuring aims to improve project activities with broad involvement of scientists/researchers working in other Divisions/Programmes of the Centre; to develop and test practical new interventions with enhanced emphasis on ESP programme needs.

FHRP studies include:

- Bangladesh fertility decline
- Development and evaluation of a community-based IMCI intervention
- Community-based interventions to reduce neonatal mortality
- Community-based protocolised management of severe malnutrition: cost-effectiveness analyses

- Addressing missed opportunities for family health needs
- Rapid appraisal tool for ESP managers
- Programmatic and non-programmatic determinants of low EPI coverage
- Cost-effectiveness of different strategies to improve access to basic obstetric care in Bangladesh
- Effectiveness of routine Hib immunisation

Challenges for FHRP and HSP include change of mentality/capacity building; scientists' security to prevent brain drain from the Centre; surveillance sites – re-focus of priorities; Centre-wide involvement; cost to the Centre; change in funding strategies.

The Programme hopes in 2 to 5 years to:

Establish a worldwide reputation for high-quality operations research; effectively transfer new knowledge and evidence-based guidelines to decision-makers, partners and practitioners; substantially reduce pneumonia and diarrhoea mortality; promote meaningful input from and participation with communities in which the Programme does operations research.

Discussion:

It was discussed that there should be a more active forum to systematically establish priorities which should be based on the Centre's activities with its collaborators. The Centre should establish proposals and protocols depending on need. Communities would need to be involved in the formative stage where ideas for the proposed study are explained, input is sought and the study progresses. It was further discussed that it was important to advance research into policy and action. Dr Pang pointed to the dengue surveillance in Kamalapur and suggested that the Division introduce KAP as a test base for other modules.

Public Health Sciences Division (PHSD)

Dr Uauy invited Dr Lars Ake Persson to present the report for the Public Health Sciences Division.

Dr Persson reported that the PHSD brings the population perspective to the Centre's mission and focuses on the development and evaluation of population-based interventions to address major health problems of poor communities in the world.

Dr Persson introduced Dr Md Yunus, Head of the Matlab Health Research Centre; Dr Abbas Bhuiya, Head of the Social and Behavioural Sciences Unit; Dr Kim Streatfield, Head of the Health and Demographic Surveillance Unit; Dr Shams El Arifeen, Head of the Child Health Unit; Prof Japhet Killewo, Head of the Reproductive Health Unit; Dr AKM Siddique, Head of the Epidemic Control and Preparedness Unit. The Division also houses Centre-wide research programmes on Child Health, Reproductive Health, Population Sciences as well as an office on poverty and health.

Dr Persson referred to 2 recent publications:

"Development through self-help: be a part of it" which is a follow-up publication to the Self Help Conference organised by SBSU, German red Cross, DASCOH, Japanese Red Cross Society, Plan International, Swiss Red Cross and UNDP, and

"Community-Based Health Care: Lessons from Bangladesh to Boston".

The Matlab Safe Motherhood project has upgraded government facilities to provide basic EOC services; renovations; staff training; provision of equipment; drugs and supplies.

Prof Persson showed the figures for 2000 for neonatal deaths by age at death in Matlab and the trends in drowning deaths in 1 to 4-year-old children in Matlab 1983-2000.

The MiniMat studies are progressing well. 1000 women have been recruited; the first baby was born and there are plans for infant follow-up.

Prof Persson also reported that the research studies on arsenic contamination and attendant side effects are continuing. Questions being addressed : Who develops arsenic-related skin lesions? Is malnutrition increasing the risk? Is foetal wastage increased? Is arsenic causing cancer and cardiovascular deaths? Are alternative water sources increasing diarrhoea morbidity? Does arsenic toxicity in pregnancy cause foetal wastage, impaired growth and development and can nutrition interventions reduce the risk?

The Division is projecting increased activity, staff, research funds; major umbrella protocols across units and divisions. Major studies are being implemented in Matlab; however there is a lack of space in Dhaka and Matlab. More women and more mid-level scientists are needed. Cost-effectiveness (staff, supply, administration) needs further improvement.

Discussion:

It was discussed whether research was being done in the area of HIV/AIDS in Matlab. Prof Persson reported that studies are ongoing on STDs. The SBSP is conducting studies in Chittagong. The Centre needs to develop more comprehensive activity with government and other partners who will have input.

The post of Health Economist is crucial to the Division and it is being increasingly difficult to fill the vacancy. Applications have been received and it is hoped that a suitable candidate would be announced shortly.

Prof Persson also reported that the Division is extending studies and health services to the elderly which will lead to data that will assist in studies on child and maternal health.

Dr Lanata pointed to a study on poverty being conducted in 5 countries – Vietnam, Peru, south Africa, Hyderabad State and Ethiopia -- looking at how to improve health service utilization by linking quality of care.

SWA Presentation
6 June 2002
Seminar Rm 2

The Staff Welfare Association met with the Board of Trustees to present issues for consideration by the Board. Dr Sirajul Islam, President of SWA thanked the BOT for the opportunity to make a presentation on behalf of the staff.

Staff salary: He extended his gratitude for the salary adjustments recommended by the BOT during the last three years, which helped to boost the morale and confidence of the staff. He stated that there were still gaps in the salary structure that needed to be addressed as a priority.

Establishment of promotion criteria for all categories of staff:

Scientific staff: The introduction of the scientific ranking system contributed much towards boosting staff morale. However, SWA expects that before further decisions are taken in this regard, that a uniform criteria be established before the next round of promotions or upgradings are considered.

Non-scientific staff: Dr Islam noted that setting up promotion criteria for this category is in progress. However, many staff members have been working in the same grade for many years and are deprived and frustrated. The SWA hopes that if promotions are being considered after the setting-up exercise, they should be implemented simultaneously for both scientific and non-scientific staff.

Pending issues: Dr Islam listed a number issues which he noted had been brought before the Board on several occasions with no result:

- Introduction of a uniform recruitment policy
- Review of salary of national vs international staff
- Review of working hours of employees at GS Level I and II
- Dependant facilities:
 - increase children's allowance from Tk500 to Tk1000
 - extend retirement age for staff up to 65 years
 - extend age limit for dependent children up to 25 years
- Increase of annual holidays from 11 to 14 days
- Three months' leave pay at the time of retirement

Dr Islam noted that some of these issues are being considered by the Head Human Resources and that SWA looks forward to timely action on these issues.

SWA benefits to the staff: Dr Islam pointed to the important role the SWA plays in addressing the needs of the staff. The SWA provides, through its medical assistance fund, an educational fund for staff dependants, cultural events, farewells and condolences, construction of the mosque in Matlab, and home gardening and fish production in Matlab.

The SWA also contributes significantly in improving staff relationship with the management with regard to administrative and other activities. Dr Islam concluded that the confidence and trust between the management and the SWA play an important role in the development of the Centre.

Small Groups and Field Visits
7 June 2002am and 8 June 2002am

On the morning of Friday 7 June and Saturday 8 June, the BOT were assigned to small groups with the Division and Programme Heads for discussions and visits to urban field areas.

6 June:

Child Health Programme and Nutrition Programme. BOT members Prof Ishikawa, Prof Azad Khan, Prof Kusin and Mr Chowdhury (**Group 1**) participated.

Infectious Diseases and Vaccine Sciences Programme and Population Programme. BOT members Dr Hamid, Prof Hull, Dr Pang and Dr Wachsmuth (**Group 2**) participated.

Reproductive Health Programme and FHRP Programme. BOT members Prof Ganguly, Mr Rahman, Dr Tanner and Prof Vlassoff (**Group 3**) participated.

Interviews and Promotions Review. BOT members Prof Jacobs, Dr Uauy, Dr Lanata and Prof Sack (**Group 4**) participated as well as Head HR and Head, LSD.

7 June:

Kamalapur field visit. **Group 1** participated.

Mirpur field visit (projects on amoeba, rotavirus vaccine, ETEC vaccine and nutrition rehabilitation at daycare). **Group 2** participated.

Safe water and HIV projects (arsenic and environmental health projects) with visits to sites where work is ongoing. **Group 3** participated.

Finance and Administration and Master Plan of the Centre

Review of the review from Price Waterhouse

Update of new HR and Finance MIS system

Resource mobilization.

Group 4 participated as well as AC members.

Strategic Plan
CSD Conf Room
6 June 2002 pm

The Board met at 15:45pm in closed session to discuss the Strategic Plan. Scientific Council members participated.

Present: BOT members

Absent (with regrets): Mr Fazlur Rahman; Mr Rolf Carriere

Invited: Scientific Council members; DSG members

Minute Secretary: Judith Bennett Henry

Prof Jacobs called on Prof Barkat e Khuda, Head, Policy and Planning, to give an overview of the process in formulating the SP.

Prof Barkat reported that following Board discussions, the Plan was reviewed and some of the issues were re-defined. With input from the Scientific and Administrative staff, the Centre has been working on the Plan for about 2 years. The Plan is geared to the year 2010 as a more realistic projection. The process was as a result of formal as well as informal input. The Centre Scientific Forum (CSF) divided the major scientific topics and analysed what major themes to present to the Centre staff. The CSF was a vehicle for the SP process and influenced the makeup of the Forum.

Prof Barkat explained that Annex 3 gives details of what the Board requested on issues that were feasible; Annex 4 addresses key questions. This information came out of the Programmes.

The Plan needs fresh eyes to review and to bring better focus on what the Centre is projecting in the Plan. Board input is needed to advise on how to translate the information for donor consumption. The issue of the change of the Centre's name is a priority to make it more marketable, but selection of the new name should await completion of the Plan to insure the name fits the Plan.

Discussion:

It was pointed out that to change the name, the Ordinance needs to be changed which would mean discussion with the GoB for approval. Dr Dagach suggested that the word "nutrition" be part of the name as it would make a big difference in the marketing of the Centre. Dr Breiman advised that the name should clearly define the Centre as one of excellence in science in all aspects including training, communications, etc. Prof Vlassoff recommended that the word "population" be omitted and "reproductive health" be considered; as the word "population" is not popular with donor agencies. Prof Jacobs advised that the word "development" be considered to link the Centre with the Millenium Development Goals.

Dr Pang suggested the new name "International Centre for Health Sciences for Development" to link the Centre with the Millenium Dev Goals and Health for All. He stated that the Centre should make a concerted effort to benefit from the Global Fund. He pointed to the matching Global Health Research Fund which is gaining momentum and advised that the Centre should place itself to tap into these funds.

Others made the following suggestions regarding the Plan. The word "international" should be retained as it influences the accessibility to international development funds.

Prof Hull noted that gender is mentioned as a priority and is not mainstreamed in the document. He advised a stronger gender tone to bullet points and to the Plan (e.g. to "mainstream" gender equality as part of the Centre's character).

It was discussed that the **Foreword** of the Plan should give an overview of the Centre's intentions which will whet the appetite of readers. It would need to fit together into a coherent Plan which should be product-oriented for donors as well as for Centre focus.

It was noted that there was a lack of sense of outreach in the **Mission** which, it was felt, should open up a broad field of activity beyond Bangladesh. It should address the global mandates and the Centre's contribution to them. The Centre should be crisp and concise in its Mission and outline what it intends to do and be confident of the balance it wants to strike. The conceptual framework should be carefully selected.

It should underline a broad vision of human development. It should be simple and sustainable and incorporate community participation in improved policies and programmes. The **Vision** should directly or indirectly contribute to the Health for All Goals by year 2015. It should be a vision for the Centre and what the Centre hopes to accomplish. The Vision should catch the spirit and content of the Plan; the Centre should appoint a marketing consultant to pull it together.

The Plan should focus on the strategies. It was suggested that the Board look again at the recommendations of Mary de Kuyper following the BoT retreat in November 1999 in which she outlined strategies and projections for the Centre and a Strategic Plan for the Board.

The meeting ended at 17:30pm and will continue deliberations the following day, 7 June 2002.

Strategic Plan
CSD Conf Room
7 June 2002pm

It was decided to bring forward the Strategic Plan discussions to the time period 14:00-15:45pm which was initially allotted to the LSD Review Preliminary Report which was moved to 16:00-17:30pm. This was to accommodate the participation of Ms Renate Pors, Chair of the Donors Support Group.

Present: BOT members

Absent (with regrets): Mr Fazlur Rahman; Mr Rolf Carriere

Invited: Scientific Council members; DSG members

Minute Secretary: Judith Bennett Henry

Prof Jacobs welcomed Ms Pors to the meeting. She noted that the Strategic Plan was still in the draft stage and looked forward to any comments or suggestions Ms Pors may offer to apprise the Board on what are donors' expectations for the Plan.

Discussion:

It was suggested that the Plan should indicate how some of the Centre's research will contribute to the 10/90 gap; the Plan should lay down goals and show parameters by which goals and objectives should be done. Financial aspects should be linked to the goals and objectives and would give vibrancy to the Plan. Health economics projections especially for south east Asia, resource flow analysis, health economics analysis should be addressed as a 5-year plan. There should be separate research packages and service packages for the national and international level.

Dr Pang suggested that the Plan should show the Centre's contribution to strengthening of national health research in Bangladesh; a case in point, Kamalapur. He questioned whether there is conscious transfer of knowledge to advance capacity among local scientists. It was necessary to inform and have dialogue with the Ministry of Health and; to increase public engagement. Dr Sack noted that 97% of the Centre's scientists were Bangladesh nationals and that the Centre liaises strongly with the Ministry.

Prof Azad Khan noted that the Centre was created by an Ordinance and has since widened its activities. He warned that there may be reluctance from the Government for a name change and there could be possible political implications for the Centre.

Dr Pang noted that the Plan should include genomics research as the Centre is the only place in Bangladesh that can do the studies.

It was discussed that the projections should be limited to a conceptual framework informed by international development goals; that the Plan should focus on continuity from what the Centre is currently doing and where it wants to be in the future. The Plan should be informed by DALYS and data from the Centre and located in a national/regional/global context; it should demonstrate how the Centre fits into this context. The Centre's values should respond to national health and sciences development and strengthening health status development in Bangladesh.

Strategy goals should be laid out in concrete terms; should look at the Centre's past and inform why it is taking a different approach. The goals should ultimately focus on research, science and excellence. The strategy should enable the Centre to contribute to national health systems research development. Priorities should be on national, regional and global impact. Activities should focus on developing, supporting and retaining scientists in Bangladesh and identifying resource flows to help research in Bangladesh.

It was agreed that there was a need to mainstream gender in the Plan; that the goals should be simple and sustainable; that issues of poverty and equity should be themes that run through the Plan. Prof Hull advised that gender mainstreaming should elicit the highest level of involvement. It was important to look at gender issues in the management of the Centre. The Board should assist the Centre in integrating the issue in all aspects of the Centre. Mr Chowdhury stated that he looked forward to the recommendations as it was an issue that was currently being addressed in the Ministry. It was agreed that Prof Hull and Prof Vlassoff will work closely with the Centre's Gender Committee to share ideas and help with its operationalisation.

Prof Sack reported that he had had a recent meeting with the Health Secretary to share the draft Plan. The HS offered to organize a meeting with selected national Government institutions to review the Plan.

Prof Sack thanked the Board for helping to bring the Plan more into focus. It was decided that the Plan should be reviewed by Prof Jacobs, with input from BoT members for completion by next Board meeting.

Ms Pors thanked the Board for the opportunity to familiarize herself with the role of the Centre and the Board and looked forward to the Donors Support Group meeting where the issues can be further discussed.

Prof Jacobs closed the meeting at 17:30pm.

Presentation of the Preliminary Report
of the LSD External Review
CSD Conf Room
7 June 2002pm

The Board met at 16:00pm to hear the report of the external reviewers of the Laboratory Sciences Division. Administrative Council members participated.

The LSD Review was held from 4-5 June 2002. The 4-member review panel comprised Dr I Kaye Wachsmuth, Dr Tikki Pang, Prof Wangpen Chaikumpa and Major General Motiur Rahman.

Dr Wachsmuth reported that the general impression of the 4-member review panel was that LSD is well positioned scientifically and that the morale of the group is high. It appears that many of the independent units are successfully funded and have established productive collaborations within LSD, with other Centre groups, and with outside entities. The Division has a productive track record, as measured by publications and their impact and by the involvement of LSD scientists in community and clinical service projects.

General Observations

Initially the review panel studied the Centre's response to the 1996 external review. Each of the 12 recommendations has been addressed, and LSD was asked to prepare a summary of the current situation in relation to that review. The panel addressed the document point by point.

Although the Centre has significantly improved the quantity and quality of the laboratory space available to LSD, there is still a need for additional space, particularly for the tuberculosis and virology work and the expanding research and service agenda, which the review panel generally endorses.

LSD has taken an integrated approach to setting research priorities and establishing links between laboratory research, community-based epidemiological investigations, and clinical studies. The review panel would encourage the expansion of this approach.

Similarly, the Centre should encourage other Divisions and Programmes to consider LSD scientists as full collaborators, including them in initial protocol development and funding efforts.

LSD has also taken a balanced approach in research activities e.g. areas of molecular biology, molecular genetics, microbiology and epidemiology. The review panel thinks that this is an effective strategy and should be strengthened where possible.

Recommendations

The panel recommended that LSD work with the Centre to identify the highest priority areas, giving these emphasis, with the possibility of de-emphasising less important areas of current research. LSD could develop a strategic, business and action plan for the Division and for individual units. This process could have the added advantage of identifying income-generating activities within priority areas.

One clear area of emphasis should be the response to emerging disease problems, particularly outbreak situations, which can be quite disruptive and difficult to co-ordinate over several

organizational units. The reviewers suggest LSD (the Centre/other Divisions?) develop a plan for how best to deploy and coordinate resources during an emergency situation.

In emphasizing the highest priority areas, LSD should consider consolidating some activities e.g. the ARI laboratory is dealing with pneumonias, dengue fever and typhoid, and the small parasitology laboratory deals with amoebic dysentery, leishmaniasis, and will probably need to become more involved in malaria research.

There are opportunities now to capitalize on the integrated approach now taken by LSD, the reviewers identifies two areas as examples.

- The excellent work done by the Environmental Microbiology Laboratory in identifying the ecological niche for *Vibrio cholerae* and in identifying a preventative approach of sari filtration could be strengthened by interactions with the molecular laboratory and with field epidemiologists. Once the work is peer reviewed and published, it will give both the Centre and WHO another "success story".
- The substantial research advances made by LSD in understanding the immunology of shigellosis could be strengthened if LSD capitalized on the advances derived from the genomics revolution and data/specimens resulting from community-based epidemiological studies. This would position the Centre on the cutting-edge of research to understand the disease pathogenesis and protective mechanisms of a severe and persistent global disease problem.

Careful consideration should be given to how LSD can participate and benefit from the ongoing revolution in pathogen genomics. The Division has demonstrated its considerable understanding of and expertise in molecular genetics and could build on this to strengthen its capacity in bioinformatics, functional genomics (i.e. protein and DNA microarrays).

While keeping abreast of and advancing its capacity in molecular research, LSD should ensure that its basic research is firmly linked to the clinical and epidemiological aspects of the disease. This is the key comparative advantage of LSD and the Centre.

The review panel also acknowledged the continuing need for a credible research group to have access to state of the art equipment while being mindful of the financial constraints and the maintenance of equipment in the setting of the Centre. Although the panel asked LSD to prepare a priority list and explanation for the Board, there were specific pieces of equipment that reviewers identified: automated blood culture system (would probably pay for itself in one year's time), fluorescent microscope for TB and environmental work, electron microscope for many LSD projects, and a computerized system for tracking and retrieving the large collection of valuable specimens in the LSD inventory.

LSD has developed a successful working relationship with GoB and should capitalize on that to advance its research and service to the Bangladesh community (which also translates into service globally). Areas of opportunity and particular concern are HIV/AIDS, viral hepatitis (B and C), TB, dengue fever/dengue hemorrhagic fever, typhoid, and *V. cholerae* 0139.

Discussion:

Dr Wachsmuth stated that the Centre made an excellent choice in its appointment of Dr Balakrish Nair as the Head of LSD. She noted that the priority area to be addressed was the issue of space that is urgently needed. She recognized that expansion has been done over the past year and the lab is making the best use of the existing space. Dr Uauy noted that the research output of the Division was excellent and lauded the LSD staff for the quality of the work of the Division as well as its support of other Divisions and external institutions.

In addition, existing equipment needs back-up and/or renewal. It was suggested that an inventory of needed equipment could be listed in negotiations with donors. Dr Nair responded that the Division proposes funding for new equipment through its protocols. LSD should collaborate with the Divisions to ascertain what equipment is required. The Division should develop links with the other Divisions and should be able to contribute to the study on community-based shigella research. The lab should be the champion of cholera studies at the global level. It was further suggested that the direction of the laboratories should be set by the Strategic Plan for the Division.

Dr Nair noted that the Division collaborates with and uses equipment as needed at NICED and JICA.

It was discussed that the Division would need to computerize its specimens and establish a repository. Dr Nair stated that the LSD is making plans to send some LSD staff to CDC for training in this area. It was also discussed that for future IPR issues, Centre scientists' patents and cell products should be protected and clearly acknowledged if used; that the Centre should first be informed before use.

Dr Pang noted that the Division is at the threshold with excellent scientific standing on an international level and should continue keeping abreast of developments and making optimal use of materials and cross-cutting with Divisions. The Division should be in place to help local institutions enter the genomics era. He further advised that the Division get access to the web of science on the ISI website for full text links to journals and other relevant information links. He would look into and send information to Dr Sack on paying reduced membership fees under an "international health organization" membership or as a WHO collaborating Centre.

Prof Ganguly stated that the Division should set goals for the next 5 years. Performance goals and major issues such as manpower development, resource generation should be outlined. This should make reviewers' task much easier.

Dr Pang stated that the World Health Report 2004 will be themed Health Research and will publish success stories in the South. He also pointed to a fund by the Rockefeller Foundation to help developing countries develop publicity activities for their research programmes.

Prof Hull advised that occupational health and safety procedures be implemented; that waste disposal/handling be brought up to standard. There needs to be a report from the Bio-Safety Committee.

Prof Ganguly stated that a state-of-the-art animal facility of international standard was needed in the Division.

Dr Wachsmuth concluded that the outlook for the Division was positive. The presentations were impressive especially that of the bio-engineering cell. She commended Dr Nair on behalf of the review panel for his leadership. Dr Nair thanked the panel and the Board for their comments and suggestions and pointed to the excellent contribution of the Division scientists and the support staff in maintaining the quality work of the Division. He thanked Prof Sack for his support and the Scientific Council for their positive interaction with the Division.

The meeting ended at 17:30pm.

DRAFT
Minutes of the Finance Committee
Saturday 8 June 2002
4:00 pm

Present:

Members of the Board of Trustees

Prof Marian Jacobs (Chair of the Board)	Prof David Sack (Director)
Prof AK Azad Khan (Chair, Finance Committee)	Dr Ricardo Uauy Dagach
Prof NK Ganguly	Prof Terence H Hull
Dr Nobukatsu Ishikawa	Prof Jane Anita Kusin
Dr Claudio F Lanata	Mr M Fazlur Rahman
Prof Marcel Tanner	Prof Carol Vlassoff
Dr I Kaye Wachsmuth	

Absent (with regrets):

Dr Rolf Carriere
Mr Anisul Huq Chowdhury
Dr Maimunah Bte Abdul Hamid
Dr Tikki Pang

Invited Staff:

Division Heads, Chief Finance Officer, Head, HR, Ms Vanessa Brooks (ER&ID), Dr Anowar Hossain, Mrs Shamima Moin, Mr M A Samad, Mr Sk Abdul Matin (Finance personnel).

Minute Secretary: Loretta Saldanha

Prof. Azad Khan welcomed all those present at the meeting and invited Mr. Stephen Sage, CFO to present the Finance report.

Mr. Sage thanked the members of the Board for inviting him to present his report, introduced the members of his finance team and reported that he was extremely pleased to work with such a professional group of individuals in his section.

He briefly highlighted the following:

- 2001 Actual Results (historical results)

Auditors' Opinion
Contributions
Project Contributions
Core Contributions
Donor Base
Expenditures
Operating Surplus/Deficit

Agenda 1: 2001 Auditor's Report and Audited Financial Statements

The auditors' opinion was clean and their report includes one qualification. Management does not agree with the qualification for not including the asset and liabilities of "ICDDR,B

Employees Separation Payment Fund" as the Centre has no control over these funds. This inclusion would materially distort the true financial position of the Centre and inflate the balance sheets.

Overall there were no disagreements with the auditors and no surprises in the accounting records. (This was specifically stated in light of the recent accounting scandals with relation to ENRON.)

Revenue

1. Contributions

Contributions from Donors and Endowment Fund increased from prior year by \$ 162,000 (1.2%) from \$13,830,000 to \$ 13,992.00.

Restricted contributions decreased by 6% relative to the prior year (\$ 744,000) primarily due to less project activities funded by several donors and absence of transfer from Hospital Endowment Fund. This decline was however offset by greater funding by the Govt of Bangladesh, International Vaccine Institute, Japan and UNICEF. Unrestricted contributions increased by 52% (\$ 906,000) vs prior year due to the generous contributions by the Netherlands and SDC (Switzerland). Contributions include a write-off of \$ 109,000 due to uncertainty of collection of a receivable from the Arab Gulf Fund that has been outstanding since 1998. Efforts are however underway to collect this money that will reverse the charge. Exchange gains and other receipts also decreased.

2. Donor Base

Efforts must be made to expand donor base.

3. Expenditures

Operating cash expenditures decreased by \$ 18,000 (0.1%) from prior year. Unrestricted (core) expenditures increased by 24%. 64% being spent on international/national salaries and consultancy payments. Restricted (project). Expenditure decreased by 6% in line with decreased revenues.

4. Operating Surplus/Deficit

Net cash surplus excluding depreciation increased by \$ 128,000 relative to the prior year, from \$ 63,000 to \$ 191,000. \$ 81,000 greater than budget. This was due to expense control. The cumulative deficit is now down to \$ 2,926,000. This was because of a transfer of \$ 240,000 from the Reserve Fund. Total expenditures excluding depreciation increased by \$ 26,000 (0.2%) from \$15,520,000 to \$ 15,546,000.

Agenda 2: 2002 Forecast

Following the approval of the budget by the Board of Trustees in November 2001, the finance department sets its goal for the year. Mr. Sage explained the differences in purpose between budget and forecast. The forecast is the mid-term monitoring of budget. It was also explained that the Centre should have a better bottom line than budget presented in November and that risks should be managed.

The following items were highlighted under this item:

Revenue: Contributions (Restricted/Project and Unrestricted/Core)
Donor Base
Expenditures
Deficit vs Surplus
From Deficit to Breakeven
Other Opportunities

1. Revenue: Contributions

Donor and endowment funds were budgeted at \$ 13,773,000 but are now forecast to increase to \$ 15,165,000. This was 10% greater and is achievable if we are aggressive in carrying out the projects that have been committed.

2. Projected Contributions (Restricted/Unrestricted)

Restricted: This is forecast to increase significantly – \$ 1,285,000 (11%) greater than budget.. Increases are due to contributions from several large donors and spending of Gates-GoB award.

Unrestricted: This is expected to increase(\$ 107,000) primarily due to additional support from USAID/Washington.

3. Donor Base

There are currently 10 donors contributing more than \$ 400,000.

4. Expenditures

Project expenses are expected to increase proportionately to increased activity.

Unrestricted expenditures decreased due to additional support from Gates-GoB.

Unrestricted expenditures in management increased due to unplanned costs of hiring and recruitment.

Net Cash Deficit vs surplus: The forecast shows that the deficit has been narrowed considerably, and there is a good chance for breakeven by years end. We are now projecting a net \$ 45,000 deficit for the year.

5. Other Opportunities

Management is developing specific action steps to reduce the forecast deficit to achieve breakeven level for the year.

Control core costs

New donors in pipeline

Collect prior year write-off

Focus on projects with full overhead

Target is surplus of \$ 150,000

Agenda 3: FUNDS (Centre's Financial Equity)

1. **Hospital Endowment Fund.** There was a market loss in 2001, but this was less than the market loss in the general equity market because some of the fund is invested in interest bearing cash deposits. The market value was \$ 5,160,000 as of December 2001. No funds were transferred to the Centre's Operation in 2001.
2. **Centre Endowment Fund.** There was a market loss in 2001 due to stock market losses. There were no contributions in 2001. \$ 130,000 was withdrawn in 2001, and the balance was \$ 3, 385,000 at April 30, 2002.
3. **Reserve Fund.** This was created to provide financial stability for the Centre and to provide guarantee for our 2 million dollars overdraft facility. The earnings from the reserve fund, in excess of 2 million dollars (\$540,000 during the last two years) has been transferred to the Operating Fund in recent years. The target is to hold the \$2 million in this reserve fund and to continue to transfer earnings to the operating fund.
4. **Operating Fund.** The cumulative deficit is better by \$996,000 over past 3 years and stands at \$ 2,926,000 at 2001 year end. Future decreases will be a slower rate, mainly because of the lower interest rate on earnings from the reserve fund. It is planned to reduce the deficit to \$ 2,000,000 in 6 years, though we will attempt to decrease it to zero as quickly as possible.

Agenda 4: Other Items

1. Appointment of Auditors for 2002:

Price Waterhouse, Kolkata and Hoda Vasi Chowdhury & Co., Dhaka were the joint auditors for 2001 and have been the Centre's auditors for the past six years and three years respectively.

Management is recommending that the audit fee not exceed \$ 15,500 same as 2001 but that the amount not be specified in the resolution in order to give the Centre management room to negotiate the terms and conditions.

2. Bank Overdraft Facility

The Centre's current \$ 2 million overdraft facility with American Express Bank will expire on July 13, 2002. Interest rates are the bank's prime rate in the USA and the equivalent rate in Bangladesh. The facility is used for any overdraft. As a result of the large cumulative deficit of the Centre there may be an ongoing overdraft requirement to cover operating costs. This overdraft is being secured by term deposits of the Reserve Fund.

In view of this the management recommends renewing the overdraft agreement of \$ 2 million for the year to July 13, 2003.

3. Cheque Signatories:

Over the past year there have been several occasions where Finance operations were hampered by absence of present signatories. Management recommends that cheque-signing authority be extended to the following persons to prevent constraints:

Head, LSD: Dr G Balakrish Nair
Head, HSID: Dr Robert F Breiman
Head, ISD: Mr Peter Thorpe

These nominated staff are in accordance with Centre policy.

4. Reserve Fund Transfers

Maintain \$ 2,000,000 budget
Transfer earnings to Operating Fund on an ongoing basis

5. Management Information System:

Centre needs have been identified integrating Centre-wide objectives (Finance, Projects, Human Resources). This activity was carried out by an external consultant. Vendors are being identified and demonstrations scheduled.

Prof Azad Khan thanked Mr. Sage for his excellent presentation.

DISCUSSION:

Following a clarification regarding the need to transfer reserve funds, Mr. Sage explained that this fund was established to provide a "cushion" to the Centre when faced with a difficult financial situation.

In response to Prof Ganguly's question whether excess funds are totally allocated towards salaries and overheads and whether the Centre could reduce this and direct funds into functions and less into salaries.

Mr Sage explained that with regard to the annual change in salaries more than 2/3 of the money goes into salaries of project staff and that reduced or limited salaries would only save a smaller percentage of costs while perhaps leaving salaries at a competitive disadvantage.

With regard to his query re: flexibility of use of funds received, Mr Sage explained that the only flexible contributions are unrestricted (core) funds. Some donors give us restricted and unrestricted contributions.

Dr Sack reported that efforts are underway to educate donors about the need to support indirect costs and requested the Board to assist with stressing this issue.

Prof Ganguly felt that the Centre's Mission and Vision Statement will greatly assist in achieving this goal.

Prof Ganguly also queried how the Centre would handle a situation where more/less money is received from a donor. Mr. Sage explained that when more money is received, the extra funds are directed towards research, and in the case of less money, scope of activity would be trimmed.

With regard to cash flow, it was queried why the Centre needed to go into overdraft and whether there is a chance for fixed salaries could be allocated to projects. Mr. Sage reported that this year the Centre dipped into the line of credit as most donors have paid after the fact. Approximately 70% of all Centre contributions come from national governments and

governments do not always pay on time. Mr. Sage further stated that the Centre tries to assign all costs to projects as much as is practical.

Dr Marcel Tanner explained that to obtain overheads the Centre should consider preparing 2 price lists. One budget should include the items that are usually supported by overheads under the items the donors who do not provide overheads will support, and one for donors who contribute towards overheads. This should however be done in consultation with the donor to ensure transparency of records.

Dr Azad Khan agreed to consider this suggestion as long as transparency was maintained with the Centre's donors and other constituencies.

Dr Terence Hull felt that the use of the term "donors" so comprehensively in the books does understate the degree of people buying the services of the Centre. Mr. Sage explained that "donor" is an institutional term and we will look how they could be categorized in the future.

Mr Sage circulated a list of the Draft Resolutions to the members for review and further action at the Full Board meeting.

The meeting concluded at 5.30 p.m.

(Note: The attachments were distributed at the meeting).

Minutes of the Personnel and Selection Committee
Saturday 8 June 2002
13:30pm

Present:

Prof Marian Jacobs (Board Chair)	Prof David Sack (Director)
Dr Claudio Lanata (Chair, P&S Committee)	Prof Jane Kusin
Prof Carol Vlassoff	Prof AK Azad Khan
Mr Anisul Huq Chowdhury	Dr Ricardo Uauy Dagach
Dr Maimunah Bte Abdul Hamid	Prof Terry Hull
Prof N K Ganguly	Dr Nobukatsu Ishikawa
Dr Tikki Pang	Prof Marcel Tanner
Dr I Kaye Wachsmuth	

Ms Diann Hill, Head HR

Absent (with regrets): Mr Rolf Carriere; Mr M Fazlur Rahman

Invited: Administrative Council members

The Personnel and Selection Committee, chaired by Dr Claudio Lanata, met to deliberate on personnel and other human resources issues. The meeting proceeded to the agenda items for review and discussion.

- 1. Approval of the agenda.** The agenda was approved.
- 2. Approval of the minutes of November 2001 meeting.** Minutes were approved.
- 3. Staffing:**

3.1 Overview: Ms Diann Hill reported that during the period 1 Oct 2001 to 31 March 2002, there were 69 separations from and 43 additions to the Centre. The net separations of 26 were mainly from the projects. The Centre continues to follow the policy of restricting external recruitment of fixed-term staff.

Total numbers by categories:

International staff	-- 15
Research (scientific, support & field)	-- 589: 196 core funded; 393 project funded.
Research (administration)	-- 356: 134 core funded; 222 project funded
Support services & human resources	-- 103: all core funded
Finance	-- 31: all core funded
International seconded staff	-- 6
Short-term staff (int'l, NO & GS)	-- 2
Community Health Workers	-- 18
Health workers	-- 92
Fellows	-- 30
Contractual service holders	-- 331
Daily wagers	-- 231
Total	1804

The Centre also has 2 adjunct scientists.

Ms Hill reported that historically, the Centre reported gender as a whole. It is now reported by level of staff. This will allow management to measure itself against going forward.

3.2 Status of recruitment of international professional staff:

3.2a Associate Director, D1, Clinical Sciences Division. This vacancy was re-advertised at D1 level. 9 applications have been received including 3 from within the Centre and are under review and will be discussed further in Closed Closed session. Dr MA Salam is currently acting in the position and receiving the acting allowance since 1 October 2001.

3.2b Chief Finance Officer, P5, Director's Division. It was announced that Stephen Sage has decided for family reasons not to continue at the Centre and will be leaving in mid-September. Ads were place in The Economist and other websites. The closing date was two days ago. The Centre will make a shortlist and submit recommendations to the Board for approval.

3.2c Head, Nutrition Research Programme, P4/5, Clinical Sciences Division. The post has been advertised in various journals and websites. Seven applications were received. Prof Sack reported that it was difficult to find suitable candidates for this position which is high priority. The Centre needs to continue the search.

3.2d Head, External Relations & Institutional Development, P4. Interviews were held the previous day and will be discussed further in Closed Closed session.

3.2e Operations Research Scientist, P4, Health Systems and Infectious Diseases Division. The search is continuing and it is anticipated that a candidate will be named within a month.

3.2f Health Economist, P4, Health Economist Unit, Public Health Sciences Division. The Centre is very eager to fill this post. Ads were placed in The Economis, The Lancet and other websites. Applications have been received. Closing date was two days ago.

3.3 Renewal of contracts

3.3a Executive Assistant to Director, P1, Director's Division. Prof Sack reported that discussions regarding the renewal of Mrs Judith Bennett Henry's contract are ongoing.

3.3b Head, Reproductive Health Programme, P5, Public Health Sciences Division. Discussions regarding the renewal of Prof Japhet Killewo's contract are ongoing.

3.4 New International Professional Staff

3.4a Associate Director, D1, Laboratory Sciences Division. Dr Balakrish Nair joined the Centre on 13 December 2001 for a period of 3 years.

3.5 Status of seconded staff contracts

3.5a Demographic Researcher, P4, PHSD. The current secondment contract of Mr Carel Van Mels will expire on 2 July 2002. The Centre is awaiting the approval of a secondment agreement with the Netherlands Interdisciplinary Demographic Institute (NIDI).

3.5b Senior Scientist, P5, LSD. Jose Bogaerts who was seconded from the BATC (now DGIC), left the Centre in December 2001 after 5 years of service. No replacement is anticipated.

3.6 New adjunct scientists

3.6a Adjunct scientist, LSD. Prof Yoshifumi Takeda, former Board member, and Professor Emeritus, Faculty of Human Life Sciences, Jissen Women's University, Tokyo, was offered a contract as Adjunct Scientist for collaborative studies with LSD for a period of 3 years effective 14 February 2002.

Dr Abdullah Baqui, former Centre scientist and Assoc Professor at Johns Hopkins University, is also contracted as an Adjunct Scientist with the Centre.

3.7 Completion of tenure

3.7a Senior Scientist, P5, Public Health Sciences Division. Dr Radheshyam Bairagi will be leaving the Centre following completion of his contract on 30 June 2002.

3.8 Reclassification of international professional post

3.8a Social Scientist and Head, SBSU, P4, PHSD. Discussion will be deferred to Closed Closed session.

3.9 Change in status for international professional post

3.9a Assoc Director and Head, PHSD. In recognition of Prof Lars Ake Persson's leadership and scientific productivity to the Centre and the Division, his contract was renewed at D2, step 4 for another three years, effective 1 March 2002.

3.10 **Establishment of new international professional posts.** Prof Sack reported that the Centre requires 3 new posts:

3.10a Deputy Director (D2), Director's Division (to be discussed in Closed closed session

3.10b Pathologist (P4), LSD. A job description is being formulated and will be submitted for Board review

3.10c Grants Administrator (P4), Director's Division (to be discussed in Closed closed session)

4. **Promotion of Bangladeshi scientists to international level.** 4 scientists were shortlisted for promotion and their applications were submitted for external review. Interviews were held the previous day with the concerned scientists and further discussions on the outcome will be held in Closed closed session.

5. **Selection of BOT members.** To be discussed in Closed closed session.

6. Any Other Business

6.1 Update on the Human Resources Agenda. Ms Diann Hill, Head HR began her update of the HR agenda with an introduction of her new baby.

She reported that the Human Resources Office was established in 1998 and the post of Head HR was filled in 2000. Priority activity was to resolve pending issues and advance new plans for human resources throughout the Centre.

HR projects included job classification, evaluation and job families; market survey; performance management system; training; promotions; compensation system; management information system; recommendation for compensation system.

Job classification: 253 posts were comprehensively evaluated under an external analysis and job titles standardized. Policies and procedures are being developed to support the JC system

Job families: The aim of the exercise was to reduce the number of job titles and create career structures. Reconciliation to date: 169 reduced to 107. Posts have been categorized into respective families and can move across divisions. Core skills have been identified for the posts.

Market survey: Annual surveys are needed to test Centre salaries and benefits against the external market; make internal adjustments to individual posts to be competitive with the market; demonstrate a fair and transparent process. The survey showed that the current trend is to convert benefits into cash and that most comparators use merit pay systems. The financial implications will determine the number of changes to be made for both classification and market adjustments; evaluate the budgetary implications of the adjustments; determine the Centre's ability to fund the adjustments.

Performance management system: The Centre would revise current appraisal forms, develop policies and procedures, train managers on basics of performance management and train staff on the new system. Revision of the current system would include:

- Feedback from employee as an accepted part of the process
- Performance as part of the team
- Measurable outcomes
- Identification of personal development needs
- Score for overall performance

Training: HR training focusses on cultural change and standardized performance for the organization:

- Training needs analysis completed in 2001
- Soft-skills training – basics of supervision (8 modules) beginning with the Performance Management module
- Hard-skills training – conducting Microsoft Office training including email and web browsing
- Recruitment of a national Training Manager

Promotions: A fair and equitable system across the organization for all staff. Promotions to be considered on an annual basis; recommendations made to Associate Director for submission to HR for convening of Compensation Committee.

Compensation system: Does the Centre want to reward staff for longevity of service? Individual performance? Team performance?

Pay options:

Current system links JE scores to pay ranges with step increases with longevity. Advantages of the current system: link to UN system, does not affect the Ordinance, minimizes resistance from staff and SWA. Disadvantages: good performance is not rewarded and poor performance is ignored.

Merit system is linked to individual performance within financial constraints. Advantages: recognises and rewards individual performance, supports organizational productivity, enhances morale of top performers. Disadvantages: subjective and open to abuse, would need more managerial input and time.

Team merit system is linked to team performance. Advantages: recognises all team contributions, team pressure to perform raises productivity. Disadvantages: top performers can be disadvantaged, the system can be subjective, is rarely used and administratively cumbersome, can result in shortcuts.

The Centre recommends the adoption of the merit system. It increases the morale of top performers and is an incentive for everyone to perform. It makes the performance review more meaningful for salary and career planning, develops developmental areas and improves donor competitiveness. The system is easy to administer, is financially controllable and fits with a grading structure. It does not allow increases for poor performers. The Centre would need to consider the effect this proposed system will have on the Ordinance.

Management Information System: Will evaluate organizational needs; identify vendors and product demonstrations; review IT resources; select MIS system; create implementation team and schedule.

Update HR Department: Transition from Personnel (admin) to Human Resources (strategic) department to enhance effectiveness and efficiency. The Dept created working groups to review recruiting, contract extension and gender equality.

Time lines: BOT approval – June 2002; Market survey completed – May 2002; job families agreed – June 2002; Reconcile JC with market survey – July 2002; Training for managers – August 2002; Performance Management system – December 2002.

The Centre requests the Board's approval to continue plans for introducing a Merit Compensation System.

Dr Lanata thanked Mrs Hill for the presentation and congratulated her and the HR staff for a comprehensive job.

Discussion:

It was discussed that the merit system would ultimately be beneficial to the staff and the Centre as a whole but should be worked out carefully. The Centre would need to work with the ERD Secretary and the Health Ministry to review its effect on the Ordinance. Further indepth discussion will continue in Closed closed session.

P&S Committee
Closed Closed session

The Board met to continue discussions and to deliberate on issues for resolution:

- Recruitment of: Associate Director for Clinical Sciences Division; and Head, External Relations and Institutional Development, Director's Division. The search for this position will continue.
- Reclassification of international professional post for Social Scientist and Head SBSU, Public Health Sciences Division. It was recommended that Dr Bhuiya should be promoted to P5 level.
- Establishment of new international professional posts for (1) Deputy Director, Director's Division and (2) Grants Administrator, Director's Division:
 1. The Board agreed that the post of Deputy Director was needed and that the job description should be for a scientific administrator, not a "pure" administrator. It should be understood that the position should not be viewed as a stepping-stone to the directorship, in fact this should be discouraged. A job description should be developed prior to the next meeting.
 2. The Grants Administrator position should be regularized since this function is becoming increasingly important.
- Selection of new members of Board of Trustees.

Annex: ICDDR,B Consultancies Policy

**ICDDR,B
Consultancies Policy**

Page 1 of 3

Revised 05 November 2001

Purpose:

To allow staff members to provide consultancies to outside organizations that would benefit both the individual and the Centre.

Guidelines:

1. The agreement for consultancies is to be made with the Centre, not the individual. All consulting proposals must be routed through the appropriate Division Director to the Head, Human Resources for review and approval. The Director will give final approval of all consultancies.
2. A consultant is defined as an individual who is participating in the consultancy and taking directions from the consulting organization. Satisfaction with the final Consultancy product will be between the consultant and consulting organization and not reviewed by the Centre.
3. Eligible staff include international level, and NOC and above.
4. Consulting fees will be based on the Centre's salary scale and should not be more than six weeks per year.
5. Cash payments to Bangladeshi nationals are in addition to their regular salary and subject to income tax. The appropriate tax (approximately 25%) will be deducted from individual cash payments and remitted by the Centre to the tax authority.
6. Leave time cannot be used for consultancies. If temporary replacement staff is needed, then the personnel costs will be borne by the consultancies.
7. Direct costs of travel, food, accommodation, business expenses and any other related materials must be borne by the consulting organization.

Rates for Consultancy:

The Consultancy rate for eligible international and national staff will be calculated by taking the total personnel cost (salary + fringe) plus twenty-five percent (25%) of direct costs divided by 250 days. This average daily rate will be used to determine the appropriate consulting rate for international and national staff members. If a national officer is conducting an international Consultancy, the salary rate will correlate with the international level equivalency. If the Consultancy is a regional or in-country consultancy then the appropriate daily rate will apply. Consultancy fees are subject to change if the Centre revises its salary scales.

A Consultancy Rate Calculation Worksheet has been developed to assist in calculating the rate and must be submitted when requesting approval for the Consultancy.

International

Average Daily Rate (mid-step of grade levels)

Level	Salary/Benefit Per Day (\$US)	Indirect Cost (25%) (\$US)	Total Daily Rate (\$US)	*Regional Rate (\$US)	**In-country Rate (\$US)
P1	228.00	57.00	285.00	199.50	114.00
P2	275.00	69.00	344.00	240.80	137.60
P3 (NOC)	326.00	82.00	408.00	285.60	163.20
P4 (NOD)	380.00	95.00	475.00	332.50	190.00
P5 (NOE)	427.00	107.00	534.00	373.80	213.60
D1	462.00	116.00	578.00	404.60	231.20
D2	502.00	126.00	628.00	439.60	251.20

*Regional rate is 70% of Total Daily Rate

** In-country rate is 40% of Total Daily Rate

If an in-country consultancy is with an Bangladeshi organization then the in-country rate would apply. If an in-country consultancy is with an International organization within Bangladesh, the international rate would apply.

If the consultant's salary is 100% covered by project funds, the individual will receive 50% of the consulting fees and the remaining 50% will be given to the individual's Division. The individual will receive the 50% as a cash payment.

If a portion of the project and a portion of core cover the consultant's salary, the appropriate percentage will be used to offset salary costs charged to core. The Division may use these funds for activities as approved by the Division Head.

Example: Consultant's salary is 60% project funded 40% Core funded
40% of the consultancy fees would be returned to Core.
30% of fees would go to the individual and 30% would go to the Division.

If an individual is 100% core funded, the individual will receive 50% of the consulting fees and the remaining 50% will be given to the individual's Division. The individual will receive the 50% as a cash payment.

Consultancy Rate Calculation Worksheet

Net Consulting fee received*	(a) \$ _____
Less indirect cost (20% * a)	(b) \$ _____
Net received (a - b)	(c) \$ _____
Proportion of salary from core	(d) _____ %
Amount returned to core (d * c)	(e) \$ _____
Amount available for distribution (c - e)	(f) \$ _____
Amount to individual (50% * f) <i>**minus income tax.</i>	(g) \$ _____
Amount to division (50% * f)	(h) \$ _____

Notes:

*Excludes all direct costs (travel accommodation, etc) reimbursed

** Applies to Bangladeshi nationals only

- Total personnel cost (salary + fringe) +25% / 250 days
- 250 days = 5 working days*52 weeks – 10 public holidays

Draft Minutes of the Full Board
CSD Conf Room
9 June 2002am

The Full Board convened at 9:00am in the CSD Conf Room to deliberate on the reports from the Programme, Finance and HR Committees; to approve the Minutes of the last Board meeting; and to finalise the resolutions emanating from the respective Committees.

Present:

Prof Marian Jacobs (Board Chair)
Prof Jane Kusin
Prof AK Azad Khan
Dr Ricardo Uauy Dagach
Prof Terry Hull
Prof N K Ganguly
Prof Marcel Tanner

Prof David Sack (Director)
Prof Carol Vlassoff
Mr Anisul Huq Chowdhury
Dr Maimunah Bte Abdul Hamid
Dr I Kaye Wachsmuth
Dr Nobukatsu Ishikawa

Absent (with regrets): Mr Rolf Carriere; Mr M Fazlur Rahman; Dr Claudio Lanata and Dr Tikki Pang (left early for pre-arranged appointments)

Invited: Administrative Council members

Minute Secretary: Mrs Judith Bennett Henry

Prof Jacobs opened the proceedings.

1. **Approval of the Draft Minutes of Nov 2001 meeting:** Prof Azad Khan moved; Prof Sack seconded.

2. **Reports and Resolutions from the Committees:**

2.1 **Programme Committee:** The draft resolutions were presented by Prof Uauy and were approved by the BOT.

Discussion:

External reviews: It was discussed that a standardized format of guidelines should be in place for reviewers. It was agreed that Prof Vlassoff, as Chair Programme Committee, should draw up the TOR with input from the Director, Division Heads and Board members. This process should be accelerated to accommodate the next review. The new format will be submitted for approval in the November meeting. It was further agreed that the CSD review should be deferred until a Head CSD is appointed.

Strategic Plan: It was agreed that the Plan should be revised under the guidance of Prof Jacobs. BoT members were requested to feedback to Prof Jacobs relevant suggestions. A draft should be ready by end of September for finalisation at November meeting.

Regarding the format of the Programme Committee, it was suggested that scientists from national collaborating institutions be invited to participate and/or present topics at the next PC meeting in November.

It was also discussed that the Centre should: review the integration of programmes; get more research scientists involved in the programmes; look at advancing from science to application.

2.2 P&S Committee: The draft resolutions were presented by Dr Lanata and approved by the BOT.

Discussion:

It was agreed that the resolution 15/BT/NOV/01 be amended to read: The Board authorizes a three-year contract with Dr Charles Larson as Senior Operations Research Scientist at P5 in the **Health Systems and Infections Diseases Division (HSID)**.

Gender policy: It was discussed that gender mainstreaming should be included in the HR agenda for next Board meeting and that the current gender equality policy be strengthened. The Board lauded the establishment of a Gender Equality Committee and noted that the GEC should take a top management role to review and implement mainstreaming. The question arose as to the status of participation in the Centre's Gender Equality Committee. The Committee is currently all-female and it was questioned whether male staff should also participate. It was agreed that the makeup of the Committee should be left to the discretion of the Director; the Board will ensure implementation.

BOT selection of members: It was discussed that for the replacement of Rolf Carriere, it was best to look for someone from UNICEF HQ. It was suggested that Mr Carriere be contacted for names of potential candidates. It was agreed that WHO should be contacted to request the continuation of Dr Pang as a Board member. It was further suggested that the Board should look at selecting more Bangladeshi candidates to serve.

Consultancies: Members discussed that the Centre is well-placed to compete for technical assistance contracts. The BOT requested feedback from Centre management on the potential and constraints. Prof Sack reported that the Centre has a consultancy policy in place. It was agreed that members should submit consultancy arrangements from their respective institutions to Prof Sack for reference. It was further suggested that the issue should be placed on the Finance and P&S agendas for the next Board as it is relevant to both Committees.

Resource mobilization: Prof Jacobs requested clarification on the Centre's expectations of the Board in mobilizing resources. Prof Sack explained that the Board could play a very important role in that regard due to members' contacts with influential individuals, groups and organizations. The Board, through their participation in government meetings and at international fora can be current on new opportunities and directions being opened up and can so advise the Centre. The Board can be the "eyes and ears" for new contacts. It was agreed that the Board could play a stronger role in indentifying donors and look at ways to help the Centre get well-connected with new initiatives and changing developments.

Dr Sack reported that the Centre recently held profile-raising events in Atlanta and in New York. The fundraising drive identifies 100 companies willing to donate US\$10,000 a year towards the Endowment Fund. It is expected to reach a wide geographic distribution of companies. The appeal will be to pharmaceutical as well as a wide variety of companies.

Members discussed what policy for accepting money from "controversial industries". Prof Sack reported that the Centre does not accept money from tobacco or armaments; that the Board should develop a policy regarding accepting funds from baby food companies. It was

suggested that the Centre should look at guidelines from UNICEF, WHO and the International Paediatric Association and bring to the Board's attention.

It was also discussed that the Board should approach possible funding contacts as individuals not necessarily as a Board member. Follow-up activities should be relayed through the ERID office.

It was noted that the Centre should become involved in the issues of the Millenium Development Goals that should garner a more committed response from donors. It was suggested that powerpoint slides and brochures should be compiled to show some of the new exciting projects and ideas. Ideas should be product-motivated. Donors would be interested and find useful "the product behind the idea". It was agreed that Division Heads should submit their "ideas" to the Director for compilation into a CD and submission to all BOT members.

2.3 Finance Committee: The resolutions were presented by Prof Azad Khan and were approved by the BOT.

Discussion:

Prof Jacobs thanked the Finance Committee for its contribution. She also commended Mr Sage on his contribution to the Centre over the past year. She expressed, on behalf of the Board, her appreciation and extended best wishes to him and his family.

Prof Azad Khan also expressed his thanks to Mr Sage and the Finance team for their excellent work and commended the Director, Mr Sage and the Finance team on making the Finance Office healthier and more focussed. Prof Azad Khan also noted that the BOT will feel the absence of Prof Jacobs following her departure from the Board.

Funding: Mr Chowdhury noted the continued funding constraints of the Centre. He suggested that he meet with the Director and ERID to discuss how funds could be tapped from donors based in Dhaka. It was noted that Mr Chowdhury's interaction with these donors would be outside of the Donors Support Group.

Date of next BOT meeting: Members discussed whether there should be full BOT presence or an Executive Committee meeting with conference call to the other members on the last day for discussions and passing of resolutions. Prof Jacobs reminded members of several international conferences carded for November added to which, Ramadan will fall early in November. Prof Sack also pointed to the costs incurred for travel of all BOT members to Dhaka. He further noted that the last meeting which comprised only the EC proved effective.

It was agreed that the next BOT would be held on 1 and 2 November 2002 with EC members and follow-up discussions by teleconference with other Board members. As a lead up to the meeting, there would need periodic consultation with the EC. The agenda should be delineated and Board members will be kept current of all documentation in readiness for precise and specific discussion during the teleconference.

Close of Full Board: Prof Jacobs thanked the Board for the opportunity to serve as Chair and extended best wishes to BoT Chair, Prof Uauy and Committee Chairs, Prof Azad Khan, Prof Carol Vlassoff, Dr Claudio Lanata and the remaining BOT members.

She declared the June BOT meeting closed at 12:30pm.

At 2:30pm, the BoT met with the Donors Support Group for presentations by the Director and Board Chair and for closed meeting with the DSG.

Draft resolutions of the Programme Committee

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

1/BT/JUN/02

The Board proposes that before each external review is undertaken, the terms of reference be specified and provided to the external reviewers in advance. Each of these reviews will be carried out by a multi-national group of three or four persons, including at least one member of the Board of Trustees. The Chair of the Programme Sub-Committee will prepare a framework for Board reviews in consultation with the Centre Director and Associate Directors.

2/BT/JUN/02

The Board appreciates the work of the Centre in developing the Strategic Plan draft document and resolves that it be revised and finalised under the guidance of Prof Marian Jacobs, taking into account the discussion and recommendations made by the Board. This should be accomplished by the end of September in order that this can be reviewed by the Board, GoB and donors prior to final approval in November.

Recommendation:

The Board recommends that greater involvement of national scientists, health programmers and other relevant members of civil society be sought for the next Programme Committee meeting. The Programme Sub-Committee can provide that opportunity.

Draft resolutions of the Finance Committee

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

3/BT/JUN/02

The Board accepts the audited financial statements of the Centre for the year ended 31 December 2001

4/BT/JUN/02

The Board appoints Price Waterhouse Kolkata and Hoda Vasi Chowdhury & Co Dhaka as joint auditors for the year 2002.

5/BT/JUN/02

The Board authorises the transfer on an ongoing basis from the Reserve Fund to the Operating Fund of all funds in excess of US\$2,000,000.

6/BT/JUN/02

The Board authorises the continuation of the overdraft facility of up to US\$2,000,000 with the American Express Bank for the year to 31 July 2003.

7/BT/JUN/02

The Board authorises Dr G Balakrish Nair (Head, Laboratory Sciences Division), Dr Robert F Breiman (Head, Health Systems and Infectious Diseases) and Mr Peter Thorpe (Head, Information Sciences Division), to sign cheques on behalf of the Centre.

Draft resolutions of the Personnel and Selection Committee

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

8/BT/JUN/02

The Board approves the Centre's request to reclassify the post of the Social Scientist and Head, Social and Behavioural Sciences Unit, PHSD, at pay level P5 and the appointment of Dr Abbas U Bhuiya to the reclassified post in recognition of his outstanding performance.

9/BT/JUN/02

The Board endorses the selection of Dr Ishtiaq Zaman as Head, ERID at pay level P4 and also records its support for Ms Vanessa Brooks to continue as Grants Administrator.

10/BT/JUN/02

The Board approves the promotion of the following staff under the Bangladesh Scientist to International Level policy:

Dr G H Rabbani, CSD
Dr M A Salam, CSD
Dr Firdausi Qadri, LSD
Dr S M Faruque, LSD

11/BT/JUN/02

The Board approves the request to rename the Personnel and Selection Committee to the Human Resources Committee.

12/BT/JUN/02

The Board approves the direction of the Human Resources agenda as presented by the Head Human Resources and approves the request for continuing plans to introduce a merit compensation system.

13/BT/JUN/02

The Board notes its support to establish the new posts of Deputy Director, and Pathologist.

14/BT/JUN/02

The Board notes the salary and benefits guidelines developed to clarify the Bangladeshi Scientist to International Level policy

15/BT/JUN/02

The Board approves the extension of Dr Ricardo Uauy Dagach as a Board member for another three-year term.

16/BT/JUN/02

The Board approves the selection of the following officers:

Chair, Board of Trustees:

Dr Ricardo Uauy Dagach

Programme Committee:

Prof Carol Vlassoff – Chair

Prof Jane Kusin -- Deputy

Human Resources Committee:

Dr Claudio Lanata -- Chair

Dr Terry Hull -- Deputy

Finance Committee:

Prof AK Azad Khan – Chair

Dr Marcel Tanner -- Deputy

17/BT/JUN/02

The Board requests UNICEF and WHO to identify a representative who can serve as Board members.

18/BT/JUN/02

The Board defers the appointment of a new BOT member pending identification of potential candidates who will be appointed at the November 2002 meeting.

Draft resolutions of the Full Board

19/BT/JUN/02

The Board resolves to request the Director to conduct a comprehensive review of fire safety and other hazard reduction procedures in Centre buildings, with particular attention to the lab facilities, to be presented to the Board in November 2002. On the basis of this review, to develop a plan to improve standards of fire safety.

20/BT/JUN/02

The Board resolves to request the Director and Division Head ISD to develop and implement a policy to eliminate the illegal use of software in all Centre computer equipment. A report should be submitted to the Board in November 2002.

21/BT/JUN/02

The Board proposes the strengthening of gender equality in the management, research agenda and service provision of the Centre. The Board commends the efforts made to date, and in particular the establishment of the Gender Equality Committee. To extend these efforts, the Board requests that the Director increase efforts to implement gender mainstreaming through the management team and regularly report initiatives, policy changes and performance indicators to the Board.

3/BT/NOV 2002

PROGRAMME COMMITTEE

**BOARD OF TRUSTEES MEETING
NOVEMBER 2002**



**PROGRAMME COMMITTEE
1 November 2002**



CENTRE
FOR HEALTH AND
POPULATION RESEARCH

Director's Report

Prepared for the

BOARD OF TRUSTEES MEETING

1-3 November 2002

Table of Contents

	Page #
1. Overview of the Board Meeting	3
2. Division Highlights	
2.1 Clinical Sciences Division (CSD).....	5
2.2 Health Systems and Infectious Diseases Division (HSID).....	6
2.3 Information Sciences Division (ISD).....	8
2.4 Laboratory Sciences Division (LSD).....	10
2.5 Public Health Sciences Division (PHSD).....	12
3. Director's Division	
3.1 Policy and Planning	13
3.2 Human Resources Department (HRD).....	14
3.3 Finance Department.....	15
3.4 External Relations and Institutional Development (ER&ID).....	16
3.5 Grants and Contracts and Related Fundraising Initiatives.....	19
3.6 Staff Development Activities.....	20
3.7 Protocols	20
3.8 Publications.....	21
3.9 Hospital Endowment Fund	21
3.10 Physical Plan.....	22

1. Overview of the Board Meeting

A schedule for the meeting is enclosed with the materials in the packet. To summarize the general schedule, the meeting will start on November 01, 2002 in the morning and continue until November 3, 2002.

The first day, November 1, will start with a presentation by the Acting Director followed by presentations by each of the Division Heads. The day will end with a presentation of the Strategic Plan and discussion on all the presentations made. Later, there will be a closed meeting of the BoT. In the evening, there will be a supper with the Scientific Council (SC) members and their spouses.

November 2 is divided into morning and afternoon sessions. During the morning, there will be presentations by the Finance and Human Resource Committees, followed by discussions. This will be followed by a joint meeting of the BoT and DGS to discuss the Strategic Plan. Later, there will be a meeting with the SWA, followed by a closed meeting of the Board. Finally, there will be a conference call with the entire BoT.

November 3 will begin with a closed meeting of the BoT, to be followed up with a joint meeting with the Administrative Council. A Donors Support Group meeting immediately follows the Board meeting in the afternoon of November 3, 2002. The rest of the afternoon is open to the BoT members for meetings with scientists of the Centre.

Follow-up from the last Board meeting in June, 2002.

- a) The Strategic Plan has been revised. Unfortunately, Prof. Marian Jacobs could not come to Bangladesh to help the Centre revise and finalize the Strategic Plan due to some medical problems. The plan has, however, been revised by Prof. David Sack and Prof. Barkat-e-Khuda with assistance from Ms. Julia Ackley and the Programme Heads, based on feedback received from the DSG after Prof. Sack's presentation of the Strategic Plan to them.
- b) The scientific programmes are now more integrated, with more scientists involved in the six cross-cutting programmes.
- c) The Centre works closely with national institutions and researchers.
- d) Dr. Abbas U Bhuiya has joined the reclassified post of Senior Social Scientist and Head, Social and Behavioural Sciences Unit, PHSD
Dr. Ishtiaque Zaman has joined as Head, ERID.
Ms. Vanessa Brooks continues as the Grants Administrator.
Ms. Julia Ackley has joined as Senior Associate, ERID.
Mr. Alec Mercer has joined as Operations Research Scientist in the Health Systems and Infectious Diseases Division (HSID).
Dr. Beena Varghese has joined as the Head of the Health Economist Unit in the Public Health Sciences Division (PHSD).

- e) Ms. Diann Hill, Head, Human Resources Department, left the Centre on September 5. Ms. Ann Walton replaced her as Interim Head, Human Resources Department.
- f) The Chief Finance Officer, Mr. Stephen Sage, will leave the Centre on November 21, and the recruitment of a new CFO is being finalized.
- g) Prof. Lars Åke Persson, Associate Director, Public Health Sciences Division, has tendered his resignation from the Centre with a request to make it effective as of March 1, 2003. Prof. Persson is leaving for better prospects as he has been offered a full Professorship and Chair at a Swedish University.
- h) The following Bangladeshi scientists have been promoted to the international level:
 - Dr. G.H. Rabbani, CSD
 - Dr. M.A. Salam, CSD
 - Dr. Ferdousi Qadri, LSD
 - Dr. S.M. Faruque, LSD
- i) A Gender Equality Committee is working to ensure that gender is mainstreamed in the Centre. This was chaired by Diann Hill until her departure and is now headed by Ms. Ann Walton. We anticipate that the committee will help to define new areas of gender equality appropriate for Bangladesh that may be different from Western countries, so we want to be sure we do limit our issues to those of other organizations.
- j) The Personnel and Selection Committee has been renamed as the Human Resource Committee.
- k) The Centre is working toward completion of the human resources agenda.
- l) The job descriptions of the new posts of Deputy Director, and Pathologists have been completed.
- m) Regarding selection of new BoT members, we are still waiting for identification of potential candidates.
- n) Regarding resource mobilization, the Centre has been making various efforts. The Centre also hopes that the Board members will try to identify potential donors for the Centre.
- o) The Centre Director met with Mr. Anisul Huq Chowdhury, Secretary, Economic Relations Division, Ministry of Finance, Government of Bangladesh. The outcome of the meeting was quite positive. The ERD Secretary, with support from the Health Secretary, has already enhanced the annual GoB contribution to the Centre. Also, the ERD Secretary has assured us that he will try to encourage the donor community to enhance their contributions to the Centre.
- p) Based on the review of the Laboratory Sciences Division in June 2002 and the suggestions to implement facilities to protect against fire hazards, a proposal is under development. Efforts are being made to plan and put into operation suitable fire fighting equipment and proper training of the staff to make them aware of these facilities and protect themselves. These include incorporation of automatic fire and smoke detectors, control of such accidents by the use of appropriate fire suppression systems and plan for easy evacuation routes for the safety of the staff. The cost of these fire protection

facilities will be substantial, since an automatic fire monitoring, detection and extinguishing system can be expected to be around US \$ 60,000.

- q) Steps have been taken to ensure that computer software in use in the Centre is properly licensed. Newly introduced programs will be acquired from official sources and their use restricted to that described in their license. A review is underway of existing software. Microsoft has been approached for the supply of MS Office and other programs under their Charitable Organization Licensing Program.

2. Division Highlights

2.1 Clinical Sciences Division (CSD)

The Clinical Sciences Division continued to perform its research, service, and training activities. The division currently has two recently-promoted international staff, one international and three national consultants, an international adjunct scientist, 192 national staff, 54 staff on CSA, 80 health workers, and 25 fellows.

CSD scientists have published 7 original articles in international, peer-reviewed journals and 3 additional articles are in press. One review article was published in the reporting period and another book chapter is in press.

The CSD has completed 14 research projects during the reporting period, and an additional 26 projects are in progress. The important findings of a few of the studies are as follows:

- Supplementation of fish-oil to women during the last trimester of pregnancy did neither reduce LBW or prematurity, nor did it improve psychomotor development of the infants. Results of another study indicate that prenatal supplementation of only zinc to poor Bangladeshi women does not seem to confer benefit on infants' mental development, and such, supplementation should be considered with caution. Among many studies of zinc carried out at the Centre, this is the only one to have suggested any detrimental effect.
- In a community-based study, individual and group peer counselling (mixed) were both found to be effective in promoting feeding colostrum as the first food, early initiation of breastfeeding, exclusive breastfeeding, and lesser pre-lacteal feeding. Based on the findings of this as well as earlier studies, breastfeeding-counselling has been established at the Dhaka Hospital as one of its routine service activities.

CSD continued its staff development efforts. One staff-member has completed his postdoctoral fellowship at UC Davis, and another has completed his M.Sc. at Harvard University under the Fogarty Fellowship Programme. Currently, 2 staff-members are enrolled in PhD programmes in Nutrition at UC Davis; 2 staff-members are enrolled in PhD Programmes at the Institute of Child Health, University College, London; and one staff-member is Master of Public Health, at the University of New South Wales, Australia.

The Dhaka Hospital provided treatment to 52,662 patients with diarrhoeal diseases with or without associated health problems. Its Child Health Programme (CHP) provided health education to 72,006 women; immunized 3,012 children (99% of those eligible) and 3,009 women (52% of the target); provided high potency Vitamin A supplementation to 1,315 children; treated 245 severely malnourished children in the Nutrition Rehabilitation Ward along with 252 follow up visits; provided treatment for TB to 33 children (21 old and 12 new cases); and provided birth spacing advice to 681 women.

The PSKP-operated franchising clinic continued to deliver services to those patients with milder diarrhoea; out of the total 52,662 patients attending the Dhaka Hospital, 16,905 (32%) were referred to the PSKP clinic, of whom, 1,450 (8.6%) were referred back for further management.

The Travellers' Clinic has undergone renovation, and its vaccination service has been expanded. Its further expansion and modification, to offer radiology, ultrasonographic and electrocardiographic services as a part of the Centre's "Diagnostic Clinic", are being planned.

The Child Development Unit of CSD is being strengthened. Two CSD staff are enrolled into Ph.D. programme at the Institute of Child Health, University of London. A project has received a grant to implement psychosocial stimulation to examine its effectiveness in improving psychomotor development of severely malnourished children admitted to the Nutrition Rehabilitation Unit of the Dhaka Hospital.

The Nandipara Clinic, established in peri-urban Dhaka in 1985, has been expanded over the years 1997-2000. A number of studies have been recently conducted to understand the role of *Helicobacter pylori* infection in hypochlorhydria and iron deficiency anaemia in children and women of reproductive age.

The Physiology Laboratory remained active during the reporting period. The activities of the laboratory include conducting experiments to understand the pathophysiology and complications of diarrhoeal diseases, particularly cholera and shigellosis, often using animal models, and to identify newer interventions. New assays such as nitrite and nitrate, thiobarbituric acid reacting substances (TBARS), glutathione (GSH), total antioxidant status, myeloperoxidase (MPO) and catalase have been set up in the lab.

The Diarrhoeal Disease Surveillance Programme, extended to Matlab Hospital in recent years, continues to obtain important sociodemographic, nutritional and medical information on the patient populations attending the Centre's hospitals at Dhaka and Matlab. Funding constraints have led to scaling back of the range of pathogens being tested in Dhaka although the pathogens being detected in Matlab have included rotavirus and ETEC in order to prepare for possible vaccine trials for these vaccines in the near future.

2.2 Health Systems and Infectious Diseases Division (HSID)

The newly-created Health Systems and Infectious Diseases Division (HSID) has a new focus on infectious diseases along the line of the Centre's expanding emphasis on emerging and re-emerging infectious diseases in Bangladesh.

The mandate of the HSID is to strengthen the national health systems through supporting operations research and to design, test, and facilitate replication of cost-effective and sustainable research outcomes for rural and urban settings with emphasis on the prevention and control of emerging and re-emerging infectious diseases.

The HSID provides infrastructure and expertise for Centre-wide operations research with adaptation and implementation of benefits of interventions identified in 'research work' into 'real world' applications and, thus, accelerates evolution of policy through research. The Division also provides an epidemiological and operational focal point for infectious diseases research.

To fulfill its mandate, the Division focuses on a multidisciplinary approach of inquiry through both quantitative and qualitative methods. It works in partnership with the Ministry of Health and Family Welfare (MoHFW) of the Government of Bangladesh (GoB) and non-government organizations (NGOs) to facilitate successful interventions field-tested in the Division's research sites Abhoynagar upazila of Jessore district and Mirsarai upazila of Chittagong district and Dhaka city. The Chittagong office has been closed.

Health Systems and Infectious Diseases Division (HSID), with a staff of 197, including 6 international staff, has been organized into five units: (i) Health and Economic Policy, (ii) Infectious Diseases, (iii) Surveillance and Data Resources, (iv) Field Interventions, and (v) FHRP Administration

In addition, two Centre-wide programmes housed and administered within the division, the Health and Family Planning System Programme and the Programme of Infectious Diseases and Vaccine Sciences, whose mandate is to facilitate the Centre's activities in emerging infectious diseases and vaccine research. The Health and Family Planning Systems Programme is largely conducting the work of the Family Health Research Project, a USAID funded project for operations research, but it can accommodate practical projects funded by other donors as well. Within the Infectious Disease Programme, areas of emphasis include: Vector-borne diseases, respiratory disease epidemiology, diarrhoeal disease epidemiology, emerging infectious diseases, vaccine evaluation, and outbreak investigations.

Three significant staff additions are:

Dr. Charles Larson, Senior Operations Researcher and Head, PHFPS, seconded from McGill joined HSID in May 2002.

Dr. Carel van Mels, seconded from the Netherlands was transferred in August 2002 from PHSD to HSID to head the newly formed Surveillance and Data Resources Unit

Mr. Alec Mercer, formerly with DFID, joined HSID as a Operations Researcher in September 2002.

The major highlights for the reporting period include:

- Approval and launching of a new phase 3 investigational influenza vaccine trial,
- Completion of a typhoid burden of disease pilot study,

Approval for a typhoid burden of disease and case control study in collaboration with the Centers for Disease Control and Prevention and the International Vaccine Institute,

Approval for continued dengue burden of disease surveillance funded by the National Institutes of Health,

Continuation of hospital-based dengue surveillance and vector surveillance,

Publication of the first edition of the Health and Science Bulletin,

Two journal articles and four working papers published, and

Development of 10 protocols on FHRP themes involving scientists across all Divisions.

2.3 Information Sciences Division (ISD)

The new Information Sciences Division (ISD), created in 2001, includes the Training and Education Unit (TEU), the Computer Information Services Unit (CISU), and the Dissemination and Information Services Centre (DISC) with its three components: Information Services Branch, Publications Services Branch, and Audio-Visuals Unit which were previously under the Director's Division. The Audio-Visual Unit (AVU) has recently been separated from DISC and now exists as a separate unit under ISD. The Data Management Unit (DMU) was recently added to the Division to provide assistance and advice to those areas of the Centre without their own data management groups.

The ISD Computer Training Laboratory, which was completed in June, has been used intensively by the Human Resources Department for staff training in the use of MS Office and in Internet searching. Also, it was used by the Training and Education Unit during several of their training courses.

Contact has been made with the Wellcome Trust (UK) in connection with the development of training courses on CD-ROM. Initial responses have been encouraging for collaboration in this work and discussions are in progress.

Corporate level virus protection is being introduced into the Centre's Internet and e-mail systems, using McAfee anti-virus software. A site license for these systems is being acquired through the licensed NAI reseller in Bangladesh.

Contacts are being made with Microsoft's Charitable Organization Licensing Program to determine the procedures for ensuring that the Centre's core software packages are properly licensed.

Training Courses and Workshop Conducted

Course/Workshop title	No. of courses/workshops (n=19)	No. of participants (n=293)	Countries represented (n=18)
International Courses/Workshops			
Reproductive Health: Rhetoric into Reality through Innovative Approaches	2	23	Bangladesh, Cambodia, India, Indonesia, Kenya, Pakistan, Philippines, Tanzania, Thailand, Vietnam, Zambia, and Zimbabwe
Clinical Management of Diarrhoeal Diseases	1	9	Bangladesh, Indonesia, Kenya, Philippines, and Thailand
Laboratory Diagnosis of Some Common Infectious Diseases Agents	01	05	Kenya, Philippines and Thailand
Emergency Response to Cholera and Shigella Epidemics	01	12	Azerbaijan, Belgium, India, Indonesia, Kenya, Sweden and Tanzania
National Courses/Workshops			
Health Research Training Courses			
Introductory Course on Epidemiology and Biostatistics	02	37	Bangladesh
Basic Course on Epidemiology and Biostatistics	01	17	Bangladesh (10 UNICEF program officers and 7 from partner organization)
Other Training Courses/Workshops			
Reproductive Health: Rhetoric into Reality through Innovative Approaches	03	30	Bangladesh
Training of Community Leaders at Matlab	08	150	Bangladesh
Training Course on Arsenic Measurements (for DPHE Engineers)	02	13	Bangladesh
Measuring Poverty: Economic Dimensions	01	18	ICDDR,B and Other Organizations
Fellowship Programme			
International Fellowship (elective, post-graduate, diploma students)		11	Austria, Bangladesh, Bhutan, Canada, India, and USA
SAARC Fellows		13	Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka
Clinical Fellows		08	Bangladesh
Nurse Fellows		12	Bangladesh

The SAARC fellows programme has largely been funded by Japan, and this will need to be stopped in view of the cut from this donor source.

2.4 Laboratory Sciences Division (LSD)

The mission of the Laboratory Sciences Division (LSD) is 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 which share our commitment to maintain healthy populations. The mandate of the Division is to apply science to alleviate diseases.

The LSD has four International Scientists, two of whom were promoted from National level to International status in June. There is one International adjunct Scientist, 28 National Scientists, 265 technical and support service staff, comprising 142 Fixed Term, 78 CSA and 45 daily wagers.

Scientists of the Division have published 16 papers in international peer-reviewed journals.

LSD researchers have presented results from studies in 25 seminars/workshops and conferences and in collaborating Institutions.

Training of staff is continuing. Five Scientific staff-members were trained abroad. In addition four have gone to Japan to pursue Doctoral degrees through Monbusho Scholarships and several have participated in different in-house training programmes to improve their computer skills and abilities in research.

Scientists of the Division have acted as consultants to WHO, IVI and JICA on a variety of specialized areas over the past six months.

A state-of-the-art RTI/STI Laboratory was inaugurated to facilitate RTI/STI research activities as well as impart training to national and international researchers in this field.

The outpatient service unit of the Clinical Laboratory Services Programme has been shifted from the first floor to improved facilities on the ground floor of the hospital building. The spacious, air-conditioned facility is more accessible for patients coming from outside the Centre resulting in a steady increase in the number of paying users.

To cope with the growing need of Scientists, an open computer facility, the "DataNest" has been installed, consisting of computers and internet connection to provide and initiate bioinformatic research.

The LSD has 33 research projects that are ongoing, including six that have been initiated recently on Infectious Diseases and Vaccine Sciences. Some important findings are as follows:

Gene sequencing of dengue-3 strains, the predominant serotype isolated from hospitalized patients during the epidemic between 2000 and 2001, show that strains cluster together and are closely related to those isolated in neighbouring regions and circulating since 1980. Strains belonging to the dengue 2 serotype have also been detected.

A Voluntary Counselling and Testing (VCT) Centre for HIV, called Jagori, has been started at ICDDR,B where confidentiality is strictly maintained. A comprehensive referral system for HIV positive people is being developed. Facilities for absolute CD4 counts have also been set up. A problem now will be how to pay for the clinical management of the patients including the testing of CD4 counts and the antiretrovirals. Ideally, there should be a reimbursement mechanisms from the MoHFW for this clinical service, but so far, there is not such a mechanism. We feel it is in the best interest of the country to insure proper treatment of the currently infected patients as part of a long term prevention approach.

Genetic characterization of strains of *M. tuberculosis* have revealed that both 'ancestral' and 'modern' strains are causing tuberculosis in Bangladesh. Strains belonging to the Beijing family, which are usually known to predominate in Asian countries and are usually resistant to one or more anti-tubercular drugs, have been identified.

A rapid method requiring only 6 days, utilizes antibodies in lymphocyte supernatants (ALS) and appears to be a simple diagnostic test for evaluation/assessment of early pulmonary tuberculosis disease activity.

Increased isolation of *S. flexneri* 1c with a decrease of serotype 1a is being observed in strains isolated from patients with shigellosis in the hospital.

In a prospective study on amoebiasis in children, siblings of an anti-trophozoite, IgG positive index child had 4.8-times-higher odds of being anti-trophozoite IgG positive, showing that serum anti-trophozoite IgG was significantly different for cases and control families.

Dose finding studies on an oral inactivated whole cell ETEC vaccine have shown that even a reduced quarter dose of the vaccine is immunogenic, giving rise to significant mucosal and systemic antibody responses. Centre scientists are eager to proceed with a phase 3 study of the vaccine in young infants to prevent hospitalization due to ETEC diarrhea in Matlab, but the plans of the company in this regard are not certain.

A significant proportion of *S. typhi* strains isolated in 2002 show decreased susceptibility to ciprofloxacin, although it is the drug of choice for the treatment of typhoid fever. Typhoid is the most commonly isolated organism from blood cultures in any group of patients in our laboratory and the rates in the under 5 year olds were about 2%. The common occurrence and high rates in young infants suggest that a vaccine is needed as an EPI vaccine.

Pandemic strains of *tdh* gene positive *V. parahaemolyticus* have been isolated from the aquatic environment for the first time in Bangladesh. This illustrates a new way to define pandemic strains using molecular markers rather than serotype.

To improve vitamin A and iron status in children living in the urban slums, a feeding trial was conducted in 600 children using small fish rich in vitamin A. The data are being analyzed. If successful, this could represent an alternative strategy for providing vitamin A to the population of Bangladesh using a sustainable approach.

2.5 Public Health Sciences Division (PHSD)

The Public Health Sciences Division (PHSD) brings the population perspective to the Centre's mission and focuses on the development and evaluation of population-based interventions to address major health problems of poor communities in the world.

The Division provides a variety of scientific skills and methods but with an emphasis on public health, epidemiology, and social sciences. Research work of the Division contributes to the understanding of how health and diseases are generated in the community, with a focus on vulnerable and disadvantaged groups. It searches for cost-effective approaches that could be widely applied and could increase the absolute level and an equitable distribution of health among population groups. The Division has a strong research infrastructure, including provision of primary healthcare services in rural Matlab and Chakaria.

Expansion of PHSD activities continues with currently about 700 staff, 10 international level scientists, some 40 scientific protocols running, and a satisfactory funding situation.

A 5-year effort of strengthening a *poverty-focus in research* activities has begun. Safe motherhood, tuberculosis, maternal nutrition, child development, malaria studies get a poverty-and-health focus. Young researchers are now being employed to work with us in these activities as a capacity building exercise. Collaborative studies on health equity in Bangladesh are ongoing.

Regarding the new priority area, *neonatal survival*, field work has started in Sylhet where health worker administration of neonatal sepsis therapy is evaluated. It is clear from the basic health statistics that the only way that Bangladesh can reach its development goal for reducing infant mortality is by reducing significantly, its neonatal mortality. The traditional interventions (e.g. improved EPI and ORS and IMCI) will not reduce the overall infant mortality sufficiently to reach the development goals.

The *reproductive health* agenda in Matlab is expanding. In addition to research activities, a series of workshops has been held with community leaders on issues of family planning and reproductive health, and a second international training course on reproductive health challenges has been completed.

The ICDDRB involvement in long-term surveillance of *cholera* has recently resulted in a major paper on epidemic and endemic cholera trends over a 33-year period. An intriguing finding from this analysis is the importance of immunity to Inaba, regardless of biotype, to subsequent protection from cholera.

The *Health Economics Unit* appointed a new head in October (Dr Beena Varghese). The unit has been active with cost-effectiveness assessments, e.g. one recently reported on the EPI programme.

The *Health and Demographic Surveillance* in Matlab has completed an electronic census, and is sharpening the verbal autopsy tools to meet the demands from forthcoming studies on neonatal mortality and adult mortality.

The *Chakaria community health project* has entered into a new phase, where health cooperatives are formed to ensure sustainability of health initiatives taken by the

villagers. Though long known, we have now documented the important role of malaria in this area and have begun testing strategies for interventions and early treatment.

Two major studies regarding *arsenic and health effects* are ongoing in Matlab, with funding from Sida, WHO, and the US Embassy (total approx 1 million dollars). So far more than 50,000 people in Matlab have been examined, a new AAS is just being installed in Dhaka and staff is trained at Karolinska Institute. First results from the studies are expected mid-2003. An important outcome of the arsenic study is the evaluation of arsenic for reproductive health adverse events. Though speculated from animal studies, this is the first opportunity (because of the concurrent MINIMat study) to examine this issue.

The first babies under the MINIMat study (focusing prevention of intrauterine growth restriction *and low birth weight*) have been born. We are now implementing plans to study functional outcomes regarding breast-feeding and lactation, infant growth, morbidity and immune function, motor milestones and cognitive development. A first annual meeting with collaborating partners from USA, UK, Mexico and Sweden is scheduled for October 2002.

3. Director's Division

3.1 Office of Policy and Planning

Based on the comments of the last Board meeting, the Centre's Strategic Plan has been further revised. The revised Strategic Plan document has an Executive Summary, which gives an overview of the Centre's intentions which will whet the appetite of readers. Other relevant modifications have been made. The Centre Director, Prof. David Sack, presented the revised Strategic Plan to the Donor Support Group (DSG) and the Government of Bangladesh, and it has been well received by both groups of stakeholders. However, based on some comments from the DSG, necessary modifications have been made.

A uniform and central computerized Project Monitoring System is being developed to track performance of the projects. The objectives of the project monitoring system are to help facilitate timely reporting to donors and keep programmes on track. This is a management tool to enable managers at different levels such as the Director, Associate Directors/Programme Heads/PIs to determine the progress of work, problems/difficulties encountered in carrying out the work, ways of resolving problems and provide the needed guidance to facilitate smooth implementation of the work.

The monitoring system consists of three forms. Form 1 will be filled-out once by RRC/ERC Secretariat and the PI and the Finance Department. The PIs shall provide information on Form 2 on a four-monthly basis (Jan-April, May-Aug, Sept-Dec). Form 3 provides financial information for each project, and information on this form shall be provided by the Finance Department on a four-monthly basis. Development of Form 1 has been completed, and development of Forms 2 and 3 will be completed by the end of March, 2003.

A manual has been prepared for the Centre staff and consultants and circulated through our Intranet to familiarize them with various procedures relating to developing and funding scientific proposals, review process of research proposal, types of donor support, external relations, recruitment policy, procurement services, staff clinic services, library and information services, publication and dissemination, computer information services, travel and estate, transport, fellowship programme, staff development, and consultant policy.

Coordinated the Centre Scientific Forum. A total of 21 seminar presentations were made by the Centre staff and their collaborators.

Assisted the Director in various administrative and other activities.

3.2 Human Resources Department (HRD)

Human Resources Department of the Centre deals with matters relating to recruitment, promotion, transfer, separation and retirement of staff. The Department also looks after the well-being of employees of the Centre and their dependants by providing free medical treatment through its Staff Clinic.

As of September 2002, the Centre had a total staff of 1946 personnel -- 175 were national officers, and 954 were in the general services category, in addition to 20 Community Health Workers and 90 Health Workers. The Centre also has 27 international staff members, 6 of whom were on secondment. In addition, there are 5 on short-term contract, 319 daily wagers, 329 on contractual service agreement, and 27 Fellows.

International Staff Updates: This is contained in the HR report to the BoT.

Hiring of Interim Head, Human Resources: Ms. Ann Walton has replaced Ms. Diann Hill, who left the Center on September 5.

Gender Equality Committee: A Dhaka-based organization has been identified to train the committee members to gain a common framework for gender awareness and understanding. The committee is collecting and evaluating existing gender policies from other organizations with the objective of drafting a gender policy for the Centre.

Job Classification Project: Following the job evaluation exercise a new job classification procedure and a process for dealing with misclassified posts has been presented to the Acting Director and the Associate Directors and the Chief Finance Officer for approval. Human Resources is now developing a communication plan for all Centre staff to convey the project outcomes.

Market Survey: A local consultant was hired to carry out a salary survey to compare the Centre's salaries and benefits against those of the external market, and this has been completed.

Performance Management and Development System: A new performance management and development system has been created for the Centre, which will support the merit pay system scheduled to be implemented in 2004. The new system will be communicated to employees in December, 2002. Training for managers on how to use the new system will begin early next year.

3.3 Finance Department

The Finance Department, with a staff of 32, has the overall responsibility for financial operations and management of the central stores and fixed assets. The financial operations include: cash management and custodianship of all funds, preparation of the annual budget, recording of all financial transactions and commitments, and preparation of accurate and timely financial reports for the Board of Trustees, management and donors. The Department is responsible for facilitating the annual audit and assuring that audits for all necessary donors' contributions are timely completed.

Financial highlights for 2002 are:

Total contributions from donors in 2002 are forecast to increase by \$1,445,000 to \$15,218,000 or 10% greater than budget.

Contributions from donors for projects in 2002 are forecast to increase by \$1,203,000 and unrestricted contributions for core activities are forecast to increase by \$242,000 compared to budget.

Total operating cash expenditure in 2002 is forecast to increase by \$900,000 to \$16,003,000 or 6% more than budget.

Operating deficit for 2002 is forecast to be \$68,000 which is a significant improvement compared to a budget deficit of \$532,000 projected in November 2001. We hope to eliminate this deficit by year's end, but cannot be sure at this point.

Cumulative deficit of operating fund is forecast to be \$2,958,000 at 2002 year end.

Market value of endowment funds at 30 September 2002 declined from beginning of year balance. Centre Endowment Fund declined 13%, and Hospital Endowment Fund declined 9%. This result mirrors the global performance of equity instruments.

During 2002, the Finance staff:

completed USAID audit of 2001 spending and indirect costs, and received additional \$100,000 to offset core costs.

hosted review visit by first vendor for MIS. Visited vendor's office for product demonstration; however, did not pursue this software proposal.

continued sourcing of integrated MIS for Finance, HR and Projects. Hosted second vendor reviews visit and product demonstration visit, and is currently in process of evaluating proposal.

developed donor funding mechanisms for budget for financing MIS.

completed recalculation of existing interdepartmental charge rates and developed initial rates for interdepartmental services to be charged for first time. In past years, Price Waterhouse staff performed this work. This year, Price Waterhouse manager taught Centre staff calculation methods so, in future, updated rates can be prepared in-house. The goal of this calculation is to insure that the fair charges are being made to projects for the services and to insure that the Centre is not unwisely subsidizing functions that should not be subsidized. Examples include transport costs, canteen, etc.

resolved issue of tax withholding by Government of Bangladesh agency on payments made per donor agreement.

re-invigorated collection of \$109,000 owed by Arab Gulf Fund and written off in 2000. Received verbal agreement and paper work to confirm this is in process.

arranged for Controller, Budget and Costing to attend five days seminar on USAID regulations and procedures.

finalized plans for Finance infrastructure and support for MIS. Implemented major portions of support plan.

completed hiring process of internal candidate for funded position in Budget and Costing unit. Hope staff will start by December.

continued to accomplish ongoing critical work of payroll, procurement, general accounts, treasury and budget & cost functions.

3.4 External Relations and Institutional Development (ER&ID)

ER&ID works with both the Centre management and scientists to address administrative issues that arise concerning the implementation of agreements between donors and the Centre.

As liaison between the donor community and ICDDR,B, its functions included: preparing the agenda for special visitors to ICDDR,B and accompanying them on the tours of the Centre's hospitals, laboratory and training facilities, and field research sites. In fulfilling its administrative function, the ER&ID Office assisted the Centre's scientists by: identifying sources of funding for ICDDR,B's new activities; identifying new donors to the Centre; working with the Scientific divisions as well as the Finance Department in ensuring budgetary support for core activities; drafting and submitting proposals for submission to the donors; and providing a final review of contracts between donors and ICDDR,B scientists to assure agreement between the parties and adequate budgetary support for its scientific endeavours. The ER&ID Office put together the

technical and financial reports as well as the annual work plans of various donor-funded protocols. It also coordinated the preparation of progress reports of several ongoing projects.

Other external relations activities included: coordinating press conferences and press briefings as well as responding to press enquiries; presenting and publicizing the Centre's achievements in scientific forums, organizing special events; developing fundraising initiatives and sponsorship for programmes and special events.

The ER&ID Office serves as the Secretariat for the Centre's Donor Support Group (DSG) and assists the Centre Director in the preparation of the Board of Trustees meetings.

Finally, the ER&ID Office continued to spearhead the efforts for the growth of the Centre Endowment Fund and the ICDDR,B Hospital Endowment Fund.

Changes in Personnel

Ms Vanessa Brooks moved over to the Director's Wing from the ERID Office. Ms Julia Ackley has joined the ERID Office and will be responsible for much of the fundraising efforts, including the North American initiatives. Ms Ackley comes extremely well prepared and has excellent fundraising track record of working in a US-based institution called CEDPA.

Major donors

The Government of Bangladesh (GoB) has decided to increase its annual contribution during the current year by US\$50,000 and by \$100,000 during the coming year. This was made possible by the initiative of the two Bangladeshi Trustees – the ERD Secretary and the Health Secretary to the Government of Bangladesh.

In response to ERID's initiatives, the GOB has agreed to organize a meeting in the Economic Relations Division of the Ministry of Finance, where the Centre will be asked to present the highlights of its research, service and training activities to the donors who are providing support to Bangladesh's national health and population programme. The Centre will also identify its needs in areas where it requires financial assistance. If ICDDR,B can establish that its activities benefit the people of Bangladesh, much of these bilateral funds could be redirected to the Centre.

The Swiss Agency for Development and Cooperation (SDC) has decided, in principle, to increase its core support to ICDDR,B from its current contribution of \$500,000 to \$750,000 in 2003 and to \$1,000,000 in 2004.

Sida has provided one million Swedish Kronor (approximately \$100,000) to ICDDR,B as a Planning Grant to initiate new research undertakings.

In the midst of these impressive happenings, there are some downside as well. The Government of Japan (GoJ) has indicated that due to its own economic difficulties, the contribution of GoJ will be substantially reduced this year as well as next year. Efforts are going on with the

assistance of the Centre's BoT member from Japan, the GoB, and the Japanese Embassy in Bangladesh to reverse this trend.

Fundraising Initiatives

The ER&ID office continued to liaise closely with the Centre's Events Committee in organizing the upcoming Annual Fundraising Dinner. The ER&ID Office is initiating discussions with local and international businesses interested in expanding their support to the ICDDR,B Dhaka Hospital as an important community caregiver.

Communication

The ER&ID Office took a lead role in the dissemination of the Centre's research findings during the tenth Annual Scientific Conference (ASCON X) by organizing press conferences, arranging media coverage, and drafting scripts for special radio and TV programmes on ASCON X. Also, it brings out the bimonthly Grants Newsletter.

The ERID Office also organized the press conference on a landmark achievement of the Centre. It joined hands with media people in New York to jointly organize a press event in Dhaka on the success of "ORS saving 40 million children." The event was well covered by the local media.

This Office also helped organize the Zinc Conference on 7 October 2002 and arranged to have the news published on the following days in 15 leading national dailies. In addition, the conference was also covered by the BBC World Service.

The Office completed the production of a new video for promotion of the Centre and its many activities. Also, the ERID Office planned the revision and publication of the Centre's theme-based new Brochure. This blue-folder will enable readers to learn about the Centre's major scientific initiatives at a glance.

The ER&ID Office also assisted in the planning and implementation of fundraising activities of its affiliates: the Baltimore-based Child Health Foundation and the London-based International Health Solution Trust. These interactions and discussions have resulted in a plan of actions for these affiliates to raise the profile of the Centre in North America and in Europe.

Special Events

Organizing special visits

The Office organized the visit to the Centre by the President of the Thrasher Research Fund, including tours to Matlab and urban field sites in Mirpur and Kamlapur.

The ER&ID Office organized visits to the Centre's Dhaka and Matlab facilities for Ambassadors/High Commissioners, senior civil servants, policy makers, academicians, researchers.

Special Submission

The ERID Office provided information that enabled the Government of Bangladesh's Health Secretary to put together impressive list of activities highlighting the Centre. Later, the Health Secretary, a BoT member of ICDDR,B, recommended ICDDR,B for the Conrad Hilton Humanitarian Award 2002.

3.5 Grants and Contracts and Related Fundraising Initiatives

The Centre has expanded collaborations and donor support adding a major donor to its portfolio of supporters and implementing a new project with another long-standing supporter of the Centre. Wellcome Trust has come on board as a new donor supporting child health research on neonatal infections and Procter & Gamble is testing new technology for arsenic mitigation. In the area of vaccine research, we continue to expand our collaborations with the International Vaccine Institute, Wyeth Lederle pharmaceutical company and CDC. We have also entered initial agreements with biotechnology firms in Austria and India with plans to collaborate on expanded research into the development of new diarrhoeal disease vaccines and antibacterial drugs.

Collaborations have expanded in each of the divisions bringing into the Centre new research partners and extending the agreements with existing collaborators. The WELL project (UK), Northumbria University (UK), Ministry of Health Mozambique are among the new collaborators since June 2002. Expanded collaborations continue with international partners including WHO, Office of Federal Disaster Assistance (US), Howard Hughes Medical Institute, Fogarty International Fellows Program, NIH, New England Hospital and Medical Center, World Bank (headquarters) and with local partners such as Kumudini Hospital, Dhaka Medical College Hospital, Holy Family Hospital, Shishu Hospital, Progoti Samaj Kallyan Protighan (PSKP) NGO Clinic network, BRAC and the Government of Bangladesh through World Bank and ADB funding.

The New York profile-raising event gave the Centre an opportunity to visit UNICEF headquarters and to have further discussions on potential future support of our low birth weight intervention and nutrition work at the Centre. Also, it gave us an opportunity to engage UNICEF headquarters in a discussion of reinstating some level of core support to the Centre. While these discussions continue, no commitment for core support has come from UNICEF. Our announcement at the New York event of the 100 Partners campaign to increase endowment support, through a partnership with companies and other private donors willing to support the Centre at \$10,000 level per year, has received its first contribution from Procter & Gamble, which donated a \$25,000 initial unrestricted grant to the Centre in August 2002. A new brochure will accompany presentations planned for 2003 to potential participants in the 100 Partners programme.

International Health Solutions Trust, our UK fundraising arm, invited the Centre to provide an update to its Board members, similar to the presentation at the UN, in July 2002 at the House of Lords, in the United Kingdom, at the invitation of Baroness Uddin of Bethel Green. At the meeting, the Trust discussed the prospect for funding a research programme through the

Community Trust Fund of the UK and sponsoring a fundraising event in London with the support of Baroness Uddin.

3.6 Staff Development Activities

Overseas

- a) Number of staff members left during the period to begin study/training (4 for PhD, and 3 for Masters) - 18
- b) Number of staff members returned during the period after completion of study/training (4 Masters) - 20
- c) Number of staff members on overseas study/training as of 30 September 2002 - 28

In-country Training

Forty-eight staff members were sent to various institutions in Bangladesh to attend short courses in different fields to gain specific knowledge and skills. The field of their training were cardio-pulmonary resuscitation, English language, computer software, computer engineering, poverty alleviation, ultrasonography, mid-wifery, supervision, and monitoring of projects.

In addition, Mr. Sentu B. Gomes of PHSD was sent to attend the MBA (evening) programme at BETS Victoria Ltd. and Progressive Meritocracy Ltd., Dhaka.

In-house Training

Five staff members attended a 4-week national "Introductory Course on Epidemiology and Biostatistics" organized by the Training and Education Unit of the Centre.

3.7 Protocols

Number of Protocols by Division

Name of Division	No. of ongoing protocols as of Sept 30, 2002	Started after April 1, 2002	Protocol approved but awaiting funds	Protocol in review process
Clinical Sciences Division	14	2	3	5
Health Systems and Infectious Diseases Division	9	-	1	4
Laboratory Sciences Division	20	3	-	3
Public Health Sciences Division	26	3	-	8
Total	69	8	4	20

3.8 Publications

Original Scientific Papers (including short reports)	35
Review Articles, Book Chapters, Papers in Conference Proceedings, and Monographs	06
Letters, Editorials, and Abstracts in Journals	08
Working Papers	04
Scientific Reports	01
Special Publications	01
Journals and Newsletters	03
Internal publication series	01

3.9 Hospital Endowment Fund

Established in 1990, the Hospital Endowment Fund (HEF) addresses the key issue of sustainability of patient care services in the face of consistently declining support for patient care by traditional donors.

While efforts are ongoing to recruit large donors both in Bangladesh and abroad, each year a group of Centre staff and supporters join together as volunteers to organize fundraising activities locally for the HEF. The annual fund raising dinner is the focal point for the fundraising initiatives, since it enables the Centre to expand its local support and heightens community awareness of the unique contribution of its hospitals.

The HEF Committee has recently organized a fundraising dinner and an art auction raising an amount of approximately US\$ 36,000. Recently, an individual donor contributed US\$ 3,000 to the Fund. The present art auction is sponsored by Duncan Brothers (Bangladesh) Ltd., for an amount of US\$ 6,000. At least 45 renowned artists have contributed 80 paintings that are on auction. The American Express Bank, Dhaka, has pledged to sponsor the next fundraising dinner by contributing US\$ 12,000. These contributions are, indeed, a testimony of the Centre's success in creating local awareness.

With sound investment strategies, the income generated by the endowment funds will help the Centre to maintain its high quality clinical services to patients and assure the availability of health care services from the hospitals which have become national asset.

3.10 Physical Plan

Development in the physical plants

To accommodate various activities, efforts are being made to remodel and reshape the existing structures to allow the Centre activities to go unhindered, though the lack of adequate space is gradually becoming a stumbling block in all our activities. The Master Plan is getting the finishing touches on the designer's board. It will be ready for execution by early next year. The implementation of the Master Plan by initiating the construction work of the main building has now become imperative for the Centre's growth. Meanwhile, some construction/renovation work has been initiated since July 2002 to accommodate increased project activities as listed below:

Work Description	Area	Start Date	Completion Date
Renovation of PHSD office area to increase working space ¹	PHSD Building	September 02	January 03
Construction of cold room/specimen bank ²	Over the Metabolic ward of the Dhaka Hospital	October 02	January 03
Renovation/remodeling of CSD offices on the ground floor for shifting offices from the second floor to accommodate the virology lab	Main Building – ground floor	August 02	November 02
Renovation of space for LSD and CSD study projects ³	Tin shed in the parking area	August 02	September 02
Construction of storage space for Finance Department	Main Building roof	September 02	November 02

¹ This will accommodate more scientists and staff while maintaining the same number of square feet of office space.

² This is needed for the HiV surveillance and will also be used for future specimen banks.

³ This will allow for longer term vaccine and nutrition projects when volunteers must stay for multi-day trials.

4/BT/NOV 2002

FINANCE COMMITTEE

WELCOME TO FINANCE COMMITTEE

**ICDDR,B: CENTRE FOR
HEALTH & POPULATION RESEARCH**



**BOARD OF TRUSTEES MEETING
FINANCE COMMITTEE**

November 2002

ICDDR,B BOARD OF TRUSTEES MEETING

FINANCE COMMITTEE - NOVEMBER 2002 MEETING

AGENDA

1. Approval of Agenda
2. 2002 Forecast Pages 2-3
3. 2003 Budget Pages 4-5
4. Staff Salaries and Allowances
(Information will be sent separately.)
 - a) National
 - b) International
5. Funds Pages 6-7
 - a) Reserve Fund
 - b) Operating Fund
 - c) Hospital Endowment Fund
 - d) Centre Endowment Fund
6. Miscellaneous Page 8
 - a) Bank Overdraft Facility / Line of Credit
 - b) Exchange Rates
 - c) Management Information System
7. Draft Resolutions Page 9

Tables:

- | | |
|-----------|---|
| Table 1. | Contributions |
| Table 1A. | Contributions - Others |
| Table 2. | Revenue by Sources and Expenditure by Categories |
| Table 3. | Unrestricted and Restricted Revenue and Expenditure |
| Table 4. | Contributions by Unrestricted and Restricted Funds |
| Table 4A. | Summary Contributions by Restricted Funds |
| Table 4B. | Others Contributions by Restricted Funds |
| Table 5. | Unrestricted Projects/Programs and Management Expenditure |
| Table 6. | Unrestricted Other Receipts |

Annexures:

- A Glossary of Acronyms and Abbreviations
- B Report of the Finance Committee of June 08, 2002

2002 FORECAST

REVENUE

Contributions budgeted at \$13,773,000 for 2002 are expected to increase to \$15,218,000. This increase of \$1,445,000 or 10% comprises:

	US\$	2002 FORECAST	2002 BUDGET	Increase (Decrease)	%
Restricted-Direct		10,789,000	9,882,000	907,000	9%
Indirect		<u>1,699,000</u>	<u>1,403,000</u>	<u>296,000</u>	21%
Projects/Programs		12,488,000	11,285,000	1,203,000	11%
Unrestricted-Core		<u>2,730,000</u>	<u>2,488,000</u>	<u>242,000</u>	10%
Total contributions		15,218,000	13,773,000	1,445,000	10%
Exchange Gains		50,000	100,000	(50,000)	(50)%
Other Receipts		<u>667,000</u>	<u>698,000</u>	<u>(31,000)</u>	(4)%
Total Revenue		<u>\$15,935,000</u>	<u>\$14,571,000</u>	<u>\$1,364,000</u>	9%

Restricted revenue will increase in line with restricted expenditure which are expected to increase due to projects funded by government of Bangladesh, DFID, Gates/GoB Award, WHO and Centre Endowment Fund, while partially offset by decreased spending on Japan government, USAID/Dhaka and USAID/Washington projects.

Forecast indirect revenue includes a one off recovery of \$390,000 for USAID/Dhaka indirect costs for 1999, 2000 and 2001. Excluding these receipts, indirect revenue was \$94,000 or 7% less than budget primarily due to reduced spending on USAID/Dhaka protocols.

Unrestricted contributions are expected to increase by \$242,000 or 10% primarily due to increased contribution from USAID/Washington, new DFID contribution, and favorable exchange rates partially offset by decreased CIDA contribution.

2002 FORECAST

EXPENDITURE

Operating cash expenditure budgeted at \$15,103,000 for 2002 is forecast to increase by \$900,000 or 6% to \$16,003,000. This increase comprises:

	US\$	2002 <u>FORECAST</u>	2002 <u>BUDGET</u>	Increase (Decrease)	%
Restricted-Direct		10,803,000	9,900,000	903,000	9%
Unrestricted-Core					
Projects/Programs		3,145,000	3,245,000	(100,000)	(3)%
Management		<u>2,055,000</u>	<u>1,958,000</u>	<u>97,000</u>	5%
Total Unrestricted-Core		5,200,000	5,203,000	(3,000)	-
Operating Cash Expenditure		<u><u>\$16,003,000</u></u>	<u><u>\$15,103,000</u></u>	<u><u>\$900,000</u></u>	6%

Restricted expenditure is expected to increase due to projects funded by government of Bangladesh, DFID, Gates/GoB Award, WHO and Centre Endowment Fund, while partially offset by decreased spending of Japan government, USAID/Dhaka and USAID/Washington projects.

Unrestricted expenditure is expected to decrease slightly with reduced spending on projects/programs offset by management costs.

Total expenditure including depreciation was budgeted at \$16,003,000 and is forecast to increase by \$954,000 or 6% to \$16,957,000.

OPERATING SURPLUS (DEFICIT)

Net cash deficit was budgeted at \$532,000. Results have improved and a deficit of \$68,000 is forecast. Causes of this improvement are the one-off USAID/Dhaka indirect costs, additional core contribution from DFID, increased contribution from USAID/Washington and favorable exchange rates partially offset by decreased CIDA contributions.

2003 BUDGET

REVENUE

Contributions for 2003 are budgeted at \$13,646,000 compared to \$15,218,000 forecast for 2002. This decrease of \$1,572,000 comprises:

	US\$	2003 <u>BUDGET</u>	2002 <u>FORECAST</u>	Increase <u>(Decrease)</u>	<u>%</u>
Restricted - Direct		9,608,000	10,789,000	(1,181,000)	(11) %
Indirect		<u>1,285,000</u>	<u>1,699,000</u>	<u>(414,000)</u>	(24) %
Projects/Programs		10,893,000	12,488,000	(1,595,000)	(13) %
Unrestricted-Core		<u>2,753,000</u>	<u>2,730,000</u>	<u>23,000</u>	1%
Total Contributions		13,646,000	15,218,000	(1,572,000)	(10) %
Exchange Gains		100,000	50,000	50,000	100 %
Other Receipts		<u>642,000</u>	<u>667,000</u>	<u>(25,000)</u>	(4) %
Total Revenue	\$	<u>14,388,000</u>	<u>15,935,000</u>	<u>\$ (1,547,000)</u>	(10) %

Restricted direct revenue is budgeted to decrease due to a reduced level of spending on projects funded by governments of Bangladesh and Japan, Ford Foundation, SIDA, Thrasher, UNICEF, USAID, NIH, WHO and partially offset by increased spending by DFID, EU and IVI.

Restricted indirect revenue is expected to decrease due to the absence of a one off recovery for USAID/Dhaka indirect costs received in 2002.

Unrestricted contributions are expected to be similar amounts from same donor group as 2002 with small increases from existing donors offsetting discontinued CIDA contributions.

2002 BUDGET

EXPENDITURE

Operating cash expenditure for 2003 is budgeted at \$15,170,000 compared to \$16,003,000 forecast for 2002. This decrease of \$833,000 or 5% comprises:

	US\$	2003 <u>BUDGET</u>	2002 <u>FORECAST</u>	Increase (Decrease)	%
Restricted-Direct		9,618,000	10,803,000	(1,185,000)	(11) %
Unrestricted-Core					
Projects/Programs		3,989,000	3,145,000	844,000	27 %
Management		<u>1,563,000</u>	<u>2,055,000</u>	<u>(492,000)</u>	(24) %
Total Unrestricted-Core		5,552,000	5,200,000	352,000	7 %
Operating Cash Expenditure		\$15,170,000	\$16,003,000	\$(833,000)	(5) %
		=====	=====	=====	

Restricted expenditure is expected to decrease due to a reduced level of spending on projects funded by governments of Bangladesh and Japan, Ford Foundation, SIDA, Thrasher, UNICEF, USAID, NIH, WHO and partially offset by increased spending by DFID, EU and IVI.

Unrestricted expenditure by management is expected to decrease significantly due to increased interdepartmental charges and rates to be charged to user departments.

Unrestricted expenditure by core projects/programs is budgeted to increase significantly due to increased salary and benefits costs, and increased staff assigned to core due to decreased restricted spending.

Total expenditure including depreciation is budgeted at \$16,067,000 and is expected to decrease by \$890,000 or 5 % compared to \$16,957,000 forecast for 2002.

OPERATING SURPLUS (DEFICIT)

Net cash deficit excluding depreciation for 2003 is budgeted to \$782,000 compared to the 2002 forecast deficit of \$68,000, a deficit increase of \$714,000.

This budget is prepared on a conservative basis including only those funding sources which have been finalized or close to finalization. Management expects that other funding requests which are in process will be approved by donors. Management intends that those additional funds and cost containment measures will result in break even or better results in 2003.

FUNDS

a) RESERVE FUND

	Market Value
Balance - January 01, 2002	\$ 2,007,408
Forecast interest earnings, average 1.5%	30,000
Forecast transfer to Operating Fund	<u>(35,000)</u>
Forecast balance December 31, 2002	<u>\$ 2,002,408</u>

The Fund is invested in time deposits at American Express Bank earning interest at short term investment yields of approximately 1.5% per annum. At this rate, the fund would earn approximately \$30,000 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.

The Board has authorized the transfer on an ongoing basis to the Operating Fund of all amounts in excess of \$2,000,000 to further reduce the cumulative historical operating deficit.

b) OPERATING FUND

Deficit balance January 01, 2002	\$ (2,925,663)
Forecast transfer from Reserve Fund	35,000
Forecast net cash deficit for 2001	<u>(68,000)</u>
Total forecast increase in deficit	<u>(33,000)</u>
Forecast deficit balance- December 31, 2002	<u>(2,958,663)</u>

Per forecast, the cumulative deficit will have decreased by \$962,743 or 25% from its peak of \$3,921,406 at the end of 1998.

c) HOSPITAL ENDOWMENT FUND

	Market Value
Balance – January 01, 2002	\$ 5,160,137
Donations and fund raising	24,158
Unrealized loss, net of earnings	<u>(454,518)</u>
Balance –September 30, 2002	<u>\$4,729,777</u>

As of September 30, 2002 this fund was invested in the following :

Equities	34 %
Debt Instruments	30 %
Cash Equivalents	31 %
Bangladesh Government Debentures	1 %
Equities and Debentures on Dhaka Stock Exchange	<u>4 %</u>
	100 %

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, 2002 for operating costs of the hospitals in 2003.

d) CENTRE ENDOWMENT FUND

	Market Value
Balance – January 01, 2002	\$ 3,418,192
Unrealized loss, net of earnings	<u>(448,905)</u>
Balance- September 30, 2002	<u>\$2,969,287</u>

This fund is invested with TIAA-CREF and currently held in the following:

Equities	52 %
Debt Instruments	47 %
Cash Equivalents	<u>1 %</u>
	100%

MISCELLANEOUS

a) BANK OVERDRAFT FACILITY / LINE OF CREDIT

The facility is authorized through July 31, 2003 with American Express Bank and is expected to be renewed on an annual basis consistent with past practice.

Interest expense is projected to be less than \$6,000 for 2002. This compares to interest expense of \$2,200 in 2001. The increase is due to timing of donor contributions vs. incurred cost.

b) EXCHANGE RATES

The 2002 budget anticipated a devaluation of 5% in the local currency of Bangladesh. Due to global economic conditions, the US\$ has weakened and such devaluation has not occurred. The forecast assumes that no devaluation will occur during the remainder of 2002.

Approximately 60% of revenue is received directly in US\$. For the remainder, the actual amount of US\$ received may vary from budget due to fluctuating exchange rates. Such exchange differences on restricted revenue are absorbed within the individual project budgets. For unrestricted revenue, exchange differences are reflected in the amount reorganized as core contributions.

c) MANAGEMENT INFORMATION SYSTEM

The Finance staff is in process of investigating proposals for a management information systems which would be integrated with Human Resources and Project functions. It is anticipated that the cost of such system will be funded by a current multiyear donor agreement.

DRAFT RESOLUTIONS

RESOLUTION - 01

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

The Board approves that the previously authorized transfer of \$200,000 from the Hospital Endowment Fund in 2002 may be carried over into 2003 as deemed necessary by the Director; and authorizes \$200,000 to be transferred from the Hospital Endowment Fund to operations in 2003.

Tables:

Table 1.	Contributions
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Table 2.	Revenue by Sources and Expenditure by Categories
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Table 4.	Contributions by Unrestricted and Restricted Funds
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Table 6.	Unrestricted Other Receipts

All amounts are presented in US\$.

Note: Where necessary prior years figures have been regrouped to conform with current year forecast.

TABLE - 1
ICDDR,B: CENTRE FOR HEALTH AND POPULATION RESEARCH
CONTRIBUTIONS 2000 - 2003

(IN US\$'000)

DONORS	2000		2001		2002		2002		2003		2003-STATUS	
	ACTUAL		ACTUAL		BUDGET		FORECAST		BUDGET		FIRM	ESTIM.
Revenue Contributions :												
AUSTRALIA - AusAID	357	2.6%	258	1.8%	245	1.8%	213	1.4%	228	1.7%	228	
BANGLADESH	497	3.6%	654	4.7%	456	3.3%	854	5.6%	663	4.9%	663	
BELGIUM - BADG/ BTC	158	1.1%	240	1.7%	186	1.4%	110	0.7%	84	0.6%	84	
CANADA - CIDA	204	1.5%	192	1.4%	192	1.4%	48	0.3%				
CENTERS FOR DISEASE CONT. & PREV.			13	0.1%	63	0.5%	168	1.1%	137	1.0%	137	
EUROPEAN UNION	910	6.6%	758	5.4%	174	1.3%	247	1.6%	404	3.0%	404	
FORD FOUNDATION	309	2.2%	285	2.0%	201	1.5%	207	1.4%				
GATES - GoB AWARD							503	3.3%	488	3.6%	488	
INTERNATIONAL VACCINE INSTITUTE			118	0.8%	376	2.7%	345	2.3%	609	4.5%	609	
JAPAN	658	4.8%	874	6.2%	982	7.1%	740	4.9%	571	4.2%	571	
NETHERLANDS	238	1.7%	1,011	7.2%	1,004	7.3%	1,111	7.3%	1,123	8.2%	1,123	
NEW ENGLAND MEDICAL CENTER	66	0.5%	126	0.9%	81	0.6%	192	1.3%	151	1.1%	151	
SAUDI ARABIA	52	0.4%	50	0.4%	50	0.4%	50	0.3%	50	0.4%	50	
SRI LANKA	4	0.0%	4	0.0%	4	0.0%	4	0.0%	4	0.0%	4	4
SWEDEN - SIDA / SAREC	444	3.2%	509	3.6%	679	4.9%	761	5.0%	609	4.5%	609	
SWITZERLAND - SDC	836	6.0%	761	5.4%	524	3.8%	500	3.3%	500	3.7%	500	
SWISS RED CROSS	243	1.8%	174	1.2%	185	1.3%	169	1.1%	175	1.3%	175	
THRASHER RESEARCH FUND	(51)	-0.4%	52	0.4%	162	1.2%	241	1.6%	84	0.6%	84	
UNICEF	3	0.0%	218	1.6%	255	1.9%	257	1.7%	76	0.6%	76	
UNITED KINGDOM - DFID	759	5.5%	828	5.9%	1,253	9.1%	1,542	10.1%	2,128	15.6%	2,128	
USAID/Dhaka	2,762	20.0%	2,233	16.0%	2,612	19.0%	2,279	15.0%	1,931	14.2%	1,931	
USAID/Washington	2,192	15.8%	2,193	15.7%	1,837	13.3%	1,864	12.2%	1,826	13.4%	1,488	338
USA - NIH	888	6.4%	775	5.5%	566	4.1%	434	2.9%	257	1.9%	257	
USA - Other Sources	197	1.4%	152	1.1%	184	1.3%	342	2.2%	151	1.1%	151	
WORLD BANK - NCoE	973	7.0%	758	5.4%								
WYETH PHARMACEUTICALS, INC.			10	0.1%	168	1.2%	160	1.1%	152	1.1%	152	
WHO	242	1.7%	176	1.3%	169	1.2%	481	3.2%	247	1.8%	247	
CENTRE ENDOWMENT FUND	66	0.5%	69	0.5%			106	0.7%	54	0.4%	54	
HOSPITAL ENDOWMENT FUND	200	1.4%			400	2.9%	400	2.6%	200	1.5%	200	
OTHERS (See Table - 1A)	623	4.5%	501	3.6%	765	5.6%	890	5.8%	744	5.5%	744	
TOTAL CONTRIBUTIONS	13,830	100.0%	13,992	100.0%	13,773	100.0%	15,218	100.0%	13,646	100.0%	13,304	342

Note: Where necessary prior years figures have been regrouped to conform with current year forecast.

TABLE - 1 A
ICDDR,B: CENTRE FOR HEALTH AND POPULATION RESEARCH
CONTRIBUTIONS - OTHERS 2000 - 2003

(IN US\$'000)

	2000		2001		2002		2002		2003		2003-STATUS	
	ACTUAL		ACTUAL		BUDGET		FORECAST		BUDGET		FIRM	ESTIM.
PLAN INTERNATIONAL	13	0.1%										
PROCTER & GAMBLE COMPANY	1	0.0%					4	0.0%				
SAVE THE CHILDREN (USA)	(4)	0.0%										
SBL VACCIN AB							34	0.2%	9	0.1%	9	
SMITHKLINE BEECHAM plc	49	0.4%	51	0.4%	85	0.6%	58	0.4%				
THE INDEPTH NETWORK			10	0.1%	4	0.0%	6	0.0%				
THE ROCKEFELLER FOUNDATION	6	0.0%	49	0.4%	140	1.0%	86	0.6%	79	0.6%	79	
THE WELLCOME TRUST							38	0.2%				
TOMEN CORPORATION			17	0.1%			3	0.0%				
UCB-OSMOTIC/SIDAC	38	0.3%										
UMEA UNIVERSITY							13	0.1%				
UNAIDS	4	0.0%	9	0.1%	6	0.0%						
UNIVERSITY OF BASEL			1	0.0%	24	0.2%	67	0.4%	73	0.5%	73	
UNOCAL FOUNDATION	35	0.3%	70	0.5%	79	0.6%	67	0.4%	9	0.1%	9	
DISASTER / EPIDEMIC :												
AusAID	13	0.1%										
UNOCAL, Cairn, Shell & Occidental	79	0.6%	15	0.1%	155	1.1%			156	1.1%	156	
SDC			5	0.0%	7	0.1%			6	0.0%	6	
OTHERS (SS)	91	0.7%	27	0.2%	47	0.3%	90	0.6%	118	0.9%	118	
TOTAL OTHERS	623	4.5%	501	3.6%	765	5.6%	890	5.8%	744	5.5%	744	

TABLE - 2

ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH
REVENUE BY SOURCES AND EXPENDITURE BY CATEGORIES - 2000 TO 2003

(IN US\$'000)

	2000 ACTUAL		2001 ACTUAL		2002 BUDGET		2002 FORECAST		2003 BUDGET		INCREASE(DECREASE) BUDGET 2003 FORECAST 2002	
REVENUE:												
UNRESTRICTED FUNDS	1,732	11%	2,638	18%	2,488	16%	2,730	16%	2,753	19%	23	1%
RESTRICTED - INDIRECT	1,404	10%	1,349	9%	1,403	10%	1,699	11%	1,285	9%	(414)	-24%
RESTRICTED - PROJECTS / PROGRAMS	10,694	73%	10,005	68%	9,882	68%	10,789	68%	9,608	67%	(1,181)	-11%
CONTRIBUTIONS	13,830	94%	13,992	95%	13,773	94%	15,218	96%	13,646	95%	(1,572)	-10%
EXCHANGE GAINS (NET)	133	1%	120	1%	100	1%	50	0%	100	1%	50	100%
OTHER RECEIPTS	700	5%	661	4%	698	5%	667	4%	642	4%	(25)	-4%
TOTAL REVENUE	14,663	100%	14,773	100%	14,571	100%	15,935	100%	14,388	100%	(1,547)	-10%
EXPENDITURE:												
LOCAL SALARIES / WAGES	6,166	42%	6,778	46%	6,674	44%	7,093	44%	6,865	45%	(228)	-3%
INTERNATIONAL SALARIES	2,451	17%	2,175	15%	2,779	18%	2,751	17%	3,390	22%	639	23%
CONSULTANTS	323	2%	226	2%	217	1%	250	2%	255	2%	5	2%
MANDATORY COMMITTEES	81	1%	99	1%	104	1%	112	1%	106	1%	(6)	-5%
TRAVEL	583	4%	583	4%	729	5%	573	4%	565	4%	(8)	-1%
SUPPLIES AND MATERIALS	1,890	13%	1,743	12%	1,924	13%	2,088	13%	1,885	12%	(203)	-10%
REPAIR AND MAINTENANCE	199	1%	191	1%	163	1%	152	1%	104	1%	(48)	-32%
RENT, COMMUNICATION AND UTILITIES	454	3%	534	4%	471	3%	424	3%	392	3%	(32)	-8%
PRINTING AND PUBLICATION	270	2%	250	2%	306	2%	298	2%	304	2%	6	2%
TRAINING AND FELLOWSHIP	224	2%	174	1%	285	2%	213	1%	224	1%	11	5%
STAFF DEVELOPMENT	143	1%	75	1%	124	1%	183	1%	81	1%	(102)	-56%
VOLUNTARY SEVERANCE PROGRAM	288	2%										
OTHER EXPENSES	869	6%	840	6%	670	4%	1,067	7%	600	4%	(467)	-44%
TOTAL INTERNAL CASH EXPENDITURE	13,941	95%	13,668	94%	14,446	96%	15,204	95%	14,771	97%	(433)	-3%
CAPITAL EXPENDITURE	659	5%	914	6%	657	4%	799	5%	399	3%	(400)	-50%
TOTAL OPERATING CASH EXPENDITURE	14,600	100%	14,582	100%	15,103	100%	16,003	100%	15,170	100%	(833)	-5%
NET CASH SURPLUS/(DEFICIT)	63		191		(532)		(68)		(782)		(714)	
DEPRECIATION	920		964		900		954		897		(57)	
NET OPERATING SURPLUS/(DEFICIT)	(857)		(773)		(1,432)		(1,022)		(1,679)		(657)	

Note: Where necessary prior years figures have been regrouped to conform with current year forecast.

TABLE - 3
ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH
UNRESTRICTED AND RESTRICTED REVENUE AND EXPENDITURE 2000 TO 2003

(IN US\$'000)

	2000	2001			2002			2002			2003		
	ACTUAL	UNRESTR.	RESTR.	TOTAL	UNRESTR.	RESTR.	TOTAL	UNRESTR.	RESTR.	TOTAL	UNRESTR.	RESTR.	TOTAL
REVENUE:													
UNRESTRICTED FUNDS	1,732	2,638		2,638	2,488		2,488	2,730		2,730	2,753		2,753
RESTRICTED - INDIRECT	1,404	1,349		1,349	1,403		1,403	1,699		1,699	1,285		1,285
RESTRICTED - PROJECTS / PROGRAMS	10,694		10,005	10,005		9,882	9,882		10,789	10,789		9,608	9,608
CONTRIBUTIONS	13,830	3,987	10,005	13,992	3,891	9,882	13,773	4,429	10,789	15,218	4,038	9,608	13,646
EXCHANGE GAINS (NET)	133	120		120	100		100	50		50	100		100
OTHER RECEIPTS	700	640	21	661	680	18	698	653	14	667	632	10	642
TOTAL REVENUE	14,663	4,747	10,026	14,773	4,671	9,900	14,571	5,132	10,803	15,935	4,770	9,618	14,388
EXPENDITURE:													
LOCAL SALARIES / WAGES	6,166	2,349	4,429	6,778	2,878	3,796	6,674	3,204	3,889	7,093	3,312	3,553	6,865
INTERNATIONAL SALARIES	2,451	1,023	1,152	2,175	1,601	1,178	2,779	1,324	1,427	2,751	1,859	1,531	3,390
CONSULTANTS	323	20	206	226	12	205	217	29	221	250	4	251	255
MANDATORY COMMITTEES	81	94	5	99	104		104	104	8	112	106		106
TRAVEL	583	35	548	583	41	688	729	89	484	573	53	512	565
SUPPLIES AND MATERIALS	1,890	747	996	1,743	692	1,232	1,924	875	1,213	2,088	825	1,060	1,885
REPAIR AND MAINTENANCE	199	88	103	191	45	118	163	62	90	152	33	71	104
RENT, COMMUNICATION AND UTILITIES	454	346	188	534	263	208	471	294	130	424	266	126	392
PRINTING AND PUBLICATION	270	153	97	250	155	151	306	168	130	298	176	128	304
TRAINING AND FELLOWSHIP	224	26	148	174	18	267	285	20	193	213	5	219	224
STAFF DEVELOPMENT	143		75	75	50	74	124		183	183		81	81
VOLUNTARY SEVERANCE PROGRAM	288												
OTHER EXPENSES	869	294	546	840	254	416	670	(266)	1,333	1,067	(76)	676	600
INTERDEPARTMENTAL SERVICES		(769)	769		(1,019)	1,019		(846)	846		(1,086)	1,086	
TOTAL INTERNAL CASH EXPENDITURE	13,941	4,406	9,262	13,668	5,094	9,352	14,446	5,057	10,147	15,204	5,477	9,294	14,771
CAPITAL EXPENDITURE	659	150	764	914	109	548	657	143	656	799	75	324	399
TOTAL OPERATING CASH EXPENDITURE	14,600	4,556	10,026	14,582	5,203	9,900	15,103	5,200	10,803	16,003	5,552	9,618	15,170
NET CASH SURPLUS/(DEFICIT)	63	191		191	(532)		(532)	(68)		(68)	(782)		(782)
DEPRECIATION	920	964		964	900		900	954		954	897		897
NET OPERATING SURPLUS/(DEFICIT)	(857)	(773)		(773)	(1,432)		(1,432)	(1,022)		(1,022)	(1,679)		(1,679)

Note: Where necessary prior years figures have been regrouped to conform with current year forecast.

TABLE - 4
ICDDR,B: CENTRE FOR HEALTH AND POPULATION RESEARCH
CONTRIBUTIONS BY UNRESTRICTED AND RESTRICTED FUNDS 2000 - 2003

(IN US\$'000)

	2000 - ACTUAL		2001 - ACTUAL				2002 - BUDGET				2002 - FORECAST				2003 - BUDGET				2003 - STATUS	
	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	FIRM	ESTIM.
UNRESTRICTED FUNDS:																				
AUSTRALIA - AusAID	297	2.1%	154		154	1.1%	145		145	1.1%	163		163	1.1%	161		161	1.2%	161	
BANGLADESH	191	1.4%	186		186	1.3%	186		186	1.4%	155		155	1.0%	173		173	1.3%	173	
BELGIUM - BADC / BTC	(11)	-0.1%	64		64	0.5%														
CANADA - CIDA	204	1.5%	192		192	1.4%	192		192	1.4%	48		48	0.3%	-		-		-	
NETHERLANDS	214	1.5%	1,004		1,004	7.2%	1,004		1,004	7.3%	1,101		1,101	7.2%	1,101		1,101	8.1%	1,101	
SAUDI ARABIA	52	0.4%	50		50	0.4%	50		50	0.4%	50		50	0.3%	50		50	0.4%	50	
SRI LANKA	4	0.0%	4		4	0.0%	4		4	0.0%	4		4	0.0%	4		4	0.0%	4	
SWEDEN - SIDA / SAREC	272	2.0%	231		231	1.7%	183		183	1.3%	224		224	1.5%	250		250	1.8%	250	
SWITZERLAND - SDC	252	1.8%	524		524	3.7%	524		524	3.8%	500		500	3.3%	500		500	3.7%	500	
UK - DFID											147		147	1.0%	176		176	1.3%	176	
UNITED STATES - USAID	275	2.0%	338		338	2.4%	200		200	1.5%	338		338	2.2%	338		338	2.5%		338
ARAB GULF FUND	(18)	-0.1%	(109)		(109)	-0.8%														
TOTAL UNRESTRICTED	1,732	12.5%	2,638		2,638	18.9%	2,488		2,488	18.1%	2,730		2,730	17.9%	2,753		2,753	20.2%	2,411	342
RESTRICTED PROJECTS/PROGRAMS FUNDS:																				
AUSTRALIA - AusAID	60	0.4%		104	104	0.7%	12	88	100	0.7%	6	44	50	0.3%	13	54	67	0.5%	67	
BANGLADESH	306	2.2%	63	405	468	3.3%	37	233	270	2.0%	117	582	699	4.6%	92	398	490	3.6%	490	
BELGIUM - BADC/ BTC	169	1.2%		176	176	1.3%		186	186	1.4%		110	110	0.7%		84	84	0.6%	84	
CENTERS FOR DISEASE CONT. & PREV.			3	10	13	0.1%	13	50	63	0.5%	27	141	168	1.1%	24	113	137	1.0%	137	
EUROPEAN UNION - BHARP	910	6.6%		758	758	5.4%		174	174	1.3%		247	247	1.6%		404	404	3.0%	404	
FORD FOUNDATION	309	2.2%	37	248	285	2.0%	26	175	201	1.5%	27	180	207	1.4%						
GATES - GoB AWARD											5	498	503	3.3%	22	466	488	3.6%	488	
INTERNATIONL VACCINE INSTITUTE			16	102	118	0.8%	71	305	376	2.7%	65	280	345	2.3%	117	492	609	4.5%	609	
JAPAN	614	4.4%	104	759	863	6.2%	92	717	809	5.9%	51	539	590	3.9%	34	426	460	3.4%	460	
NETHERLANDS	24	0.2%	1	6	7	0.1%					1	9	10	0.1%	3	19	22	0.2%	22	
NEW ENGLAND MEDICAL CENTER	66	0.5%	30	96	126	0.9%	19	62	81	0.6%	45	147	192	1.3%	36	115	151	1.1%	151	
SWEDEN - SIDA/SAREC	172	1.2%	37	241	278	2.0%	85	411	496	3.6%	72	465	537	3.5%	58	301	359	2.6%	359	
SWITZERLAND - SDC	584	4.2%	20	217	237	1.7%														
SWISS RED CROSS	243	1.8%	23	151	174	1.2%	24	161	185	1.3%	22	147	169	1.1%	23	152	175	1.3%	175	
THRASHER RESEARCH FUND	(51)	-0.4%	3	49	52	0.4%	10	152	162	1.2%	16	225	241	1.6%	5	79	84	0.6%	84	
UNITED KINGDOM - DFID (See Table - 4A)	759	5.5%	87	741	828	5.9%	61	1,192	1,253	9.1%	5	1,390	1,395	9.2%	1,952	1,952	1,952	14.3%	1,952	
UNDP/UNOPS - Japan	44	0.3%		11	11	0.1%		173	173	1.3%		150	150	1.0%		111	111	0.8%	111	
UNICEF	3	0.0%	19	199	218	1.6%	22	233	255	1.9%	22	235	257	1.7%	7	69	76	0.6%	76	
USAID/Dhaka (See Table - 4A)	2,762	20.0%	393	1,840	2,233	16.0%	506	2,106	2,612	19.0%	797	1,482	2,279	15.0%	451	1,480	1,931	14.2%	1,931	
USAID/Washington (See Table - 4A)	1,917	13.9%	340	1,515	1,855	13.3%	292	1,345	1,637	11.9%	291	1,235	1,526	10.0%	297	1,191	1,488	10.9%	1,488	
USA - NIH (See Table - 4A)	888	6.4%		775	775	5.5%		566	566	4.1%		434	434	2.9%		257	257	1.9%	257	
USA - Other Sources (See Table - 4A)	197	1.4%	23	129	152	1.1%	15	169	184	1.3%	38	304	342	2.2%	12	139	151	1.1%	151	
WORLD BANK - NCoE	973	7.0%	99	659	758	5.4%														
WYETH PHARMACEUTICALS, INC.			2	8	10	0.1%	34	134	168	1.2%	33	127	160	1.1%	35	117	152	1.1%	152	
WHO	242	1.7%	1	175	176	1.3%		169	169	1.2%	4	477	481	3.2%		247	247	1.8%	247	
CENTRE ENDOWMENT FUND	66	0.5%		69	69	0.5%						106	106	0.7%		54	54	0.4%	54	
HOSPITAL ENDOWMENT FUND	200	1.4%						400	400	2.9%		400	400	2.6%		200	200	1.5%	200	
OTHERS (See Table - 4B)	641	4.6%	48	562	610	4.4%	84	681	765	5.6%	55	835	890	5.8%	56	688	744	5.5%	744	
TOTAL RESTRICTED	12,098	87.5%	1,349	10,005	11,354	81.1%	1,403	9,882	11,285	81.9%	1,699	10,789	12,488	82.1%	1,285	9,608	10,893	79.8%	10,893	
TOTAL CONTRIBUTIONS	13,830	100%	3,987	10,005	13,992	100%	3,891	9,882	13,773	100%	4,429	10,789	15,218	100%	4,038	9,608	13,646	100%	13,304	342

Note: Where necessary prior years figures have been regrouped to conform with current year forecast.

TABLE - 4 A
ICDDR,B - CENTRE FOR HEALTH AND POPULATION RESEARCH
SUMMARY CONTRIBUTIONS BY RESTRICTED FUNDS 2000 - 2003

(IN US\$'000)

	2000 - ACTUAL		2001 - ACTUAL				2002 - BUDGET				2002 - FORECAST				2003 - BUDGET				2003 - STATUS	
	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	FIRM	ESTIM.
RESTRICTED FUNDS:																				
UNITED KINGDOM - DFID:																				
- DFID / Equitable Health				79	79	0.6%	56	1,155	1,211	8.8%		1,345	1,345	8.8%		1,952	1,952	14.3%		1,952
- DFID / HIV	168	1.2%		11	11	0.1%						10	10	0.1%						
- DFID / Health Economist	94	0.7%	41	187	228	1.6%	5	37	42	0.3%	5	35	40	0.3%						
- DFID / Modernization of Matlab DSS	497	3.6%	46	464	510	3.6%														
Sub-total	759	5.5%	87	741	828	5.9%	61	1,192	1,253	9.1%	5	1,390	1,395	9.2%		1,952	1,952	14.3%		1,952
UNITED STATES:																				
- USAID/Dhaka																				
- ORP/FHRP	2,528	18.3%	393	1,608	2,001	14.3%	506	2,046	2,552	18.5%	797	1,394	2,191	14.4%	451	1,480	1,931	14.2%		1,931
- JSI	234	1.7%		232	232	1.7%		60	60	0.4%		88	88	0.6%						
Sub-total	2,762	20.0%	393	1,840	2,233	16.0%	506	2,106	2,612	19.0%	797	1,482	2,279	15.0%	451	1,480	1,931	14.2%		1,931
- USAID/Washington																				
- Research and Others	1,818	13.1%	340	1,515	1,855	13.3%	259	1,213	1,472	10.7%	257	1,096	1,353	8.9%	243	974	1,217	8.9%		1,217
- Nepal	99	0.7%					33	132	165	1.2%	34	139	173	1.1%	54	217	271	2.0%		271
Sub-total	1,917	13.9%	340	1,515	1,855	13.3%	292	1,345	1,637	11.9%	291	1,235	1,526	10.0%	297	1,191	1,488	10.9%		1,488
- USA - NIH																				
- CASE WESTERN RESERVE UNIVERSITY								96	96	0.7%		61	61	0.4%		60	60	0.4%		60
- JOHNS HOPKINS UNIVERSITY	542	3.9%		407	407	2.9%		266	266	1.9%		48	48	0.3%						
- NIH												12	12	0.1%						
- UNIVERSITY OF MARYLAND & BIOTECH. INSTI.	176	1.3%		133	133	1.0%		50	50	0.4%		81	81	0.5%		16	16	0.1%		16
- MASSACHUSETTS GENERAL HOSPITAL	6	0.0%		144	144	1.0%		74	74	0.5%		136	136	0.9%		134	134	1.0%		134
- RAND CORPORATION	24	0.2%																		
- STANFORD UNIVERSITY				11	11	0.1%		16	16	0.1%		25	25	0.2%		3	3	0.0%		3
- UNIVERSITY OF CALIFORNIA - DAVIS	55	0.4%		2	2	0.0%						6	6	0.0%		2	2	0.0%		2
- UNIVERSITY OF ALABAMA	5	0.0%		2	2	0.0%														
- UNIVERSITY OF VIRGINIA	80	0.6%		76	76	0.5%		64	64	0.5%		65	65	0.4%		42	42	0.3%		42
Sub-total	888	6.4%		775	775	5.5%		566	566	4.1%		434	434	2.9%		257	257	1.9%		257
- USA OTHER SOURCES:																				
- UNIVERSITY OF PENNSYLVANIA	12	0.1%		16	16	0.1%		12	12	0.1%		4	4	0.0%						
- HOWARD HUGHES MEDICAL INSTITUTE	3	0.0%	5	43	48	0.3%	5	42	47	0.3%	5	42	47	0.3%	5	45	50	0.4%		50
- INTERNATIONAL SCIENCE & TECHNO. INSTI.											25	95	120	0.8%	3	11	14	0.1%		14
- OFFICE OF U.S. FOREIGN DISASTER ASSTN.	43	0.3%		1	1	0.0%		74	74	0.5%		134	134	0.9%		68	68	0.5%		68
- JOHNS HOPKINS UNIVERSITY	139	1.0%	18	69	87	0.6%	10	41	51	0.4%	8	29	37	0.2%	4	15	19	0.1%		19
Sub-total	197	1.4%	23	129	152	1.1%	15	169	184	1.3%	38	304	342	2.2%	12	139	151	1.1%		151

TABLE - 4 B
ICDDR,B - CENTRE FOR HEALTH AND POPULATION RESEARCH
OTHERS CONTRIBUTIONS BY RESTRICTED FUNDS 2000 - 2003

(IN US\$'000)

	2000 - ACTUAL		2001 - ACTUAL				2002 - BUDGET				2002 - FORECAST				2003 - BUDGET				FIRM	ESTIM.
	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%	UNRESTR.	RESTR.	TOTAL	%		
RESTRICTED FUNDS: - OTHERS																				
AMERICAN EXPRESS FOUNDATION			3	10	13	0.1%														
BGS ARGOSS	10	0.1%																		
BDG/DGHS/ARI	3	0.0%																		
CANADA-CIDA/CHC	15	0.1%																		
CIRCLE AROUND THE CENTRE				22	22	0.2%					3	72	75	0.5%	18	18	0.1%	18	0.1%	
CYTOS PHARMACEUTICALS INC.	49	0.4%		25	25	0.2%		5	5	0.0%		50	50	0.3%	5	5	0.0%	5	0.0%	
DARTMOUTH COLLEGE				11	11	0.1%						3	3	0.0%						
DUNCAN BROTHERS (BANGLADESH) LTD.	10	0.1%	2	6	8	0.1%						56	56	0.4%		95	95	0.7%	95	
ELLISON FOUNDATION											1	7	8	0.1%	3	34	37	0.3%	37	
FUTURES GROUP	67	0.5%	(9)	(37)	(46)	-0.3%														
GEORGE MASON FOUNDATION												7	7	0.0%						
JAPAN - JICWELS	50	0.4%		80	80	0.6%		98	98	0.7%		62	62	0.4%		24	24	0.2%	24	
JAPAN - EMBASSY				78	78	0.6%														
JAPAN - UNIVERSITY OF TOKYO			9	33	42	0.3%		2	2	0.0%	7	29	36	0.2%						
LONDON SCHOOL OF HYG.&TROP.MED.												26	26	0.2%		42	42	0.3%	42	
MACRO INTERNATIONAL INC.	(1)	0.0%																		
NESTLE RESEARCH FOUNDATION	20	0.1%		24	24	0.2%		84	84	0.6%		69	69	0.5%		55	55	0.4%	55	
NATIONAL INSTITUTE ON AGING												24	24	0.2%		18	18	0.1%	18	
NORWAY - NORAD	4	0.0%																		
NORTHFIELD LABORATORIES	18	0.1%																		
NOVARTIS NUTRITION RESEARCH AG	12	0.1%	8	23	31	0.2%														
NEWCASTLE UNIVERSITY	63	0.5%	16	52	68	0.5%	4	12	16	0.1%	2	6	8	0.1%						
PRAXIS	(4)	0.0%																		
PLAN INTERNATIONAL	13	0.1%																		
PROCTER & GAMBLE COMPANY	1	0.0%													4	4	0.0%			
SAVE THE CHILDREN (USA)	(4)	0.0%																		
SBL VACCIN AB											7	27	34	0.2%	2	7	9	0.1%	9	
SMITHKLINE BEECHAM plc	49	0.4%	10	41	51	0.4%	17	68	85	0.6%	6	52	58	0.4%						
THE INDEPTH NETWORK				10	10	0.1%		4	4	0.0%		6	6	0.0%						
THE ROCKEFELLER FOUNDATION	6	0.0%	2	47	49	0.4%	21	119	140	1.0%	13	73	86	0.6%	10	69	79	0.6%	79	
THE WELLCOME TRUST												38	38	0.2%						
TOMEN CORPORATION			3	14	17	0.1%					1	2	3	0.0%						
UCB-OSMOTIC/SIDAC	38	0.3%																		
UMEA UNIVERSITY																				
UNAIDS	4	0.0%		9	9	0.1%		6	6	0.0%		13	13	0.1%						
UNIVERSITY OF BASEL				1	1	0.0%		24	24	0.2%	4	63	67	0.4%	8	65	73	0.5%	73	
UNOCAL FOUNDATION	35	0.3%	4	66	70	0.5%	8	71	79	0.6%	11	56	67	0.4%	2	7	9	0.1%	9	
DISASTER / EPIDEMIC :																				
AusAID	13	0.1%																		
UNOCAL, Calm, Shell & Occidental	79	0.6%		15	15	0.1%	31	124	155	1.1%					31	125	156	1.1%	156	
SDC				5	5	0.0%		7	7	0.1%						6	6	0.0%	6	
OTHERS (SS)	91	0.7%		27	27	0.2%		47	47	0.3%						118	118	0.9%	118	
TOTAL RESTRICTED - OTHERS	641	4.6%	48	562	610	4.4%	84	681	765	5.6%	55	835	890	5.8%	56	688	744	5.5%	744	

TABLE - 5
ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH
UNRESTRICTED PROJECTS/PROGRAMS AND MANAGEMENT EXPENDITURE 2000 TO 2003

(IN US\$ '000)

	2000 ACTUAL		2001 ACTUAL				2002 BUDGET				2002 FORECAST				2003 BUDGET			
	NET COSTS	%	GROSS COSTS	RECOVERY	NET COSTS	%	GROSS COSTS	RECOVERY	NET COSTS	%	GROSS COSTS	RECOVERY	NET COSTS	%	GROSS COSTS	RECOVERY	NET COSTS	%
PROJECTS/PROGRAMS																		
CLINICAL SCIENCES:																		
DHAKA HOSPITAL DIVISIONAL	621	4.3%	1,390	(391)	999	6.9%	1,457	(640)	817	5.4%	1,596	(843)	753	4.7%	1,642	(503)	1,139	7.5%
	96	0.7%	60	(58)	2	0.0%	221	(58)	163	1.1%	133	(63)	70	0.4%	370	(69)	301	2.0%
PUBLIC HEALTH SCIENCES:																		
MATLAB CLINICAL RESEARCH	194	1.3%	373	(137)	236	1.6%	381	(135)	246	1.6%	353	(73)	280	1.7%	342	(71)	271	1.8%
MATLAB ADMINISTRATION	218	1.5%	266	(60)	206	1.4%	269	(69)	200	1.3%	316	(70)	246	1.5%	286	(68)	218	1.4%
MATLAB COMMUNITY RESEARCH DIVISIONAL	95	0.7%	184		184	1.3%	262		262	1.7%	252		252	1.6%	223		223	1.5%
HEALTH & DEMOGRAPHIC SURVEILLANCE	173	1.2%	315		315	2.2%	386		386	2.6%	410		410	2.6%	517		517	3.4%
	43	0.3%	30	(1)	29	0.2%	80		80	0.5%	63		63	0.4%	122		122	0.8%
LABORATORY SCIENCES:																		
LABORATORY SERVICES DIVISIONAL	235	1.6%	956	(731)	225	1.5%	1,253	(791)	462	3.1%	1,016	(696)	320	2.0%	1,159	(749)	410	2.7%
			120	(120)			113	(113)			148	(143)	5	0.0%	100	(100)		
HEALTH SCIENCES & INFECTIOUS DISEASES DIVISIONAL			85		85	0.6%	364		364	2.4%	470		470	2.9%	485		485	3.2%
INFORMATION SCIENCES:																		
DISC	188	1.3%	266	(13)	253	1.7%	270	(21)	249	1.6%	220	(15)	205	1.3%	243	(12)	231	1.5%
TRAINING & DISSEMINATION	33	0.2%	153	(100)	53	0.4%	137	(203)	(66)	-0.4%	172	(134)	38	0.2%	130	(100)	30	0.2%
COMPUTER SERVICES DIVISIONAL	19	0.1%	162	(108)	54	0.4%	163	(92)	71	0.5%	128	(112)	16	0.1%	116	(95)	21	0.1%
			14		14	0.1%	11		11	0.1%	17		17	0.1%	21		21	0.1%
TOTAL PROJECTS/PROGRAMS	1,915	13.2%	4,374	(1,719)	2,655	18.2%	5,367	(2,122)	3,245	21.3%	5,294	(2,149)	3,145	19.7%	5,756	(1,767)	3,989	26.3%
MANAGEMENT																		
DIRECTOR'S BUREAU	336	2.3%	302		302	2.1%	318		318	2.1%	316		316	2.0%	215		215	1.4%
EXTERNAL RELATIONS & INSTITUTIONAL DEV.	75	0.5%	84		84	0.6%	215		215	1.4%	257		257	1.6%	324		324	2.1%
POLICY AND PLANNING	37	0.3%	149		149	1.0%	149		149	1.0%	151		151	0.9%	153		153	1.0%
BoT & COMMITTEES	100	0.7%	108		108	0.7%	121		121	0.8%	116		116	0.7%	126		126	0.8%
ADMINISTRATION & PERSONNEL	598	4.1%	922	(191)	731	4.9%	748	(201)	547	3.6%	883	(261)	622	3.9%	837	(223)	614	4.0%
FINANCE	334	2.3%	387		387	2.7%	366		366	2.4%	420		420	2.6%	382	(378)	4	0.0%
VOLUNTARY SEVERANCE PACKAGE	288	2.0%																
CAPITAL EXPENDITURE	48	0.3%	150		150	1.0%	109		109	0.7%	143		143	0.9%	75		75	0.5%
OTHER	169	1.2%	77	(87)	(10)	-0.1%	206	(73)	133	0.9%	128	(98)	30	0.2%	132	(80)	52	0.3%
TOTAL MANAGEMENT	1,985	13.5%	2,179	(278)	1,901	13.0%	2,232	(274)	1,958	12.8%	2,414	(359)	2,055	12.8%	2,244	(681)	1,563	10.1%
TOTAL PROJECTS/PROGRAMS AND MANAGEMENT	3,900	26.7%	6,553	(1,997)	4,556	31.2%	7,599	(2,396)	5,203	34.5%	7,708	(2,508)	5,200	32.5%	8,000	(2,448)	5,552	36.6%
UNRESTRICTED EXPENDITURE	3,900	26.7%			4,556	31.2%			5,203	34.5%			5,200	32.5%			5,552	36.6%
RESTRICTED EXPENDITURE	10,700	73.3%			10,026	68.8%			9,900	65.5%			10,803	67.5%			9,618	63.4%
TOTAL EXPENDITURE	14,600	100.0%			14,582	100.0%			15,103	100.0%			16,003	100.0%			15,170	100.0%

Note: Where necessary prior years figures have been regrouped to conform with current year forecast.

TABLE - 6
ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH
UNRESTRICTED OTHER RECEIPTS 2000 TO 2003

(IN US\$ '000)

	ACTUAL 2000		2001 ACTUAL				2002 BUDGET				2002 FORECAST				2003 BUDGET			
	NET COSTS	%	GROSS COSTS	RECOVERY	NET COSTS	%	GROSS COSTS	RECOVERY	NET COSTS	%	GROSS COSTS	RECOVERY	NET COSTS	%	GROSS COSTS	RECOVERY	NET COSTS	%
PROJECTS/PROGRAMS																		
CLINICAL SCIENCES:																		
DHAKA HOSPITAL	(20)	2.9%		(24)	(24)	3.6%		(13)	(13)	1.9%		(16)	(16)	2.4%		(13)	(13)	2.0%
HOSPITAL SURVEILLANCE DIVISIONAL											(2)	(2)	0.3%					
PUBLIC HEALTH SCIENCES:																		
MATLAB CLINICAL RESEARCH			43	(60)	(17)	2.6%	45	(68)	(23)	3.3%	41	(66)	(25)	3.7%	42	(62)	(20)	3.1%
MATLAB ADMINISTRATION	(15)	2.1%																
MATLAB COMMUNITY RESEARCH DIVISIONAL	(1)	0.1%																
HEALTH & DEMOGRAPHIC SURVEILLANCE																		
LABORATORY SCIENCES:																		
LABORATORY SERVICES DIVISIONAL	(414)	59.1%		(373)	(373)	56.4%		(427)	(427)	61.2%		(421)	(421)	63.1%		(429)	(429)	66.8%
HEALTH SCIENCES & INFECTIOUS DISEASES DIVISIONAL											2	(2)			1		1	-0.2%
INFORMATION SCIENCES:																		
DISC	(7)	1.0%		(8)	(8)	1.2%		(16)	(16)	2.3%		(15)	(15)	2.2%		(15)	(15)	2.3%
TRAINING & DISSEMINATION	(23)	3.3%		(8)	(8)	1.2%		(19)	(19)	2.7%		(15)	(15)	2.2%		(10)	(10)	1.6%
COMPUTER SERVICES DIVISIONAL	(1)	0.1%																
TOTAL PROJECTS/PROGRAMS	(481)	68.8%	43	(473)	(430)	65.1%	45	(543)	(498)	71.1%	43	(537)	(494)	74.1%	43	(529)	(486)	75.7%
MANAGEMENT																		
DIRECTOR'S BUREAU											(1)	(1)	0.1%					
EXTERNAL RELATIONS & INSTITUTIONAL DEV. POLICY AND PLANNING																		
BoT & COMMITTEES																		
ADMINISTRATION & PERSONNEL	(78)	11.1%	45	(133)	(88)	13.2%	59	(143)	(84)	12.0%	60	(166)	(106)	15.9%	69	(171)	(102)	15.9%
FINANCE	(15)	2.1%		(44)	(44)	6.7%		(17)	(17)	2.4%		(31)	(31)	4.6%		(19)	(19)	3.0%
VOLUNTARY SEVERANCE PACKAGE																		
CAPITAL EXPENDITURE																		
OTHER	(120)	17.1%		(78)	(78)	11.8%		(81)	(81)	11.6%		(21)	(21)	3.1%		(25)	(25)	3.9%
TOTAL PROJECTS/PROGRAMS AND MANAGEMENT	(213)	30.3%	45	(255)	(210)	31.8%	59	(241)	(182)	25.9%	60	(219)	(159)	23.8%	69	(215)	(146)	22.5%
UNRESTRICTED OTHER RECEIPTS	(694)	99.1%	88	(728)	(640)	96.8%	104	(784)	(680)	97.4%	103	(756)	(653)	97.9%	112	(744)	(632)	98.4%
RESTRICTED OTHER RECEIPTS	(6)	0.9%			(21)	3.2%			(18)	2.6%			(14)	2.1%			(10)	1.6%
TOTAL OTHER RECEIPTS	(700)	100.0%			(661)	100.0%			(698)	100.0%			(667)	100.0%			(642)	100.0%

Note: Where necessary prior years figures have been regrouped to conform with current year forecast.

Annexures:

- A** Glossary of Acronyms and Abbreviations
- B** Report of the Finance Committee of June 08, 2002

Annexure A

Glossary of Acronyms and Abbreviations

AGF	Arab Gulf Fund
AID	Agency for International Development
ARGOSS	Advisory and Research Group on Geo Observation Systems and Services
ARI	Acute Respiratory Tract Infection
ASCON	Annual Scientific Conference
ASSTN.	Assistance
AusAID	Australian Aid for International Development
BADC	Belgian Administration for Development Cooperation
BDG	Bangladesh Government
BGS	British Geological Survey
BHARP	Bangladesh Health and Family Welfare Action Research Project
BINP	Bangladesh Integrated Nutrition Programme
BIOTECH	Biotechnology
BoT	Board of Trustees
BT	Board of Trustees
BTC	Belgian Technical Cooperation
CDC	Centers for Disease Control and Prevention
CEF	Centre Endowment Fund
CFO	Chief Finance Officer
CHC	Canadian High Commission
CIDA	Canadian International Development Agency
Co.	Company
communi.	communication
Cont	Continued
CONT. & PREV.	Control and Prevention; Centers for Disease (CDC)
CSD	Clinical Sciences Division
Dev.	Development
DFID	Department for International Development (UK)
DGHS	Director General of Health Services
DISC	Dissemination Information Services Centre
DSS	Demographic Surveillance System
ER&ID	External Relations & Institutional Development
Estim	Estimated
EU	European Union
exp.	expenditure
FHRP	Family Health Research Project
Fin	Finance
Gates/GoB	Gates - Government of Bangladesh
GoB	Government of the People's Republic of Bangladesh
HC-LFMO	High Commission-Local Fund Management Office
HEF	Hospital Endowment Fund
HIV	Human Immune Deficiency Virus

HR	Human Resources
HSID	Health Sciences and Infectious Diseases Division
Hyg. & Trop. Med.	Hygiene & Tropical Medicine; London School of
INC.	Incorporated
INSTI	Institute
ISD	Information Sciences Division
IVI	International Vaccine Institute
JICWELS	Japan International Cooperation of Welfare Services
JSI	John Snow Inc.
Jun	June
LSD	Laboratory Sciences Division
LTD.	Limited
MIS	Management Information System
NBR	National Board of Revenue
NCoE	Nutrition Centre of Excellence
NEMC	New England Medical Center Hospitals, Inc.
NIDI	Netherlands Interdisciplinary Demographic Institute
NIH	National Institutes of Health
NORAD	Norwegian Administration for Development
Nov	November
ORP	Operations Research Project
P & P	Policy and Planning
PHSD	Public Health Sciences Division
PI	Principal Investigator
Prof.	Professor
PTE.	Private
Restr	Restricted
SAREC	Swedish Agency for Research Cooperation with Developing Countries
SDC	Swiss Development Agency for Cooperation
SIDA	Swedish International Development Cooperation Agency
Sidac	UCB Sidac Limited Registered Office
SS	Self Sustaining Funds
TECHNO	Technology
TIAA-CREF	TIAA-CREF Trust Company FSB
UCB	UCB Fims PLC - Osmotics Division
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
Unrestr	Unrestricted
US; USA	United States of America
USAID/D	United States Agency for International Development / Dhaka
USAID/W	United States Agency for International Development / Washington
vs.	versus
WB	World Bank
WHO	World Health Organization

Minutes of the Finance Committee
Saturday 8 June 2002

Present:

Members of the Board of Trustees

Prof Marian Jacobs (Chair of the Board)	Prof David Sack (Director)
Prof AK Azad Khan (Chair, Finance Committee)	Dr Ricardo Uauy Dagach
Prof NK Ganguly	Prof Terence H Hull
Dr Nobukatsu Ishikawa	Prof Jane Anita Kusin
Dr Claudio F Lanata	Mr M Fazlur Rahman
Prof Marcel Tanner	Prof Carol Vlassoff
Dr I Kaye Wachsmuth	

Absent (with regrets):

Dr Rolf Carriere
Mr Anisul Huq Chowdhury
Dr Maimunah Bte Abdul Hamid
Dr Tikki Pang

Invited Staff:

Division Heads, Chief Finance Officer, Head, HR, Ms Vanessa Brooks (ER&ID), Dr Anowar Hossain, Mrs Shamima Moin, Mr M A Samad, Mr Sk Abdul Matin (Finance personnel).

Minute Secretary: Loretta Saldanha

Prof. Azad Khan welcomed all those present at the meeting and invited Mr. Stephen Sage, CFO to present the Finance report.

Mr. Sage thanked the members of the Board for inviting him to present his report, introduced the members of his finance team and reported that he was extremely pleased to work with such a professional group of individuals in his section.

He briefly highlighted the following:

- 2001 Actual Results (historical results)

Auditors' Opinion
Contributions
Project Contributions
Core Contributions
Donor Base
Expenditures
Operating Surplus/Deficit

Agenda 1: 2001 Auditor's Report and Audited Financial Statements

The auditors' opinion was clean and their report includes one qualification. Management does not agree with the qualification for not including the asset and liabilities of "ICDDR,B Employees Separation Payment Fund" as the Centre has no control over these funds. This inclusion would materially distort the true financial position of the Centre and inflate the balance sheets.

Overall there were no disagreements with the auditors and no surprises in the accounting records. (This was specifically stated in light of the recent accounting scandals with relation to ENRON.)

Revenue

1. Contributions

Contributions from Donors and Endowment Fund increased from prior year by \$ 162,000 (1.2%) from \$13,830,000 to \$ 13,992.00.

Restricted contributions decreased by 6% relative to the prior year (\$ 744,000) primarily due to less project activities funded by several donors and absence of transfer from Hospital Endowment Fund. This decline was however offset by greater funding by the Govt of Bangladesh, International Vaccine Institute, Japan and UNICEF. Unrestricted contributions increased by 52% (\$ 906,000) vs prior year due to the generous contributions by the Netherlands and SDC (Switzerland). Contributions include a write-off of \$ 109,000 due to uncertainty of collection of a receivable from the Arab Gulf Fund that has been outstanding since 1998. Efforts are however underway to collect this money that will reverse the charge. Exchange gains and other receipts also decreased.

2. Donor Base

Efforts must be made to expand donor base.

3. Expenditures

Operating cash expenditures decreased by \$ 18,000 (0.1%) from prior year.

Unrestricted (core) expenditures increased by 24%. 64% being spent on international/national salaries and consultancy payments.

Restricted (project). Expenditure decreased by 6% in line with decreased revenues.

4. Operating Surplus/Deficit

Net cash surplus excluding depreciation increased by \$ 128,000 relative to the prior year, from \$ 63,000 to \$ 191,000. \$ 81,000 greater than budget. This was due to expense control. The cumulative deficit is now down to \$ 2,926,000. This was because of a transfer of \$ 240,000 from the Reserve Fund. Total expenditures excluding depreciation increased by \$ 26,000 (0.2%) from \$15,520,000 to \$ 15,546,000.

Agenda 2: 2002 Forecast

Following the approval of the budget by the Board of Trustees in November 2001, the finance department sets its goal for the year. Mr. Sage explained the differences in purpose between budget and forecast. The forecast is the mid-term monitoring of budget. It was also explained that the Centre should have a better bottom line than budget presented in November and that risks should be managed.

The following items were highlighted under this item:

Revenue: Contributions (Restricted/Project and Unrestricted/Core)

Donor Base

Expenditures

Deficit vs Surplus

From Deficit to Breakeven

Other Opportunities

1. Revenue: Contributions

Donor and endowment funds were budgeted at \$ 13,773,000 but are now forecast to increase to \$ 15,165,000. This was 10% greater and is achievable if we are aggressive in carrying out the projects that have been committed.

2. Projected Contributions (Restricted/Unrestricted)

Restricted: This is forecast to increase significantly – \$ 1,285,000 (11%) greater than budget.. Increases are due to contributions from several large donors and spending of Gates-GoB award.

Unrestricted: This is expected to increase(\$ 107,000) primarily due to additional support from USAID/Washington.

3. Donor Base

There are currently 10 donors contributing more than \$ 400,000.

4. Expenditures

Project expenses are expected to increase proportionately to increased activity.

Unrestricted expenditures decreased due to additional support from Gates-GoB.

Unrestricted expenditures in management increased due to unplanned costs of hiring and recruitment.

Net Cash Deficit vs surplus: The forecast shows that the deficit has been narrowed considerably, and there is a good chance for breakeven by years end. We are now projecting a net \$ 45,000 deficit for the year.

5. Other Opportunities

Management is developing specific action steps to reduce the forecast deficit to achieve breakeven level for the year.

Control core costs
New donors in pipeline
Collect prior year write-off
Focus on projects with full overhead
Target is surplus of \$ 150,000

Agenda 3: FUNDS (Centre's Financial Equity)

1. **Hospital Endowment Fund.** There was a market loss in 2001, but this was less than the market loss in the general equity market because some of the fund is invested in interest bearing cash deposits. The market value was \$ 5,160,000 as of December 2001. No funds were transferred to the Centre's Operation in 2001.
2. **Centre Endowment Fund.** There was a market loss in 2001 due to stock market losses. There were no contributions in 2001. \$ 130,000 was withdrawn in 2001, and the balance was \$ 3, 385,000 at April 30, 2002.
3. **Reserve Fund.** This was created to provide financial stability for the Centre and to provide guarantee for our 2 million dollars overdraft facility. The earnings from the reserve fund, in excess of 2 million dollars (\$540,000 during the last two years) has been transferred to the Operating Fund in recent years. The target is to hold the \$2 million in this reserve fund and to continue to transfer earnings to the operating fund.
4. **Operating Fund.** The cumulative deficit is better by \$996,000 over past 3 years and stands at \$ 2,926,000 at 2001 year end. Future decreases will be a slower rate, mainly because of the lower interest rate on earnings from the reserve fund. It is planned to reduce the deficit to \$ 2,000,000 in 6 years, though we will attempt to decrease it to zero as quickly as possible.

Agenda 4: Other Items

1. Appointment of Auditors for 2002:

Price Waterhouse, Kolkata and Hoda Vasi Chowdhury & Co., Dhaka were the joint auditors for 2001 and have been the Centre's auditors for the past six years and three years respectively.

Management is recommending that the audit fee not exceed \$ 15,500 same as 2001 but that the amount not be specified in the resolution in order to give the Centre management room to negotiate the terms and conditions.

2. Bank Overdraft Facility

The Centre's current \$ 2 million overdraft facility with American Express Bank will expire on July 13, 2002. Interest rates are the bank's prime rate in the USA and the equivalent rate in Bangladesh. The facility is used for any overdraft. As a result of the large cumulative deficit of the Centre there may be an ongoing overdraft requirement to cover operating costs. This overdraft is being secured by term deposits of the Reserve Fund.

In view of this the management recommends renewing the overdraft agreement of \$ 2 million for the year to July 13, 2003.

3. Cheque Signatories:

Over the past year there have been several occasions where Finance operations were hampered by absence of present signatories. Management recommends that cheque-signing authority be extended to the following persons to prevent constraints:

Head, LSD: Dr G Balakrish Nair
Head, HSID: Dr Robert F Breiman
Head, ISD: Mr Peter Thorpe

These nominated staff are in accordance with Centre policy.

4. Reserve Fund Transfers

Maintain \$ 2,000,000 budget
Transfer earnings to Operating Fund on an ongoing basis

5. Management Information System:

Centre needs have been identified integrating Centre-wide objectives (Finance, Projects, Human Resources). This activity was carried out by an external consultant. Vendors are being identified and demonstrations scheduled.

Prof Azad Khan thanked Mr. Sage for his excellent presentation.

DISCUSSION:

Following a clarification regarding the need to transfer reserve funds, Mr. Sage explained that this fund was established to provide a "cushion" to the Centre when faced with a difficult financial situation.

In response to Prof Ganguly's question whether excess funds are totally allocated towards salaries and overheads and whether the Centre could reduce this and direct funds into functions and less into salaries.

Mr Sage explained that with regard to the annual change in salaries more than 2/3 of the money goes into salaries of project staff and that reduced or limited salaries would only save a smaller percentage of costs while perhaps leaving salaries at a competitive disadvantage.

With regard to his query re: flexibility of use of funds received, Mr Sage explained that the only flexible contributions are unrestricted (core) funds. Some donors give us restricted and unrestricted contributions.

Dr Sack reported that efforts are underway to educate donors about the need to support indirect costs and requested the Board to assist with stressing this issue.

Prof Ganguly felt that the Centre's Mission and Vision Statement will greatly assist in achieving this goal.

Prof Ganguly also queried how the Centre would handle a situation where more/less money is received from a donor. Mr. Sage explained that when more money is received, the extra funds are directed towards research, and in the case of less money, scope of activity would be trimmed.

With regard to cash flow, it was queried why the Centre needed to go into overdraft and whether there is a chance for fixed salaries could be allocated to projects. Mr. Sage reported that this year the Centre dipped into the line of credit as most donors have paid after the fact. Approximately 70% of all Centre contributions come from national governments and governments do not always pay on time. Mr. Sage further stated that the Centre tries to assign all costs to projects as much as is practical.

Dr Marcel Tanner explained that to obtain overheads the Centre should consider preparing 2 price lists. One budget should include the items that are usually supported by overheads under the items the donors who do not provide overheads will support, and one for donors who contribute towards overheads. This should however be done in consultation with the donor to ensure transparency of records.

Dr Azad Khan agreed to consider this suggestion as long as transparency was maintained with the Centre's donors and other constituencies.

Dr Terence Hull felt that the use of the term "donors" so comprehensively in the books does understate the degree of people buying the services of the Centre. Mr. Sage explained that "donor" is an institutional term and we will look how they could be categorized in the future.

Mr Sage circulated a list of the Draft Resolutions to the members for review and further action at the Full Board meeting.

The meeting concluded at 5.30 p.m.

(Note: The attachments were distributed at the meeting).

5/BT/NOV 2002

**HUMAN RESOURCES
COMMITTEE**

**BOARD OF TRUSTEES MEETING
November 2002**



CENTRE
FOR HEALTH AND
POPULATION RESEARCH

HUMAN RESOURCES COMMITTEE MEETING

HUMAN RESOURCES COMMITTEE MEETING

Saturday, 2 November 2002

Agenda

1. Approval of agenda
2. Approval of the minutes of June 2002 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. Deputy Director, D2, Director's Division
 - b. Associate Director, D1, Clinical Sciences Division
 - c. Chief Finance Officer, P5, Director's Division
 - d. Head, Human Resources, P5, Director's Division
 - e. Head, Nutrition Research Programme, P4/P5, Clinical Sciences Division
 - f. Pathologist, P4, Laboratory Sciences Division
 - g. Executive Assistant to Director, P1, Director's Division
 - 3.3 Renewal of contract
 - a. Head, Reproductive Health Unit, P5, Public Health Sciences Division
 - b. Medical Anthropologist, P4, SBSU, Public Health Sciences Division
 - 3.4 Information on new international professional staff
 - a. Head, External Relations & Institutional Development, P4, Director's Division
 - b. Operations Research Scientist, P4, Health Systems and Infectious Diseases Div.
 - c. Health Economist, P4, Health Economics Unit, Public Health Sciences Division
 - d. Senior Scientist, P4, Laboratory Sciences Division
 - e. Scientist, P4, Laboratory Sciences Division
 - f. Scientist, P4, Clinical Sciences Division
 - g. Chief Physician, P4, Clinical Sciences Division
 - 3.5 Information on new international short-term staff
 - a. Senior Associate, ER&ID, Director's Division
 - 3.6 Status of seconded staff contracts
 - a. Demographic Researcher, P4, Health Systems and Infectious Diseases Division
 - b. Scientist, ECPU, P4, Public Health Sciences Division
 - 3.7 Separation of international professional staff
 - a. Head, Human Resources, P5, Director's Division
 - b. Executive Assistant to Director, P1, Director's Division
 - c. Chief Finance Officer, P5, Director's Division
 - 3.8 List of established international professional posts

Contd...P/2

4. Selection of members of the Board of Trustees
5. Update on the ongoing Human Resources agenda
6. Staff salaries
 - 6.1 International professional category
 - 6.2 NO & GS categories
7. Any other business
 - 7.1 Associate Director, D2, PHSD
 - 7.2 Curriculum Vitae of Ms. Julia Ackley, Mr. Alec Mercer and Dr. Beena Varghese

73

74

Minutes of the Personnel and Selection Committee
Saturday 8 June 2002
13:30pm

Present:

Prof Marian Jacobs (Board Chair)	Prof David Sack (Director)
Dr Claudio Lanata (Chair, P&S Committee)	Prof Jane Kusin
Prof Carol Vlassoff	Prof AK Azad Khan
Mr Anisul Huq Chowdhury	Dr Ricardo Uauy Dagach
Dr Maimunah Bte Abdul Hamid	Prof Terry Hull
Prof N K Ganguly	Dr Nobukatsu Ishikawa
Dr Tikki Pang	Prof Marcel Tanner
Dr I Kaye Wachsmuth	

Ms Diann Hill, Head HR

Absent (with regrets): Mr Rolf Carriere; Mr M Fazlur Rahman

Invited: Administrative Council members

The Personnel and Selection Committee, chaired by Dr Claudio Lanata, met to deliberate on personnel and other human resources issues. The meeting proceeded to the agenda items for review and discussion.

1. **Approval of the agenda.** The agenda was approved.
2. **Approval of the minutes of November 2001 meeting.** Minutes were approved.
3. **Staffing:**
 - 3.1 **Overview:** Ms Diann Hill reported that during the period 1 Oct 2001 to 31 March 2002, there were 69 separations from and 43 additions to the Centre. The net separations of 26 were mainly from the projects. The Centre continues to follow the policy of restricting external recruitment of fixed-term staff.

Total numbers by categories:

International staff	-- 15
Research (scientific, support & field)	-- 589: 196 core funded; 393 project funded.
Research (administration)	-- 356: 134 core funded; 222 project funded
Support services & human resources	-- 103: all core funded
Finance	-- 31: all core funded
International seconded staff	-- 6
Short-term staff (int'l, NO & GS)	-- 2
Community Health Workers	-- 18
Health workers	-- 92
Fellows	-- 30
Contractual service holders	-- 331

Daily wagers

-- 231

Total 1804

The Centre also has 2 adjunct scientists.

Ms Hill reported that historically, the Centre reported gender as a whole. It is now reported by level of staff. This will allow management to measure itself against going forward.

3.2 Status of recruitment of international professional staff:

3.2a Associate Director, D1, Clinical Sciences Division. This vacancy was re-advertised at D1 level. 9 applications have been received including 3 from within the Centre and are under review and will be discussed further in Closed Closed session. Dr MA Salam is currently acting in the position and receiving the acting allowance since 1 October 2001.

3.2b Chief Finance Officer, P5, Director's Division. It was announced that Stephen Sage has decided for family reasons not to continue at the Centre and will be leaving in mid-September. Ads were placed in The Economist and other websites. The closing date was two days ago. The Centre will make a shortlist and submit recommendations to the Board for approval.

3.2c Head, Nutrition Research Programme, P4/5, Clinical Sciences Division. The post has been advertised in various journals and websites. Seven applications were received. Prof Sack reported that it was difficult to find suitable candidates for this position which is high priority. The Centre needs to continue the search.

3.2d Head, External Relations & Institutional Development, P4. Interviews were held the previous day and will be discussed further in Closed Closed session.

3.2e Operations Research Scientist, P4, Health Systems and Infectious Diseases Division. The search is continuing and it is anticipated that a candidate will be named within a month.

3.2f Health Economist, P4, Health Economist Unit, Public Health Sciences Division. The Centre is very eager to fill this post. Ads were placed in The Economist, The Lancet and other websites. Applications have been received. Closing date was two days ago.

3.3 Renewal of contracts

3.3a Executive Assistant to Director, P1, Director's Division. Prof Sack reported that discussions regarding the renewal of Mrs Judith Bennett Henry's contract are ongoing.

3.3b Head, Reproductive Health Programme, P5, Public Health Sciences Division. Discussions regarding the renewal of Prof Japhet Killewo's contract are ongoing.

3.4 New International Professional Staff

3.4a Associate Director, D1, Laboratory Sciences Division. Dr Balakrish Nair joined the Centre on 13 December 2001 for a period of 3 years.

3.5 Status of seconded staff contracts

3.5a Demographic Researcher, P4, PHSD. The current secondment contract of Mr Carel Van Mels will expire on 2 July 2002. The Centre is awaiting the approval of a secondment agreement with the Netherlands Interdisciplinary Demographic Institute (NIDI).

3.5b Senior Scientist, P5, LSD. Jose Bogaerts who was seconded from the BATC (now DGIC); left the Centre in December 2001 after 5 years of service. No replacement is anticipated.

3.6 New adjunct scientists

3.6a Adjunct scientist, LSD. Prof Yoshifumi Takeda, former Board member, and Professor Emeritus, Faculty of Human Life Sciences, Jissen Women's University, Tokyo, was offered a contract as Adjunct Scientist for collaborative studies with LSD for a period of 3 years effective 14 February 2002.

Dr Abdullah Baqui, former Centre scientist and Assoc Professor at Johns Hopkins University, is also contracted as an Adjunct Scientist with the Centre.

3.7 Completion of tenure

3.7a Senior Scientist, P5, Public Health Sciences Division. Dr Radheshyam Bairagi will be leaving the Centre following completion of his contract on 30 June 2002.

3.8 Reclassification of international professional post

3.8a Social Scientist and Head, SBSU, P4, PHSD. Discussion will be deferred to Closed Closed session.

3.9 Change in status for international professional post

3.9a Assoc Director and Head, PHSD. In recognition of Prof Lars Ake Persson's leadership and scientific productivity to the Centre and the Division, his contract was renewed at D2, step 4 for another three years, effective 1 March 2002.

3.10 **Establishment of new international professional posts.** Prof Sack reported that the Centre requires 3 new posts:

3.10a Deputy Director (D2), Director's Division (to be discussed in Closed closed session)

3.10b Pathologist (P4), LSD. A job description is being formulated and will be submitted for Board review

3.10c Grants Administrator (P4), Director's Division (to be discussed in Closed closed session)

4. Promotion of Bangladeshi scientists to international level. 4 scientists were shortlisted for promotion and their applications were submitted for external review. Interviews were held the previous day with the concerned scientists and further discussions on the outcome will be held in Closed closed session.

1. **Selection of BOT members.** To be discussed in Closed closed session.

2. **Any Other Business**

6.1 Update on the Human Resources Agenda. Ms Diann Hill, Head HR began her update of the HR agenda with an introduction of her new baby.

She reported that the Human Resources Office was established in 1998 and the post of Head HR was filled in 2000. Priority activity was to resolve pending issues and advance new plans for human resources throughout the Centre.

HR projects included job classification, evaluation and job families; market survey; performance management system; training; promotions; compensation system; management information system; recommendation for compensation system.

Job classification: 253 posts were comprehensively evaluated under an external analysis and job titles standardized. Policies and procedures are being developed to support the JC system

Job families: The aim of the exercise was to reduce the number of job titles and create career structures. Reconciliation to date: 169 reduced to 107. Posts have been categorized into respective families and can move across divisions. Core skills have been identified for the posts.

Market survey: Annual surveys are needed to test Centre salaries and benefits against the external market; make internal adjustments to individual posts to be competitive with the market; demonstrate a fair and transparent process. The survey showed that the current trend is to convert benefits into cash and that most comparators use merit pay systems. The financial implications will determine the number of changes to be made for both classification and market adjustments; evaluate the budgetary implications of the adjustments; determine the Centre's ability to fund the adjustments.

Performance management system: The Centre would revise current appraisal forms, develop policies and procedures, train managers on nasics of performance management and train staff on the new system. Revision of the current system would include:

- Feedback from employee as an accepted part of the process
- Performance as part of the team
- Measurable outcomes
- Identification of personal development needs
- Score for overall performance

Training: HR training focusses on cultural change and standardized performance for the organization:

- Training needs analysis completed in 2001
- Soft-skills training – basics of supervision (8 modules) beginning with the Performance Management module
- Hard-skills training – conducting Microsoft Office training including email and web browsing
- Recruitment of a national Training Manager

Promotions: A fair and equitable system across the organization for all staff. Promotions to be considered on an annual basis; recommendations made to Associate Director for submission to HR for convening of Compensation Committee.

Compensation system: Does the Centre want to reward staff for longevity of service? Individual performance? Team performance?

Pay options:

Current system links JE scores to pay ranges with step increases with longevity. Advantages of the current system: link to UN system, does not affect the Ordinance, minimizes resistance from staff and SWA. Disadvantages: good performance is not rewarded and poor performance is ignored.

Merit system is linked to individual performance within financial constraints. Advantages: recognises and rewards individual performance, supports organizational productivity, enhances morale of top performers. Disadvantages: subjective and open to abuse, would need more managerial input and time.

Team merit system is linked to team performance. Advantages: recognises all team contributions, team pressure to perform raises productivity. Disadvantages: top performers can be disadvantaged, the system can be subjective, is rarely used and administratively cumbersome, can result in shortcuts.

The Centre recommends the adoption of the merit system. It increases the morale of top performers and is an incentive for everyone to perform. It makes the performance review more meaningful for salary and career planning, develops developmental areas and improves donor competitiveness. The system is easy to administer, is financially controllable and fits with a grading structure. It does not allow increases for poor performers. The Centre would need to consider the effect this proposed system will have on the Ordinance.

Management Information System: Will evaluate organizational needs; identify vendors and product demonstrations; review IT resources; select MIS system; create implementation team and schedule.

Update HR Department: Transition from Personnel (admin) to Human Resources (strategic) department to enhance effectiveness and efficiency. The Dept created working groups to review recruiting, contract extension and gender equality.

Time lines: BOT approval – June 2002; Market survey completed – May 2002; job families agreed – June 2002; Reconcile JC with market survey – July 2002; Training for managers – August 2002; Performance Management system – December 2002.

The Centre requests the Board's approval to continue plans for introducing a Merit Compensation System.

Dr Lanata thanked Mrs Hill for the presentation and congratulated her and the HR staff for a comprehensive job.

Discussion:

It was discussed that the merit system would ultimately be beneficial to the staff and the Centre as a whole but should be worked out carefully. The Centre would need to work with the ERD Secretary and the Health Ministry to review its affect on the Ordinance. Further indepth discussion will continue in Closed closed session. e

P&S Committee Closed Closed session

The Board met to continue discussions and to deliberate on issues for resolution:

- Recruitment of: Associate Director for Clinical Sciences Division; and Head, External Relations and Institutional Development, Director's Division. The search for this position will continue.
- Reclassification of international professional post for Social Scientist and Head SBSU, Public Health Sciences Division. It was recommended that Dr Bhuiya should be promoted to P5 level.
- Establishment of new international professional posts for (1) Deputy Director, Director's Division and (2) Grants Administrator, Director's Division:
 1. The Board agreed that the post of Deputy Director was needed and that the job description should be for a scientific administrator, not a "pure" administrator. It should be understood that the position should not be viewed as a stepping-stone to the directorship, in fact this should be discouraged. A job description should be developed prior to the next meeting.
 2. The Grants Administrator position should be regularized since this function is becoming increasingly important.
- Selection of new members of Board of Trustees.

Table-3
BOT/HR/NOV/2002

STAFFING STATUS
FIXED-TERM

As of September 30, 2002

Sl. No.	Location	International Professional			<u>NO</u>	<u>GS</u>	Total
		Fixed Term	Short Term	Seconded			
1.	Director's Division	5	3	1	14	124	147
	-Director's Office	2	1	1	-	2	6
	-Human Resources	1	1	-	3	8	13
	-Finance	1	-	-	6	25	32
	-ER&ID	1	1	-	1	1	4
	-Support Services	-	-	-	4	87	91
	-SWA	-	-	-	-	1	1
2.	Public Health Sciences Division	7	-	4	67	392	470
3.	Clinical Sciences Division	2	-	-	32	160	194
4.	Laboratory Sciences Division	4	-	-	24	143	171
5.	Health Systems and Infectious Diseases Division	2	1	1	29	115	148
6.	Information Sciences Division	1	1	-	9	20	31
Total		21	5	6	175	954	1161

Table-4
BOT/HR/NOV/2002

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

As of September 30, 2002

Sl. No.	Location	Seconded Staff (Int'l)	Short-term			CHWs	Total	HW
			Int'l	NO	GS			
1.	Director's Division	1	3	-	-	-	4	-
2.	Public Health Sciences Division	4	-	-	-	20	24	-
3.	Clinical Sciences Division	-	-	-	-	-	-	90
4.	Laboratory Sciences Division	-	-	-	-	-	-	-
5.	Health Systems and Infectious Diseases Division	1	1	-	-	-	2	-
6.	Information Sciences Division	-	1	-	-	-	1	-
Total		6	5	-	-	20	31	90

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

LIST OF INTERNATIONAL PROFESSIONAL STAFF
As of September 30, 2002

FIXED-TERM

Sl. No.	Name	Country	Job Title	Pay Level	Contract Start Date	Contract End Date
1.	ARIFEEN, Dr. Shams El	Bangladesh	Epidemiologist & Head, CHU	P3	21.11.2000	20.11.2003
2.	BENNETT HENRY, Ms Judith G.	Trinidad & Tobago	Executive Assistant to Director	P1	01.10.1999	30.09.2002
3.	BHUIYA, Dr. Abbas Uddin	Bangladesh	Social Scientist & Head, SBSU	P5	*01.07.1994	31.12.2004 *
4.	BLUM, Dr. Lauren S.	USA	Anthropologist, SBSU, PHSD	P4	23.01.2000	22.01.2003
5.	FARUQUE, Dr. Shah Md.	Bangladesh	Scientist, LSD	P4	01.07.2002	30.06.2005 *
6.	HILL, Ms. Diann M.	USA	Head, Human Resources	P5	30.04.2000	23.10.2002
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	31.07.2003
9.	KILLEWO, Prof. Japhet Z. J.	Tanzania	Head, Reproductive Health Unit, PHSD	P5	27.10.1999	26.10.2002
10.	LARSON, Dr. Charles P.	Canada	Senior Operations Research Scientist, HSID	P5	01.05.2002	30.04.2005
11.	MARCER, Mr. Alec	UK	Operations Research Scientist, HSID	P4	30.09.2002	29.09.2005
12.	NAIR, Dr. Gopinath Balakrish	India	Associate Director and Head, LSD	D1	09.04.2000	12.12.2004

* per Policy of promotion of Bangladeshi Scientists to International Level

LIST OF INTERNATIONAL PROFESSIONAL STAFF
As of September 30, 2002

FIXED-TERM

Sl. No.	Name	Country	Job Title	Pay Level	Contract Start Date	Contract End Date
13.	QADRI, Dr. Firdausi	Bangladesh	Senior Scientist, LSD	P4	01.07.2002	30.06.2005 *
14.	RABBANI, Dr. Golam Hassan	Bangladesh	Scientist, CSD	P4	01.07.2002	30.06.2005 *
15.	SALAM, Dr. M. Abdus	Bangladesh	Chief Physician and Acting Associate Director, CSD	P4	01.07.2002	30.06.2005 *
16.	PERSSON, Prof. Lars Åke	Sweden	Associate Director, PHSD	D2	01.03.1999	28.02.2005
17.	SIDDIQUE, Dr. A. K. M	Bangladesh	Epidemiologist, ECPU, PHSD	P4	01.07.1996	30.06.2003 *
18.	STREATFIELD, Dr. Peter K.	Australia	Head, Health & Demographic Surveillance Unit, PHSD	P5	18.07.1999	17.07.2005
19.	SAGE, Mr. Stephen E.	USA	Chief Finance Officer, DD	P5	21.08.2001	21.11.2002
20.	THORPE, Mr. Peter	UK	Head, Information Sciences Division	P5	01.08.2001	31.07.2004
21.	ZAMAN, Mr. Ishtiaque A.	Bangladesh	Head, External Relations & Institutional Development, DD	P4	01.07.2002	30.06.2005

* per Policy of promotion of Bangladeshi Scientists to International Level

SHORT-TERM

Sl. No.	Name	Country	Job Title	Pay Level	Contract Start Date	Contract End Date
1.	ACKLEY, Ms. Julia	USA	Senior Associate, ER&ID	--	21.08.2002	20.01.2003
2.	ALAM, Dr. A. N.	Bangladesh	Head, Training & Education Dept.	P4	01.05.1996	31.03.2003
3.	BROOKS, Ms. Vanessa J.	USA	Grants Administrator, DD	P4	01.10.1997	28.02.2003
4.	HADLEY, Ms. Mary	UK	Project Coordinator, FHRP	--	24.01.2002	23.12.2002
5.	WALTON, Ms. Ann G.	Canada	Interim Head, Human Resources	--	08.09.2002	07.06.2003

Table-7
BOT/HR/NOV/2002

LIST OF SECONDED STAFF
As of September 30, 2002

Sl. No.	Name	Country	Job Title	Pay Level	Contract Start Date	Contract End Date	Seconding Institution
1.	BREIMAN, Dr. Robert F.	USA	Associate Director & Head, HSID	D1	01.08.2000	09.07.2004	CDC/US Embassy
2.	BROOKS, Dr. W. Abdullah	USA	Scientist, HSID	P4	01.07.2001	30.06.2003	JHU
3.	DIELTIENS, Dr. Greet	Belgium	Technical Advisor, RHU	P4	09.01.2001	08.01.2004	BTC
4.	MELS, Mr. Carel T. van	Netherlands	Demographic Researcher, HDSU	P4	29.12.1999	31.12.2005	NIDI
5.	SACK, Dr. David A.	USA	Director, ICDDR,B	ADG	01.10.1999	30.09.2005	JHU
6.	WAGATSUMA, Dr. Yukiko	Japan	Scientist, ECPU	P4	17.01.2000	31.12.2002	JHU

CDC : Centre for Disease Control
JHU : The Johns Hopkins University

BTC : Belgian Technical Cooperation
NIDI : Netherlands Interdisciplinary Demographic Institute

Table-8
BOT/HR/NOV/2002

LIST OF ADJUNCT SCIENTIST
As of September 30, 2002

Sl. No.	Name	Country	Job Title	Contract Start Date	Contract End Date
1.	ABOUD, Prof. Frances E.	CANADA	Adjunct Scientist	18.03.2002	17.03.2005
2.	BAQUI, Dr. Abdullah H.	BANGLADESH	Adjunct Scientist	01.07.2001	30.06.2004
3.	TAKEDA, Prof. Yoshifumi	JAPAN	Adjunct Scientist	14.02.2002	13.02.2005

3.2 Status of Recruitment of International Professional Staff

Agenda 3.2a Deputy Director, D2, Director's Division

Aedol

Following the establishment (13/BT/June/02) of this important post –the Centre is currently trying to put together an appropriate job description to suit the real needs for which the post has been envisaged i.e. 1) to take most of the administrative loads off the Director and to look after the day to day non-scientific activities of the Centre on a routine basis, 2) to also be able to provide appropriate guidance and leadership in the scientific areas during the occasional absence of the Director from the Centre, 3) to be able to liaise with Donors, GoB and other development partners, etc.

A final draft job description will be ready for presentation to the Human Resources Committee Meeting during the ensuing meeting, reflecting the scientific/administrative split of the responsibilities of the post.

Agenda 3.2b Associate Director, D1, Clinical Sciences Division

As reported in the June 2002 meeting, the search for suitable candidates for the position of the Associate Director, CSD at pay level D1 is still continuing. In the meantime, Dr. M. A. Salam who has now been promoted to P4 grade under the policy of 'Bangladeshi Scientists to International Level' is holding the charge of the Division and receiving the acting allowance, as per rules.

3.2 Status of Recruitment of International Professional Staff

Agenda 3.2c Chief Finance Officer, P5, Director's Division

Mr. Stephen E. Sage, Chief Finance Officer tendered his resignation from the services of the Centre on personal grounds, which has been accepted to be effective on the close of business, on 21 November 2002.

The position in the meantime, has been announced to be filled in urgently. The search process resulted in a few responses out of which two candidates having met the advertised criteria have been short-listed for interview. The CVs of these candidates have already been circulated to members of the Executive Committee of the Board, for their evaluation.

Further, the interview for the two short-listed candidates have been scheduled for 9 and 21 October 2002.

This is for the information of the Board.

Agenda 3.2d Head, Human Resources, P5, Director's Division

Mrs. Diann M. Hill, Head, Human Resources submitted her resignation from the services of the Centre on 7 August 2002 due to personal reasons. The resignation has been accepted to be effective from the close of business on 23 October 2002. However, Mrs. Hill left the Centre for Adelaide, Australia on 5 September 2002. For the remaining days of her tenure, she will be enjoying her accumulated annual leave.

Pending finalization of this recruitment, Ms. Ann G. Walton, a Canadian national, has been locally recruited on a short-term basis, effective 8 September 2002 for period of 9 (nine) months. Ms. Walton joined part-time (50%) for the first month and joined the Centre full-time on 8 October 2002.

Further recommendations related to this recruitment, will be presented during the meeting of the Human Resources Committee of the Board.

3.2 Status of Recruitment of International Professional Staff

**Agenda 3.2e Head, Nutrition Research Programme, P4/P5
Clinical Sciences Division**

The Centre is still finding it difficult to identify a suitable person to fill in this high priority position. However, the search continues and the Board will be kept posted, hopefully if any development takes place meanwhile.

Agenda 3.2f Pathologist, P4, Laboratory Sciences Division

As per a resolution (13/BT/JUN/02) of the June 2002 meeting of the Board, the post of a Pathologist has been established. The Centre by using its standard announcement procedures, has made vacancy announcements for this post both nationally and internationally. It is hoped that by the Board meeting time, a few responses will be available which may be shared with the Human Resources Committee.

Agenda 3.2g Executive Assistant to Director, P1, Director's Division

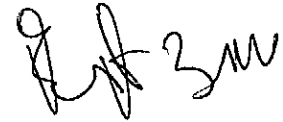
At the expiry of her three years' contract, Mrs. Judith G. Bennett Henry left the Centre on 30 September 2002 (afternoon). Although no formal vacancy announcement has yet been made, a temporary arrangement to man the post has been made by an internal reassignment of Mrs. Loretta Saldanha Ansari, from the Clinical Sciences Division.

This post and its future needs will further be evaluated and a report made to the Human Resources Committee.

Agenda 3

BOT/HR/NOV/2002

3.3 Renewal of Contracts

A handwritten signature in black ink, appearing to be 'J. Z. J. Killewo' or similar, written in a cursive style.

Agenda 3.3a

Head, Reproductive Health Programme, P5
Public Health Sciences Division

The current incumbent to the post, Prof. Japhet Z. J. Killewo's contract will expire on 26 October 2002. Discussions are still on between him and his university in Tanzania and also with the Centre as to how best a solution could be arrived at. A report to this effect will be made during the Human Resources Committee meeting.

**ICDDR,B
Consultancies Policy**

Page 1 of 3

Revised 05 November 2001

Purpose:

To allow staff members to provide consultancies to outside organizations that would benefit both the individual and the Centre.

Guidelines:

1. The agreement for consultancies is to be made with the Centre, not the individual. All consulting proposals must be routed through the appropriate Division Director to the Head, Human Resources for review and approval. The Director will give final approval of all consultancies.
2. A consultant is defined as an individual who is participating in the consultancy and taking directions from the consulting organization. Satisfaction with the final Consultancy product will be between the consultant and consulting organization and not reviewed by the Centre.
3. Eligible staff include international level, and NOC and above.
4. Consulting fees will be based on the Centre's salary scale and should not be more than six weeks per year.
5. Cash payments to Bangladeshi nationals are in addition to their regular salary and subject to income tax. The appropriate tax (approximately 25%) will be deducted from individual cash payments and remitted by the Centre to the tax authority.
6. Leave time cannot be used for consultancies. If temporary replacement staff is needed, then the personnel costs will be borne by the consultancies.
7. Direct costs of travel, food, accommodation, business expenses and any other related materials must be borne by the consulting organization.

Rates for Consultancy:

The Consultancy rate for eligible international and national staff will be calculated by taking the total personnel cost (salary + fringe) plus twenty-five percent (25%) of direct costs divided by 250 days. This average daily rate will be used to determine the appropriate consulting rate for international and national staff members. If a national officer is conducting an international Consultancy, the salary rate will correlate with the international level equivalency. If the Consultancy is a regional or in-country consultancy then the appropriate daily rate will apply. Consultancy fees are subject to change if the Centre revises its salary scales.

A Consultancy Rate Calculation Worksheet has been developed to assist in calculating the rate and must be submitted when requesting approval for the Consultancy.

International

Average Daily Rate (mid-step of grade levels)

Level	Salary/Benefit Per Day (\$US)	Indirect Cost (25%) (\$US)	Total Daily Rate (\$US)	*Regional Rate (\$US)	**In-country Rate (\$US)
P1	228.00	57.00	285.00	199.50	114.00
P2	275.00	69.00	344.00	240.80	137.60
P3 (NOC)	326.00	82.00	408.00	285.60	163.20
P4 (NOD)	380.00	95.00	475.00	332.50	190.00
P5 (NOE)	427.00	107.00	534.00	373.80	213.60
D1	462.00	116.00	578.00	404.60	231.20
D2	502.00	126.00	628.00	439.60	251.20

*Regional rate is 70% of Total Daily Rate

** In-country rate is 40% of Total Daily Rate

If an in-country consultancy is with an Bangladeshi organization then the in-country rate would apply. If an in-country consultancy is with an International organization within Bangladesh, the international rate would apply.

If the consultant's salary is 100% covered by project funds, the individual will receive 50% of the consulting fees and the remaining 50% will be given to the individual's Division. The individual will receive the 50% as a cash payment.

If a portion of the project and a portion of core cover the consultant's salary, the appropriate percentage will be used to offset salary costs charged to core. The Division may use these funds for activities as approved by the Division Head.

Example: Consultant's salary is 60% project funded 40% Core funded
40% of the consultancy fees would be returned to Core.
30% of fees would go to the individual and 30% would go to the Division.

If an individual is 100% core funded, the individual will receive 50% of the consulting fees and the remaining 50% will be given to the individual's Division. The individual will receive the 50% as a cash payment.

Consultancy Rate Calculation Worksheet

Net Consulting fee received* (a) \$ _____

Less indirect cost (20% * a) (b) \$ _____

Net received (a - b) (c) \$ _____

Proportion of salary from core (d) _____ %

Amount returned to core (d * c) (e) \$ _____

Amount available for distribution (c - e) (f) \$ _____

Amount to individual (50% * f) ***minus income tax* (g) \$ _____

Amount to division (50% * f) (h) \$ _____

Notes:

*Excludes all direct costs (travel accommodation, etc) reimbursed

** Applies to Bangladeshi nationals only

- Total personnel cost (salary + fringe) +25% / 250 days
- 250 days = 5 working days*52 weeks – 10 public holidays

Draft resolutions of the Personnel and Selection Committee

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

8/BT/JUN/02

The Board approves the Centre's request to reclassify the post of the Social Scientist and Head, Social and Behavioural Sciences Unit, PHSD, at pay level P5 and the appointment of Dr Abbas U Bhuiya to the reclassified post in recognition of his outstanding performance.

9/BT/JUN/02

The Board endorses the selection of Dr Ishtiaq Zaman as Head, ERID at pay level P4 and also records its support for Ms Vanessa Brooks to continue as Grants Administrator.

10/BT/JUN/02

The Board approves the promotion of the following staff under the Bangladesh Scientist to International Level policy:

Dr G H Rabbani, CSD
Dr M A Salam, CSD
Dr Firdausi Qadri, LSD
Dr S M Faruque, LSD

11/BT/JUN/02

The Board approves the request to rename the Personnel and Selection Committee to the Human Resources Committee.

12/BT/JUN/02

The Board approves the direction of the Human Resources agenda as presented by the Head Human Resources and approves the request for continuing plans to introduce a merit compensation system.

13/BT/JUN/02

The Board notes its support to establish the new posts of Deputy Director, and Pathologist.

14/BT/JUN/02

The Board notes the salary and benefits guidelines developed to clarify the Bangladeshi Scientist to International Level policy

15/BT/JUN/02

The Board approves the extension of Dr Ricardo Uauy Dagach as a Board member for another three-year term.

16/BT/JUN/02

The Board approves the selection of the following officers:

Chair, Board of Trustees:

Dr Ricardo Uauy Dagach

Programme Committee:

Prof Carol Vlassoff – Chair

Prof Jane Kusin -- Deputy

Human Resources Committee:

Dr Claudio Lanata -- Chair

Dr Terry Hull -- Deputy

Finance Committee:

Prof AK Azad Khan – Chair

Dr Marcel Tanner -- Deputy

17/BT/JUN/02

The Board requests UNICEF and WHO to identify a representative who can serve as Board members.

18/BT/JUN/02

The Board defers the appointment of a new BOT member pending identification of potential candidates who will be appointed at the November 2002 meeting.

3.1 Overview of the staffing situation

There were 83 additions and 27 separations during this reporting period (April 01, 2002 – September 30, 2002). The total number of Centre fixed-term staff belonging to all categories thus increased by 56 as shown in Table 1 below. The net additions of 83 were mostly for the project positions. The Centre however, continues to follow the policy of restricting external recruitment of fixed-term staff as far as practical.

Table 1

OVERVIEW OF STAFFING SITUATION

April 2002 – September 2002

Separations/Additions of Staff

	<u>Restricted</u>		<u>Unrestricted</u>		<u>Total</u>		<u>Net Change</u>
	<u>Sep</u>	<u>Add</u>	<u>Sep</u>	<u>Add</u>	<u>Sep</u>	<u>Add</u>	
International	(1)	+6	--	+1	(1)	+7	+6
Research (Scientific Support & Field)	(13)	+50	(7)	+5	(20)	+55	+35
Research (Administration)	(4)	+16	(1)	+5	(5)	+21	+16
Human Resources & Supt. Services	--	--	(1)	--	(1)	--	-1
Finance	--	--	--	--	--	--	--
	(18)	+72	(9)	+11	(27)	+83	+56

Net additions : 56

ICDDR,B

**OVERVIEW OF THE
STAFFING STATUS**CF - Core funded
PF - Project funded

Functional Area	2001 (Sep 30)	2002 (Mar 31)	2002 (Sep 30)
-International Professional staff	15	15	21
-Research (Scientific, Support & Field)	614	589	624
	CF 199 PF 415	CF 196 PF 393	CF 194 PF 430
-Research (Administration)	360	356	372
	CF 138 PF 222	CF 134 PF 222	CF 138 PF 234
-Support Services & Personnel	100	103	102
	CF 100 PF 0	CF 103 PF 0	CF 102 PF 0
-Finance	31	31	31
	CF 31 PF 0	CF 31 PF 0	CF 31 PF 0
Sub Total	1120	1094	1150
-International Seconded Staff	7	6	6
-Short term staff (Int'l, NO & GS)	2	2	5
-Community Health Worker	19	18	20
Sub Total	28	26	31
Health Worker	72	92	90
Fellows	27	30	27
Contractual Service Holder	379	331	329
Daily Wagers	274	231	319
GRAND TOTAL	1900	1804	1946

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

Functional Area	2001 (Sept 30)	2002 (Mar 31)	2002 (Sept 30)
Unrestricted	468	464	465
Restricted	637	615	664
International Professional	15	15	21 / c.
Total	1120	1094	1150

3.3 Renewal of Contracts

**Agenda 3.3b Medical Anthropologist, P4, Social & Behavioural Sciences Unit
Public Health Sciences Division**

The first three years' contract of Dr. Lauren S. Blum, Medical Anthropologist, Social & Behavioural Sciences Unit, Public Health Sciences Division will expire on 22 January 2003. A productive researcher, Dr. Blum's presence has been very beneficial to the Centre and her performance, during the period, has also been highly satisfactory.

Hence, the Centre recommends to the Board for a three years' extension of the current employment contract of Dr. Lauren S. Blum.

*To Monday
EU Judy*

Draft resolution:

The Board resolves that the current employment contract of Dr. Lauren S. Blum with the Centre, be extended by another term of 3 (three) years effective 23 January 2003 under the same terms and conditions.

3.4 Information on new International Professional Staff

**Agenda 3.4a Head, External Relations & Institutional Development, P4
Director's Division**

As per the Board's endorsement of the selection of Dr. Ishtiaque A. Zaman (9/BT/JUN/02) as Head, External Relations & Institutional Development, at pay level P4; he was offered the position for a period of three years.

Dr. Zaman joined the new position on 01 July 2002.

**Agenda 3.4b Operations Research Scientist, P4
Health Systems and Infectious Diseases Division**

The Centre is happy to report to the Board that Mr. Alec Mercer, a British national has joined this position as a result of a competitive search process, on 27 September 2002. Mr. Mercer who is familiar to both Dhaka and ICDDR,B is expected to take much less time than others for his orientation as well as familiarization with the Centre.

Agenda 3.4c Health Economist, P4, Public Health Sciences Division

The Centre is also happy to report to the Board that Dr. Beena Varghese, an Indian national (currently US immigrant) has been selected for the post, through the Centre's recruitment process. She is currently working at the CDC, Atlanta.

Dr. Varghese will be joining the Centre on 10 October 2002.

3.4 Information on new International Professional Staff

Agenda 3.4d Senior Scientist, P4, Laboratory Sciences Division

As per the approved policy of Bangladeshi Scientists' promotion to International Professional levels, Dr. Firdausi Qadri, a National Officer, having qualified (10/BT/JUN/02) for a promotion, has been offered the post of Senior Scientist at pay level P4, under the Laboratory Sciences Division. Dr. Qadri joined on 01 July 2002.

This is for the information of the Board.

Agenda 3.4e Scientist, P4, Laboratory Sciences Division

As per the approved policy of Bangladeshi Scientists' promotion to International Professional levels, Dr. Shah Md. Faruque, a National Officer, having qualified (10/BT/JUN/02) for a promotion, has been offered the post of Scientist at pay level P4, under the Laboratory Sciences Division. Dr. Faruque joined on 01 July 2002.

This is for the information of the Board.

Agenda 3.4f Scientist, P4, Clinical Sciences Division

As per the approved policy of Bangladeshi Scientists' promotion to International Professional levels, Dr. Golam Haider Rabbani, a National Officer, having qualified (10/BT/JUN/02) for a promotion, has been offered the post of Scientist at pay level P4, under the Clinical Sciences Division. Dr. Rabbani joined on 01 July 2002.

This is for the information of the Board.

Agenda 3.4g Chief Physician, P4, Clinical Sciences Division

As per the approved policy of Bangladeshi Scientists' promotion to International Professional levels, Dr. M. Abdus Salam, a National Officer, having qualified (10/BT/JUN/02) for a promotion, has been offered the post of Chief Physician at pay level P4, under the Clinical Sciences Division. Dr. Salam joined on 01 July 2002.

This is for the information of the Board.

Agenda 3

BOT/HR/NOV/2002

3.5 Information on new International Short-term Staff



Agenda 3.5a Senior Associate, ER&ID, Director's Division

This is for the information of the Board that Ms. Julia Ackley, an American national has joined the Centre as the Senior Associate on August 21, 2002 to work with the External Relations and Institutional Development (ER&ID) department under the Director's Division. Ms. Ackley's current short-term contract will expire on January 20, 2003.

3.6 Status of seconded staff contracts

Agenda 3.6a Demographic Researcher, P4, HSID

The Demographic Researcher of HSID, Mr. Carel T. van Mels' current secondment contract with the Centre has been further renewed for another 3½ (three and a half) years effective 01 July 2002 through the Netherlands Interdisciplinary Demographic Institute (NIDI).

Agenda 3.6b Scientist, ECPU, P4, PHSD

The current secondment contract of Dr. Yukiko Wagatsuma with the Johns Hopkins University expires on 31 December 2002. As Dr. Wagatsuma's services are essentially required by the Centre for the coming years, it is expected that the Johns Hopkins University will consider the Centre' request for a further renewal of the current secondment contract by at least 3 (three) years.

This is for the information of the Board.

3.7 Separation of international professional staff

Agenda 3.7a Head, Human Resources, P5, Director's Division

Mrs. Diann M. Hill, Head, Human Resources, P5, Director's Division left the Centre on resignation, on 5 October 2002.

This is for the information of the Board.

Agenda 3.7b Executive Assistant to Director, P1, Director's Division

At the expiry of her employment contract with the Centre, Mrs. Judith G. Bennett Henry, Executive Assistant to Director, P1, was released effective the afternoon of 30 September 2002.

This is for the information of the Board.

Agenda 3.7c Chief Finance Officer, P5, Director's Division

Mr. Stephen E. Sage, Chief Finance Officer has resigned from the service of the Centre. His resignation has been accepted by the Director. Mr. Sage will be leaving the Centre on 21 November 2002.

This is for the information of the Board.

3.8 List of established international professional posts

Director's Division

<u>Sl.</u>	<u>Job Title</u>	<u>Grade</u>	<u>Post establishment date</u>	<u>Remarks</u>
01	Director	ADG	January 1982	
02	Deputy Director	D2	June 2002	Vacant
03	Associate Director, P&P	D1	July 2000	
04	Head, Human Resources	P5	April 2000	
05	Chief Finance Officer	P5	September 1988	
06	Head, ER&ID	P4	November 1998	
07	Executive Assistant to Director	P1	January 1982	
08	Grants Administrator, ER&ID (ST)	P4	October 1997	

Public Health Sciences Division

<u>Sl.</u>	<u>Job Title</u>	<u>Grade</u>	<u>Post establishment date</u>	<u>Remarks</u>
01	Associate Director, PHSD	D2	March 2002	
02	Head, HDSU	P5	November 1995	
03	Head, Reproductive Health Unit	P5	July 1997	
04	Social Scientist, Head, SBSU	P5	June 2002	
05	Scientist	P4	January 2000	
07	Epidemiologist & Head, ECPU	P4	July 1996	
08	Medical Anthropologist	P4	January 2000	
09	Epidemiologist & Head, CHU	P3	November 2000	
10	Health Economist	P4	January 1997	Vacant
11	Demographer	P4	April-1995	Vacant
12	Adjunct Scientist	--	June 2001	

3.8 List of established international professional posts

Clinical Sciences Division

<u>Sl.</u>	<u>Job Title</u>	<u>Grade</u>	<u>Post establishment date</u>	<u>Remarks</u>
01	Associate Director, CSD	D1	January 1982	Vacant
02	Head, Nutrition Research Program	P4/P5	November 2001	Vacant
03	Chief Physician	P4	July 2002	
04	Scientist	P4	July 2002	
05	Adjunct Scientist	--	March 2002	

Laboratory Sciences Division

<u>Sl.</u>	<u>Job Title</u>	<u>Grade</u>	<u>Post establishment date</u>	<u>Remarks</u>
01	Associate Director, LSD	D1	January 1982	
02	Scientist	P4	July 2002	
03	Scientist	P4	July 2002	
04	Pathologist	P4	July 2002	Vacant
05	Environmental Microbiologist	P4	July 2001	
06	Adjunct Scientist	--	February 2002	

Health Systems and Infectious Diseases Division

01	Associate Director, HSID	D1	August 2000	
02	Sr. Operations-Research-Scientist	P5	November 2001	
03	Operations Research Scientist	P4	February 1989	
04	Demographic Researcher	P4	December 1999	
05	Project Coordinator (ST)	--	January 2002	

Information Sciences Division

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

Agenda 4

BOT/HR/NOV/2002

Selection of members of the Board of Trustees

This agenda item will be incorporated on receipt of inputs from the Director's Office.

Agenda 5

BOT/HR/NOV/2002

Update on the ongoing Human Resources agenda

An update on this agenda item will be provided during the meeting.

Agenda 6

BOT/HR/NOV/2002

Agenda 6.1: Staff salaries: International Professional Category

A report on this agenda item will be presented during the Board meeting.

Agenda 6

BOT/HR/NOV/2002

Agenda 6.2:

Staff salaries: NO & GS categories

A report on this agenda item will be presented during the Board meeting.

Agenda 7

BOT/HR/NOV/2002

Any other business

Agenda 7.1

Prof. Lars Åke Perssson, Associate Director, D2
Public Health Sciences Division

Prof. Lars Åke Perssson, Associate Director, D2, Public Health Sciences Division has tendered his resignation from the Centre with a request to make it effective as of 1 March 2003. Prof. Persson is leaving for better prospects as he has been offered a full Professorship and Chair at a Swedish University.

Agenda 7

BOT/HR/NOV/2002

Any other business

Agenda 7.2

Curriculum Vitae of Ms. Julia Ackley,
Mr. Alec Marcer and Dr. Beena Varghese

JULIA ACKLEY

HR - To File
Barker
File
02-09-02

Citizenship: United States
Mailing Address: 6120 Dhaka Place, Dulles, VA, 20189-6120
Local Address: Road 7, House 24, Apartment #2, Baridhara, Dhaka, Bangladesh
Telephone: 882-1467
E-Mail: jm_ackley@yahoo.com

PROFESSIONAL EXPERIENCE

09/99 – 03/02 Senior Associate, Grants Development (06/00 promoted from Associate) Centre for Development and Population Activities (CEDPA), Washington, DC

- Served as a grant writer; producing donor proposals and reports on CEDPA's programs worldwide. Topics included: reproductive health, HIV/AIDS/STIs, gender, non-formal education, youth development, adolescent RH and sexuality, capacity building, social mobilization, economic sustainability, advocacy and civil society. Focus countries included: India, Nepal, Guatemala, Haiti, Nicaragua, Ghana, Mali, Nigeria and South Africa.
- Tracked USAID funding opportunities for senior management and was as a member on multiple USAID RFA, RFP and APS response teams.
- Designed and implemented training sessions on proposal development and donor relations for CEDPA workshops.
- Worked closely with the Director of Grants Development to perform internal strategic planning processes and develop annual department workplans and budgets.
- Established and maintained the organization's grant database.
- Worked with headquarter- and country-based staff to conceptualize and design projects for funding.
- Researched public and private donors and produced donor assessment reports for senior staff.

01/98 – 09/99 Program Development Associate Population Resource Center (PRC), Washington, DC

- Served as a congressional liaison. Met with House and Senate staff to advocate for PRC's position on population-related legislation including international family planning assistance and Census 2000. Tracked legislation at the floor and committee level and reported to senior staff.
- Researched foundations and assisted writing grant proposals.
- Contributed to public relations materials including annual reports, organizational brochure and newsletters.
- Assisted in managing projects, meeting deadlines, working with staff to conceptualize programs and manage PRC fellows program.

**06/96 – 01/98 Program Assistant (06/97 promoted from Staff Assistant)
BASS and HOWES, Inc., Washington, DC**

- Handled federal relations activities for clients; including tracking legislation, attending hearings, compiling and drafting education materials for congressional staff, and scheduling congressional meetings.
- Administered Political Action Committee membership program for United Airlines, generated company data analysis for senior staff, and produced quarterly newsletters.
- Assisted in administering a national campaign on emergency contraception for the Reproductive Health Technologies Project, worked with team members on campaign strategy, coordinated distribution of materials, and drafted end-of-year report.

**03/96 – 06/96 Intern
National Women's Health Network (NWHN), Washington, DC**

- Represented NWHN at a series of product liability meetings (specifically pertaining to breast implant litigation) sponsored by the White House Office of Women's Affairs.
- Researched, compiled and produced NWHN's informational material on mifepristone.

EDUCATION

Currently Enrolled: "Certificate in Core Public Health Concepts" (Distance Learning Program)
University of North Carolina, School of Public Health. Expected graduation date: June 2004.

B.A. Political Science, Public Service Emphasis
University of California Santa Barbara, Santa Barbara, CA

PROFESSIONAL EDUCATION

Participant: "Fundraising Fundamentals", Association of Fundraising Professionals, New York, June 2000.

Participant: "Proposal Writing Basics", Foundation Center, Washington, DC, April 2000.

LANGUAGE

Completed: Bengali Language Training, Foreign Service Institute, U.S. Department of State, Fairfax, VA, March 4 – April 26, 2002.

Native language: English.

COMPUTER SKILLS

Microsoft Word, Excel, Power Point, Access, Word Perfect, PageMaker, Filemaker Pro, SPSS, Internet.

CURRICULUM VITAE

ALEC MERCER

C/o DFID, British High Commission,
Baridara, Dhaka,
Bangladesh.

Tel: 00-2-8810800 (work)
Tel: 00-2-8824586 (home)
Fax: 00-2-8826454 (work)
E-mail: a-mercerc@agni.com

KEY EXPERIENCE

Health programmes in developing countries:

Twelve years experience in Africa and Asia working on health projects and programmes:

- Managing a health survey programme, advising on survey design and conducting research
- Reviewing NGO proposals for health projects, advising on selection, monitoring progress
- Managing an NGO health programme, monitoring, and developing new projects

Research:

- Design and conduct of health surveys for monitoring and evaluation
- Conducting rapid assessment surveys of nutrition, health and population in relief situations
- Development of a health information system for refugee camps
- Conducting studies on the epidemiology and treatment of visceral leishmaniasis
- Research on disease patterns, mortality and demographic transition
- Analysis of socio-economic differentials in mortality
- Fieldwork and interviewing on surveys of health and social conditions

Teaching:

- Lecturing on basic epidemiology and statistics for health planning
- Teaching basic statistics to social scientists

QUALIFICATIONS

MPhil

Research thesis on the epidemiological-demographic transition
University of London, 1980-87

MSc

Demography
London School of Economics & Political Science, 1977-78

BSc(Econ)

Economics and Sociology (including social statistics, survey methods and demography)
London School of Economics & Political Science, 1967

EMPLOYMENT

Sector Manager (Health and Population), DFID (7/99 -)

Bangladesh: Managing the DFID, Bangladesh NGO programme for the sector consisting of several projects (PHC, reproductive health, HIV/AIDS prevention and surveillance, leprosy control): working with project managers to achieve objectives; monitoring progress; assessing poverty-focus and health outcomes; conducting and commissioning project reviews and evaluations; strategic development of projects, new projects and initiatives in the context of national sector-wide strategies and programmes. Overall responsibility for a project contracting NGOs for PHC services and developing mechanisms for Government-NGO collaboration. Representing DFID at meetings with Government, development partners and NGOs on health sector issues; leading on DFID support to the National AIDS/STD Programme. Providing health input to other DFID sectoral programmes, including water and sanitation, environment and livelihoods.

Lecturer in Health and Population/ Adviser to DFID (12/95-6/99)

Centre for Development Studies, University of Wales, Swansea, UK

Teaching basic epidemiology and statistics on an MSc course in Health Planning and Development; supervising students, and conducting research. Reviewing NGO health project proposals and advising DFID on selection for funding; conducting monitoring visits to projects, including:

Uganda: Review of 10 health projects: HIV/AIDS prevention and care; integrated community development; slum sanitation; occupational health; family life education. (10/98)

Nepal: Review of 6 health projects: tuberculosis control; family planning and reproductive health; water and sanitation; community health, HIV/AIDS prevention. (10/96)

India: Review of 5 health projects: family planning and community development; community health; water and sanitation; HIV/AIDS awareness and prevention (11/96)

Technical Adviser on Health Surveys, MSF - Holland (2/92 - 11/95)

Conducting surveys; analysing data; managing a refugee health survey programme:

Bosnia: Analysis of health survey data in Sarajevo (9-10/95)

Based in Nairobi for fieldwork in East Africa region (7/93-4/95)

South Sudan: Studies on the epidemiology and treatment of leishmaniasis; nutrition and mortality surveys in Western Upper Nile; monitoring of TB treatment compliance (7/93-4/95)

Zaire: Health surveillance in Rwandan refugee camps (9-10/94)

Uganda: Analysis of data from a child nutrition survey (8/94)

Rwanda: Evaluation of a therapeutic feeding programme (11/93)

Somalia: Health, mortality and population survey among displaced people in Baidoa; review of the health surveillance system (1/93)

Based in Peshawar on the Afghan refugee programme (2/92-5/93)

Pakistan: Technical adviser/manager for the Afghan refugee health surveillance programme (MSF-Holland/UNHCR): design, data analysis and reporting on surveys for UNHCR and NGOs; studies of nutrition, infant mortality and maternal and child health (UNHCR); evaluation of a school health education project (LORCS); KAP survey to evaluate effectiveness of community health workers (SCF-UK); survey of nutrition and household needs in Afghan villages (SCF-US); study of pathogens and treatment of dysentery among refugee children (Pakistan Medical Research Council/UNICEF).

Research Fellow (11/90-5/91)

Medical Demography Unit, London School of Hygiene and Tropical Medicine.

Research on health inequalities in the UK using data from the Office of Population Census and Surveys: linking census and vital registration data to investigate relationships between social and household characteristics and subsequent mortality.

Health Data Analyst (10/89-10/90)

Refugee Health Unit (Government of Sudan/UNHCR), Showak, Eastern Sudan

Health surveillance; development of computerised database and information system; training staff

Research Fellow (4/89-10/89)

Social Statistics Research Unit, City University, London.

Research on socio-demographic and household characteristics in relation to mortality differentials.

Part-time research student at University of London (1979-88)

Financed by part-time work and research contracts, including:

Social Survey Fieldworker

Harris Research Centre, London

Lecturer in Social Statistics

University of North London (part-time)

Research Associate in Housing Studies

School of Advanced Urban Studies, Bristol University

Research Assistant in Population Studies

London School of Economics and Political Science

MSc student in Demography at London School of Economics (1977-78)

District Health Information Officer (4/77-10/77)

Sunderland Health Authority

Collection and analysis of health statistics for district planning

Health Information Officer (11/74-4/77)

South District, Westminster Hospital, London

Research on health information system; analysis of health data for district planning.

KEY PUBLICATIONS

Jacobs B, and Mercer AJ (1999) Feasibility of hospital-based blood banking: a Tanzanian case study. *Health Policy and Planning*, 14, iv, 354-362.

Guthmann JP, Mercer AJ, Gandubert C and Morin F (1996) Guinea worm disease in Ayod, Upper Nile Province, southern Sudan: a cross-sectional study. *Tropical Medicine and International Health*, 1, i.

Seaman J, Mercer AJ, Sondorp HE and Herwaldt BL (1996) Epidemic visceral leishmaniasis in Southern Sudan: treatment of severely debilitated patients under wartime conditions and with limited resources. *Annals of Internal Medicine*, 124, vii, 664-672.

Seaman J, Mercer AJ and Sondorp E (1996) The epidemic of visceral leishmaniasis in Western Upper Nile, Southern Sudan: course and impact, 1984-1994. *International Journal of Epidemiology*, 25, iv, 862-871.

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Mercer AJ (1992) Mortality and morbidity in refugee camps in Eastern Sudan: 1985-90. *Disasters*, 16, i, pp 28-42.

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Mercer AJ (1990) *Disease, Mortality and Population in Transition*, Leicester University Press; and St Martins Press, New York.

Mercer AJ, Goldblatt P and Pugh H (1989) Family and demographic circumstances and mortality differences among married women of working age. *LS Working Paper No 65, Social Statistics Research Unit*, City University, London.

Mercer AJ (1986) Relative trends in mortality from related respiratory and airborne infectious diseases. *Population Studies*, 40, i, 129-145.

Mercer AJ (1985) Smallpox and epidemiological-demographic change in Europe: the importance of vaccination. *Population Studies*, 39, ii, 287-307.

Mercer AJ (1981) Risk of dying from tuberculosis and cancer: evidence of a possible association. *International Journal of Epidemiology*, 10, iv, 377-380.

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- Current Position** Health Economist (Senior Service Fellow) 1999 - present
Prevention Services Research Branch
Division of HIV/AIDS Prevention
Centers for Disease Control and Prevention, Atlanta, GA
- Economic evaluation of HIV prevention programs
 - Decision analysis and quantifying risk of HIV acquisition
 - Modeling allocation of HIV prevention resources among different countries in Africa.
- Post-doctoral** Prevention Effectiveness Fellow 1997- 1999
Prevention Services Research Branch
Division of HIV/AIDS Prevention
Centers for Disease Control and Prevention, Atlanta, GA
- Cost-effectiveness of HIV prevention methods
 - Cost-effectiveness of HIV testing technology
- International Research Experience**
- Delhi and Karnataka AIDS Control Societies (In progress) 10/2001
India
- Use decision models to identify cost-effective HIV prevention interventions for sex workers in India.
 - Use a resource allocation model to develop a HIV prevention plan.
- Short-term consultant 3/1998
UNAIDS, Geneva, Switzerland
- Contributed to the preparation of the Report on the Global AIDS Epidemic (1998) by analyzing
 - the association between HIV/AIDS and socio-economic indicators of various developing countries.
 - impact of AIDS on human development indices, infant mortality and life expectancy.
- Economic Consultant 11/1997
Ministry of Health, Almaty, Kazakhstan
- Cost-analysis and economic evaluation of the current tuberculosis treatment plans

Teaching/Consultant

Prevention Effectiveness Course CDC, Atlanta	03/2002
CDC Consultant, Atlanta, GA Role of cost-effectiveness analysis in HIV prevention resource allocation	02/2001
Prevention Effectiveness Training State Health Department, Augusta, ME Decision analysis and economic evaluation of public health practices	10/2000

Professional Interests

- Operation research -- planning, implementation, and evaluation of health interventions in developing countries
- Developing structural and social interventions for HIV prevention
- Policy issues using knowledge of economics and public health

Other Training

Principles of Research on AIDS and STD, Seattle, WA	07/2001
Science of Scientific Writing, Atlanta, GA	05/2001
Principles of Epidemiology, Atlanta, GA	06/2000
Scientific Ethics Training, Atlanta, GA	03/2000

Education

PhD, University of Memphis, TN Health Economics (major); Sociology (minor)	1997
MS, North Dakota State University, Fargo, ND Agricultural Economics	1993
BS, Andhra Pradesh Agriculture University, India Agriculture	1988

Awards

Fogelman Academic Excellence Award Highest academic honor awarded to the top 1% of students College of Business and Economics, University of Memphis, TN	1996
Full Scholarship for Undergraduate Degree Awarded to top 5% of students for their academic performance Andhra Pradesh State Board of Education	1984 - 1988

Other Experience

Research Assistant Bureau of Business and Economic Research, University of Memphis	1995-1996
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Research Assistant	1991-1993
Department of Agricultural Economics, North Dakota State University	
Adjunct Faculty	1996
Christian Brothers University, Memphis, TN	
• Intermediate Microeconomics & Macroeconomics	
Instructor	1996
University of Memphis, TN	
• Introduction to Microeconomics & macroeconomics	
Instructor	1993-1994
Moorhead State University, Moorhead, MN	
• Introduction to Microeconomics & Macroeconomics	
• Intermediate Microeconomics & Macroeconomics	

Professional memberships

International Health Economic Association
International AIDS Economics Network

Computer Skills SAS, SUDAAN, various word processing and spreadsheet packages

Language Skills Fluent in English, Hindi, and Malayalam
Working knowledge of Telugu, Bengali, and Tamil

References

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Publications

Theses

1. Synthetic demand for feed barley 1993, North Dakota State University
2. The economics of pesticides and breast cancer 1997, University of Memphis.

Journal Articles

1. Varghese B, Maher JE, Peterman TA, Branson BM and Steketee RW. Reducing the risk of sexual transmission of HIV: Quantifying the per-act risk for HIV infection based on choice of partner, sex act and condom use. *Sexually Transmitted Diseases* 2002; 29:38-43.
2. Varghese B and Peterman TA. Cost-effectiveness of HIV counseling and testing in U.S. Prisons. *Journal of Urban Health* 2001,78; 304-312.
3. Varghese B, Peterman TA and Mugalla C. Cost-effectiveness of voluntary counseling and testing in Kenya and Tanzania. (Letter) *Lancet* 2001, 357:144-145.
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6. Varghese B, Newman D, and Husain IZ. Resource allocation for developing countries: How to get the most bang for your buck? (In preparation)
7. Varghese B, Kassler W, Kamb ML, and Peterman TA. Cost-effectiveness of HIV counseling Interventions – Project RESPECT. (In preparation)
8. Chesson HW, Scotton CR, and Varghese B. Does funding for STD and HIV prevention matter? (In preparation).
9. Varghese B and Johnson D. Analyzing the demand for feed barley. *Agribusiness and Applied Economics Reports*, 1993, 303. (North Dakota State University Publications).

Abstracts

1. Varghese B, Newman D, and Husain IZ. Resource allocation for developing countries: How to get the most bang for your buck? To be presented at the International AIDS Economic Network symposium, Barcelona, July 6-7, 2002.
2. Varghese B, Peterman TA. Economic Evaluation of HIV counseling and testing program at Hampden County Correctional Center. National STD prevention Conference, San Diego, March 4-7, 2002. Abstract # 132.
3. Varghese B, Kassler W, Kamb ML, and Peterman TA. Cost-effectiveness of HIV counseling Interventions – Project RESPECT. International Congress for Sexually Transmitted Diseases, Berlin, Germany, June 23-27, 2001. Abstract # 100.
4. Varghese B, Maher JE, Peterman TA, Branson BM and Steketee RW. Quantifying the reduction in risk for HIV infection by choice of partner, sex act and condom use. XIII International AIDS Conference, Durban South Africa, July 9-14, 2000. Poster # WePeC4303.
5. Varghese B and Branson BM. Cost and cost-effectiveness of oral fluid testing compared to serum testing. XIII International AIDS Conference, Durban. July 9-14, 2000. Poster # ThPeC5433.
6. Varghese B and Peterman TA. Test and Protect: HIV counseling and testing for HIV prevention in Africa. International AIDS Economics Network Symposium, Durban, July 7 –8, 2000.
7. Varghese B, Maher JE, Peterman TA, Branson BM. What's love got to do with it? Quantifying the risks of HIV acquisition. National HIV Prevention Conference, Atlanta, GA, August 30-31, 1999.
8. Varghese B and Peterman TA. Cost-effectiveness of HIV counseling and testing in U.S prisons. Meeting of the Expert Panel on Communicable Diseases, National Commission on Correctional Health Care, Chicago, IL, June 15, 1999.
9. Varghese B, Peterman TA, and Holtgrave DR Cost-effectiveness of HIV counseling and testing and partner notification: a decision analysis. National STD Prevention Conference, Dallas, December 6-9, 1998. Poster # 31.
10. Varghese B and Peterman TA. Cost-effectiveness of HIV partner notification and counseling and testing: a decision analysis. XII International AIDS Conference, Geneva, Switzerland. June 28-July 3, 1998. Poster # 44248
11. Varghese B and White-Means S. From the Earth to My Bosom: Pesticides and Breast Cancer. Southern Economic Association Meeting, Washington, DC - November 23-25, 1996.

Saturday 02 November 2002
15:45-16:15 pm – SWA Presentation

**Representation of the ICDDR,B Staff Welfare Association (SWA) to
The Board of Trustees meeting, November 2002**

Welcome !

Hon'ble Chairperson of the ICDDR,B Board of Trustees Dr. Ricardo Uauy Dagach, respected Trustees, representatives of the Government of Bangladesh, Patron-in-Chief of the Staff Welfare Association, 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 amid their busy time schedule. I hope, the issues that I am going to raise will receive your favorable consideration.

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 salary adjustments during the last three years. 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 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 this, they have been continuing their efforts to accomplish the Centre's goals in promoting health and human welfare world-wide. The Gate's Global Public Health Award which has been given to the ICDDR,B and which reflects the contribution of the staff at all levels is a good example.

It should be emphasized that the Centre's strength is its skilled employees. Hence, their morale and interest must be protected judiciously against all odds. This will ensure an uninterrupted growth and development of the Centre.

I would therefore, strongly urge upon the Board and the management that they consider a definite plan of action, preferably in co-operation with the staff members, as to how the salary gap could be resolved on a priority basis, in the best possible way, considering the interest of the Centre, its financial situation, staff expectation, and the regulatory issues. Without having such a plan, the future is left to chance and uncertainty with little probability of success. I would therefore request the Board and the management to raise the salary along with the increase of children allowance from TK.500.00 to TK.1000.00

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

Benefits by the SWA to the staff: I would like to bring to your kind attention, the important role that the SWA has been playing in accomplishing the overall goal of the Centre. Through its medical assistance fund, the SWA provides monetary benefit to employees, provides educational funds to staff dependents, organizes cultural activities including picnic, annual dinner, farewell to outgoing staff, condolences of deceased staff, construction of mosque in Matlab, and home gardening and fish production in Matlab. Through the Co-operative Society, the SWA has been significantly contributing to staff welfare by its credit programme.

Conclusion: By interacting with the management, the SWA also contributes significantly in improving staff relationship with the management with regard to the administrative, financial, and regulatory activities.

We believe that the confidence and trust between the SWA and the management is very important for the development of the Centre and we must ensure that our mutual cooperation definitely leads to an even more productive future.

Thank you.



Dr. Md. Sirajul Islam

President, ICDDR, B Staff Welfare Association

6/BT/NOV 2002

**STRATEGIC PLAN
TO THE YEAR 2010**

*Awarded the first-ever
Gates Award for Global
Health, May 2001*



Centre for Health and
Population Research

Investing in solutions at the heart of the problem

Strategic Plan to the year 2010

Acknowledgements

This Strategic Plan represents the collective work of the scientists and staff of the ICDDR,B: 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 un-official as well as official discussions relating to the Centre. We appreciate all of these contributions.

Vision, Mission, and Values

The Centre's vision

- Sees opportunities for people in developing countries to be healthy, to raise healthy children, and to avoid many of the health hazards that are now keeping the current generation from reaching their potential,
- Understands how health research, in its broadest context, can help to fulfil this vision of a healthy next generation,
- Feels that an international centre, bringing expertise from varied geographic backgrounds, and many disciplines, can play a unique role in carrying out the research that will build knowledge for improving health,
- Will help to care for the current generation, even while it carries out research that will help the next,
- Will be a partner with national and other international organizations in fulfilling its vision for a healthier future generation.

The Centre's Mission

The mission of the Centre is to develop, test, and disseminate realistic solutions to the major health and nutrition problems facing those living in the poorer nations, through advanced research, training, and communication, and caring for patients and communities. These activities are coordinated to lead to responsible and efficient health practices and improved policies and programmes.

The Centre's guiding values

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

VISION, MISSION, AND VALUES	2
I. FOREWORD	5
II. EXECUTIVE SUMMARY	6
BUILDING ON ACCOMPLISHMENTS.....	6
PLANNED ACCOMPLISHMENTS DURING THE COMING DECADE.....	7
CONSTRAINTS TO THE CENTRE'S SUSTAINABILITY	12
STRATEGIES.....	13
<i>Continually improving our Infrastructure.....</i>	13
<i>Maintaining and strengthening the Centre's cooperation with the Government of Bangladesh and national institutions.</i>	15
<i>Maintaining and strengthening the Centre's cooperation with international health networks.</i>	15
<i>Increasing donor support for both core and projects, and broadening our donor base.....</i>	16
<i>Continuously improving the expertise of our professional and technical staff</i>	17
<i>Completing our master plan.....</i>	17
<i>Broadening Our International Reach.....</i>	18
<i>Costs for the strategic plan.....</i>	18
III. BACKGROUND	21
HISTORY OF THE CENTRE	21
ORGANIZATIONAL MANAGEMENT.....	23
<i>Board of Trustees.....</i>	23
<i>Divisions</i>	23
Clinical Sciences Division (CSD)	23
Public Health Sciences Division (PHSD)	23
Laboratory Sciences Division (LSD).....	24
Health Systems and Infectious Diseases Division (HSID)	24
Information Sciences Division (ISD).....	24
<i>Programmes</i>	24
Child Health Programme.....	24
Reproductive Health Programme.....	25
Nutrition Programme.....	25
Infectious Diseases and Vaccine Sciences Programme.....	25
Health and Family Planning Systems Programme	25
Population Sciences Programme.....	25
New Programmes	25
<i>Administration</i>	26
ORGANIZATIONAL APPROACH	26
<i>Interdisciplinary and Inter-divisional Approach</i>	26
<i>Review Mechanisms</i>	27
<i>Ethical Reviews</i>	27
<i>ICDDR,B Research Way.....</i>	27
<i>Collaborations</i>	28
<i>Infrastructure.....</i>	28
<i>Surveillance Systems</i>	29
<i>Financial systems</i>	29
FUNDING.....	29
IV. CONTEXT	31
GLOBAL SETTING	31
BANGLADESH SETTING	34
V. PROGRAMMATIC DIRECTIONS.....	36
PRIORITY SETTING.....	36
<i>Life Cycle Approach.....</i>	36
<i>Conceptual Framework.....</i>	38
PROGRAMME PRIORITIES.....	38

<i>Child Health</i>	38
<i>Reproductive Health</i>	42
<i>Nutrition</i>	45
<i>Infectious Diseases and Vaccine Sciences</i>	47
<i>Health and Family Planning Systems</i>	50
<i>Population Sciences Programme</i>	53
VI. INSTITUTIONAL DEVELOPMENT AND EXPANDED SERVICES	56
CLINICAL, LABORATORY AND FIELD RESOURCES	56
<i>Dhaka Hospital</i>	56
<i>Clinical Laboratory and Diagnostic Unit (CLDU)</i>	57
<i>Research Laboratories</i>	58
<i>Urban and Rural Field Areas</i>	58
Matlab	58
Other Rural Field Areas.....	59
Urban Field Areas.....	59
<i>Information Sciences</i>	60
Training and Education Unit (TEU)	62
DISC.....	62
Computer Information Services (CIS).....	62
INSTITUTIONAL SUPPORT SERVICES.....	63
<i>Human Resources Management</i>	63
<i>Financial Management</i>	64
<i>Procurement</i>	64
<i>Transportation, maintenance, general services, catering, physical plant management</i>	64
VII. FINANCIAL SUSTAINABILITY	65
<i>Resource Mobilization</i>	65
<i>Centre endowments</i>	65
<i>Common institutional costs</i>	66
<i>Income Generating Projects</i>	66
VIII CONCLUSION.....	68

I. FOREWORD

At a June 2000 meeting, the Board of Trustees (BoT) asked the Centre to develop a Strategic Plan for the next few 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 finalized two sets of questionnaires and disseminated one to the Principal Investigators and the other to the Associate Directors and Programme Heads. Subsequently, the SPCG developed checklists to generate additional information and reach consensus on other organizational 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

At the June 2001 BoT meeting, the draft Strategic Plan was presented. Useful discussion followed, and the draft plan was modified accordingly. There was further discussion at the November BoT meeting and the revised plan was shared with the Government of Bangladesh (GoB). The second draft of Strategic Plan was considered at the June 2002 BoT meeting and will now be distributed to invested parties for additional input before final consideration by the BoT in November 2002. 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.

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.

Tracking of activities will be done every four months by means of monitoring tools, giving an update of deliverables, targets completed during the reporting period, reasons for delays, key findings, presentations and publications and implications for policy and action. Further, each Programme will identify new areas of research, not included in the Strategic Plan, for consideration of the Scientific Council.

II. EXECUTIVE SUMMARY

The ICDDR,B: Centre for Health and Population Research (The Centre), and recipient of the **first-ever Gates Award for Global Health**, is a maturing health research and service institution, based in Bangladesh, with a global sphere of influence. Although already recognized as a leading institution in international health research, service, and training, it sees an even more productive era during the decade.

Building on Accomplishments

- The Centre has made outstanding contributions to the health of families around the world. Its discovery and further development of oral dehydration solution is hailed as one of the most outstanding medical discoveries of the last century and has saved the lives of 40 million children with diarrhoea.
- Its findings on the proper management of enteric infections, antibiotic resistance, and epidemiology of these diseases have formed the knowledge base for the rest of the world. Through its work in its hospitals, it has saved the lives of over 200,000 patients during the last 20 years at a cost of about \$10 per patient treated.
- The creation of the population based field area of Matlab is a model for public health strategies around the world. Continuously, public health decision makers turn to the ICDDR,B and Matlab to understand what underlying factors are important for making decisions.
- The development of appropriate and successful family planning strategies in Bangladesh has made this country a family planning success story, and these strategies are being used around the world. The success of the Bangladesh family planning programme has resulted in a current population that is 50 million fewer than it would have been if the programme had not been started.
- Its research on immunizations have shown how routine and new vaccines can decrease illness and death rates in developing countries and this research continues to guide the use of vaccines around the world.
- Its advances in the treatment of children with severe malnutrition has shown that this is a treatable and not a fatal disease, and has shown how it can be implemented even when hospital care is not available.
- Its combined programmes in child health and family planning have led to a 75% reduction in the annual number of childhood deaths in the last 25 years in its field area.
- Its findings on the benefits of micronutrients have led the way to further improvements in the health of children.
- The Centre's evolution has shown how an international centre, with staff from many countries working side by side, can benefit from multiple cultures to develop cost effective solutions for the major health problems facing the world.
- It has also shown how an international health centre can function as a partner with the government and the people of Bangladesh in a way that respects and supports each other to the benefit of the people of the country and to the benefit of other poor countries.

- It has shown how a Centre can grow from a laboratory, highly focused on cholera, to a full-fledged comprehensive health centre of research, service and training. Furthermore, it has shown how an institution with vision, purpose and principles can thrive through changes in governments, changes in donor priorities, and changes in senior staff. In short, it has matured into a world-class institution.

Because of these and other outstanding achievements, the Centre was awarded the "first-ever" Gates Award for Global Health in May 2001 with a prize of \$1 million, and the Government of Bangladesh provided an equivalent matching grant.

Planned Accomplishments During the Coming Decade

The Centre is now planning for an even more ambitious agenda during the coming decade. Building on the strengths, capabilities and opportunities, the Centre will continue its mission and will gradually expand its role in the international health field.

Although the accomplishments of the past have resulted in rapid progress that is now benefiting families around the world, here are some examples of the advances from the Centre that will occur before the end of the decade. These are not goals, hopes, or dreams; these are the actual advances that can be made through the efforts of the Centre's staff, in partnership with others, within a relatively short time. **The one major condition to this promise is that the resources must be made available for these accomplishments to occur, but they are real promises that the Centre can make to the donor community.**

1. **The Centre will help to improve the health of infants during the neonatal period.** In Bangladesh currently more than 70% of all infant deaths are occurring in the first 28 days of life. Thus, if we are to improve overall infant mortality, we will have to learn how to reduce the deaths in this age group. The Centre is now embarking on major projects to solve this problem of high neonatal mortality and do it in a cost-effective and reproducible manner. **With the interventions that we are now piloting, we expect a decrease in neonatal mortality of 50% during the decade.**

With the introduction of zinc supplements, we expect a decrease of 50% in all-illness deaths during childhood (age 1 to 5).

2. **The Centre will help to improve the health of children through breast-feeding, improved nutrition, vaccines and treatment of common illnesses.**

We must, and will, find a way to give children a healthier and bigger start

2.1. The Centres scientists have already learned how to improve rates of proper breast-feeding and will learn how these can be scaled up so that all children can benefit from this healthy start.

2.2. Forty-five percent of the newborn children in Bangladesh weigh less than 2500 grams (the recognized cut-off for low birth weight) and this proportion is the highest in the world. The Centre's scientists have identified **low birth weight** as a marker of high risk for children and have initiated major interventions to understand how to increase the birth weight and how to help children born too small. While the initial project will require four years to complete, the long-term studies will continue to have rewards for at least 20 years as we learn the long-term consequences of our interventions.

2.3. The Centre's scientists have already learned the benefits of **zinc** when given to children with diarrhoea and pneumonia: it reduces duration of diarrhoea, and lessens the chance it will become chronic, it shortens episodes of pneumonia, and when it was used consistently, it lowered the overall number of deaths in children by 50%. The work of the Centre will now further validate the effectiveness of zinc in other conditions and in learning how this simple and inexpensive micronutrient can benefit all children.

2.4. The Centre's scientists have already learned how to care for **severely malnourished children** and have lowered the fatality rate from this life-threatening condition by 75%. The work of the Centre will now be to show how this simple standard treatment can be extended to all children who need it in Bangladesh and the region.

2.5. The Centre's scientists have already shown how **vaccines given during childhood and during pregnancy** save lives and reduce illness. The work of the Centre will be to: a) expand the appropriate use of the **current EPI vaccines** to eliminate measles, b) assist the EPI programme in **introducing new vaccines** for hepatitis B and others, and c) assist in the development and evaluation of **new vaccines for rotavirus, cholera, E. coli, shigella, bacterial pneumonia, influenza, dengue, and tuberculosis.**

Several new life-saving vaccines will be tested at the Centre during the coming decade.

2.6. The Centre's scientists have been instrumental in introducing **IMCI** (integrated management of childhood illness) in Bangladesh and in evaluating its effectiveness in real conditions in a rural area. The work of the Centre will now be to continue the evaluation, and improve its cost effectiveness in the community and first level health facilities.

2.7. The Centre has been treating thousands of patients with diarrhoea at a very low cost. Diarrhoea is an example of a **common, acute, life-threatening illness** that can be easily and inexpensively treated. \$10 is all that is needed to save the life of a child who would otherwise die of the disease. The work of the Centre will be to identify other easily-treated, common, acute life threatening illnesses such as pneumonia, severe malnutrition, acute fevers (typhoid, dengue, malaria) and to develop a strategy for treating these patients through a 24-hour short-stay clinic.

Diarrhoea is not the only life threatening disease that should benefit from simple treatment. No child should die from an easily treated, easily prevented disease.

2.8. The Centre's scientists have already developed the standard case management for diarrheal diseases using **oral rehydration solution** and have improved it with rice based ORS and low osmolar ORS. The work of the Centre now is to further improve ORS and improve case management of common enteric illnesses. This is possible with some of the newer drugs and nutrients that are being developed at the Centre and these will further hasten the recovery of children with diarrhoea and improve their nutritional rehabilitation. Although ORS is saving many lives, there are still improvements to be made and ways to help speed recovery.

We can improve the treatment of diarrhoea with medicines and with improved ORS, and we can show others how to use these more effectively.

3. **The Centre will conduct research to improve the way women are treated during pregnancy, during delivery, and following their delivery. The Centre will also need to**

learn how reproductive health services can best be delivered to the people in the communities and the cities.

Women have the right to a safe pregnancy and a safe delivery. The Centre will help to make this happen.

3.1. The Centre's scientists have already identified and documented the problems leading to high maternal mortality and have developed a model programme for reducing this through prenatal clinics, subcentres, safe delivery with trained midwives, and follow-up of women following delivery. The task for the Centre now is to translate this model into a workable system for routine care of women.

3.2. The medical community has identified the involvement of men as being critical to the overall success of reproductive health. The Centre will now need to increase the scope of this male involvement and identify ways to make it meaningful on a wide scale.

3.3. The Centre's scientists have identified sexually transmitted infections as a serious health concern for Bangladesh (as it is in most countries), and have identified especially the problem of increasing antibiotic resistance among the STDs. The task for the Centre now is to increase the effectiveness of programmes to control the spread of STDs.

3.4. The Centre's scientists have found that adolescents have insufficient knowledge regarding reproductive health and practice risky sexual behaviours. The Centre will develop and test strategies for improving the knowledge, and reducing risky practices of adolescents in Bangladesh so that these interventions can serve as models for other countries.

3.5. The Centre's scientists have observed that the decline in fertility that was so dramatic in Bangladesh has now levelled off. The Centre will conduct studies to understand the reasons for this plateauing of fertility in order to help the nation reach replacement fertility by the end of the decade.

A further decline in fertility is essential if Bangladesh is to reach replacement fertility and achieve a healthy country. The Centre will work with the Government to help reach this goal.

4. The Centre has a renewed emphasis on issues of poverty, equity and health.

4.1. The Centre's scientists have identified that **inequity of health services** continues to be a problem throughout the world, including Bangladesh. The Centre will conduct studies to monitor the equity of various health interventions so that the successful ones can also be equitable.

4.2. The Centre's scientists have found direct **correlations between poverty and health**. They will conduct studies to better understand this relationship in order to document the economic benefits of good health as well as the economic consequences of ill health. Similarly, they will identify the ways to improve overall development of the country through the promotion of healthy communities.

Just because a family is poor should not mean it does not receive good health care. Every family is precious.

4.3. The nation has many development projects that impact on the economic life of the country. The Centre will assist in monitoring the **health consequences of these developments** since some of them may have beneficial or adverse health consequences that must be understood.

4.4. Our scientists understand the difficult nature of providing health care services at a low cost. The Centre is **documenting the costs** of IMCI, the costs of the ESP services, the costs of nutrition services, and is exploring alternative ways to fund these services. The Centre is also working with communities to see if there can be a community-based Health Cooperative model that will be more responsive to the community needs and will allow for more community control and input.

In a poor country, every Taka should be well used. The lessons from Bangladesh will help other poor countries around the world.

5. Emerging infections are a threat to Bangladesh and the Centre is assisting to understand and to control these infections.

5.1. The Centre's scientists have identified a new strain of cholera, *V. cholerae* O139 (Bengal) and have traced its evolution. This is the first time that scientists have been able to watch a new pathogen emerge and evolve prospectively. We expect that this strain will be the next (8th) pandemic strain. The Centre is in a position to prepare the world how to deal with this new pandemic strain, and potentially to develop a vaccine that would protect others so that it does not kill so many people as past cholera pandemics have done.

The Centre can help the world prepare for the next cholera pandemic. Likely it has already started.

5.2. The Centre has been conducting surveillance for HIV-AIDS and will continue to assist the Government of Bangladesh for this infection.

5.3. Bangladesh faces an HIV-AIDS epidemic as part of the global pandemic but it is (at this point) a low prevalence country. The Centre will assist the nation in preventing this epidemic, and will also help to formulate a preventive strategy for low prevalence countries. Special emphasis at the Centre will be on reaching adolescents, voluntary counselling and testing, and preventing mother to child transmission. The Centre feels that we must help the infected if we are to prevent the epidemic spread.

The HIV-AIDS epidemic will be coming to Bangladesh; it's a matter of time. We must prepare, or be held accountable for not doing everything we can do to limit its damage.

5.4. The Centre's scientists have initiated studies on tuberculosis to understand its antibiotic resistance and its epidemiology in a defined rural area. The Centre will now continue its work on tuberculosis by conducting research on its spread in urban areas, improving the effectiveness of DOTS therapy, early detection of tuberculosis, and improving diagnosis and treatment of children with tuberculosis. The Centre also will build the capacity for conducting field trials of new therapies and improved vaccines. This is an especially high priority area since there now exists a window of opportunity to control tuberculosis before the HIV-AIDS epidemic strikes and greatly amplifies the ongoing tuberculosis problem.

Tuberculosis kills 70,000 people each year in Bangladesh.

5.5. The Centre's scientists have been conducting research on dengue fever and have documented the serotypes and the epidemiology of the infection in the country. The Centre will now carry out more advanced research to improve case management, reduce incidence through innovative mosquito reduction strategies and evaluation of new vaccines.

5.6. The Centre's scientists have begun to document the burden of disease of multi-resistant *P. falciparum* malaria in Bangladesh. This infection threatens 10 to 15 million Bangladeshi citizens (more than most African countries). The Centre will develop community-based strategies for controlling malaria and using one of its field area (Charkaria) to develop models that will be useful for all of Southeast Asia. Within the malaria arena, it seems that Asian malaria has been relatively neglected, and our field area is ideal for evaluating community-based interventions.

5.7. The Centre's scientists have been conducting surveillance for other emerging infections and are prepared to respond, in cooperation with the Government of Bangladesh and the World Health Organization to these new threats. These include, but are not limited to, influenza, leishmaniasis, and Nipah virus.

5.8. Understanding the control of infectious diseases requires an understanding of basic mechanisms and the Centre's scientists have undertaken basic studies of how certain bacteria survive in the environment, how they spread to people, what genetic properties they possess that allows them to be pathogenic, and the immune responses that protect people. The Centre will continue to conduct this type of basic research that is so vital to a complete understanding of host-infection interaction and eventual control of diseases. This is especially true for cholera, amebiasis, and other enteric infections.

One cannot separate basic science from applied; both are needed to create the knowledge base for controlling disease.

6. The Centre has a substantial physical, scientific and administrative infrastructure, but this can become even more productive and efficient. Importantly however, the Centre will have to grow to accomplish the tasks that lie ahead.

6.1. The Centre has a computerized and reliable accounting system, but the Centre will be obtaining a **new financial and HR management system** to streamline the management of the Centre. About 48% of the staff are women, but the Centre is determined to insure **gender equality** at all levels of the organization.

6.2. The Centre has a well functioning and independent **ethical review committee** that is mandated by the ordinance and certified by the U.S. government. The Centre will maintain the high ethical standards that already exist and will contribute to the debates on ethical standards and processes for developing countries.

6.3. The Centre has **scientific review** mechanisms in place that insure the quality and relevance of protocols being carried out at the Centre. These will be further strengthened through the scientific programmes at the Centre.

6.4. The Centre has a **staff development programme** that has led to the training of over 50 Bangladeshi scientists through to the level of the PhD even more to the master's level. The Centre will continue to assist with the development of talented Bangladeshi scientists in order to build the future leadership at the Centre while it assists in the prevention of brain drain from Bangladesh. Being an international Centre, it will also provide opportunities for young scientists from other countries, but especially from Asia.

Constraints to the Centre's Sustainability

While the Centre has a stellar list of accomplishments and a bright future, it also has several constraints that must be overcome. While the strategic plan does not dwell on these constraints, it does understand them and is working to overcome them. These can be categorized into three major categories: financial, staffing, and physical facilities.

The Centre's finances are not stable since it has a relatively small endowment given the size of its annual operating budget. The Centre engages in long term planning but is able to garner only short term funding. Most income (about 85%) is based on project funds and much of this is year-by-year income. Also, many donors have policies against full funding for the projects they choose to fund; that is, they do not pay for fully for the indirect costs (also called common operating costs). Rather they appear to expect other donors to make up for this shortfall. Since the Centre is not a government institution, there is no way to make up for these indirect cost losses that are, in fact, real costs of carrying out the projects.

Short term funding with long-term institution building is a major constraint. A sizable endowment is needed to provide stability and long-term productivity

An unknown situation exists with respect to the "Global Funds." The global funds could potentially attract funding from our traditional funding sources, thereby decreasing our core support. The global funds may also redirect the funds to more highly focused projects, and these do not necessarily have the broad-based comprehensive approach that our Centre promotes. Since the global funds are just starting, it is not yet clear how they will impact our funding base, and we will have to learn how best to interact with them.

High quality scientific and other professional staff are always difficult to recruit, and Dhaka is not a particularly attractive location for many international experts who may have the option to locate in western capital cities. Our requirements may also be unique because of the multi-cultural nature of the Centre and the need to find people that will be able to attract funding of their own within a short time. Though difficult, we have been fortunate in identifying and retaining excellent staff, because of our reputation and the academic and humanitarian vision at the Centre. The Centre is also increasingly identifying highly qualified national professionals to assume leadership positions and our staff development programme has yielded very productive scientists. By recruiting highly qualified Bangladeshi scientists, we have found that we have not changed the essential international character of the Centre, but rather have made it even stronger, and this has enhanced the national character of the Centre.

The lack of physical facilities is increasingly a constraint. In the laboratories the scientists are needing increasingly sophisticated equipment in order to continue to be at the cutting edge, and all divisions are crowded and in need of space. The library and training units need to double in size, and the HIV-AIDS and immunology laboratories are very cramped. The Centre would also like to increase its ability to build capacity with the government institutes, and this will require space as well. Finally, the infrastructural utilities need to be upgraded with our independent power generator. Major capital items like this are especially difficult to procure since

The Centre needs to expand its laboratories, library, training and office space if it is to meet the challenges.

most of our income is specifically project-funded and funds from these sources cannot justify major capital items that are used for the Centre as a whole.

Strategies

The strategies for reaching the targets as described above involve a) maintaining our already strong infrastructure and further strengthening these resources, b) maintaining and strengthening the Centre's cooperation with the Government of Bangladesh, c) increasing donor support for both core and projects, and broadening our donor base, d) continuously improving the expertise of our professional and technical staff, e) completing our master plan for increased space, including increased space for high quality laboratories, library, training, computer, and offices, and f) broadening our international reach to regional and international areas of the world.

Continually improving our Infrastructure

The infrastructure includes the human resources, the hospitals and laboratories, the administrative systems, and the relationships with government and non-government agencies. The scientific reputation of the Centre is well known, but the Centre is also well known for the quality of its services to patients and to those who use our clinical laboratory facilities. It is also known as an institution where financial reports are dependable and transparent, and where personnel actions are fair.

In spite of the excellence that the Centre has achieved, there are certainly opportunities for improvements that will lead to greater efficiencies. Some of these include:

➤ **Scientific Reorganization.** Following a prolonged evaluation of our organizational structure, the Centre **created an administrative structure that involves both Scientific / Technical Divisions and Cross-divisional Programmes.** This organization allows for the clear lines of authority and efficiency of responsibility as well as the mechanism for fostering the broad-based interdivisional projects that the Centre is uniquely qualified to carry out. From the basic laboratory, to the field, and to implementation, we are not aware of any other institution in the world, that can carry out the range of public health interventions that are possible at the ICDDR,B. This reorganization was completed during 2001, but we expect that refinements to it will continue to occur to meet the needs of the emerging tasks to be done.

➤ **Strengthening the clinical research capacity.** The Centre already has a study ward (sometimes called clinical research ward) and a metabolic unit, and can also conduct research in the general ward. The research capacity will however be strengthened through a renovation of

Clinical Research has been a mainstay of the Centre's scientific productivity and this will become even stronger. Our clinical research, in the future, will emphasize nutrition, pneumonia, dengue, tuberculosis as well as diarrhoea.

the metabolic unit allowing for nutritional studies even more efficiently, a reorganization of the study ward to more efficiently complete studies, a separate unit for monitoring Good Clinical Practice, and increased facilities for long term follow up of outpatient research subjects. A strength of the Centre is the ability to conduct clinical research effi-

ciently, and this quality will become even stronger. The Centre's ability to carry out GCP studies rapidly and efficiently should attract donors who need such facilities for testing new pharmaceuticals and biologics.

➤ **Renovations to the hospitals in Dhaka and Matlab.** The hospitals are too crowded and should provide an atmosphere that provides more respect for the patients that is not possible now. When the master plan is finished, there will be additional space for hospital patients, but in the short term, we will make needed improvements to the hospital to provide some sub-divisions in the wards so the wards are not so large. This will also allow for increased sanitation and hand-washing facilities, as well as general maintenance and improved cleaning.

➤ **Strengthening of the basic science laboratories.** The Centre "takes science where the problem is" and it is critical for the Centre to use advanced scientific methods to solve major public health problems. Thus, the Centre must maintain first-world laboratories with first-world expertise even though it is located in Bangladesh. Thus, the Centre will have to renovate and enlarge certain laboratories. This is especially true for HIV, virology, environmental microbiology, molecular biology, parasitology, nutritional biochemistry, and for outbreak investigations. The Centre will increasingly use molecular techniques (e.g. PCR) for routine diagnosis in its clinical laboratory as well. The Centre will also require a separate laboratory to support the various vaccine trials that will be taking place and these laboratories will need to meet GLP standards.

➤ **Improved computer networks.** The Internet and computer technology will continue to evolve and the Centre will need to keep pace with these developments.

➤ **Expansion of the Diagnostic Unit.** The Centre's clinical laboratory provides laboratory services to the Dhaka community and is valued for the quality of the service. The reception area of the diagnostic unit was recently renovated to improve the quality of the service. Given the laboratory equipment available at the Centre and the quality control procedures in place, there is opportunity to expand the laboratory services to other cities in Bangladesh, perhaps to Chittagong or other major cities. This may provide needed quality service to the people of Bangladesh and also strengthen the financial position of the Centre.

➤ **Expansion of the franchising of clinical care.** The Centre initiated a programme to introduce ICDDR,B quality care into NGO clinics in Dhaka and potentially other cities in Bangladesh. This has begun at the PSKP clinic in Mohakhali, but it now needs to be extended to many other facilities.

➤ **Continued maintenance of the ICDDR,B field areas.** Matlab is world famous for its public health research and the people of the Matlab area benefit from their partnership with the Centre. The Centre also has several other field areas that are less intensive than Matlab. The Centre intends to limit the field areas where it will be involved to those in which projects are currently ongoing, but not to expand to other areas. This does not exclude involvement for brief projects in other areas, but these other areas would not be seen as permanent ICDDR,B field areas.

➤ **A new financial and HR automated management information system.** New systems are being evaluated and the Centre expects the new system to be initiated by early 2003. Although the current systems are computerised and accurate, the new system will provide more current information to the scien-

A new management information system will improve the Centre's administrative and scientific efficiency.

tists and managers allowing them to improve performance. In the long run, it will allow the Centre to increase its work output without increasing the number of administrative staff.

Maintaining and strengthening the Centre's cooperation with the Government of Bangladesh and national institutions.

The ICDDR,B is the only international health research organization based in a developing country and the Government of Bangladesh is the only developing nation in the world that has fostered such an institute. The international character should not detract from the important role of the host government: indeed, the original name given to the Centre reflects both its international scope as well as its base in Bangladesh. Soon, the Centre will have completed 25 years as an international centre, and the government has already renewed the ordinance for another 25 years. During this next 25 years, the Centre anticipates an increasing role as a partner with the Government. The Centre's Board of Trustees includes the Secretary of the External Resources Division and the Secretary of Health and Family Welfare, and these official links with the Government greatly facilitate our cooperation.

In the past, the primary interactions were with regard to diarrhoeal disease, family planning, and health systems. In the future, the Centre anticipates much more interaction with all of its scientific programmes and especially intends to a) insure that the research findings are much better known to the Ministry officials so that they can result in policy and action, b) insure that the research projects addresses practical questions of the health system, and c) assist the Ministry in preparation of major projects and assist with their evaluations. Special emphasis will be given to working with the Government with regard to tuberculosis, HIV-AIDS, malaria, dengue, pneumonia and other communicable diseases, malnutrition and micronutrients, safe motherhood, IMCI and neonatal mortality, and vaccination programmes. The Centre hopes to play an important role by conducting practical, operations research in support of the new sector wide health, nutrition, and population programme and in support of strengthening the Essential Services Package.

The ICDDR,B is the only international health research organization based in a developing country and the Government of Bangladesh is the only developing nation in the world that has fostered such an international health organization.

To increase our partnership with the Government as well as with NGOs, the Centre will have regular meetings with various stakeholders whenever large-scale projects are being considered in order to gain their experience, opinions, and ownership, and will also share the findings of our projects through dissemination seminars, as well as regular health bulletins and journals (e.g. JHPN). Furthermore, the library serves as a resource for the local health professionals.

Maintaining and strengthening the Centre's cooperation with international health networks.

The Centre collaborates and cooperates with multiple international partners in its research and service and training programmes. These include the World Health Organisation, UNICEF and UNAIDS, and other UN agencies, as well as universities in North America, Europe and UK, Asia (especially including Japan), Ministries of Health and pri-

vate companies in many countries. As an international centre based in a developing countries, these international links are critical to remaining at the forefront of health research. The collaborations are carried out through Memoranda of Understanding that describes the nature of the joint projects.

Increasing donor support for both core and projects, and broadening our donor base

The plan being described here will require increased support from the existing donors and expansion of the donor base to include new donors. And this increase must come at a time when the global economy is not favourable. The strategy for increasing our funding base will include the following:

- Demonstrating that investment in the Centre yields very positive and dependable results. Thus, although funds are scarce, we will demonstrate that the ICDDR,B is a good place to put the limited funds that are available. Furthermore, long term funding in the Centre is the right thing to do from both a humanitarian as well as scientific standpoint.
- For individual donors, that **investment in the Centre will provide satisfaction** that the funds are being used correctly, and will benefit the poorest of the poor. We will point out that the Centre does provide high quality care to those who need it most and at the same time, helps to alleviate the underlying problems so that the next generation need not suffer in the same way as the current one.
- For donors who provide funding on a project-by-project basis, the Centre will encourage them to request the Centre to be a partner, but at the same time, these donors will need to understand the need for **full funding of projects**, including the indirect costs (common operating cost). The Centre will adhere to the stated indirect cost rates. In return, the Centre will provide audited statement of these indirect costs so that they are transparent and reliable to all donors¹. By definition, the indirect costs are not limited to those costs that are directly related to the specific project, but include the costs for maintaining the institution as an international Centre of Excellence.
- **The Centre has launched two campaigns** for raising funds from non-traditional donors.
 - The "**Circle Around the Centre**" is targeted to alumni and relatively small donors who would like to participate in the Centre's programmes, and especially with the staff development programme that facilitates higher training for the Bangladeshi staff at the Centre.
 - The "**100 Partners**" is a special endeavour for companies and donors groups who are able to contribute at least \$10,000 annually. The 100 partners is specifically for the Centre's endowment, and if we are successful, this programme will add \$1 million to the endowment.
- The Centre will enhance certain income generating activities by providing services that are within its area of expertise and within the scope of its programmes. Thus, the Centre can become less dependent on outside donors. Using this strategy, a positive balance in one cost centre can help to offset a negative in another. With decen-

¹ All too frequently, we are finding that other agencies pass funds through to the Centre, but in the process, indirect costs are retained by the "middle-man" and are not available to the Centre, even though the Centre actually implements the project. This is both unfair and is not financially sustainable for the developing country institution.

irialization, income generation in one field area can be reinvested in that same field area.

- Explore with the "Global Funds" ways that the Centre can become a "research arm to these programmes.
- Continue with Profile Raising Events and communications to let people know about the Centre. Profile raising usually implies dinners and receptions, and these will be planned, but we will also stress communications via popular press, CD's, review papers, and policy briefs.
- Importantly, we will improve overall donor relations through a reorganized External Relations and Institutional Development Office (ERID) office with additional staff and clear lines of communications for the donors. With the financial crisis a few years ago, the resources of the ERID office were hampered, but the reorganized office should improve this communication.

Continuously improving the expertise of our professional and technical staff

The Centre's productivity is only possible because of the excellence of its staff, and we must continually upgrade the capability of the staff. The staff development programme will invest in graduate level training for professional staff, in both scientific and administrative tracks. Much of the current leadership at the Centre has developed through the staff development programme. This is a worthwhile investment in the capacity of Bangladeshi professionals.

As many of the Centre's Bangladeshi scientists have already received their PhD (or equivalent), increasing emphasis will be on helping these scientists keep on top of their field through sabbaticals and other types of postdoctoral training. This is a change from the past practices in which there was little training or post-doctoral development following the doctoral degree.

The Centre will also increasingly stress in-service training for its staff to continuously upgrade their skills. The training will include use of computers, scientific methods, scientific writing, as well as soft skills like group building and personnel supervision. The goal is to build a unified workforce of capable people who understand the vision of the Centre and can carry out the projects needed to carry this out.

Completing our master plan

The original master plan was developed nearly 25 years ago and was updated in 2002. It is now time to complete the plan to provide the needed facilities to carry out the plan as described. It will be possible to continue to survive with the current buildings, but this would be a major mistake to just survive. The Centre has the potential to become a truly great institution, but it will require additional buildings, laboratories, libraries, and offices.

The master plan includes completing the eight-storied main building (that was started in the early 1980s), adding a 20-story tower office complex beside the main building, and providing for independent electric power generation. The completion of the main building will allow for the accommodation of the ongoing activities more appropriately and will provide for sufficient space to care for patients in a more respectable manner (without providing for additional patients). The tower will only be half occupied by

Centre staff, but the other half would be rented for the first five years. After five years, the Centre will likely require all of the space. This plan assumes that the Centre will continue to occupy all of its current space at its Mohakhali campus.

The health needs of the poor people of the world are great and it is only logical and appropriate that the one institution based in a poor country and devoted to helping solve the health needs of developing countries, should have the space needed to carry out this important work.

Broadening Our International Reach

The Centre is based in Bangladesh and has field areas in many districts of the country. It has a considerable international outreach and the Centre plans to strengthen this aspect. The international outreach for the Centre includes a) the international relevance of its research including publication in international journals, b) the Centre's scientific methods being used as models for other institutions (e.g. the widely used demographic surveillance system of Matlab), c) the training that has brought more than 20,000 trainees to the Centre from 78 countries, d) consultations by Centre scientists to other countries, e) Centre scientists serving on international committees and policy making boards, f) collaborative projects with institutions in other countries. In the future the Centre will particularly highlight the collaborations with institutions in the region. Currently we have ongoing work with the Ministry of Health in Nepal and we anticipate that this may expand. Theoretically, the Centre could establish an office in other countries, but this will depend on the individual projects. The Centre also has capacity to assist certain African countries deal with cholera, its microbiology and clinical management, and this is another area that we will explore further.

Costs for the strategic plan

The current annual budget of the Centre is about \$15.5 million. This has grown from about \$12 million just 3 years ago. This includes about \$ 4 million for basic infrastructure of the Centre and 11.5 million for specific projects. The projects will continue to increase with the increasing activities of each of the Divisions and Programmes. To give some examples:

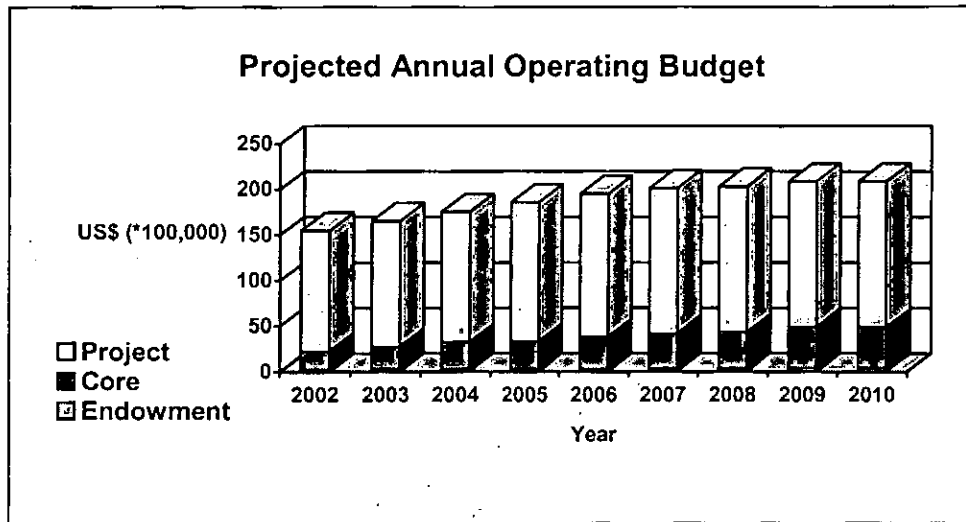
➤ The Infectious Disease and Vaccine Programme has identified vaccine development projects for vaccines to prevent cholera, rotavirus, enterotoxigenic *E. coli*, pneumococcal infections, *H. influenzae*, viral influenza, dengue and tuberculosis. Each one of these vaccines could result in protocols totalling several million USD. Each is feasible and each can be done, but each will have to be funded. If funded and if the vaccines can be implemented, the enteric vaccines could reduce diarrhoea hospital admissions by 70%, and this would have a major impact on the workload of our own hospital.

➤ The same programme also has projects planned to help control tuberculosis through improved diagnosis and treatment, better surveillance, and improved DOTS therapy. Additionally, the Centre is embarking on major projects to help prevent HIV-AIDS, and to control morbidity and mortality due to malaria, dengue, kala azar and several other communicable diseases. The costs for these projects will again be several million USD each. If funded the results of these projects could decrease the burden of these diseases substantially.

- The Nutrition Programme is undertaking major interventions for low birth weight, increasing appropriate use of zinc and evaluating micronutrients, extension of management of severe malnutrition outside the hospital, operations research in support of the Bangladesh (Integrated) National Nutrition Project. Each of these are multi-year and multi million USD projects and if funded will result in improvement in health and nutrition in Bangladesh as well as lessons for the world.
- The Child Health Programme is undertaking major projects on prevention of neonatal mortality, improvement in the IMCI approach, evaluating programmes for improved child development, reducing deaths from drowning (now the leading cause of childhood deaths in rural Bangladesh).
- The Population programme is attempting to understand the dynamics of population changes to assist the family planning efforts of the country and also to understand basic principles of population that will assist other countries. It is also increasingly using its databases to expand its efforts toward study of equity and health, and toward the social sciences and their relation to improving health, and toward the study of aging population and disability. These latter groups will become increasingly important in future years and the Centre's scientist can assist with the planning for future needs.
- The Reproductive Health Programme is developing ways to make pregnancy and delivery safer for both mother and child. It is also attempting to address the constraints that women face in achieving safer deliveries and obtaining quality services. It also is finding ways to involving both men and women among their client groups. Since sexually transmitted infections are common, the programme is also finding solutions for both treating these properly as well as preventing them through programmes aimed at the youth and adolescents.
- The Health and Family Planning Systems Programme is conducting operations research to help solve the problems of providing quality health care. While the focus is Bangladesh, the projects have global implications.
- The Centre anticipates starting a new programme on Safe Water and this will include major initiatives on solving the problems of arsenic in the tube wells and in reducing the rates of water borne diseases. The tube wells of Matlab are heavily contaminated with arsenic and major studies are ongoing to quantify the health risks from arsenic using the unique Matlab Health and Demographic Surveillance System. No other site exists to conduct such detailed analysis of the risks as well as the solutions to the arsenic problem.

With this ambitious agenda, the budget of the Centre is expected to rise by about \$1 to \$2 million each year until it reaches \$20 million. While the projects outlined above may justify an even greater increase, the Centre is aware of the dangers of growth that is too rapid, and will therefore gauge its growth so as not to overstep its capacity. When the budget reaches \$20 million, the rate of increase will slow to keep pace with inflation. Of this rise in budget, we anticipate the increase will be broken down as follows.

While the operating budget is increasing, we anticipate the endowment will also grow by \$2 million annually, though this is less predictable since endowment income is less predictable. \$1 million should come from the 100 partners and the other million will need to come from large donations. Thus, our goal will be for the endowment to reach \$30 million by the end of the decade.



III. BACKGROUND

History of the Centre

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 and a series of cholera vaccine trials was initiated. In 1966, CRL established the Demographic Surveillance System (DSS), and in 1968 completed the first successful clinical trials of Oral Rehydration Solution (ORS). 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 recognizing this achievement.

In 1978, the Government of Bangladesh (GoB) passed an Ordinance, making CRL an international institution, and renaming it the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B),

The Centre is both an international & national organization.

hereinafter referred to as the "Centre". Under the Ordinance, an international Board of Trustees (BoT) was set up and global health priorities, as well as national, were established to guide the Centre's programmes. With the Ordinance, the Centre became and remains the only international health research centre based in a developing country.

However, the Centre remains true to its original mission to serve the people of Bangladesh and is still a local organization in many respects. About 97% of the scientific staff are Bangladeshi nationals. The Centre provides medical services to over 120,000 local patients per year in its Dhaka and Matlab hospitals and provides services to thousands others throughout the country. In addition, the Centre provides technical assistance to the Government of Bangladesh and non-governmental agencies (NGOs) working on the ground.

Since its founding, the Centre has progressed considerably in expanding its research agenda. Originally focussed 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.

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 rice-based 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 <i>Vibrio cholerae</i> O139 – 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. WHO recommends use of oral cholera vaccine based largely on studies carried out at the Centre in 1985. Journal of Diarrhoeal Disease Research is re-launched as the Journal of Health Population and Nutrition
2001	Centre is awarded the first ever Gates Award for Global Health. Government of Bangladesh provides matching funds to create Gates-Bangladesh fund at the Centre. Low birth weight study starts to define potential interventions to reduce low birth weight and improve child health and development Operations Research Project converted to Family Health Research Project to support Essential Services Package Arsenic and health outcomes project starts
2002	Major studies on neonatal health are started. First report of mortality benefit from supplemental zinc Centre celebrates 40 million children saved from ORS at event at UN in New York

Organizational Management

Board of Trustees

A 17-member international Board of Trustees, comprising distinguished researchers, representatives of the GoB and the private sector, and public health professionals governs the Centre. A majority of the members are nationals of developing countries including three from Bangladesh. While there is no specific geographic representation, the Board has traditionally represented different regions of the world. The Board also includes one representative from the World Health Organization and one from an UN agency, currently UNICEF. The Board is a self-selecting body and members serve for three-year terms with a maximum service of two terms. 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.

Divisions

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 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. Each of these programmes has a "home" in one of the Divisions, but are clearly Centre-wide in their scope.

Clinical Sciences Division (CSD)

CSD conducts hospital- and community-based clinical research in diarrhoeal diseases, respiratory infections, nutrition and child development. The Division operates the Centre's Dhaka Hospital that provides treatment to around 120,000 patients each year (about 60% of them are children under the age of five) with uncomplicated and complicated diarrhoeal diseases and associated health problems including malnutrition and pneumonia. Prevention strategies such as immunization of children and women; education of mothers on prevention and home management of diarrhoeal diseases and malnutrition; and counselling to lactating mothers on exclusive breastfeeding are also undertaken at the hospital. In addition, CSD provides theoretical and hands-on training in case management of diarrhoeal diseases and associated health problems and research methodology.

Five scientific/technical Divisions supervise the research, service & training

Public Health Sciences Division (PHSD)

The PHSD is organised through seven units: reproductive health, child health, health and demographic surveillance, Matlab health research, epidemic control preparedness, health economics, and social and behavioural sciences. PHSD evaluates and tests community-based interventions to improve the health of the population, particularly of the poor. Major current studies include integrated management of childhood illnesses (IMCI), essential services package, safe motherhood, family planning, nutrition, and reproductive health interventions. The Division has recently broadened its agenda by conducting research on low birth weight, tuberculosis, arsenic contamination of ground water, and interaction of poverty and health. PHSD operates the unique Matlab field

site and management of the Health and Demographic Surveillance System (HDSS) that has been running for 35 years covering a population of over 200,000.

Laboratory Sciences Division (LSD)

The LSD conducts laboratory-based research 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. LSD has several state-of-the-art laboratories including laboratories for Enteric and Respiratory Microbiology, Environmental Microbiology, Immunology, Molecular Genetics, Nutritional Biochemistry, Parasitology, Reproductive Tract Microbiology, Tuberculosis, Virology and Clinical Diagnostic laboratories. In addition, LSD has taken up activities on HIV surveillance, voluntary counselling and testing and other research projects for investigating the dynamics of a possible HIV epidemic in Bangladesh. Some recent discoveries involve the molecular and genetic mechanisms for pathogenesis of enteric bacteria, increasing antibiotic resistance of enteric, respiratory and sexually transmitted organisms, immune mechanisms of amoebiasis, and changing serotypes of rotavirus. The mandate of the Division is to apply high quality science to alleviate diseases.

Health Systems and Infectious Diseases Division (HSID)

The HSID, in cooperation with the Government of Bangladesh, conducts community-based family health research in maternal and child health, communicable diseases, immunization, nutrition, reproductive health, and health-delivery systems. The HSID maintains urban field areas in Dhaka and rural field areas in Mirsurai and Abhoynagar where large-scale effectiveness studies are carried out. Current activities include trials of new vaccines, tests of nutritional interventions, studies on the appropriate management of sexually transmitted infections, and epidemiology of dengue fever.

Information Sciences Division (ISD)

The ISD facilitates the two-way transfer of knowledge in and out of the Centre. The Dissemination and Information Services Centre (DISC) provides library and information services to the Centre staff and external library members and is responsible for the production of the Centre's publications, including the quarterly Journal of Health, Population and Nutrition, two newsletters, Annual Report, working papers, scientific reports, and special publications. The Training and Education Unit (TEU) arranges national and international courses on the clinical management and laboratory diagnosis of diarrhoeal diseases, reproductive health and family planning, child health and survival, nutrition, epidemiology, and research methods. The Computer Information Services (CIS) is responsible for maintaining and developing the local computer network and for access to email and the Internet, and for assistance in developing new software and applications, and data storage and manipulation.

Programmes

The six programmes are described below.

Child Health Programme

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, to further develop-

Six cross-divisional programmes help define research priorities & facilitate moving research basic findings to useful knowledge.

ment and evaluation of the Integrated Management of Childhood Illness, and to improving child caring practices.

Reproductive Health Programme

The mandate is to address issues related to reproductive health research with major emphasis on safe motherhood and reducing maternal mortality, improving family planning acceptance and performance, and prevention and treatment of sexually transmitted infections. Major emphasis is given to including adolescents and men into reproductive health programmes.

Nutrition Programme

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 Programme

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 Programme

The mandate is to conduct research on high priority health and family planning issues of direct relevance to policy and programme development in Bangladesh. This includes the identification of cost-effective and sustainable interventions, the provision of evidence-based guidelines, and 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 Sciences Programme

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 expectations. Special emphasis is given to studies to understand the levelling of the fertility rates at a level above replacement rates and to factors affecting increasing urbanization, as well as the health impacts of the lowering fertility and urbanization.

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.

Administration

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 the Asian Scientific Conference on Diarrhoeal Diseases and Nutrition (ASCODD).

During the last few years, 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 DISC², the Computer Information Services (CIS) and the Training & Education Unit (TEU) into 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 Head of Finance and Administration.

A theme for the reorganization has been decentralization of authority, stimulating individual initiative while encouraging cooperation and crosscutting activities. Good science and good programmes work together, and the Centre encourages this synergy. 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.

Organizational Approach

As an international centre, based in Bangladesh, it stands in contrast to other international organizations based in Geneva or New York. It not only organizes and coordinates work, but it also implements the programmes in a region of the world where the problems exist. To carry out the research, the Centre has developed mechanisms to insure the quality of these activities from a scientific and technical perspective as well as an ethical and financial perspective.

Interdisciplinary and Inter-divisional Approach

The tenet of the Centre's approach is interdisciplinary and inter-divisional research in which clinical and laboratory research interacts with epidemiologic, social sciences,

² Dissemination and Information Services Centre includes the library, publications, and audio-visual unit.

and health systems research. This breadth of disciplines among the Centre's scientific staff is truly unique and allows the Centre to develop comprehensive understanding of health and population problems and potential solutions.

For example, laboratory scientists and epidemiologists help scientists identify pathogens and disease patterns affected by emerging and re-emerging diseases such as dengue, TB, STI and malaria, while social scientists examine the changes in human behaviour and demographers analyse the effects on population. The results of their work are then fed into health care delivery systems, which are then refined and optimised by means of health systems research. Mechanisms for facilitating the cross-disciplinary interchange include the Scientific Council, inter-divisional Programmes, weekly Centre Scientific Forum (CSF), other seminars and working groups on specific topics.

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 and their implementation. In addition, the BoT commissions external reviews of the divisions on a regular basis.

Ethical Reviews

The Ethical Review Committee (ERC), established through provision in the Centre's Ordinance, subjects each protocol involving human subjects to a review. The ERC reports to the Board of Trustees, but its members serve in their individual capacity with the exception of the Bangladesh Medical Research Council (BMRC) that 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 a Federal Wide Assurance (FWA 00001468) with the United States government. 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.

ICDDR,B Research Way

"The ICDDR,B Research Way" characterizes the Centre's methods for research. Unlike projects carried out by many other research-oriented agencies who piggy-back their projects onto other's services, most of the Centre's research projects ensure that participants in the research and their communities benefit through provision of medical services appropriate to the study being conducted. Sometimes this results in projects that seem more expensive in the short term, but the concept of "partnering" with communities results in long-term benefits both in the creation of new knowledge and to the communities who participate. And, the Centre feels this is the ethical way to conduct research among vulnerable populations.

Collaborations

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. Over the years, the Centre has entered into collaborative agreements with many of the world's leading international health research institutions. These agreements provide the basis for international collaboration and partnership in health and population research activities as well as staff development for the Centre's scientists.

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 ICDDR, 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.

EXAMPLES OF COLLABORATIONS OF THE CENTRE

	Bangladesh	International
CSD	INFS/DU, Dhaka Medical College (DMC)	JHU, USAID, SDC, Institute of Child Health, UCL, Univ California-Davis, Industrial partners
HSID	MOHFW, DGHS, DFP, DCC, NIPHP Partners, IHE/DU	Partners in Population and Development (PPD), NIH-USA, CDC-Atlanta, International Vaccine Institute, Industrial partners
LSD	DMC, Salimullah Medical College, Shishu Hospital, GoB, NGOs (BWHC, Concern)	University of Leuven, Karolinska Institute, National Institute of Child Health and Human Development, Maryland, JHU, SMI- Stockholm, Sweden, National Institute of Cholera and Enteric Diseases, - India, National Institute of Infectious Diseases -Japan, CDC-Atlanta, Emory University, University of Edinburgh, Industrial partners
PHSD	MOHFW, DGHS, DFP, DHC, BIRDEM, Universities, BIDS, Bangabandhu Medical University, Holy Family Red Crescent Hospital, BRAC, other NGOs	JHU, PRISMA, Peru, Univ Maryland, London School of Tropical Medicine, INDEPTH, NIDI-Netherlands, Cornell Univ
ISD	GOB, Shishu Hospital,	WHO, UNICEF, OFDA, JICWELS, Cornell Univ, Univ California-Davis, UNAIDS

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 proportion 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 Demo-

graphic Surveillance System (HDSS) area in Matlab. The surveillance records data on etiologic agents, physical findings, anthropometrics, socio-economic, 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.

Surveillance Systems

The Centre's extensive rural and urban community-based health and family planning interventions 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 scientists to examine changes over time. The longitudinal data is included in the HDSS database. 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.

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. Reputable audit firms audit the Centre's accounts annually. 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. interdepartmental charges, risk management of the financial system, etc.) A specific audit is conducted of the "common institutional costs" (sometimes called indirect costs).

Funding

The Centre's current annual budget is US\$ about 15 million dollars. Based on the projects outlined in the Strategic Plan, the Centre will increase its activities by about US\$1 million each year during the decade. This budget increase is based on funding for on-going projects and for new projects in which funding has already been identified.

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. The Centre has initiated a special campaign to obtain contributions to the Hospital Endowment Fund (HEF), and with prudent investments, a goal of US\$ 20 million by the year 2010 has been set.

The Centre has traditionally relied on financial input from government donor agencies of the United States, the UK, Bangladesh, the Netherlands, Japan, Switzerland, Canada, Belgium, Sweden, Australia and others. Additional funding has come from private foundations such as Ford Foundation, Rockefeller, and more recently Gates Foundation. New to the Centre has been funding from the National Institutes of Health and the World Health Organization and private companies such as UNOCAL.

Between 1994 and 1999, the Centre accumulated a deficit of about US\$ 4 million dollars. The deficit was due, in large part, by a rapid shift in funding from core to project support in combination with the costs incurred to maintain hospital services in Dhaka and Matlab. It was not possible to make adjustments in expenditure as fast as the donors changed their policies, while still maintaining clinical services. The unfortunate accumulation of deficit had a negative impact on the creativity and flexibility of the Centre's programmes. However, since 1999, the Centre has balanced its annual accounts and has been able to decrease the accumulated deficit by \$ 1 million over three years. By the year 2010, the deficit should be eliminated. 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.

IV. CONTEXT

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. Only 10 countries, with 21 percent contributed by India and 15 percent by China, contribute sixty percent of the world population increase. Every year, the population of Asia increases by 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 globalisation is presumably opening many opportunities for millions of people around the world. Increased trade, new technologies, foreign investments, expanding media and Internet connections are expected to fuel 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 indicates that most of the low-income countries have been unable to realize the opportunities of economic and technological globalisation. These countries are becoming even more marginalized. 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: Globalisation 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 ma-

jority 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 globalisation, 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 globalisation, 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 that 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.

The UN has established UN Millennium Goals and these goals include several goals that are key for the Centre's strategic plan. Goal #1 includes the "Eradication of extreme poverty and hunger", and the Centre has included prevention and treatment of malnutrition as a key target for our plan. Goal # 3 is to "Promote gender equality and empower women" and the Centre has included gender equity as a priority for our public health programmes and gender equality as a value for our staff. Goal # 4 is to "Reduce child mortality" by two thirds, and the Centre's primary focus is on finding ways to improve child survival and development, and to develop strategies to make this goal

possible. Goal # 5 is to "Improve maternal health," and the Centre has developed a research programme on reproductive health and essential obstetric care. Goal #6 is to "Combat HIV-AIDS, malaria and other major diseases," and the Centre is at the forefront of the battle against many of the communicable diseases. Goal #7 is to "Ensure environmental sustainability" and the Centre is actively involved in the research on the relation of environment and health. Goal #8 is to "Develop a global partnership for development" and the Centre is a partner with many others to communicate and cooperate with others in its mission.

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.

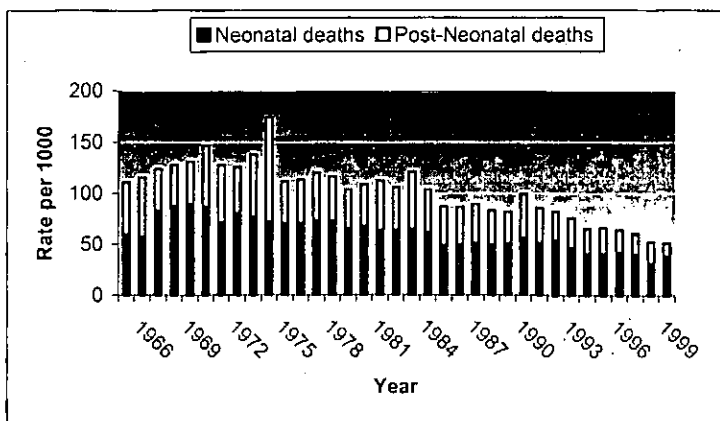
Bangladesh is the eighth most populous country in the world with a population of around 130 million. The country has the highest population density in the world. It is one of poorest countries in the world with a per capita income of around US\$ 380. As a result of overcrowding, poverty, and poor access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

Among the infant deaths, those that occur during the first month represent an increasing proportion as child health interventions have been more effective for the older infants and children above age one



year. Clearly, Bangladesh and other developing countries will not reach the millennium goal of reducing child mortality by two thirds unless effective interventions are found to reduce neonatal mortality. Among interventions that have been targeted to the neonates, the one with most impact has been immunization of mothers with tetanus vaccine to prevent neonatal tetanus, but additional research is needed to save newborn lives.

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.

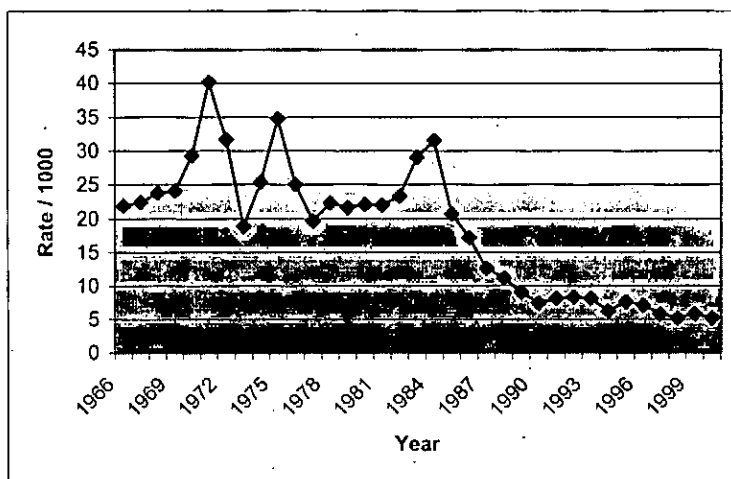
Deaths associated with complications of childbirth continue to be a major cause of concern.

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 dropout 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 that 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.



Childhood mortality (1 to 4 year) in Matlab from 1968

V. PROGRAMMATIC DIRECTIONS

Priority Setting

Priority setting at the Centre represents a complex interaction of numerous factors, but begins with the Centre's mission statement, the regional burden of disease, and the local burden of disease as measured in our own field areas as well as the Centre's relative strengths.

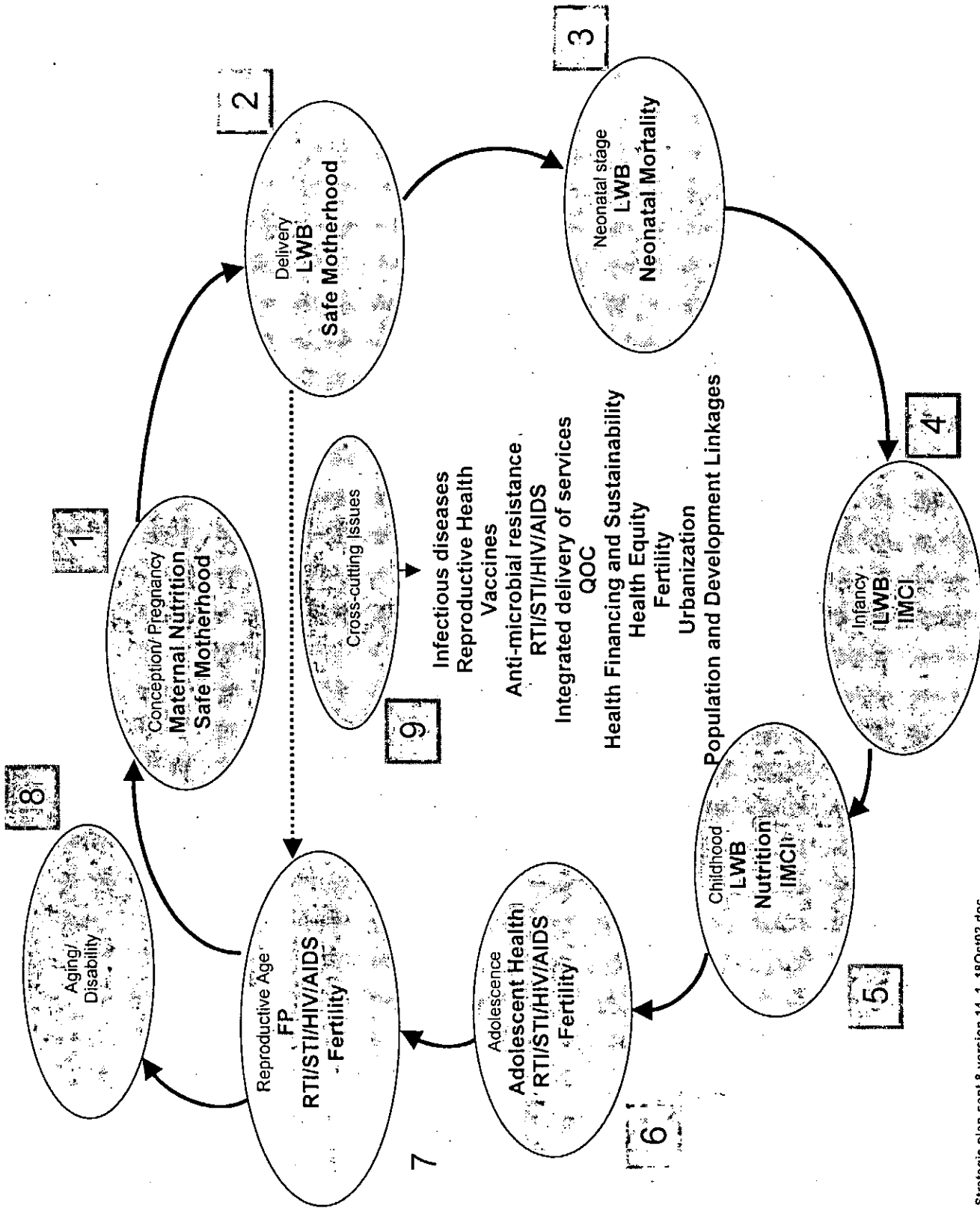
The Centre primarily attempts to carry out applied and downstream research but it does not shy away from using state-of-the-art tools to provide a better understanding of the issues it studies. For example, studies on cholera range from molecular studies of the bacterial genes, to clinical studies on new treatments, epidemiologic and vaccine studies, and economic analyses.

Life Cycle Approach

In general, the "life cycle" approach conceptualises the health, development, and research issues of individuals and families, and suggests intervention points in the life cycle where the efforts can give the maximum improvements. For example, the Centre places a great 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 emphasises certain vulnerable periods of vulnerability, especially those common illness that are preventable or easily treatable using cost-effective methods.

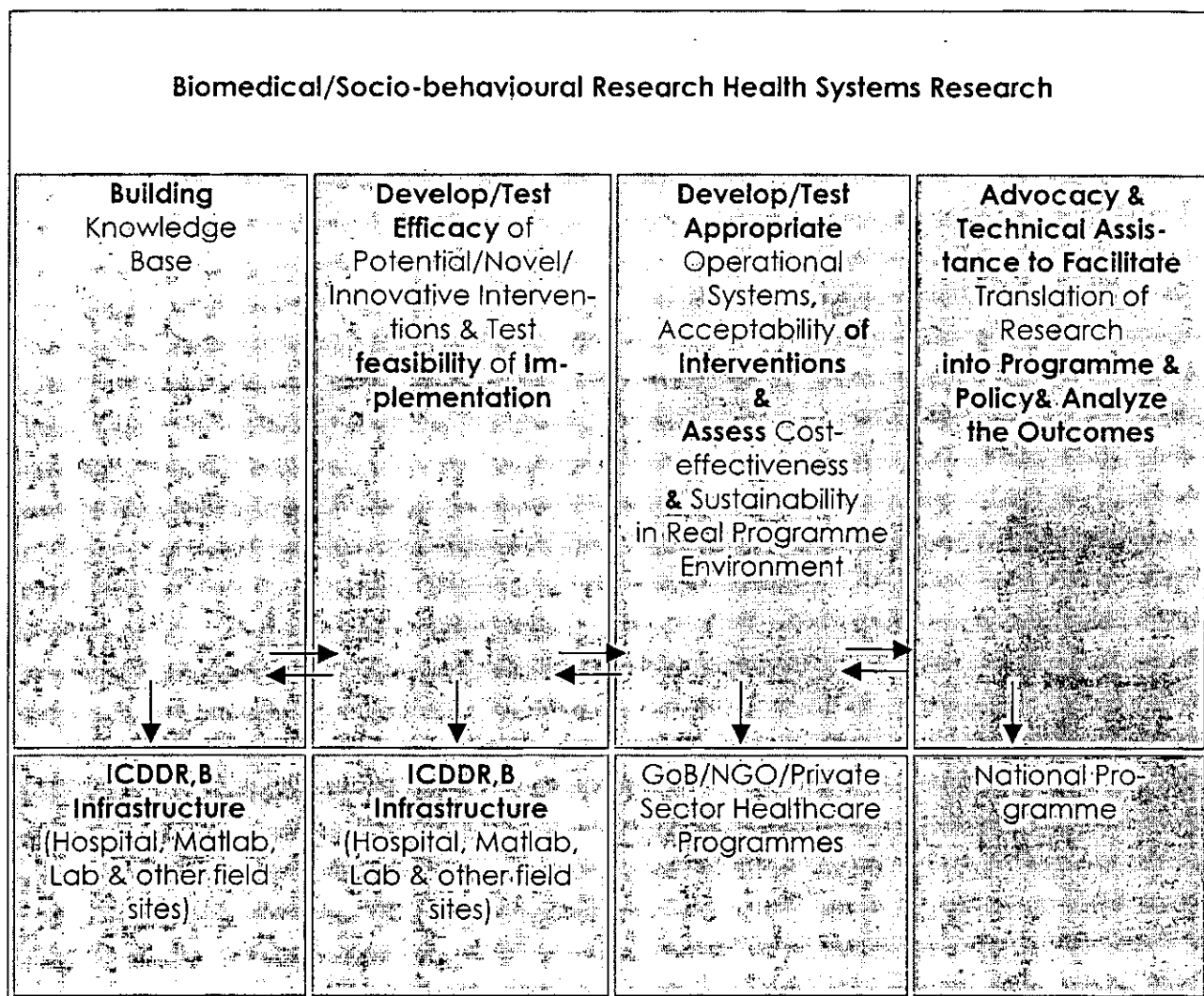
While using the life cycle model and emphasizing certain critical stages, this model does not exclude other periods of life (later childhood, adolescence, later adult years), but it suggests that most efforts should target particularly vulnerable periods. Interventions for these vulnerable periods will 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 globalisation and ecological changes, and non-communicable diseases with the rapid growth of medical technology and their implications on the costs of the health systems.



Conceptual Framework

In conducting this priority research, the Centre will follow the conceptual framework, as shown.



Programme Priorities

The priorities that follow are grouped according to the major programme areas, but many are cross-cutting. Thus, these are to be viewed as Centre priorities; they are not owned by any division or programme but are the collective priorities of the Centre.

Child Health

Problems identified. Though child mortality rates have decreased in recent years, they are still much too high. The largest share of infant deaths occurs during the first few days of lives, and specific caring practices are needed to help these neonates,

Many also start out life much too small; 45% of newborn infants in Bangladesh weigh less than 2500 grams. Since child survival and health is directly linked with birth weight, the high incidence of low birth weight is viewed as a major obstacle to improving child health and development. Large-scale nutrition programmes attempt to improve nutrition of pregnant mothers with a goal to increase birth weight, but the efficacy of such programmes and the optimal nutritional supplements are not well defined.

Acute infectious diseases continue to cause many infant and child deaths, and many of these can be easily treated or prevented. Diarrhoea, pneumonia, severe malnutrition, typhoid fever, dengue, and malaria (in certain areas) are major causes of morbidity and mortality.

Health services for infants and children in developing countries remain constrained by limited availability and access, poor quality and utilization. The Integrated Management of Childhood illness (IMCI) strategy has been designed to provide good quality health care services for children through primary health systems for the most common and important medical conditions. IMCI also focuses on improving health systems and community and family practices. However, questions remain about the design, content and delivery of IMCI and its effectiveness.

New problems are now being recognized as increasingly important, such as drowning which is now a leading cause of death among 1-4 year old children. Child development is another new area as the focus shifts from mere child survival to the development of these children to their full potential through appropriate caring practices

Opportunities. Many neonatal deaths can be prevented if proper care is given in a timely manner. Neonatal deaths are largely due to infections, asphyxia, birth trauma, and improper care of the newborn. The Centre believes that community based strategies are possible to reduce risk of infection, reduce asphyxia and birth trauma, and improve newborn care. With training, community workers can recognize and manage neonatal infections and begin early treatment. Mothers and caretakers can be trained to improve routine newborn care, such as feeding the baby and keep it warm. Linkages with safe-motherhood interventions can prevent asphyxia and birth trauma.

Nutritional and other interventions aimed towards the mother and child can improve foetal growth and minimize the ill effects of low birth weight. There is increasing interest and experience with improving child development through child caring, stimulation and nutritional interventions.

Furthermore, management of children with common acute life threatening illnesses can be improved. The prototype of this category of illness is acute diarrhoea, but other acute illnesses should be included: pneumonia, dengue, malaria, typhoid and severe malnutrition. We have shown that a treatment costing US \$10 can save the life of a patient with diarrhoea who would otherwise have died. We will examine how to treat these other life threatening illnesses in a similar cost effective way, by determining the needs of facilities, treatments and training needed to accomplish this. The Centre will then establish a model facility where these methods can be taught.

Relative Strengths. The Centre has many resources to address issues of child health. There is an experienced pool of professionals with varied and complementary skills. It has field areas where strategies can be tested and their success documented. Through government and NGO partners, specific interventions for improving newborn care and recognizing and treating neonatal infections can be developed.

Working collaborating partners, the Centre can develop and evaluate strategies for improving child caring and stimulation interventions. The Matlab field area, with its community based programmes and demographic surveillance system is absolutely unique for testing strategies for increasing birth weight and for assessing nutritional interventions on the subsequent health of the children. Its relations with the Ministry and local health programmes allow for testing the efficacy of IMCI strategies in a manner that is not possible in any other site in the world. This will allow for further refinement and adaptation of the IMCI strategy for Bangladesh.

The Centre's hospital and laboratory facility provides an ideal setting for conducting clinical trials of new agents, new drugs and new ORS solutions.

Priorities. Based on continuing challenges of child health, opportunities, and relative strengths, the Centre has identified the following priorities for improving child health.

1. Sustain surveillance for indicators of child survival and ill health, simplify these indicators so that others can assess the health status of children, and help guide policy with appropriate information.
2. Conduct studies to evaluate the effectiveness of nutritional supplements to increase birth weight and to improve child survival
3. Test strategies to reduce neonatal mortality through community-based strategies to improve routine and sick newborn care.
4. Conduct research to improve management of children with common acute life threatening illnesses, strengthen and evaluate integrated management strategies, and develop the health systems for delivering and scaling up these strategies.
5. Strengthen child health and development interventions through research on effective child caring, stimulation and health-seeking practices in the homes.
6. Continue to improve on clinical treatments for common childhood illnesses by testing improved ORS solutions, anti-secretory drugs, antibiotics and new treatments for pneumonia.

Strategies. Funding is currently available from several agencies to support most activities under the priority areas. This will have to be sustained and complemented as new research questions emerge. Umbrella funding will be essential for priority 6, and additional funding is required to cover all aspects of priorities 4-5. Potential donor agencies will be identified. Several research protocols are currently underway or will be starting soon. It is anticipated that results these initial studies will generate additional research and operational questions that will require new research protocols. In addition, protocols will need to be developed to address aspects of priorities 4-5, and priority 6. To track and analyse trends in indicators, the programme will collaborate with health indicator surveys and surveillances within and outside the Centre.

The Matlab field site will continue to be a significant data collection area and the newer sites in Sylhet and Mirzapur will continued to be maintained. Activities may expand to other sites depending on need and partner activities. Achievement of priorities will require an expansion in skilled professional staff, especially in the fields of health systems and community-based interventions, behavioural sciences, neonatologists and obstetricians, nutritionists, epidemiologists and child development experts. This will have to include the training of existing staff, but more importantly, new recruitment. Some additional office space will be sought.

Continued and expanded collaboration with national and international agencies and institutions will not only strengthen the capacity of the Centre to undertake these activities, but are prerequisites for success.

Research Issues: Child Health	EXPECTED PRIORITY		
	2000	2005	2010
1 Surveillance and management of common childhood illnesses ⇒ Levels, trends and patterns of childhood illness and death ⇒ Management of childhood illnesses (IMCI) ⇒ Prevention and management of childhood illness in the community	++	+++	++
2. Improving perinatal / neonatal health ⇒ Levels, trends and causes of neonatal death ⇒ Management of neonatal sepsis ⇒ Newborn care ⇒ Prevention and management of asphyxia ⇒ Pregnancy and delivery based interventions	+	+++	+++
3. 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	+	+	+
4. Childhood growth and development ⇒ Improving caring practices in the community ⇒ Incorporating nutritional interventions in child health services ⇒ Childhood development interventions ⇒ Preventing foetal growth retardation	+	++	++
5. Strengthening health systems for the delivery of child health services ⇒ Improving child health services ⇒ Improving health services in support of IMCI ⇒ Impact and cost-effectiveness of IMCI ⇒ Alternative service delivery strategies	+	++	++
6. Understanding and responding to emerging childhood health problems ⇒ Prevention of childhood injuries ⇒ Levels, trends, patterns and consequences of non-communicable morbidities in children	+	+	+

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++ Indicates the Centre will be involved at a moderate level of effort, and will often take the lead in these projects, but often in partnership with others.

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Reproductive Health

Problems identified. Although the Centre has been involved in increasing the rates of contraceptive methods for many years, it recognizes that reproductive health encompasses a wide variety of issues that are important to families. High maternal mortality rates continue in Bangladesh and over 90% of deliveries take place at home without skilled attendance. While there are goals to increase the numbers of facility-based deliveries attended by skilled birth attendants, a majority of deliveries will continue to take place in the home.

Most families wish to limit the number of children or to space their pregnancies using contraceptives, but many families still experience difficulty in using them. This is seen in a high proportion of families who discontinue their family planning method, sometimes because of perceived side effects. Unintended pregnancies are still common. Family planning programmes now approach this issue as a way to assist families achieve their desired family size rather than as a method for "population control"; however, the issue of providing appropriate family planning services is obviously of crucial importance to national strategies designed to achieve a replacement fertility level in the near future.

Because of unwanted pregnancies, induced abortions will continue. Unfortunately, complications from abortion are common and there is need to improve management of post-abortion complications like infection, perforation and bleeding. On the other hand, high quality family planning programmes reduce rates of abortion in Bangladesh, and this is likely to occur globally.

Sexually transmitted diseases are becoming more commonly recognized. While sexually transmitted infections (STIs) are especially common among commercial sex workers, they are also occurring in families not normally considered high risk. While about 35% of sex workers were positive for syphilis, about 4% of pregnant women attending a prenatal clinic in Dhaka were similarly positive. Along with STI, antibiotic resistance is increasing. The proportion of *N. gonorrhoea* isolates resistant to ciprofloxacin (the most commonly recommended antibiotic) has risen from 7% to 87% in the last 5 years; this rate of resistance is among the highest in the world.

HIV-AIDS is a major threat in Bangladesh because of the high-risk behaviour in many groups. Networks of persons exist in Bangladesh that share needles, and purchase sex commercially and many of these also have spouses suggesting that the virus may rapidly spread from the high risk to the general population. These networks have already led to the development of high rates of syphilis and hepatitis C, which is a likely indication for an explosive HIV epidemic in the near future.

Opportunities. Although deliveries generally take place at home, women are willing to use delivery facilities, especially for emergencies. Our projects have demonstrated how to improve basic obstetric facilities and to make them acceptable and effective at low cost. These improvements prepare families for possible obstetric emergencies, including post abortion complications.

Most families are now using contraceptives, but they need assistance in using them appropriately. There is opportunity for improving the method mix to more closely adapt to the changing needs of families (e.g. long acting methods for those who have completed their families).

STI prevention will require behaviour changes and increased use of condoms, but the treatment of current infections will also be required. Antenatal clinics will need to begin screening women for STI's in order to prevent complications (pelvic infections and transmission of infection to the newborn).

Adolescents are eager to learn about reproductive health and the new awareness of the need to educate the younger generation provides a new opportunity to improve the lives of the next generation.

Regarding HIV-AIDS, Bangladesh has an opportunity to avoid the epidemic if the issue can be addressed rapidly. The nation already has a good surveillance system in place, and through coordinated interventions, the HIV epidemic might be avoided, but the window of opportunity is rapidly closing.

Relative Strengths. The Centre has considerable expertise in developing successful family planning programmes. More recently, it has acquired skills in the range of reproductive health and has developed a model reproductive health programme in Matlab that can be used to test strategies for and improving services and reducing maternal mortality. Being in Matlab, it can then be used for training and extension of the lessons learned to other areas of the country and elsewhere in the developing world. The Centre has also acquired considerable expertise in adolescent health, especially in relation to communications and reproductive health education.

The laboratories of the Centre are excellent resources for documenting the burden of disease, and these laboratories are not available elsewhere in the country. Furthermore, the Centre is able to partner with many of the NGO's working with CSW's to help them improve their programmes.

Priorities. Based on continuing challenges, opportunities, and relative strengths, the Centre has identified the following actions for improving reproductive health:

1. Improving emergency and essential obstetric care and safe motherhood
2. Improving family planning services including developing services to increase male involvement in reproductive health
3. Meeting the needs of adolescent's reproductive health
4. Prevention and treatment of STI/RTI/HIV-AIDS
5. Improving maternal nutritional status and newborn health, particularly birth weight
6. Minimizing the need for and improving post-abortion care
7. Understanding the issue of violence against women in the social context and developing public health strategies to reduce this.

Strategies: Current funding for priority areas 1 to 4 and 7 is provided through the Asian Development Bank, DFID, European Union (EU), Governments of Bangladesh and Japan, USAID, UNICEF, UNDP, and WHO. Discussions are ongoing with the EU, the William and Flora Hewlett Foundation, USAID, World Bank and the WHO Regional Office for additional funding. Three new protocols are currently being developed in priority area 1 and one protocol in priority area 4.

Matlab will continue to be a significant study site, however, other sites such as Chakaria and Abhoynagar will be utilized. Additional expansion to other field sites is dependent on new funding. The Centre is in the process of hiring new staff under the RH Programme to implement new protocols and/or develop additional protocols. In addition, training of new staff is ongoing to increase the programme's capacity to address the priority areas.

Maternity clinics and male clinics are now in place in Matlab for providing services and for studying the process and impact of interventions. A maternity unit for comprehensive EOC services has been established as a government facility for referral.

Current equipment is available for making accurate assessments of fetal development for the study of maternal nutrition and birth weight. Additional office space is being sought.

The Centre is collaborating with the Government of Bangladesh on a number of projects in addition to ongoing and planned collaborations with NGOs. Current activities with NGOs include assessment of their effectiveness and impact.

Research Issues: Reproductive Health	EXPECTED PRIORITY		
	2000	2005	2010
1. Safe motherhood ⇒ Determine 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 and extent to which safe motherhood interventions reach the poor	++	+++	+++
2. Family Planning ⇒ Determine the most cost-effective, acceptable and affordable interventions to further reduce fertility to reach replacement levels ⇒ Develop strategies to access them	++	++	++
3. Adolescent health ⇒ Determine factors responsible for health risk behaviour among adolescents ⇒ Develop appropriate health indicators for behavioural change in unmarried adolescents ⇒ Develop service delivery approaches for reproductive health services for adolescents	+	+	+
4. STI-RTI / HIV-AIDS ⇒ Develop public health interventions to prevent / combat HIV/AIDS in a low prevalence country like Bangladesh ⇒ Determine impact of interventions on STI -RTI / HIV-AIDS/Sexual health in preventing further transmission	+	+++	+++
5. Maternal nutrition ⇒ Explore causes for poor nutrition in women, especially during pregnancy ⇒ Determine effect / impact of maternal nutrition/nutrition supplementation on maternal morbidity, pregnancy outcome and birth-weight	+	+++	+++
6. Abortion care ⇒ Develop strategies to reduce abortion-related mortality and morbidity	+	+	+
7. Violence against women ⇒ Assess magnitude, type and reasons for violence against women ⇒ Develop strategies to reduce violence against women	+	+	+

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Nutrition

Problems identified. Malnutrition is central to many of the health issues in Bangladesh as it is in many developing countries, with its attendant poor growth, susceptibility to infections, slow cognitive development low birth weight. Protein energy malnutrition (PEM) is the most obvious, but other specific deficiencies are also common, including vitamin A, iron, zinc and iodine deficiency. Because so many children are small, PEM may not be recognized as abnormal. Similarly, health care providers do not recognize children as malnourished when they come for treatment of common illnesses.

Unfortunately, mothers do not exclusively breast feed for six months, and in fact they begin supplemental feeding at an early age, making their infants more susceptible to infections and malnutrition.

Vitamin A is a needed supplement, and the national programme is effectively distributing this to most children under five years.

Opportunities. Malnutrition is a condition that can be treated, but it requires a comprehensive approach. The Centre's scientists have demonstrated the effectiveness of a protocolized management of severe malnutrition, and they have shown that this can be applied outside the hospital and at very low cost. Although vitamin A is distributed routinely in Bangladesh, there are opportunities for improving the vitamin A intake of children through identifying foods rich in vitamin A as well as food fortification. Centre scientists have also demonstrated the benefit of zinc supplements as adjunct treatment of diarrhoea, pneumonia, and they have demonstrated that zinc reduces future episodes of illness. Most importantly, it reduces overall mortality. Studies at the Centre have also shown that it is possible to dramatically increase rates of exclusive breastfeeding.

Relative Strengths. The Centre has clinical (including a metabolic balance ward) and field resources for identifying and treating children with malnutrition, and developing new strategies for addressing the needs of families with malnourished children. It also has an excellent nutrition biochemistry laboratory for conducting nutrition research. Based on the successful experience with managing severe PEM, the Centre has opportunities for training and extension of the successful methods. The Centre also has strong collaborations with nutrition centres around the world.

Priorities. Based on continuing challenges, opportunities, and relative strengths, the Centre has identified the following actions for improving nutrition:

1. Decreasing rates of low birth weight
2. Improving maternal nutrition
3. Prevention and management of severe and moderate malnutrition
4. Improving child feeding including increasing rates of exclusive breastfeeding
5. Understanding the interaction between nutrition and child development
6. Improving micronutrient nutrition through fortification and other strategies.
7. Understanding the interaction between infectious diseases and nutrition and learning how to break the malnutrition – infectious disease cycle.

Strategies: Current funding for priority areas is provided by ADB & PMC, Allen Foundation, Fogarty International, NIH, SCF (USA), SIDA; Thrasher Research Fund, UNICEF, USAID, World Bank/BINP and WHO. Continued efforts are being made for identification of funds for new projects including research in micronutrients, child develop-

ment, malnutrition, child feeding practice, infection and immunity and maternal nutrition and low-birth weight.

Field sites will include Dhaka-based clinics and peri-urban sites and Matlab for intervention and data collection purpose. Capacity building and hiring of new staff will be continued to meet programme needs. New office space for Nutrition Programme has been allocated and laboratory support has been improved in the bio-chemistry and nutrition lab with new equipment.

The Nutrition Programme collaborates with leading international institutions for technology support and transfer (e.g. stable isotopes). National institutions also form a large part of nutrition collaboration, they include BNNC, BRAC, CHE, DMCH, DSH, INFS, IPHN, ICMH, MOHFW, NIPORT, and PSKP among others.

Research Issues: Nutrition	EXPECTED PRIORITY		
	2000	2005	2010
1. Newborn health and breast feeding ⇒ Develop strategies to reduce neonatal mortality and to increase exclusive-breastfeeding ⇒ Determine barriers to appropriate breastfeeding	+	+++	+++
2. 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	+	+++	+++
3. Severe and Moderate Malnutrition ⇒ Understanding the determinants of moderate and severe malnutrition ⇒ Clinical studies to improve treatment of complications of severe malnutrition ⇒ Extend treatment of severe malnutrition to the community	+++	+++	++
4. Infant and Child Feeding ⇒ Strategic studies to improve breast feeding practices ⇒ Understanding and behavioural study on complementary feeding ⇒ Improving complementary feeding and child growth	++	++	++
5. Child Development ⇒ Studies on physiology, magnitude and determinants of development ⇒ Studies on improving child development with malnutrition with different biological and social implications	+	++	++
6. Micronutrient Research and Intervention ⇒ Impact and determinants of micronutrients deficiencies ⇒ Test strategies for improving micronutrient malnutrition	++	+++	+++
7. Infectious Disease and Nutrition interaction ⇒ Impact, magnitude and determinant studies on infection-malnutrition ⇒ Strategic studies on prevention and curative measures of infection-malnutrition cycle.	+	+	+

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Infectious Diseases and Vaccine Sciences

Problems identified. Infectious diseases continue as the major cause of morbidity and mortality in Bangladesh and worldwide. As a result of poverty, population density, poor sanitation, malnutrition, and disease-transmitting insect vectors, there is further need for enhanced prevention, diagnosis and management of a wide array of diseases with infectious aetiologies including pneumonia, diarrhoeal diseases, tuberculosis, measles, vector-borne diseases like dengue, malaria, visceral leishmaniasis (kala azar) and filariasis, and sexually transmitted infections. HIV/AIDS will exponentially increase the impact of many of these diseases. Drug-resistant infectious diseases will continue to strain resources and threaten existing methods for effective therapy. Of added concern are serious diseases for which effective prevention strategies already exist remain a problem for much of Bangladesh, such as measles (for which existing affordable vaccines are under-utilised) and *Haemophilus influenzae* type B (Hib), Hepatitis B, typhoid, and pneumococcal diseases (for which safe and effective vaccines exist, but cost is a barrier to their introduction, acceptance, and use).

Opportunities. Childhood and adult mortality can be reduced dramatically through improved management of infectious diseases and prevention via introduction of vaccines and behaviour modification. New technologies are providing opportunities for rapid, practical diagnostic tests which will improve management, vaccines which can provide prevention opportunities and options for treatment, including enhanced "super ORS" and novel antimicrobial therapies.

Relative Strengths. Bangladesh is unfortunately home to many of the infectious diseases of importance, and these occur at high rates in the field sites of the ICDDR,B. Thus, the Centre has a unique epidemiological strength to conduct studies on disease incidence, disease burden, as well as to study prospective interventions to control disease. It also has excellent laboratory facilities and laboratory scientists who can carry out the basic and applied studies to describe, in a comprehensive manner, the epidemiological, clinical and pathophysiological characteristics of the disease pathogens. The presence of several field areas, the epidemiologic expertise and the laboratories, gives the Centre a distinct advantage for conducting all phases of vaccine evaluations for enteric and respiratory infections, as well as new vaccines for tuberculosis and dengue.

Priorities. Based on continuing challenges, opportunities, and relative strengths, the Centre has identified the following actions for infectious diseases and vaccine sciences:

1. Improve surveillance for and management of selected infectious diseases including diarrhoea, ALRI (pneumonia), sexually transmitted diseases, HIV/AIDS, tuberculosis, dengue, malaria, kala azar, and drug-resistant infections.
2. Defining disease burdens of selected infectious diseases to better define the need for selected vaccines, e.g. hepatitis B.
3. Enhance the capacity to investigate, study and manage outbreaks of communicable diseases in the region.
4. Evaluate promising new vaccines for enteric (rotavirus, cholera, ETEC, typhoid) and respiratory infections (*H. influenzae*, *S. pneumoniae*, viral influenza, RSV), dengue, and tuberculosis.
5. Develop and/or evaluate rapid or simple diagnostic tests to improve case detection and surveillance.

6. Assist with technology transfer to allow other countries to manage the emerging infectious diseases, especially related to cholera and rotavirus (world-wide), and HIV-AIDS in the region.
7. Work closely with operations scientists in the planning, execution, and analysis of all of the above in order to adapt these findings into programmes if evidence supports meaningful public health benefit.

Strategies. Current funding for protocols is provided by the Centres for Disease Control and Prevention (CDC), DfID, International Vaccine Institute, National Institutes of Health and USAID. Additional funding is presently being sought from CDC, Program for Appropriate Health Technologies (PATH) and Wyeth corporation. New protocols will be developed for vaccine trials in dengue, TB, and diarrhoeal diseases. In addition, future protocols will be developed to build on knowledge gained from current protocols.

Programme activities will be conducted at Kamalapur (urban), and Mirpur (peri-urban) field sites with future studies conducted at Aboynagor and Mirzapur (peri-urban), and Matlab (rural). At least two additional epidemiologists and one dedicated medical anthropologist will be required. In addition, research investigators will need to build on their current epidemiological skills with some formal training. One research investigator has completed a MPH at Johns Hopkins University and has assumed the role of a junior scientist.

Virology lab capacity has been strengthened with recent training in viral isolation, neutralising antibody detection, and new enzyme-linked immunosorbent assay (ELISA) equipment, for both vector-borne and respiratory viruses. Lab personnel are being added for bacterial isolation and typing and additional personnel are being considered to handle an increased volume of blood cultures, MAC ELISA and neutralisation tests. Furthermore, additional office space is being sought for the epidemiology, medical anthropology, and research investigator staff.

International collaboration to achieve priorities 1-3 will include Armed Forces Research Institute of Medical Sciences, CDC, Johns Hopkins University, Massachusetts General Hospital, and Queensland University of Technology. National collaboration includes Chittagong Medical College Hospital, Dhaka City Corporation, Dhaka Medical College, Dhaka Shishu Hospital, and Holy Family Hospital. National collaborations will continue with increased ties to the Health Ministry of the Government of Bangladesh.

Research Issues: Infectious Diseases And Vaccine Sciences	EXPECTED PRIORITY		
	2000	2005	2010
1. Define disease incidence and burden of disease ⇒ Diarrhoeal diseases ⇒ Respiratory diseases ⇒ TB ⇒ Vector-borne diseases ⇒ Sexually-transmitted infections	+++	+++	+++
2. Evaluate promising vaccine candidates ⇒ Diarrhoeal diseases ⇒ Respiratory diseases ⇒ Dengue and vector-borne ⇒ TB	++	+++	+++
3. Define risk factors, clinical, sociologic, nutritional, and other characteristics when developing strategies for prevention and control ⇒ Diarrhoeal diseases ⇒ Respiratory diseases ⇒ Vector-borne diseases ⇒ Sexually-transmitted infections ⇒ Newly emerging diseases	+++	+++	+++
4. Identify, implement and evaluate strategies for reducing morbidity and mortality from infectious diseases ⇒ Treatment regimens ⇒ Community interventions/awareness ⇒ Improved management	+	+++	+++
5. Enhance Centre-wide focus on research of the priority infectious diseases:	+	+++	+++
6. Enhance capacity to investigate infectious disease outbreaks in Bangladesh and the region to use scientific methods to develop and implement strategies for outbreak control ⇒ Lab "surge potential" ⇒ Epidemic response teams (national) ⇒ Other out-breaks ⇒ Regional response team	+	+++	+++

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Health and Family Planning Systems

Problems identified. Medical services in Bangladesh are sorely needed, yet resources available are extremely limited. Funds for medical services through the government are about \$4 per capita per year. Thereby, the majority of medical services obtained are from non-government sources. However, existing services are limited, inadequately supported, and have been subjected to major transitions in an attempt to make them more cost-effective and sustainable. Adapting to these changes is extremely difficult which leads to uncertainty and compromised effectiveness.

Past programmes, especially the family planning programmes were delivered "at the door step." These were effective but were considered too expensive to continue. Thus, community clinics have been implemented in an attempt to provide services in a more cost-effective manner.

Decisions regarding the allocation of limited resources should, whenever possible, be based upon scientifically supported evidence. Evidence applicable to such decision-making is very limited and what does exist is not effectively disseminated to the decision makers. These represent the major challenges of the programme: to produce relevant knowledge and to appropriately communicate the findings.

Opportunities. The National Health and Population Sector Programme (HPSP) is due for renewal in 2003. The next HPSP will set the stage for the next 5 years within the MOHFW. The Centre has been in a position to influence decisions that will shape the next HPSP and has the opportunity to continue working with the MOHFW as it implements the next HPSP. Within the NGO sector, the formerly separate rural and urban service delivery programmes have been united under a single National Service Delivery Programme (NSDP). There exist tremendous opportunities to work with the NSDP, both in terms of evaluation of current programmes as strategies (such as depot-holders) and in identifying new direction and knowledge-based interventions.

Within the SE Asia region and internationally, there is increasing interest and support for multi-national collaborations. Because of its long-term work with institutions throughout the world and its reputation, the Centre is well positioned to playing an active role in promoting international cooperation and actively participating in joint operational research activities.

Relative strengths. The Centre has considerable experience in conducting operations research to strengthen health and family planning services, and in evaluating these services. Building on what has been learned from intensive studies in its hospital and field sites (e.g. Matlab), programmes can be recommended for implementation in MOHFW or NGO facilities and further studied in terms of their acceptability, cost, impact, and sustainability. These can then be scaled up, further evaluated, and improved. This has been the case with ORS, family planning and can now be true for other interventions.

Priorities. Based on continuing challenges, opportunities, and relative strengths, the HFPSP has established the following priorities:

1. The evaluation of alternative service strategies
2. The economic analysis of programmes
3. The identification of disparities in health within populations and explanations for the disparities
4. Establishing participatory research partnerships with communities, the NGO sector, the private sector, and the MOHFW.

5. Translation of research findings into policy and programmes
6. Improving medical information systems and evidence-based decision making
7. Assist all Divisions in the Centre in moving research findings with the potential of improving the health of Bangladeshis to the level of application and effective integration into the public and private sectors.

Strategies: Current activities are supported by USAID/Dhaka cooperative agreement. Additional funding will be sought to carry out health and family planning systems research. The Programmes will identify fields of comparative advantage with the Centre and then devise short and longer term work plans for the formative and operational research needed to scale up promising interventions and programmes. Present examples include zinc supplementation as a treatment and environmental health interventions. Furthermore, the programme will strengthen the linkage of the targeted research protocols to the demographic surveillance data collected in the Centre's field sites.

Under the USAID-Dhaka cooperative agreement, the Centre has been able to hire two additional international operations research scientists. This will further strengthen the HFPSP capacity. In addition, plans are underway to initiate a two-year fellowship programme in health systems/operations research. The programme will take on one new trainee each year with the goal being these individuals will join the HFPSP as capable, independent researchers. Finally the programme will identify a mechanism for hiring a biostatistician.

The programme will strengthen the Centre's collaboration with private sector organizations involved in social marketing and behavioural change communication and establish a more deliberate and consistent communication and dissemination plan with the MOHFW and NGO sectors.

Research Issues: Health And Family Planning Systems	EXPECTED PRIORITY		
	2000	2005	2010
1. Service delivery for 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 ⇒ Strategies for use of monitoring/evaluation tools and results for local level planning of ESP programme	++	+++	+++
2. Economic analyses and financing of health and family planning systems ⇒ Demand, costing and cost-effectiveness analyses ⇒ Strategies for health financing and improved financial sustainability	++	++	++
3. Health equity ⇒ Mechanisms to analyse/monitor types, extent and causes of inequities ⇒ Design and testing pro-equity intervention(s)	++	+++	++
4. Public-private partnership ⇒ Design and testing effective strategies for public-private partnership in ESP delivery	+	++	++
5. 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	++	++	++
6. 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	+++	+++	+++

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Population Sciences Programme

Problems Identified. Bangladesh is the world's most densely populated agricultural country. The Centre has contributed to the success of the national family planning programme in reducing fertility and consequent growth rate. Available evidence suggests that the population will finally stop growing at double the present size. If fertility could be reduced to below replacement level soon, the final population could be as much as 60 million fewer than otherwise. Much needs to be understood about the obstacles to further decline in fertility levels, and what policies may alleviate the future impact of population momentum stemming from the youthful population age structure.

Regarding family planning, the use of long acting, low cost clinical methods of contraception are declining, and temporary methods have high discontinuation rates. Better systems are needed to increase long acting methods and to improve continuation of temporary methods.

Regarding social policy, it would seem that increased opportunities for young women to be educated, and employed in the formal sector will result in delayed commencement of childbearing and overall lower fertility. What other policies might have a similar impact?

The decline in fertility, while beneficial through slowing population growth, has other less desirable consequences. The elderly population (over 60 years) will multiply almost ten-fold, from 6.8 million to 65 million, raising the elderly from 5% of the population to 26%. The (dependency) ratio of working age to elderly population will decline from eleven to two creating an enormous burden on the workers. Thus the needs of the elderly will become increasingly important during the 21st century.

Arguably the major demographic phenomena of this century will be the massive increase in the numbers of urban poor. This global migration is driven by a search for employment. In rural areas, this the urban migration will change the nature of nuclear families, lack of support for elderly, increase in sexually transmitted infections, and safety and security problems. In the cities, it will accentuate infectious diseases, will complicate provision of affordable health services and will compound family instability, alienation, lawlessness, drug use, etc.

Opportunities. The Centre, through its operations research programme has demonstrated in the past how the fertility rate can be reduced in a culturally acceptable manner and surveys do show that the families of Bangladesh do desire smaller family sizes. Thus, continued efforts to improve family planning programmes with appropriate targeting of services are likely to be effective. Female education is increasing at a rapid rate and other social changes will likely favour lower fertility.

The dangers of urbanization can be studied in order that the adverse health impacts of these social changes can be minimized. If the dynamics of urbanization are understood in their social context, the health services can be planned effectively.

Relative Strengths. The ICDDR,B has several large rural and urban demographically defined field sites. The demographic surveillance at these sites collects vital event data and provides a sampling frame for more intensive studies. Health interventions in the areas allow Centre scientists to test health interventions (e.g. micronutrients, vaccines, systems), determine burden of disease, and conduct social science research to understand the dynamics of population shifts. The longitudinal data collection systems at the Centre are unique in the world and form the model for other demographic systems in the world.

Priorities. Based on continuing challenges, opportunities, and relative strengths, the Centre has identified the following actions for population sciences:

- Investigations of the fertility decline in Bangladesh, understanding how to reduce fertility rates to replacement level or below, and how to minimize the impact of population momentum through social interventions.
- Understanding adult health problems, including non-communicable diseases, and including how families provide the necessary resources, both in terms of financial and social support, to deal with the growing health demands of an ageing population.
- Understanding the economic and social forces motivating out-migration from rural areas. This understanding is linked to monitoring of changes in family structure, especially in terms of social and financial support for family members remaining behind in the rural communities.
- To collaborate with other surveillance systems, through the In-Depth network, to improve the capacity of such systems to develop and monitor interventions for better managing health and population challenges in other areas of the world.
- Understanding the relation between family planning programmes and abortion in order to minimize the latter
- Understanding health equity and developing tools for monitoring health equity, especially in relation to rapid population growth and urbanization.

Research Issues: Population	EXPECTED PRIORITY		
	2000	2005	2010
1. Fertility decline in Bangladesh ⇒ Understand the levelling of fertility decline ⇒ Focusing new interventions to overcome the resistance to further fertility decline.	+++	+++	+++
2. Contraceptive use dynamics ⇒ Understanding relation of discontinuation and choice of contraceptives ⇒ Understanding high discontinuation-rates	++	++	+
3. Interrelation between abortion and contraceptive use ⇒ Determine how to maximize family planning programmes to avoid unintended pregnancy ⇒ Transfer lessons from Matlab to the GoB ⇒ Identify families with high risk of abortion	+++	++	+
4. Health & Demographic Surveillance System ⇒ Maintain the HDSS ⇒ Archive cohorts from past for future analysis. ⇒ Begin comparative studies with others in the In-Depth network ⇒ Validate rapid demographic methods	+++	+++	+++
5. Ageing and adult health issues ⇒ Characterize adult health issues ⇒ Quantify burden of disease from disability	+	+++	+++
6. Education and family size ⇒ Characterize relation between education, other SES factors, and demographic events	+++	++	+
7. Poverty and rapid population growth	+++	++	++
8. Urbanization and rural-urban migration ⇒ Characterize the push and pull factors for urbanization	++	+++	+++
9. Utilization of health and family planning services ⇒ Urban areas ⇒ Rural areas	++	++	+
10. Health equity, poverty and population ⇒ Develop methods for measuring equity in programmes ⇒ Describe characteristics of equitable and non-equitable interventions	+++	+++	+++

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VI. INSTITUTIONAL DEVELOPMENT AND EXPANDED SERVICES

The Centre is able to achieve the programmatic goals only because of the institutional resources available. The institutional resources include hospitals, field areas, as well as the academic and administrative support facilities of a large Centre. While the Centre can be defined by the intellectual ideas, as stated in the priorities above, it is also partially defined by many of the ongoing facilities that provide services to the people of Bangladesh.

Clinical, Laboratory and Field Resources

Dhaka Hospital

The Dhaka Hospital was originally established as a clinical research centre where clinical studies of cholera and other diarrhoeal diseases could be conducted. Over the years, it became popular because of the high quality and dependable service, 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 have been saved is incredibly high – estimated to be about 10 to 15,000 patients per year. Thus, the treatment at the ICDDR,B hospital is very cost-effective; but because of the high patient volume, the total costs have been high – about US\$1.2 to \$1.5 million per year.

Common, Treatable, Life-Threatening Illnesses.

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, are life threatening, but are easily and inexpensively treated once the appropriate case management system has been developed. Other illnesses also fit these criteria: common, life-threatening, easily-treated at low cost. Other illnesses include pneumonia, severe malnutrition, malaria, and dengue⁵. 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 is the intent of the Centre to put this message into practice. Thus, we intend that the Hospital should develop a model for treating, with a very low cost, these common, life-threatening diseases.



In order for the Centre's diarrhoea hospital to evolve into a facility for these illnesses, 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.

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

- 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 and Family Welfare and other hospitals understand 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 a new urgent care facility

Financial Plan For New Treatment Facility. 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 income⁶:

Income from Hospital Endowment Fund	200,000
Income from the Diagnostic Centre	350,000
Income from surcharge on research studies	100,000
Income from patient recovery	50,000
Income from Government of Bangladesh ³	500,000
Total	1,100,000

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. Recently a new diagnostic unit was established on the ground floor of the hospital to improve its access to the public. The new facility will grow in order to provide an increased range of services including 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 Diagnostic Centre is to provide services to the

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

³ This would require an increase in commitment from the Government of Bangladesh.

greater Dhaka area and to generate some revenue to subsidize the Hospital. 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 and flow cytometry.

Research Laboratories

The laboratories conduct 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) are in the process of renovation on the second floor to provide this extension, but even more space will be needed when added floors are built.

Urban and Rural Field Areas

Matlab

Matlab remains as the major rural field area of the Centre. With over 35 years of continuous demographic information on a population of over 200,000 people, the Matlab area is a major public health resource for the world. Many crucial public questions can only be answered definitively in Matlab, and many of these are ones that were never anticipated even five years ago.

The Centre has recently embarked on a major study on low birth weight, testing of nutritional interventions in an attempt to reduce low birth weight and improve health and survival. Other interventions are reproductive health, including subcentre-based emergency obstetric care and male involvement, community-based IMCI, water filtration to prevent cholera, the epidemiology of tuberculosis in rural Bangladesh, and measuring the health impact of arsenic in drinking water. Additional research projects include characterization of family planning successes and constraints, con-

traceptive use dynamics, defining the relationship between 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 recorded demographic data while the latter recorded



illness and health care service 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 and Internet access for Matlab. We anticipate that it will also allow for video-conferencing between Dhaka and Matlab.

Plans for Matlab include completing some needed expansion to the hospital building, and implementing EOC services in the recently completed obstetric facilities in cooperation with the Government of Bangladesh.

Other Rural Field Areas

The Centre works in several other field areas in addition to Matlab and each of these adds much-needed capabilities and resources. The largest of these are the rural extension areas that are part of the Family Health Research Project (FHRP), but other areas include the very innovative self-help project in Chakaria, the Epidemic Control and Preparedness Project sentinel surveillance sites, and BINP sites, the new site for neonatal interventions in Sylhet and Mirzapur 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, with its population of 140,000 is located close to the train station in a slum area and is rapidly becoming an "urban Matlab." It has been extremely useful for studies on pneumonia, and is now the site for studies on shigellosis, influenza vaccine, and dengue and we anticipate that it will be useful for additional studies of communicable diseases as well as health systems research. 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 amoebiasis 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.

Map of Bangladesh showing location of field areas



Information Sciences

The Information Sciences Division (ISD) was formed in 2001 as a way to bring together the Computer Information Services (CIS), the Dissemination and Information Services Centre (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. This unit also coordinates short-term fellowship programmes. 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 focuses 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 avail-

able 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
- Optimising 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.

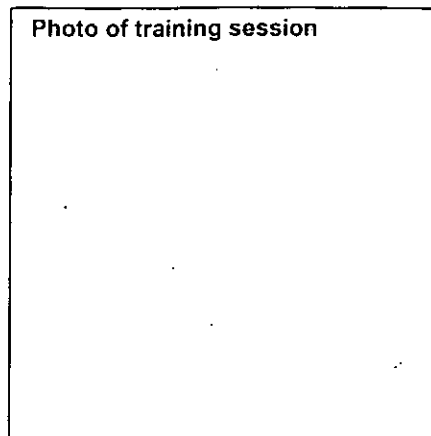
During the next period, DISC's strategy is to:

- Evolve into an electronic information store by creating digitised 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, only users in the library can consult these materials – digitisation enables copies 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.

Photo of training session



Computer Information Services (CIS)

CIS is responsible for the provision of modern IT services, including email and Internet, to all scientific and support divisions in the Centre. This includes maintenance and management of the local area network (over 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's future plans will 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, informa-

tion 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 TEU. 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.

Institutional Support Services

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. The market place for research 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 is nearing completion 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 at present. For positions that are in high demand, however, the newer system will be more adaptable to market forces. For Bangladeshi scientists who have exhibited a keen sense of innovativeness and productivity, the Centre has instituted a plan that allows them to have international salaries in proportion to the grants they secure.

The HR agenda also aims to increase emphasis on internal training, cross training, development of career tracks ("job families"), 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, outsourcing, increasing automation, and selection of highly qualified staff.

Certain financial aspects of the human resources are also under review. Specifically, the costs for personnel benefits (medical benefits, taxes, end of service payments, etc.) are now included in the personnel costs charged to the projects rather than to the common operating cost (indirect cost) pool.

The Centre formerly followed a "six-year rule" for international staff that was interpreted 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. Further, the "six-year rule" was effectively modified to a "nine-year" rule for the Director with an amendment to the Ordinance in 1996.

A major need in the HR agenda is an improved management information system (MIS) to manage both finance and human resources in a unified fashion. A decision will be made during the next year to adopt such a system.

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.

Financial Management

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.

Procurement

The procurement of supplies and equipment is managed through a unit to insure that purchases are transparent, follow rules of the donors, and provide the best value for conducting the activity. Obtaining supplies in Bangladesh is more complicated than in industrialized countries. Higher shipping costs, customs formalities, transportation delays, special needs for refrigerated items add to both costs and complexities. Some donors also impose certain regulations for source and origin of supplies and equipment and this also adds to the costs and administrative paper work. These additional requirements are managed well through the procurement offices and the Centre's annual audits insure that they are carried out accurately.

Transportation, maintenance, general services, catering, physical plant management

The Centre operates a large fleet of vehicles for both land and water transport. Also it has its own maintenance units and general services units for maintaining efficient functioning of this complex organization. The frequent special functions (e.g. national and international meetings) are managed efficiently at the Centre.

VII. FINANCIAL SUSTAINABILITY

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 endowments

The Centre's endowments, raised during the last ten years, total about US\$ 9 million, but need 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 that 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 administrative offices, procurement, the Director's Office, or costs for the Board of Trustees, etc.) These costs are, thus, categorized as the common institutional costs that 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 universities⁴, and are much lower than for-profit organizations.

The Centre receives income in the form of both project as well as unrestricted⁵ support. The unrestricted donations are available for the Centre to use in the most effective way for the overall benefit of the programme of the Centre. Project funds, however, are designated for specific projects, and all costs for these projects 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 donors have rules that do not allow these common costs, or set a cap on the percent that can be included as common institutional costs. When a project donor provides less than the full cost of the project, the core donors must co-fund the project in order for the project to be completed. 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 would not be possible without this core support. Likely, some projects may not be possible if the primary donor is not willing to pay common institutional costs, if there are not sufficient funds from unrestricted sources to co-fund the project.

Income Generating Projects

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 is in the process of improving 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 increase its range of tests.

⁴ US universities typically have indirect costs of about 60 to 80%.

⁵ Sometimes referred to as "core" support.

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.

VIII CONCLUSION

The ICDDR,B will be celebrating its 25th anniversary as an international Centre in 2003⁶. As it begins its next 25 years, the Centre has identified a plan for addressing many of the crucial health research needs that face Bangladesh and other developing countries. The Centre's productivity over the last 25 years is due to the many donors who have shared the vision of the Centre, and to the many scientists and staff and scientific partners who were devoted to the Centre's mission. It is also due to the relationship the Centre has had with the Government of Bangladesh and with the communities where the Centre has worked.

The next 25 years will bring many new challenges. The Centre is not the same as it was 25 years ago when it was highly focused on diarrhoeal diseases and population. The Centre must now also address issues of other critical communicable diseases, issues of reproductive health. HIV-AIDS, dengue, arsenic toxicity are but some examples of crucial health issues that were not foreseen 25 years ago. The Centre must continue to evolve in a manner that is response to the evolving needs of poor countries.

Now, we turn to the donor community to renew our partnership for the benefit of the people who live in developing countries. Each of the 25 years has been a financial struggle and one wonders if financial stability will ever be possible for institutions like ours that work for the benefit of the poor. However, financial stability is not our goal, rather the goal is to be as productive as possible for the benefit of the health of those living in poor countries.

Sometimes research and public health programmes are seen as opposing ways to allocate resources. This is a false dichotomy. One cannot conduct programmes unless one first learns how to use the resources. Continuing to use "old knowledge" far past its relevance is wasteful, and failing to acquire new knowledge is foolish. Just as programmes cannot do without research, research must also be coordinated with programmes. We are not in the business of acquiring knowledge just to publish paper, but rather to develop the knowledge that will be useful and practical.

It took 10 years for ORS to progress from basic understanding to programmes. It has taken 15 years for the oral cholera vaccine to even begin to be used. These delays are too long, and it is only through the joint cooperation and communication between research and programmes that the recipients will benefit from the new findings.

Sometimes people ask why an International Health Research Centre should be located in Bangladesh. Why not Geneva or London or Washington DC? The answer is simple: this is where the problem. This is where the problems can best be understood in all their complexities. This is where science and programmes meet, and this is where they are integrated into practical and cost effective solutions. We trust that the donors will join with us during the next 25 years; not to provide financial stability, but to provide the needed financial resources so that the Centre, along with its partners will live up to its potential.

⁶ And its 43rd anniversary since its founding as the Pakistan Seato Cholera Research Laboratory