# ICDDR,B

# BOARD OF TRUSTEES MEETING

## 11-13 June 2004

# PROGRAMME OF THE

# BOARD OF TRUSTEES MEETING

## 11-13 June 2004

DRAFT (8 June 2004)

# PROGRAMME
# EXECUTIVE COMMITTEE MEETING OF THE BOARD OF TRUSTEES
## 11-13 June 2004

**Prof. Ricardo Uauy Dagach (Chair, BoT)**
**Dr. Marcel Tanner (Chair, Programme Committee),**
**Dr. Claudio Lanata (Chair, Human Resources Committee),**
**Prof. AK Azad Khan (Chair: Finance Committee),**
**Dr. Kul Gautam (Chair: Fund Development Committee) (unable to attend),**
**Mr. AFM Sarwar Kamal (Chair: National Liaison Committee),**
**Dr. David A Sack (Executive Director, ICDDR,B),**

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| **10 June** | Board Members arrive | Guest House |
| **3:00 pm.** | **Meeting with Centre Directorate** | ED's Conf Room ICDDR,B |
| **Evening:** | **Free** | |

## Friday 11 June 2004
## Programme, Human Resources, Finance Committee & DPG Meetings
## Sasakawa Auditorium & Seminar Room

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| 08.00 - 09.00 am | Meeting of the Executive Committee<br>- Approval of PC Minutes<br>- Review - November 03 Resolutions | BoT, CD Seminar Room |
| 09.00 - 09.45 am | Director's Report | BoT, scientific staff: NOA and above, donors |
| | Scientific Presentations: | |
| 09:45 - 10:15 am | New findings and Directions on Cholera<br>- Dr. G B Nair | |
| 10.15 - 10.30 am | TEA | |
| 10.30 - 11.00 am | Neonatal Health<br>-Dr. Shams-el-Arifeen | |
| 11:00 - 11:30 am | Plateauing of the Bangladesh Fertility Decline<br>- Dr. P K Streatfield | |
| 11:30-12:30 pm | Development Partners Group meeting | BoT, SC (Sem. room) |
| 12.30 – 01.30 pm | LUNCH | BoT, DPG, SC, |
| 01.30 – 03.30 pm | Finance Committee | BoT, SC |
| 03.30 – 03.45 pm | TEA | BoT, SC |
| 03.45 – 05.00 pm | Human Resources Committee | BoT, CD |
| 05.00 - 06.00 pm | Prepare report for teleconference | BoT, CD |
| Evening | Free | |

**Saturday 12 June 2004**
**Seminar Room**
**Full Board, SWA**

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|---|---|---|
| 08:00 - 10.30 am | Approval of the Minutes<br>Discussion on November BoT Retreat | BoT, CD |
| 10.30 - 11.15 am | TEA | BoT, SC |
| 11.15 - 12.00 noon | SWA Presentation | BoT |
| 12.00 - 12:30 pm | Any Other Business<br>- Appointment to committees of the Board<br>- Extension of term of Trustee<br>- Selection of new Trustee<br>- External Programme Review of the Board: ISD: June 2005 (Selection of Review Committee) | BoT |
| 12:30 - 02.00 pm | LUNCH | BoT, SC & SWA |
| 02.00 - 04.00 pm | Finalize report to Board Members | BoT, CD |
| 04.00 pm | Teleconference | BoT |
| 7:00pm | Dinner (at Heritage) | BoT, CD |

**Sunday 13 June 2004**
**Auditorium**
**GUEST LECTURE**

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|---|---|---|
| 09.00-10.00 am | Guest Lecture by Member, BoT<br>(**Title:** Reducing Maternal Mortality in Peru: A quality improvement and accreditation of health services intervention.<br>**Guest Speaker:** Dr. Claudio F. Lanata) | Auditorium (Open) |
| 10:00-10:15 am | TEA | |
| 10:15-11:00 am | Report to staff by Chair, BoT & Executive Director, ICDDR,B | Auditorium (Open) |
| 12:30 pm | LUNCH | BoT, CD |

1/BT/JUNE 2004

# APPROVAL OF THE AGENDA

2/BT/JUNE 2004

# APPROVAL OF THE DRAFT MINUTES

# OF THE MEETING

# HELD ON 31 Oct-2 Nov 2003

# MINUTES OF THE MEETING OF THE BOARD OF TRUSTEES, ICDDR,B
## 31Oct-2 Nov 2003

### Minutes of the Programme Committee
### Seminar Room/Sasakawa Auditorium
### 31 October 2003

The Board of Trustees held its meeting in Dhaka, Bangladesh from 31 October to 2 November 2003. The proceedings of the Programme Committee commenced at 8.00 am in the Seminar Room.

**Present:**

Dr. Ricardo Uauy Dagach (Chair, BoT)
Mr Mirza Tasadduq Hussain Beg
Dr. Kul Gautam
Prof. A K Azad Khan (Chair, Finance Committee)
Prof. Jane Kusin
Prof. Terence Hull
Dr. Claudio Lanata (Chair, HR Committee)
Dr. Halima Ramadhan Abdullah Mwenesi
Prof. David Sack (Director, ICDDR,B)
Prof. Marcel Tanner
Prof. Carol Vlassoff (Chair, Programme Committee)
Dr. I Kaye Wachsmuth

**Absent (with regrets):**

Prof. N K Ganguly
Dr. Maimunah Bte Abdul Hamid
Dr. Nobukatsu Ishikawa
Mr AFM Sarwar Kamal
Dr. Tikki Pang

**Invited**: Centre Directorate
Minutes: Ms Loretta Saldanha

Dr. Ricardo Uauy Dagach, Chair, BoT opened the meeting by welcoming all. He requested the new Board members Dr Halima Ramadhan Abdullah Mwenesi and Dr. Kul Gautam as well as the Centre Directorate to introduce themselves. Dr. Uauy also thanked Mr Mirza Tasadduq Hussain Beg, Secretary, ERD, for participating. Mr. Beg has replaced Mr. Anisul Huq Chowdhury (former Secretary, ERD). Dr. Sack joined Dr. Uauy in welcoming Mr. Beg and reported on the excellent relationship with the Government of Bangladesh.

Dr. Uauy presented the Agenda for approval of the members. Referring to the agenda on Standing Committees of the Board, he said that apart from discussions on the Standing Committees of the Board specifically the Fund Development and Oversight, and National Liaison Committees, discussions will also include Governance issues.

Dr. Sack briefly introduced discussions at the last BoT meeting on the Standing Committees. He suggested break-out sessions by the Board together with senior management (divide the group into 3 - one focusing on the Fund Development and Oversight Committee, another on National Liaison and the third focusing on the functions of the Executive Committee). The break-out sessions would address some specific questions and their observations and findings will be shared with the whole group. The overall goal would be to see how these Committees would operate – their functions, reports the management needs to provide these Committee to enable them to carry out their functions, and activities the Board should be involved in to carry out its functions. He further clarified that these are Board Committees and the senior management in the Committees will act as resource persons and will provide some guidance to the Board. The Executive Committee will discuss and define a number of issues related to Board governance and Centre management. He said there tends to be a cycle of the Board -- when things are going smoothly, the Board tends to have their "hands off" and during a crisis they "jump in" with both feet and start micro-managing—both of these extremes are not appropriate. The Board should be active in ensuring that management tools are in place while avoiding micro-management when a crisis occurs.

Dr. Sack also requested the Board to delay final approval of the By-laws until after the break-out sessions.

Dr. Uauy drew the attention of the new Board members to the Centre's Strategic Plan which, he explained, is important because it is also part of the work of the Board, and provides a background on the work of the Centre. He said several resolutions passed at the June Board meeting addressed the need to have the work of the Centre based on the Strategic Plan, and it is therefore important to keep this document at hand as the Board reviews the progress of the Centre.

1. **Approval of the Minutes of the Programme Committee Meeting held in June 03**

The Minutes were approved with the following corrections:

Page 7: 25 Years of ICDDR,B: 2nd line: "Data Warehouse" – it was clarified that this the data is stored on a disc.

Page 8: CHNRI: Dr. Sack clarified that an update will be provided in his report to the Board.

Resolution 9: It was reported that this was taken up at the CSD review and it would be possible to provide a final report based on the outcome of the review.

It was agreed that at the end of the Minutes, an update on the resolutions should be provided by the Director on actions requested by the Board in November 2003

Page 11: Following a query on the use of the term "Centre Directorate" and whether this was formalized, it was reported that the Directorate consists of the Associate Directors, Head, HR & Finance, but has not been formalized in the sense of having by-laws. This group meets almost every week

Dr. Uauy invited the Board to flag issues, if they noted any, that were not acted upon

Guest Lecture by Board: Prof. Vlassoff pointed out the Board's earlier proposal given the fact that considerable experience relevant to the work of the Centre exists in the Board, that specific individuals be invited to give a lecture (perhaps in one of the evenings of the Board meeting) and Centre staff, individuals from the community and stake holders be invited. This would be an opportunity for the Centre to take advantage of the experience available on the Board, and should be considered in the future. It was agreed that Prof. Azad Khan take this up for discussion by the National Liaison Committee.

To ensure consistency and coherence from one meeting to the next, the Board agreed to hold an informal closed session to follow up on the Resolutions. It was also agreed that a report should be provided by the individuals responsible (eg Centre Directorate) on follow up actions and an explanation for resolutions where no follow up action was taken. Henceforth, a follow-up on the resolutions will be recorded in the Minutes. Dr. Sack responded that follow-up on resolutions were included in his report (Director's Report).

Amendment to the Ordinance:

- Change in name of ICDDR,B: Dr. Sack reported that this is a Parliamentary decision and will be proposed only if the Board approves the request to change the name.

Millennium Development Goals (MDG): It was reported that for the next 12 years or so the international community will be very focused on the MDG. From the strength of the Strategic Plan everything that the Centre does is supportive of the MDG. If funding and resources are part of the Centre's concern, in terms of presentation it would be useful for the Centre to project itself as a Centre that has the capability for the achievement of the MDG. Referring to the recent series of articles in the Lancet on Child Survival which also showed a slackening of progress but that tremendous opportunities exist, it was reported that the international community have had some discussions about what should be done to gear this up. Dr. Gautam said that in terms of marketing thereby achieving greater success in attracting resources, the Centre should do more to align its work in support of the MDG, including the child survival goals.

Dr. Uauy thanked Dr. Gautam for this suggestion and agreed that further discussions were necessary in this regard. He requested a one-page proposal that addresses this issue on how the Centre sees its Strategic Plan in line with the MDGs.

Indicators: Following discussions with researchers at the Centre with re to measuring indicators and problems with following indicators, Prof. Hull reported that the Centre is doing much research which are fairly critical to the data problems and interpretation of data and that the issue with problems of measuring some of the indicators particularly in developing country settings are quite severe. ICDDR,B has a unique setting for commenting on this issue, and hence, wished to endorse the idea of the goals being brought into consideration during the planning process and in terms of the actual research programme. The Centre could assist in helping the international community realize the problems some countries are facing in trying to deal with the problems of indicators. Prof.. Hull further referred to the Director's report (page 16) on a project on nutrition rehabilitation (CSD) and requested that the Board be provided with a copy of this study. The reason for raising this was that the brief description appeared to be gender naïve.

It was also agreed that the next Programme Committee report should take up this initiative (MDGs) so that this could be reported to the Development Partners, and that the Centre should develop indicators that will enable a report to the Board about what the Centre is doing in so far as tracking changes in relation to the MDG.

Dr. Lanata was invited to present a brief update on the CSD review and flag issues that the Board should consider over the next two days.

The Programme Committee reconvened at 9.15 am in the Sasakawa Auditorium:

**Present:** Members of the Board
**Invited:** Scientific Council Members, Development Partner representatives, Centre scientific staff.

**Minutes:** Ms Loretta Saldanha

Dr. Uauy welcomed those present to the meeting of the Programme Committee. He said he was pleased to see that the Centre is working to meet the goals of the Strategic Plan.

Prof. Vlassoff was invited to Chair the proceedings of this meeting.

Prof. Vlassoff said that she was pleased with the format this year. She said, the format is more consolidated and perhaps will allow for more interaction. She invited Dr. Sack to give his presentation.

## 2. Director's Report:

Dr. Sack explained the change in format, whereby the Director summarizes the main achievements of all Divisions, and a few highlights are selected for presentation and more detailed discussion, and the process leading to this change. He said the topics were selected because these were new issues and the intention therefore was to downplay the Division reports as detailed reports were presented at the last June meeting. In future presentations would be more in line with the Strategic Plan. However, following his presentation, the Division Heads would be available for questions.

Dr. Sack began with a follow-up from the last meeting (Resolutions 7, 8, 9, 10 & 11) and the agenda for the forthcoming Board Retreat in November 2004. He reported that the Centre is considering an amendment to the Ordinance which would include a change in the name of the Centre to International Centre for Health & Population, Bangladesh (ICHAP, Bangladesh) bearing in mind its national and international characteristics; change the basis for determining salary away from the UN Structure to a salary based on market forces and, a provision to create an "NGO" or "service Organization" under the Centre's direction. Dr. Sack moved on to present an update on staff transitions during the reporting period, Human Resources update, followed by an overview of Finances – the Centre's present budget is US$ 16 million – the Board may need to consider whether we should grow or remain at this level; changes in physical plant, training, conferences/workshops, major trends and policy issues for Bangladesh and their relation to the Centre's Programme, collaboration with James P. Grant School of Public Health with BRAC, a report on the Development Partners Group (DPG); Division updates, expected accomplishments, assessment of the Strategic Plan: Child Health Programme, Reproductive Health Programme, Nutrition Programme, Infectious Diseases and Vaccines, Health & Family Planning Systems and Population Sciences and concluded with highlighting important achievements during the year.

He further reported on the profile-raising event being organized in London at the House of Lords of November 21.

Prof. Vlassoff thanked Dr Sack for the excellent progress made during the year and the attempts the Centre is making with regard to amendments to the Ordinance.

Dr. Uauy thanked Dr Sack for reporting on the strengths of the Centre and called upon the Division Directors to briefly report on what might be considered as the weaknesses of the Centre including:

a. Few senior staff carry out most of the functions, and hence there may be a shortage of senior scientists in the next 10-12 years.
b. Funding
c. Recruitment of required skills (define skills required).
d. Enhancement of infrastructure – shortage of funding for this activity.
e. Increase communications – make research findings better known.
f. Sustained support for infrastructure especially field operations.

Prof. Vlassoff noted the lack of women in senior positions and urged the Centre to find ways to improve this situation. She said that she would be pleased to hear about the impact of the Centre's gender policy in the divisions and how the development partners might support the implementation of this policy.

Health Systems Research: Questions were again raised regarding the profile and the position of Health Systems Research at ICDDR,B and how Health System Research will be more coherently addressed in the future. Dr. Sack responded that this Health Systems Research is on the Centre's priority list, but unfortunately funds for this activity have been decreasing. The Centre hopes to participate actively in the HNPSP which will be discussed in the Development Partners Group meeting. If there are partners worldwide who would assist in sustaining the Centre, this should be explored. With regard to importance of such partnerships, the Centre's role in the HNPSP was cited. In response to the suggestion that the Centre continue to keep connected with the Gates Foundation, it was reported that concept papers were submitted for the Grand Challenges. It was also reported that the submissions to the Grand Challenges included proposals for oral vaccine, lung injury (how do we treat pneumonia), improvement in the treatment of diarrhoeal diseases, etc.

In response to whether the Centre plans to look at food borne diseases, it was reported that several projects in HSID and LSD are moving in this direction. However, funds for this activity are limited. How the Centre plans to trade off between "Health Systems" and "Disease Systems" was also queried. Prof. Vlassoff invited Dr. Tasnim Azim to present.

**2. HIV/AIDS Programme:**

Dr. Tasnim Azim reported that activities under this Programme started even before the Strategic Plan was developed. The goal of the Programme is to expand ongoing activities to control the HIV/AIDS epidemic. Dr. Azim presented the issues around HIV/AIDS, the Bangladesh scenario, vulnerable population groups, other studies at ICDDR,B, work in the region and plans over the next year.

Dr. Azim further reported that the Centre is developing a model for Bangladesh and would escalate this to the Public Health arena. With regard to WHO estimates and whether these are useful for policy makers, it was reported that the figures are not popular with the Government of Bangladesh and hence the Programme will revisit this issue and will be looking at the gaps in the data. Regarding information on potentially affected children, a dialogue has just started with UNICEF.

Prof. Vlassoff thanked Dr. Azim for a very comprehensive and impressive presentation and said that the Programme is an excellent example of early intervention.

Dr. Abbas Bhuiya was invited to make his presentation.

**Poverty & Health:**

Dr. Abbas Bhuiya presented the goals, areas of concentration, progress and research framework of the Programme. He said the goals of the Programme included research and organizational aspects. Areas of Concentration included visibility, capacity development, knowledge generation and dissemination. Dr. Bhuiya also highlighted findings from selected studies which included the tuberculosis study, safe motherhood, elderly health, and measurement of poverty. He concluded by providing information on the Chakaria Community Health Project.

Prof. Vlassoff thanked Dr. Bhuiya for a very rich presentation which, she said, also answered questions raised earlier by Dr Jane Kusin's concern re education.

Discussion: It was suggested that the Programme include: nutrition (anthropometry studies); education – development of children and access; and mental health. The studies on measurements was appreciated, but how funding is making a difference and how social progress would correct this issues was questioned. With regard to the absence of vulnerability and resiliance in the framework, Dr. Bhuiya agreed to look into this.

Prof. Vlassoff invited Dr. Charles Larson to make his presentation.

**Scaling up Zinc as a treatment for childhood diarrhea (SUZY) project:**

Dr. Charles Larson began by providing a legacy of scientists involved with zinc related work at the Centre. He reported that zinc deficiency is a common problem in young children, and places them at increased risk for morbidity and mortality. Options for zinc augmentation include food fortification, daily/weekly supplementation as well as a treatment for diarrhea. Zinc as a treatment – a summary of the current state of knowledge was presented. The Larson said that the goals of the project included implementation of marketing and delivery strategies in public, private and NGO sectors. This will set the project on the path to reaching all children of Bangladesh, regardless of gender, income or where they live and provide zinc as a treatment for any diarrhoeal disease episode.

Discussion: It was felt that the activity is only concentrating on diarrhea and not on other childhood illnesses like pneumonia. However, though potential problems exist with this, the activity might also consider other childhood diseases or a wrong message will be introduced if the concentration is only on diarrhea. Dr. Larson responded that additional research is needed in this regard but that there is a consensus of the efficacy of zinc with diarrhea. A consensus does not exist yet for its efficacy for other illnesses. In response to marketing the work, Dr. Larson reported that the MoH needs to create a team to start planning and that discussions are ongoing with WHO and UNICEF who have shown much enthusiasm and are encouraging the Ministries of Health all over the world. Plans for partnership in Ethiopia and Mali are being considered.

It was further stated that despite the great potential of zinc to alleviate nutritional problems, equal attention should still be paud to the many underlying problems of malnutrition.

Prof. Vlassoff thanked Dr. Larson for a very concise and interesting presentation.

### 3. Staff Welfare Association Presentation:

The Executive Committee of the Staff Welfare Association presented their report to the Board. The SWA presentation emphasized a definite plan of action to resolve the salary gap in the salary structure and requested the BoT to advise the Centre on how to generate more income to provide stability to the Centre in the future. SWA also raised the issue of proper child care facilities (crèche). It was noted that this could not be upgraded due to lack of space.

**Afternoon Session: Programme Committee – Sasakawa Seminar Room**

**Present**: Board Members
**Invited:** Centre Directorate
**Minutes:** Loretta Saldanha

### 4. Reflections on the Morning Session:

i. Format for presentations:

Following discussions on the format it was felt that more time should be set aside for discussions and that highlights should be reduced in length. It was recommended that the Centre keep the present format and in future link it even more coherently with the Strategic Plan, with separate projects clearly integrated into lines of research and to standardize fully the reporting format across divisions, particularly with regard to the presentation of publications and staffing. It was also noted that the breadth of activities is impressive. However, the Centre needs to ensure that its work is known and appreciated. The Board recommended against a major journalistic/dissemination effort but recommended that the Centre should continue the successful links with the national and international press, continue to aim at excellent scientific publications and develop more information material such as fact sheets and circulars. The Board also felt that the website is an important source for information dissemination. The Board, however, commented on the publications which they felt has been fairly low in the last six months.

ii. The position and the profile of Health Systems Research still requires attention by the Centre to meet the need to render efficacious interventions effective at the community level. It was recommended that the Centre illustrate new trends and focus on new studies in this area in relation to the Strategic Plan. The Centre could plan on a workshop to which donors should also be invited, at which existing data could be presented together with new trends and, finally, a discussion on the agenda for the country.

Dr. Sack informed the Board that the Centre has identified a couple of problems on current issues for discussion at the Development Partners Group meeting (DPG): 1) Zinc and, 2) the need for Operations Research in support of the HNPSP. The question is, is there a mechanism for the donors to fund this type of Operations Research in support of the HNPSP. This will be a major discussion item for the DPG. A further report on the activities of the Centre in Operations Research and donor perspective was presented by Prof. Barkat-e-Khuda for the information of the Board.

The Board recommended the inclusion of Health Systems Research (HSR) in the Centre's portfolio (balance between health systems approach and disease systems approach) and recommended that the Centre provide a comprehensive documentation on the HSR portfolio including the plans for the future to be reviewed at the next BoT meeting.ii. A Check-list of Resolutions requiring action followed:

Resolution 1: Confirm whether Minutes have been made more succinct and recorded along issues rather than transcripts. (Confirmed)

Resolution 4: A yearly progress report in relation to the Strategic Plan (it was agreed that this report should be programmatic – show how the activities lead to one result. The Director and Division Heads need to decide on the format for presentation).

Resolution 7: Review of the CSD. (completed)

Resolution 8: Update on CHNRI (Director's report)

Resolution 9: Models for the hospital (covered by the review)

Resolution 10: The Centre Directorate to define core and essential activities. (Finance Committee)

Resolution 11: Intra-divisional distribution of funds.(Finance Committee)

Resolution 14: Recruitment Process (HR Committee)

Resolution 15: Strategy for Recruitment Process (HR Committee)

Resolution 16: Final Stage of implementation of the Gender Policy (HR Committee)

Resolution 17: Report on the implementation of the HR Plan(HR Committee)

Resolution 22: Job description for Deputy Director (Discussed in closed session of the BoT)

Resolution 34: Develop a system to report to the Board the roles of the Standing Committees (Discussed – to be taken up at the Board Retreat).

**Fund Management Committee** : Dr. W.B. Greenough, Chairman, Fund Management Committee, Baltimore (who was present in Dhaka for the CSD review) was invited to make a brief presentation on the activities of the Committee. It was agreed that to raise funds in the future, the Centre would provide details of how these funds have been spent to enable the Committee to relay these stories to the donors. It was also agreed that these funds should be placed under a separate legal entity.

**5. Discussion on Standing Committees:**

**Break-out sessions:**

**Fund Development & Oversight Committee:**

Dr. Kaye Wachsmuth, Dr. Marcel Tanner, Prof. Terrence Hull, Dr. Kul Gautam
(Centre staff: Dr. I. Zaman, Ms. Julia Ackley, Ms. Hannah Lemon, Dr. D Sack)

Professor Tanner reported on the discussions. It is expected that the Board should be more involved in fundraising activities of the Centre and discussed several ways how this could be done. The following points were discussed:

1. The Board should act as a platform.
2. The Board should be very vigilant to identify new donors.
3. The Board should be active in providing access to these individuals in building bridges so that the Centre and these target groups/individuals can be reached.

The group did not focus on the text of the by-laws but discussed the responsibilities the Board can take over the next 12 months. The Centre should assist the Board members by providing fact sheets, provide unique information and also information to enable appropriate PR. The Board will discuss this in their meetings each year and assignments will be provided. It was mentioned that the roles can be summarized in a few points and not as detailed in the by-laws and hence the Centre will need to reformulate these by-laws. The group did not discuss the membership of the Committee.

It was felt that discussions always center around money when fundraising is discussed and that it would be useful to develop other kinds of international relationships which do not necessarily imply funding.

The Board were also informed that one of the reasons to form this Committee was that most individuals who join the Board, at the time they accepted the responsibility to be on the Board, did not see their roles as primary fund raisers for the Centre and this was not generally a part of the mandate of the Board. It is common that Board members often do not realize that there is a significant role for Board members in fundraising. Fundraising is one of the key functions of the Board.

It was agreed that this point should be taken up at the Retreat. Dr. Uauy also suggested that this role should be indicated in the initial letter to the Board.

**Governance:**

Prof. Carol Vlassoff, Dr. Claudio Lanata, Dr. Ricardo Uauy Dagach
(Centre Staff: Prof. Barkat-e-Khuda, Ms. V. Brooks, Dr. M A Salam, Dr. R. Breiman, Ms Ann Walton, Mr A Neogi)

Prof. Vlassoff summarized the discussions as follows:

The discussion focused mainly on the degree to which the Directorate of the Centre used a participatory approach to decision-making and information sharing. The discussion began with a review of the powers of the BoT as specified in the Ordinance. It was agreed that the powers specified there were in fact those which the BoT exercised, but that the intensity of BoT intervention depended very much on the circumstances and needs of Centre management. When management is seen as strong, the BoT has more of an oversight function, whereas the BoT becomes more involved when the Director is absent for long periods or when there is a gap between Centre Directors.

In terms of the participatory nature of the Directorate, it was acknowledged that the process of decision-making could be more participatory, but it was also unanimously agreed that participatory and consensual decision-making is the present norm and practice at the Centre. The weekly meetings of the Centre Directorate has been adopted and is working well. Examples were given, including the follow up of the resolutions of the Board of Trustees, Nov. 2002. While this process was difficult, it was overall a satisfactory and inclusive process. Areas in which greater participation is still needed include lower levels of Centre staff and greater gender equality in decision-making and knowledge sharing.

It was observed that not all scientists are natural managers and that more capacity building of Centre scientists in management and administration would be useful. For example, delegation of responsibility from more senior to more junior staff is key to the sustainability of the Centre and a feeling of self-worth and empowerment of junior staff. This may not always be practiced within the Centre, and more attention to staff development in general was thought necessary.

Follow up will include a discussion and clarification of BoT Committee role and procedures as well as further debate and discussion at the BoT retreat in Nov 2004.

Although it was hoped that issues of governance by the BoT would be discussed, the focus was on Centre Management rather than Board Governance.

**National Liaison Committee**

Dr. Halima Mwenesi, Dr. Jane Kusin, Prof. Azad Khan
(Centre staff: Dr. Abbas Bhuiya, Dr. Kim Streatfield, Dr. G B Nair, Mr. Peter Thorpe, Dr. Shams-el-Arifeen).

Prof. Azad Khan informed the meeting that if a decision is made to form a Committee only Centre scientists should be involved. This Committee will report to the Board members who will participate in the process. The Centre would send reports to the Board for their review. The Board could look at the processes and the data and make sure that the Centre is on track.

Secretary of the Committee: Secretary, Ministry of Health & Family Welfare
Members: Dr. Halima Mwenesi
Dr. Jane Menken
Dr. Tikki Pang

Following a presentation made by the above Committees following the break-out sessions, it was agreed that in addition to the three existing Chairs (Programme, HR and Finance) two new Chairs of Standing Committees be created together with alternate Chairs – National Liaison Committee and the Fund Development Committee. The Chair of the Fund Development Committee will be invited to the next Executive Committee meeting of the Board.

It was also agreed that discussions on the by-laws for the Fund Development Committee be suspended for a year until the November 2004 retreat.

It was further suggested that, for the Committees to stay informed that the key committees have a Chair and an alternate with no particular work definition other than to Chair the meeting of the Board.

**6. Change in name of ICDDR,B:**

Detailed discussions were held on the subject. It was noted that the Centre is looking for a more marketable name without necessarily compromising the essence of ICDDR,B, something that would be more appealing to some of the donors, and a name that describes the work of the Centre. The Board however discouraged the Centre's need to change its name at this stage and suggested that the Centre conduct a market survey since this is a research centre and changes should be based on evidence. The Board suggested that ER&ID conduct an informal survey and report its findings to the Board. However, in the meantime Ms. Ackley and Mr. Thorpe should provide the Board with a course of action and time-lines. Once a decision is reached in this regard, the Centre should continue with the process for the other amendments (attached) to the Ordinance as proposed

**1 November 2003: The Programme Committee meeting reconvened at 2.00 pm for a presentation of the report on the Progamme Committee Review of the Clinical Sciences Division.**

Present: Members of the Board
Absent Mr. Mirza Tasadduq Hussain Beg (including Board members as indicated earlier)
Invited: Dr. I. Kabir, Mr. Muyeed Chowdhury (CSD Reviewers) Scientific Council and CSD senior staff
Minutes: Loretta Saldanha

**CSD External Review Report**

Dr. Claudio Lanata, Chair of the Review Committee was invited to present a report on the review. He introduced the members of the Review Committee (Prof. A K Azad Khan, Dr. D. Mahalanabis, Dr. W.B. Greenough, Dr. I. Kabir, Mr. Muyeed Chowdhury). He said the team was well chosen and each member brought in a wealth of experience. The main issues discussed were research and service issues. Training issues could not be discussed in detail due to time constraints. He proceeded to describe the process of the review. He said the team did not have the opportunity to meet with division heads individually due to shortage of time, but met with them as a group. The team appreciated the inclusion of a visit to the Kamlapur field site. Dr. Lanata thanked the Director, the staff of the CSD as well as Dr. M A Salam for the support provided to the review.

Generally, the Division has an excellent research component, with some outstanding research lines that should be preserved and fostered; current research portfolio does not reflect the new areas outlined in the Centre's Strategic Plan; service being provided to a large number of patients, which has lately become stable even though Dhaka's population continues to increase. He said the team has made recommendations with regard to management, research, service and training components. The list is extensive – some of these could be achieved over a short period of time and some would take years.

Dr. Sack thanked the review team for their excellent work and said that it was reassuring to hear about the research in the Division. He said he was concerned that the research programme had deteriorated due to shortage of funding, particularly USAID funds that provided major support to clinical research. He also highlighted the importance of the exit interview which he said was possible only because of the skills and experience of the staff in conducting Operations Research. He said the review team should consider the costs of the recommendations and that it would be interesting to hear their views on this.

Referring to the major weaknesses and major opportunities, the Board felt that in terms of training the Centre could be a premier training centre internationally. ICDDR,B should consider co-sponsoring training with a Western premier university.

In response to questions raised by the Board whether the Centre has clear thoughts about running the hospital as a business centre, Dr. Salam responded that the recommendations would be discussed internally together with costs involved as well as implications. The Centre will have to be careful about increasing fees charged to patients since this is the only hospital that provides care to the poorest of the poor and hence the Centre needs to establish a very effective safety net if a decision is made to increase charges. ICDDR,B is the only institution in Bangladesh that provides primary health care and a 24-hour clinic.

The review team also felt that some recommendations need directives/guidance from the Board as these are policy issues. Once these directives are given by the Board, then the second level will be for the Centre to identify which recommendations can be taken up immediately.

Dr. Lanata concluded that though the team could not look into many issues in detail, nevertheless the team felt that they had laid the path for the Division for the next 50 years. A detailed report will be provided to the Board which listing priorities, steps, etc. All the recommendations made should be fed into a plan by the Division/Centre for presentation to the Board.

Prof. Vlassoff thanked Dr. Lanata for a very comprehensive presentation and the team for the excellent work and for the preliminary report and recommendations. The Board endorsed the recommendations provided and requested the Division and the Centre to implement those recommendations that can be implemented immediately and that a plan be developed for the recommendations that will require more time. A progress report should be given to the next BoT meeting.

The meeting concluded at 4.30 pm.

A closed session of the Board followed after tea break.

**Minutes of the Human Resources Committee Meeting**
**1 November 2003**
**Sasakawa Training Lecture Room**

The Human Resources (HR) Committee of the Board of Trustees (BoT) held its meeting on 1 November 2003 at 8.30 am in the Sasakawa Training Lecture Room.

**Present:**

Dr. Ricardo Uauy Dagach (Chair, BoT)
Dr. Kul Gautam
Prof. A.K. Azad Khan (Chair, Finance Committee)
Prof. Jane Kusin
Prof. Terence Hull
Dr. Claudio Lanata (Chair HR Committee)
Dr. Halima Ramadhan Abdullah Mwenesi
Prof. David Sack (Director, ICDDR,B)
Prof. Marcel Tanner
Prof. Carol Vlassoff (Chair, Programme Committee)
Dr. I Kaye Wachsmuth

**Absent (with regrets):**

Mr Mirza Tasadduq Hussain Beg
Prof. N.K. Ganguly
Dr. Maimunah Bte Abdul Hamid
Dr. Nobukatsu Ishikawa
Mr. AFM Sarwar Kamal
Dr. Tikki Pang

**Invited**: Centre Directorate
**Minutes:** Loretta Saldanha

Dr. Ricardo Uauy Dagach, Chair, BoT welcomed all to the meeting and invited Dr. Claudio Lanata to Chair the proceedings.

Dr. Lanata briefly reported on the progress of the HR Agenda since the last Board meeting. Ms Ann Walton was invited to assist with questions raised.

1. **Approval of the Agenda:**

The agenda was approved.

2. **Approval of the Minutes of the June 2002 meeting:**

The Minutes were approved with the correction to para one on gender calculation: 27% should read 25%.

Page 2, 3.2 Status of Recruitment of a Deputy Director, it was reported that no action was taken re the resolution from the June Board meeting and it was suggested that detailed discussions will be held in a closed session of the Board.

Page 6, Gender Policy: A final document will be circulated to the Board. An update will however be provided during the meeting.

### 3. Staffing Status

**There were 46 additions and 40 separations during this reporting period (April 01, 2003 – September 30, 2003). The total number of Centre fixed-term staff belonging to all categories thus increased by 6 as shown in Table 1. The Centre continues to follow the policy of restricting recruitment of core positions.**

Ms. Walton reported that this information has not been ideally presented but this would be possible once "Suchona" is in place.

The Board suggested that a breakdown, similar to the information provided for Project and Core staff (for national staff), should also be provided for international level staff.

The Board suggested a need to monitor the age structure and the anticipated times of retirement of staff. How does the Centre deal with successions for staff retiring ? This information would provide insights into the retirement projections and also the life-cycle approach to staffing for all professionals/categories. Ms. Walton reported that the Centre has started to look into this and that a succession plan is underway. The Board suggested that this plan should also include counseling etc. A table showing age and sex structure will henceforth be provided.

Following the list of staff and their country of origin, the absence of staff from Africa was queried. It was clarified that efforts have been made to hire staff from Africa and that a staff member from that region had recently separated from the services of the Centre. It was also mentioned that Africa has been consistently represented on the Board including a former Director, Dr. Demissie Habte. The Centre will however continue to make a direct and concerted effort to try and get scientists from Africa.

The Board agreed to assist the Centre by directing the Centre to individuals who could be approached and provide the Centre with information on key conferences/groups in the region to enable posting of advertisements for vacancies for senior level staff.

### 3. Status of Recruitment of International Professional Staff

3.2a **Associate Director, D1, Public Health Sciences Division**

The position of the Associate Director and Head, Public Health Sciences Division at pay level D1, was announced on November 28, 2002. After a detailed review of the candidates who responded, Dr. Roger Shrimpton, a British national was invited to visit the Centre and meet with the selection committee. Dr. Shrimpton visited the Centre with his spouse and a formal interview was held on August 20, 2003.

It was reported that Dr. Shrimpton declined the offer and will not be joining the Centre for personal reasons. Dr. Marge Koblinksy has in the meantime been contacted with a request to her to reconsider her earlier decision. The Board was reminded that Dr. Koblinsky had already been interviewed by the Executive Committee of the Board via a teleconference..

Ms. Walton also reported that for the first time the Centre has paid special attention to the spouse following a resolution approving the conditions stipulated in the document "Strategy for the Recruitment and Retention of Senior Staff".

It was also suggested that a Search Committee be formed for hiring individuals in senior level positions and this should not be restricted to Centre Staff or the Board.

**3.3 Renewal of Contracts**

**Agenda 3.3a Head, Information Sciences Division, P5**

The 3 (three) years' employment contract of Mr. Peter Thorpe, Head, Information Sciences Division expires on July 31, 2004. Mr. Peter Thorpe during this tenure of contract has contributed to the growth of the division as well as to the overall growth of the Centre. His performance during this period has been very good.

The Centre recommends to the Board that the current employment contract of Mr. Peter Thorpe be extended by another term of 3 (three) years effective August 01, 2004 under the existing terms and conditions.

**Agenda 3.3b Environmental Microbiologist, P4**
**Laboratory Sciences Division**

Dr. M. Sirajul Islam, Environmental Microbiologist, Laboratory Sciences Division will be completing his 3 (three) years of International Professional appointment with the Centre on June 30, 2004. Dr. M. Sirajul Islam was appointed to this position as per policy of "Promotion of Bangladeshi Scientists to International Levels". Dr. Islam is a highly productive and enthusiastic scientist of the Centre. His performance during this period has been very good.

The Centre intends to renew Dr. M. Sirajul Islam's employment contract under the same terms and conditions for a period of another term of 3 (three) years effective July 01, 2004.

**This is for the information of the Board.**

CLOSED SESSION OF THE BOARD:

The Board also discussed the contract of Prof. Barkat-e-Khuda and a resolution was drafted.

The Board also noted that Resolution 22/BT/June 03 had not been followed up by the Centre Directorate and urged that high priority be given to the preparation of a job description for the post of Deputy Director and that it be circulated to the BoT by email for comments. The initial stages of recruitment of a Deputy Director should be undertaken before the June 04 BoT meeting so that ideally a short list of candidates can be presented to the BoT on that occasion.

### 3.4 Information on New International Professional Staff

**Agenda 3.4a Associate Director and Head, Clinical Sciences Division, D1**

Dr. M. A. Salam, a Bangladeshi national joined the Centre on July 01, 2003 as the Associate Director and Head, Clinical Sciences Division, at pay level D1, on a three years' fixed-term employment contract. He was recruited through the Centre's competitive recruitment process. Earlier, Dr. Salam was serving the Centre as Chief Physician at pay level P4 and was Acting Associate Director and Head, Clinical Sciences Division from August 01, 2002.

This is for the information of the Board.

**Agenda 3.4b Executive Assistant to Director, P1, Director's Division**

Ms. Loretta Saldanha, an Indian national, joined the Centre on April 10, 2003 on a fixed-term three years' contract as the Executive Assistant to Director under the Director's Division. Ms. Loretta Saldanha was the Executive Secretary of the Clinical Sciences Division and was acting as the Executive Assistant to Director since October 2002. She has been recruited through the Centre's competitive recruitment process.

This is for the information of the Board.

## 3.5 Status of Seconded Staff Contracts

**Agenda 3.5a** **Associate Director and Head**
**Health Systems and Infectious Diseases Division, D1**

The two years secondment agreement between the Centre for Disease Control and Prevention (CDC), Department of Health and Human Services (DHHS), USA and ICDDR,B; seconding the services of Dr. Robert F. Breiman to ICDDR,B as Associate Director and Head, Health Systems and Infectious Diseases Division will expire on July 09, 2004.

The Centre requires the services of Dr. Breiman for another term and accordingly the Centre requests Board's approval to start negotiating with CDC for another secondment agreement for an additional period of 2 (two) years.

*This was approved.*

**Agenda 3.5b** **Senior Operations Research Scientist, P5**
**Health Systems and Infectious Diseases Division**

The existing secondment contract of Dr. Greet Dieltiens, Technical Advisor of the Public Health Sciences Division will expire on January 07, 2004. She was seconded through an agreement between the Belgian Technical Cooperation (BTC), Brussels and ICDDR,B for a period of three years effective January 08, 2001.

Dr. Greet Dieltiens will be leaving the Centre on January 07, 2004. The Board would like to put on record their thanks for her contributions to the Centre.

The Board placed on record its thanks to Dr. Dieltiens for her contributions to the Centre.

**Agenda 3.5c** **Scientist, P4, Epidemic Control & Preparedness Unit**
**Public Health Sciences Division**

The existing secondment contract of Dr. Yukiko Wagatsuma, an Assistant Scientist of the Department of International Health, School of International Hygiene and Public Health, at Johns Hopkins University (JHU) has been, at the request of the Centre, extended for an additional term of 18 (eighteen) months effective January 17, 2003 which will expire on July 16, 2004.

This was approved.

### 3.6 Renewal Contract of Adjunct Scientist

**Agenda 3.6a** **Dr. Abdullah H. Baqui**

The current Adjunct Scientist contract of Dr. Abdullah H. Baqui, a faculty member of Johns Hopkins University (JHU), Bloomberg School of Public Health to ICDDR,B will expire on June 30, 2004. As Dr. Baqui's involvement with the ongoing projects of the Centre are very essential, the Centre requests the Board's approval for initiating an extension of this contract from Johns Hopkins University for another period of three years.

This was approved.

### 3.7 A List of established International Professional Posts was provided for the information of the Board together with a list of established International Professional Posts.

### 4. Promotion of Bangladeshi Scientists to International Professional Levels

A report on was presented to the Board (attached). The Board wished to specify the process it will follow to review the applications for promotions to the international Professional level. The Centre's Promotion Committee will forward a recommendation to the Chair of the Human Resources Committee according to the process outlined in the policy. The Committee reviewed the recommendations and presented a resolution to the Board.

### 5. HR Agenda Update

An update on ongoing HR Agenda was provided by Ms. Walton (attached). For the information of the new Board members Ms. Walton provided a brief background of the HR agenda the Board adopted in the year 2001. In addition, at the last Board meeting three items were added to the list of "to dos" by the HR, essentially a paper presenting the recruitment strategy for international staff, the beginning of the Human Resource Plan and the Gender Policy.

The Board noted that Gender training was scheduled for December 2003 and that the performance review system will go on line in June 2004 and whether it would be possible to meet these time lines.

Ms. Walton further reported on the reduction of active post titles. She said, this exercise also took into consideration its interpretation in the community which is not something you could necessarily take into account in other situations. Citing an example whereby HR streamlined all secretarial staff who would henceforth be called Administrative

Officers she said, this was also done with the consent of the staff as that is what they preferred.

Gender Policy: The policy is in the final stages of translation and will be circulated to the Board by email. It will be published in a bilingual booklet format for distribution to all staff members as part of a centre-wide dissemination scheme.

Ms. Walton said that the HR agenda is proactive but it may evolve over a longer period of time. The Board highly appreciated the work being done and suggested that the Centre propose time-lines for these activities. The Board also suggested that a realistic plan be drawn up in consultation with the Division Heads.

The Board expressed their satisfaction and congratulated the Centre for the work accomplished on the HR Agenda and will look forward to receiving updates on further progress made, at the next BoT meeting.

**6. Staff Salaries: International Professional Category & National Officer & General Services Categories**

**This agenda item was discussed in a closed session of the Board.**

**Minutes of the Finance Committee Meeting**
**1 November 2003**
**Sasakawa Training Lecture Room**

A meeting of the Finance Committee of the Board of Trustees (BoT) was held on 1 November 2003 at 11.30 am in the Sasakawa Training Lecture Room.

**Present:**

Dr. Ricardo Uauy Dagach (Chair, BoT)
Dr. Kul Gautam
Prof. A K Azad Khan (Chair, Finance Committee)
Prof. Jane Kusin
Prof. Terence Hull
Dr. Claudio Lanata (Chair, HR Committee)
Dr. Halima Ramadhan Abdullah Mwenesi
Prof. David Sack (Director, ICDDR,B)
Prof. Marcel Tanner
Prof. Carol Vlassoff (Chair, Programme Committee)
Dr. I. Kaye Wachsmuth

**Absent (with regrets)**

Mr Mirza Tassaduq Hussain Beg
Prof. N. K. Ganguly
Dr. Maimunah Bte Abdul Hamid
Dr. Nobukatsu Ishikawa
Mr. AFM Sarwar Kamal
Dr. Tikki Pang

**Invited:** Scientific Council
**Minutes:** Loretta Saldanha

Dr. Ricardo Uauy Dagach, Chair, BoT, welcomed all to the meeting and invited Prof. Azad Khan to Chair the proceedings.

1. Prof. Khan outlined the process of the meeting. Following approval by the Board on the agenda he invited Mr. Neogi, Head, Finance to make his presentation.

Mr. Neogi presented an overview of the 2003 forecast (June vs November), the 2004 budget, financial update, update on foreign exchange fluctuations, a brief update on salaries and benefits, Endowment Funds, Core Fund allocation. At this point he would

accept questions and continue with discussions on Employees Separation Payment Fund, Sustainability Plan (status report) in two separate session.

**2. 2003 Forecast:** The Centre is projecting a deficit of US$280,000 but will break even if the Centre can withdraw US$ 200,000 from the Hospital Endowment Fund (HEF) in 2003 depending on the year-end market value of the Endowment Funds. What has not been shown in the report is the over-allocation of USAID/W funds in 1998 by US$ 1 million which is being absorbed in 2003. If this was not the case the finances would have shown a surplus for this year.

**3. 2004 Budget:** Mr. Neogi reported the process and the basic assumption that goes into preparing this budget. He said only signed agreements are taken into consideration. The cost is projected based on information of the previous year. No funds have been allocated from the Hospital Endowment Fund. He further presented a breakdown of contributions by categories: Project funds were at 60%, overheads from projects is approximately 10% and core 20%. A further breakdown of contributions (restricted/unrestricted) by donors was also presented, with DFID leading as the largest donor of the Centre. He reminded the Board that in future with the "Suchona" project it would be possible to provide a one-year projection of the budget.

There has been a 2 million drop in projects, however, there are projects in the pipeline which have not been considered because Agreements have not been signed. Steps have been taken to break even: information on staff salaries falling back on core has been circulated to all Division Heads to enable them to plan and monitor these expenditures. No funds have been set aside for future replacement of assets (hand to mouth situation) and hence the Centre will try to generate some surplus every year for this purpose.

Comparing the forecast for 2003 vs the budget for 2004 it was shown that the revenue of the Centre has decreased by 11% but the expenditure has not decreased proportionately (only 7%).

This being the 25$^{th}$ year of the Centre as an international Centre, information on revenue and expenditure over 25 years as well information of expenditure by categories for 25 years was presented with a 5 yearly average of revenue and expenditure. The Centre has grown four-fold from 4 million to 16 million. This is a steady growth. With regard to where the Centre will plateau, Mr. Neogi reported that presently the Centre is at 70% project and 30% core funding and almost 6-7 million core funding is required. With regard to expenditure the growth is consistent with a consistent percentage increase in every expenditure e.g. salary, supplies etc. A report on funding over 10 years for core and project activities was presented.

Since contributions by donors are made in different currencies, the Centre operates in a multi-currency environment. Mr. Neogi felt that it would be interesting to see how strong the Taka has been against these currencies in the last 10 years.

**4. National and International Staff Salary and allowances:**

This agenda was discussed in a closed session of the Board.

**5. Update on the Endowment Funds (donations/growth/withdrawals)**

Detailed discussions were held at the June meeting. However, for the benefit of new members Mr. Neogi revisited this discussion. In 2001 and 2002 no funds have been withdrawn from the HEF fund. It was also reported that in 2003 the Board had agreed to allow the Centre to take a loan from the fund towards purchase of a Generator but these funds were not withdrawn for various reasons.

Allocation of Core Funds: Following a Resolution from the June Board meeting, Mr. Neogi presented information on the allocation of core funds by Division and Categories and a comparative picture for 2003 and 2004. These costs included support to the Division Heads and some divisional costs, core funded research (project activities no longer being funded by the donor) and support services.

Further information from each division showing core costs divided under the categories indicated was provided as below:

CSD: Major expenditure is the hospital. Increase in hospital due to the recruitment of full time Division Director and costs of projects falling on core.

LSD: Core funded research is expected to decrease in 2004 because of new projects. Divisional expenditures have increased because loss of Japanese support.

PHSD: Expenditure due to support to different ongoing activities. The divisional expenditures is expected to increase when a full-time Division Head is recruited. Cost of support services will increase due to decline in project support.

HSID: Consumes a small part of core funds. Core funds are being utilized to cover salary support of some international staff who are not fully funded and because of the nature of the USAID/FHRP which is 30% ICDDR,B and 70% USAID.

ISD: Consumes a small part of the core funds. Under-recovery in CIS. A major part of the funds is spent towards the Library. Efforts are being made to charge out the Library costs to projects.

Director's Division: The expenditure for the Director's Bureau – the position of Head, P&P has been budgeted up to June and the position of Deputy Director from July and hence there is a shift of cost. This also includes unrecovered costs by the support services. Expenditures in the ERID have increased because of hiring of one staff member. Expenditures for BoT and other committees the costs have not increased over the years and HR and Finance have remained almost static.

Discussion:

Despite information on core categories, it is understood that the core structure has two components – 1) what has it been given for and, 2) how this has been spent. It was understood that the funds provided to core is seen as income and anything that is not funded is supported by core. It was felt that this was not good management. The Board felt that the Centre had made a good attempt to dissect core costs, but that efforts should be made to relate this back to the main activities and priorities of the Strategic Plan and that they would like to see for each of the divisions, what core activities are needed to fulfill the priorities of the Centre and it would help us to analyze where the Centre should invest and enable a reallocation, and hopefully assist in managing the deficit. A follow-up to the resolution of the June Board meeting was requested.

Concern was expressed on two aspects of the Pie Charts:

1) Hospital and clinical costs: With regard to the forecast on essentially the trend of business, it was felt that the Board should not endorse the Pie Chart for 2004 as if business as usual was acceptable. The concern was that these Charts indicate that business cannot be as usual and that something needs to be done to relieve the pressure of that expenditure on the activities particularly the research activities of the Clinical Sciences Division.

2) Core and Project costs: Following a suggestion to charge out library costs to projects, it was felt that the Library is a core activity and to charge it to projects will set a system where the Centre Scientists will not assist in improving the Library, but would in time suggest a radical change e.g. of shutting it down. Libraries in a research institution like this should be part of the Capital. The system of charging the project in a transparent way is a difficult system. It is an issue for the ISD. However since the new James Grant School of Public Health (BRAC) will be relying on this Library, something much more fundamental needs to be done (eg request them to support some costs). It is not something for the Finance Committee to speculate upon, but that action needs to be taken by the Centre to explore how this can be done.

**6. Other Items:**

a) Over-draft Facilities: a report on the overdraft facilities and borrowing from the Hospital Endowment Fund was provided.

b) Cheque signatories: The recommendation to include Dr. M A Salam, Associate Director and Head, CSD as a cheque signatory was approved.

**7: Employees Separation Fund Payment:**

It was agreed that with the Establishment of the Centre's Employees Separation Payment Fund, the Board resolved under Resolution # 9/Dec 1983 to accept the Fixed Income plan offered by American International Reinsurance Company (AIRCO), Bermuda, effective January 1984 under an inatermediary agreement with the Institute of International Education (IIE) New York. However, as a result of AIRCO litigation, the Management decided to transfer the Fund to ASSICURAZIONI GENERALI SpA, Channel Islands, UK with the accounts of individual members of this fund at the close of October 1987.

Subsequently, ASSICURAZIONI GENERALI SpA, transferred their business under a long term agreement with Generali Worldwide Insurance Company Limited during August 1993. The Management accordingly, approved the transfer of the Fund to Generali Worldwide Insurance Company Limited under a Novation Agreement signed on 2nd January 1994.

The Board agreed to accept the audited financial statements of the Fund, acknowledge and accept the report of transfers as made by the Management, and that the Separation Payment Fund Trust be constituted as detailed in the Resolution.

It was also suggested that the Centre's lawyer be consulted for advice since this could have implications with re to the Ordinance. It was also suggested that a meeting of the SWA with the lawyer be arranged.

**Sustainability Plan:**

Presenting the Sustainability Plan, Mr. Neogi reported on tasks accomplished which included:

- Establishment of guidelines based on the Strategic Plan
- Broad review of overall costs of the Centre as well as that of each Division.
- Strategies for Cost Optimization identified based on ":Best Practices" relevant to the Centre's activities.
- Identification of revenue augmentation opportunities for all Divisions.
- Finalization of model plans for the Hospital and Diagnostic labs.
- Market research.

He also presented the following strategies for cost optimization:

- Develop annual allocation plans for major resources.
- Regularly monitor resource utilization and performance.
- Design appropriate systems to recognize and motivate employees.
- Explore the benefits of outsourcing activities.
- Manage the contractor selection process.
- Harness technology to achieve productivity.

Prof. Azad Khan concluded by summarizing the above discussions. He said efforts are ongoing to reduce the cumulative deficit by generating a surplus and that the deficit seems to be manageable. He assured the Board that the decline in project funds can be reversed if projects in the pipeline materialize. The Centre has managed to recover the loss suffered in the year 2002 in the Endowment Funds. Much has been accomplished with regard to the sustainability plan, and that the Centre will provide a report on further progress at the June BoT meeting.

Dr. Uauy thanked Mr. Neogi for presenting an informative and detailed report. He thanked Prof. Azad for Chairing the meeting and providing inputs to questions raised.

The meeting concluded at 12.45 pm for a closed session of the Board.

**Minutes of the Full Board Meeting**
**2 November 2003**
**Sasakawa Training Lecture Room**

A meeting of the Full Board was held on 2 November 2003 at 8.00 am in the Sasakawa Training Lecture Room.

**Present:**

Dr. Ricardo Uauy Dagach (Chair, BoT)
Dr. Kul Gautam
Prof. A K Azad Khan (Chair, Finance Committee)
Prof. Jane Kusin
Prof. Terence Hull
Dr. Claudio Lanata (Chair, HR)
Dr. Halima Ramadhan Abdullah Mwenesi
Prof. David Sack (Director, ICDDR,B)
Prof. Marcel Tanner
Prof. Carol Vlassoff (Chair, Programme Committee)
Dr. I.Kaye Wachsmuth

**Absent (with regrets):**

Mr. Mirza Tassadaq Hussain Beg
Prof. N.K. Ganguly
Dr. Maimunah Bte Abdul Hamid
Dr. Nobukatsu Ishikawa
Mr AFM Sarwar Kamal
Dr. Tikki Pang

Minutes: Loretta Saldanha

Dr. Ricardo Uauy Dagach opened the meeting.

1. **Discussions on applications for International Ranking:**

Considerable discussions were held following a review of the applications by several members of the Board as well as the process for reviewing applications. The Board specified the process it will follow to review the applicants for the Promotion of National Officer level scientists to the International Professional level. The Centre's Promotions Committee will forward a recommendation to the Chair of the Human Resources Committee according to the process outlined in the policy. The Committee will review the recommendations and present a resolution to the Board of those approved. The BoT

also requested the Centre Directorate to examine the criteria applied by the Promotions Committee in the promotion of National Officer level scientists to the International Professional level considering the variety of career path that should be recognized.

**Agenda 2: Review and Finalize Resolutions**

The Resolutions were reviewed and revised accordingly. The resolutions as finalized by the Full Board were signed by Dr. Uauy before his departure from the Centre.

**Agenda 3: Extension of Term of Board members**

The Board approved the extension of the terms of the following Board members for a second term of 3 years with effect from the date of termination of their first 3-year term:

Dr. Maimunah Bte. A Hamid
Dr. Terence H. Hull
Dr. Nobukatsu Ishikawa
Dr. Claudio Franco Lanata
Dr. I. Kaye Wachsmuth

With regard to a replacement for Prof. Carol Vlassoff, her term ending in June 2004, it was agreed that the Board and the Centre Directorate provide names of probable candidates to Dr. Sack.

Following the appointment of Professor Marcel Tanner as Chair of the Programme Committee, Prof. Vlassof's proposal, that Prof. Tanner attend the June meeting of the Executive Committee in June, was accepted.

The resolution that the Chair of the Fund Development Committee be invited to attend the June Board Meeting of the Executive Committee was noted.

**Agenda 4: Dates of the next Board meetings:**

The Board agreed to Dr. Sack's proposal to delay November Board meeting until after Eid and the June meeting to the 2nd week of June, it was agreed that:

10-13 June 2004 – Executive Committee Meeting of the Board (Phone Conference 12/13*)
25 November 2004 – BoT Retreat
26-28 November 2004 – Full Board Meeting

*to be decided.

The Full Board meeting concluded at 11.00 am

## BOARD RESOLUTIONS

## PROGRAMME COMMITTEE
## 31Oct-2 Nov 2003

**1/BT/Nov 03**

The BoT was impressed by the progress made at the Centre and the results achieved at all levels in research, training and services provision. The BoT congratulates the Centre for the excellent performance and considers that the Centre is very well on track to implement the Strategic Plan.

**2/BT/Nov 03**

The BoT was pleased with the new format of the Director's Report complemented by presentations of Centre's highlights. It is recommended:

- to keep the format in future and to link it even more coherently with the Strategic Plan, with separate projects clearly integrated into lines of research
- to standardize fully the reporting format across Divisions, particularly with regard to the presentation of publications and staffing.

**3/BT/Nov 03**

The BoT welcomes the strong inclusion of Health Systems Research (HSR) in the Centre's portfolio. The BoT recommends that the Centre provide a comprehensive documentation on the HSR portfolio including the plans for the future to be reviewed at the next BoT.

**4/BT/Nov 03**

The BoT welcomes the plan of the Centre to increase efforts to disseminate the results and achievements of the Centre by (i) continuing to aim at excellent scientific publishing, (ii) developing more information material (hard copy and web-based) such as fact sheets and circulars (e.g. Equity Dialogue, Health & Science Bulletin) and (iii) continue the successful links with the national and international press.

**5/BT/Nov 03**

The BoT followed up on the BoT resolution 4/BT/Jun 03 and concluded that the Centre Directorate should provide yearly plans based on the Strategic Plan and grouped by the main programme priorities.

**6/BT/Nov 03**

In follow up to BoT resolutions 10/BT/Jun 03 and 11/BT/June 03, the BoT welcomed the presentation by the Finance Department on core vs. project support. The financial analysis further needs to be complemented by a programmatic analysis showing all core resources (including staff) required to fulfill the main priorities of the Strategic Plan and the need for feedback to donors. This will provide a basis for decision making on areas where the Centre needs to invest, as well as the basis for the Centre's budget.

**7/BT/Nov 03**

**Fund Development Committee**
The BoT resolves that it will strengthen its support of the Centre fundraising by enhancing roles and activities of BoT members to:

i) support Centre research, services and training.
ii) facilitate access to potential donors and other funding sources.

In recognition of this resolution the BoT has established a Fund Development Committee to monitor these activities. The BoT asks the Directorate to provide new information material, particularly fact sheets to be used by BoT members in their fundraising activities.

**8/BT/Nov 03**

The BoT requests the Centre to draft the respective by-laws of the Fund Development Committee to reflect the conclusions of the discussions in the breakout groups and with the aim of keeping these by-laws as brief as possible.

**9/BT/Nov 03**

The BoT resolves that, in addition to the three existing Chairs (Programme, Human Resources and Finance Committees), two new Chairs of Standing Committees be created to take responsibility for the National Liaison Committee and the Fund Development Committee. The Chair of the Fund Development Committee will be invited to the next Executive Committee meeting of the BoT. The following appointments/extensions were named for Committee Chairs:

Programme: Professor Marcel Tanner (December 03 – June 05)
Human Resources: Dr. Claudio Lanata (Dec 03 – Dec 05)
Finance: Professor A. K. Azad Khan (upto August 2005)
National Liaison: Mr AFM Sarwar Kamal (Dec 03 – Dec 04)
(Alternate – Prof. Azad Khan)
Fund Development: Dr. Kul Gautam (Dec 03- Dec 05)

**10/BT/Nov 03**

The Board recognizes the excellent work done by the External Review Committee of the Clinical Sciences Division and expressed its thanks for the preliminary report and recommendations. The Board endorsed the recommendations provided and requested the Division and the Centre to implement those recommendations that can be implemented immediately. For those recommendations that require more time or a strategic decision by the Centre, a plan should be developed for implementation. A progress report should be given to the Board at the next BoT meeting.

## HUMAN RESOURCES
## 2 Nov 2003

**11/BT/Nov 03**

The BoT thanked Professor Barkat-e-Khuda for his important contribution to the Centre during his service as an international scientist, especially during the absence of the Director over an extended period. It wished him every success in his future career when his term ends as Associate Director, and Head, Policy and Planning in June 2004.

**12/BT/Nov 03**

The BoT noted that Resolution 22/BT/Jun 03 had not been followed up by the Centre Directorate and urged that high priority be given to the preparation of a job description for the post of Deputy Director and that it be circulated to the BoT by email for comments. The initial stages of recruitment of a Deputy Director should be undertaken before the June 04 BoT meeting, so that ideally a short list of candidates can be presented to the BoT on that occasion.

**13/BT/Nov 03**

The Board resolves that the current employment contract of Mr. Peter Thorpe with the Centre, be extended by another term of 3 (three) years effective August 01, 2004 under the same terms and conditions.

**14/BT/Nov 03**

The Board resolves that the current secondment agreement of Dr. Robert F. Breiman between CDC and ICDDR,B be extended by another 2 (two) years period effective July 01, 2004.

**15/BT/Nov 03**

The Board records their thanks to Dr. Greet Dieltiens for her contributions to the Centre.

**16/BT/Nov 03**

The Board resolves that the current secondment agreement of Dr. Yukiko Wagatsuma between Johns Hopkins University and ICDDR,B be extended by another 18 months effective July 17, 2004.

**17/BT/Nov 03**

The BoT approves the Centre's request to initiate an extension of the present contract of Dr. Abdullah H Baqui, Adjunct Scientist, a faculty member of Johns Hopkins University for another period of three years effective July 1, 2004.

**18/BT/Nov 03**

The Board wishes to specify the process it will follow to review the applicants for the Promotion of National Officer Level Scientists to the International Professional Level. The Centre's Promotion Committee will forward a recommendation to the Chair of the Human Resources Committee according to the process outlined in the policy. The Committee will review the recommendations and present a resolution to the Board of those approved.

**19/BT/Nov 03**

The BoT requests the Centre Directorate to examine the criteria applied by the Promotions Committee in the promotion of National Officer level scientists to the International Professional Level considering the variety of career path that should be recognized.

**20/BT/Nov 03 (SEALED RESOLUTION)**

Promotion of Dr. Md. Yunus to the International Level.

**21/BT/ Nov 03**

The BoT expresses their satisfaction and congratulates the Centre for the work accomplished on the HR Agenda and will look forward to receiving updates on further progress made at the next meeting of the BoT.

## FINANCE COMMITTEE
## 1 Nov 2003

**22/BT/Nov 03**

The Board agrees to approve the 2003 forecast. The Centre Directorate is encouraged to continue to take all measures possible to avoid the projected $280,000 deficit in 2003.

**23/BT/Nov 03**

The Board agrees to approve the 2004 budget as presented, noting that in June 2004 the Board will review the financial position of the Centre. The Centre Directorate should continue to take all measures possible to avoid the projected $926,000 deficit in 2004. The BoT will review the deficit reduction plan of the Centre Directorate in its June BoT meeting.

**24/BT/Nov 03**

The Board approves a salary increase of 2% (two percent) for all NO and GS staff effective January 1, 2004 and a 1% (one percent) salary increase for all international staff effective January 1, 2004.

The BoT resolves to make future reviews of remuneration only at Full BoT meetings in November when the annual budget projects are available.

**25/BT/Nov 03**

Dr. Mohammad Abdus Salam, is the Associate Director and Head, Clinical Sciences Division (CSD) effective July 01, 2003. Centre Directorate recommends that the name of Dr. Salam be inducted as authorized signatory from Group II.

**26/BT/Nov 03**

The Board accepts the audited financial statements of the ICDDR,B Employees Separation Payment Fund for the years ended December 31, 1992 to 2002.

**27/BT/Nov 03**

The Board resolves to acknowledge and accept the report of transfers (as detailed in the Auditors Report) of the Employees Separation Payment Fund as made by the Management.

**28/BT/Nov 03**

The Board resolves that the Separation Payment Fund Trust be constituted as follows: That the Centre Directorate should work with the Staff Welfare Association (SWA) to prepare a draft plan for the Employees Separation Payment Fund (ESPF) and to draft relevant by-laws so that this process can be implemented. A report should be presented to the BoT at the June 2004 Board meeting.

## FULL BOARD RESOLUTIONS
## 2 November 2003

**29/BT/Nov 03**

The Board approves the extension the terms of the following Board members for a second term of 3 years with effect from the date of termination of their first 3-year term.

Dr Maimunah B A Hamid
Dr Terence H Hull
Dr Nobukatsu Ishikawa
Dr Claudio Franco Lanata
Dr I Kaye Wachsmuth

**30/BT/Nov 03**

Dates of the next Board Meetings:

10-13 June 2004, Executive Committee Meeting of the BoT (Phone conference 12/13*)
25 November 2004 – BoT Retreat
26-29 November 2004 – Full Board Meeting

*to be decided

3/BT/JUNE 2004

# PROGRAMME COMMITTEE

# BOARD OF TRUSTEES
# EXECUTIVE COMMITTEE MEETING
# JUNE 2004


CENTRE
FOR HEALTH AND
POPULATION RESEARCH

## PROGRAMME COMMITTEE
11 June 2004

**Draft**

# PROGRAMME COMMITTEE

## Friday 11 June 2004

**Agenda:**

| | | |
|---|---|---|
| 08.00 - 09.00 am | Meeting of the Executive Committee<br>- Approval of PC Minutes<br>- Review - November 03 Resolutions | BoT, CD<br>Seminar Room |
| 09.00 - 09.45 am | Director's Report | BoT, scientific staff: NOA and above, donors<br>Auditorium |
| 09:45 - 10:15 am | Scientific Presentations:<br>New findings and Directions on Cholera<br>- Dr. G B Nair | |
| 10.15 - 10.30 am | TEA | |
| 10.30 - 11.00 am | Neonatal Health<br>- Dr. Shams-el-Arifeen | |
| 11:00 - 11:30 am | Plateauing of the Bangladesh Fertility Decline<br>- Dr. P K Streatfield | |
| 11:30-12:30 pm | Development Partners Group meeting | BoT, SC (Sem. room) |
| 12.30 – 01.30 pm | LUNCH | BoT, DPG, SC, |

**Minutes of the Programme Committee**
**Seminar Room/Sasakawa Auditorium**
**31 October 2003**

The Board of Trustees held its meeting in Dhaka, Bangladesh from 31 October to 2 November 2003. The proceedings of the Programme Committee commenced at 8.00 am in the Seminar Room.

**Present:**

Dr. Ricardo Uauy Dagach (Chair, BoT)
Mr. Mirza Tasadduq Hussain Beg
Dr. Kul Gautam
Prof. A K Azad Khan (Chair, Finance Committee)
Prof. Jane Kusin
Prof. Terence Hull
Dr. Claudio Lanata (Chair, HR Committee)
Dr. Halima Ramadhan Abdullah Mwenesi
Prof. David Sack (Director, ICDDR,B)
Prof. Marcel Tanner
Prof. Carol Vlassoff (Chair, Programme Committee)
Dr. I Kaye Wachsmuth

**Absent (with regrets):**

Prof. N K Ganguly
Dr. Maimunah Bte Abdul Hamid
Dr. Nobukatsu Ishikawa
Mr AFM Sarwar Kamal
Dr. Tikki Pang

**Invited**: Centre Directorate
Minutes: Ms Loretta Saldanha

Dr. Ricardo Uauy Dagach, Chair, BoT opened the meeting by welcoming all. He requested the new Board members Dr Halima Ramadhan Abdullah Mwenesi and Dr. Kul Gautam as well as the Centre Directorate to introduce themselves. Dr. Uauy also thanked Mr Mirza Tasadduq Hussain Beg, Secretary, ERD, for participating. Mr. Beg has replaced Mr. Anisul Huq Chowdhury (former Secretary, ERD). Dr. Sack joined Dr. Uauy in welcoming Mr. Beg and reported on the excellent relationship with the Government of Bangladesh.

Dr. Uauy presented the Agenda for approval of the members. Referring to the agenda on Standing Committees of the Board, he said that apart from discussions on the Standing Committees of the Board specifically the Fund Development and Oversight, and National Liaison Committees, discussions will also include Governance issues.

Dr. Sack briefly introduced discussions at the last BoT meeting on the Standing Committees. He suggested break-out sessions by the Board together with senior management (divide the group into 3 - one focusing on the Fund Development and Oversight Committee, another on National Liaison and the third focusing on the functions of the Executive Committee). The break-out sessions would address some specific questions and their observations and findings will be shared with the whole group. The overall goal would be to see how these Committees would operate – their functions, reports the management needs to provide these Committee to enable them to carry out their functions, and activities the Board should be involved in to carry out its functions. He further clarified that these are Board Committees and the senior management in the Committees will act as resource persons and will provide some guidance to the Board. The Executive Committee will discuss and define a number of issues related to Board governance and Centre management. He said there tends to be a cycle of the Board -- when things are going smoothly, the Board tends to have their "hands off" and during a crisis they "jump in" with both feet and start micro-managing—both of these extremes are not appropriate. The Board should be active in ensuring that management tools are in place while avoiding micro-management when a crisis occurs.

Dr. Sack also requested the Board to delay final approval of the By-laws until after the break-out sessions.

Dr. Uauy drew the attention of the new Board members to the Centre's Strategic Plan which, he explained, is important because it is also part of the work of the Board, and provides a background on the work of the Centre. He said several resolutions passed at the June Board meeting addressed the need to have the work of the Centre based on the Strategic Plan, and it is therefore important to keep this document at hand as the Board reviews the progress of the Centre.

1. **Approval of the Minutes of the Programme Committee Meeting held in June 03**

The Minutes were approved with the following corrections:

Page 7: 25 Years of ICDDR,B: 2nd line: "Data Warehouse" – it was clarified that this the data is stored on a disc.

Page 8: CHNRI: Dr. Sack clarified that an update will be provided in his report to the Board.

Resolution 9: It was reported that this was taken up at the CSD review and it would be possible to provide a final report based on the outcome of the review.

It was agreed that at the end of the Minutes, an update on the resolutions should be provided by the Director on actions requested by the Board in November 2003

Page 11: Following a query on the use of the term "Centre Directorate" and whether this was formalized, it was reported that the Directorate consists of the Associate Directors, Head, HR & Finance, but has not been formalized in the sense of having by-laws. This group meets almost every week

Dr. Uauy invited the Board to flag issues, if they noted any, that were not acted upon

Guest Lecture by Board: Prof. Vlassoff pointed out the Board's earlier proposal given the fact that considerable experience relevant to the work of the Centre exists in the Board, that specific individuals be invited to give a lecture (perhaps in one of the evenings of the Board meeting) and Centre staff, individuals from the community and stake holders be invited. This would be an opportunity for the Centre to take advantage of the experience available on the Board, and should be considered in the future. It was agreed that Prof. Azad Khan take this up for discussion by the National Liaison Committee.

To ensure consistency and coherence from one meeting to the next, the Board agreed to hold an informal closed session to follow up on the Resolutions. It was also agreed that a report should be provided by the individuals responsible (eg Centre Directorate) on follow up actions and an explanation for resolutions where no follow up action was taken. Henceforth, a follow-up on the resolutions will be recorded in the Minutes. Dr. Sack responded that follow-up on resolutions were included in his report (Director's Report).

Amendment to the Ordinance:

- Change in name of ICDDR,B: Dr. Sack reported that this is a Parliamentary decision and will be proposed only if the Board approves the request to change the name.

Millennium Development Goals (MDG): It was reported that for the next 12 years or so the international community will be very focused on the MDG. From the strength of the Strategic Plan everything that the Centre does is supportive of the MDG. If funding and resources are part of the Centre's concern, in terms of presentation it would be useful for the Centre to project itself as a Centre that has the capability for the achievement of the MDG. Referring to the recent series of articles in the Lancet on Child Survival which also showed a slackening of progress but that tremendous opportunities exist, it was reported that the international community have had some discussions about what should be done to gear this up. Dr. Gautam said that in terms of marketing thereby achieving greater success in attracting resources, the Centre should do more to align its work in support of the MDG, including the child survival goals.

Dr. Uauy thanked Dr. Gautam for this suggestion and agreed that further discussions were necessary in this regard. He requested a one-page proposal that addresses this issue on how the Centre sees its Strategic Plan in line with the MDGs.

Indicators: Following discussions with researchers at the Centre with re to measuring indicators and problems with following indicators, Prof. Hull reported that the Centre is doing much research which are fairly critical to the data problems and interpretation of data and that the issue with problems of measuring some of the indicators particularly in developing country settings are quite severe. ICDDR,B has a unique setting for commenting on this issue, and hence, wished to endorse the idea of the goals being brought into consideration during the planning process and in terms of the actual research programme. The Centre could assist in helping the international community realize the problems some countries are facing in trying to deal with the problems of indicators. Prof.. Hull further referred to the Director's report (page 16) on a project on nutrition rehabilitation (CSD) and requested that the Board be provided with a copy of this study. The reason for raising this was that the brief description appeared to be gender naïve.

It was also agreed that the next Programme Committee report should take up this initiative (MDGs) so that this could be reported to the Development Partners, and that the Centre should develop indicators that will enable a report to the Board about what the Centre is doing in so far as tracking changes in relation to the MDG.

Dr. Lanata was invited to present a brief update on the CSD review and flag issues that the Board should consider over the next two days.

The Programme Committee reconvened at 9.15 am in the Sasakawa Auditorium:

**Present:** Members of the Board
**Invited:** Scientific Council Members, Development Partner representatives, Centre scientific staff.

**Minutes:** Ms Loretta Saldanha

Dr. Uauy welcomed those present to the meeting of the Programme Committee. He said he was pleased to see that the Centre is working to meet the goals of the Strategic Plan.

Prof. Vlassoff was invited to Chair the proceedings of this meeting.

Prof. Vlassoff said that she was pleased with the format this year. She said, the format is more consolidated and perhaps will allow for more interaction. She invited Dr. Sack to give his presentation.

**2. Director's Report:**

Dr. Sack explained the change in format, whereby the Director summarizes the main achievements of all Divisions, and a few highlights are selected for presentation and more detailed discussion, and the process leading to this change. He said the topics were selected because these were new issues and the intention therefore was to downplay the Division reports as detailed reports were presented at the last June meeting. In future

presentations would be more in line with the Strategic Plan. However, following his presentation, the Division Heads would be available for questions.

Dr. Sack began with a follow-up from the last meeting (Resolutions 7, 8, 9, 10 & 11) and the agenda for the forthcoming Board Retreat in November 2004. He reported that the Centre is considering an amendment to the Ordinance which would include a change in the name of the Centre to International Centre for Health & Population, Bangladesh (ICHAP, Bangladesh) bearing in mind its national and international characteristics; change the basis for determining salary away from the UN Structure to a salary based on market forces and, a provision to create an "NGO" or "service Organization" under the Centre's direction. Dr. Sack moved on to present an update on staff transitions during the reporting period, Human Resources update, followed by an overview of Finances – the Centre's present budget is US$ 16 million – the Board may need to consider whether we should grow or remain at this level; changes in physical plant, training, conferences/workshops, major trends and policy issues for Bangladesh and their relation to the Centre's Programme, collaboration with James P. Grant School of Public Health with BRAC, a report on the Development Partners Group (DPG); Division updates, expected accomplishments, assessment of the Strategic Plan: Child Health Programme, Reproductive Health Programme, Nutrition Programme, Infectious Diseases and Vaccines, Health & Family Planning Systems and Population Sciences and concluded with highlighting important achievements during the year.

He further reported on the profile-raising event being organized in London at the House of Lords of November 21.

Prof. Vlassoff thanked Dr Sack for the excellent progress made during the year and the attempts the Centre is making with regard to amendments to the Ordinance.

Dr. Uauy thanked Dr Sack for reporting on the strengths of the Centre and called upon the Division Directors to briefly report on what might be considered as the weaknesses of the Centre including:

a. Few senior staff carry out most of the functions, and hence there may be a shortage of senior scientists in the next 10-12 years.
b. Funding
c. Recruitment of required skills (define skills required).
d. Enhancement of infrastructure – shortage of funding for this activity.
e. Increase communications – make research findings better known.
f. Sustained support for infrastructure especially field operations.

Prof. Vlassoff noted the lack of women in senior positions and urged the Centre to find ways to improve this situation. She said that she would be pleased to hear about the impact of the Centre's gender policy in the divisions and how the development partners might support the implementation of this policy.

Health Systems Research: Questions were again raised regarding the profile and the position of Health Systems Research at ICDDR,B and how Health System Research will be more coherently addressed in the future. Dr. Sack responded that this Health Systems Research is on the Centre's priority list, but unfortunately funds for this activity have been decreasing. The Centre hopes to participate actively in the HNPSP which will be discussed in the Development Partners Group meeting. If there are partners worldwide who would assist in sustaining the Centre, this should be explored. With regard to importance of such partnerships, the Centre's role in the HNPSP was cited. In response to the suggestion that the Centre continue to keep connected with the Gates Foundation, it was reported that concept papers were submitted for the Grand Challenges. It was also reported that the submissions to the Grand Challenges included proposals for oral vaccine, lung injury (how do we treat pneumonia), improvement in the treatment of diarrhoeal diseases, etc.

In response to whether the Centre plans to look at food borne diseases, it was reported that several projects in HSID and LSD are moving in this direction. However, funds for this activity are limited. How the Centre plans to trade off between "Health Systems" and "Disease Systems" was also queried. Prof. Vlassoff invited Dr. Tasnim Azim to present.

**2. HIV/AIDS Programme:**

Dr. Tasnim Azim reported that activities under this Programme started even before the Strategic Plan was developed. The goal of the Programme is to expand ongoing activities to control the HIV/AIDS epidemic. Dr. Azim presented the issues around HIV/AIDS, the Bangladesh scenario, vulnerable population groups, other studies at ICDDR,B, work in the region and plans over the next year.

Dr. Azim further reported that the Centre is developing a model for Bangladesh and would escalate this to the Public Health arena. With regard to WHO estimates and whether these are useful for policy makers, it was reported that the figures are not popular with the Government of Bangladesh and hence the Programme will revisit this issue and will be looking at the gaps in the data. Regarding information on potentially affected children, a dialogue has just started with UNICEF.

Prof. Vlassoff thanked Dr. Azim for a very comprehensive and impressive presentation and said that the Programme is an excellent example of early intervention.

Dr. Abbas Bhuiya was invited to make his presentation.

**Poverty & Health:**

Dr. Abbas Bhuiya presented the goals, areas of concentration, progress and research framework of the Programme. He said the goals of the Programme included research and organizational aspects. Areas of Concentration included visibility, capacity development, knowledge generation and dissemination. Dr. Bhuiya also highlighted findings from

selected studies which included the tuberculosis study, safe motherhood, elderly health, and measurement of poverty. He concluded by providing information on the Chakaria Community Health Project.

Prof. Vlassoff thanked Dr. Bhuiya for a very rich presentation which, she said, also answered questions raised earlier by Dr Jane Kusin's concern re education.

Discussion: It was suggested that the Programme include: nutrition (anthropometry studies); education – development of children and access; and mental health. The studies on measurements was appreciated, but how funding is making a difference and how social progress would correct this issues was questioned. With regard to the absence of vulnerability and resiliance in the framework, Dr. Bhuiya agreed to look into this.

Prof. Vlassoff invited Dr. Charles Larson to make his presentation.

**Scaling up Zinc as a treatment for childhood diarrhea (SUZY) project:**

Dr. Charles Larson began by providing a legacy of scientists involved with zinc related work at the Centre. He reported that zinc deficiency is a common problem in young children, and places them at increased risk for morbidity and mortality. Options for zinc augmentation include food fortification, daily/weekly supplementation as well as a treatment for diarrhea. Zinc as a treatment – a summary of the current state of knowledge was presented. The Larson said that the goals of the project included implementation of marketing and delivery strategies in public, private and NGO sectors. This will set the project on the path to reaching all children of Bangladesh, regardless of gender, income or where they live and provide zinc as a treatment for any diarrhoeal disease episode.

Discussion: It was felt that the activity is only concentrating on diarrhea and not on other childhood illnesses like pneumonia. However, though potential problems exist with this, the activity might also consider other childhood diseases or a wrong message will be introduced if the concentration is only on diarrhea. Dr. Larson responded that additional research is needed in this regard but that there is a consensus of the efficacy of zinc with diarrhea. A consensus does not exist yet for its efficacy for other illnesses. In response to marketing the work, Dr. Larson reported that the MoH needs to create a team to start planning and that discussions are ongoing with WHO and UNICEF who have shown much enthusiasm and are encouraging the Ministries of Health all over the world. Plans for partnership in Ethiopia and Mali are being considered.

It was further stated that despite the great potential of zinc to alleviate nutritional problems, equal attention should still be paud to the many underlying problems of malnutrition.

Prof. Vlassoff thanked Dr. Larson for a very concise and interesting presentation.

### 3. Staff Welfare Association Presentation:

The Executive Committee of the Staff Welfare Association presented their report to the Board. The SWA presentation emphasized a definite plan of action to resolve the salary gap in the salary structure and requested the BoT to advise the Centre on how to generate more income to provide stability to the Centre in the future. SWA also raised the issue of proper child care facilities (crèche). It was noted that this could not be upgraded due to lack of space.

**Afternoon Session: Programme Committee – Sasakawa Seminar Room**

**Present:** Board Members
**Invited:** Centre Directorate
**Minutes:** Loretta Saldanha

### 4. Reflections on the Morning Session:

i. Format for presentations:
Following discussions on the format it was felt that more time should be set aside for discussions and that highlights should be reduced in length. It was recommended that the Centre keep the present format and in future link it even more coherently with the Strategic Plan, with separate projects clearly integrated into lines of research and to standardize fully the reporting format across divisions, particularly with regard to the presentation of publications and staffing. It was also noted that the breadth of activities is impressive. However, the Centre needs to ensure that its work is known and appreciated. The Board recommended against a major journalistic/dissemination effort but recommended that the Centre should continue the successful links with the national and international press, continue to aim at excellent scientific publications and develop more information material such as fact sheets and circulars. The Board also felt that the website is an important source for information dissemination. The Board, however, commented on the publications which they felt has been fairly low in the last six months.

ii. The position and the profile of Health Systems Research still requires attention by the Centre to meet the need to render efficacious interventions effective at the community level. It was recommended that the Centre illustrate new trends and focus on new studies in this area in relation to the Strategic Plan. The Centre could plan on a workshop to which donors should also be invited, at which existing data could be presented together with new trends and, finally, a discussion on the agenda for the country.

Dr. Sack informed the Board that the Centre has identified a couple of problems on current issues for discussion at the Development Partners Group meeting (DPG): 1) Zinc and, 2) the need for Operations Research in support of the HNPSP. The question is, is there a mechanism for the donors to fund this type of Operations Research in support of the HNPSP. This will be a major discussion item for the DPG. A further report on the activities of the Centre in Operations Research and donor perspective was presented by Prof. Barkat-e-Khuda for the information of the Board.

The Board recommended the inclusion of Health Systems Research (HSR) in the Centre's portfolio (balance between health systems approach and disease systems approach) and recommended that the Centre provide a comprehensive documentation on the HSR portfolio including the plans for the future to be reviewed at the next BoT meeting.

ii. A Check-list of Resolutions requiring action followed:

Resolution 1: Confirm whether Minutes have been made more succinct and recorded along issues rather than transcripts. (Confirmed)

Resolution 4: A yearly progress report in relation to the Strategic Plan (it was agreed that this report should be programmatic – show how the activities lead to one result. The Director and Division Heads need to decide on the format for presentation).

Resolution 7: Review of the CSD. (completed)

Resolution 8: Update on CHNRI (Director's report)

Resolution 9: Models for the hospital (covered by the review)

Resolution 10: The Centre Directorate to define core and essential activities. (Finance Committee)

Resolution 11: Intra-divisional distribution of funds.(Finance Committee)

Resolution 14: Recruitment Process (HR Committee)

Resolution 15: Strategy for Recruitment Process (HR Committee)

Resolution 16: Final Stage of implementation of the Gender Policy (HR Committee)

Resolution 17: Report on the implementation of the HR Plan(HR Committee)

Resolution 22: Job description for Deputy Director (Discussed in closed session of the BoT)

Resolution 34: Develop a system to report to the Board the roles of the Standing Committees (Discussed – to be taken up at the Board Retreat).

**Fund Management Committee**: Dr. W.B. Greenough, Chairman, Fund Management Committee, Baltimore (who was present in Dhaka for the CSD review) was invited to make a brief presentation on the activities of the Committee. It was agreed that to raise funds in the future, the Centre would provide details of how these funds have been spent to enable the Committee to relay these stories to the donors. It was also agreed that these funds should be placed under a separate legal entity.

**5. Discussion on Standing Committees:**

**Break-out sessions:**

**Fund Development & Oversight Committee:**

Dr. Kaye Wachsmuth, Dr. Marcel Tanner, Prof. Terrence Hull, Dr. Kul Gautam
(Centre staff: Dr. I. Zaman, Ms. Julia Ackley, Ms. Hannah Lemon, Dr. D Sack)

Professor Tanner reported on the discussions. It is expected that the Board should be more involved in fundraising activities of the Centre and discussed several ways how this could be done. The following points were discussed:

1. The Board should act as a platform.
2. The Board should be very vigilant to identify new donors.
3. The Board should be active in providing access to these individuals in building bridges so that the Centre and these target groups/individuals can be reached.

The group did not focus on the text of the by-laws but discussed the responsibilities the Board can take over the next 12 months. The Centre should assist the Board members by providing fact sheets, provide unique information and also information to enable appropriate PR. The Board will discuss this in their meetings each year and assignments will be provided. It was mentioned that the roles can be summarized in a few points and not as detailed in the by-laws and hence the Centre will need to reformulate these by-laws. The group did not discuss the membership of the Committee.

It was felt that discussions always center around money when fundraising is discussed and that it would be useful to develop other kinds of international relationships which do not necessarily imply funding.

The Board were also informed that one of the reasons to form this Committee was that most individuals who join the Board, at the time they accepted the responsibility to be on the Board, did not see their roles as primary fund raisers for the Centre and this was not generally a part of the mandate of the Board. It is common that Board members often do not realize that there is a significant role for Board members in fundraising. Fundraising is one of the key functions of the Board.

It was agreed that this point should be taken up at the Retreat. Dr. Uauy also suggested that this role should be indicated in the initial letter to the Board.

**Governance:**

Prof. Carol Vlassoff, Dr. Claudio Lanata, Dr. Ricardo Uauy Dagach
(Centre Staff: Prof. Barkat-e-Khuda, Ms. V. Brooks, Dr. M A Salam, Dr. R. Breiman, Ms Ann Walton, Mr A Neogi)

Prof. Vlassoff summarized the discussions as follows:

The discussion focused mainly on the degree to which the Directorate of the Centre used a participatory approach to decision-making and information sharing. The discussion began with a review of the powers of the BoT as specified in the Ordinance. It was agreed that the powers specified there were in fact those which the BoT exercised, but that the intensity of BoT intervention depended very much on the circumstances and needs of Centre management. When management is seen as strong, the BoT has more of

an oversight function, whereas the BoT becomes more involved when the Director is absent for long periods or when there is a gap between Centre Directors.

In terms of the participatory nature of the Directorate, it was acknowledged that the process of decision-making could be more participatory, but it was also unanimously agreed that participatory and consensual decision-making is the present norm and practice at the Centre. The weekly meetings of the Centre Directorate has been adopted and is working well. Examples were given, including the follow up of the resolutions of the Board of Trustees, Nov. 2002. While this process was difficult, it was overall a satisfactory and inclusive process. Areas in which greater participation is still needed include lower levels of Centre staff and greater gender equality in decision-making and knowledge sharing.

It was observed that not all scientists are natural managers and that more capacity building of Centre scientists in management and administration would be useful. For example, delegation of responsibility from more senior to more junior staff is key to the sustainability of the Centre and a feeling of self-worth and empowerment of junior staff. This may not always be practiced within the Centre, and more attention to staff development in general was thought necessary.

Follow up will include a discussion and clarification of BoT Committee role and procedures as well as further debate and discussion at the BoT retreat in Nov 2004.

Although it was hoped that issues of governance by the BoT would be discussed, the focus was on Centre Management rather than Board Governance.

**National Liaison Committee**

Dr. Halima Mwenesi, Dr. Jane Kusin, Prof. Azad Khan
(Centre staff: Dr. Abbas Bhuiya, Dr. Kim Streatfield, Dr. G B Nair, Mr. Peter Thorpe, Dr. Shams-el-Arifeen).

Prof. Azad Khan informed the meeting that if a decision is made to form a Committee only Centre scientists should be involved. This Committee will report to the Board members who will participate in the process. The Centre would send reports to the Board for their review. The Board could look at the processes and the data and make sure that the Centre is on track.

Secretary of the Committee: Secretary, Ministry of Health & Family Welfare
Members: Dr. Halima Mwenesi
Dr. Jane Menken
Dr. Tikki Pang

Following a presentation made by the above Committees following the break-out sessions, it was agreed that in addition to the three existing Chairs (Programme, HR and

Finance) two new Chairs of Standing Committees be created together with alternate Chairs – National Liaison Committee and the Fund Development Committee. The Chair of the Fund Development Committee will be invited to the next Executive Committee meeting of the Board.

It was also agreed that discussions on the by-laws for the Fund Development Committee be suspended for a year until the November 2004 retreat.

It was further suggested that, for the Committees to stay informed that the key committees have a Chair and an alternate with no particular work definition other than to Chair the meeting of the Board.

**6. Change in name of ICDDR,B:**

Detailed discussions were held on the subject. It was noted that the Centre is looking for a more marketable name without necessarily compromising the essence of ICDDR,B, something that would be more appealing to some of the donors, and a name that describes the work of the Centre. The Board however discouraged the Centre's need to change its name at this stage and suggested that the Centre conduct a market survey since this is a research centre and changes should be based on evidence. The Board suggested that ER&ID conduct an informal survey and report its findings to the Board. However, in the meantime Ms. Ackley and Mr. Thorpe should provide the Board with a course of action and time-lines. Once a decision is reached in this regard, the Centre should continue with the process for the other amendments (attached) to the Ordinance as proposed

**1 November 2003: The Programme Committee meeting reconvened at 2.00 pm for a presentation of the report on the Programme Committee Review of the Clinical Sciences Division.**

| | |
|---|---|
| Present: | Members of the Board |
| Absent | Mr. Mirza Tasadduq Hussain Beg (including Board members as indicated earlier) |
| Invited: | Dr. I. Kabir, Mr. Muyeed Chowdhury (CSD Reviewers) Scientific Council and CSD senior staff |
| Minutes: | Loretta Saldanha |

**CSD External Review Report**

Dr. Claudio Lanata, Chair of the Review Committee was invited to present a report on the review. He introduced the members of the Review Committee (Prof. A K Azad Khan, Dr. D. Mahalanabis, Dr. W.B. Greenough, Dr. I. Kabir, Mr. Muyeed Chowdhury). He said the team was well chosen and each member brought in a wealth of experience. The main issues discussed were research and service issues. Training issues could not be discussed in detail due to time constraints. He proceeded to describe the process of the review. He said the team did not have the opportunity to meet with division heads individually due to shortage of time, but met with them as a group. The team appreciated

the inclusion of a visit to the Kamlapur field site. Dr. Lanata thanked the Director, the staff of the CSD as well as Dr. M A Salam for the support provided to the review.

Generally, the Division has an excellent research component, with some outstanding research lines that should be preserved and fostered; current research portfolio does not reflect the new areas outlined in the Centre's Strategic Plan; service being provided to a large number of patients, which has lately become stable even though Dhaka's population continues to increase. He said the team has made recommendations with regard to management, research, service and training components. The list is extensive – some of these could be achieved over a short period of time and some would take years.

Dr. Sack thanked the review team for their excellent work and said that it was reassuring to hear about the research in the Division. He said he was concerned that the research programme had deteriorated due to shortage of funding, particularly USAID funds that provided major support to clinical research. He also highlighted the importance of the exit interview which he said was possible only because of the skills and experience of the staff in conducting Operations Research. He said the review team should consider the costs of the recommendations and that it would be interesting to hear their views on this.

Referring to the major weaknesses and major opportunities, the Board felt that in terms of training the Centre could be a premier training centre internationally. ICDDR,B should consider co-sponsoring training with a Western premier university.

In response to questions raised by the Board whether the Centre has clear thoughts about running the hospital as a business centre, Dr. Salam responded that the recommendations would be discussed internally together with costs involved as well as implications. The Centre will have to be careful about increasing fees charged to patients since this is the only hospital that provides care to the poorest of the poor and hence the Centre needs to establish a very effective safety net if a decision is made to increase charges. ICDDR,B is the only institution in Bangladesh that provides primary health care and a 24-hour clinic.

The review team also felt that some recommendations need directives/guidance from the Board as these are policy issues. Once these directives are given by the Board, then the second level will be for the Centre to identify which recommendations can be taken up immediately.

Dr. Lanata concluded that though the team could not look into many issues in detail, nevertheless the team felt that they had laid the path for the Division for the next 50 years. A detailed report will be provided to the Board which listing priorities, steps, etc. All the recommendations made should be fed into a plan by the Division/Centre for presentation to the Board.

Prof. Vlassoff thanked Dr. Lanata for a very comprehensive presentation and the team for the excellent work and for the preliminary report and recommendations. The Board endorsed the recommendations provided and requested the Division and the Centre to

implement those recommendations that can be implemented immediately and that a plan be developed for the recommendations that will require more time. A progress report should be given to the next BoT meeting.

The meeting concluded at 4.30 pm.

A closed session of the Board followed after tea break.

## PROGRAMME COMMITTEE RESOLUTIONS
## 31Oct-2 Nov 2003

**1/BT/Nov 03**

The BoT was impressed by the progress made at the Centre and the results achieved at all levels in research, training and services provision. The BoT congratulates the Centre for the excellent performance and considers that the Centre is very well on track to implement the Strategic Plan.

**2/BT/Nov 03**

The BoT was pleased with the new format of the Director's Report complemented by presentations of Centre's highlights. It is recommended:

- to keep the format in future and to link it even more coherently with the Strategic Plan, with separate projects clearly integrated into lines of research
- to standardize fully the reporting format across Divisions, particularly with regard to the presentation of publications and staffing.

**3/BT/Nov 03**

The BoT welcomes the strong inclusion of Health Systems Research (HSR) in the Centre's portfolio. The BoT recommends that the Centre provide a comprehensive documentation on the HSR portfolio including the plans for the future to be reviewed at the next BoT.

**4/BT/Nov 03**

The BoT welcomes the plan of the Centre to increase efforts to disseminate the results and achievements of the Centre by (i) continuing to aim at excellent scientific publishing, (ii) developing more information material (hard copy and web-based) such as fact sheets and circulars (e.g. Equity Dialogue, Health & Science Bulletin) and (iii) continue the successful links with the national and international press.

**5/BT/Nov 03**

The BoT followed up on the BoT resolution 4/BT/Jun 03 and concluded that the Centre Directorate should provide yearly plans based on the Strategic Plan and grouped by the main programme priorities.

**6/BT/Nov 03**

In follow up to BoT resolutions 10/BT/Jun 03 and 11/BT/June 03, the BoT welcomed the presentation by the Finance Department on core vs. project support. The financial analysis further needs to be complemented by a programmatic analysis showing all core resources (including staff) required to fulfill the main priorities of the Strategic Plan and the need for feedback to donors. This will provide a basis for decision making on areas where the Centre needs to invest, as well as the basis for the Centre's budget.

**7/BT/Nov 03**

**Fund Development Committee**
The BoT resolves that it will strengthen its support of the Centre fundraising by enhancing roles and activities of BoT members to:

i) support Centre research, services and training.
ii) facilitate access to potential donors and other funding sources.

In recognition of this resolution the BoT has established a Fund Development Committee to monitor these activities. The BoT asks the Directorate to provide new information material, particularly fact sheets to be used by BoT members in their fundraising activities.

**8/BT/Nov 03**

The BoT requests the Centre to draft the respective by-laws of the Fund Development Committee to reflect the conclusions of the discussions in the breakout groups and with the aim of keeping these by-laws as brief as possible.

**9/BT/Nov 03**

The BoT resolves that, in addition to the three existing Chairs (Programme, Human Resources and Finance Committees), two new Chairs of Standing Committees be created to take responsibility for the National Liaison Committee and the Fund Development Committee. The Chair of the Fund Development Committee will be invited to the next Executive Committee meeting of the BoT. The following appointments/extensions were named for Committee Chairs:

Programme: Professor Marcel Tanner (Dec 03 – June 05)
Human Resources: Dr. Claudio Lanata (Dec 03 – Dec 05)

Finance: Professor A. K. Azad Khan (upto August 2005)
National Liaison: Mr AFM Sarwar Kamal (Dec 03 – Dec 04)
(Alternate – Prof. Azad Khan)
Fund Development: Dr. Kul Gautam (Dec 03- Dec 05)

**10/BT/Nov 03**

The Board recognizes the excellent work done by the External Review Committee of the Clinical Sciences Division and expressed its thanks for the preliminary report and recommendations. The Board endorsed the recommendations provided and requested the Division and the Centre to implement those recommendations that can be implemented immediately. For those recommendations that require more time or a strategic decision by the Centre, a plan should be developed for implementation. A progress report should be given to the Board at the next BoT meeting.

**Response to Board Resolutions from November 2003**

**Programme Committee**

**1/BT/Nov 03**

The BoT was impressed by the progress made at the Centre and the results achieved at all levels in research, training and services provision. The BoT congratulates the Centre for the excellent performance and considers that the Centre is very well on track to implement the Strategic Plan.

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The BoT was pleased with the new format of the Director's Report complemented by presentations of Centre's highlights. It is recommended:

- to keep the format in future and to link it even more coherently with the Strategic Plan, with separate projects clearly integrated into lines of research
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**3/BT/Nov 03**

The BoT welcomes the strong inclusion of Health Systems Research (HSR) in the Centre's portfolio. The BoT recommends that the Centre provide a comprehensive documentation on the HSR portfolio including the plans for the future to be reviewed at the next BoT.

*This issue will be addressed during this meeting.*

**4/BT/Nov 03**

The BoT welcomes the plan of the Centre to increase efforts to disseminate the results and achievements of the Centre by (i) continuing to aim at excellent scientific publishing, (ii) developing more information material (hard copy and web-based) such as fact sheets and circulars (e.g. Equity Dialogue, Health & Science Bulletin) and (iii) continue the successful links with the national and international press.

*A series of fact sheets are under development. These will be discussed. The HSB is an especially important new publication.*

**5/BT/Nov 03**

The BoT followed up on the BoT resolution 4/BT/Jun 03 and concluded that the Centre Directorate should provide yearly plans based on the Strategic Plan and grouped by the main programme priorities.

*This requires further discussion with the Board to determine the nature of this request. The Suchona data base will provide a major source of information for clarifying the programme priorities, but the Centre's management is not in favor of preparing a new "Annual Work Plan" since its research projects do*

*not lend themselves to "Annual Plans." The Annual Report and the Directors Report at each Board meeting will highlight the work of the Centre on an annual basis, so is in keeping with the spirit of this resolution.*

**6/BT/Nov 03**

In follow up to BoT resolutions 10/BT/Jun 03 and 11/BT/June 03, the BoT welcomed the presentation by the Finance Department on core vs. project support. The financial analysis further needs to be complemented by a programmatic analysis showing all core resources (including staff) required to fulfill the main priorities of the Strategic Plan and the need for feedback to donors. This will provide a basis for decision making on areas where the Centre needs to invest, as well as the basis for the Centre's budget.

*The Suchona system will provide an amazing amount of data that will allow management and the BoT to follow the work of the Centre and the financial allocations.*

## Fund Development Committee

**7/BT/Nov 03**

The BoT resolves that it will strengthen its support of the Centre fundraising by enhancing roles and activities of BoT members to:

i) support Centre research, services and training.
ii) facilitate access to potential donors and other funding sources.

In recognition of this resolution the BoT has established a Fund Development Committee to monitor these activities. The BoT asks the Directorate to provide new information material, particularly fact sheets to be used by BoT members in their fundraising activities.

*The Centre staff are in the process of developing these materials.*

**8/BT/Nov 03**

The BoT requests the Centre to draft the respective by-laws of the Fund Development Committee to reflect the conclusions of the discussions in the breakout groups and with the aim of keeping these by-laws as brief as possible.

*The management felt that this issue should be deferred until the November since it is likely to be a major issue at the retreat. Also, it should be clarified that the bylaws are for the Centre's BOT, and that the bylaws of the committees are included in the overall bylaws (e.g. each committee does not have a separate set of bylaws.)*

**9/BT/Nov 03**

The BoT resolves that, in addition to the three existing Chairs (Programme, Human Resources and Finance Committees), two new Chairs of Standing Committees be

created to take responsibility for the National Liaison Committee and the Fund Development Committee. The Chair of the Fund Development Committee will be invited to the next Executive Committee meeting of the BoT. The following appointments/extensions were named for Committee Chairs:

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| Human Resources: | Dr. Claudio Lanata (Dec 03 – Dec 05) |
| Finance: | Professor A. K. Azad Khan (upto August 2005) |
| National Liaison: | Mr AFM Sarwar Kamal (Dec 03 – Dec 04) (Alternate – Prof. Azad Khan) |
| Fund Development: | Dr. Kul Gautam (Dec 03- Dec 05) |

*All have been invited to the June meeting. Dr Gautam is unable to attend due to a prior commitment.*

**10/BT/Nov 03**

The Board recognizes the excellent work done by the External Review Committee of the Clinical Sciences Division and expressed its thanks for the preliminary report and recommendations. The Board endorsed the recommendations provided and requested the Division and the Centre to implement those recommendations that can be implemented immediately. For those recommendations that require more time or a strategic decision
by the Centre, a plan should be developed for implementation. A progress report should be given to the Board at the next BoT meeting.

*Document attached.*

## Human Resources Committee

**11/BT/Nov 03**

The BoT thanked Professor Barkat-e-Khuda for his important contribution to the Centre during his service as an international scientist, especially during the absence of the Director over an extended period. It wished him every success in his future career when his term ends as Associate Director, and Head, Policy and Planning in June 2004.

**12/BT/Nov 03**

The BoT noted that Resolution 22/BT/Jun 03 had not been followed up by the Centre Directorate and urged that high priority be given to the preparation of a job description for the post of Deputy Director and that it be circulated to the BoT by email for comments. The initial stages of recruitment of a Deputy Director should be undertaken before the June 04 BoT meeting, so that ideally a short list of candidates can be presented to the BoT on that occasion.

*An update will be provided in the HR report. The advertisement has been widely circulated and the BOT members are encouraged to recommend suitable candidates. At this time, it is not known if a shortlist can be presented at this board meeting.*

**13/BT/Nov 03**
The Board resolves that the current employment contract of Mr. Peter Thorpe with the Centre, be extended by another term of 3 (three) years effective August 01, 2004 under the same terms and conditions.

**14/BT/Nov 03**
The Board resolves that the current secondment agreement of Dr. Robert F. Breiman between CDC and ICDDR,B be extended by another 2 (two) years period effective July 01, 2004.

*Unfortunately, Dr. Breiman will be departing to head a new CDC programme on emerging infectious diseases in Kenya and is expected to have left the Centre in early June, prior to the BOT meeting. We expect that CDC will name a replacement for Dr. Breiman and that the new person will be joining the Centre in summer 2004.*

**15/BT/Nov 03**
The Board records their thanks to Dr. Greet Dieltiens for her contributions to the Centre.

**16/BT/Nov 03**
The Board resolves that the current secondment agreement of Dr. Yukiko Wagatsuma between Johns Hopkins University and ICDDR,B be extended by another 18 months effective July 17, 2004.

**17/BT/Nov 03**
The BoT approves the Centre's request to initiate an extension of the present contract of Dr. Abdullah H Baqui, Adjunct Scientist, a faculty member of Johns Hopkins University for another period of three years effective July 1, 2004.

**18/BT/Nov 03**
The Board wishes to specify the process it will follow to review the applicants for the Promotion of National Officer Level Scientists to the International Professional Level. The Centre's Promotion Committee will forward a recommendation to the Chair of the Human Resources Committee according to the process outlined in the policy. The Committee will review the recommendations and present a resolution to the Board of those approved.

*A response to this issue will be included in the HR report.*

**19/BT/Nov 03**
The BoT requests the Centre Directorate to examine the criteria applied by the Promotions Committee in the promotion of National Officer level scientists to the International Professional Level considering the variety of career path that should be recognized.

*A response to this issue will be included in the HR report.*

**20/BT/Nov 03 (SEALED RESOLUTION)**

*Promotion of Dr. Md. Yunus to the International Level.*

**21/BT/ Nov 03**

The BoT expresses their satisfaction and congratulates the Centre for the work accomplished on the HR Agenda and will look forward to receiving updates on further progress made at the next meeting of the BoT.

*A response to this issue will be included in the HR report*

**Finance Committee**

**22/BT/Nov 03**

The Board agrees to approve the 2003 forecast. The Centre Directorate is encouraged to continue to take all measures possible to avoid the projected $280,000 deficit in 2003.

*The Centre was able to end the year with a small surplus. Details of this will be provided in the Finance committee.*

**23/BT/Nov 03**

The Board agrees to approve the 2004 budget as presented; noting that in June 2004 the Board will review the financial position of the Centre. The Centre Directorate should continue to take all measures possible to avoid the projected $926,000 deficit in 2004. The BoT will review the deficit reduction plan of the Centre Directorate in its June BoT meeting.

*This will be considered during the Finance Committee.*

**24/BT/Nov 03**

The Board approves a salary increase of 2% (two percent) for all NO and GS staff effective January 1, 2004 and a 1% (one percent) salary increase for all international staff effective January 1, 2004.

The BoT resolves to make future reviews of remuneration only at Full BoT meetings in November when the annual budget projects are available.

**25/BT/Nov 03**

Dr. Mohammad Abdus Salam, is the Associate Director and Head, Clinical Sciences Division (CSD) effective July 01, 2003. Centre Directorate recommends that the name of Dr. Salam be inducted as authorized signatory from Group II.

**26/BT/Nov 03**

The Board accepts the audited financial statements of the ICDDR,B Employees Separation Payment Fund for the years ended December 31, 1992 to 2002.

**27/BT/Nov 03**
The Board resolves to acknowledge and accept the report of transfers (as detailed in the Auditors Report) of the Employees Separation Payment Fund as made by the Management.

**28/BT/Nov 03**
The Board resolves that the Separation Payment Fund Trust be constituted as follows: That the Centre Directorate should work with the Staff Welfare Association (SWA) to prepare a draft plan for the Employees Separation Payment Fund (ESPF) and to draft relevant by-laws so that this process can be implemented. A report should be presented to the BoT at the June 2004 Board meeting.

*This will be presented at the Finance Committee. A final plan will be made to the November meeting, but significant progress has been made to form the trust.*

**Full Board Resolutions**

**29/BT/Nov 03**
The Board approves the extension the terms of the following Board members for a second term of 3 years with effect from the date of termination of their first 3-year term.

Dr Maimunah B A Hamid
Dr Terence H Hull
Dr Nobukatsu Ishikawa
Dr Claudio Franco Lanata
Dr I Kaye Wachsmuth

**30/BT/Nov 03**
Dates of the next Board Meetings:

10-13 June 2004, Executive Committee Meeting of the BoT
(Phone conference 12/13*)
25 November 2004 – BoT Retreat
26-29 November 2004 – Full Board Meeting

*For June 2004, the arrival date will be 10 June with the meeting starting on 11 June, and the telephone conference call on 12 June (Saturday).*

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In addition the Board requested the ERID office to develop a plan for identifying a new name for the ICDDR,B. It is widely thought that the ICDDR,B name does not properly describe our work and is not an attractive name for understanding our mission, nor for fund raising. The management will provide an update on the progress of the name change process.

**External Review of the Clinical Sciences Division**

**October 28-30, 2003**

## Introduction

Centre's scientific divisions periodically reviewed by external experts to critically appraise their activities, identify strengths and weaknesses, availability and allocation of resources, and recommend future directions.

A team, constituting of the following members, reviewed the Clinical Sciences Division during October 28-30, 2003:

1. Dr. Claudio F. Lanata (Representing BoT): Chair
2. Prof. Azad Khan
3. Mr. Abdul Muyeed Chowdhury
4. Prof. William B Greenough III
5. Dr. Dilip Mahalanabis
6. Dr. Ahmed Al-Kabir

## Process

### (i) Before actual conduct of the review

The division prepared a document and forwarded that to the reviewers, which included:

- updated curriculum vitae of all scientific staff of CSD
- reprints of all divisional publications for the last three years
- list of ongoing protocols
- list of protocols under preparation
- summary of research, service, and training activities of the division
- major accomplishments and obstacles observed during the last three years
- plans for the next 1-2 years, and
- options on the future of the Dhaka Hospital.

**(ii) On site**

- Meeting with the Centre Director followed by Dr. MA Salam, Acting Head, CSD to discuss review objectives, finalize agenda and schedule of the processes, and briefly discuss divisional activities and determine if any additional information is required.
- A tour of the facilities including the hospital, the physiology laboratory, diagnostic clinic, the PSKP clinic, and the laundry.
- Presentation of divisional activities by Dr. Salam (acting Head) to the review team, which was attended by CSD's scientific staff and key administrative and support staff, and heads of other division and scientific programme of the Centre.
- Presentation of the findings of an "Exit Interview", conducted earlier to understand patients' satisfaction of the services received at the Dhaka Hospital, and their ability and willingness to pay for the services.
- Presentation of research findings by selected CSD scientists.
- Meeting with various groups of CSD staff, and scientific staff on an appointment basis.

Reviewers Inspecting the Hospital Laundry

Reviewers on a Tour of the Facilities

The reviewers prepared their draft report, which was discussed initially with the Acting Head, CSD and then with the Centre Director. Key findings were presented to the members of the Board of Trustees, and to the Centre staff.

**Major Comments/Recommendations, and Response of the Division**

1. Research

1.1 General satisfaction about divisional research activities, and suggestion to develop annual work plan aiming at preservation of current research lines including basic physiologic research; more clinical research in ALRI including basic physiology studies, tuberculosis, and tropical diseases such as dengue; and recruitment of an international scientist, expert

in respiratory diseases to expand research on ALRI, as an initial step. Reviewers recommended continued encouragement of staff for develop their own research projects with proper funding.

Response: CSD considers all suggestions and recommendations appropriate, and hopes to develop its new annual work plan by this fall, taking into consideration of current funding difficulties to undertake clinical studies. The division would seek Centre's help for allocation of fund to recruit an international scientists for strengthening its ALRI research as well as assist in its efforts to build in-house capacity.

1.2 Taking a phasic approach, expand clinical research in newer areas such as tropical diseases, neonatology and maternal health, in collaboration with other institutions /organizations, particularly those already funded by major donors (ADB, USAID, World Bank, etc).

Response: These are important research areas in which CSD scientists, in collaboration with others, could make significant contribution. The division would review current gaps in knowledge in these areas, and identify important topics for addressing in its research studies.

**2. Service**

2.1 "Exit Interview" was considered an excellent initial study on quality of care and patient's satisfaction, and satisfaction with key findings e.g. no waiting time, no major problem of extra payments, general acceptance of the current registration fees and willingness to pay for food, lodging and medications.

2.2 Concern about very little time spent for provider-patient interactions required to reassure/counsel patients and to provide support/education to mothers'/ patients' attendants and recommended their appropriate addressing. Although the "Exit Interview" did not find privacy as a major concern, the reviewers recommended its provision.

Response: The division has conducted several sessions with various categories of hospital staff to inform them the findings and their importance, and the need to improve patient-provider interactions and supporting patients/attendants. CSD is already in a process of

improving physical facilities of the hospital including improvement of space for patients, better privacy, and hand washing facilities and hospital hygiene.

2.3 Overall satisfaction about services offered and their quality, including the franchising activity; however, suggested establishment of an effective system to provide explanation for referring patients to the PSKP clinic.

Response: The division is working to strengthen and expand the franchising activities, including effective implementation of an established system for providing explanation to the patients referred to the PSKP clinic.

2.4 Excellent patient care systems with waiting for initial attention; however, recommended implementation of a system to ensure assessment of all patients by a medical doctor within shortest possible time of their arrival.

Response: CSD is in the process of restructuring the division including re-organisation of its patient care services that would include effective addressing of the suggestion.

2.5 Recognition of still too low staff:patients ratios, and suggestion to conduct studies to define ideal ratio, examine options to solve this problem, and explore possibilities for receiving voluntary services e.g. those from students.

Response: An earlier exercise in 1998 demonstrated staff shortage, which was re-confirmed in a recent workforce assessment. The findings would be reviewed within the division before their submission to the Centre administration.

2.6 Establish a team approach to ensure active participation of nurses and other staff along with doctors in management and improvement of quality of care and services, and initiation of activities for technical updates and professional development of staff, particularly nurses.

Response: The division is already working on reorganization of the division including re-structure its patient care activities. A number of teams, constituting of physicians, nurses, and other workers will be formed to operate various functional units of the hospital. The

teams would be responsible for developing case-management manuals with their periodic updating, ensure service quality and efficient use of resources, prepare budget, assess need of staff development and training, and maintain hygiene and implement effective infection control policies within respective areas. Once a consensus is achieved within the division, it would be shared with Centre administration for approval and implementation.

2.7 Separate hospital administration, under the Division's Associate Director.

Response: The division considers this a very important recommendation, and would like to attach it to the development of an efficient divisional organization structure for improving efficiency and work quality, fostering teamwork, establishing accountability and a transparent hierarchy, and effective appraisal systems.

2.8 Develop a well-documented cost structure and establish an effective system for payment for the CSD services received by all users.

Response: Although cost structures do currently exist, CSD will work with the Finance Department to re-examine them and ensure that they are done appropriately in a transparent way, and find ways for their efficient implemented through encouraging all concerned to share costs.

2.9 Establish a fee for food and lodging as well as for medication costs. Future fees require further studies to decide when they should be implemented. The vision is that all major services provided should be charged for, with a safety net to deal with individuals unable to pay.

Response: This issue has been discussed with various groups of divisional staff, and there is a general consensus to implement changes, in phases, along with establishment of systems to monitor if and to what extent, and in which direction their implementations affect the stakeholders.

2.10 Develop a well thought through strategic plan to solve the financial problems of the hospital including establishment of an effective system to get paid by Centre's users (projects, training, etc), encouragement of other divisions/programmes to use CSD services as much as possible without duplicating them, earmarking GoB support for

patients care, use of funds generated from Centre's new business initiatives, get support from charitable donors, efficient use of endowment funds in a transparent manner consistent with the wishes of the donors, identifying as person to bringing funds for the service component (a champion), and possible patents or licensing fees, and use of savings to open new-research/clinical services.

Response: CSD shares the views; however, implementation of some of the above would require recognition of the need and utilization of available resources within CSD by other divisions and scientific programmes, while others would need defining of and implementation of effective central policies.

2.11 Expand the franchising model with a network of primary and secondary care clinics, at strategic locations, with ICDDR,B but outside of its Human Resources structure, either in collaboration with existing NGOs or through other mechanisms, to reduce patient visits at the Dhaka Hospital.

Response: This has been discussed within the division. In fact, Centre's Executive Director had conceived a model of "emergency care" facility, for nesting into Essential Service Package (ESP) of the NSDP, and is very supportive of establishment of such a clinic. CSD believes that it would not only be a cost-effective approach but would additionally fill-in the current gaps between the primary care set-ups of the ESP clinics and the tertiary care at the large public/academic institutions. The model could be made more attractive/efficient through establishment of an effective referral system that currently lacks in the country. This concept has recently been discussed with NSDP in presence of representatives of USAID, donor of the NSDP, and there has been a decision to develop such a proposal for further discussion. If the model is successful, with adjustments if required, it could be implemented at other NSDP clinics nationwide.

2.12 Expand income-generating activities of the Division through a well-developed business plan with appropriate marketing strategy.

Response: The division would make efforts to strengthen its existing income generating activities at the Special Procedure Clinic (consultation on payment, endoscopy, and immunization), and widen the scope through addition of newer facilities e.g.

ultrasonographic investigations, and energy expenditure and body composition measurements. It would; however, be better to incorporate CSD's income generating activities within the Central Diagnostic Unit.

**3. Training**

Perform CSD's training activities under a well-structured system, and full utilization of their potentials, including income-generation, through a business-like approach along with effective marketing strategies both for training and trainees, and develop a strategic plan to improve training e.g. through liaising with other organizations.

Response: CSD appreciates these constructive suggestions, and feels that they could be effectively implemented only through centrally coordinated efforts, in which Training and Education Unit would lead and monitor the programme. CSD would; however, take initiatives for strengthening its in-house Clinical Fellowship and Nurse Fellowship programmes through better understanding of their needs and re-structuring of the programmes in discussion with them.

**4. Management Aspects**

4.1 Continue encouragement of staff's development of their own research projects with proper funding.

Response: The CSD scientists are making efforts and would continue their efforts to explore funds required for its traditional studies, as well as studies in newer fields.

4.2 Abolish the current need to divide time between service and research. Allocate individual's time according to his/her expertise and division's need and resource availability.

Response: The current 50:50 research and service divide, in terms of time management of CSD scientists, has been introduced nearly a decade ago. Despite recognition of inefficiencies of the system, it would take a while to change the system to an efficient system, which would require efforts for common understanding and acceptance of the staff for the required change. Discussion has already been initiated for the change, and a positive attitude among the staff has been observed. This activity is related to re-organization of the divisional structure that is also necessary for addressing other issues.


CENTRE
FOR HEALTH AND
POPULATION RESEARCH

# Director's Report

Prepared for the

**BOARD OF TRUSTEES**
**EXECUTIVE COMMITTEE MEETING**
**11-13 June 2004**

# Director's Report for the June 2004 Meeting of the ICDDRB Board of Trustees



## 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 Friday June 11 in the morning and last until June 13. Dr. Lanata will give a special lecture to staff and guests on the morning of the 13th. All the meetings will be held in the seminar room next to the Sasakawa auditorium, except for the large open sessions that will be held in the auditorium. Since this is an executive meeting, the numbers of Board members will be fewer than last meeting, but we will have a teleconference with the other board members on Saturday afternoon. You will already have received instructions for this conference call.

As with the last board meeting, the first day (June 11) will start with a brief closed meeting of the Board members in the seminar room to approve the minutes of the last meeting and to have an introduction to the meeting. If there are amendments to the minutes, it would help if you could forward these to us prior to the meeting. The brief closed meeting will be followed immediately by an open meeting in the auditorium for the Director's report. The Director's report will incorporate the information from the Divisions, but we do not plan to have separate oral reports from each Division. (Full division reports will take place during the November meeting.)

The Director's Report will be followed by presentations from three of the Centre scientists to inform the Board of some of the new findings and new directions at the Center. This includes some new information on cholera from Dr G.B. Nair[1], an update on the neonatal studies from Dr Shams El Arifeen, and a report on studies of the fertility plateau from Dr. Kim Streatfield.

A change from past meetings: we are planning to invite the Development Partners to this opening session and then to ask them to participate in a Development Partners Group (DPG) meeting at the end of the morning – followed by lunch with the Development Partners.[2] During the afternoon we will consider the HR and Finance reports.

On the second day (June 12) we will focus on the plans for the retreat to be held in November, and we will need to finalize the resolutions and perhaps deal with other issues in preparation for the conference call. **It will be important to consider carefully those issues that can be discussed meaningfully by the entire board and to communicate these via email to the other members.** The board members who are not in Dhaka cannot be expected to have a full understanding of complex issues, thus the discussion of the conference call will need to be planned carefully.

## *INTRODUCTION*

### Follow-up from the last meeting in November.

The minutes of the last meeting are included in your folder. A copy of the resolutions are included in your folders so we can review these resolutions and can update the Board on each. In addition the Board requested the ERID office to develop a plan for identifying a new name for the ICDDR,B. It is widely thought that the ICDDR,B name does not properly describe our work and is not an attractive name for understanding our mission, nor for fund raising. The management will provide an update on the progress of the name change process.

## Administrative updates

### Transitions of International Staff

The Centre nearly always has some transitions in staffing, though these are fewer than in the past.

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[1] This report will help to remind the Board that the Centre is still the world leader in cholera research, even though we have expanded to many other areas.

[2] This change to have the DPG meeting early in the meeting was to accommodate a schedule of our DPG chair, but I believe it is a welcome opportunity to have them hear some important scientific findings as well as participate in the DPG meeting.

- Dr Rob Breiman will be leaving the Centre in June 2004 to take up a new CDC post in Kenya. He will be replaced soon by another epidemiologist from CDC. The name of the new person from CDC is not yet known, but we should know who is chosen prior to the board meeting. The Centre has participated in the selection, having input into the short list of applicants, but the final selection will be by CDC. We have been extremely pleased with the interest of several well qualified applicants from the CDC.
- Mary Hadley, coordinator for the Family Health Research Project, left the Centre in April to take up a new post in Zambia. We are still in the process of identifying a replacement.
- Julia Ackley, senior associate in the ERID office, is leaving the Centre in June to return to the US with her husband. We will be seeking her replacement.

## Suchona – The New Management Information System

The Centre is now operating under the new computerized Management Information System using MS-Navision to provide a unified system for finance, HR and projects. The system "went live" on schedule on February 1, 2004. Since then, there have been some start up problems, but from discussions of other organizations with such major restructuring of their system, our problems have been better than most. We will provide an update of the new system during the meeting.

## HR Update

The HR report provides details of the activities related to HR, but there are few items to highlight. Mr. S.K Deb joined the Centre in November 2003 as Senior Manager Human Resources, effectively replacing Mr Wahabuzzaman who had served the Centre for so many years as CPO.

The Gender Policy[3] is now being implemented through the recruitment of a gender specialist, Ms. Shamima Nasreen Mili who joined in February 2004, and a review of our gender practices. A consultant group is helping the Centre identify issues related to Gender and their report will be available soon. The Gender Policy is published in both Bangla and English and discussions about our Gender policy have been presented widely in Divisional meetings. An especially important aspect of the ongoing "gender review" will be the identification of unique manifestation of gender discrimination that may be occurring within the Centre that are unique to Bangladesh and how to manage these within the Bangladeshi culture. The Gender Equality Committee participated in a 2 day training session in April designed to familiarize new members with gender related concepts and allowed all committee members an opportunity to prioritize issues for the Gender Audit.

The Human Resources Department along with Finance and Projects has been very involved in the implementation of Suchona including training of all HR staff in the use of the new system, training of Centre staff as well as handling post-go live issues. The data migration of all HR records and payroll processing has been particularly demanding. Progress on Suchona will be reviewed during the meeting. The Centre has issued new identification cards to all staff members since new employee identifications were issued with Suchona and the completion of the job classification project.

The job description for the Deputy Executive Director post has been completed. Both this position and the Director, HSID have been advertised and sent to all Board members. A recruitment progress report will be presented at the HR committee.

[3] The published Gender Policy is being included in your packet of materials.

The CD was concerned with some incidents recently encountered by our field staff in Mirsarai and Matlab developed Security Guidelines for its staff especially for those who are working in the field.

## Overview of the Financial Situation

The details of the Centre's finances will be described in the information for the Finance Committee and in the enclosed report from the ERID office. As usual, there is both good news and bad.

The good news first...the Centre did end the last year with a small positive balance for the fifth year. We had been concerned that there would be a deficit, but through strict controls and the very welcome contributions from our development partners, we were able to achieve a balance. Our current year's projection is still in flux since there are several funds that are promising, but are not yet finalized. Assuming these agreements are finalized soon, the Centre will be able to project a positive budget for the year.

Among the most promising new opportunities is a large fund from the Government of Bangladesh and the Japanese Government (the DRGA fund) that will provide significant funding for many of the essential activities of the Centre as well as provide significant support for our collaborations with national institutes. Thus, this provides the opportunity for the Centre to finally eliminate our cumulative deficit as well as significantly increase our collaborations with national institutions. I anticipate that we will be able to announce finalization of this grant by the time of the Board meeting.

Another major potential project grant is from the Government of Canada who is anticipating a project on reproductive health in three geographic areas of Bangladesh. We are in touch with CIDA to develop the project.

In terms of core funding, as reported at the last meeting, the Centre continues to receive core grants from the Government of the Netherlands, Switzerland, Canada, and Bangladesh along with others. Unfortunately, USAID is no longer a core donor but USAID/Dhaka is still the largest single donor through project funds.

There is not too much bad news...just that our new project with USAID / Washington is still not clear and that Washington / USAID may no longer be a significant source of support for the Centre. This is a matter I will be discussing with officials in Washington soon since I believe this was not an expected outcome of their change in funding mechanisms.

## Grants & Contracts Office update.

The expansion and scope of the Centre's collaborations is reflected in the diversity of the types of agreements that we are presently entering into as an institution. These include expanding to new partnerships, expanding research among existing partners and the extension of ongoing subcontracts between academic and research institutions in the United States, Europe and Japan, primarily. Ensuring that guidelines for ownership of data are included in our contracts and that the Centre retains its rights of ownership of data and specimens and right to publish over all research conducted at the Centre has become an agreement provision that often requires discussion and acceptance of a differing standard than initially anticipated by some collaborators. It has slowed down the approval process for some contracts but

ultimately agreed to in all cases. Another problem faced in our contract revisions is revising the cost of shipment of specimens which has tripled since 2001 due to security issues.

As the Centre continues to expand its collaboration and capacity building with local institutions, we are expanding our contracts with local institutions. These are largely service agreements and allow local collaborators to participate or provide some component of the work to be done in the research with primary contractors among our collaborating institutions globally. These agreements are primarily with health providers, local laboratories and hospitals, and local NGOs. ICDDR,B continues to conduct research for GOB programmes and entered into a major contract with the GOB to provide components of the National Nutrition Programme and to subcontract components of the research to NGOs.

## Protocols and non-Protocol Activities.

A significant change is being implemented through the Suchona, to review and approve all non-protocol activities. All budget codes will be either a protocol or an activity, e.g. any budget code that is not an approved protocol will be considered an "activity." In the past the non-protocol budget codes were maintained from year-to-year, but they have not been as carefully scrutinized as they might have been. Under the new system, all "activity PI's" will submit information on their activities, including categorical data, similar to that submitted for protocols, as well as narratives justifying the budgets being requested. The CD will act as the reviewing committee to approve the activity budgets. We feel that this more careful monitoring of all budgets will improve the management of the Centre's resources.

## Changes in Physical Plant

The physical facilities are gradually being improved, though there continues to be some urgent needs. These include renovating the offices of the HSID, upgrading our electrical generator, replacing some of our wiring and renovating some of our hospital space. These are expected to be completed during this calendar year. The LSD is continuing to take the lead in terms of fire prevention and fire fighting efforts, in keeping with the recommendations of the LSD review from last year.

***Recent renovations***

| Work Description | Area | Status |
|---|---|---|
| False ceiling | LSD | Completed, April 04 |
| Renovation for radio-isotope room | LSD | Completed, Mar 04 |
| Renovation of toilet | Medical Records area | Completed, Mar 04 |
| Major renovations and addition to kitchen | Canteen | Completed, Mar 04 |
| Aluminum partitions | Various areas | Completed, April 04 |
| Installation of ATM | Bank Building | Approved |
| Renovation of Special Care Unit | Hospital | Approved |
| Major civil and electrical renovations | HSID offices | Planned |
| New Generator | Generator Building | Planned |

The Centre has hired a consultant to assist with development of a donor document to apply for a large grant for completion of our main building in Dhaka which is likely to cost about $10 million. If we are able to identify funds for the building, we would like to start construction within 12 months and to complete the eight floors within 36 months. This new building would greatly improve our institutional capacity and would allow the John P Grant School of Public Health to move to our facilities. (see below). The plans will be sent to the Board prior to starting any major building projects, but we do hope to move forward as soon as possible.

## Directions in Research

### Progress on the Strategic Plan

Monitoring of the strategic plan is built into the Suchona system. Each of the plan's priorities in the plan is included in the data base, and the scientists and directors can see which priorities are being addressed through the protocols and activities. The highest priorities listed in the Strategic Plan were as shown in the table below.

**Priorities listed in the Strategic Plan**

| | Priority as stated in the Plan | Protocols addressing the priority |
|---|---|---|
| 1. | Introduce cost effect strategies for zinc therapy for diarrhoea | SUZY project (zinc scale up) |
| 2 | Help reduce maternal morbidity and mortality and improve perinatal and neonatal health | MINIMat, neonatal mortality intervention and the IMCI project, |
| 3 | Develop a package for the prevention of foetal growth restriction | MINIMat |
| 4 | Help identify a package of suitable vaccines for diarrhea and acute respiratory infections | Vaccine protocols for rotavirus, cholera, *S. pneumoniae* |
| 5 | Define the burden from tuberculosis and identify effective strategies for prevention and control | Protocols on epidemiology, molecular epidemiology, drug resistance, rapid diagnostics for tuberculosis and collaboration with national TB programme |
| 6 | Address stagnation of fertility decline | Protocols to understand fertility plateau and interventions to address the plateau. |
| 7 | Help prevent epidemic of HIV-AIDS and RTI-STI | HIV-AIDS surveillance and several protocols on HIV-AIDS, surveillance for STI, and evaluation of rapid tests |
| 8 | Contribute to knowledge that can impact the burden of vector borne disease | Studies on dengue, kala azar, malaria |

### Other high profile and new projects at the Centre

The number of projects at the Centre is too extensive to review each, but I want to highlight some high profile developments.

1. The Centre has been conducting an investigation of the Nipah virus outbreak in Bangladesh in collaboration with IEDCR, WHO, CDC with additional assistance from scientists and public health professionals from Canada and Malaysia. This outbreak was one of international interest because the virus is one of the new emerging pathogens and it changed its clinical and transmission characteristics during the epidemic. It started with sporadic cases of encephalitis with very high case fatality rates (>75%), but then it presented later as severe pneumonia that appeared clinically like SARS with person-to-person spread, and continued to have the very high case fatality rate. Because of the high interest and potential threat from Nipah virus, the Centre is considering hosting an international conference on Nipah disease during the coming year.

The outbreak investigations are continuing, though it appears to have stopped its transmission for now. The HSB describes the outbreak during the early phase of the outbreak and later issues will describe the SARS like picture. The reservoir for the virus is the fruit bat. The mechanism of transmission from bats to people is not known, but it may be bat droppings or contamination of fruits or juices. Small outbreaks have occurred during each of the last three years in the western side of the country during the months of January to April; thus, this is a disease that will need careful study to learn how to control. The occurrence of person to person spread of this infection with such a high case fatality rate would appear to have pandemic potential.

2. A major invited review on cholera, authored by Drs. Sack, Sack, Nair and Siddique was published by The Lancet.[4]

3. Another important clinical study, also published in Lancet in May 2004, and authored by Brooks, et al, has shown the clinical benefits of zinc treatment for severe pneumonia. Follow-up studies are being conducted in Kamalapur to confirm this in another setting in children with outpatient pneumonia.

4. Based largely on studies carried out at the ICDDRB and elsewhere, the World Health Assembly is expected to confirm a recommendation from WHO and UNICEF advising that all children under age 5 years with diarrhea should receive the low osmolar ORS and a 10 to 14 day course of zinc.

## Interactions between financial situation and prioritization

The financial situation of the Centre has a direct relationship to the ability of the Centre to carry out its mission according to the Strategic Plan. When all research projects are directly dependent on project support, the Centre's management has relatively little control over the priority of the individual projects. Although we consistently insure that projects being carried out are within the Plan (e.g. we do not obtain funds simply because they are available), but the order and resources available for these studies is sometimes beyond our control.

Assuming that the financial situation of the Centre improves significantly prior to the Board meeting, we will be faced with a new and welcome problem: that of having to make our own decisions about the order of projects, the utilization of our core resources, whether and how much to expand, etc. I am highlighting these new opportunities for allocating resources by the Centre's Directorate since they will also present potential problems in determining how to do this efficiently, in a manner that is most productive.

In the past, when the Centre has received large grants that allowed for multiple projects to be determined by Centre management, a "Portfolio Approach" was used, similar to that carried out by NIH and many other funding agencies. That is, the general area was defined, and scientists were requested to submit concept papers for research in that particular area. Among the concept papers submitted, the "best projects" received funding and proceeded. An alternate approach is the "Corporate Model" in which the CD, with input from the Programmes, define goals of a Centre (as has been done under the Strategic Plan), and specific projects (similar to subcontracts) are provided to units that are best suited for carrying out the work.

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[4] Sack DA, Sack RB, Nair GB, Siddique AK. Cholera. Lancet. 363:223-33, 2004.

The Centre will have to find the optimal blend of Portfolio and Corporate Models to best follow the Strategic Plan and to continue to be creative and encourage staff development.

## Major meetings organized /or hosted by the ICDDRB

### *10th Asian Conference on Diarrhoeal Diseases and Nutrition (10th ASCODD)*

ASCODD held from December 7-9 in Dhaka at the Bangladesh-China Friendship Conference Centre was a great success. Over 800 attended from many countries. The Honorable Prime Minister was the Chief Patron and the Inaugural Session was opened by the President who presented an award to Dr. Dhiman Barua for his lifetime achievements and contributions to control of diarrheal diseases. He also unveiled a special ICDDRB stamp to commemorate the occasion of the 25th anniversary of the signing of the ordinance. The conference was organized by a local organizing committee, and special thanks are due to Dr Salam for his excellent chairing of the scientific programme. Many others, especially Ms Loretta Saldanha, were responsible for smooth functioning of the meeting.

### *US – Japan Cooperative Panel Meeting – Emerging and Reemerging Infections in the Pacific Rim*

This meeting held immediately following the ASCODD at the Pan Pacific Hotel was attended by about 200 from US, Japan, and Bangladesh and other countries on December 11-12. This meeting concentrated on issues of diarrheal diseases and HIV-AIDS. The presentations were of very high quality and allowed many important visitors from NIH to visit the ICDDRB.

### *WHO workshop on control of shigellosis (Feb 16-18)*

Because of the increasing and continuing threat from shigellosis, the ICDDRB hosted a workshop on shigellosis organized jointly with WHO, USAID and IVI. About 50 participants attended, primarily from Asia and Africa, to review the situation and make recommendations on further improving treatment and prevention of shigellosis. The workshop will result in a revised documents from WHO on this topic.

### Workshop with the MOHFW on the Role of Research in the Provision of Health Services in Bangladesh. (January 24, 2004).

This day-long workshop at the Sheraton Hotel, sponsored by DFID, highlighted the potential for research in improving and guiding the government and non-government programmes in Bangladesh. Participants included the current and former Health Secretary, the Joint Chief (Planning), the Director General, Heads of National Institutes, and selected scientists from the ICDDRB. The major aims of the workshop included the following:

- How to establish a strategy for dialogue between policy makers, programme managers and researchers
- How to identify priorities for research to reflect the decision making process
- Through what mechanism can existing knowledge be used and a research agenda created.

An outcome of the workshop was a realization that a minimal proportion (2 to 4%) of the new sector wide programme should allocated for research and that there be links between the programme staff and the researchers.

## Black and White Ball (Feb 13)

The Annual Ball (affectionately known in Dhaka as the Diarrhea Ball) was a great success. About 400 people attended in their formal attire and had good food and fun while helping our hospital raise about $30,000

## Update on the Planned John P Grant School of Public Health with BRAC University.

The Centre has had several discussions with BRAC to collaborate on a School of Public Health. The Dean is expected to be Dr Habte, former ICDDRB director. During the early discussions, the Centre was to contribute faculty to the school, but more recently, BRAC has approached us to inquire if they could locate the campus for the school at the ICDDRB. They are willing to contribute a significant amount of money to the building if they can locate the school here. In discussions among the Centre Directorate and other staff, this concept is considered favorably since it would bring an increased academic atmosphere to the Centre, it will mean a significant collaboration with a very successful local NGO, and it will complement our own training programme very nicely.

When the plan has been more fully developed, this will be presented to the Board for their approval, hopefully at the November meeting.

## Director's Travels

During the last six months, I have made a few trips to Europe and the US.
During April – May, I traveled to Stockholm, along with Dr. Rubhana Raquib and Motiur Rahman to present our Sida/ SAREC funded projects to the funding agency and to coordinate our work with the Swedish collaborators.. The SAREC support is unusual (and excellent) in that the portion of the funds for targeted research is jointly carried out with Swedish scientists. Although only a small portion of the funds is used in Sweden, the collaboration between our groups has been very productive. In each case, the Bangladeshi and Swedish scientists have been enthusiastic about the work and all of the projects have yielded significant results. Our only problem is that the level of funding is fixed so that the success has not yet led to increased funding.
In May, I attended two meetings on enteric vaccines, in Virginia and in Jamaica. The Virginia meeting was especially enlightening since it was a small meeting funded by the Gates Foundation with the intent to prioritize prospects for enteric vaccines. At this meeting, it seemed clear that the Foundation was willing to invest a significant amount of money in enteric vaccines and possibly other enteric disease interventions and they will be looking to the Centre for guidance as to how best to invest. The decision by the Foundation was determined through their strategic planning this year in which they concluded that their investments did not match the burden of disease and that they needed to increase their investments in enteric diseases.
In June, I will be attending the Global Health Council meeting in Washington D.C. The Centre has not been represented at this meeting since the meeting in 2001 when we received the Gates Award. This meeting is expected to prove very exciting in terms of this year's winner of the award.

## Reports from the Divisions

I had requested the Divisions to provide an update on their activities and these are included below. This is a supplement to the Annual Report which will be provided at the time of the meeting. (It is currently "in press"). Though some of the reports are quite lengthy, they do provide much information about the ongoing work.

# Clinical Sciences Division

Headed by Dr Salam, the Clinical Sciences Division is responsible for the Dhaka Hospital and for Clinical Research at the Centre. It carries out much of its work through "units" (e.g. Child Development Unit (CDU), Physiology Laboratory, etc. The staffing pattern is shown in Table 1.

Table 1. Current Staffing of the Clinical Sciences Division

| Category | | Number |
|---|---|---|
| International (Bangladeshi) | | 2 |
| Adjunct Scientist | | 1 |
| Consultants | | |
| | International | 1 |
| | National | 1 |
| Staff at NO Levels | | 37 |
| Staff at GS Levels | | 162 |
| Staff on CSA | | 36 |
| Health Workers | | 88 |
| Fellows (trainees): | | |
| | Doctors | 15 |
| | Nurses | 10 |

Several members of the division are currently on long term training as shown in Table 2.

Table 2. Ongoing Staff Development Activities

| Name | Degree/Fellowship | Institution |
|---|---|---|
| Dr. Fahmida Tofail | Ph. D. Child Development | University of London |
| Dr. Iqbal Hossain | Ph. D. Clinical Nutrition | UC Davis, USA |
| Dr. Md. Munirul Islam | Ph. D. Clinical Nutrition | UC Davis, USA |
| Dr. Wasif Ali Khan | Fellowship, Clinical Pharmacology, and Masters in Health Science | JHU, USA |

The Dhaka Hospital, also known as the Clinical Research and Service Centre, cares for a large number of patients, many of whom have life threatening illness. All of the patients who come to the hospital are first seen by a trained nurse who refers them to one of the appropriate units. Those with mild illness are referred to the PSKP clinic, while those who are more ill are treated in one of the wards of the hospital. The numbers of patients treated in each area are shown in Table 3.

**Table 3. Patient Care Services.** The monthly patient visits, numbers referred to the franchising clinic (PSKP), and their distribution by various wards during the reporting period (October 2003 through March 2004).

| Month | Total patients | PSKP | | | Pts in ORT | Short Stay Ward | Long Stay Ward | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Refd to | Refd back | Treated in PSKP | | | GW | SCU | NRU | RW |
| Oct '03 | 7629 | 2276 | 317 | 1959 | 62 | 5608 | 432 | 171 | 19 | 38 |
| Nov | 7488 | 2300 | 297 | 2003 | 71 | 5414 | 295 | 109 | 14 | 24 |
| Dec | 6650 | 2641 | 262 | 2379 | 32 | 4239 | 361 | 95 | 24 | 15 |
| Jan '04 | 5857 | 2663 | 320 | 2343 | 11 | 3503 | 397 | 129 | 32 | 20 |
| Feb | 4881 | 2243 | 268 | 1975 | 26 | 2880 | 394 | 96 | 30 | 09 |
| Mar | 8000 | 3023 | 363 | 2661 | 84 | 5255 | 530 | 156 | 23 | 52 |
| **Total** | **40,505** | **15,146** | **1,827** | **13,320** | **286** | **26,299** | **2,409** | **756** | **142** | **158** |

Within the hospital, a special team, coordinated by Dr Tahmeed Ahmed, called the Mother and Child Health Services (MCHS) provides preventive and nutritional services to the patients. The team consists of 37 persons including two medical doctors, paramedics and health workers, the MCHS offers preventive health services to patients attending the Dhaka Hospital and their mothers/attendants. MCHS provide the following cost-free services based on the "missed opportunities" concept:

1. Nutritional rehabilitation of severely malnourished children
2. Growth monitoring and promotion of severely malnourished children
3. Health and nutrition education
4. Immunization
5. Vitamin A supplementation
6. Promotion of oral rehydration therapy
7. Childhood tuberculosis program
8. Family planning counseling and services
9. Training of health professionals.

Table 4 shows the numbers of services provided by the MCHS in 2003.

Table 4.

| **Services provided** | **Provider** | **No. beneficiary** |
|---|---|---|
| In-patient nutrition rehabilitation | NRU | 257 |
| Growth monitoring and nutrition rehabilitation | NFU | 1,661 |
| Health and Nutrition Education | Health Workers | 96,7088* |
| EPI vaccines (doses) | Immunization Centre | 3,367 |
| Tetanus toxoid (women 15-45y; dose) | Do | 13,402 |
| Vitamin A (200,000 unit/Cap) | | 2,197 |
| Diagnosis and Tx of children with TB | | 51 |
| Birth spacing counseling + material supply | | 113 |

**The MCHS trains a large number of national and international health providers. These are illustrated as follows.**

- Provided technical services to Chittagong Medical College Hospital (CMCH) and assisted in establishing a nutrition service block in its Pediatrics Department, which

would also serve as a training platform for medical and nursing students and postgraduate doctors

- Provided technical advice to Centre for Rehabilitation of the Paralyzed (CRP) in Savar, Dhaka, in using standardized dietary protocol developed at the MCHS for catch-up growth and nutritional management children under their care.
- Provided practical experience to medical students from outside Bangladesh.

Within the HCSC, research projects are conducted. The topics of the ongoing research projects include:

1. Simplification of diagnosis and treatment of TB in children
2. Assessment of the effect of psychosocial stimulation on outcome of treatment of severely malnourished children, and
3. Defining effective ways of improving outcome of children who refuse nutritional rehabilitation or those who default on follow-up.

The ICDDRB was a pioneer with WHO in developing the Protocolized Management of Severe Malnutrition. Based on the WHO manual, the Centre is now attempting to train others in its use through a regional training approach. This has included the following activities.

- A training course has been developed based on six instructional modules by the WHO, which were field-tested at ICDDR,B in December 2000.
- The MCHS staff organized/directed courses based on these modules in Dhaka, Afghanistan, and very recently in Cambodia.
- Dr. Tahmeed Ahmed directed a regional course in Cambodia, participated by doctors and nurses from Laos, the Philippines and Cambodia.
- He also conducted a training workshop on severe malnutrition in Mulago Hospital, Kampala.

**Franchising ICDDR,B Services.** The Centre has been attempting to promote the use of "ICDDR,B standard diarrhea management" in NGO clinics in Dhaka and other parts of Bangladesh. As a first step toward this goal, we have introduced the concept of franchising of services at PSKP clinics, starting at the clinic on the ICDDRB campus. During 2003, 40,505 patients visited the Dhaka Hospital, and 15,137 of them were referred to PSKP. Of the referred patients 1,826 (8.29%) were referred back to the CRSC due to failure to manage their dehydration by oral rehydration therapy consequent to severe purging and/or vomiting, or suspected complications e.g. dyselectrolytaemia.

**Breastfeeding Counseling Services.** Counseling for promotion and support of exclusive breastfeeding (EBF) is now a routine service provided to the mothers of infants and young children aged (<2 years of age) admitted to the CRSC. During the reporting period, 2, 254 mother-infant pairs were included in the breastfeeding counseling sessions, of whom 621 mothers of infants under 6 months were counseled to re-establish EBF and the rest 1618 mothers of infant aged 6-24 months were counseled to continue breastfeeding until 2 years of age of their children and beyond, and to starting appropriate complementary foods on completion of 6 months of age. At discharge from hospital, 68% (sixty eight) of mothers were exclusively breastfeeding their babies.

**Special Procedure Clinic.** The clinic served 1129 clients during the reporting period, and generating revenues of approximately Taka 780,000 (US$13,265)

## PUBLICATIONS/ABSTRACTS/ONGOING PROTOCOLS (for CDU???)

| Description | Number |
|---|---|
| Original articles published in international peer-reviewed journals | 5 |
| Review Article | 1 |
| Manuscripts accepted for publication | 8 |
| Ongoing protocols | 19 |

### Child Development Unit (CDU)

**Awards.** The organizers of the 2nd World Congress of Pediatric Gastroenterology, Hepatology and Nutrition (3-7 July 2004, Paris, France) have awarded a Young Investigator Award to Dr. Baitun Nahar, a member of the CDU, for her submitted paper [Do severely malnourished hospitalized children differ in their development and behaviour from severely malnourished children attending community nutrition centres?].

**Several research projects are ongoing in the CDU. These include the following:**

1. Professor Frances Aboud from the Psychology Department of McGill University, Canada has joined the unit as an adjunct scientist in 2002. She has completed the first study of a series under the project "Evaluation of early childhood initiatives of Plan Bangladesh", and submitted the results to the donor.

2. The Unit is involved in the Child Development component of the MINIMat project. Dr. Fahmida Tofail will use the data from this project for her PhD thesis.

3. Another study, under the MINIMat project is assessing association between children's urinary levels of arsenic and their mental development.

4. Dr. Baitun Nahar is comparing current child development activities at the Nutritional Rehabilitation Unit (NRU) of the Dhaka Hospital with a low-cost, culturally appropriate, systematic program of psychosocial stimulation and parental counseling. Half of the study has been completed.

5. CDU developed two new projects in collaboration with the Institute of Child Health of the Pennsylvania State University and the University of Dhaka. The first will assess the effects of iron supplementation and/or psychosocial stimulation on mental development and behaviour of children with iron deficiency anaemia. This study will be followed by the second study, in which the effects of giving bio-fortified rice with or without psychosocial stimulation on children's development will be examined. The projects would be partly funded by ADB, DfID and Harvest Plus.

**The Physiology Laboratory studies the interaction of laboratory parameters with clinical outcomes to understand disease and protective mechanisms. Some of the ongoing activities include**

1. L-Histidine and cytokines: The aim of this basic study is to measure levels of cytokines such as TNFa, IFNg, LTC4, LTB4, PGF2A, PGE2 and Fecal Lactoferrin by

using ELISA in children with shigellosis, and subsequently assess the role of L-Histidine in modifying inflammatory response in shigellosis. L-histidine has already been shown in rabbits to decrease the inflammatory response from shigellosis and is currently being tested in children.

2. Tea polyphenols: This collaborative study with the University of Dhaka, will examine the effects of polyphenols (apple polyphenol has earlier been shown to possess beneficial effects in reducing arsenic-induced toxicity in animals) extracted from black tea and green tea in reducing arsenic toxicity in rabbits by measuring arsenic toxicity-related biochemical profiles.

**Set-up for new assays:** Thiobarbituric acid reacting substances (TBARS), glutathione (GSH), total antioxidant status, myloperoxidase (MPO) and catalase, nitrite and nitrate

**Research collaboration**: Continuing with the Albany Medical College, NY; Pasteur Institute, Paris; INSERM, Paris; McGill University, Canada; University of Alabama; Chiba University, Japan; Tokushima University, Japan; Tomen Corporation, Japan; the University of Texas at Galveston, School of Medical Sciences; and the University of Dhaka.

**Current donors**: Thrasher Research Fund, USA, USAID, Cytos Pharmaceuticals, USA, and the Government of Bangladesh.

**Nandipara Clinic.** Established in the late 1970's in peri urban Dhaka, the Nandipara community, with a population of approximately 7000 in an area of 3.5 square kilometers, continues to provide opportunities to CSD scientists for carrying out community-based research. Currently, the ongoing activity is a study on "The usefulness of ferrous fumarate and ferric pyrophosphate as food fortificants in developing countries." A clinic at the site provided medical services to the 3,750 patients, predominant women and children, living in the study area in support of our research projects.

**Hospital Surveillance.** The Dhaka hospital (along with the Matlab Hospital) maintains a surveillance system in which every 50% patient is enrolled in the surveillance. Based on this 2% sample, it is possible to estimate the numbers and types of patients being treated at the facility. (The Matlab surveillance enrolls all patients coming from the HDSS villages.) Based on the surveillance system, the following table shows the major pathogens isolated at Dhaka and Matlab. Each of the pathogens have some seasonality and age specificity, and the surveillance system, which has been in continuous operation since 1980, is able to discern long term and seasonal trends.

Table 5. Aetiology of Diarrhoea-Surveillance, Dhaka and Matlab Hospitals (October 01, 2003 through February 29, 2004)

| Pathogen Identified | Dhaka n= 636 (%) | Matlab n=464 (%) |
|---|---|---|
| *V. cholerae* O1 | 136 (21.4) | 71 (15.3) |
| *V. cholerae* O139 | 0 (0.0) | 0 (0.0) |
| *Shigella* | 59 (9.3) | 67 (14.4) |
| Rotavirus | 206 (32.4) | 111 (23.9) |
| *Salmonella* | 9 (1.4) | 10 (2.2) |
| *E. histolytica* | 8 (1.3) | 4 (0.9) |
| *Giardia lamblia* | 16 (2.5) | 12 (2.6) |

**Research projects.** The following summarizes several of the recent projects being conducted through the CSD.

**Fecal occult blood test and lactoferrin latex agglutination test in diarrhea.** PI: Dr. Hasan Ashraf Fund: University of Basel, Switzerland. This study compared faecal occult blood test (FOBT) and lactoferrin latex agglutination test (LT) in distinguishing invasive (ID) diarrhoea from non-invasive diarrhoea (NID) using standard diagnostic methods (culture and ELISA) as gold standards. The study group constituted of patients enrolled in the 2% systematic sampling of the Dhaka Hospital Surveillance system, and evaluation of FOBT and LT were done in 465 of these patients from whom either a single enteropathogen (317) or no pathogen (148) could be identified. The sensitivities, specificities, PPVs, NPVs, and accuracies of NE, FOBT and LT were 36%, 76%, 21%, 87%, and 62%; 58%, 64%, 22%, 90%, and 63% and 51%, 64%, 20%, 88%, and 62%, respectively. The screening tests like FOBT and LT are not effective in differentiating ID from NID.

**Absorption of Water and Electrolytes from a Liposomal Oral Rehydration Solution (ORS): An *In-vivo* Perfusion Study of Rat Small Intestine.** PI: Dr. Pradip Kumar Bardhan Fund: Creative Research Management, California, USA

In a rat model using in-vivo perfusion of entire small intestine, this study examined if incorporation of ORS components into liposomes increases small intestinal absorption of water from ORS. The rats (n=83) were divided into three groups: normal rats (n=28), rats exposed to cholera toxin (CT; n=24), and rats exposed to 5-fluorouracil (5-FU; n=31). Using PEG as marker, the net movements of water was compared between a Tapioca-based ORS containing liposomes (Aquis Liposomal ORS), a Tapioca-based ORS without liposomes (Tapioca-ORS), and the recently WHO-recommended hypo-osmolar ORS (WHO-ORS). All the three ORS solutions resulted in significant absorption, but the highest level of absorption was observed with Aquis Liposomal, which tastes less salty. Results of the 5-FU treated rats indicated increased absorption in damaged mucosa. Comparing the results of the Aquis Liposomal ORS with the Tapioca-ORS indicate that the liposomes were responsible for the significant increase in the absorption of water and electrolytes.

**Green banana and pectin improve small intestinal permeability and reduce fluid loss in Bangladeshi children with persistent diarrhea.** Authors: Rabbani GH, Teka T, Saha SK, Zaman B, Majid N, Khatun M, Wahed MA, GJ Fuchs. This study evaluated the effects of green banana and pectin (as non-digestible, dietary sources of colonic short chain fatty acids [SCFA]) on intestinal permeability. Fifty-seven boys (5-12 months) with persistent diarrhoea (≥14 days) were given a week's treatment with a rice-based diet containing cooked green banana (n=19), pectin (n=17), or rice diet alone (n=21). Intestinal permeability was assessed before and after treatment by giving a lactulose-mannitol (LM) drink and measuring urinary recovery after 5 hr. Treatment with banana significantly ($p<0.05$) reduced lactulose recovery, increased mannitol recovery, and decreased the LM ratio indicating improvement of permeability. Pectin produced similar results. Permeability changes were associated with a 50% reduction in stool weights, which correlated strongly (green banana, $r^2=0.84$, pectin, $r^2=0.86$) with the LM ratio. Green banana derived-and SCFA-mediated stimulation of colonic as well as small bowel absorption is responsible for their antidiarrhoeal effects. The antidiarrhoeal effects of green banana and pectin are mediated by improvement of small intestinal permeability in addition to the known colonotrophic effects of SCFA.

**Rice-ORS versus Glucose-ORS in the management of severe cholera due to *Vibrio cholerae* O139 Bengal: a randomized, controlled clinical trial.** Authors: Hossain MS, Salam MA, Rabbani GH, Kabir I, Biswas R, Mahalanabis D. This randomized study compared the efficacies of rice-based oral rehydration solution (R-ORS) and glucose-based oral rehydration solution (G-ORS) in the management of severe cholera due to *Vibrio cholerae* O139 Bengal. In total, 113 evaluable adult males with culture proven cholera due to *V. cholerae* O139 were enrolled (57 in R-ORS and 56 in G-ORS). They were initially rehydrated with intravenous (i.v.) fluid and observed for 4 hours before allocation to the study interventions, and they received usual hospital diet and tetracycline capsules (500 mg 6 hourly for 3 days). Duration of diarrhoea, stool volume in the first 24-hours of intervention, and treatment failure, defined by the need to re-institute intravenous fluid-therapy after initiation of trial therapy, were the primary outcome measures. The admission characteristics of the two treatment groups were comparable. No significant differences in the median (inter-quartile range) duration of diarrhoea [32 (24-48) hours in R-ORS group vs. 32 (24-56) hours in G-ORS group; p=0. 64] or stool output [179 (67-206) g/kg in R-ORS group vs. 193 (80-237) g/kg in G-ORS group; p=0.052], or the incidences of unscheduled intravenous fluid-therapy [21% (12/57) in R-ORS group vs. 25% (14/56) in G-ORS group; p=0.78] were observed. Results indicate that rice-based ORS is effective but not superior to the standard glucose-based ORS in the management of adult males with severe cholera due to *V. cholerae* O139.

**Efficacy and tolerability of racecadotril in the treatment of cholera in adults: a double blind, randomised, controlled clinical trial.** Authors: NH Alam, H Ashraf, WA Khan, MM Karim, G J Fuchs. The aim of this randomized, double blind study was to determine the role of racecadotril, an inhibitor of encephalinase with intestinal antisecretory activity that reinforces physiological activity of endogenous enkephalins, as an adjunct to the standard treatment of cholera in 110 male adult cholera patients who received either racecadotril (n=54) or placebo (n=56) in addition to standard cholera treatment. The major outcome measures (stool output, oral rehydration solution (ORS) intake, requirements for unscheduled intravenous fluid infusion, and duration of diarrhoea) were compared between the groups. Admission clinical characteristics of two groups were comparable. There was no significant difference in the mean (SD) total stool output (racecadotril v placebo 315 (228) vs. 280 (156) g/kg), total ORS intake (390 (264) vs. 369 (240) ml/kg), or duration of diarrhoea (35 (15) vs.

32 (13) hours) between the groups. Clinical success, defined as resolution of diarrhoea within 72 hours of initiation of study intervention, was also similar in both groups (racecadotril vs. placebo 96% vs. 89%). The number of patients receiving unscheduled intravenous infusions was not significantly different between the groups (racecadotril vs. placebo 22% vs. 14%). No drug related adverse effect was noted. The study observed that although safe, racecadotril therapy does not provide additional benefit in the treatment of severe cholera in adults.

**Water and electrolyte salvage in an animal model of dehydration and malnutrition** Authors: Islam S, Abely M, Alam NH, Dossou F, Chowdhury AKA, Desjeux J-F. The aim of this study was to assess the effect of malnutrition on renal and intestinal responses to dehydration, and to compare intestinal water and electrolyte absorption from ReSoMal (new formulation of oral rehydration solution (ORS) developed specifically for management of diarrhoea is severely malnourished children) and from the standard World Health Organization-Oral Rehydration Solution (WHO-ORS). This project successfully developed a rabbit model of malnutrition and dehydration to study the effect of malnutrition on renal and intestinal responses to dehydration, and to compare intestinal water and electrolyte absorption from ReSoMal an oral solution containing lesser amount of sodium and higher amount of potassium developed specifically for management of severely malnourished children with diarrhoea. The study also observed that in dehydration the kidneys and intestine of malnourished animals respond in a similar way to those of healthy animals, and also that, expectedly, the absorption of sodium and water are less and that of potassium is higher from ReSoMal compared to the standard WHO-ORS.

## ONGOING RESEARCH PROTOCOLS

**Impact of breast feeding counseling in the MINIMat project.** Nested into the MINIMat project, a study has been designed to quantify breast milk intake by infants, assess the impact of breastfeeding counseling on breast milk intake, and validate mother's report on breastfeeding practices. In total, 100 mother-infant pairs were enrolled. Mothers were fed 10 g of deuterium oxide on day 0 after obtaining their baseline saliva samples, and urine samples from the babies (3-3.5 months) were also collected. A further three saliva and five urine samples were collected over a 14-day period. All saliva and urine samples will be analyzed for isotopic enrichment by IRMS at MRC Cambridge, UK. The data and sample collection have been completed on February 29, 2004. Half of the samples had already been shipped to UK. Rest of the samples will be shipped at an earliest convenience.

**Identification and validation of an optimum clinical scoring system and objective markers for diagnosis of tuberculosis and estimation of prevalence of multiple drug resistance in children. PI: Tahmeed Ahmed. Funded by: DFID.** The diagnosis of TB is difficult in children due to their inability to produce sputum for diagnostic tests and the fact that skin test is mostly negative in children with malnutrition, prevalent in the developing countries including Bangladesh. The aim of this study is to validate two clinical scoring systems - the modified Kenneth Jones score (KJS; currently used at the Dhaka Hospital of ICDDR,B) and the WHO-recommended TB score (TBS) in the diagnosis of childhood TB by comparing their sensitivity, specificity and predictive values against objective markers of TB including culture and PCR, and clinical cure following treatment. The magnitude of antimicrobial resistance will also be assessed by susceptibility testing of the mycobacterial isolates from gastric aspirate or from sputum in case of older children. The modified KJS and the TBS will be applied to children suspected to have TB i.e. severely malnourished children

failing to respond to nutritional rehabilitation or those who do not show clinical/radiological response to appropriate treatment for pneumonia with broad-spectrum antibiotics. If a child fulfills either of the 2 scores, anti-TB treatment would be started according to the standard regimen and tests for objective markers performed. So far 62 children have been enrolled out of a required number of 100 children. The results of the study will enable us to prepare a simplified and validated diagnostic algorithm for diagnosis of TB in children.

## VISITORS/ STUDENTS

1. A six-member team headed by Mr. Yuko Ohsawa of Economics faculty, Nagoya city University, Japan visited the Clinical Research and Service Centre on 15th February 2004.

2. A 22-member team of Japanese Scouts visited the Clinical Research and Service Centre on 22nd February 2004.

3. At least 22 distinguished professionals have visited Clinical Sciences Division during the reporting period, mostly in relation to collaborative research works and/or to explore feasibility on future research and interacted with a number of CSD scientists.

4. A good number of students have visited the hospital

5. Dr Johannes Beltinger and Mr. Eric Pflimlin from Department of Gastroenterology, Basel University Hospital, Switzerland visited the Centre during November 16-21 to set up the video-endoscopy unit at the Special Procedure Clinic of CRSC and train identified division staff on their maintenance.

## CONFERENCE/SEMINAR/WORKSHOP ATTENDANCE

| Conference/Seminar/Workshop | No. Staff Attended |
|---|---|
| 11th United European Gastroenterology Week (UEGW), Madrid, Spain, 1-5 November 2003. | 3 |
| Meeting on Community Therapeutic Care, 8-10 October 2003, Dublin. | 1 |
| Workshop on Childhood Malnutrition, University of Makerere, Kampala, Uganda, 4-12 November 2003 | 1 |
| Inter-country training course on Severe Malnutrition, Phnom Penh, Vietnam, November 24 through December 12, 2003. | 1 |
| 10th Asian Conference on Diarrhoeal Diseases and Nutrition (ASCODD), 7-9 December 2003, Dhaka, Bangladesh. | 28 |
| 1st National Congress on Cerebral Palsy, Shishu Bikash Network, Dhaka, Bangladesh, 2-3 October 2003. | 3 |
| 2nd National Conference of Bangladesh Society of Allergy and Immunology, 16 March 2004, Dhaka, Bangladesh | 1 |
| 1st training course on Nutrition in Emergency, 21-25 March 2004, Dhaka, Bangladesh. | 1 |
| Annual Meeting of The Chest and Heart Association of Bangladesh, 24 March, Dhaka, Bangladesh | 1 |
| Meeting at Institute of One World Health, USA (project development) | 1 |

# Health Systems & Infectious Diseases (HSID) Division

## 1. Division

### 1.1. Administration

Dr. Robert Breiman, HSID division Director, announced that he will be leaving the Centre in July, 2004. He has accepted a position as the first director of newly created Centre for Emerging Diseases, located in Kenya. In February, 2004 Dr. Charles Larson assumed the position of Acting Director.

### 1.2. Health Sciences Bulletin

The 4th (September) and 5th (December) issues of the HSB have been published and distributed. The next issue is scheduled for publication in April, 2004 (copy is included in this packet). Topics in the December issue included the following:

- Mortality due to suicide in rural Bangladesh
- Sociocultural explanations for delays in careseeking for pneumonia
- Evolution of MDR *Shigella dysenteriae* type 1

### 1.3. HSID Rounds

The Division continued to hold weekly rounds for the purpose of presenting and critically appraising research protocols under development.

## 2. Health & Family Planning Systems Programme and HSID Health Systems and Economics Unit

In December 2003, the Health and Economic Policy Unit (HEPU) was expanded through a transfer of staff from the Health Economics Unit in PHSD. It has been renamed the Health Systems and Economics Unit (HSEU) and now consists of about twenty researchers. The broad research agenda of the unit is concerned with access to health care, utilization, coverage and health outcomes; and measurement of these through information systems, surveillance and surveys. Other key themes are the organization, management and financing of service delivery. During 2003 and early 2004, the HEPU pursued research on health service delivery and economic aspects of health, nutrition and population services. The unit continues to be a focus for projects under the Health and Family Planning Systems Programme, particularly those related to the Centre's priorities of evaluating alternative service strategies, economic analysis of programmes, improvement of health and family planning services, information systems and evidence-based planning of health systems. The health economics team within the Unit will focus on a variety of research issues apart from conducting simple cost analyses. These include: economics of poverty and health issues (equity of different interventions); cost-effectiveness of maternal and child health interventions, STD and HIV/AIDS interventions; economics of urban health care, especially the garment sector; health care financing issues, including immunization and demand side

financing. The unit is also working on building national capacity in health economics through linkages with Institute of Health Economics, Dhaka University and Health Economics Unit, Govt. of Bangladesh.

### 2.1. Research completed since September 2003

**Effectiveness of an NGO primary health care programme in rural Bangladesh: evidence from the management information system on coverage and death rates.**
This study reviewed data from the management information system of a large NGO programme in rural Bangladesh (BPHC). The data indicated high coverage of selected child and maternal health services and a reduction of about 50% in neonatal mortality from 1999-2002. Data disaggregated by socio-economic status indicated equity in coverage and a similar reduction in infant mortality among the poorest one-third. A paper will be published in "Health Policy and Planning" in July 2004 and further research is planned (see below).

**Identifying and addressing unmet needs in PHC clinics: evaluation of a screening tool.**
This study evaluated use of a screening tool by comparing changes in the needs identified and additional services provided in selected Government and NGO intervention and comparison clinics. Systematic screening significantly increased the amount of checking for additional needs, the number of additional needs identified, and the proportion of those needs that were met through services. Improvements were statistically significant and significantly greater than in the respective comparison areas. A working paper is in print and a paper was submitted for publication in October 2003.

**Programmatic and non-programmatic determinants of low immunization coverage in Bangladesh.**
This study interviewed service providers and mothers of 12-23 month old children to identify immunization status and reasons for incomplete immunization. The results were disseminated in March 2004. It was found that supply-side factors, such as irregular and unreliable EPI sessions and failure to inform mothers about the required immunization schedule, contribute more to low coverage and drop-out than demand-side factors, such as side-effects and fatalism.

**Exit survey among users of the Cholera Hospital in Dhaka**
A study was completed in 2003 to assess patients' satisfaction with the quality of ICDDR,B hospital care, and their willingness and ability to pay for services. Data were collected through exit interviews, observation of patient-provider interactions and a review of records. The majority of patients were fairly satisfied with the quality of hospital care. They indicated willingness to pay for medicines, food and lodging, and a preference for attending the hospital or an ICDDR,B facility, rather than a franchised service nearer to their home.

**Technical assistance for a Health Management Information System in two Municipalities**
CONCERN has been providing technical assistance to strengthen the capacity of municipal authorities to deliver specific child survival interventions to improve the health status of mothers and children. HSID staff conducted a situation analysis and provided technical support for the design and implementation of an HMIS for municipalities, from May-November 2003. Further support will be given for dissemination to concerned policy makers and program implementers.

**Cost analysis of protocolized management of severely malnourished children at NGO clinics.**
This study in collaboration with Progati Samaj Kallayan Sangstha (PKSP) assessed the cost of integrating protocolized management of severely malnourished children into the ESP delivery system at selected urban NGO clinics. It showed that the provider's unit cost (irrespective of outcome) was US$41, but this could be lowered with active outreach and increased enrolment. The protocol interventions were "self-targeted" on the poorest and with fine-tuning could be replicated in similar urban ESP clinics. Most of the cost was attributed to the personnel cost

**Review of Women's Reproductive Health Status and Poverty in Bangladesh.**
The HSEU has worked with the Reproductive Health Unit in PHSD on this five-month project for the World Bank. The final report was submitted in March 2004. The report examined the status of women's reproductive health in Bangladesh in particular focusing on poor women. This involved a literature review, extensive analysis of the latest BDHS data, stakeholder interviews and two field trips to Ishwardi and Ullapara. The Bangladesh report will be part of a five-nation study and contribute towards the Analytic and Advisory Activity of the Bank on Better Reproductive Health for Poor Women in South Asia. One of the important policy recommendations of the report is that focusing on the bottom SES quintile or the poorest of the poor is not an appropriate strategy to tackle the burden of reproductive disease amongst women.

## 2.2. Ongoing research

**Use of ESP services in the transition to a static clinic system: 1998-2002**
This study provides the only reliable evidence of changes in use of ESP services during the major transition in the Government PHC service delivery system. Data from the HSID surveillance areas (Abhoynagar and Mirsarai) have been used to compile quarterly trends in selected indicators over the period of transition, 1998-2002. Trends compared for wards that introduced community clinics and those which did not indicate a major change in health seeking behaviour, which is in line with the intended policy of shifting from domiciliary/satellite clinic services to fixed site community clinics. Key indicators (CPR; ANC and EPI coverage) were not adversely affected during the transition and in some cases they improved. A draft report has been submitted to the donor and dissemination will be held in April 2004.

**Evaluation of a six-month pilot to introduce community health volunteers in urban areas.**
This study was designed to evaluate a pilot of NGOs introducing community health volunteers (depot holders) in three types of municipal area. A household survey of 4,800 women of reproductive age was completed in 2003, which provided baseline indicators on service use and coverage in intervention and comparison areas. Many women preferred the volunteers as they were known to them, provided low cost services quickly, were knowledgeable and willing to accompany women to the clinic. A preliminary review of service statistics indicated that use of ESP services at the NGO clinics had increased. A follow up household survey is underway to assess the short-term impact of the volunteers on the selected service coverage indicators.

**Economic evaluation of shigellosis in an urban area of Dhaka, Bangladesh**
This collaborative study is being conducted in Kamalapur, the HSID urban surveillance area, as part of an IVI-supported, multi-country project on diseases of the most impoverished (DOMI). It will assess the costs of illness with shigella infection in terms of patient/household and provider costs. All three rounds of scheduled household interviews were completed in January 2004, and 191 children and 30 adult patients were enrolled. Analysis of the household survey data is underway and the facility-level survey for provider cost estimation is ongoing at the ICDDR,B clinic. The study will be completed in December 2004.

**Socioeconomic status and child morbidity**

This study aims to analyze trends in child morbidity patterns in Matlab across different socio-economic groups over the period of 1996-2002. This is being done in collaboration with the Institute of Health Economics, Dhaka University. A poverty and health fellow is the lead on this project. Preliminary analyses are complete. More rigorous analyses in underway towards preparation of manuscript.

**Economics of Arsenic Mitigation Options**

This study funded by SIDA started in October 2003 and is part of a larger study looking at various aspects of arsenic exposure and mitigation options in Bangladesh. Apart from measuring the cost-effectiveness of different mitigation options, we will also measure the equity of distribution of different mitigation options across different socioeconomic groups. We have developed questionnaires to collect information on the availability and cost of different mitigation options and data collection is underway.

**Economic impact of illness on households**

The economic impact of Tuberculosis illness and treatment on households:
This project is under the DFID funded poverty and health project in collaboration with the Child Health Unit. This research aims to identify the short-term and long-term impact of TB illness and then treatment on economic status of households. This will enable to address the policy issue of development of relevant interventions needed to address or alleviate short-term or long-term poverty caused due to illnesses. Data collection is underway.

**Cost of cholera illness of cholera in Matlab**

Work has begun on this study of the cost of cholera illnesss. Field Research Assistants have been recruited and household interviews will begin in April 2004. This collaborative IVI project will be completed in August 2005.

**2.3. Projects planned to start in 2004**

**Health needs and care seeking behaviour of street dwellers in Dhaka**

This study will use modified cluster sampling methods to conduct a cross-sectional survey among different socio-demographic sub-groups of homeless people in eleven locations in Dhaka. It will ascertain their residence history, health needs, use of ESP services and

perceived barriers to access. Negotiations are in progress with USAID who may be interested in funding this project which could start in May 2004.

**Use of ESP services and other factors associated with neonatal survival in rural areas of Bangladesh served by a large NGO programme (BPHC)**

This study will conduct interviews with women who gave birth in 2003 in 12 NGO-served areas to ascertain their use of selected PHC services. Data from case mothers (children who died in the neonatal period) will be compared with that from control mothers (child survived) to identify programmatic and other factors that might explain the relatively low neonatal mortality recorded in the NGO areas. DFID has expressed interest in funding the project, which could start in April/May 2004.

**Vulnerability to HIV/AIDS of migration-affected families**

This study will ascertain the level of knowledge about HIV/AIDS, awareness of risks for migrant workers and reported sexual behaviour among men and women in HSID surveillance areas (Abhoynagar and Mirsarai). It will assess the relative vulnerability to HIV/AIDS of married people who are living apart, or have lived apart, due to work-migration, by comparing them with those who have not lived apart. The study is likely to be funded by USAID and is planned to start in June/July 2004.

**Impact of the private sector on tuberculosis case-finding and health seeking behaviors of symptomatic adults**

The aim of this study is to improve our understanding of health seeking behaviors among adults with chronic cough, with particular interest in their use of the private sector. Among private sector providers, the study also aims to document current practices, capacity to detect suspected tuberculosis patients and referral patterns. The study will be carried out in the urban municipal centers of Dhaka and Chittagong.

**Cost-effectiveness and equity of interventions preventing neonatal morbidity and mortality.**

This study carried out with the Child Health Unit will compare the effectiveness of home based neonatal care with community-clinic based care in reducing neonatal mortality. The health economics team will collect data to estimate costs and equity of these different interventions, This is expected to start during the second quarter of 2004.

**Cost-effectiveness of introducing Hib vaccine in preventing Hib related illnesses.**

We have estimated the cost of disease using cost-of-illness data for Hib pneumonia and meningitis. We are awaiting results from the effectiveness study to incorporate the prevention benefits of Hib Vaccine along with data from literature to develop a decision model to estimate the cost-effectiveness of Hib vaccines for prevention of Hib-related illnesses.

**Other Information**

Dr. Beena Varghese was nominated by GAVI to be a member of the GAVI International Review Committee. She is serving as a member of the Financial Sustainability Review Team. She participated in the first FSP review held at the GAVI Secretariat in Geneva during February 2004.

## 3. Programme of Infectious Diseases and Vaccine Sciences and HSID Infectious Diseases Unit

### 3.1. Completed Investigations

#### Immune response after cholera infection in patients and household contacts

The study analyzed in 125 hospitalized cholera patients and 326 household contacts suggest that the serum vibriocidal response is not the primary mediator of immunity. Further studies are being carried out to study other immune parameters in the mucosal secretions and in the circulation, which may be more useful predictors of protection from cholera. Immune response to the major subunit of the toxin co-regulated pilus, TcpA after natural cholera infection.

#### Rapid diagnosis using dipsticks developed by Institut Pasteur, France

The Centre for Health and Population Research and the CDC and are evaluating diagnostic assays for *Vibrio cholerae* O1 in an effort to identify a sensitive diagnostic test that is effective when performed by low-skilled personnel. Every 50$^{th}$ symptomatic patient at a diarrhoea treatment centre in Dhaka, Bangladesh was enrolled in the study. The SMART™, Medicos™ Cholera Dip Stick and an immunochromatographic dipstick from the Institut Pasteur (IP) were performed on stool by high- and low-skilled staff and compared to stool culture. The study team calculated sensitivity, specificity, and positive and negative predictive values. A preliminary analysis of the data shows that the IP dipstick had the highest sensitivity (93%), irrespective of skill level. Patient enrolment was completed by the reporting period and data cleaning and analysis are ongoing. A manuscript will be prepared with these results in the second quarter of 2004.

#### Typhoid disease burden study

This study, in partnership with The Centres for Disease Control (Atlanta, GA in USA) began data collection in December 2003. By 31 December 2003, 69 blood cultures were positive for S. typhi (7.2%), of which 62% were less than 5 years of age. The case-control study was completed in February 2004 and will soon be analysed and published. The data from this present study is being analysed and a manuscript prepared. A manuscript for the pilot data conducted in 2001 has been prepared and is being submitted for publication.

#### Typhoid rapid diagnostic study

The rapid diagnostic tests of Typhidot® and Tubex™ have both shown higher than expected positive rates in this endemic community, likely reflecting the high prevalence of circulating antibody. These studies concluded in February 2004. Analysis and write-up is underway.

**Dengue hospital-based study**

In the hospital study, 163 suspected dengue cases were identified at Dhaka Medical College Hospital and Holy Family Red Crescent Hospital. Data collection was completed late in the reporting period. Data from these patients indicate that patients with DHF are more likely than febrile controls to have platelet count ≤ 100 thousands, positive tourniquet test, severe weakness, rash, abdominal pain, pruritus, and subconjunctival haemorrhage. This study demonstrated that ultrasonography, a non-invasive procedure, could be used in hospital to detect ascites (accumulation of fluid in serous cavities), and therefore likely cases of DHF. It also demonstrated that DHF was nearly three times more common among patients with at least one prior dengue infection than among first time dengue patients. Three abstracts from the hospital surveillance data were presented in the 10th ASCODD, held in Dhaka on 7-9 December 2003.

**Dengue community-based studies**

The NIH-funded community-based study completed a pre- and post-season cross-sectional sero-survey of approximately 800 people, to determine disease burden (incidence) and identify circulating dengue virus types. Longitudinal fever surveillance from a cohort of 21,000 persons was completed in January 2004. Neutralising antibody tests remain to be completed on the cross-sectional survey. One of the study team is being sent to Mahidol University in Thailand for a training seminar on the technique from 26 April to 06 May 2004.

**A Prospective, Randomized, Double Blind, Placebo-Controlled, Multi-Centre Trial to Assess Safety, Efficacy, Tolerability and Immunogenicity of Influenza Virus Vaccine, Trivalent, Types A & B, Live Cold-Adapted, Liquid Formulation (CAIV-T), Administered Concomitantly with a Combination Live, Attenuated, Mumps, Measles, and Rubella Vaccine in Healthy Children Aged 11 – 24 Months.**

Phase III multicentre efficacy, immunogenicity and tolerability study for licensing of an experimental live vaccine successfully enrolled and vaccinated 150 children, completing the data collection phase on 31 May. The study site was successfully closed on 30 January 2004. The site's performance was as follows:

| | |
|---|---|
| Date first subject enrolled: | 15 OCT 2002 |
| Date last subject enrolled: | 20 OCT 2002 |
| No. of screen failures : | 16 |
| No. of subjects enrolled : | 150 |
| No. of subjects who completed the study on 31 May 2003 : | 123 |
| No. of subjects who dropped out : | 27 |
| No. of subjects who received the first dose of the study vaccine : | 150 |
| No. of subjects who received the second dose of the study vaccine : | 138 |
| No. of SAEs reported from this site : | 5 |

## 3.2. On-Going Research Activities

### 3.2.1. Enteric Diseases

**Shigella burden of disease study**

This study, in partnership with International Vaccine Institute (IVI) began its second year of disease burden surveillance on a cohort of 20,000. As of 16 February 2004, there have been 3,498 stool specimens collected, from which 590 (16.4%) have had isolates. Of these, 466 (12.4% of total, 75.7% of isolation fraction) have been shigella. Features of shigella in the urban population include that 71% of the shigella cases are children less than five years old. The median age for shigella patients is 2.7 years. Children less than five years old continue to have nearly 20 times the risk (RR = 19.8; 95% CI 16.0, 24.6) of shigellosis than older children and adults.The study is under consideration to continue data collection until 30 June 2004.

**Shigella rapid diagnosis**

In late November 2003, ciprofloxacin and ofloxacin-resistant Sd1 was isolated from stool diarrhoea stool specimens from residents of a tea estate in northeastern Bangladesh. Surveillance is ongoing to detect a *Sd* 1 epidemic. Once an epidemic has been confirmed by the ICDDR,B laboratory, these patients will be asked to provide stool samples for the study. ICDDR,B and CDC scientists will compare the results of the rapid Shiga toxin ELISA test with PCR and with routine microbiologic stool culture to evaluate its effectiveness.

**Phase I/II safety and immunogenicity studies of Peru 15 (candidate for *V. cholerae* O1 in Bangladeshi children and adults)**

The adult component of the study, completed in 70 healthy men and women, was unblinded in December 2003 and results show that the vaccine is safe and without any major adverse effects. Immunogenicity of the vaccine in the Bangladeshi volunteers is also very encouraging with vaccine specific antibodies in a majority of vaccinees. Studies in the toddlers 2-5 years of age are being completed and the testing in infants will be initiated in early 2004.

### 3.2.2. Emerging and Re-emerging Diseases

**Nipah Virus**

The third outbreak of Nipah virus in Bangladesh occurred in January and February of 2004. Through 29 March 2004, 22 probable cases were identified in Bangladesh, including 11 laboratory confirmed cases; 17 (77%) died. While many were from Goalanda in Rajbari District, confirmed cases were also identified from as far as 150 kilometers away in Joypurhat, Naogaon, Faridpur, Gopalganj, and Manikganj Districts. The investigation is ongoing and includes a case-control study to evaluate risk factors for infection, which may be helpful in characterizing how illness was transmitted. A Nipah virus antibody prevalence study among 266 residents of Goalanda did not detect any antibody positive individuals. Over 450 animals, including bats, fowl, pigs, horses, goats, cows, rodents, shrews, cats and dogs were sampled and their specimens were tested for evidence of Nipah infection. Preliminary studies confirm that bats of the genus *Pteropus* have evidence of Nipah virus infection.

### 3.2.3. Vaccine Studies

**A randomised, placebo-controlled study of the safety, reactogenicity and immunogenicity of an orally administered human rotavirus vaccine (RIX4414) in healthy children in Bangladesh.** ICDDR,B has started a study on rotavirus vaccine in urban Dhaka to assess the reactogenicity and immunogenicity of a live, attenuated human-derived rotavirus vaccine (RIX4414) among young children. The second part of the study enrolled 340 infants who received either 2 doses of $10^{6.7}$ ffu (136 subjects), 3 doses of $10^{6.7}$ ffu (136 subjects) or placebo. Stool and blood samples were collected for rotavirus antigen detection and to measure rotavirus IgA antibody titres. The study will form the foundation for conducting Phase III studies of effectiveness and safety in Bangladesh.

### 3.2.4 Other On-going Investigations

**Etiology & Epidemiology of encephilitis**

ICDDR,B and CDC scientists are collecting epidemiological and clinical information, cerebrospinal fluid, and blood from patients with encephalitis at three main government hospitals in Bangladesh to create a profile of the aetiology and epidemiology of encephalitis in Bangladesh. This information will be used locally to prevent and manage this disease as well as to document emerging pathogens and to establish priorities for further research. Since recruitment began in June of 2003, approximately 170 patients have been enrolled in this surveillance project. Some samples have already been sent to CDC for testing and test results are expected in early 2004.

**Respiratory Virus Surveillance**

This study was approved in October 2003. It seeks to determine the disease burden of respiratory viruses in the urban poor population. In addition, the study seeks to determine the proportion of pneumonia and febrile disease caused by such viruses, and which specific viruses are most important. This study will be conducted in collaboration with the Centre for Disease Control and is a follow-on to an earlier pilot study that found a high proportion of influenza and metapneumovirus among febrile patients. Training and consent were completed in February 2004. It will be synchronised to begin with the pneumococcal disease burden study.

**Pneumococcal Disease Burden Surveillance**

This study was recently approved by the RRC/ERC in October 2003. This is part of a multicentre study in partnership with Johns Hopkins University, and is funded by GAVI's Accelerated Development and Introduction Plan (ADIP) for pneumococcal conjugate vaccines. This study will determine the *S.* Pneumoniae disease burden, and will look at prevalent serotypes, spectrum of illness, antimicrobial resistance patterns, and risk factors. It has a sentinel surveillance component in 7 hospitals around Bangladesh, and community based surveillance to determine disease burden in Mirzapur (rural) and Kamalapur (urban).

- In conjunction with the respiratory virus study, the Kamalapur field site expects to determine the attributable fraction of bacterial and non-bacterial pathogens for pneumonia disease burden in children less than five years old.
- Training and consent for the urban site, and is about to start for the rural site. Discussions are still underway with JHU on the revised budget, which has delayed the launching of data collection.

**Tuberculosis disease burden**

Tuberculosis disease burden urban surveillance began in March 2003 in Kamalapur. This study is ongoing and is conducted with sponsorship from DfID.

### 3.2.5. Collaborative Activities

NCID provides general support for the Programme on Infectious Diseases and Vaccine Sciences (PIDVS) at ICDDR,B, including the secondment of Dr. Robert Breiman and funding for administrative staff. Dr. Breiman has facilitated CDC-ICDDR,B scientific collaborations. Since 2000, approximately 40 CDC scientists and 9 EIS officers have worked directly with CDC-ICDDR,B projects.

### 3.3. Planned studies

**Efficacy of zinc in outpatient pneumonia among children less than 2 years old**

This study will be funded by the Gates Foundation, as part of the Zinc Scaling Up project, and is a follow-on to a similar study on severe pneumonia in hospitalised children. The objective will be to determine whether zinc can reduce the duration of illness for a broad spectrum of pneumonia in an outpatient setting, reduce the rate of treatment failure (including progression to severe pneumonia) and whether acute administration for pneumonia can affect the risk of subsequent illness. The study is being submitted for approval during the reporting period, and is projected to commence within the next two months.

## 4. Family Health Research Project

The mission of the Family Health Research Project (FHRP) is "to improve the health of the people of Bangladesh by improving the effectiveness of the Essential Services Package (ESP) that provides basic medical services to the families of the country with emphasis on improving services to vulnerable populations, and on developing new, more cost-effective methods for using resources

### 4.1. Leadership and Co-ordination, Management and Administration

Within FHRP support unit (Leadership, Coordination and Research Development-LCRD), activities continued to support the Centre's scientists in producing high quality research. The emphasis was on dissemination of completed studies, involvement of potential users of the research in the ongoing studies through Technical Interest Groups and demand-led development of new research proposals. Collaboration with the USAID supported NGO Service Delivery Programme in the areas of ARI, Safe Motherhood, Laboratory services and tuberculosis control was strengthened. The Operations Research Scientists continued to support the Centre's scientists in developing proposals, conducting research to high standards and disseminating findings through meetings, seminars and reports.

Existing databases were developed and new databases developed to provide ready information on logistics, human resources and financial aspects of the project to enhance the FHRP support unit's ability to provide information to Research Teams, under the Targeted research component, to ensure compliance with USAID regulations and to provide ad hoc information to the Population Health and Nutrition Team of USAID at short notice. A project coordinator report form was introduced into the Centres MIS system to provide easy access to information required for regular USAID reporting.

### 4.2. Research under development

In the reporting period seven of the 34 studies submitted for consideration for funding in July 2003 were revised to meet the demands of the Project Co-ordinator (Research) of the USAID PHN. At the end of this reporting period approval was pending on the following concept or protocol submissions.

- Role of private practitioners in the detection of active tuberculosis cases and their referral.
- Validity of prenatal syphilis screening
- Behavioral factors explaining drowning in children under 5 years of age and potential interventions
- Health seeking behaviors and needs of urban street dwellers
- IHI/AIDS high risk behaviors of migrant workers
- Demand side financing of community clinics
- Essential laboratory services: Baseline assessment of current practices and capacity in NGO and MOHFW sectors.

### 4.3. Surveillance sites

In the surveillance sites data was collected as set out in the Annual Work plan and mechanisms were developed to provide a user-friendly data set. A standardised verbal autopsy form was introduced into the field sites to improve compatibility between all the Centre's data surveillance field sites. A report of the surveillance activities for the years 2000 and 2001 was compiled and submitted to USAID in the reporting period and development the 2002 report commenced.

### 4.4. Targeted Research

Research projects were carefully monitored and were conducted as per individual monitoring and evaluation plans. The two ongoing studies from the former Operations Research Project were:

- Strategies for Prevention and Management of RTI/STD's: validity assessment of the syndromic management flow charts for vaginal discharge and
- Reproductive Health Services for Adolescents

Informal dissemination of the findings of these two studies continued in addition to more formal modes such as working papers and reports.

Several studies had been completed by the end of the reporting period; namely:

- Programmatic and non-programmatic determinants of low immunization coverage
- Community-based protocols Management of Severe Child Malnutrition: Cost and Cost Effectiveness Analyses of PSKP Services
- Rapid Assessment Tool for Better Health: Helping ESP managers to be more effective
  - Meeting Additional Family Health Needs of Clients by Addressing Missed Opportunities at the ESP Clinics
  - Plateauing of Bangladesh Fertility Decline

It has been noted that a high proportion of the studies completed activities with some funds to spare through maintaining a tight budget throughout. However a number of investigators underestimated the amount of time required to complete the final report writing and dissemination activities. This issue is under discussion at the Centre. Reminder systems have

been installed into the new MIS system to alert scientists and their supervisors of activities requiring their attention.

The remaining studies are continuing with either data analysis or on going interventions:

- An Effectiveness Study of *Haemophlus Influenzae* type b Vaccine The acceptability, effectiveness and cost of strategies designed to improve access to basic obstetric care in rural Bangladesh
  - Community-based Interventions to reduce neonatal mortality in Bangladesh The community-based component of the evaluation of the health and economic impact of the IMCI Strategy in Bangladesh
  - Introduction of new hypo-osmolar ORS to routine use (Assessment of unwantedness status of births
  - Study of NGOs introducing Depot Holders in three types of urban area: evaluation of cost effectiveness and impact after 6 months of community activities

Interest Groups, comprised of policy makers and programme implementers in the area of each study, continued to be held.

**5. Scaling Up Zinc for Young Children (SUZY) Project**

**The following has been taken from the first annual report to the Gates Foundation (the full report is available to BoT members upon request): The ultimate objective of the project is to implement and scale up a zinc treatment scheme in Bangladesh, which will reach all children during a diarrheal illness episode, regardless of socio-economic status, gender or where they live. Special emphasis will be given to reaching the poorest of the poor and malnourished children.**

**Accomplishments:**

- Local production of 200,000 zinc blister packs for research purposes
- Completion of baseline formative and observational studies of caretakers of children with active diarrheal illnesses
- Agreement obtained from Health Secretary, Ministry of Health and Welfare to create two committees that will assist with scaling up in the public sector: 1) planning and implementation committee, and 2) a steering committee headed by the Health Secretary
- Completed study protocols with scientific and ethical approval allowing us to implement safety monitoring and to assess acceptance of zinc tablets plus compliance with 10 day treatment schedule

As we proceed through the regulatory steps required to register the zinc tablet formulation and obtain an import permit, it is anticipated we may face a delay of 3 months in initiating the onset of the rollout. This should not lead to additional costs, but will set all related activities back a proportional period of time. At the onset of the Project it was not entirely clear what we would be required to complete in terms of drug registration and regulatory permits. It is now evident, as an initial step, the tablet formulation must be registered by SMC, who will also seek an importation license..

The one activity that has not unfolded as planned is the proposed zinc treatment effectiveness trial to be conducted in sub-Saharan Africa. The site selected, Ethiopia, had been part of a zinc consortium coordinated through Johns Hopkins University and supported by a USAID grant. Following discussions with the PI of this grant, it was concluded it would not be

feasible to proceed with an effectiveness trial in Ethiopia as initially planned. An alternative site in Mali was also considered, but it is now apparent the size of the sampling frame is inadequate. The Project PI will be discussing the possibility of implementing a trial in Kenya (in coordination with the newly established Centre for Emerging Infectious Diseases).

**Lessons Learned:**

- Partnerships, if they are to work, require a great deal of attention to detail and constant, transparent communication. This, in turn, translates into a large commitment of time.
- We need to keep assumptions to a minimum and, instead, aim to proceed in accordance with clearly agreed upon MOUs.
- Researchers/ICDDR,B staff have a lot to learn about the private sector, what motivates companies and why they would want to participate in this project (what you know you don't know).

## Objectives and Outcomes

| SL. | Objectives | Outcome Indicator | Baseline | Target | Progress |
|---|---|---|---|---|---|
| 1. | Sustainable local production of a dispersible zinc tablet formulation | Zinc premix is being produced, tablets compressed and packaged in Bangladesh by one-or-more laboratories | No capacity | Transfer of the technology and sustained local production of dispersible zinc tablets<br>>20 million packs/year | 1. Local compression and packaging of tablets for research purposes by Square Pharmaceuticals<br>2. Development of a technology transfer protocol by Nutriset and ICDDR,B<br>3. Identification of two local manufacturers with the required facilities and technical ability |
| 2. | Conducting research on zinc<br>In support of scaling up | The number of research projects successfully conducted.<br>Integration of research results into project design and implementation. | 4 concept papers | Completion of at least 8 investigations in support of zinc scale up | 3 investigations being conducted<br>3 studies being implemented<br>2 protocols ready for submission to RRC/ERC<br>1 concept paper prepared |
| 3. | Developing a marketing and promotion campaign for zinc tablets | 1. Marketing and promotion campaign concluded successfully.<br>2. Zinc tablets are established in the market<br>3. Zinc universally accepted by providers and caretakers as a treatment for childhood diarrhea | Unknown product | Universal awareness among caretakers of zinc as a treatment for childhood diarrhea is the eventual target – we will aim to reach 40% of caretakers within 2 years of onset | 1. Social Marketing Company has completed a business plan following consultations from Futures Group<br>2. Advertising agency RFP completed and an agency (Bitopi) selected<br>3. Branding RFP in progress<br>4. Willingness to pay protocol prepared |
| 4. | Distribution of zinc and integration of zinc treatment protocols into health services found in private, NGO, and public delivery systems | 1. Zinc tablets are available through providers and in most common outlets.<br>2. Zinc routinely prescribed for the treatment of childhood diarrhea | Non-existent | 1. Distribution of zinc to all of SMC network of providers/drug sellers<br>2. Distribution of zinc to all MOHFW static sites | 1. Pilot testing of zinc for acceptance completed in 4 sub-districts<br>2. Pilot training curriculum developed and conducted with SMC sales officers |

| | | | | | |
|---|---|---|---|---|---|
| | | | | all MOHFW static sites<br>3. Distribution to selected NGOs (NSDP, BRAC, PLAN)<br>4. 20% of childhood diarrhea episodes treated with zinc | officers<br>3. Agreement by Health Secretary to create planning and implementation committee within MOHFW |
| 5. | Dissemination of project results | 1. Local stakeholders are aware of and contribute to the SUZY project.<br>2. Internationally, interested parties have access to the strategies | Awareness limited to local and international partners | To have informed all interested professional and service institutions in the region of the zinc scale up project by means of:<br>a Project website<br>1 conference /yr<br>2 newsletters/yr<br>2 journal articles/yr<br>2 mass media articles/yr | 1. Project web-site created<br>2. Publications and conference presentations made. |
| 6. | Management of the SUZY project | The project is being implemented on time and with the resources available. | Project housed within and supported by ICDDR,B | 1. Administrative support for the successful conduct of the project<br>2. Budgetary control and routine preparation of financial statements | 1. Project management team in place<br>2. Procurement as per plan occurring<br>3. Monthly financial statements prepared and broken down by project activity centres |

**Outline of Research activities**

| Sl. | Activity | Output Indicator | Baseline | Target | Progress |
|---|---|---|---|---|---|
| 1. | Formative research project | Completed conduct of formative studies before and after the roll out of zinc as a treatment for childhood diarrhea | Insufficient knowledge of behavioral issues | To provide objective guidance to providers and promoters of zinc on behavioral aspects of zinc treatment | Baseline studies of caretakers of children with active diarrheal illness completed in one rural and one urban subdistrict. Provider interviews underway. |
| 2. | Observation study | Completed conduct of observational studies before and after the roll out of zinc as a treatment for childhood diarrhea | Insufficient knowledge of current diarrhea management practices | To document diarrhea management practices among providers and caretakers before and after the introduction of zinc treatment | Baseline observation of caretakers of children with active diarrheal illness completed in one rural and one urban subdistrict (not those included in 1).<br>Listing of linked providers to be observed/interviewed underway |
| 3. | Coverage survey | Information from all divisions, urban and rural population of Bangladesh detailing impact of introducing zinc treatment on other treatment practices, expenditures, and equity | Insufficient knowledge of treatment practices, expenditures and variation by gender, SES or geography | To know what impact zinc treatment is having on use of ORS, antibiotics, household expenditures and equity of utilization | Baseline coverage survey completed in one division |
| 4. | Safety study | On-going safety monitoring | No reported toxicity at recommended dose. Zinc is considered to be safe. | To identify and report potential side effects if they occur | Protocol has passed through RRC and ERC approval. Recruitment initiated. |
| 5. | Syrup vs. tablet RCT | To learn if either the syrup or tablet formulation has a distict advantage in terms of acceptance and adherance to | Unknown | Results to be used in finalizing the decision to promote zinc tablets only or both formulations | Protocol has passed through RRC and ERC approval. Recruitment initiated |

| | | | | | |
|---|---|---|---|---|---|
| | | acceptance and adherence to treatment instructions | | both formulations | |
| 6. | Duration of treatment study | To determine if shorter duration of treatment offers equivalent clinical benefits | Unknown | To decide whether shorter duration of treatment can be recommended | Protocol to be submitted to RRC in April |
| 7. | Zinc – pneumonia study | To establish the efficacy of zinc as a treatment for childhood pneumonia in a community-based population | Proven to be efficacious in hospital-based population | To be able to proceed, if efficacious, with introduction studies and an eventual scaling up effort | Protocol to be submitted to RRC in April |
| 8. | Zinc acceptance surveys | To determine if children will accept the dispersed zinc formulation and to assess treatment adherence (compliance) in rural and urban populations | All trials to date have not indicated problems with acceptance. Compliance is a problem. | To provide the information necessary for local production and marketing interests to commit themselves to a zinc tablet strategy | SMC sales officers trained and blister packs distributed to drug sellers in 4 subdistricts. FU household interviews indicate 75% acceptance, 99% correct preparation. A second study is planned to confirm these results and document adherence. |
| 9. | Zinc treatment vs supplementation: immune and clinical outcomes | To determine whether there are important added benefits to continuing with zinc supplementation following treatment. And, if so, why. | Unknown. No reported trials. | To be able to decide if the zinc treatment approach to the prevention of diarrhea and other infectious illnesses is adequate or whether supplementation offers important added value. Also, to match outcomes among a sub-set with ETEC diarrhea with changes in immune status | Protocol to be submitted to RRC in April |

**6. Surveillance & Data Resources Unit**

### 6.1. Completed and on-going activities

The unit is responsible for the preparation of routine surveillance reports as well as assisting investigators within the division in planning for data collection and analyses. Activities completed over the past 6 months include the following:

- Preparation of the HSID Surveillance Report for 2000 and 2001.
- Assistance to the questionnaire design and preparation of the data entry and editing programs for several surveys. These include surveys on the Nipah virus outbreak, for the SUZY project and the Shigella study.
- Coding, entering and cleaning of the surveillance data from the rural Abhoynagar/Keshobpur and Mirsarai sites, including preparation of the three-monthly surveillance reports. The data of the first surveillance round of urban Kamalapur were also processed.
- Printing of the surveillance books for the rural sites.
- Preparation of the new verbal autopsy questionnaires in collaboration with the Fields Sites Unit and the Infectious Diseases Unit. From January 2004 onwards ICD 10 codes are used instead of ICD 9.
- Provision of statistical analysis expertise to the HIV/AIDS Programme.
- Participation in INDEPTH workshops on surveillance databases, HIV/AIDS surveillance, multi-level models and adult health and aging. INDEPTH stands for International Network of field sites with continuous Demographic Evaluation of Populations and Their Health in developing countries. It unites almost 40 surveillance organisations in Africa and Asia. The HSID Surveillance System is one of the members.
- As head of the technical committee for the Management Information System, the unit head took part in the prototype workshop in Kolkata and was involved in the testing, debugging and implementation of this MIS.
- Redesigning of the HSID surveillance databases continues to improve its accessibility and user friendliness.

## 7. Field Sites Unit

Demographic and programmatic Surveillance is continuing in both rural field sites (Abhoynagar/ Keshobpur and Mirsarai). To standardize data collection and codes, a verbal Autopsy Questionnaire (VAQ) using ICD-10 has been introduced. Utilizing surveillance data, three oral and two poster presentations have been made at ASCODD 2003. The following health system research studies have been completed or are under progress in two rural sites.

### 7.1. Abhoynagar

- Programmatic and Non-programmatic Determinants of Low Immunization Coverage in Rural Bangladesh (completed).
- Use of ESP Services in the Transition to Static Clinic System in Two Rural Upazilas: 1998-2000 (completed).

### 7.2. Mirsarai

- Randomized, Double blind controlled Trial of Wheat Flour (Chapatti) Fortified with Vitamin A and Iron in Improving Vitamin A and Iron Status in Healthy School Aged Children in Rural Bangladesh (completed)
- Meeting additional family health needs of clients by addressing missed opportunities at the ESP clinic (completed).
- Incident case study of acute childhood diarrhea: Phase 1 baseline study prior to role out of zinc as a treatment for childhood diarrhea (in progress).
- Programmatic and Non-programmatic Determinants of Low Immunization Coverage in Rural Bangl;adesh
- Use of ESP Services in the Transition to Static Clinic System in Two Rural Upazilas: 1998-2000 (completed)
- Green banana diet for the treatment of acute and persistent childhood diarrhea (being implemented)

## 8. Other Information

Dr. Beena Varghese was nominated by GAVI to be a member of the GAVI International Review Committee. She is serving as a member of the Financial Sustainability Review Team. She participated in the first FSP review held at the GAVI Secretariat in Geneva during February 2004.

# Information Science Division

## CIS/DMU

- CIS were involved in the preparatory work for the implementation of Navision in February, and since then have been working on the fine tuning and training
- CIS and DMU are providing the help desk services for Navision
- Maintenance of the Navision server has now been added to CIS routine tasks
- CIS have installed the firewall and all computers on the Centre's network are now protected

## TEU

- WHO Regioal Training Workshop on the Management of Severe Childhood Malnutrition - supported by DFID under the Poverty and Health Programme – May
- Emergency response to cholera and shigella epidemics – OFDA/USAID – April
- Emerging Infections for Japanese Physicians – JICWELS – March
- Introductory Course on Epidemiology and Biostatistics – Self-funding – February

## DISC

- Heavily involved in the management of abstracts submitted for ASCODD in December
- Design, layout and production of abstracts book, souvenir programme and ancillary printed materials for ASCODD
- Recently much concerned with production of 2003 Annual Report
- Special issue of JHPN devoted to Health Equity produced late 2003
- *Smriti; ICDDR,B in memory* published for 25th Anniversary

## ACTIVITY REPORT OF MANDATORY COMMITTEES, June 2004

**Research Review Committee (RRC):**
The RRC met 6 times during the reporting period and reviewed 19 research proposals out of which 15 were approved and the other four are in process for approval. Moreover, the RRC considered 10 addendum proposals, requests for time extension of a number of research proposals for the approved protocols.

**Ethical Review Committee (ERC):**
The ERC met 7 times during the period and considered 16 protocols and 10 addendum proposals to the previously approved protocols.

Mr. Mohammadullah, one of the ERC members, completed 6-year and he was replaced by Ms. Rabia Khatun, Principal, College of Nursing.

## Staff Development

Each year the Centre sends some staff abroad for training using a budget of about $50,000 from its core budget. Staff development needs are determined firstly on the basis of the capacity that needs to be developed and secondly on the desires and aspirations of the staff involved. The tables on the following pages show the details of the persons who have been on staff development.

| | | |
|---|---|---|
| 1. Number of staff returned during the period after completing training /study | | 10 |
| - PhD | 4* | |
| - Masters | 1 | |
| - Short focused training | 5 | |
| 2. Number of staff who left for study/training | | 10 |
| - PhD | 4** | |
| - Masters | 2 | |
| - Short focused training | 4 | |
| 3. Total number of staff abroad on study/training | | 32 |
| - Postdoctoral training | 1 | |
| - PhD | 21 | |
| - Masters | 8 | |
| - Short focused training | 2 | |

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* Three staff returned after completing the partial requirement and now conducting research for dissertation for PhD degree.

** One of them left to return to the Centre after completing partial requirement for PhD degree to conduct research for dissertation at the Centre.

## STAFF RETURNED AFTER COMPLETING OVERSEAS STUDY OR TRAINING
## 1 October 2003 – 31 March 2004

| Sl # | Name of the Staff Members | Outcome of training/Study |
|---|---|---|
| 1 | Dr. Md. Munirul Islam<br>Medical Officer<br>CSD | Completed the course work for PhD degree in Nutrition and returned to conduct research for doctoral dissertation |
| 2 | Ms. Shirajum Monira<br>Research Officer<br>RTI/STI Lab.,LSD | Attended course on Microbiology at the Conservetoire Nationale des Arts et Metiers (CNAM), Paris, France. |
| 3 | Dr. AM Waheedul Hoque<br>Research Investigator<br>Child Health Unit, PHSD | Completed partial requirement only and now conducting research for dissertation for PhD degree in Epidemiology. |
| 4 | Dr. Kaisar Ali Talukder<br>Assistant Scientist<br>LSD | Attended course to learn advanced techniques of molecular biology on PCR, knocking down gene expression by siRNA, SSCP, Western, Northern and Southern blotting, and mammalian cell at the University of Medicine and Dentistry of New Jersey, and Robert Wood Johnson Medical School, USA. |
| 5 | Dr. Rubina Shaheen<br>Sr. Medical Officer<br>Reproductive Health, PHSD | Completed partial requirement only and now conducting research for dissertation for PhD degree in Epidemiology and Public Health at the Umea University, Sweden. |
| 6 | Dr.Dilruba Ahmed<br>Senior Scientific Officer<br>Clinical Laboratory Services Program<br>LSD | Obtained PhD degree in Microbiology from University of Otago, New Zealand. |
| 7 | Ms. Zinat Ferdous<br>Sr. Research Assistant<br>Health & Demographic Surveillance Unit, PHSD | Completed masters programme in Demography at Australian National University, Australia |
| 8 | Mr. Samiran Barua<br>Programmer, HDSU<br>PHSD | Attended course on Oracle Programming & Database Administration at the SQL Start International, Kolkata, India |
| 9 | Dr. Md. Manirul Islam<br>Training Physician<br>Training and Education Unit, Information Sciences Division | Attend a training programme in Sphere at the Asian Institute of Technology, Bangkok, Thailand. |
| 10 | Ms. Ferdousy Begum<br>Sr. Research Assistant<br>Breastfeeding Counseling Programme<br>CSD | Attended a training programme on maternal and child nutrition at the London School of Hygiene and Tropical Medicine, UK |

# STAFF WHO LEFT TO BEGIN OVERSEAS STUDY OR TRAINING
## 1 October 2003 - 31 March 2004

| Sl # | Name of the Staff Members | **Field of Study/Training and Institution** |
|---|---|---|
| 1 | Ms. Shereen Shoma Mohsin<br>Senior Research Officer<br>ARI Lab., LSD | Doctoral Programme in Clinical Bacteriology at the Department of Microbiology, Graduate School of Medicine, Kyoto University, Japan. |
| 2* | Dr. Rubina Shaheen<br>Sr. Medical Officer<br>Reproductive Health, PHSD | Doctoral programme (sandwich model) in Epidemiology and Public Health at the Umea University, Sweden. |
| 3* | Mr. Samiran Barua<br>Programmer, HDSU<br>PHSD | To attended a training course on Oracle Programming & Database Administration at the SQL Start International, Kolkata, India |
| 4 | Mr. Mohammad Aminul Islam, Research Officer<br>Enteric Bacteriology Lab.<br>Lab. Sciences Division | Doctoral programme (sandwich model) in Molecular Biology at Inspectorate for Health Protection and Veterinary Public Health, Zutphen, the Netherlands |
| 5* | Dr. Md. Manirul Islam<br>Training Physician<br>Training and Education Unit,<br>Information Sciences Division | To attend a training programme in Sphere at the Asian Institute of Technology, Bangkok, Thailand. |
| 6 | Ms. Ferdousy Begum<br>Sr. Research Assistant<br>Breastfeeding Counseling Programme, CSD | To attend a training programme on maternal and child nutrition at the London School of Hygiene and Tropical Medicine, UK |
| 7 | Dr. Sirajuddin Ahmed<br>Medical Officer, Epidemic Control Preparedness Unit, PHSD | Master's programme in International Public Health Programme at the University of Sydney, Australia. |
| 8 | Dr. Kaisar Ali Talukder<br>Enteric Microbiology Laboratory, LSD | Orientation training on molecular mechanism of bacterial pathogenesis at the Department of Pharmacology, Robert Wood Johnson Medical School of UMDNJ, USA. |
| 9 | Dr. Mohammad Enamul Hoque<br>Research Officer<br>Social and Behavioural Sciences Unit, PHSD | Masters programme in Public Health at the University of Queensland, Australia. |
| 10 | Dr. Kaniz Gausia<br>Medical Officer<br>Reproductive Health Unit, PHSD | Doctoral Programme in Public Health at Edith Cowan University, (ECUIS), Perth, Australia. |

* Returned to the Centre.

**Distribution by discipline and outcome of study/ training of staff members abroad as on 31st March 2004**

| Field of training | PhD* (n= 22) | Masters (n= 8) | Training (n= 2) | Total (n= 32) |
|---|---|---|---|---|
| Population studies | 1 | | | 1 |
| Health Economics | 3 | | | 3 |
| Interdisciplinary studies | 1 | | | 1 |
| Women's studies /Reproductive Health | 3 | | | 3 |
| Anthropology | 1 | | | 1 |
| Mathematical Statistics | 1 | | | 1 |
| Molecular parasitology /Molecular Biology/ Bacterial Pathogenesis | 2 | | 1 | 3 |
| Sociology | 1 | | | 1 |
| Microbiology / Clinical Bacteriology / Immunology | 3 | | 1 | 4 |
| Bioinformatics | | 1 | | 1 |
| Nutritional Immunology/Nutrition/ Maternal & Child Nutrition | 4 | | | 4 |
| Demography | 1 | | | 1 |
| International Public Health / Public Health | 1 | 4 | | 5 |
| Clinical Pharmacology | | 1 | | 1 |
| Epidemiology | | 1 | | 1 |
| Public Administration | | 1 | | 1 |
| | | | | |

* One postdoctoral fellowship training

## STAFF WHO ARE ON OVERSEAS STUDY OR TRAINING
## AS OF 31 MARCH 2004

| Sl # | Name of the Staff Members | **Field of Study/Training and Institution** |
|---|---|---|
| 1 | Mr. Abdullah Al Mamum<br>Senior Research Officer<br>Health Economics Unit (HEU), Public Health Sciences Division (PHSD) | Postdoctoral fellowship training Population Studies at University of Queensland, Australia. |
| 2 | Dr. Suhaila H. Khan<br>Sr. Operations Researcher<br>HEU, PHSD | Doctoral Programme in Health Economics at the Dept. of International Health, Tulane School of Public Health in New Orleans, USA. |
| 3 | Dr. Sharful Islam Khan<br>Research Fellow<br>Social and Behavioural Sciences Unit (SBSU), PHSD | Doctoral Programme in Interdisciplinary studies with special focus on RH and Sexual Health at the Edith Cowan University (ECU), Perth, Australia |
| 4 | Mr. Ashraful A. Neeloy<br>Senior Research Officer<br>SBSU, PHSD | Doctoral Programme in Anthropology (focused on health culture) at Australian National University (ANU), Australia |
| 5 | Mr. Ariful Islam<br>Operations Researcher<br>FHRP, HSID | Doctoral Programme in Statistics at Southern Methodist University, Dallas, TX, USA |
| 6 | Dr. Disha Ali<br>Research Investigator<br>HEU, PHSD | Doctoral Programme in Health Economics at the Department of International Health and Development, Tulane School of Public Health, USA |
| 7 | Mr. Ibne Karim Md. Ali<br>Sr. Research Officer<br>Parasitology, Lab, LSD | Doctoral Programme in Molecular Parasitology at the London School of Hygiene and Tropical Medicine, UK |
| 8 | Ms. Sabrina Rasheed.<br>Research Officer<br>SBSU, PHSD | Doctoral Programme in Maternal and Child Nutrition at Cornell University, USA. |
| 9 | Dr. Quamrun Nahar<br>Sr. Operations Researcher<br>FHRP, HSID | Doctoral Programme in Sociology at the University of Hawaii, USA |
| 10 | Ms Parveen A Khanum<br>Operations Researcher<br>FHRP, HSID | Doctoral Programme (Women's Studies) at Monash University, Australia |
| 11 | Dr. Kuntal Kr. Saha<br>Assistant Scientist<br>CHU, PHSD | Doctoral Programme in Maternal and Child Nutrition at Cornell University, USA |

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| 12 | Ms. Papreen Nahar<br>Research Investigator<br>SBSU, PHSD | Doctoral Programme in Women's studies with major in Medical Anthropology at School of Political & Social Inquiry, Dept. of Women's studies, Monash University, Australia. |
| 13 | Dr. Shakil Ahmed<br>Sr. Operations Researcher<br>HEU, PHSD | Doctoral Programme in Health Economics at Tulane university, USA. |
| 14 | Mr. Zahid Hayat Mahmud<br>Research Officer Environmental Microbiology, LSD | Doctoral Programme in Microbiology at University of Tokushima, Japan. |
| 15 | Mr. Md. Maqsud Hossain<br>Research Officer<br>RTI/STI Lab, LSD | Master's Programme in Bioinformatics at University of Abertay Dundee, Scotland, UK |
| 16 | Dr. Tanvir Ahmed<br>Sr. Research Investigator<br>Immunology Lab., LSD | Postdoctoral training in Nutritional Immunology at the Tufts University, USA. |
| 17 | Mr. Mohammad Bakhtiar Hossain<br>Research Officer<br>Parasitology Lab. LSD | Doctoral Programme in Nutrition at University of California Davis, USA. |
| 18 | Dr. ASM Mesbahoul Alam Medical Officer<br>ECPP, PHSD | Master's programme in International Public Health at University of Sydney, Australia. |
| 19 | Dr. Rumana A. Saifi***<br>Senior Research Officer<br>FHRP, HSID | Doctoral programme in Demography at the Institute for Population and Social Research, Mahidol University, Thailand. |
| 20 | Dr. Md. Saifur Rahman<br>Senior Operations Researcher, FHRP, HSID | Doctoral Programme in Reproductive Health Epidemiology at the Australian National University, Australia. |
| 21 | Dr. Wasif Ali Khan<br>Assistant Scientist<br>CSD | Master's programme in Clinical Pharmacology (supervisor – Dr. Craig W. Hendriz), at the Division of Clinical Pharmacology, the Johns Hopkins University School of Medicine, USA. |
| 22 | Mr. Firoz Ahmed<br>Senior Research Officer<br>Immunology Unit, LSD | Doctoral Programme in Immunology at the Institut Pasteur, Paris, France |
| 23 | Dr. Anwarul Iqbal<br>Medical Officer<br>ECPP, PHSD | MPH programme at Umea University, Sweden. |
| 24 | Dr. Kazi M. Rahman<br>Research Investigator<br>Child Health Unit (CHU), PHSD | M. Sc. Programme in Epidemiology at the Harvard School of Public Health, Harvard University, USA. |
| 25 | Mr. Shakeel Al Mahmood<br>Sr. Administrative Officer, FHRP, HSID | Master leading to Doctoral programme in Public Administration (specialization in Health Care Administration) at University of Maine, USA. |

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| 26 | Ms. Shereen Shoma Mohsin<br>Senior Research Officer<br>ARI Laboratory, LSD | Doctoral Programme in Clinical Bacteriology at the Dept. of Microbiology, Graduate School of Medicine, Kyoto University, Japan. |
| 27 | Mr. Md. Ashfaqul Alam<br>Research Officer<br>Immunology Lab, LSD | Training in microbiology/immunology at the Massachusetts General Hospital and Harvard Medical School, USA. |
| 28 | Mr. M Aminul Islam<br>Sr. Research Officer<br>Enteric Bacteriology Laboratory, LSD | Doctoral Programme (sandwich model) in Molecular Biology at Inspectorate for Health Protection and Veterinary Public Health, Zutphen, the Netherlands. |
| 29 | Dr. Sirajuddin Ahmed<br>Medical Officer, ECPP<br>PHSD | Master's programme in International Public Health Programme at the University of Sydney, Australia. |
| 30 | Dr. Kaisar Ali Talukder<br>Enteric Microbiology Laboratory, LSD | To attend orientation training on molecular mechanism of bacterial pathogenesis at the Department of Pharmacology, Robert Wood Johnson Medical School of UMDNJ, USA. |
| 31 | Dr. Mohammad Enamul Hoque<br>Research Officer<br>Social and Behavioural Sciences Unit, PHSD | Masters programme in Public Health at the University of Queensland, Australia. |
| 32 | Dr. Kaniz Gausia<br>Medical Officer<br>Reproductive Health Unit, PHSD | Doctoral Programme in Public Health at Edith Cowan University, (ECUIS), Perth, Australia. |

*** no guarantee for employment on return after completion of her study.

# Laboratory Sciences Division

**No. of Publications from (November 2003 to March 2004) : 20**

**No. of Publications in Press : 5**

**No. of Protocols ongoing : 35**

**No. of Protocols completed : 6**

## Important Achievements of the Laboratory Sciences Division:

**Cholera vaccine trials.** The first study in Bangladesh of a live oral cholera vaccine, Peru 15 is progressing at ICDDR,B in a dose escalating and age decreasing design. The study has been completed in 70 healthy men and women and 120 toddlers. Results unblinded in the adults show that the vaccines did now have any major adverse effects. Immunogenicity of the vaccine in the Bangladeshi volunteers was also very encouraging with vaccine specific antibodies in a majority of vaccinees, and in nearly all of those with low baseline titers. Studies in the toddlers 2-5 years of age are being completed and the testing in infants have been initiated.

***V. cholerae* O139 and O1.** *V. cholerae* O139 strains isolated in the spring of 2002 show increased susceptibility to killing in the complement mediated antibody assay as well as by neutrophils. This may be due to loss of the capsule which is commonly seen in O139 strains.

Cholera patients infected with *V. cholerae* O1 and 0139 show mucosal and systemic immune responses to the El tor toxin co-regulated pilus antigen (TcpA). These results demonstrate that TcpA is immunogenic following natural *V. cholerae* infection and that this antigen should be a component of a vaccine to improve protective efficacy.

The National Institute of Health (NIH) supported project entitled "Epidemiology and Ecology of *Vibrio cholerae* in Bangladesh" is operating NIH-environmental surveillance in south-western brackish-water environment of Bangladesh for the next four years. Faculty from the Department of Microbiology, University of Dhaka has been appointed as Consultant of this project. The team already started environmental sampling in Mathbaria and Bakerganj. The project required a renovation of the enteric laboratory and this was accomplished during early 2004.

**Zinc and Immunity**. A short course zinc, given as adjunct therapy for treatment of acute shigellosis resulted in significant induction of IpA specific IgA antibodies , increased lymphocyte proliferation response and *Shigella* spp specific serum bactericidal activity. This confirms one mechanism of action of zinc in the immune system.

**Tuberculosis.** Sixty-four strains of *Mycobacterium tuberculosis* complex isolated from tuberculosis patients of Matlab were genotyped following Spoligotyping technique. These spoligo patterns were matched with the International spoligo database located at the National Mycobacteria Reference Laboratory of the Netherlands. It was observed that among 64 strains, 18 were unique i.e. new in the Database. These results indicate existence of new types of *M. tuberculosis* complex strains in Bangladesh.

Regarding antimicrobial resistance of tuberculosis, a total of 115 sputum samples from suspected MDR-TB patients (previously treated) from the National Institute of Chest Diseases Hospital (NIDCH) was investigated. Culture and sensitivity testing was done using rapid Mycobacteria Growth Indicator Tube (MGIT) method. The mean time to detection of *Mycobacterium tuberculosis* from clinical specimens using MGIT was 9.3 days. Out of 115 samples 89 (77%) was found to be resistant to one or more anti-tubercular drugs and 47% were found to be MDR-TB cases (resistant to both isoniazid and rifampicin). Deletion analysis and PCR-RFLP of *rpoB* gene reveal that all strains are *M. tuberculosis*, 35% were ancestral type and 65% were of modern type. Of the modern strains 35% were Beijing strains which are known to be associated with resistance to conventional anti-TB drugs.

A rapid test for active tuberculosis was developed using antibodies specific for tuberculosis detected in secretions of lymphocytes. This method can also be used for detecting latent TB in exposed, asymptomatic contacts at an early stage of infection. The method for identifying active tuberculosis patients has been patented in the US.

A specimen bank for tuberculosis has been initiated at ICDDR,B. This project is initiated and funded by WHO/TDR in joint collaboration with USAID. The bank will include sputum, serum and antibodies in lymphocyte supernatant from about 200 patients testing positive for TB from whom samples will also be tested for HIV. These specimens will be housed in a WHO designated distributor in the USA and will be available for assessment of newly developed diagnostic methods for TB.

**Amebiasis.** The NIH has renewed our Mirpur cohort study on amebiasis titled "Field studies of human immunity to amebiasis". Recently we have expanded this cohort study and we are following over 400 children prospectively to understand acquired immunity and community impact of amebiasis. We have looked at the HLA class II alleles in our cohort children. We have identified a potential protective association with the class II allele DQB1*601 and the DQB1*601-DRB1* 1501 haplotype with *E. histolytica* infection among the cohort children followed over a 3 years period.

**Vitamin A.** Based on usual pattern of food intake, vitamin A deficiency is high among Bangladeshi children. But there is inconsistent association among serum retinol and usual pattern of food or Consumption Index and that could be due to inability of IVACG recommended method to capture actual food intake or unreliable food composition database. Studies are being considered to re-define

**Microbiology Consultancy in Africa.** As requested by the International Vaccine Institute (IVI) and the Ministry of Health, Mozambique, Mr. M Ansaruzzaman visited twice (December, 2003 and Feb-Mar, 2004) to the Laboratory of Hygiene, Water and Food, Beira, Mozambique to help set up a standard microbiology laboratory and trained laboratory staff for isolation and identification of *V.cholerae* and related organisms. The results from the isolations will help analysis of a case control study after mass oral cholera vaccination which was being conducted by MSF, WHO, and MOH, Mozambique) in a cholera epidemic area at Beira, Mozambique. The study has been progressing well with the correct isolation and identification of *V.cholerae* O1 by stool culture and a rapid diagnosis by IP dipstick method. Strains from Mozambique are genetically unique, and these genetic results, including genotyping the strains and gene sequencing of selected genes were accomplished in Dhaka within 2 months of their isolation. We will be submitting a joint publication with the workers in Mozambique, IVI, WHO, and MSF shortly.

**Recently Achievements in Laboratory Sciences Division.**
A new diagnostic set up has been initiated under clinical laboratory services for molecular and serodiagnostic services for the paying users and internal patients including research protocols. Initially, the laboratory will estimate viral load for hepatitis B and hepatitis C and determine genotyping of hepatitis C, in addition to its routine activities of serodiagnosis of infectious diseases and some tumor markers.

Physical facilities of the clinical laboratory services have been improved further by adding automation in blood culture in clinical microbiology; PCR, electrophoresis and ELISA reader for molecular and serodiagnostic laboratory. Out patients area has also been improved by adding audio-visual system for waiting patients.

Laboratory management software has been developed and is on trial from March 16, 2004 and will be operating live from April 1, 2004. This will replace the manual method to automation in total management of the laboratory.

A diagnostic laboratory has been opened at the Chakaria field project site to support the project activities and to provide Laboratory diagnostic services for the local paying users.

As Bio-safety is an important issue for the LSD and the centre, Biomedical Engineering Unit has been actively participating in implementation of LSD's Fire Control and Protection Scheme. It is also working out in materializing the integrated Bio-safety plan for the centre. It played commendable role in management of Medical Waste and contributed positively in the National policy level.

The TB lab has recently been upgraded to achieve Safety Level III compliances. BMEU is continuing to support the BSMMU to maintain their Safety Level III lab. As part of assistance towards National Institutions, BMEU had offered technical expertise in overcoming the problems with the Intravenous Fluid Plant of IPH.

# Public Health Sciences Division

1. Organogram: Attached

2. Number of scientists and staff with changes made during Sept-March period
   - Greet Dieltiens completed her tenure and left ICDDR,B (March)
   - Dr Ishtiaq Bashir, Senior Medical Officer has been reassigned from RHU to ECPU

3. Publications: Attached

4. Physical space offices, hospitals, field areas with maps and photographs
   Renovation works completed for PHSD offices in Dhaka
   And out-patient dept and 3 sub centers in Matlab

**5. Progress on major ongoing activities**

5(1) **Arsenic and health**

The project aims at determining the associations between arsenic exposure and health effects. It includes screening of the entire population for early arsenic-induced effects in the form of skin lesions, and assessment of arsenic exposure based on concentrations in all tube wells, in combination with retrospective histories of water sources over time, as well as concentrations in urine. In cases of elevated arsenic concentrations, mitigation activities are initiated.

**Water arsenic analysis.** ***The distribution of arsenic concentration in tube wells in Matlab is shown by using either the available AAS results or, if not yet analysed, the original screening data. Median arsenic concentration is 179 µg/L.***

Table 1. Tube well water arsenic concentration in Matlab, Bangladesh (Analysed by AAS, so far n=8639 and for the remaining tube wells by E-Merck, n=4719)

| As concentration µg/L | n | % |
|---|---|---|
| 0 | 2840 | 21.3% |
| 1-9 | 440 | 3.3% |
| 10-49 | 1696 | 12.7% |
| 50-99 | 828 | 6.2% |
| 100-499 | 6277 | 47.0% |
| >=500 | 1277 | 9.6% |
| Total | 13358 | 100% |

*Arsenic skin cases.* In total, 504 individuals were identified in the three-step screening procedure with skin lesions that were confirmed to be arsenic-induced by expert assessments. Male cases were more common than female. Majority of

cases were from age group of 31-40. The youngest case identified was a 10-year-old girl. The analysis of arsenic exposure over time and the risk of skin lesions also in relation to age and gender will be analysed after completing the analyses of concentrations by AAS within the next few months. 1579 referents were randomnly selected from HDSS. Almost 1000 urine samples have, so far, been analyzed for arsenic. The average concentration is 137 μg/L, which is more than 10 time higher than in non-exposed populations. This demonstrates that the people are highly exposed to arsenic via the drinking water. Plasma samples are currently being analyzed at UC Davis for micronutrients e.g. serum iron, zinc, selenium, vitamin B12 and folate.

*Mitigation activities.* The mitigation component of the project aims at providing safe water options in arsenic affected areas in Matlab through a participatory process with the villagers. Community meetings have been organized in the villages before and after testing of tube well water. The post-testing meeting has been arranged to inform the villagers and their Village Arsenic Mitigation Committees about the arsenic problem in their area and to discuss mitigation options. Priority has been given to villages with a high prevalence of contaminated tube wells. BRAC has also initiated People's Theatre for delivering messages and initiate discussion with the community regarding arsenic mitigation. In a follow-up survey BRAC has made a rapid assessment of the mitigation process so far. After the initial screening it is estimated that half of the households with "red" tube wells, i.e. tube wells with water concentrations above the permissible concentration, have shifted to a green tube well in the neighbourhood. Another 10-15% had started to use some of the alternative water sources or safe water options that already have been installed or distributed in Matlab by BRAC.

***Arsenic and reproduction***

This study incepted in November 2001. About 5000 pregnant women have been identified by the CHRWs and subsequently 4436 women have been enrolled in the MINIMat study. Recruitment ended in November 2003. Data collection and entry are going on simultaneously. Urine samples in early pregnancy (week 6-8) from the about 2600 women recruited during 2002 have been analysed for arsenic. The overall average urinary arsenic concentration is 100 μg/L, but there is considerable variation between individuals, from about 10 to more than 1800 μg/L. Also, there are obvious differences between the geographical blocks in Matlab. About 440 urine samples have, so far, been analyzed for the various arsenic metabolites. The metabolite pattern seems to be similar to those reported from most other places, i.e. 17% inorganic arsenic, 14% MMA and 69% DMA. However, there is a large inter-individual variation. For example, the fraction of urinary MMA varies from 4 to 30%. Table 3.Number of children tested with the various developmental tests

| Age | Psychomotor test | Number of children tested |
|---|---|---|
| 7 months | Milestone | 1742 |
| 12 months | Home inventory | 140 |
| 18 months | Home inventory | 121 |

*AsMat follow-up.* The plans for the continued "*Arsenic and Health*" project during the period 2003-2006 include a number of activities related to exposure, health effects and mitigation activities. Currently the field workers interviewed 3900 household and the physicians assessed 100 cases for reversibility.

5(2) **Combined Interventions to Promote Maternal and Infant Health (MINIMat)– a study in Matlab.**

MINIMat is a large multi-component intervention study to understand how to improve maternal and foetal nutrition, and child growth. The initial project will require four years to complete and has multiple components. However the long-term studies will continue to have rewards for at least 20 years as we learn the long-term consequences of low birth weight and the benefits of the interventions. The project is also a unique example of collaboration with more than 40 investigators from 10 institutions/partners participating. Apart from ICDDR,B, these partners include BRAC, GoB, Cornell University, London School of Hygiene & Tropical Medicine, Institute of Child Health - London; Umeå University; UC Davis, London University, National Inst of Public Health - Mexico, Barts Hospital - London, Uppsala University, and Karolinska Institute. This research initiative is being implemented in Matlab in the context of the NNP interventions and with support from UNICEF, DFiD and many other sources Enrolment started in November 2001 and was completed 24 months later in October 2003. A total of 4,436 pregnant women were enrolled. On average, the women gained about 5.65 kg by week 30 of pregnancy. However, a substantial proportion of the women actually lost weight during pregnancy. By March 2004, about 3,400 babies were born. The last birth among the MINIMat women is expected by June 2004. In the study we are following the women who receive food and micronutrient supplements during pregnancy through a full reproductive cycle.Compared to previous years before the study, there had been an overall increase in the proportion of institutional deliveries (overall approximately 40%). The overall prevalence of LBW in the study population is 37% (based on data available at this time). Mean birth weight was 2,613 g (SD=427) (Figure 1). The study had measured gestational age (GA) using both ultrasound and LMP (Figure 2). The mean GA is exactly the same (38.6 weeks) from the two methods, but the LMP-based methods are more variable, i.e., the distribution for the LMP-based estimates has longer tails. A consequence of this is that the estimated pre-term prevalence is higher using LMP (14.1%) compared with ultrasound (10.1%).

Some of the unique components of the study include assessments of food security, determinants of compliance of supplementation, workload during pregnancy, dietary intake, violence and stress - including measurement of salivary cortisol, serial foetal ultrasound, breast-milk intake using deuterium, child cognitive and motor development, infant immune function (thymus ultrsound, cells, breastmilk), and arsenic and reproductive functions. There is a nested randomized treatment trial for bacterial vaginosis and the MINIMat mothers into their next pregnancy upto 12 months post partum.

**Figure 1: Distribution of births by birth weight as of 31 October 2003 – MINIMat Study**

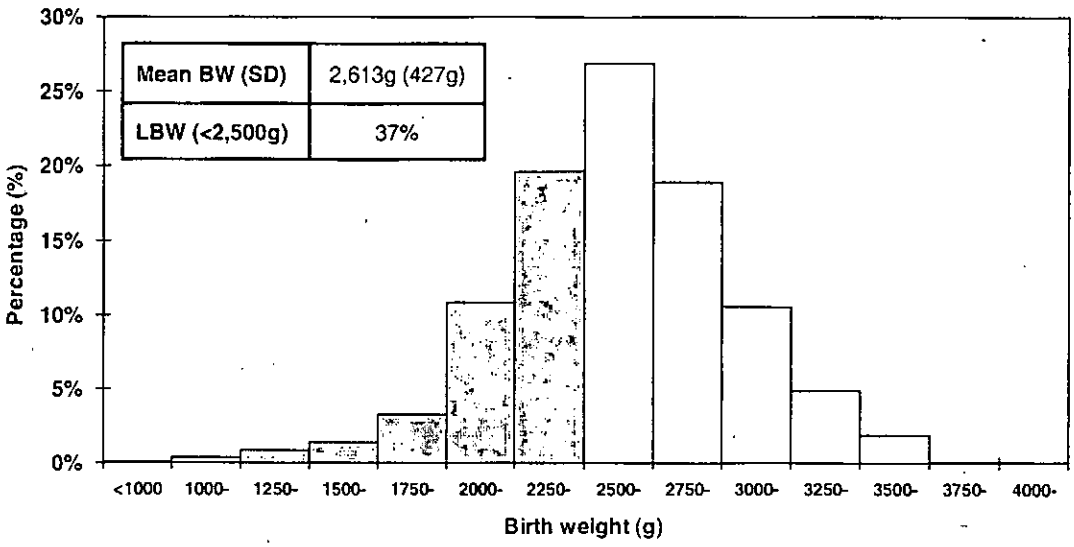
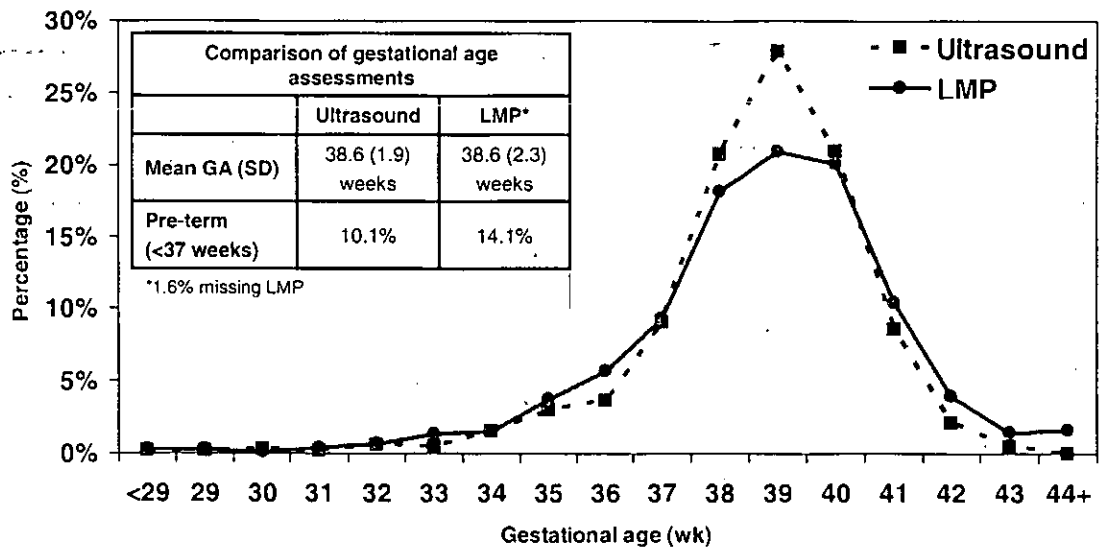



**Figure 2: Distribution of births by gestational age and method of gestational age measurement as of 31 October 2003**



## 5(3) Projahnmo- Neonatal Health Intervention Research Settings: Sylhet (Projahnmo-I), Mirzapur (Projahnmo-II)

Neonatal mortality remains high in Bangladesh and is now the largest component of under-five mortality. In 2002, the Centre initiated two major intervention research projects on neonatal health named '**Projahnmo**'. Projahnmo aims at evaluating the impact of a package of pregnancy, delivery and newborn care interventions on neonatal mortality. Both studies use a cluster randomized experimental design.

**Projahnmo-I** is a partnership of ICDDRB, Johns Hopkins University-USA, Shimantik-a national NGO, MOHFW, Dhaka Shishu Hospital, BRAC and ICDDRB with support from USAID and SNL. It is being implemented in three upazilas of Sylhet district with aim to evaluate two alternative service delivery strategies: home-based care and clinic-based care. The study also investigates anti-microbial resistance in the community. Total study population is about 475,000.

**Projahnmo-II**, is a partnership of ICDDRB, JHU, Oxford University, Kumudini Hospital and Dhaka Shishu Hospital with support from the Wellcome Trust and implemented in the Mirzapur upazila of Tangail district. The focus is on home based care with an additional aim to assess bacterial etiology of neonatal infection in the community. Total study population is about 290,000.

The formative phase of the two studies have been completed, including qualitative research, baseline household surveys and verbal autopsy. Selected findings from the baseline household survey are presented here (table 1). About two thirds of the neonatal death occur in the first week of life. In contrast to Sylhet, certain immediate newborn care practices like cutting the cord before the delivery of placenta is more common in Mirzapur. More than one third of the newborn babies are left alone after birth in Sylhet while in Mirzapur this practice is rare.

**Table: 1 Immediate newborn care practices**

| Immediate newborn care | Sylhet | Mirzapur |
|---|---|---|
| First task done immediately after delivery | | |
| Cut cord | 54% | 95% |
| Baby left alone | 41% | 0% |
| Baby not dried till delivery of placenta | 87% | 86% |
| Baby not wrapped till delivery of placenta | 86% | 85% |
| Baby kept till delivery of placenta on the floor | 68% | 86% |
| Feeding colostrum | 61% | 96% |

Like other areas in Bangladesh, institutional delivery was very low (6%) in Sylhet, while in Mirzapur it was about 14%. Senior female family members commonly

reported as birth attendants in Sylhet (39%). In Mirzapur trained TBAs attended about 36% deliveries as opposed to only 14% in Sylhet.

Overall neonatal mortality rates are similar (45.7%-48.5%) across the study arms, namely home care, clinic care and comparison. However, there is large variations between upazillas. For example, in Zakiganj upazilla the rate was 62/1,000 livebirths, it was only 28/1,000 live-births in Beanibazar. The NMR in Mirzapur was 28/1,000 live births.

At present, interventions are being implemented both study areas. The interventions focuses on behavior change communication in the community and at the household level regarding newborn and maternal care, recognition and management of neonatal infections by mother and first level community health worker. The activities which are being implemented in the community includes pregnancy identification, birth and newborn preparedness visits, newborn care visits, referral for newborn and maternal danger signs/complications. In the home care model of Projahnmo-I and in Projahnmo-II the interventions are being delivered by a team of community based workers. Projahnmo has developed a comprehensive MIS for effective and quality-assured intervention delivery. In Projahnmo-I , we have just complete the first of a series of household surveys to assess adequacy of interventions. An independent mid-term review of this project will be conducted in June 2004.

**Figure 1: A CHW demonstrating drying and wrapping a newborn to pregnant women and other family members**

5(4) **Epidemiology and surveillance of multidrug resistant *Mycobacterium tuberculosis* and assessment of directly observed therapy short course (DOTS) programme in selected areas of Bangladesh PI: K. Zaman**

Bangladesh ranked as the fourth highest tuberculosis disease burden among 210 countries in the world in 2003. ICDDR,B has established surveillance for tuberculosis in rural Matlab and in urban Dhaka to characterize the epidemiology of TB and drug susceptibility patterns. Identification of suspected TB cases, patients referral and follow up are done by the field workers. A total of 57,726 (85%) persons aged ≥15 years living in the Matlab health and demographic surveillance system (HDSS) area was interviewed. The overall prevalence of cough >21 days was 7% and was significantly higher among males compared to females (9.1% vs 5.6%). Among 3,826 persons examined for acid fast bacilli (AFB), 52 (1.4%) of them were smear positive, more common among males (2.1%) than females (0.6%). The overall population-based prevalence of smear positive cases was (96/100,000), significantly higher in males (191/100,000) compared to females (32/100,000). Of 657 isolates, resistance to one or more drugs was observed in 48.4%. Resistance to streptomycin, isoniazid, ethambutol and rifampicin was observed in 45.2%, 14.2%, 7.9% and 6.4% respectively. Multidrug resistance (MDR), defined as resistance to both isoniazid and rifampicin, was observed in 5.5%. It was significantly higher among persons who received tuberculosis treatment of one month or more (15.4% vs. 3.0%, p <0.0001). Patients who received antitubercular treatment of one month or more were more likely to have MDR tuberculosis (OR: 6.12, 95% CI 3.03, 12.34). No significant difference was observed in resistance patterns between rural and urban areas. High burden of tuberculosis in rural population warrants appropriate measures to control tuberculosis in Bangladesh. The magnitude of the problem of anti-tuberculosis drug resistance in Bangladesh is high. Our results indicate an urgency to initiate appropriate measures to control and prevent drug resistant tuberculosis in Bangladesh to reduce mortality and transmission.

5(5) **A randomised, placebo-controlled study of the safety, reactogenicity and immunogenicity of an orally administered human rotavirus vaccine (RIX4414) in healthy children in Bangladesh** PI: K. Zaman

Rotavirus is the most common etiological agent of severe diarrhoea in young children. In Bangladesh, there are about 20,000 deaths in a year and an estimated 1 in 200 Bangladeshi children die from rotavirus diarrhoea by 5 years of age. ICDDR,B has started a study on rotavirus vaccine in urban Dhaka to assess the reactogenicity and immunogenicity of a live, attenuated human-derived rotavirus vaccine (RIX4414) among young children. A total of 90 toddlers received a single dose of vaccine (viral concentrations of $10^{5.8}$ ffu or $10^{6.7}$ ffu) or placebo. The vaccine was found to be safe among toddlers and reported solicited symptoms were in general mild and of short duration. The second part of the study completed enrolment of 340 infants who received either 2 doses of $10^{6.7}$ ffu (136 subjects), 3 doses of $10^{6.7}$ ffu (136 subjects) or placebo (68 subjects). Stool and blood samples were collected for rotavirus antigen detection and to measure rotavirus IgA antibody titres. The study will form the foundation for conducting Phase III studies of effectiveness and safety

in Bangladesh. Ultimately, the goal will be to have available a practical, safe, and effective vaccine for use in prevention of rotavirus morbidity globally.

5(6) **Epidemiology of Hepatitis E Virus Infections in Bangladesh PI: K. Zaman**

Hepatitis E virus (HEV) infections result in serious morbidity and mortality, especially among pregnant women; they also cause significant annual economic losses. This is a two-year, multi-component, population-based study to describe the epidemiology and quantify the burden of HEV infections and disease in rural southern Bangladesh. These studies are nested within the Matlab cohort encompassing of 110,000 population. The age-specific population prevalence of IgM and IgG antibodies to HEV will be determined using an inclusive random sample of 1290 individuals. Data are being collected at baseline, 12 months, and 18 months. Incidence of HEV infection and disease will be calculated from HEV antibody seroconversion rates and by extracting reports of hepatitis disease from the surveillance system records. A ratio of subclinical or asymptomatic HEV infections to clinical HEV will be estimated.

A nested case-control study will be conducted to identify potential risk factors associated with sporadic HEV disease. A risk-factor questionnaire will be administered to identify potential behavioural, animal and/or environmental factors associated with incident HEV disease. As Matlab has been GIS mapped, cases will be analysed for spatial or temporal clustering. Finally, ten isolates of HEV from acute cases will be sequenced for a phylogenetic analysis of Bangladesh HEV. So far, blood samples have been collected from 950 persons for serology.

5(7) **Effectiveness of large-scale supplementation activities for pregnant women: The role of community nutrition promoters, PI – Ruchira T. Naved**

Maternal malnutrition is high in Bangladesh contributing to prevalence of 45% of low birth weight. A national food supplementation program benefiting pregnant women is being implemented through community based nutrition promoters (CNPs). The aim of our sub study is to determine how characteristics of the CNPs influence the effectiveness of the food supplementation activity. The focus is factors potentially associated with job performance of the CNP such as her nutritional status, job satisfaction and social status. This will be related to the pregnant women's participation and compliance to the food supplementation activity and subsequently to impact on maternal and fetal nutrition. This study will generate important information useful for increasing effectiveness of community based nutrition activities. This study is a sub study to the ongoing MINIMat trial that is assessing efficacy and effectiveness of the supplementation program.

5(8) **Unmet Obstetrics Needs (UON)**

**UON project** has been working with a new indicator (MOI-AMI) since 2001. It has several parts (validation of the UON –indicator, district piloting and others).

Validation part has been carried out in Matlab, ICDDR,B study area. By the end of 2003, this strictly research part is nearly completed. Interviews of around 1200 women from Matlab-HDSS who delivered in comprehensive EOC-facilities during the study-period were completed by this time, were coded and double entered in the computer. They were checked and cleaned. Analysis is still in process.
The translation of open parts (detailed account of events during delivery) of all verbal autopsies (818 in no.) were completed and additional 217 questionnaires (the women who survived by obstetric surgery) were also being translated for comparison. There is a plan to compile a story book with them.
The second part of the project (use of the research-findings for Public Health benefits) began in December'2003. This was to introduce the new indicator in the districts of Bangladesh for use by the health- care providers themselves. The districts were selected mainly by DGHS, in collaboration with UNICEF and ICDDR,B (UON team). Seven districts were selected out of six divisions.
District-work in Mymensingh began in the mid of February, is nearly at the end now. Data collection is completed from all health facilities (Gov. and private) having comprehensive EOC, they were now being entered for analysis and final results will be presented in the beginning of April.
Work in district level will be continued in other 5 selected districts in 2004 and there is a plan for compiling a story book. Due to budget constraints, we are looking for additional fund to fulfill our plan for publishing a story book.

5(9) **Safer motherhood project in Matlab (DFID-Funded)**

Safer Motherhood project is addressing the following activities:

a) To develop and evaluate a home-based skilled attendance strategy for deliveries using community midwives
b) To determine the effectiveness of community awareness raising efforts about pregnancy danger signs and about use of upgraded facilities and services and
c) To monitor and evaluate the process and impact indicators of improved basic and comprehensive EOC services on service utilization at Union and Upazila level facilities in Matlab.

Behavioural Change Communication on pregnancy danger signs, pregnancy planning and availability of basic and comprehensive EOC services is going on in four out of eight EU intervention unions in addition to ICDDR,B service area by the GOB fieldworkers (health assistants and family welfare assistants). In ICDDR,B service area the midwives at sub-centres and community health research workers are carrying out these activities with the help of pictorial cards.

Limited supplies are being provided to upgraded GOB facilities to continue provision of basic and comprehensive EOC services for the people of Matlab.

Monitoring and service statistics data collection activities are going on both in ICDDR'B service area and eight EU intervention unions in addition to data from MCU of Matlab government thana health complex

5(10) **Acceptability, effectiveness and cost of strategies designed to improve access to basic obstetric care in rural Bangladesh (ACES-EOC) project (USAID-funded)**

Substantial progress has been made in analysis of data of the effectiveness component of the study. In addition, following tasks are also in progress:

a) A study report is being prepared.
b) A manuscript is being drafted on determinants of use of ICDDR,B obstetric care services in MCH-FP area, in Matlab during 1987-2001.
c) Preparation of further analysis is on progress to validate the link between process indicators and outcomes including maternal, perinatal and neonatal mortality.

5(11) **Bangladesh Health Equity Watch (BHEW)**

Bangladesh Health Equity Watch (BHEW), is a collaborative project of BBS (Bangladesh Bureau of Statistics), BIDS (Bangladesh Institute of Development Studies), BRAC, and ICDDR,B Centre for Health and Population Research. The Social and Behavioural Sciences Unit of the Centre houses the secretariat of BHEW. The project sets its activities according to four basic objectives: 1) Incorporation of equity dimensions, such as socioeconomic groups, geographical location, health outcome and healthcare utilization variables and the like in the existing data collection systems in various organizations (this will also include assessment of the impact of the poverty alleviation and community development oriented health programmes in reducing health inequity); 2) establishment of a new system in a nationally representative sample which can eventually be adopted by the national system; 3) dissemination of findings among the policy makers, researchers, NGO leaders, and members of civil society in a regular fashion to facilitate actions to minimize inequity; and 4) development of national capacity to carry out equity focused research and analysis.

**Progress on major activities:**

- Equity dimensions have been included in the data collection systems of various organizations including the Nutrition survey of Save the Children, UK, and Immunization survey of UNICEF. Various studies within ICDDR,B have incorporated an equity focus in their data collection mechanisms. Some of these projects include Safer Motherhood, Tuberculosis, Adult Health, Child Health, Neonatal Health, and the Health and Demographic Surveillance System.

- The BHEW Watch Survey data set is being analyzed with an equity focus. Analysis with an equity perspective of the following data sets have been completed: the Bangladesh Demographic and Health Survey 1999-2000, and the Household Income and Expenditure Survey conducted by the Bangladesh Bureau of Statistics (BBS).

- The second round of data collection of the Health Watch of BRAC was carried out last year, which included equity relevant modules and covered a nationally representative sample. The data is being analyzed.

- A rapid assessment tool for measuring poverty in its multidimensionality has been extensively tested and finalized. BHEW administered the tool to a nationally representative sample in 12 districts of Bangladesh in collaboration with BRAC. The data is currently being analyzed and report writing is underway.

- The 8th issue of the Bibliographical Alert: Health, Poverty, and Equity have been published. The Bibliographical Alert is a resource published quarterly to inform concerned individuals and organizations of health, equity and poverty related literatures. The Alert is compiled through conducting searches on the Internet and popular databases such as Popline and Medline. Hard copies of the Alert are being distributed among interested organizations and individuals. All the issues are also available on the web.

5(12) **Chakaria Community Health Project (CCHP)**

This project in Chakaria works to mobilize the community people through indigenous self-help organizations and make the community people aware of their health needs, available health resources, and utilization of these resources in improving their health conditions through participatory methods. At the existing 7 village health posts, formed by the villagers, the project doctors and the paramedics extend preventive health care services to the community people.

**Progress on major activities:**

- One of the major health services provided by the village health posts is safer motherhood service. With the efficient services provided by the trained community midwives under the project the demand for antenatal care, postnatal care services in the community is increasing everyday. The project currently is monitoring the maternal mortality cases in the community on regular basis. This would allow identification of the factors influencing maternal death in the community, based on which the efficiency of the services already being provided could be improved.
- Knowledge generation, awareness building are continuing through the various meetings with the villagers
- The project has also set up a laboratory with modern diagnostic equipments to render some of the diagnostic services to the community people at reasonable cost.

The health cooperative is a comparatively new approach formed with an aim to serve as a social insurance for health care for the community people. By the end of December 2003 a total of 77 health cooperatives were formed by the community people in Chakaria. The villagers have started to take loans from the cooperatives and use them to meet their health care needs. The project is encouraging more and more villagers to get involved with the cooperatives through extending additional

advantages to the cooperative members in getting the health care services at the village health posts (e.g. lower consultancy fee, lower fee for health cards etc.). Although the project is handling the management and distribution of cooperative funds, it is expected that the community people will take full responsibility to run the cooperatives by themselves.

## 6. Major new initiatives during the period

6(1) **A study to understand reproductive health practices and sexual network among men in general population in Bangladesh,** PI- Kim Streatfield
Donor - The Family Health International (FHI), Bangladesh

RRC has cleared the proposal. This will be a cross-sectional descriptive study to be conducted among men, 18-55 years of age in the community. A stratified cluster sampling technique will be employed to select 6000 male (2400 in urban areas and 3600 in rural areas) for the study. Sample will be drawn from all the 6 administrative divisions covering statistical metropolitan areas in divisional headquarters, municipal areas in district levels and rural areas in thana level or below. The study findings will help design an pragmatic HIV/STI prevention program for general population especially male in the community. The project duration is six months and is expected to start from April 2004.

6(2) **An evaluation of existing community-based skilled birth attendant (SBA) programs for obstetric care services in rural Bangladesh**

The study proposal has been developed with the following aims: In order to determine the utilization of SBA programs by the community for home-based obstetric care services; to assess the quality of care provided by these programs and to determine what support systems are needed by these programs to provide sustainable skilled care in the community level. The possibilities of USAID funding are currently being explored.

6(3) **Reinitiating Fertility Decline in Bangladesh by Meeting the Needs of High Parity Couples, Principal Investigator: Abbas Bhuiya, Ph.D.**

The project aims at reducing the total fertility rate (TFR) in Bangladesh through meeting the need of effective family planning services among couples with more than three children.

6(4) A proposal has been submitted to PATH on surveillance of rotavirus in two Thana Health Complex at Bakerganj of Barisal and Mathbaria of Pirojpur

## 7. Major findings and implications of these findings.

7(1) **Sexuality And Risky Sexual Behavior In Rural Bangladesh**
PI: Ruchira Tabassum Naved, Donor: Cornell University

This small study attempted to shed some light on the risky sexual practices in rural Bangladesh and their driving forces. It also tried to explore how the males and females in the rural area perceive risks of sexual disease transmission and what are the constraints faced in using proper protection against disease transmission. Here we highlight a few key findings from the study.

The study finds that almost no groups of population in rural Bangladesh are really free of risks of somehow or other being involved in risky sexual behavior. The young children often get involved due to their ignorance and more so as victims of violence. The whole scenario in rural Bangladesh with its strict gender segregation promotes male-to-male sex at the age when males start exploring their own sexuality. At puberty males start having wet dreams, which are dreaded in the community for its adverse effects on health and manhood. Males soon find out that masturbation helps to avoid wet dreams. Masturbation in its turn is also condemned in the society and believed to lead to disastrous consequences for a man. These misperceptions give rise to psychosexual problems, which are quite common. At different levels of the society in different forms vaginal sex is prescribed for putting a stop to both wet dreams and masturbation and thus doing away with the psychosexual problems suffered mostly by adolescents. This again boosts risky sexual behavior on the part of the adolescents. Overriding concerns of maintaining potency makes some of them adamant enough to engage in extremely risky sexual behavior. Although the risks of contacting sexually transmitted diseases from the commercial sexual workers is part of common knowledge this still does not stop them repeatedly having sex with them without any proper protection. Those who have experience of premarital sex and particularly of having sex with commercial sex workers often continue to be promiscuous after marriage.

In this gender segregated society male-to-male anal sex is a natural outcome. Once males and females reach puberty they are not usually allowed to mix with each other. Thus, when a pubescent male starts to explore sexuality he often tries out anal sex with male partner/s. Involvement with male-to-male anal sex may often be forced upon. The majority of the men abandon this practice once they enter into marriage. But a few of them continue to have anal sex with men even after marriage.

Thus, apart from the commercial sex workers it seems critical to pay attention to the following groups in the rural area: 1) Both male and female children, who are vulnerable to sexual abuse; 2) Adolescents, who share a lot of misperceptions prevailing in the society and get involved in risky behavior; 3) Migrant population and their spouses; and 4) Females in all ages who are vulnerable to sexual abuse within and outside marriage.

Lack of measures of protection is overwhelming in sex here. The major concern for protection is avoiding conception rather than avoiding sexually transmitted diseases. The concern about sexual pleasure and convenience overrides the concerns about disease transmission. Thus, use of condoms is extremely low in both marital and non-marital sexual relationships. People concerned with protection against disease transmission sometimes are guided by misperceptions. One of them is that washing the sexual organs well before and after sex will provide proper protection. The other one is that nothing can go wrong if one has sex with a commercial sex worker along with his friends who he knows.

Given the situation it seems critical to explode the myths regarding wet dreams and masturbation. This would have two major effects: One is on the psychosexual health of men and secondly, it would help them escape a lot of risky sexual behavior that can potentially lead to development of sexually transmitted diseases.

It is shocking that in rural Bangladesh the perpetrators of sexual violence against women and children get away easily with their crime. Stigma and fear of causing them more harm play into the hands of the perpetrators. Awareness regarding this issue must be raised and the issue of stigma addressed. Moreover, misconceptions regarding protection such as washing helps and sharing a woman among known people must be addressed in intervention programs.

7(2) **Reaching the Poor Project (World Bank-funded):** Secondary analysis of monitoring and service data from ICDDR,B service area reveled that during 1997-2001, 19.0% births took place in ICDDR,B facilities, 4.0% in other facilities (public & private) and an additional 2.6% births were attended by ICDDR,B midwives at home. Women from poorer households used ICDDR, B facilities significantly less than their better-off counterparts for delivery purposes, and the rich: poor ratio was 2.9. While the same ratio was 3.7 for home-delivery by ICDDR, B midwives. Disparities were persistent over the years in all areas. Other factors that could predict utilization of maternity services are: number of ANC visits, area of residence, birth order, maternal education, age of mothers and year of delivery.

Service register data reveals that those who delivered at ICDDR, B facilities, 31.9% were from least poor quintile households while only 12.5% were from poorest quintile households. This disparity was more for centrally located Matlab clinic than for peripheral level subcentres.

Utilization is improving in ICDDR'B service area but persistent inequality is a growing concern. Pro-poor health-strategies need to be formulated; demand side financing may be a policy option. ANC should be emphasized as a service improvement tool for better utilization of EOC services.

7(3) **Unmet Obstetrics Needs (UON) project findings of Noakhali :**
The met need in Noakhali is found to be 24%(207cases) and unmet need is

76%(661cases) for the year 2002. Out of this met need, Gov. managed 53% cases and Private sector managed 47% cases. There is no NGO having com-EOC in Noakhali district.

7(4) **Male Involvement in Reproductive Health project:**

As part of the Male involvement project, four male clinics were established in four geographical blocks in Matlab to provide reproductive health and family planning services. Most of the project activities were closed since the project funding is over from the European Union. However, with support from the ICDDR,B some of the basic clinical activities are ongoing in four male clinics by Medical Assistants such as curative services for reproductive tract infections and FP counseling. Sociodemographic and services related data are being collected routinely from all clinic attendees and computerize periodically.

7(5) **Male sexuality and masculinity: Implications for HIV and sexual health interventions in Bangladesh, Principal Investigator:** Sharful Islam Khan
**Donor:** AusAID and Edith Cowan University
**Collaborating organization:** Bandhu Social Welfare Organization and DMSS, Khanjanpur, Jaipurhat

Khan, S., Hasan, M.A.K., Bhuiya, A., Hudson-Rodd, N. and Saggers, S. (2003). How safe is sex with condoms?: An in-depth investigation of the condom use pattern during the last sex act in an urban area of Bangladesh. International Journal of Men's Health. 2(3), 167-182

Interviews with 20 hotel-based, female sex workers and 15 (male) clients were conducted to explore patterns of claimed condom use during the last sex act.
Major findings:

- The Health Belief Model guided this study and was found deficient in providing an understanding of condom use.
- The clients' perceptions of dominating sexuality and "the male's right" to enjoy sexual intercourse in commercial settings increased partial condom use.
- The invisibility of AIDS reduced participants' perceived susceptibility to and severity of suffering from the disease, while using condoms at any time during intercourse was perceived as being beneficial.
- Condom interventions need to be based on deeper understanding of the complexity of people's lives.

Khan, S., Bhuiya, A. and Uddin, A.S.M. (in press). Application of the Capture-Recapture Method for Estimating the Number of Mobile Male Sex Workers (MSWs) in the Port City of Bangladesh. *Journal of Health, Population and Nutrition.*

Male sex workers (MSWs) and sex trades are not embryonic in Bangladesh. Current HIV interventions for MSWs require expansions in major cities, which warrant

scientific estimations of the size of MSWs. Although the two-sample capture-recapture surveys are suitable for closed populations, the study applied this to indirectly estimate the size of mobile MSWs in a conservative social setting, a port city of Bangladesh.

Major findings:

- Total number of MSWs, who picked up clients only at open and known contact venues were found to be 248 (95% CI, 246-250). This estimate does not reflect the total number of MSWs as the study could not reach MSWs who worked in unknown hidden venues.
- Experience suggests that the two-sample capture-recapture method is a simple technique for reliably estimating an unrecognized population with limitations. This limitation could be minimized by shortening the time gap between surveys and creating an enabling environment to encounter harassment of MSWs and safety to peer-staff.

### 7(6) Rapid assessment tool (RAT) for better health: helping essential service package managers to be more effective

The task of data analysis and their interpretation is technical and requires expertise beyond the domain of programme management. In this respect, the lot quality assurance sampling (LQAS) method is more rapid, simple, time efficient and less costly compared to others because it is based on a much smaller sample size.

The study compared the proportion of inadequately performing areas in terms of Essential Service Package programme identified by LQAS methods with those derived by using data from the Matlab Health and Demographic Surveillance System (HDSS).

Major findings:

- The proportion of areas identified to perform inadequately by using LQAS methods and HDSS data were found to be statistically similar implying that the conclusion derived about the performance of the area by using LQAS and surveillance data is not different.

- Its application in the field situation is very easy. Once the decision rules are made, ideally in consultation with the policy makers and programme managers, the task of collecting the required data and their use in deciding which of the health facility is working adequately or not, is very simple.

- The method can also be used for a variety of other outcome variables. LQAS was applied to identify inadequately performing CHW-work areas on the basis of a predefined threshold level of utilization.

- While the LQAS method is found to be of acceptable reliability, the challenge is to adopt it in the regular monitoring system at the lowest level of the programme.

7(7) Plans also included surveillance of rotavirus diarrhoea in two rural hospitals.

**8. Strategic plan goals and priorities**

a. How is the Division keeping on track (by monthly meeting --Dr Abbas)
b. Constraint to meeting SP priorities (Unit Heads)
c. Suggested modifications to SP priorities and reasons (Unit Heads)

**9. Plans for 2004**

**Staffing:**

Some of the staff of the former Health Economics unit remained back with Social and Behavioural Sciences Unit.

**Projects:**

9(1) One new project "Reinitiating Fertility Decline in Bangladesh by Meeting the Needs of High Parity Couples" lead by Abbas Bhuiya has gone through the RRC, ERC process and is expecting funds from USAID.

**Funding sources:**

- Funding for the Bangladesh Health Equity Watch (BHEW)- Phase II has been approved by Rockefeller foundation
- Expecting fund from USAID for the new proposal on "Reinitiating Fertility Decline in Bangladesh by Meeting the Needs of High Parity Couples"

9(2). **A phase III, double-blind, randomized, placebo-controlled study to assess the efficacy of oral live attenuated human rotavirus (HRV) vaccine in healthy infants.** PI: K. Zaman

We propose to conduct a randomized cluster, double-blind, placebo controlled trial in the Matlab field area of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) to determine the efficacy of a live oral human rotavirus (HRV) vaccine in Bangladeshi children. The vaccine is called RIX4414. The active ingredient of the vaccine is based on the human rotavirus strain 89-12. The 89-12 strain belongs to the serotype G1P1A and genotype P8. Over a one-year period, about 2106 children in the Matlab Field Area will be enrolled at the time of their first immunization and randomized to receive either 2 or 3 doses of rotavirus vaccine or placebo at about 8, 12, and 16 weeks of age along with their routine immunizations. Severe adverse events will be monitored through home visits of subjects and passively at the clinics in Matlab. An immune response to the vaccine will be monitored as an elevated IgA titer to rotavirus antigen in blood samples collected at baseline and one month after the last dose from a sub-sample. The primary outcome measure will be diarrhoea and rotavirus diarrhoea recorded when a study patient visits the Matlab hospital or the community treatment centre at Nayargaon for a diarrhoeal illness. Stool specimens collected at these encounters will be tested for rotavirus using an Enyzme Immunoassay (EIA) and all positive specimens will be further characterized for rotavirus P and G type.

9(3) **Defining incidence of intussusception (IS) in Bangladesh in preparation for a phase III trial of a new rotavirus vaccine PI(s): RF Breiman and K. Zaman**

We will conduct retrospective and prospective studies to define baseline incidence rates for IS in Bangladesh. We will review existing data from hospitalization in Matlab at three ICDDR,B hospitals which service the Matlab area. Using the Brighton Case Definition for IS, we will estimate rates for probable IS.

Prospectively, we will establish surveillance for IS at the three ICDDR,B treatment centres serving Matlab, 4 District and sub-districts (upazilas) government hospitals, and 3 district-based private clinics serving people living in the Matlab area. Prospective surveillance will include systematic confirmation of IS (with ultrasound in Matlab and other procedures, if necessary, in Dhaka). Infants and children diagnosed with IS will be transported to Dhaka Shishu Hospital for further evaluation and treatment.

9(4) **Low Birth Weight and Prematurity in Rural Bangladesh: Levels, Determinants and Consequences for Neonatal Morbidity and Survival. PI. Dewan S. Alam**

Low birth weight (LBW), i.e. weight at birth <2500g, is associated with higher risk of mortality, morbidity and impaired growth during infancy and childhood. One third of over 10 million annual neonatal deaths reported to be attributable to LBW only. LBW may result from preterm delivery or intrauterine growth restriction (IUGR) or a combination of both. Bangladesh is reported to have the highest rate of LBW with some reports showing the incidence as high as 50%. Though largely nutritional, there are multiple immediate and underlying factors that determine the incidence of LBW. Since most deliveries take place at home in Bangladesh and babies are not weighed at birth the true incidence in the population is not clearly known.

To measure the incidence of LBW, its determinants and major consequences in rural Bangladesh we propose this study within the context of three other ongoing studies in ICDDR,B: Centre for Health and Population Research. Nesting this study with other studies will substantially minimize the cost and will also allow us to deliver good quality information from a large cohort (8000 births) within the stipulated time frame in the request for Proposal. The ongoing studies are: MINIMat, a randomized food and micronutrient intervention study in Matlab in which pregnant women are randomly assigned to one of the six groups which in the timing of starting food supplementation and type of micronutrient supplementation receives. Wide range of data are being collected including SES and demographic data, prepregnancy weight, repeated anthropometry during pregnancy, repeated ultrasound assessment of fetal growth, food intake, workload, stress and violence, and birth weight of infants. The other two intervention studies called PROJAHNMA-1 & -2 are being conducted in Sylhet and Mirzapur aiming at reducing the neonatal mortality through a package of pregnancy, delivery and newborn care interventions. However, maternal anthropometry and birth weight data are not collected which we plan to collect in this proposed study. All these three studies offer the opportunity to measure the incidence of LBW, IUGR and prematurity and their determinants. The research setting will also

allow us to assess the effect of LBW on neonatal mortality and morbidity in three different populations with varying levels of health and socioeconomic indicators. This study will provide a population-based estimate of the incidence of LBW, prematurity and IUGR in rural Bangladesh. The results will allow us to quantify the etiologic fractions of major determinants of these outcomes and their interactions including the contribution of social, environmental, and cultural factors. The data will also allow us to conduct advanced analysis to quantify the relative contribution of LBW, prematurity and IUGR and its sub-classifications on neonatal mortality and morbidity after accounting for different population attributes and interventions.

9(5) **Efficacy of short course zinc therapy with 20 mg elemental zinc daily in the treatment of acute diarrhoea: A community-based double-blind randomized trial,** PI. Dewan S. Alam

Diarrhoea continues to be a major cause of mortality and morbidity in young children especially in many developing countries. Although the mortality burden of diarrhoea has substantially reduced, largely due to improved case management through promotion and use of ORS over the last decade, the morbidity pattern remained almost unchanged. One of the major goals of current diarrhoea control programme is to to reduce the duration of diarrhoea, which still remains as an outstanding challenge. While ORS has important role in preventing deaths from acute dehydrating diarrhoea, it does have any effect on the duration of the episode. Recent randomized controlled supplementation trials in developing countries have consistently shown that zinc has the potential to reduce the duration of diarrhoea as well as has preventive effect on childhood diarhroea in subsequent months. Currently, international health agencies recommend zinc as an important adjunct therapy to treat diarrhoea in developing countries where zinc deficiency is highly prevalent and diet is poor in zinc. The recommendation is to provide 20 mg elemental zinc daily for 10 days during each episode of diarrhoea. This recommended duration of zinc therapy is much longer than most acute diarrhoeal episodes, which usually resolve between 3-6 days. Zinc is a soluble nutrient and there is no known mechanism of storage in the body. From practical point of view, zinc therapy of shorter duration than 10 days should work considering the metabolic characteristics of zinc, the duration of acute diarrhoea and possible compliance issue. Again shorter the duration is more likely the treatment would be acceptable in the community and would be less likely to cause toxicity. However, before recommending a shorter duration of therapy a careful evaluation of its efficacy need to be determined. This study aims at evaluating the relative efficacy of three length of zinc therapy (5 vs 10 days) during acute diarrhoea in a rural community.
This study will be a community-based individually randomized controlled trial with 20 mg zinc daily and will be conducted in six villages in the ICDDR,B Matlab study area. Children with acute diarrhoea will be randomly allocated to one of the three treatment schedules (20 mg of zinc daily for 5 or 10 days). Children who will be allocated to any of the shorter duration therapy will receive placebo for the remaining days to complete 10-day treatment. Daily surveillance at home will be conducted in the study by Female Field Workers (FFWs) to detect and enrol children with

diarrhoea. FFW will visit each child in her surveillance area daily and administer zinc directly. Outcomes will also be assessed daily during routine home visit by FFWs. All children treated with diarrhoea will be followed for three months to evaluate the preventive effect of zinc on diarrhoeal incidence.

## 10. Matlab

During the period a total of 33525 patients were treated at our Matlab Health Research Centre (MHRC)
Period: October'2003 to March'2004
Number of diarrhoeal patients treated

| | |
|---|---|
| - Matlab diarrhoea treatment centre | 5643 |
| - Community based treatment center | 425 |
| Sub Total (A) | 6068 |

Reproductive and Child Health related patient care
(Matlab Hospital and four sub-centre)

| | |
|---|---|
| - Women of child bearing age – for all illness and maternity care | 18178 |
| - < 5 children | 8967 |
| - Male sexual health related problem | 312 |
| Sub Total (B) | 27457 |
| Total (A+B) | 33525 |

Room for Child Development tests under MINI-Mat Study in Sub-centre-A. A Psychologist is seen performing the test.

New out-patient area for reproductive and child health services in Block-A sub-centre

Newly constructed floor on top of diarrhoeal out opatient department in Matlab HRC

**Matlab**

**4. Physical Space offices, hospital, filed areas with maps and photograph**

The following expansion and renovation of physical facilities were completed during the report period in order to cope with increased need for research, health service delivery and office space in Matlab HRC and in the Sub-centers.

(i) A second floor comprising of about 2000 Sq. ft. area has been constructed on the top of the diarrhoeal out-patient building. Two new research projects have already been accommodated in this floor and provision for accommodating the proposed Rota Virus vaccine trial project has been kept. (A photograph of the new floor is attached).

(ii) Expansion and re-modeling of two sub-centres under Block-A and Block-C have been completed with additional space of 750 Sq. ft and 860 Sq.ft respectively. This has facilitated in providing necessary space for different projects and routine Sub-Centre based activities (Photograph showing activities in a sub-centre).

(iii) Re-modeling, renovation and expansion of Matlab Staff Clinic has also been completed recently. This has provided physical facilities for all required activities of the staff clinic including separate male and female in-patient space.

The reorganized staff clinic facility will help delivering standard health services for Matlab staff members.

**"Health Profile of The Elderly in Matlab, Rural Bangladesh"**

This study aims to explore how biological, environmental and societal factors are interrelated, and how they affect ageing. It will describe the morbidity pattern and functional status (cognitive and physical functioning) of population aged 60 years and older in a rural area of Bangladesh. It further aims to identify determinants of good/ ill health in the elderly population.

Data was collected in two different settings; firstly survey interview held at respondent's home setting and then they were brought to the health centers for cognitive tests and clinical examinations. Survey interview was completed successfully for 597 respondents. And for the cognitive and clinical part 473 interviews have been completed. Blood sample from 460 respondents have been collected. Data entry is completed for all three sections. Some data processing is going on for the cognitive and clinical part. We expect to complete the data processing for the rest within two months from now.

Preliminary results show that the study population has a mean age of 70 years, 55 percent are female, 57 percent are currently married, and 42 percent are widows or widowers, and mean number of people living in the household is five. 42 percent live by some household work (16% of males and 86% of females). About half (47%) are household heads (201 males and 78 females).

The most commonly self reported morbidities are micturition problems - 53% of males and 60% of females. Other conditions include: pain in the waist (61% of males and 77% of females); pain in the joints (46% of males and 56% of females), which is suggestive of arthritis; cloudy vision (59% of males and 72% of females), which is suggestive of cataract.

With aging physical functioning and Activities of Daily Living (ADL) declines for both males and females. Old people contribute to household work. 33% are the earning members of the family. 47% are living with at least one child and 57% with at least one child's family. 82% receives financial help regularly from family members, but 5% never receive any help from anybody.

A sub-study on care, support and living arrangements in the family for elderly is using the longitudinal data from Matlab Health and Demographic Surveillance System (HDSS) fom 1974 to 1996. It is observed that widowers increased and widows decreased over the period 1974 to 1996. Nuclear families are increasing and the extended families are decreasing. Among elderly widowers, 74 percent were staying with children in 1974 and it increased to 82 percent in 1996 whereas for elderly widows, 68 percent were staying with children in 1974 and it increased to 71 percent in 1996. Elderly widowers/ widows were more likely to stay with children, and the propensity to stay with children has increased over the years, whereas living 'alone and with others' has decreased over the period for both widowers and widows. The proportion of elderly staying with married daughter, though small, has shown an increase over the years. It was only one percent (among all elderly) in 1974 and increased to 5 percent in 1996. Older women and men

are not only the recipients of care; in many cases they are caregivers themselves. Most widowers were cared for by daughters-in-law. Female elderly were also mostly cared by daughter-in-laws, followed by daughters. This pattern is the same whether she is married or widow. Married males were mostly cared for by wives (89 percent) whereas only a few married women (9%) were cared for by their husband. Widower (74%) and widow (52%) received financial support from their son. The findings of this study also illustrates the extends to which older person contribute directly to household activities. About 38 % male and 30% female regularly performed atleast one household works. Female tends to provide greater assistance than men in the household work. The greatest contributions regularly made by the elderly women are seen in help food preparation followed by cleaning utensils/ dishes and house cleaning. Most men gave assistance to care grandkid and tend animals regularly.

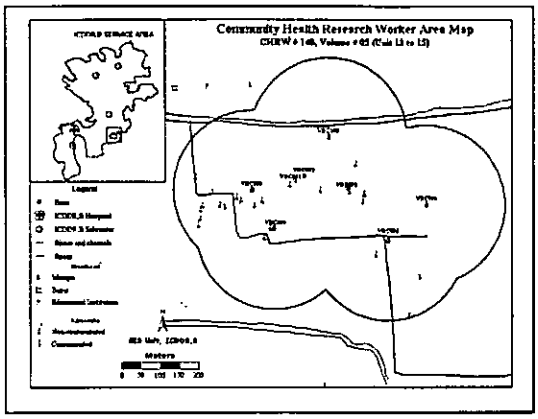
A positive interpretation of these findings would be that the living arrangements of Bangladeshi elderly are favorable for their overall well being, since co-residence with kin is assumed to be a reliable source of assistance and support. Most support for the elderly is still being provided by the family member. At the same time, along with socio-economic development, family structure is also changing. This will reduce opportunities for providing support in traditional ways. Continued monitoring will be necessary to determine the nature and extent to which changes in living arrangements and other forms of familial support occur as well as their implications for the elderly's welfare. The welfare of the aged will, therefore, require the strengthening of family support systems and development of supplementary community-based programmes concerning matters such as employment, health, nutrition and medical care; housing and living arrangements and personal social services.

Physician: Examining the respondent.

Respondent: Participating in the cognitive test.

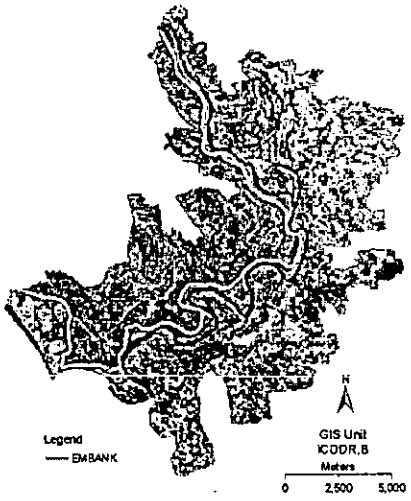
**GIS activities:**

Currently included in the Matlab GIS is the location of tube wells, ditches, ponds, health facilities, educational institutes etc. Spatial data collection, processing and spatial analysis is still ongoing for additional projects like IMCI, arsenic studies and MINIMat. The map shows how a new CHRW working area was defined in our areas indicating the bari locations with some other structures to identify a bari in that area.

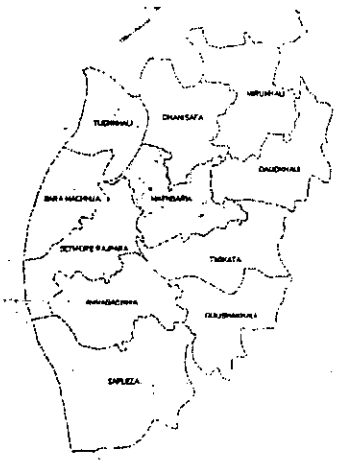



Due to developments with new software and satellite images, there will be opportunities to expand GIS activities in different fields. The GIS unit currently generates thematic maps, creating spatial variables and doing spatial analysis with georeferenced data. Spatial analysis can generate surface maps to understand the spatial and temporal relationship on space. Any kind of spatial information can be extracted from high-resolution imagery and it can assist researchers to visualize spatial relationship among diseases. Population distribution, cluster of population, disease patterns can be visualized using GIS tools and it can facilitate research according to the needs of the researcher more efficiently and effectively.

Satellite Image of Matlab Study Area




A Landsat TM image shows the difference of vegetation within embankment and outside of embankment in Matlab study area.



Spatial data like household location, water bodies, location of the facilities will also be collected at Mathbaria and Bakergonj upazila to fulfills the requirements of the project "Epidemiology and Ecology of *V. Cholerae* in Bangladesh." In this study, five neighbouring unions adjacent to the upazila hospital will be included in the GIS since these are the unions from which most of the patients come. Identify the spatial clustering of the cholera patients; any ecological effect of the clustering and any other spatial relationship will be investigated.

**New Verbal Autopsy Tools For Improving The Quality Of Data On Causes Of Death In Matlab HDSS**

In Bangladesh, adult mortality is relatively high and declining at a slower rate than childhood mortality. High adult mortality and serious adverse effects of adult deaths on health and well-being of other family members have drawn the attention of policy makers to population-based data on causes of adult deaths for planning interventions. However, such data are very limited.

HDSS data on causes of death based in open-ended verbal autopsy are more accurate for infectious diseases and for non-communicable diseases occurring simultaneously with other acute symptoms. The current verbal autopsy is inadequate to classify a high proportion of adult and elderly deaths. To improve the quality of data on causes of death, HDSS has formed a trained death survey team and introduced structured verbal autopsy questionnaires (for neonates, post-neonates and children, and adults and elderly) and supervision of a public health physician in 2003. The community health research workers detect death and the trained death survey team, on receiving the information, interviews the deceased family members with new VA tools.

Each VA questionnaire is reviewed and assigned possible ICD-10 code for cause of death by the physicians and the medical assistant independently. Comparison of causes of death assigned by the physicians and the medical assistant will provide feedback on disease burden to policy makers for undertaking actions. The VA work is in progress.

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# Executive Director's Division

**External Relations and Institutional Development Office**
Head: Ishtiaque Zaman, PhD

Since ICDDR,B is a non-profit institution, the Centre relies on financial support from its many development partners. With a staff of five, the task of identifying funding for initiatives, and maintaining relations with the Government of Bangladesh (GoB), development partners, the media and the general public, falls largely on the External Relations and Institutional Development (ER&ID) Office. The ER&ID Office works closely with the Executive Director of the Centre, the Centre Directorate, and scientists to prepare proposals and communications on the activities of the Centre. Identifying donors for endowment funds is an important priority for the ER&ID Office since it is the endowment that provides stability for the Centre's future.

*Major Highlights*

A highlight of the reporting period from 1st October 2003 to 31st March 2004 was the return of the Canadian International Development Agency (CIDA) as a core donor to the Centre. Canada had been a consistent donor to the Centre's programme from the beginning, so their return after a short hiatus was especially welcome. In making their contribution, representatives from CIDA expressed the importance of funding the Centre's overall strategic plan, rather than specific projects or protocols, since, in their opinion, this was the most effective means to help the Centre achieve its mission and, through this, to improve the health of the people of Bangladesh.

Another development was the decision by GoB to substantially increase its own annual contribution, and in addition, to partially covering the costs of the 10th Asian Conference on Diarrhoeal Diseases and Nutrition (ASCODD) and many of the costs of the 25th Anniversary celebrations. The Centre is also participating with GoB on specific projects, including the national surveillance of HIV-AIDS, the baseline survey of the National Nutrition Programme, and anticipated projects with the National Tuberculosis Programme. The GoB's annual contribution to ICDDR,B has nearly reached US$1 million, a threshold level (we call the million dollar club) that includes just four other donors.

*Other Achievements*

Other development partners who significantly increased their funding to the Centre during the reporting period include the Netherlands (core funding of 1 million euro per year for four years from January 2004), and the Swiss Agency for Development and Cooperation or SDC (US$1 million of core funding in 2004). The US Government supports the Centre through two agreements: one based in Dhaka and one in Washington. The cooperative agreement with USAID/Washington expired in 2003, but a follow-on 5-year project called HARP (Health Research Project), led by The Johns Hopkins

University and Boston University, has replaced it. This new project is focusing on research leading to the introduction of new child health interventions with both country specific and global relevance. Additionally, the Centre has joined with Deloitte Touche Tohmatsu Emerging Markets Limited to provide technical services to USAID under its TASC II programme. A large multi-year grant from the Bill & Melinda Gates Foundation made it possible for a major new nationwide project to encourage the use of zinc for the treatment of diarrhoea. This project is being carried out in collaboration with GoB, NGOs, and the Social Marketing Company, and builds on much of the clinical research at the Centre, funded by USAID, that has shown the remarkable clinical benefits for providing a 10-day course of zinc to children whenever they have a diarrhoeal illness.

***Fundraising Initiatives***

*i. U.K.*

A noteworthy event to help celebrate the Centre's 25th Anniversary was a formal Fundraising Dinner at the House of Lords in London on 21st November 2003. We involved the International Health Solutions Trust, our UK fundraising arm, to prepare the groundwork for a successful hosting of this event. The dinner attracted high-level British and Bangladeshi prospects, companies, media groups and donors, and raised over £100,000 of unrestricted funds for the Centre from corporate table sales and individual gifts. The dinner was hosted by Baroness Pola Uddin of Bethnal Green, a peer of the House of Lords and a renowned and well-respected figure among the Anglo-Asian communities in the UK. In addition to generating much needed support for the Centre from the international community, the event also provided a valuable profile-raising opportunity, leading to a prominent news article entitled "In Search of Humanitarian Science" in the British Medical Journal.

*ii. Bangladesh*

Another special event was the Fundraising Ball, the *Black & White Ball*, held at the Winter Garden of the Dhaka Sheraton on 13th February 2004. This has become an annual event in Dhaka and provides an opportunity for the community to help support the work of the Centre's hospital and to enjoy a social evening together. More than 400 people attended the Ball helping the Centre raise over US$35,000 for the Hospital Endowment Fund.

*iii. Fundraising Brochure*

The design and format of a new fundraising brochure was completed. The brochure will be used for all prospective donor audiences but, most specifically, will be used to target non-traditional individual donors, including corporations, private foundations and individuals.

The brochure was facilitated by the ER&ID office, in tandem with a top London design studio, Fetherstonhaugh Associates. The brochure, which will feature pictures by the

Pulitzer Prize nominee, Mr Brent Stirton, was sponsored by one of the Centre's new private major donors.

*Grants Monitoring*

The ER&ID Office routinely reviewed the terms and conditions of grants entered into by the Centre to ensure fair partnerships, and that the work of the Centre's scientists was protected. The ER&ID Office also worked with the Finance Office to ensure that the full cost of each project was sufficiently realised, and that the appropriate indirect cost or overhead rate was included in the budget component of the project proposals submitted to the development partners.

The ER&ID Office continued to update the database of the Centre's donor-funded activities. It worked with the scientists as well as the Finance Department to prepare technical and financial reports as well as the annual work plans of various donor-funded protocols for timely submission to the respective donors.

The ERID Office helped implement the new Centre-wide MIS system, also known as the *Suchona* Project. Staff worked to post all records electronically to facilitate the flow of information on donors, grant tracking and financial reporting. By early 2004, the ERID office successfully transferred its extensive paper filing system to an integrated MIS system linking with the Finance, HR and Programme Offices. The customized package will improve the Centre's donor compliance significantly.

*Development Partners Group (DPG)*

To ensure open lines of communication with development partners, meetings of the Centre's Development Partners Group (DPG) are held after each Board meeting. These meetings provide an opportunity for the Centre to present its programme, some important findings, and its funding needs. It also provides an opportunity for the partners to interact with the senior members of the Centre's management team, scientists, and trustees. After the departure of Ms Renate Pors, of the Netherlands Embassy, from Bangladesh in mid-2003 on expiry of her tenure, Dr Neil Squires of DFID/Bangladesh became the new DPG chair of ICDDR,B. Dr Squires chaired the November 2003 DPG meeting.

*Communication*

*i. Dissemination*

The Office responded to press enquiries and publicized the Centre's many achievements in scientific forums. During the reporting period, the sero surveillance report on HIV/AIDS for Bangladesh was completed by the Centre and was presented to the media. For the week-long training workshop, sponsored by the US-based Howard Hughes Medical Institute (HHMI), the ER&ID Office produced a press release and secured coverage in six Bangla newspapers.

The ER&ID Office organized press conferences, including one prior to the 10th ASCODD and one prior to the 8th International Conference on Emerging Infectious Diseases in the Pacific Rim, both held in December 2003. A full-page special supplement on ASCODD was simultaneously released on 7th December 2003 in nine major dailies. Moreover, in December 2003, the Centre celebrated its twenty-fifth anniversary of its internationalization. A press briefing was organized on 15th December to highlight the many achievements of the Centre over the past twenty five years. The ER&ID Office was also a member of the 25th Year Anniversary Celebration Committee, and was an integral part in the planning processes of these events. A special publication, the *Smrity* book, that includes memoirs from past and current employees of the Centre with highlights of its organizational history, was published in December 2003 by Centre volunteer, Mrs Jean Sack.

A special press conference was organized at the Centre to assist the Ministry of Health and Family Welfare (MOHFW) to provide journalists the findings, on the mysterious disease that took the lives of several individuals in Gualondo, Faridpur, conducted by infectious diseases specialists from the Centre and from CDC, Atlanta. The Health Secretary Mr Sarwar Kamal revealed that the deaths were caused by Nipa and Hendra viruses, and assured all that the deaths were not related to the Asian bird flu syndrome.

The ER&ID Office took a lead role in the dissemination of these events by organizing press releases, arranging media coverage, and drafting scripts for special radio and TV programme. These media events led to more national as well as international coverage of the Centre's work in the electronic and print media.

### *ii. Commemorative Stamp*

A commemorative stamp on ICDDR,B was unveiled by the Hon'ble president for its contribution in the health and population sector in the country. The stamp, along with the first day cover, is available for sale at the ER&ID Office.

### *iii. Organizing special visits*

The ER&ID Office provides a lot of time and energy to put together travel itinerary for distinguished visitors, and these visits do make a real impact. For example, a visit in April 1995 by the then U.S. First Lady Hillary Rodham Clinton left a lasting impression which she describes in her recent autobiography 'A Living History.' She described how impressed she was that a health research institution [ICDDR,B] located in a developing country was leading the world by example. Likewise, a visit to Matlab by American journalist Amy Waldman led to an article describing ICDDR,B's achievements in the Sunday edition of the New York Times. Similarly, the visit by an American movie team led to the production of a video called 'The Hot Zones' which was aired on the US channel PBS and led to donations towards projects to improve water supply in Bangladesh.

*Visitors to the Centre*

A number of dignitaries visited the Centre during the reporting period. They are: Mr Victor Carvell, Director of the Bangladesh Programme from the CIDA Headquarters; Ms Judith Robinson, Director of South Asia section from AusAID, Canberra; HE Mr Harry K Thomas, American Ambassador to Bangladesh; HE Mr Gerry Campbell, Canadian High Commissioner to Bangladesh; HE Mr Borje Mattson, Swedish Ambassador to Bangladesh; HE Mr Walter Gyger, Swiss Ambassador to Bangladesh; Mr Fazlur Rahman, Secretary to the Government; Mr AFM Sarwar Kamal, Secretary, MOHFW; British Commonwealth Parliamentary delegation; Professor Jeffrey Turnbull, Dean of the Faculty of Medicine, University of Ottawa; Baroness Pola Uddin from Bethnel Green, UK; Ms Carin Jamtin, Minister for International Development, Sweden; Mr Christian Collard from the EU Headquarters in Brussels; Mr John Rogosch, Chief, Division of Maternal & Child Health, USAID, Washington; and many others.

## Support Services Department

The components of the Support Services Department comprised of skilled managers, technicians and operatives numbering 233 provided the most valuable administrative, technical and logistical support to the scientific divisions and the staff to carry out their activities most productively. The major highlight of the Department during the year is coordinating and arranging the administrative and logistical arrangements for holding the ASCODD 10 and the US – Japan Medical Cooperative Conference in December 03.

## Travel & Estate Unit

The Travel & Estate Unit coordinated the hospitality arrangements of International visitors and the in country or foreign travel arrangements of Centre staff including the Members of the Board of Trustees numbering 396 individuals. Maintained the Guest House facilities and provided limited catering services to the Center. Arranged for lease of accommodation of foreign nationals staff including coordinating and completing their immigration and customs related formalities in liaison with the Government Departments. Arranged for the collection and payment of utility bills of the leased properties and other services in liaison with the Finance Department. Administered T&T telephones. The unit did a splendid job of handling the hospitality arrangement of for 169 foreign guests attending the IMCI Meeting, ASCODD 10 and the US – Japan Medical Cooperation Meeting held during the second and the third week of December 03.

## Civil Engineering Unit

The Unit routinely maintained utility services and facilities. The Unit planned and initiated numerous renovation and new construction works within the Centre to accommodate different departments in new settings to facilitate their functioning. Following are the major works done during the period under review:

## Electrical & Telecomm Engineering Unit

The Unit planned and developed the electrical and telecommunication infrastructure facilities of the center in coordination with the Civil Engineering Unit. With its skilled technicians the unit helped in the planning for the procurement, installing and maintenance of equipment. It maintained the 16 KVA Electrical Substation along with the stand by 750 KVA generator. The Unit also operated and maintained the Center's telephone infrastructure of T&T lines and the 250 lines PABX.

## Transportation Unit

The Unit directed and coordinated the transport operations, using Centre's vehicles and those hired from contractors. It provided pick-up and drop services for approximately 350 personnel every day. The vehicle maintenance workshop provided minor and major repair facilities for all the vehicles. The Unit manager coordinated the operations of the

transport movement and support required for smooth conduct of the ASCODD 10 and the US – Japan Medical Cooperative Meeting during December 03.

**General Services Unit**

The General Services Unit coordinated and controlled the security services for the grounds and the property by coordinating the Centre's guards and those contracted from outside. The Unit also provided services for cleaning, mail receipt and dispatch, logistics management of conferences and training activities of the Centre. The unit coordinated the security and related logistics services during the ASCODD 10 vary efficiently.

**Cafeteria Services Unit**

The cafeteria services were provided to the staff by maintaining the Staff Cafeteria and the Corridor Café for lunch, morning and evening teas. An average of 500 members of the staff made used of the canteen facilities every working day. Besides, the catering services also arranged meals for all the major and minor functions held by the Divisions/Departments. It coordinated the catering services during the ASCODD 10 very commendably where over a thousand participants / guests were entertained for three days.

# Report to the ICDDR,B Board of Trustees, June 2004

...Celebrating 26 Years As An International Centre and 44 years as an institution in Bangladesh


## Overview of the Presentation

1. Review major events and changes during the year
2. Highlight major future trends and/or changes, especially with regard to relations with MOHFW and NGO partners.
3. Review progress on the Strategic Plan
4. Review developments for Master Plan

# Celebrations for the 25th year

| | |
|---|---|
| February 2003 | Gala Ball |
| June | Children's Art Contest |
| September | Howard Hughes course in advanced biotechnology |
| November | House of Lords banquet |
| December | ASCODD/IMCI meetings<br>Commemorative Stamp<br>US-Japan Meeting<br>Smriti Publication |
| February 2004 | Black and White Ball |

# Overview of the Board Meeting

| | |
|---|---|
| Day 1 – AM | Director's report and presentation of new developments, followed by Development Partners Group |
| Day 1 – PM | Finance and HR Committees |
| Day 2 – AM | Planning for retreat in November |
| Day 2 – PM | Defining issues for the conference call with other Board Members |
| Day 3 – AM | Lecture from Dr Lanata |

# Transitions of Staff

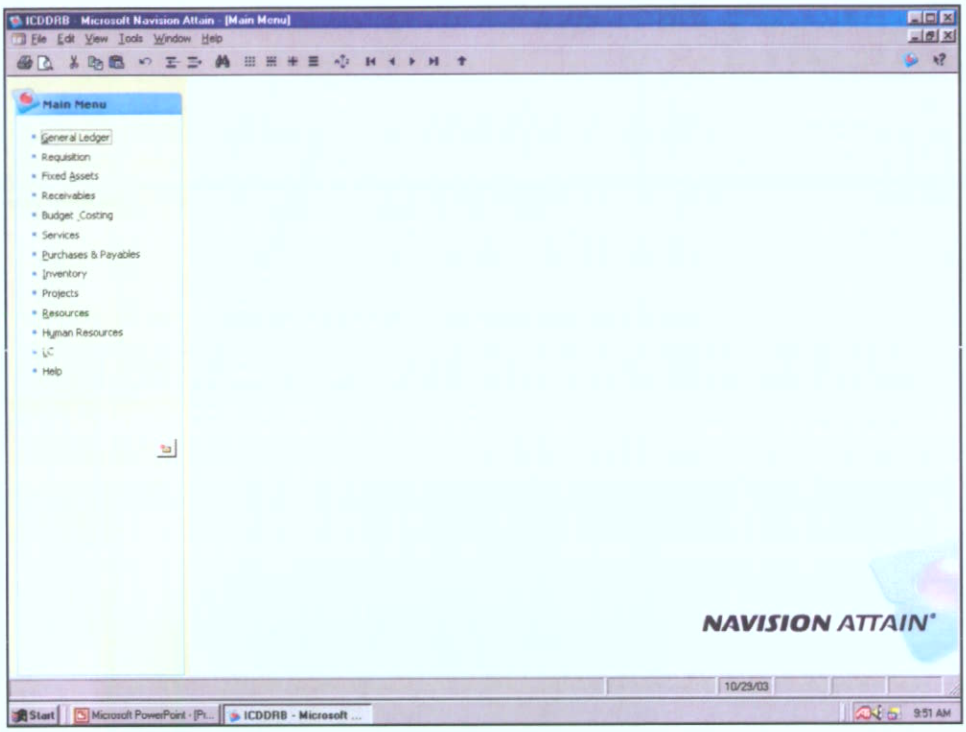
- **Dr Rob Breiman**, Head of the IDVS Programme left the Centre in June 2004 to take up a new CDC post in Kenya. **Dr. Steve Luby** from CDC will take up this post in August.
- **Dr. Marge Koblinsky** will be joining the Centre as Director of the PHSD in September, 2004. We thank **Dr. Abbas Bhuiya** for his leadership during the last year.
- **Mary Hadley**, coordinator for the Family Health Research Project, left the Centre in April to take up a new post in Zambia. **Mr. Helal** has been recruited to fill this post in July.
- **Julia Ackley**, Senior Associate in the ERID office, left the Centre in June to return to the US. We wish her well as she awaits her first child. We will be seeking a replacement

## New Management Information System

- Windows-based MS-Navision, a unified system for finance, HR and projects.
- "Went live" in February
- Involved most in the Centre and > 20 professionals at PWC
- Forced re-evaluation of our entire administrative system
- Expected early problems; confident it will serve us well
- Will add CRM soon

**Suchona – "New Beginnings"**

It needed a push, but now it's picking up steam!
Soon it will be cruising along.




# HR update

2003

- Suchona organization
- Completed job reclassification
- Completed job families
- Completed the Gender Equality Policy

2004

- Implementing Suchona
- Implementing the Gender Equality Policy
  - Recruited a Gender Specialist
  - Gender review ongoing
- Recruitment of senior positions

Will discuss details in HR committee

## Overview of Finances

### *The good news*

- Five years of balanced budgets
- Long term core commitments from Holland, Canada, UK, Swiss, Bangladesh, Sweden
- Large project grant from Gates Foundation for SUZY (Zinc)
- Large project grants from NNP, NIH, others
- The scientists are the major fund raisers at the Centre
- Prospects for
  - significant "one off" funds Bangladesh/Japan through DRGA
  - significant "one off" from Bangladesh/US.
  - Additional large projects for rotavirus vaccines, emerging infections, reproductive health

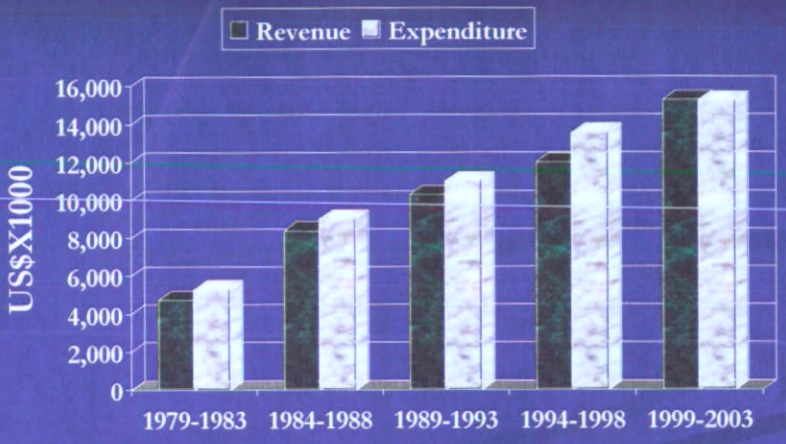
## Overview of Finances

### *The bad news*

- Some donors have withdrawn funding or changed conditions because of their own finances or priorities
- May be difficult to balance budget in 2004, but assuming that several new projects start as planned, we should be back in black.
- Bad stock market during 2001-2002 hurt endowment funds, but this is now improving

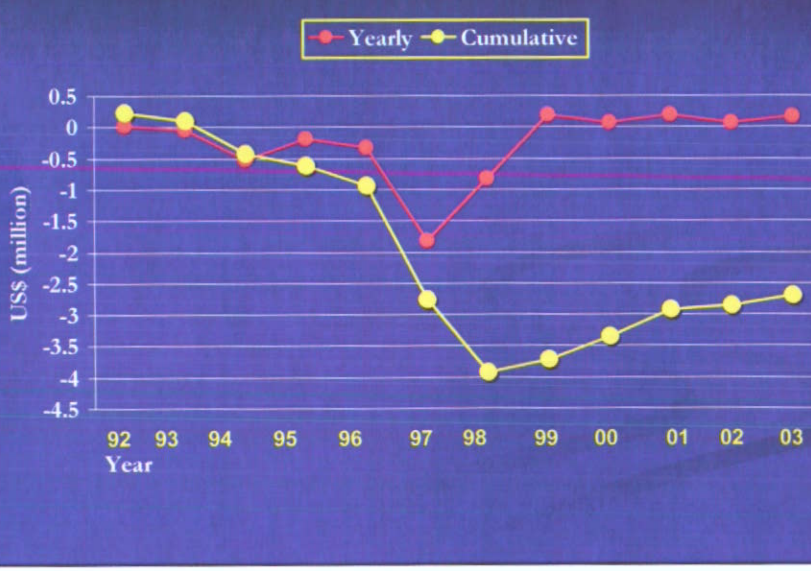
# Long Term Overview of Finances

## 25 Yrs. Revenue & Expenditure (1979-2003)




No additions to admin staff since 1998

# Surplus / Deficit – 1992 - 03

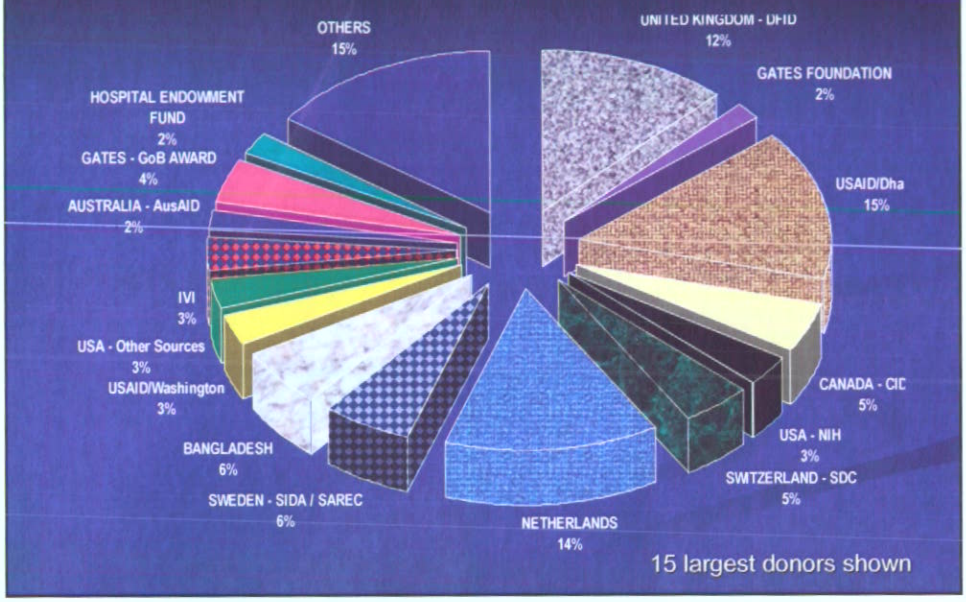


## Lessons From These Financial Trends

- Easier to get into debt than to get out of it.
- Our approach: Be frugal
  - ✓but be productive
- Be worthy of investments by Development Partners (i.e. donors).
- Be persistent

## Revenue and Expenditure during 2002 and 2003

# Contributions, 2003




# Lessons from the mix of donors

- Large number of donors = healthy
- Largest single donor contributes 15% of the total.
- The increase in total revenue increases ability to
  - contribute to the international agenda
  - fulfill strategic plan

## Financial Projections for 2004

- Projected budget for 2004… $17,169,000
- Projected revenue… $16,559,000
- Projected gap… $610,000

- Steps to reduce gap
  - Continue to be frugal
  - Increase project revenue
  - Work closely with the MOHFW to insure relevance

## Tracking of financing in the future

- With Suchona (new MIS), will track expenditures by
  - Division, Programme, Protocol, and Activity
  - Donor (including multiple grants from the same donor).
  - Reports to donors from all PI's.
  - Strategic plan priorities
  - Categories such as "essential core," as well as other categories
- Will do this "on line"
- Will provide much more detailed information in future

## Name change for the Centre?

- An agenda item for the Board is a process for potential name change
- The name should reflect the current activities and vision of the Centre
- It should also be "marketable"

## Changes in Physical Plant

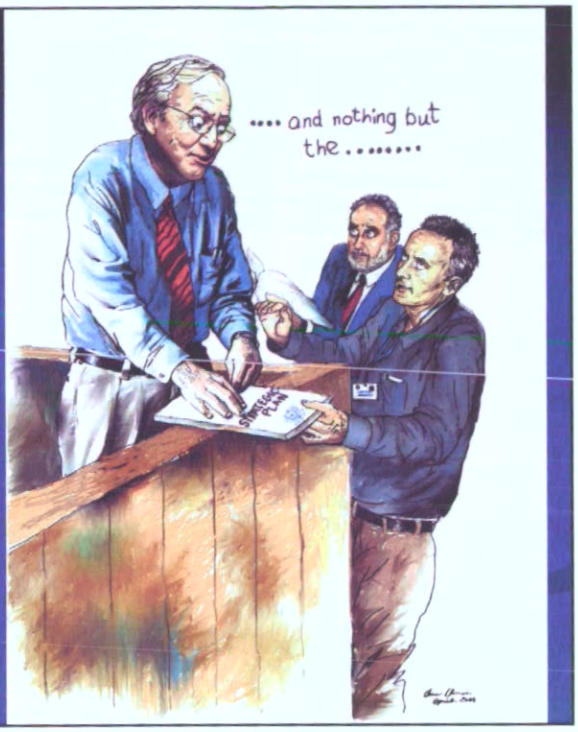
Completed or underway

- LSD various renovations
- Canteen- renovations
- Hospital – Special Care Unit Renovation

Planned

- HSID major renovation
- Generator
- Hospital

# The Strategic Plan




## Expected Accomplishments During The Coming Decade

| Priorities from Strategic Plan | |
|---|---|
| 1. | Introduce cost effect strategies for zinc therapy for diarrhoea |
| 2 | Help reduce maternal morbidity and mortality and improve perinatal and neonatal health |
| 3 | Develop a package for the prevention of foetal growth restriction |
| 4 | Help identify a package of suitable vaccines for diarrhea and acute respiratory infections |
| 5 | Define the burden from tuberculosis and identify effective strategies for prevention and control |
| 6 | Address stagnation of fertility decline |
| 7 | Help prevent epidemic of HIV-AIDS and RTI-STI |
| 8 | Contribute to knowledge that can impact the burden of vector borne disease |

## New Programmes to Add to the Strategic Plan

- HIV-AIDS
- Poverty and Health
- Safe Water

## Division Updates-CSD

- New (and improved) ORS using liposomes
- Shigellosis
- Poorly absorbed starch (green banana) as treatment for diarrhoea
- Metronidazole for severe malnutrition?
- Child Development Unit
- International consultations on severe malnutrition

## Division Updates-LSD
## New International Initiatives

- Collaboration: Instituto de Investigacion Nutricional (IIN) funded by Third World Network of Scientific Organizations (TWNSO).
- HIV/AIDS Program activity in Nepal - USAID, Nepal.
- RTI/STI Laboratory, molecular diagnostic services for HIV/STI surveillance among sex workers and male truckers in Nepal, FHI-Nepal.
- LSD collaboration with Ministry of Health, Mozambique on cholera.

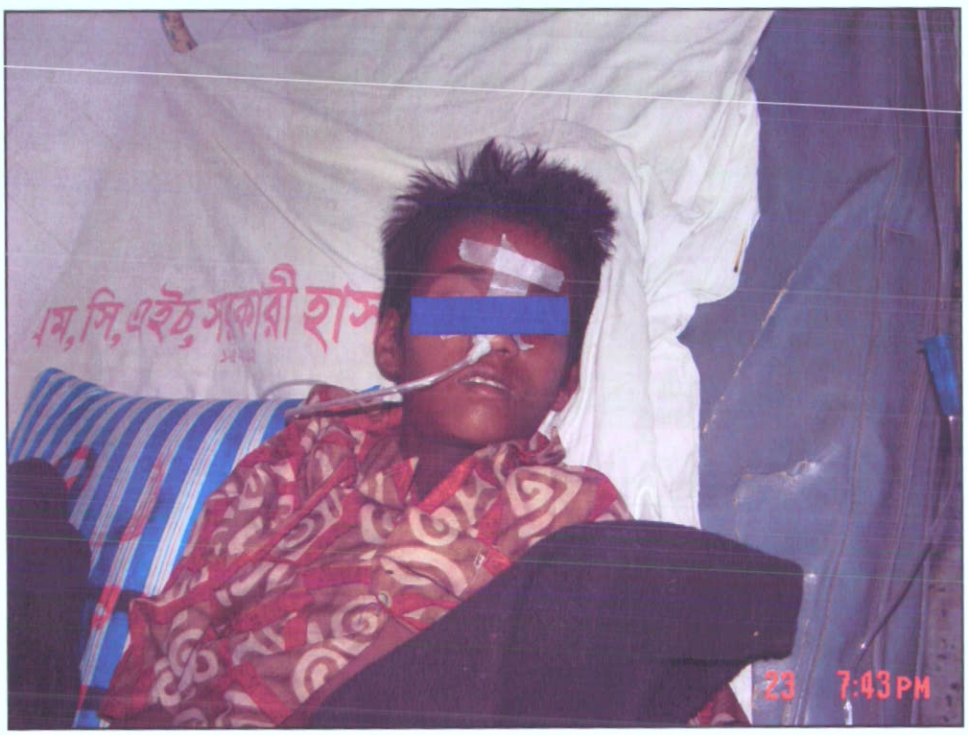
## Division Updates-LSD
## New Initiatives

- **New findings**
  - Caliciviruses
  - HIV Surveillance
  - Live oral cholera vaccine
  - Shigella and antibiotic resistance
- **New Equipment**
  - ABI Prism 310 Automated Nucleotide Sequencer
  - Real Time PCR Machine

*Dr. Firdausi Qadri has joined a 12 member WHO International Vaccine Review (IVR) Steering Committee on Diarrhoeal Disease Vaccines*

# Division Updates - HSID
# New Initiatives

- Zinc
  - Zinc treatment of severe pneumonia
  - SUZY – Scaling up the use of Zinc in Bangladesh
  - Efficacy of zinc in pneumonia, community study
- Health systems
  - Unintended pregnancies in rural Bangladesh
  - Micronutrient fortification of chapattis
- Surveillance
  - Respiratory Virus Surveillance
  - Pneumococcal Surveillance
  - Typhoid
  - Kala Azar
  - Dengue
  - Nipah
- Vaccines
  - Preparation for dengue, Tb, typhoid



## Division Updates - PHSD Major Initiatives

- Health consequences of arsenic
- Epidemiology of cholera in Bangladesh
- Hib Vaccine Effectiveness
- The Unmet Obstetric Needs project
- Micronutrients to reduce morbidity
- Maternal Infant Nutrition Intervention (MINIMAT)
- IMCI Evaluation Study
- Neonatal mortality
- Fertility plateau

## Ongoing education and sharing

- 31 seminars and lectures since the last board meeting
  - **DPG members are welcome to attend weekly seminars**
- Additional coordination meetings within divisions
- Ongoing training: international and national courses
- Suchona Training for staff

## Knowledge-based policy-making for HNPSP "Getting Research into Policy and Action"

- 22 January 2004 – Workshop to define a research agenda for HNPSP
- Attended by senior planners from MOHFW along with national institutes and WHO
- Goals
  - Establish a strategy for dialogue between policy makers, programme managers and researchers
  - Identify priorities for research to reflect the decision making process
  - Define mechanisms for using knowledge and creating a research agenda

## Funding for a Research Agenda

- Development Partners currently fund research on a bilateral basis
- There may be support from Development Partners for "pool financing" to MOHFW if…
  - There was a clearly defined research agenda
  - There was a clear link between the research and the policies and programmes
  - Such allocations could be shown to be cost effective

## Research ⟷ Policy

- Two way relationship needed between research and policy
- Government departments need to be involved in defining the research questions, the implementation, and dissemination
- Information must be readily available to policy makers
- Reduce barriers that separate researchers from policy makers
- Policy makers should be committed to using the results of the research that they commission.
- Need for flexibility in programmes to accommodate new research findings

## Setting Research Priorities for HNPSP

- Guided by MDG's
- National goals and targets
- Opportunities based on resources available
- Priority setting needs to involve many stakeholders

## DRGA Fund and Additional Collaborations with the Ministry

- Conclusions from January meeting can be "made real" with funding from DRGA
- Steering and Technical Committees (MOHFW and ICDDRB) will guide DRGA funding
- 14 core areas in work plan to provide services for the people of Bangladesh in collaboration with national institutions
- Additional funds sought for the national institutes' research agendas

## BRAC wins the 2004 Gates Award for Global Health, the 2nd from Bangladesh

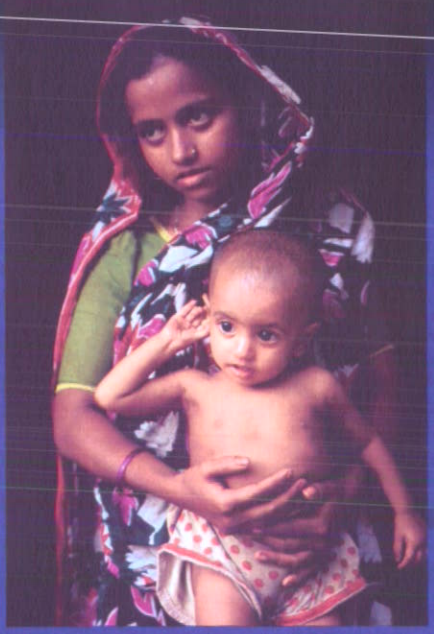
- ICDDRB to collaborate with the BRAC School of Public Health (James P Grant School).
  - Share faculty
  - Joint courses, share library resources, facilities.
  - Will host students in research projects.
- Developing plans to host the School in a newly constructed ICDDRB building
- Need to jointly raise construction funds to complete our master plan

## Conclusions

- Anniversary Year was productive and demanding
- Stability does not mean wealth: but future can be planned.
- Suchona will provide benefits in years to come.
- Improved financial stability with several key donors.
- Improved relations with the Government of Bangladesh and a feeling of partnership with development partners

## Thanks to many

- The scientists, administrative and support staff at the Centre.
- The Ministry of Health, ERD and the National Institutions. GoB as a key "development partner."
- External development partners who make it all possible.



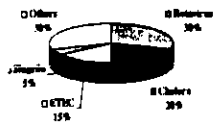
# Scientific Presentations

1. **New findings and directions on cholera**
   G. Balakrish Nair, Ph.D.
   Director
   Laboratory Sciences Division

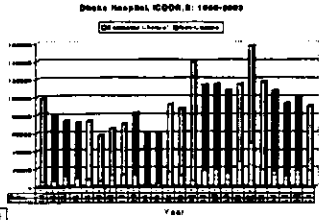
2. **Community-based Interventions to Reduce Neonatal Mortality**
   Dr. Shams El Arifeen
   Head, Child Health Programme
   Public Health Division

# New findings and directions on cholera

G. Balakrish Nair, Ph.D.
Director,
Laboratory Sciences Division

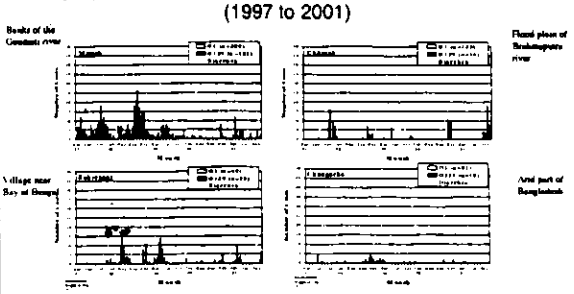


**Leading Causes of Diarrhea at the ICDDR,B Dhaka Hospital, 1999**



**20% of diarrhea cases to our Dhaka hospital are confirmed as cholera – 20,000 (up to 55,000 cases) cases annually**

Fortnightly surveillance in 4 widely separated geographic locales (1997 to 2001)

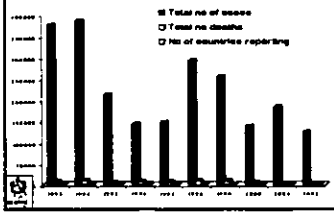


**Both serogroups were found in all locations; outbreaks were seasonal and often occurred simultaneously**

**The correlation of disease periodicity with geographic proximity to riverine and /or marine aquatic environments reinforces the importance of water ecology in the epidemiology of cholera**

# Burden of Cholera in Bangladesh

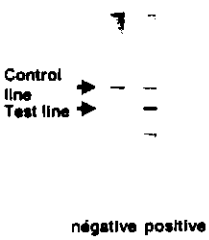
| Area | Rate per 1000 population |
|---|---|
| Chatak | 2.19 |
| Bakerganj | 2.73 |
| Chaugacha | 0.75 |
| Begumganj | 3.94 |
| Matlab | 3.28 |



- **Incidence ranged from 0.75 to 3.94 per 1000 population**
- **Average for five sites was 2.58 per 1000 population**
- **Assuming the rate of cholera for the population as a whole is about 2.5 per 1000**
- **Then with a population of 140 million, the best estimate of cholera leading to hospitalization is about 350,000**

WHO Yearly Global Cholera Statistics are gross underestimates, since many countries either do not report of under-report cholera

## Evaluation of the cholera dipsticks




**From stool specimens**

O1: Sensitivity 94.2%; Specificity 84%

O139: Sensitivity 100%; Specificity 92.5%

**Rectal Swabs after 4 hours enrichment**

O1: Sensitivity 96%; Specificity 92%

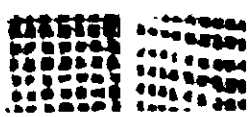
O139: Sensitivity 93%; Specificity 98%

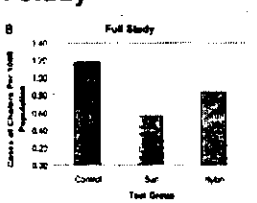
Nato et al., 2003 Clin. Diagn. Lab. Immunol. 10:476-478
Bhuiyan et al., 2003. 264.J. Clin. Microbiol. 41: 3939-3941

## New insights into the epidemiology of cholera

- The risk factors of cholera include proximity to surface water, high population density, and low education status and these risk factors were same for both the biotypes (Ali *et al.*, Health and Place 2001).
- Epidemic and endemic cholera trends over a 33 year period in Bangladesh show the Inaba subtype confer short-term population-level immunity for a longer period than those of Ogawa suggesting that Inaba antigen should be maximized in cholera vaccine designs (Longini *et al.*, J. Infect. Dis. 2002).
- Water-use patterns showed that bathing and washing clothes in tube-well water was significantly protective for cholera (Sack *et al.*, J. Infect. Dis. 2003)

## Sari filtration study





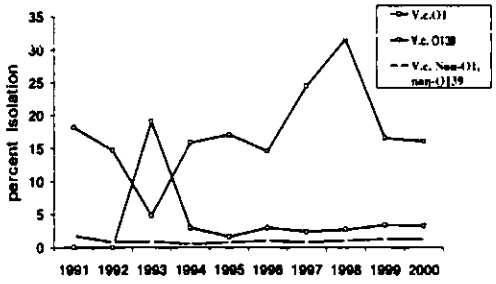

Deployment of a sari filtration procedure from September 1999 through July 2002 in 65 villages of rural Bangladesh (total population for the entire study comprised about 133,000 individuals) yielded a 48% reduction in cholera ($p < 0.005$) compared with the control

Colwell *et al.*, 2003. PNAS. 100:1051-1053

## Future Directions

- Identify temporal correlations between climate and the biannual peaks in cholera incidence in Bangladesh.
- Quantify environmental parameters in riverine and marine environments over time and to identify temporal correlations between fluctuations in these measurements and increases in the weekly rate of cholera.
- We expect that these models will be useful in cholera prevention and control in many parts of the world. Furthermore, these environmental studies will increase our understanding of the impact of the aquatic environment on the incidence of diseases caused by waterborne pathogens.

**Isolation of *V. cholerae* from surveillance patients at ICDDR,B Dhaka during 1991-2000**



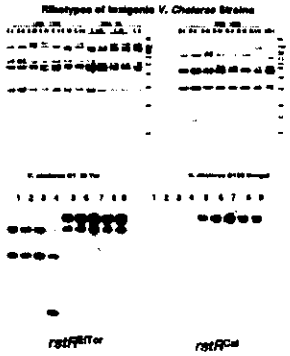

# Recent findings on O139

- The O139 serogroup of *V. cholerae* is derived from multiple *V. cholerae* O1 or Non-O1 progenitors

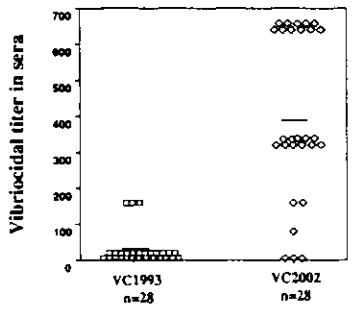
Faruque et al. (2000) J. Infect. Dis. 182:1141-1148

- Reemergent *V. cholerae* O139 associated with epidemic cholera has subtle genetic changes

Faruque et al. (2003) Emerging Infectious Dis. 9: 1116-1121

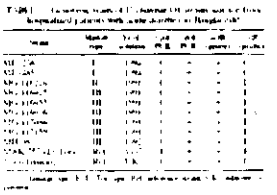



**Vibriocidal antibody titers with O139 strains isolated in 1993 and 2003**




VC2002 compared to VC1993 show:
- similar susceptibility to lysis by bacteriophage JA1
- less capsular polysaccharide content
- similar LPS profile
- ↑ susceptibility to bactericidal activity of normal human sera
- ↑ lysis by antibodies in convalescent sera in the complement mediated vibriocidal assay
- ↑ Killing by polymorphonuclear neutrophils

Individual titer and median values shown. Pooled sera from patients with *V.cholerae* O139 infection used in assay

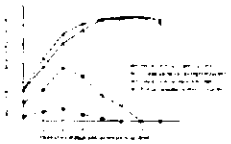


The **Matlab Variants** of *Vibrio cholerae* : hybrids between classical and El Tor biotypes

Nair *et al.*, 2002. J. Clin. Microbiol. 3296-3299

## Cholera Toxin Phage Biology

- Induction of CTXϕ in naturally occurring strains of toxigenic *V. cholerae* O1 & O139
- Molecular basis of origination of new strains with epidemic potential
- Sunlight induced propagation of the lysogenic phage encoding cholera toxin
- Diminished diarrheal response to *V. cholerae* strains carrying the replicative form of the CTX ϕ genome instead of CTX ϕ lysogens in adult rabbits
- Description of RS1 as a new filamentous phage exploiting the morphogenesis genes of CTX ϕ
- CTX ϕ-independent production of RS1 satellite phage

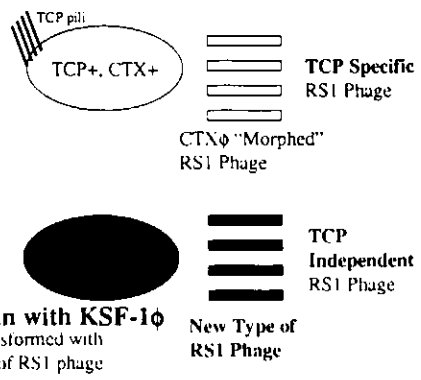


**RS1 element of *V. cholerae* can form a filamentous phage using CTX phage morphogenesis genes.**

CTX phage genome

Excised RS1-element

## Environmental Amplification of RS1 Phage



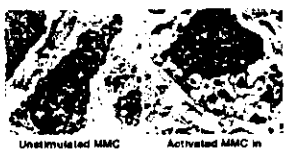

## Future Directions

- Genetic screens
- Transcription profiling of genes switched on in the environment and in the human intestine
- Molecular fingerprints
- Emergence of new toxigenic clones of *Vibrio cholerae*
- Tracing evolution of pathogenic clones of *Vibrio cholerae*

# Immunological aspects of cholera

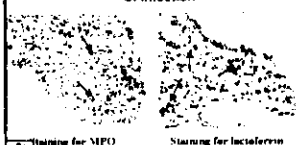
- Acute disease caused by O1 and O139 induces elevated concentrations of lactoferrin, myeloperoxidase, prostaglandin $E_2$, leukotriene $B_4$ and nitric oxide as well as other metabolites indicating that the innate defense system is activated (**Qadri et al., 2002. Clin. Diagn. Lab. Immunol. 9: 221-229**).
- The inflammatory process is also activated in both adults and pediatric patients infected with *V. cholerae* O1 and O139 (**Qadri et al., 2002. Clin. Diagn. Lab. Immunol. 9: 221-229**).
- Ability to generate specific mucosal immune responses in reproductive tract tissues after intestinal presentation of antigen could facilitate development of vaccines effective against reproductive tract pathogens.

**Transmission electron micrographs of mucosal mast cells**



Unstimulated MMC | Activated MMC in cholera

**Immunohistochemistry of duodenal mucosa of an adult patient with cholera at the acute stage of infection**



Staining for MPO | Staining for lactoferrin

## Innate and inflammatory mediators in cholera

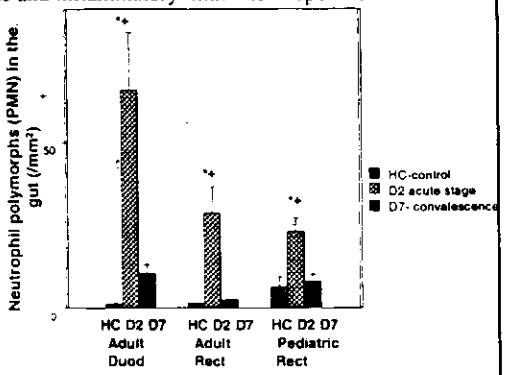
**Cholera induces activation of neutrophil polymorphs, mast cells and eosinophils in the gut. Specific mediators also up-regulated in the mucosal as well as the systemic compartments**

**The activation of innate immunity leads to the development of antigen specific immunity which in cholera is protective.**

**For a vaccine to be protective against cholera it may need to simulate these features seen in natural infection**

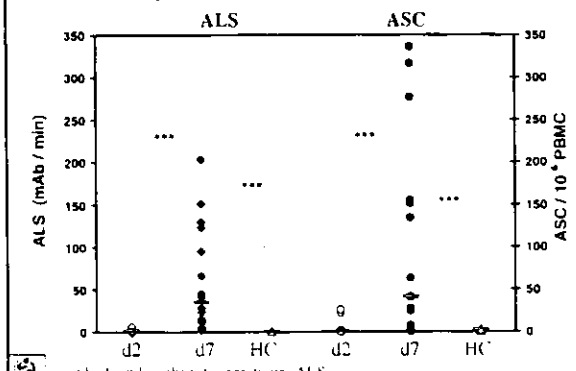
**Qadri et al., 2002. Clin. Diagn. Lab. Immunol. 9: 221-229**

## Innate and inflammatory immune responses in cholera




Qadri *et al.*, 2003 Gut 53: 62-69

## LPS- specific ALS and ASC IgA responses

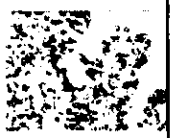



antibody in lymphocyte secretions· ALS

## Involvement of immunomodulating cells in the gut in toxin mediated diarrhea

T and B cells in the duodenal biopsies:
at the acute stage:
↑ CD3, CD4 in the lamina propria- T cell markers
↑ CD8 in surface epithelium- T suppressor/cytotoxic phenotype

At convalescence:
↑ CD4 in lamina propria
↑ CD19- B cell marker in the lamina propria



Other activations:
↑ CD68-macrophages
↑ Ki67- the proliferation marker

Cellular interplay observed with mucosal response directed through Th2 driven increase of CD4 cells

## Cytokines at the mucosal surface in cholera

| Cytokines | Cholera patients | | Healthy subjects |
|---|---|---|---|
| | Acute | Convalescence | |
| IL-3 | 0.61 (0.38-0.96)*+ | 5.28 (3.68-7.56) * | 0.19 (0.08-0.40) |
| IL-4 | 2.22 (1.4-3.5) | 3.46 (2.2-5.44) | 1.9 (1.6-2.3) |
| SCF | 5.14 (4.0-6.57)* | 3.19 (2.43-4.17)* | 0. 872 (0.56-1.33) |
| Eotaxin | 7.8 (6.8-8.9)*+ | 2.29 (1.87-2.8) | 1.5 (1.35-1.71) |
| TNF-α | 6.2 (5.3-7.2)*+ | 0.61 (0.53-0.71) | 0.25 (0.12-0.51) |

**Adult patients with *V. cholerae* O1 (n=10) infection and healthy subjects (n=10) were studied. Mean value of cytokine positive cells per $1X10^6 \mu m^2$ tissue area and range ($25^{th}$ and 75% percentile) shown. P≤0.05 in comparisons between patients and healthy controls or between the two groups of patients.+**

## Summary of results on the T cell responses in Blood

Natural cholera infection results in:

- Induction of T helper cells, confirming the Th2 pathway of activation of CT mediated activity
- Increase of CD8 T cell responses suggesting a possible role of intraepithelial lymphocytes
- A transient increase in Integrin β7-expressing CD4 T cells and B cells, indicating that antigen-specific lymphocytes are expanded by the infection, and then move back to the intestine

## Immunological aspects of cholera

- Susceptibility of *V. cholerae* O139 to antibody dependent complement mediated bacteriolysis and development of vibriocidal assay techniques of O139
- Increased nitrite and nitrate concentration in sera and urine of patients with cholera
- Development of methods for assessing seroconversion to El Tor TCP following cholera
- Demonstration of mucosal and systemic IgA immune response against the major subunit of TcpA in patients with cholera caused by O1 and O139 (Attridge et al., 2004.Infect. Immun. 72:1824-1827)

## Immunogenicity of Tcp

- Robust mucosal intestinal IgA antibodies are produced to TcpA after natural cholera infection in all groups of cholera patients.
- The toxin co-regulated pilus, to date the best described colonization factor for *V. cholerae*, is a mucosal immunogen which gives rise to antibodies of the IgA isotype after natural infection with *V. cholerae* serogroups O1 and O139.

TcpA specific IgA antibodies in sera of patients

TcpA specific IgA antibodies in fecal extracts



## Effect of zinc and vitamin A on the immunogenicity of the killed cholera vaccine

Albert, Qadri *et al.*, 2003

Vibriocidal antibody responses in vaccinees

| Group | Subjects | After 1st dose | After 2nd dose |
|---|---|---|---|
| Zinc | 63 | 33(52) | 39(62) |
| Vit A | 61 | 25(41) | 34(56) |
| Zn +VitA | 62 | 36(58)* | 41(66)* |
| Placebo | 63 | 23(36) | 29(46) |

*P<0.05; $\chi^2$ or fisher exact test used; N(%) shown

Additive effect of Zinc and vitamin A on the immune response children to Cholera

| Study groups* | Vibriocidal antibodies % |
|---|---|
| Zinc (n=125) | 43 |
| Vit A (n=123) | 12 |
| Zinc + Vitamin A | 59 |

*Response compared to placebo recipients

**Supplementation with zinc, but not vitamin A, improves seroconversion in children given an oral cholera vaccine as measured by vibriocidal antibody**

## Search for better oral rehydration solutions

- Rice-based oral rehydration solution is as effective as glucose-based oral rehydration solution in treatment of cholera.
- Efficacy of packaged rice oral rehydration solution among children with cholera and cholera-like illness.
- Poorly absorbed starches such as the starch in Green bananas

## Newer antimicrobial regimens

- Single-dose azithromycin is as effective for treatment of cholera in children as standard erythromycin therapy (12 doses over 3 days), and is associated with less vomiting as compared to erythromycin (Khan et al., Lancet, 2002, 360:1722-1727)
- Clinical efficacy of tetracycline, ampicillin and erythromycin in the treatment of cholera in children was comparable (Roy et al., 2003; ASCODD)

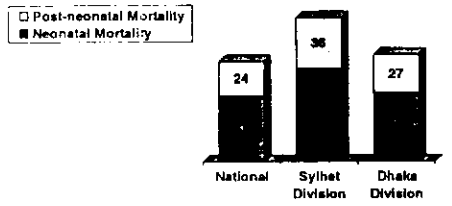
Community-based Interventions
to Reduce Neonatal Mortality

**Projahnmo**

**Not for Sharing**

1

## Infant mortality rate: 1997-2001
## Neonatal / post-neonatal




Source: Bangladesh Maternal Health Services and Maternal Mortality Survey 2001

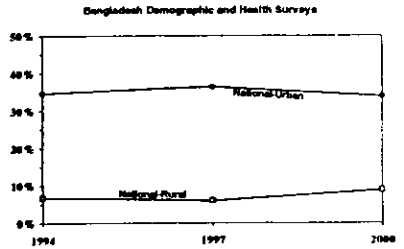
2

## Infant Mortality in Bangladesh

Source: Bangladesh Maternal Health Services and Maternal Mortality Survey 2001

3

## Deliveries attended by trained attendant*: Bangladesh




*Doctor, trained nurse/midwife or other health professional

4

- Most investments in ensuring safe deliveries has been supply side – limited efforts on modifying family/community behaviours
- No or limited focus on the newborn- newborn care; practices remain poor even when other health care behaviours have improved
- Many of these practices are based on deeply entrenched beliefs
- Health services not ready to meet the needs of the sick newborn

5

## Partnership

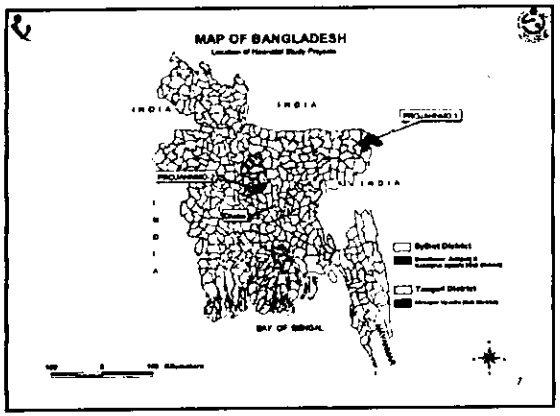
**Partners**
- Government of Bangladesh
- ICDDR,B
- Shimantik
- BRAC
- Institute of Child and Mother Health
- Dhaka Shishu Hospita
- Kumudini Hospital
- Save the Children Federation
- Johns Hopkins University

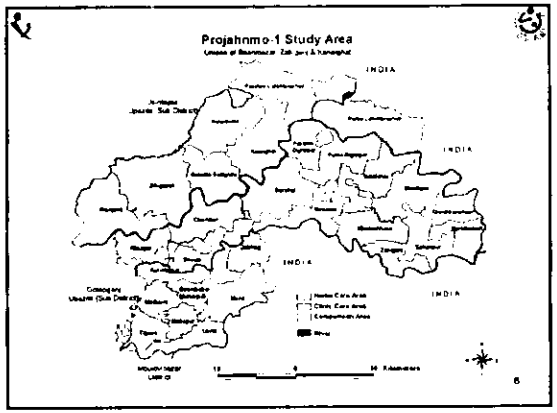
**Sponsors**

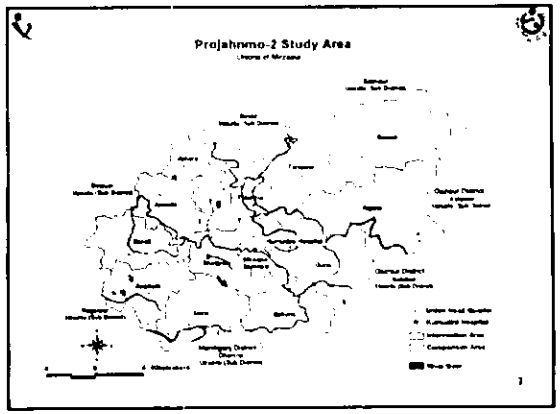
Projahnmo-1
- USAID/Dhaka & Washington
- Saving Newborn Lives Initiative/SCF, USA

Projahnmo-2
- The Wellcome Trust

6




## Objectives

- To evaluate the impact of a package of obstetric and neonatal care interventions
- To improve newborn care and the recognition and management of serious neonatal infections
- To identify the principal agents of serious bacterial infections in the community (Mirzapur only)

10

## Study Design

Cluster Randomized Trials

**Projahnmo-1 (Sylhet)**

- 3 sub-districts of Sylhet District with 475,000 population
- 24 unions randomly allocated to 3 study arms:
  1. Home care
  2. Clinic care
  3. Usual care (comparison)

**Projahnmo-2 (Mirzapur)**

- 1 sub-districts of Tangail District with 400,000 population
- 12 unions randomly allocated to 2 study arms:
  1. Home care (intervention)
  2. Usual care (comparison)

Expecting to improve maternal and newborn care practices and reduce neonatal mortality by 40%

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## Study Phases

- **Phase I**
  Formative Research and Design of Intervention
- **Phase II**
  Intervention implementation and evaluation
- **Phase III**
  Analysis, write-up, dissemination, policy advocacy

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## Study Outcomes

- Mortality - overall and cause specific
- Knowledge and practices
  - Pregnancy, delivery and post-partum care
  - Essential and sick newborn care
- Etiology of neonatal infections in the community, antimicrobial resistance patterns
- Equity analysis- knowledge, practices, mortality
- Cost effectiveness- cost per neonate treated, neonatal death averted (sepsis, asphyxia)

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## Formative Research

**Comparative selected findings from Sylhet and Mirzapur**

**Overall picture**

| Practices for newborn health are better | Mirzapur ⟺ Sylhet | Practices harmful to newborn health |
|---|---|---|

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## Location of labor and delivery and delivery position in Sylhet and Mirzapur

| | | |
|---|---|---|
| | Usually in the compound of the husband's family | Usually in the compound of the woman's family |
| | Typically a small corner in the kitchen | Typically a room other than the kitchen or the main living room |
| | Bed on the floor made out of bamboo and/or jute mat, sack or katha. The baby and the mother stay there for seven days after the birth | Bed on the floor made out of plastic sheet on a bamboo mat. After delivery, the baby can shift over to the high bed, but the mother needs to stay on the floor till |
| | Supine | Squatting |

15

## Tasks performed on delivery

N = SYL: 38, MZP: 40

| | SYL | MZP | SYL | MZP | SYL | MZP | SYL | MZP | SYL | MZP |
|---|---|---|---|---|---|---|---|---|---|---|
| | 4 | 1 | 0 | 0 | 4 | 0 | 15 | 4 | 1 | 0 |
| | 10 | 11 | 9 | 10 | 5 | 0 | 2 | 1 | 0 | 1 |
| | 4 | 12 | 1 | 14 | 0 | 7 | 0 | 2 | 36 | 1 |
| | 10 | 11 | 0 | 13 | 3 | 0 | 1 | 1 | 1 | 1 |
| | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| | 0 | 0 | 7 | 12 | 4 | 0 | 5 | 1 | 1 | 1 |

16

## Who cares for the newborn?

N = SYL: 38, MZP 40

| | Syl | Mzp | Syl | Mzp | Syl | Mzp | Syl | Mzp |
|---|---|---|---|---|---|---|---|---|
| | 0 | 3 | 15 | 3 | 3 | 7 | 16 | 16 |
| | 3 | 9 | 7 | 5 | 11 | 15 | 13 | 13 |
| | 5 | 1 | 7 | 4 | 11 | 16 | 10 | 10 |
| | 7 | 11 | 6 | 3 | 10 | 17 | 9 | 9 |
| | 10 | 11 | 7 | 3 | 10 | 17 | 7 | 9 |
| | 11 | 13 | 6 | 2 | 10 | 16 | 6 | 7 |
| | 15 | 16 | 5 | 2 | 8 | 14 | 5 | 7 |
| | 16 | 14 | 4 | 2 | 8 | 14 | 5 | 7 |
| | 18 | 18 | 3 | 1 | 6 | 11 | 5 | 2 |

*Other: This includes paternal and maternal aunts along with TBA, doctors, and husbands of BDWs if any

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## Feeding practices

| | | |
|---|---|---|
| | Universal | Universal |
| | Sometimes | Usually |
| | Universal | Common |
| | Banana, rice powder, mukh saline (ORS), misrir pani, honey, | No food. Fluids: misrir pani, honey, goat's milk, cow's milk or powdered milk |

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## Careseeking behavior

| | | |
|---|---|---|
| | Low use of ANC | High use of ANC but want to deliver in home |
| | Prefer homeopath for newborns, also go to kobiraj, mis-eeb, imam, jhar-fuk | Prefer allopathic doctor and hospital, like Kumudini Hospital. Also consult kobiraj who treats with talpora but not panipora or purpora |
| | Road communication is good in Sylhet though the rate of hospital delivery is low. | Road communication is bad compared to Sylhet though the rate of hospital delivery is much greater than in Sylhet |
| | Avoidance of hospital care, very rare for people to go to the hospital. | At Mirzapur, people have good knowledge about hospital and go there whenever they need it. |

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## Intervention design process

Principles:

- Test of principle
- Feasible, possible to scale up

Process

- Literature review of evidence for impact of interventions
- Consultation among researchers, programme managers, policymakers, stakeholders; local and international health care leaders in neonatal and maternal health
- Local programme experience
- Formative research and behavioral trials of improved practices in study area
- Allowing for evolution

20

## Sequence of Actions During the First Hour of Life

| Current sequence of actions according to formative research | Potential compromise between current and ideal sequence of actions | Ideal sequence of actions to be promoted |
|---|---|---|
| 1. Birth<br>2. Baby placed on [illegible] placenta delivered, baby slapped on back if not crying or moving<br>3. Delivery of placenta<br>4. Placenta or cord buried if baby not crying or moving<br>5. Mother or young child eats cord<br>6. Baby massaged with mustard seed oil<br>7. Baby is bathed for 10–15 minutes, held over bowl of water, mix of warm & cold water, water changed 3 times, vernix removed<br>8. Baby wiped dry with soft cloths<br>9. [illegible]<br>10. Baby wrapped<br>11. Baby fed mixed puja, regular puja, ghee or sugar<br>12. Baby is held, usually by [illegible] or dhonai, sometimes by mother<br>13. Colostrum is thrown out<br>14. Baby is breastfed if milk is present, otherwise fed mixed puja (sweet cream) or kola (fat + cream) | 1. Birth<br>2. Baby dried and wrapped<br>3. Massaging of back and other gentle stimulation if not been doing yet<br>4. Perform mouth-to-mouth breathing if still not breathing well<br>5. Baby given to mother and breastfed or held by another relative<br>6. Delivery of placenta<br>7. Mother or young child eats cord<br>8. Gentle massaging of uterus if mother still bleeding<br>9. Baby is bathed for 10 minutes maximum, held over bowl of water, mix of warm & cold water, water changed 3 times, no vernix removed<br>10. Baby wiped dry with soft cloths<br>11. Baby wrapped from head to toe immediately after bath<br>12. Baby fed mixed puja, try to negotiate on pure/mixed feeding<br>13. Baby given back to mother and thereafter exclusively breastfed<br>14. Referral of mother and baby if baby not breathing well or mother continues to bleed | 1. Birth<br>2. Cord cut immediately<br>3. Baby dried and either placed skin-to-skin and covered or wrapped from head to toe<br>4. Massaging of back and other gentle stimulation if not breathing yet<br>5. Perform mouth-to-mouth breathing if still not breathing well<br>6. Baby given to mother and put to breast<br>7. Delivery of placenta<br>8. Gentle massaging of uterus if mother still bleeding<br>9. Referral of mother and baby if baby not breathing well or mother continues to bleed |

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## Pre-testing of Recommended Behaviors

- Cutting of the umbilical cord and immediate care of the newborn
- Management of asphyxia
- Alternative bathing practices
- Alternative feeding practices
- Alternatives for wrapping of the newborn

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## Summary of results

| Lower acceptability | Medium acceptability | Higher acceptability |
|---|---|---|
| • Early cutting of cord<br>• Have person other than mother cut cord<br>• Delay of bathing | • Immediate wrapping<br>• Have mother hold baby<br>• Immediate BF<br>• Avoid removal of vernix during 1st bath | • Gentle massaging to stimulate breathing<br>• Mouth-to-mouth for non-breathing baby |

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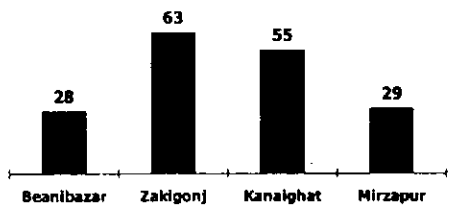
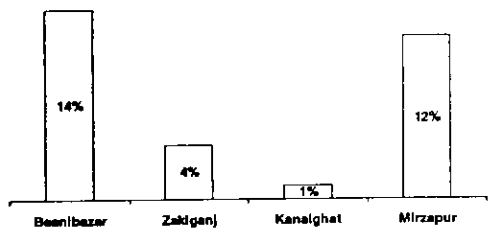
## Neonatal mortality rates/1,000 live births Sylhet and Mirzapur, 2002-3




24

## Delivery in health facility




25

## Baseline Survey – selected findings

**Female Education Level – 5+ years of Edu.**

| Age-group | Sylhet | | | Tangail |
|---|---|---|---|---|
| | B'Bazar | Zakiganj | K'ghat | Mirzapur |
| 15-19 | 59% | 50% | 74% | 77% |
| 20-24 | 65% | 55% | 48% | 70% |
| 25-29 | 51% | 38% | 31% | 47% |
| 30-34 | 38% | 24% | 16% | 31% |
| 35-39 | 28% | 18% | 10% | 21% |
| 45-49 | 12% | 8% | 4% | 14% |
| Overall | 47% | 36% | 29% | 52% |

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## Intervention Components

BCC, service delivery and facilitation on -

- Antenatal care with focus on birth and newborn care preparedness
  - HH level
  - Community level
- Delivery and postnatal care
- Newborn care including recognition, referral and management of serious neonatal infections
- Health systems strengthening & capacity building:

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## Care/contact during pregnancy

- Counseling and education –
  - Recognition of danger signs
  - Family support for pregnancy and newborn care (maternal diet, hygiene, rest, work-load sharing)
  - Health care seeking
  - Safe and clean delivery
  - Emergency preparedness (savings, transport, family/community support)
  - Immediate newborn care
  - Breastfeeding

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## Care/contact during pregnancy

- Services –
  - Referral for routine ANC, TT, delivery care
  - Distribution of IFA
  - Screening for danger signs
  - Referral of complication
  - Distribution of clean delivery kits

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## Care/contact during pregnancy

- Facilitation of birth preparedness –
  - Selection of birth attendants and newborn care person
  - Appropriate environment and place of delivery
  - Arrangement of essentials for delivery
  - Emergency preparedness (transport assistance)

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## Delivery and postnatal care

- Education and counseling
  - Skilled birth attendant
  - Clean delivery
  - Danger signs
  - Emergency obstetric care
  - Promotion of routine PNC
  - Vit A
  - Diet and work-load sharing
- Services and facilitation
  - ensuring birth attendant and newborn care person
  - Referral for complication

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## Neonatal care

- Education and counseling
  - Resuscitation
  - Thermal management (drying, wrapping and skin-to-skin contact)
  - Delayed bathing
  - Early initiation and exclusive breastfeeding
  - Danger signs
  - Umbilical care
  - Skin care
  - Immunization

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## Neonatal care

- Services and facilitation
  - Immediate newborn care including resuscitation, holding, drying and wrapping of the newborn
  - Newborn assessment and follow-up
  - Referral for complication
  - Management of sick newborn in case of failed referrals

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## Health systems strengthening

- Training of health care providers at different levels
- Strengthening logistics and supply
- Improving relevant program planning and management
- Technical and Management capacity building of Kumudini Hospital at Mirzapur

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## Intervention Delivery Strategy

- Household level (Home care arm only)
  - Pregnancy surveillance by CHWs (bi-monthly rounds)
  - Household visits for education, negotiation, screening and management- during pregnancy (2 visits), neonatal period (3 in Sylhet, 4 in Mirzapur), sick child visits (10 daily visits)
- Community level (both arms)- male/female mobilization meetings and targeted advocacy meetings with leaders, imams, teachers, village doctors
- Health facility level (both arms)- improved care at GOB/NGO facilities with education

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## Intervention Delivery Strategy

- Household level
  - Home care arm of Sylhet and Mirzapur Intervention area only
  - One Community Health Worker for 4,000 population
  - Pregnancy surveillance by CHWs (bi-monthly rounds)
  - Household visits for education, negotiation, screening and management- during pregnancy (2 visits), neonatal period (3 in Sylhet, 4 in Mirzapur), sick child visits if needed (10 daily visits)

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## Intervention Delivery Strategy

- Community level
  - both arms of Sylhet
  - male/female mobilization meetings and targeted advocacy meetings with leaders, imams, teachers, village doctors
- Health facility level
  - Care for pregnant/delivering mothers, sick neonates
  - Improved care at GOB/NGO primary care facilities
  - Improved referral care at GOB facilities

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## Intervention strategies by area and study arms

| Intervention strategy | Sylhet | | Mirzapur |
|---|---|---|---|
| | Home care | Clinic care | |
| Pregnancy surveillance | √ | | √ |
| Birth and neonatal care preparedness | √ | √ | √ |
| Community mobilization meetings | √ | √ | |
| Targeted advocacy meetings | √ | √ | |
| Clean delivery and identification and referral of emergency obstetric cases | √ | √ | √ |
| Newborn care visits, identification and referral of sick newborns and mothers | √ | | √ |
| Improved routine maternal and neonatal health care at health facilities | √ | √ | √ |
| Management of maternal and newborn complications at health facilities | √ | √ | √ |
| Home mgmt. of sepsis if referral fails | √ | | √* |

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A CHW demonstrating drying and wrapping a newborn to pregnant women and other family members

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## Intervention: Who does what?

| Providers | Sylhet | | Mirzapur |
|---|---|---|---|
| | Home Care | Clinic Care | |
| Primary providers | CHW & CM | CM | CHW |
| Referral providers | FWV, NGO Paramedic, MA, SACMO | FWV, NGO Paramedic, MA, SACMO | FWV, NGO Paramedic, MA, SACMO Doctors, Nurses |
| Secondary providers | Depot holder, TBA FWA, female HA | Depot holder, TBA FWA, female HA | Depot holder, TBA FWA, female HA |
| Supervisors | Project Field Supervisors | Project Field Supervisors, FPI, AHI | Project Field Supervisors |

## Training and Orientation

| Topics Covered | # of trainee | | Module | Durtn. |
|---|---|---|---|---|
| Antenatal care , Birth & Newborn Care preparedness, Care at Birth, Immediate Newborn Care, Newborn Resuscitation, Postnatal care, management of sick newborn Breastfeeding Counseling & Negotiation Essential Newborn Care, Newborn Resuscitation & Management of sick newborn ( Training duration 5 weeks to 6 days ) | Project Doctors & GTs | 10 | Developed by Proshhmo | 12 |
| | CHW CM | 95 | Developed by Proshhmo | 159 |
| | FSS & CSS | 20 | Adapted by Proshhmo | 30 |
| | MOH & Kumudini – Doctors & Nurses | 54 | Adapted by Proshhmo | 15 |
| | MOH , FWV SACMOs/MA | 28 | Adapted by Proshhmo | |
| Clean & Safe delivery practices Normal delivery, Manual Removal of Placenta , Immediate Newborn Care ( Training duration 28 days ) | FWVs | 11 | Developed by OGSB | 84 |
| | CGS | 4 | | |
| Project briefing, Birth & Newborn Care preparedness, Immediate Newborn care, Program operation Project briefing ( Training duration 1 days orientation ) | FWA HA, AHI &FPI | 100 | Developed by Proshhmo | 4 |
| | NGO paramedics | | | 1 |
| | Depot-holders | 12 | | |
| | MOH, NGO & Project staffs | 30 | | 2 |
| | | 105 | | |

41

## Training and Orientation

| Topics Covered | # of trainee | | Module | Durtn. |
|---|---|---|---|---|
| Project administrative issues,Record keeping & MIS, Use of tools & Guideline for BNCP, NC visit & Clinical assessment of Newborn ( Duration 10 days) | Project staffs CHW,CM, FSS & CSS | 56 | Developed by Proshhmo | 30 |
| Conducting community group meeting on Antenatal care , Birth & Newborn Care preparedness, Immediate Newborn Care Referral of complicated mother & sick newborn | CMs FSS | 16 | Developed by Proshhmo | 6 |
| Birth & Newborn Care preparedness, Clean delivery practice, Immediate Newborn Care, Identification of sick newborn ( Training duration 3 days to 1 days ) | TBAs FBAs | 464 2400 (targeted ) | Developed by Proshhmo BRAC & SNL | 78 84 |
| Refresher training on Use of tools & Guideline for BNCP, NC visit & Clinical assessment of Newborn, Newborn Resuscitation ( Duration 5 - 1 days) | CHW FSS & CSS | 78 20 | | 15 CME 1 days per week in a group |

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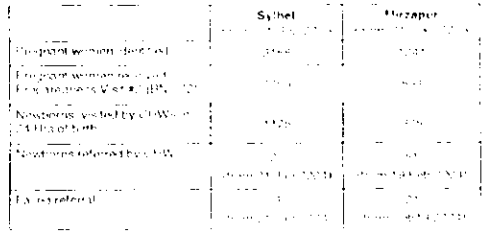
## Monitoring and quality assurance

- Monitoring and adequacy indicators –
  - Intervention coverage
  - Intervention implementation process
  - Immediate effect and compliance
  - Quality of inputs
- Fortnightly data compilation, review and feed-back for regular monitoring
- Six-monthly independent sample household survey for adequacy assessment

## Where we are now....

- Completed baseline surveys, formative research
- Behavioral trials completed, developed training/educational materials, and completed staff training
- Interventions being implemented:
  - Projahn no-1: since July 2003
  - Projahn no-2: since October 2003
- 1st adequacy survey completed last month in Sylhet
- Mid-term review – June 6-16, 2004

## Present Status of the Project as of March 31, 2004




## Coordination and advocacy

- Technical Review Committee (TRC) at national level
- Regular District level coordination meeting
- Upazilla level coordination meetings (with GoB and NSDP) – monthly
- Union level advocacy meetings

## Unique features

- Wide partnership based on comparative advantage of organizations/ institutions
- Birth and new born care preparedness visits at HH level
- Negotiation with families for alternative choices in delivery and newborn care practices
- Identification and education of family birth attendants and newborn care person at HH level
- Identification of high volume TBAs and orientation
- Ensuring presence of CHW during delivery/ within 24 hours
- Newborn care visits at HH level
- Strengthening of GoB primary and referral facilities on routine essential newborn care and management of referral

## *Plateauing of the Bangladesh Fertility Decline*

**Investigators**:

- Peter Kim Streatfield, Carel van Mels, Abdur Razzaque, Karar Zunaid Ahsan, Abbas Bhuiya, Mehrab Ali Khan, Ahmed al-Sabir (NIPORT),

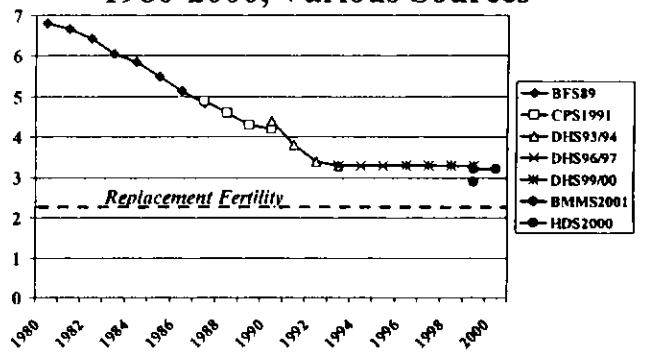
**Consultants**:

- *London University*: Prof. John Cleland,
- *Dhaka University*: Nitai Chakraborty,

- This study was supported by **USAID/Dhaka**

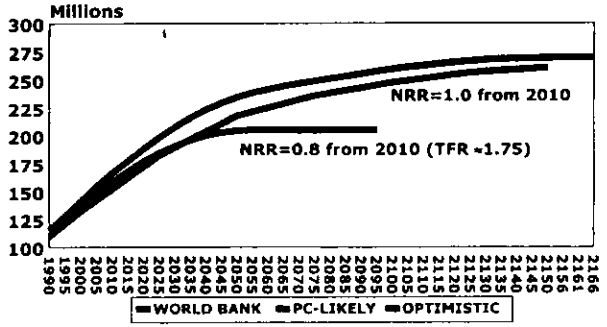
1

## Trends in Fertility, Bangladesh, 1980-2000, Various Sources




2

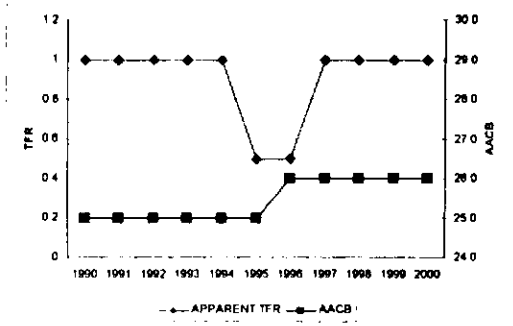
## Population Projections
### Bangladesh, 1990-2150




3

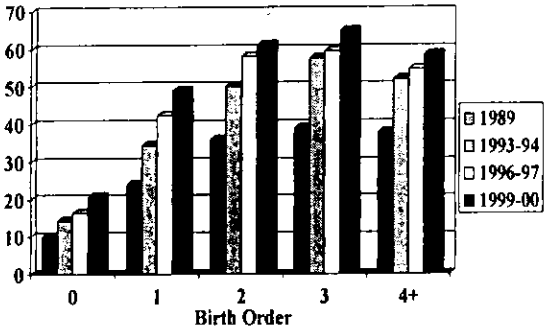
Source: Streatfield

TFR halves to 0.5 for 2 years (1995 & 1996), although all women will have 1 child during their lifetimes. Cross-sectional fertility decline is real, but apparent lifetime fertility decline is due to 'tempo' effect.

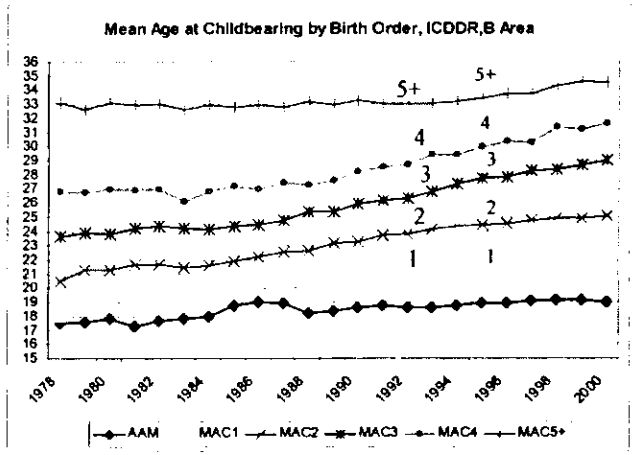



4

## Trends in FP Use between marriage, and subsequent births, 1989, 1993, 1996, 1999

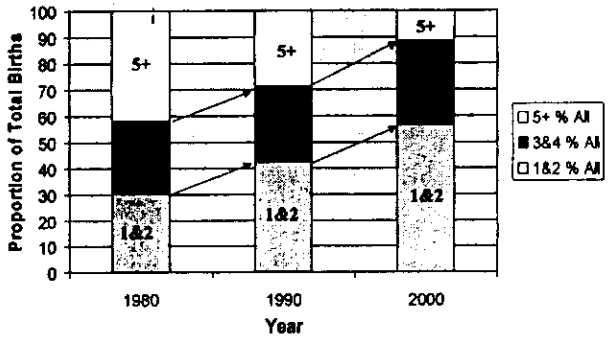



5



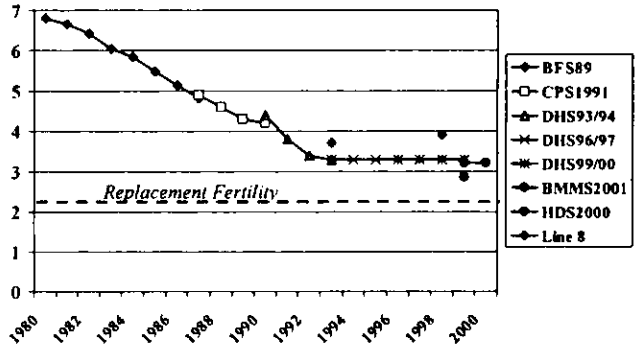

6

## Distribution of Births by Birth Order (1st&2nd, 3rd&4th, 5th+), Matlab 1980-2000




7

## Trends in Fertility, Bangladesh, 1980-2000, Various Sources



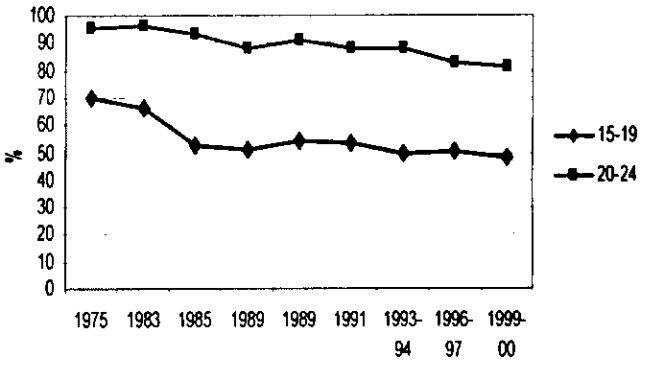

8

## Factors which Determine Fertility Levels

1. **Exposure factors**
   - *Proportions married*
2. **Deliberate marital fertility control factors**
   - *Contraception*
   - *Induced abortion*
3. **Natural marital fertility control factors**
   - *Lactational infecundability*
   - *Frequency of intercourse*
   - *Sterility*
   - *Spontaneous intrauterine mortality*
   - *Duration of the fertile period*

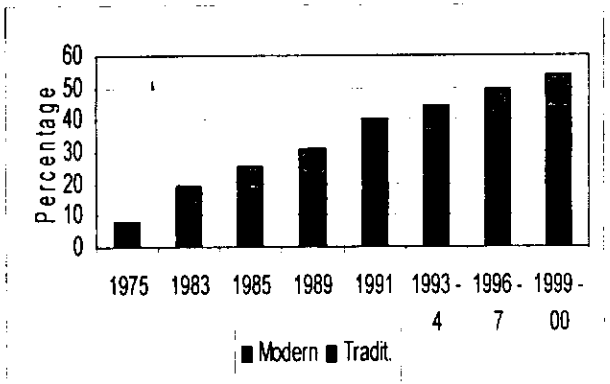
9

## Trends in Proportions Ever Married among Women 15-19 and 20-24



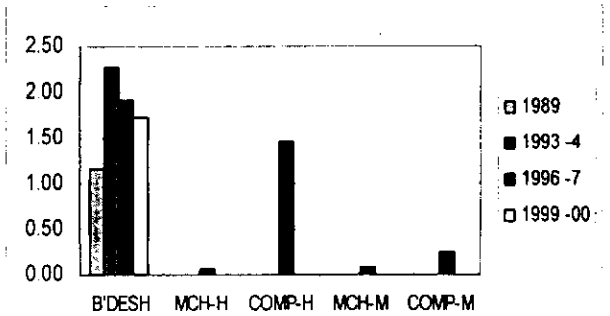

10

## Trends in Contraceptive Use




11

## Total Abortion Rates, Bangladesh, and Matlab (Heidi Johnston & Mizanur Rahman)



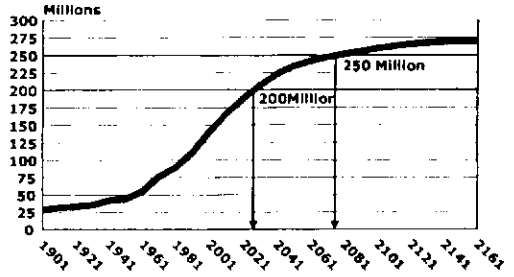

12

## Conclusion to Section 1.

- The halving of fertility (TFR) during the 1980s-early 1990s, and plateau since then, is genuine.
- There has been a "tempo effect" due to rising age at childbearing. This brought down TFR quicker by 0.5 - 1.0 child, than if there was no effect.
- The "tempo effect" is now mostly out of the system. This is due to shift to low parity births, which do not show rising age at childbearing.
- Paradox of flat TFR but rising CPR is possibly due to declining MR/abortion (substituted by FP).

13

## Population of Bangladesh
### Ten-fold Growth in Two Centuries



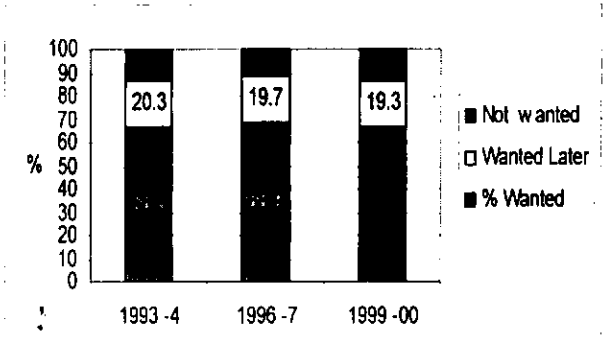

14

## What is the Future?

- Future Growth (1996-2051) = 107 Million
  - 15% (16m.) Unwanted Fertility
  - 3% (3m.) High desired family size
  - 82% (88m.) Population momentum
- The first two are more important in the short term, population momentum in longer term.

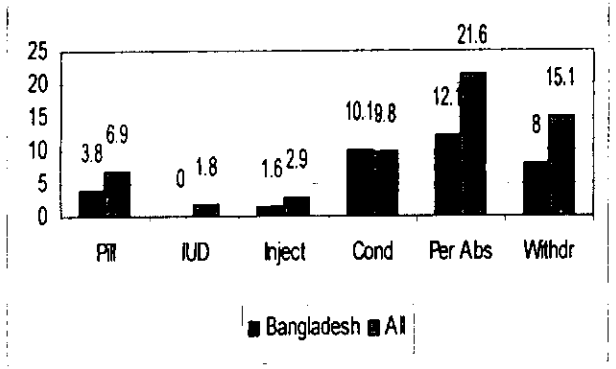
15

## Planning ("Wantedness") Status of Births in Past 3 Years



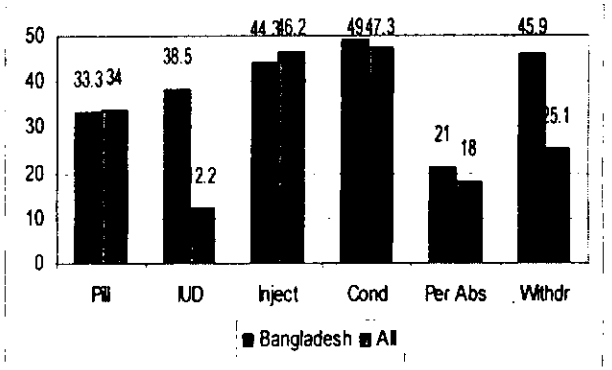

16

## 12 Month Failure Rates




17

## 12 Month Method-Specific Discontinuation Rates




18

## Interventions to reduce unwanted births

- Many of the couples who have already had 3 births and do not want any more are not using FP (high 'unmet need for FP').
- These couples can be focused on by the FP Program. (Study by Abbas Bhuiya et al.).
- Effective FP for all groups also necessary. Especially clinical and long-term methods.

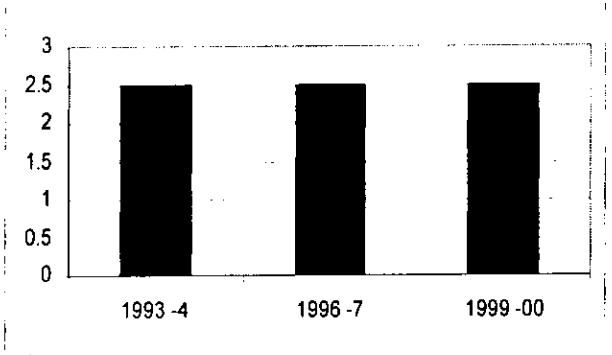
19

## High Desired Family Size

- What factors drive high desired family size?
  - Child Survival – Old age security.
  - Gender preference for sons – linked to security, inheritance, etc.
  - Economic value of children: costs versus benefits of children

20

## Mean Ideal Number of Children Wanted




21

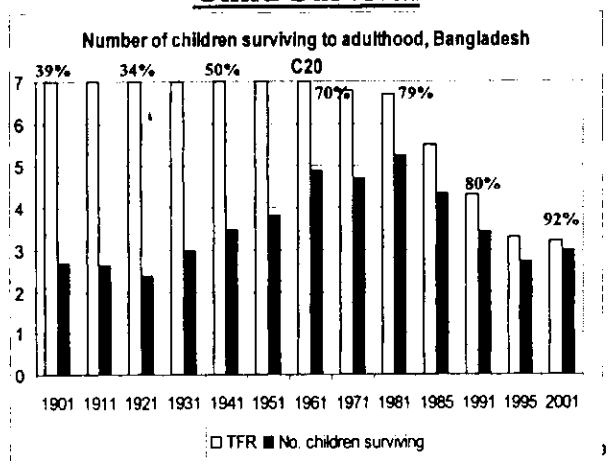
"The achievement of a two-child norm in conditions of such low socio-economic development and high (child) mortality seems inherently unlikely.

The available evidence suggests that, under present conditions, the total fertility rate could fall to a level of 3.0 to 3.5 births per woman but no lower".

*John Cleland, & Peter Kim Streatfield,*
*'The Demographic Transition: Bangladesh',*
*UNICEF, Sept. 1992.*

22

## Child Survival

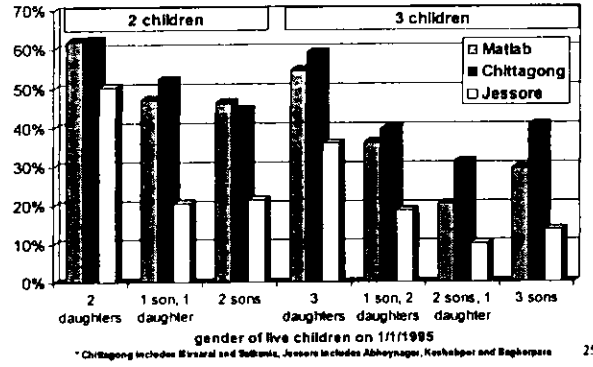



23

## Influence of Gender Composition on Subsequent Fertility

24

**Proportions of women under 45 with 2 or 3 living children on 1/1/1995 having additional live birth(s) during the next four years, by gender of children and surveillance area***




* Chittagong includes Bimaral and Sadhanis, Jessore includes Abhoynagar, Keshabpur and Bagherpara



# Interventions to Reduce Gender Preference

- Increased education opportunities for girls.
- Increased employment opportunities for young women (especially in rural areas).
- Reduction/elimination of dowry.
- Affirmative action in certain employment areas.



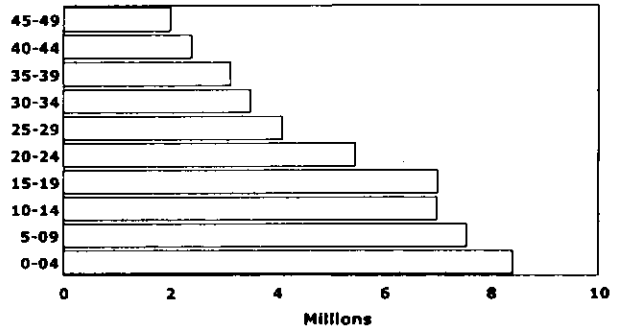
# Population Momentum

- What is population momentum?
  - *Consequence of "young" age structure.*
- What can be done to minimize it?
  - *Delay marriage and delay childbearing (enforce marriage law, birth certificates)*
  - *Increase FP use within marriage, especially for newly weds.*
  - *Increasing female education & employment will have an impact.*



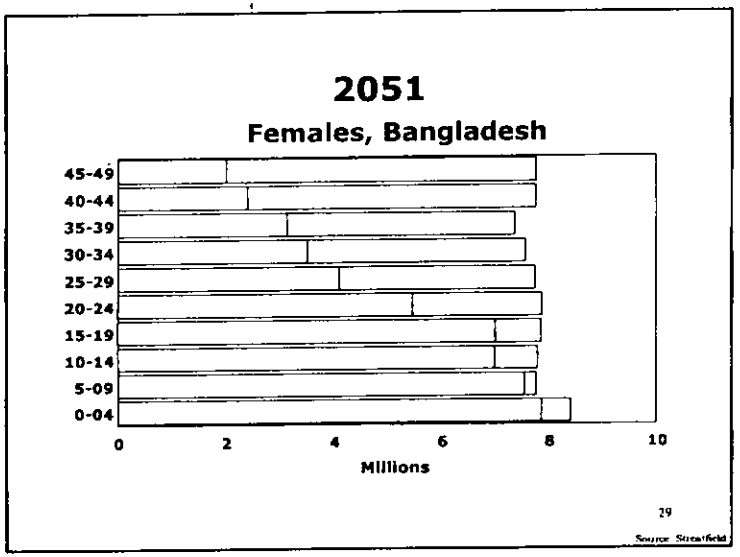
**1991**

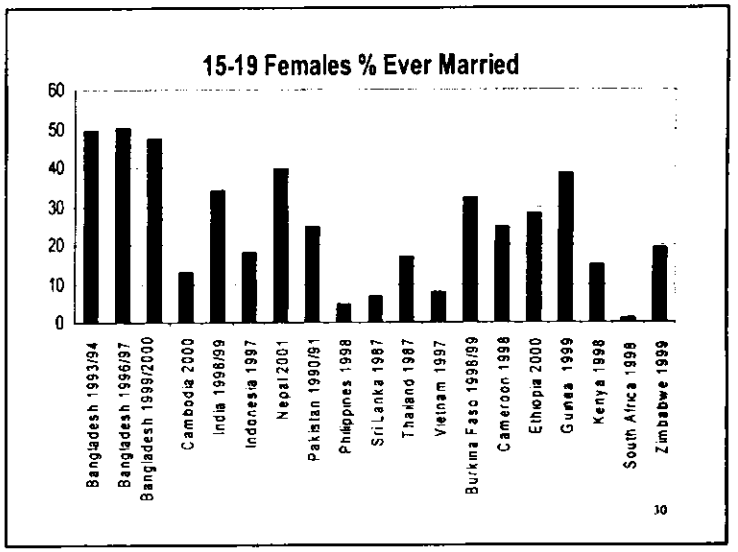
**Females, Bangladesh**

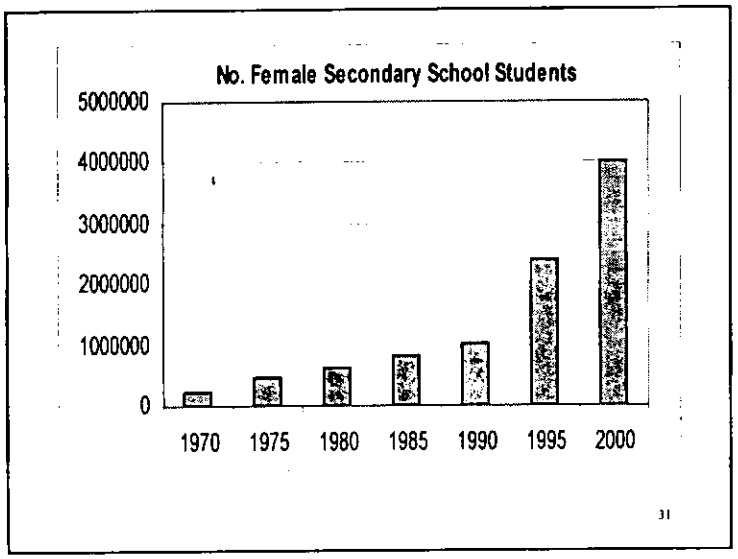





Source: Streatfield




Population Growth between 1996 and 2051 (107 million) will have 3 components:

- Unwanted fertility (15%)
- *High desired family size* ( 3%),
- *Population momentum* (82%).

•*Unwanted fertility*: needs effective FP;

•*High desired family size*: requires change in '(economic) value of children', gender preference, improved child survival;

•*Population momentum*: needs to minimize impact of 'young' age structure by raising average age of childbearing through delaying marriage and first births. Strong FP Program also needed.

32

Source: Stren

4/BT/JUNE 2004

# HUMAN RESOURCES COMMITTEE

# BOARD OF TRUSTEES MEETING
## June 2004


CENTRE
FOR HEALTH AND
POPULATION RESEARCH

## HUMAN RESOURCES COMMITTEE MEETING

# HUMAN RESOURCES COMMITTEE MEETING
## Friday, 11 June 2004

## Agenda

1. Approval of agenda

2. Approval of the minutes of November 2003 meeting

3. Staffing:

   3.1 Staffing status

   3.2 Status of recruitment of International Professional Staff

   a. Deputy Executive Director, D2, Executive Director's Division
   b. Director, D1, Health Systems & Infectious Diseases Division
   c. Director, D1, Public Health Sciences Division

   3.3 Completion of tenure in International Professional Post

   a. Director, D1, Policy & Planning

   3.4 Renewal of contracts

   a. Director, D1, Laboratory Sciences Division
   b. Head, Health & Demographic Surveillance Unit, P5, PHSD
   c. Head, External Relations & Institutional Development, P4, EDD

   3.5 Status of seconded staff contracts

   a. Dr. David A. Sack
   b. Dr. Abdullah H. Baqui
   c. Dr. Abdullah Brooks
   d. Dr. Charles P. Larson

   3.6 List of established International Professional Posts

4. Human Resources Agenda update

5. Any other business

**Minutes of the Human Resources Committee Meeting**
**1 November 2003**
**Sasakawa Training Lecture Room**

The Human Resources (HR) Committee of the Board of Trustees (BoT) held its meeting on 1 November 2003 at 8.30 am in the Sasakawa Training Lecture Room.

**Present:**

Dr. Ricardo Uauy Dagach (Chair, BoT)
Dr. Kul Gautam
Prof. A.K. Azad Khan (Chair, Finance Committee)
Prof. Jane Kusin
Prof. Terence Hull
Dr. Claudio Lanata (Chair HR Committee)
Dr. Halima Ramadhan Abdullah Mwenesi
Prof. David Sack (Director, ICDDR,B)
Prof. Marcel Tanner
Prof. Carol Vlassoff (Chair, Programme Committee)
Dr. I Kaye Wachsmuth

**Absent (with regrets):**

Mr Mirza Tasadduq Hussain Beg
Prof. N.K. Ganguly
Dr. Maimunah Bte Abdul Hamid
Dr. Nobukatsu Ishikawa
Mr. AFM Sarwar Kamal
Dr. Tikki Pang

**Invited**: Centre Directorate
**Minutes:** Loretta Saldanha

Dr. Ricardo Uauy Dagach, Chair, BoT welcomed all to the meeting and invited Dr. Claudio Lanata to Chair the proceedings.

Dr. Lanata briefly reported on the progress of the HR Agenda since the last Board meeting. Ms Ann Walton was invited to assist with questions raised.

1. **Approval of the Agenda:**

The agenda was approved.

2. **Approval of the Minutes of the June 2002 meeting:**

The Minutes were approved with the correction to para one on gender calculation: 27% should read 25%.

Page 2, 3.2 Status of Recruitment of a Deputy Director, it was reported that no action was taken re the resolution from the June Board meeting and it was suggested that detailed discussions will be held in a closed session of the Board.

Page 6, Gender Policy: A final document will be circulated to the Board. An update will however be provided during the meeting.

3. **Staffing Status**

There were 46 additions and 40 separations during this reporting period (April 01, 2003 – September 30, 2003). The total number of Centre fixed-term staff belonging to all categories thus increased by 6 as shown in Table 1. The Centre continues to follow the policy of restricting recruitment of core positions.

Ms. Walton reported that this information has not been ideally presented but this would be possible once "Suchona" is in place.

The Board suggested that a breakdown, similar to the information provided for Project and Core staff (for national staff), should also be provided for international level staff.

The Board suggested a need to monitor the age structure and the anticipated times of retirement of staff. How does the Centre deal with successions for staff retiring ? This information would provide insights into the retirement projections and also the life-cycle approach to staffing for all professionals/categories. Ms. Walton reported that the Centre has started to look into this and that a succession plan is underway. The Board suggested that this plan should also include counseling etc. A table showing age and sex structure will henceforth be provided.

Following the list of staff and their country of origin, the absence of staff from Africa was queried. It was clarified that efforts have been made to hire staff from Africa and that a staff member from that region had recently separated from the services of the Centre. It was also mentioned that Africa has been consistently represented on the Board including a former Director, Dr. Demissie Habte. The Centre will however continue to make a direct and concerted effort to try and get scientists from Africa.

The Board agreed to assist the Centre by directing the Centre to individuals who could be approached and provide the Centre with information on key conferences/groups in the region to enable posting of advertisements for vacancies for senior level staff.

## 3. Status of Recruitment of International Professional Staff

### 3.2a Associate Director, D1, Public Health Sciences Division

The position of the Associate Director and Head, Public Health Sciences Division at pay level D1, was announced on November 28, 2002. After a detailed review of the candidates who responded, Dr. Roger Shrimpton, a British national was invited to visit the Centre and meet with the selection committee. Dr. Shrimpton visited the Centre with his spouse and a formal interview was held on August 20, 2003.

It was reported that Dr. Shrimpton declined the offer and will not be joining the Centre for personal reasons. Dr. Marge Koblinksy has in the meantime been contacted with a request to her to reconsider her earlier decision. The Board was reminded that Dr. Koblinsky had already been interviewed by the Executive Committee of the Board via a teleconference..

Ms. Walton also reported that for the first time the Centre has paid special attention to the spouse following a resolution approving the conditions stipulated in the document "Strategy for the Recruitment and Retention of Senior Staff".

It was also suggested that a Search Committee be formed for hiring individuals in senior level positions and this should not be restricted to Centre Staff or the Board.

### 3.3 Renewal of Contracts

### Agenda 3.3a Head, Information Sciences Division, P5

The 3 (three) years' employment contract of Mr. Peter Thorpe, Head, Information Sciences Division expires on July 31, 2004. Mr. Peter Thorpe during this tenure of contract has contributed to the growth of the division as well as to the overall growth of the Centre. His performance during this period has been very good.

The Centre recommends to the Board that the current employment contract of Mr. Peter Thorpe be extended by another term of 3 (three) years effective August 01, 2004 under the existing terms and conditions.

### Agenda 3.3b Environmental Microbiologist, P4 Laboratory Sciences Division

Dr. M. Sirajul Islam, Environmental Microbiologist, Laboratory Sciences Division will be completing his 3 (three) years of International Professional appointment with the Centre on June 30, 2004. Dr. M. Sirajul Islam was appointed to this position as per policy of "Promotion of Bangladeshi Scientists to International Levels". Dr. Islam is a highly productive and enthusiastic scientist of the Centre. His performance during this period has been very good.

The Centre intends to renew Dr. M. Sirajul Islam's employment contract under the same terms and conditions for a period of another term of 3 (three) years effective July 01, 2004.

This is for the information of the Board.

CLOSED SESSION OF THE BOARD:

The Board also discussed the contract of Prof. Barkat-e-Khuda and a resolution was drafted.

The Board also noted that Resolution 22/BT/June 03 had not been followed up by the Centre Directorate and urged that high priority be given to the preparation of a job description for the post of Deputy Director and that it be circulated to the BoT by email for comments. The initial stages of recruitment of a Deputy Director should be undertaken before the June 04 BoT meeting so that ideally a short list of candidates can be presented to the BoT on that occasion.

### 3.4 Information on New International Professional Staff

**Agenda 3.4a** **Associate Director and Head, Clinical Sciences Division, D1**

Dr. M. A. Salam, a Bangladeshi national joined the Centre on July 01, 2003 as the Associate Director and Head, Clinical Sciences Division, at pay level D1, on a three years' fixed-term employment contract. He was recruited through the Centre's competitive recruitment process. Earlier, Dr. Salam was serving the Centre as Chief Physician at pay level P4 and was Acting Associate Director and Head, Clinical Sciences Division from August 01, 2002.

This is for the information of the Board.

**Agenda 3.4b** **Executive Assistant to Director, P1, Director's Division**

Ms. Loretta Saldanha, an Indian national, joined the Centre on April 10, 2003 on a fixed-term three years' contract as the Executive Assistant to Director under the Director's Division. Ms. Loretta Saldanha was the Executive Secretary of the Clinical Sciences Division and was acting as the Executive Assistant to Director since October 2002. She has been recruited through the Centre's competitive recruitment process.

This is for the information of the Board.

### 3.5 Status of Seconded Staff Contracts

**Agenda 3.5a** **Associate Director and Head**
**Health Systems and Infectious Diseases Division, D1**

The two years secondment agreement between the Centre for Disease Control and Prevention (CDC), Department of Health and Human Services (DHHS), USA and ICDDR,B; seconding the services of Dr. Robert F. Breiman to ICDDR,B as Associate Director and Head, Health Systems and Infectious Diseases Division will expire on July 09, 2004.

The Centre requires the services of Dr. Breiman for another term and accordingly the Centre requests Board's approval to start negotiating with CDC for another secondment agreement for an additional period of 2 (two) years.

*This was approved.*

**Agenda 3.5b** **Senior Operations Research Scientist, P5**
**Health Systems and Infectious Diseases Division**

The existing secondment contract of Dr. Greet Dieltiens, Technical Advisor of the Public Health Sciences Division will expire on January 07, 2004. She was seconded through an

agreement between the Belgian Technical Cooperation (BTC), Brussels and ICDDR,B for a period of three years effective January 08, 2001.

Dr. Greet Dieltiens will be leaving the Centre on January 07, 2004. The Board would like to put on record their thanks for her contributions to the Centre.

The Board placed on record its thanks to Dr. Dieltiens for her contributions to the Centre.

**Agenda 3.5c** **Scientist, P4, Epidemic Control & Preparedness Unit Public Health Sciences Division**

The existing secondment contract of Dr. Yukiko Wagatsuma, an Assistant Scientist of the Department of International Health, School of International Hygiene and Public Health, at Johns Hopkins University (JHU) has been, at the request of the Centre, extended for an additional term of 18 (eighteen) months effective January 17, 2003 which will expire on July 16, 2004.

This was approved.

**3.6 Renewal Contract of Adjunct Scientist**

**Agenda 3.6a** **Dr. Abdullah H. Baqui**

The current Adjunct Scientist contract of Dr. Abdullah H. Baqui, a faculty member of Johns Hopkins University (JHU), Bloomberg School of Public Health to ICDDR,B will expire on June 30, 2004. As Dr. Baqui's involvement with the ongoing projects of the Centre are very essential, the Centre requests the Board's approval for initiating an extension of this contract from Johns Hopkins University for another period of three years.

This was approved.

**3.7 A List of established International Professional Posts was provided for the information of the Board together with a list of established International Professional Posts.**

**4. Promotion of Bangladeshi Scientists to International Professional Levels**

A report on was presented to the Board (attached). The Board wished to specify the process it will follow to review the applications for promotions to the international Professional level. The Centre's Promotion Committee will forward a recommendation

to the Chair of the Human Resources Committee according to the process outlined in the policy. The Committee reviewed the recommendations and presented a resolution to the Board.

5. **HR Agenda Update**

An update on ongoing HR Agenda was provided by Ms. Walton (attached). For the information of the new Board members Ms. Walton provided a brief background of the HR agenda the Board adopted in the year 2001. In addition, at the last Board meeting three items were added to the list of "to dos" by the HR, essentially a paper presenting the recruitment strategy for international staff, the beginning of the Human Resource Plan and the Gender Policy.

The Board noted that Gender training was scheduled for December 2003 and that the performance review system will go on line in June 2004 and whether it would be possible to meet these time lines.

Ms. Walton further reported on the reduction of active post titles. She said, this exercise also took into consideration its interpretation in the community which is not something you could necessarily take into account in other situations. Citing an example whereby HR streamlined all secretarial staff who would henceforth be called Administrative Officers she said, this was also done with the consent of the staff as that is what they preferred.

Gender Policy: The policy is in the final stages of translation and will be circulated to the Board by email. It will be published in a bilingual booklet format for distribution to all staff members as part of a centre-wide dissemination scheme.

Ms. Walton said that the HR agenda is proactive but it may evolve over a longer period of time. The Board highly appreciated the work being done and suggested that the Centre propose time-lines for these activities. The Board also suggested that a realistic plan be drawn up in consultation with the Division Heads.

The Board expressed their satisfaction and congratulated the Centre for the work accomplished on the HR Agenda and will look forward to receiving updates on further progress made, at the next BoT meeting.

**6. Staff Salaries: International Professional Category & National Officer & General Services Categories**

**This agenda item was discussed in a closed session of the Board.**

## HUMAN RESOURCES RESOLUTIONS
## 2 Nov 2003

**11/BT/Nov 03**

The BoT thanked Professor Barkat-e-Khuda for his important contribution to the Centre during his service as an international scientist, especially during the absence of the Director over an extended period. It wished him every success in his future career when his term ends as Associate Director, and Head, Policy and Planning in June 2004.

**12/BT/Nov 03**

The BoT noted that Resolution 22/BT/Jun 03 had not been followed up by the Centre Directorate and urged that high priority be given to the preparation of a job description for the post of Deputy Director and that it be circulated to the BoT by email for comments. The initial stages of recruitment of a Deputy Director should be undertaken before the June 04 BoT meeting, so that ideally a short list of candidates can be presented to the BoT on that occasion.

**13/BT/Nov 03**

The Board resolves that the current employment contract of Mr. Peter Thorpe with the Centre, be extended by another term of 3 (three) years effective August 01, 2004 under the same terms and conditions.

**14/BT/Nov 03**

The Board resolves that the current secondment agreement of Dr. Robert F. Breiman between CDC and ICDDR,B be extended by another 2 (two) years period effective July 01, 2004.

**15/BT/Nov 03**

The Board records their thanks to Dr. Greet Dieltiens for her contributions to the Centre.

**16/BT/Nov 03**

The Board resolves that the current secondment agreement of Dr. Yukiko Wagatsuma between Johns Hopkins University and ICDDR,B be extended by another 18 months effective July 17, 2004.

**17/BT/Nov 03**

The BoT approves the Centre's request to initiate an extension of the present contract of Dr. Abdullah H Baqui, Adjunct Scientist, a faculty member of Johns Hopkins University for another period of three years effective July 1, 2004.

**18/BT/Nov 03**

The Board wishes to specify the process it will follow to review the applicants for the Promotion of National Officer Level Scientists to the International Professional Level. The Centre's Promotion Committee will forward a recommendation to the Chair of the Human Resources Committee according to the process outlined in the policy. The Committee will review the recommendations and present a resolution to the Board of those approved.

**19/BT/Nov 03**

The BoT requests the Centre Directorate to examine the criteria applied by the Promotions Committee in the promotion of National Officer level scientists to the International Professional Level considering the variety of career path that should be recognized.

**20/BT/Nov 03 (SEALED RESOLUTION)**

**21/BT/ Nov 03**

The BoT expresses their satisfaction and congratulates the Centre for the work accomplished on the HR Agenda and will look forward to receiving updates on further progress made at the next meeting of the BoT.

## 3.1 Staffing Status

There were 57 additions and 29 separations during this reporting period (October 01, 2003 – March 31, 2004). The total number of Centre fixed-term staff belonging to all categories thus increased by 28 as shown in Table 1.

**Table 1**

**STAFFING OVERVIEW**
**October 2003 – March 2004**

**Separations/Additions of Staff**

| Functional Areas | Unrestricted Funds | | Restricted Funds | | **Total** | | **Net Change** |
|---|---|---|---|---|---|---|---|
| | Sep. | Add. | Sep. | Add. | **Sep.** | **Add.** | |
| Administrative | (1) | 2 | -- | 2 | **(1)** | **4** | **3** |
| Clinical | (1) | -- | -- | 2 | **(1)** | **2** | **1** |
| Computing | -- | -- | -- | 1 | **--** | **1** | **1** |
| Finance/Procurement | (1) | 1 | -- | -- | **(1)** | **1** | **--** |
| Human Resources | -- | 2 | -- | -- | **--** | **2** | **2** |
| Information Services | -- | -- | -- | 1 | **--** | **1** | **1** |
| International | (1) | 1 | -- | -- | **(1)** | **1** | **--** |
| Laboratory | -- | 1 | (3) | 2 | **(3)** | **3** | **--** |
| Maintenance | -- | -- | -- | -- | **--** | **--** | **--** |
| Research/Technical | (2) | 1 | 16 | 31 | **18** | **32** | **14** |
| Scientific | (1) | -- | -- | 2 | **(1)** | **2** | **1** |
| Support Services | (3) | 5 | -- | 2 | **(3)** | **7** | **4** |
| Training | -- | -- | -- | 1 | **--** | **1** | **1** |
| | (10) | 13 | (19) | 44 | **(29)** | **57** | **28** |

**Net additions : 28**

**Table-2**
**BOT/HR/JUN/2004**

**ICDDR,B**
**STAFFING STATUS**

**as of March 31, 2004**

**RF** – Restricted Funds
**UF** – Unrestricted Funds

| Fixed-Term Staff | March 2003 | | | September 2003 | | | March 2004 | | |
|---|---|---|---|---|---|---|---|---|---|
| | RF | UF | Total | RF | UF | Total | RF | UF | Total |
| Administrative | 28 | 63 | **91** | 31 | 63 | **94** | 33 | 65 | **98** |
| Clinical | 25 | 105 | **130** | 28 | 105 | **133** | 30 | 104 | **134** |
| Computing | 46 | 31 | **77** | 48 | 32 | **80** | 49 | 32 | **81** |
| Finance/Procurement | 1 | 22 | **23** | 1 | 22 | **23** | 1 | 22 | **23** |
| Human Resources | 0 | 6 | **6** | 0 | 6 | **6** | 0 | 8 | **8** |
| Information Services | 3 | 7 | **10** | 5 | 8 | **13** | 6 | 8 | **14** |
| International | 2 | 15 | **17** | 2 | 16 | **18** | 2 | 17 | **19** |
| Laboratory | 8 | 36 | **44** | 8 | 36 | **44** | 10 | 37 | **47** |
| Maintenance | 1 | 21 | **22** | 1 | 21 | **22** | 1 | 21 | **22** |
| Research/Technical Support | 218 | 207 | **425** | 239 | 208 | **447** | 253 | 207 | **460** |
| Scientific | 16 | 41 | **57** | 17 | 41 | **58** | 19 | 40 | **59** |
| Support Services | 42 | 195 | **237** | 44 | 198 | **242** | 46 | 201 | **247** |
| Training | 2 | 2 | **4** | 2 | 2 | **4** | 3 | 2 | **5** |
| **Subtotal** | **392** | **751** | **1143** | **426** | **758** | **1184** | **453** | **764** | **1217** |
| **Other contract types** | | | | | | | | | |
| Seconded | 5 | 4 | **9** | 5 | 4 | **9** | 3 | 5 | **8** |
| Short-Term | 1 | 3 | **4** | 2 | 3 | **5** | 3 | 3 | **6** |
| Contractual Service Agreement | 172 | 54 | **226** | 261 | 61 | **322** | 336 | 65 | **401** |
| Primary Health Care Provider | 20 | 0 | **20** | 20 | 0 | **20** | 20 | 0 | **20** |
| Health Worker | 29 | 58 | **87** | 29 | 58 | **87** | 30 | 58 | **88** |
| Fellow | 5 | 13 | **18** | 5 | 21 | **26** | 5 | 25 | **30** |
| Daily Wager | * | * | **311** | * | * | **175** | 175 | 23 | **198** |
| **Subtotal** | **232** | **132** | **675** | **322** | **147** | **644** | **572** | **179** | **751** |
| **GRAND TOTAL** | **624** | **883** | **1818** | **748** | **905** | **1828** | **1025** | **943** | **1968** |
| **%** | | | | | | | **52** | **48** | **100** |

* Not available from the previous HRIS system

**Table-3**
**BOT/HR/JUN/2004**

## STAFFING STATUS
## By Division

**as of March 31, 2004**

| Sl. No. | Location | International Professional | | | National | | Total |
|---|---|---|---|---|---|---|---|
| | | Fixed-Term | Short-Term | Seconded | Fixed-Term | Others | |
| 1. | Director's Division | 5 | 3 | 1 | 135 | 37 | 181 |
| 2. | Public Health Sciences Division | 5 | - | 3 | 475 | 262 | 745 |
| 3. | Clinical Sciences Division | 2 | - | - | 199 | 144 | 345 |
| 4. | Laboratory Sciences Division | 4 | - | - | 180 | 129 | 313 |
| 5. | Health Systems and Infectious Diseases Division | 2 | 2 | 4 | 179 | 158 | 345 |
| 6. | Information Sciences Division | 1 | 1 | - | 30 | 7 | 39 |
| | **Total** | **19** | **6** | **8** | **1198** | **737** | **1968** |

**Table-4**
BOT/HR/JUN/2004

## STAFFING STATUS BY GENDER AND DIVISION
**as of March 31, 2004**

| Employment Types / Contract Types | CSD | | LSD | | PHSD | | HSID | | DD | | ISD | | Subtotal | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | |
| International | | | | | | | | | | | | | | | |
| Fixed-Term | 1 | 0 | 1 | 0 | 3 | 1 | 1 | 1 | 3 | 2 | 1 | 0 | 10 | 4 | 14 |
| Short-Term | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 3 | 1 | 0 | 1 | 5 | 6 |
| Seconded | 0 | 0 | 0 | 0 | 3 | 0 | 3 | 1 | 1 | 0 | 0 | 0 | 7 | 1 | 8 |
| Fellow | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 1 |
| Subtotal | 1 | 0 | 1 | 0 | 6 | 1 | 4 | 4 | 4 | 5 | 3 | 0 | 20 | 10 | 30 |
| Bangladeshi Int'l | 1 | 0 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 1 | 5 |
| National | | | | | | | | | | | | | | | |
| Fixed-Term | 108 | 91 | 152 | 28 | 229 | 246 | 97 | 82 | 121 | 14 | 26 | 4 | 733 | 465 | 1198 |
| CSA | 15 | 19 | 48 | 22 | 63 | 135 | 20 | 45 | 15 | 16 | 02 | 0 | 163 | 237 | 400 |
| PHCP | 0 | 0 | 0 | 0 | 6 | 14 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 14 | 20 |
| Health Worker | 2 | 68 | 0 | 3 | 0 | 3 | 0 | 8 | 0 | 4 | 0 | 0 | 2 | 86 | 88 |
| Fellow | 8 | 16 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 9 | 21 | 30 |
| Daily Wagers | 7 | 9 | 47 | 9 | 14 | 26 | 17 | 66 | 2 | 0 | 1 | 0 | 88 | 110 | 198 |
| Subtotal | 140 | 203 | 247 | 62 | 313 | 424 | 134 | 201 | 138 | 34 | 29 | 9 | 1001 | 933 | 1934 |
| **GRAND TOTAL** | 142 | 203 | 250 | 63 | 320 | 425 | 138 | 205 | 142 | 39 | 32 | 9 | 1024 | 944 | 1968 |
| % | 41 | 59 | 80 | 20 | 43 | 57 | 40 | 60 | 78 | 22 | 78 | 22 | 52 | 48 | 100 |

**Table-5**
BOT/HR/JUN/2004

## LIST OF INTERNATIONAL PROFESSIONAL STAFF
**as of March 31, 2004**

**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 | P4 | 21.11.2000 | 20.11.2006 |
| 2. | BHUIYA, Dr. Abbas Uddin | Bangladesh | Social Scientist & Head, SBSU | P5 | 01.07.1994 | 31.12.2004 * |
| 3. | BLUM, Dr. Lauren S. | USA | Anthropologist, SBSU, PHSD | P4 | 23.01.2000 | 22.01.2006 |
| 4. | FARUQUE, Dr. Shah Md. | Bangladesh | Scientist, LSD | P4 | 01.07.2002 | 30.06.2005 * |
| 5. | ISLAM, Dr. Sirajul | Bangladesh | Environmental Microbiologist | P4 | 01.07.2001 | 30.06.2004 * |
| 6. | KHUDA, Dr. Barkat-e- | Bangladesh | Director, Policy & Planning | D1 | 01.08.1997 | 30.06.2004 |
| 7. | MERCER, Mr. Alec | UK | Operations Research Scientist, HSID | P4 | 29.09.2002 | 28.09.2005 |
| 8. | NAIR, Dr. Gopinath Balakrish | India | Director, LSD | D1 | 09.04.2000 | 12.12.2004 |
| 9. | NEOGI, Mr. Aniruddha | India | Director, Finance | P5 | 18.11.2002 | 17.11.2005 |

* per Policy of Promotion of Bangladeshi Scientists to International Level

contd.....

**Table-5**
BOT/HR/JUN/2004

**FIXED-TERM**

| Sl. No. | Name | Country | Job Title | Pay Level | Contract Start Date | Contract End Date |
|---|---|---|---|---|---|---|
| 10. | QADRI, Dr. Firdausi | Bangladesh | Senior Scientist, LSD | P4 | 01.07.2002 | 30.06.2005 * |
| 11. | RABBANI, Dr. Golam Hassan | Bangladesh | Scientist, CSD | P4 | 01.07.2002 | 30.06.2005 * |
| 12. | SALAM, Dr. M. Abdus | Bangladesh | Director, CSD | D1 | 01.07.2003 | 30.06.2006 |
| 13. | SALDANHA, Ms. Loretta | India | Executive Assistant to Executive Director | P1 | 10.04.2003 | 09.04.2006 |
| 14. | STREATFIELD, Dr. Peter K. | Australia | Head, Health & Demographic Surveillance Unit, PHSD | P5 | 18.07.1999 | 17.07.2005 |
| 15. | THORPE, Mr. Peter | UK | Director, ISD | P5 | 01.08.2001 | 31.07.2004 |
| 16. | VARGHESE, Dr. Beena | Indian/USA | Health Economist | P4 | 10.10.2002 | 09.10.2005 |
| 17. | WALTON, Ms. Ann G. | Canada | Director, Human Resources | P5 | 04.03.2003 | 03.03.2006 |
| 18. | YUNUS, Dr. Mohammad | Bangladesh | Senior Scientist and Head, MHRC | P4 | 01.01.2004 | 31.12.2006 * |
| 19. | ZAMAN, Mr. Ishtiaque A. | Bangladesh | Head, External Relations & Institutional Development, ED | P4 | 01.07.2002 | 30.06.2005 |

* per Policy of Promotion of Bangladeshi Scientists to International Level

**Table-6**
BOT/HR/JUN/2004

## LIST OF INTERNATIONAL PROFESSIONAL STAFF
**as of March 31, 2004**

**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 | 31.08.2004 |
| 2. | ALAM, Dr. A. N. | Bangladesh | Head, Training & Education Dept. | P4 | 01.05.1996 | 31.01.2005 |
| 3. | BROOKS, Ms. Vanessa J. | USA | Grants Administrator, ED | P4 | 01.10.1997 | 31.01.2005 |
| 4. | HADLEY, Ms. Mary B. | UK | Project Coordinator, FHRP | -- | 24.01.2002 | 31.03.2004 |
| 5. | GURLEY, Ms. Emily Suzanne | USA | Programme Officer | -- | 01.10.2003 | 31.07.2004 |
| 6. | LEMON, Ms. Hannah R. | UK | Senior Associate, ER&ID | -- | 14.05.2003 | 13.12.2004 |

**Table-7**
BOT/HR/JUN/2004

## LIST OF SECONDED STAFF
**as of March 31, 2004**

| Sl. No. | Name | Country | Job Title | Pay Level | Contract Start Date | Contract End Date | Seconding Institution |
|---|---|---|---|---|---|---|---|
| 1. | BAQUI, Dr. Abdullah H. | Bangladesh | Scientist | P4 | 04.01.2003 | 31.03.2005 | JHU |
| 2. | BREIMAN, Dr. Robert F. | USA | Head, PIDVS | D1 | 01.08.2000 | 09.07.2004 | CDC/US Embassy |
| 3. | BROOKS, Dr. W. Abdullah | USA | Scientist, HSID | P4 | 01.07.2001 | 30.06.2005 | JHU |
| 4. | LARSON, Dr. Charles P. | Canada | Senior Operations Research Scientist, HSID | P5 | 01.05.2002 | 30.04.2005 | McGill |
| 5. | MELS, Mr. Carel T. van | Netherlands | Demographer, HSID | P4 | 29.12.1999 | 31.12.2005 | NIDI |
| 6. | SACK, Dr. David A. | USA | Executive Director, ICDDR,B | ADG | 01.10.1999 | 30.09.2005 | JHU |
| 7. | SERAJI, Dr. Habibur Rahman | Bangladesh | Scientist | -- | 09.11.2001 | 11. 08.2004 | JHU |
| 8. | WAGATSUMA, Dr. Yukiko | Japan | Scientist, HSID | P4 | 17.01.2000 | 16.07.2004 | JHU |

CDC : Centre for Disease Control
JHU : Johns Hopkins University
McGill : McGill University
NIDI : Netherlands Interdisciplinary Demographic Institute

**Table-8**
BOT/HR/JUN/2004

## LIST OF ADJUNCT SCIENTIST
**as of March 31, 2004**

| 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. | PERSSON, Prof. Lars Åke | Sweden | Adjunct Scientist | 01.03.2003 | 28.02.2006 |
| 4. | 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 Executive Director, D2, Executive Director's Division

The position of Deputy Executive Director at pay level D2, following the circulation of the job description to the Board members, was announced on April 26, 2004. The vacancy announcement was published through the Economist, the New England Journal of Medicine and the Lancet. It is also posted on several websites including Reliefweb, DevNetJobs.org, The Development Executive Group and ICDDR,B. Copy of the vacancy announcement was sent to different collaborative institutions, CGIAR Gender Diversity Database and JHPN distribution list for further circulation. The International Civil Service Commission (ICSC) has created a link to the Centre website. This vacancy announcement was also posted at the Global Health Conference as a part of the conference Career Connection Programme. The closing date for receiving application is June 06, 2004.

A report on the status of this recruitment will be made during the meeting of the Board.

### Agenda 3.2b Director, D1, Health Systems & Infectious Diseases Division

The position of the Director, Health Systems and Infectious Diseases Division and at pay level D1 was announced on April 26, 2004. The vacancy announcement was published through the Economist, the New England Journal of Medicine and the Lancet. It is also posted on several websites including Reliefweb, DevNetJobs.org, The Development Executive Group and ICDDR,B. Copy of the vacancy announcement was sent to different collaborative institutions, CGIAR Gender Diversity Database and JHPN distribution list for further circulation. The International Civil Service Commission (ICSC) has created a link to the Centre website. This vacancy announcement was also posted at the Global Health Conference as a part of the conference Career Connection Programme. The closing date for receiving application is June 06, 2004.

A report on the status of this recruitment will be made during the meeting of the Board.

## 3.2 Status of Recruitment of International Professional Staff

**Agenda 3.2c Director, D1, Public Health Sciences Division**

The position of the Director, Public Health Sciences Division at pay level D1 was announced on November 28, 2002. Following Dr. Roger Shrimpton's withdrawing his candidacy for family reasons, Dr. Marge Koblinsky – an American national visited the Centre in January 2004 for 5 days. She met with the Executive Director, Directors and senior officials of different divisions in relation to the recruitment.

Dr. Abbas U. Bhuiya, Social Scientist and Head, Social and Behavioural Sciences Unit continues as Acting Director, PHSD.

A report on the status of this recruitment will be made during the meeting of the Board.

## 3.3 Completion of tenure in International Professional Post

**Agenda 3.3a** **Director, Policy & Planning, D1**
**Executive Director's Division**

On completion of his fixed-term employment contract with the Centre – Dr. Barkat-e-Khuda, Director, Policy & Planning, Executive Director's Division will be released from the services of the Centre on the closing business of June 30, 2004.

This is for the information of the Board.

*Draft resolution:*

*The Board wishes to put on record their appreciation for Dr. Barkat-e-Khuda's contributions during his tenure at the Centre.*

## 3.4 Renewal of Contracts

### Agenda 3.4a Director, D1, Laboratory Sciences Division

The current fixed-term employment contract of Dr. Gopinath Balakrish Nair as the Director, Laboratory Sciences Division will expire on December 12, 2004. Dr. Nair during this tenure of contract has contributed to the growth of various research programs of the division as well as to the overall growth of the Centre. His performance during this period has been very good.

The Centre recommends to the Board that the employment contract of Dr. Gopinath Balakrish Nair with the Centre be extended up to April 08, 2006 under the existing terms and conditions to complete 6 (six) years of service as a fixed-term international professional staff.

*Draft resolution:*

*The Board resolves that the current employment contract of Dr. Gopinath Balakrish Nair with the Centre, be extended up to April 08, 2006 under the same terms and conditions.*

### Agenda 3.4b Head, Health & Demographic Surveillance Unit, P5 Public Health Sciences Division

Dr. Peter Kim Streatfield, Head, Health and Demographic Surveillance Unit, Public Health Sciences Division will complete 6 (six) years service as an International Professional Staff on July 17, 2005.

The Centre seeks the Board's decision for further action to be taken by the Centre for this position.

## 3.4 Renewal of Contracts

**Agenda 3.4c** **Head, External Relations and Institutional Development, P4**
**Executive Director's Division**

The first 3 (three) years' employment contract of Dr. Ishtiaque A. Zaman, Head, External Relations and Institutional Development, Executive Director's Division at pay level P4 will expire on June 30, 2005. Dr. Zaman during this tenure of contract has contributed to the overall growth of the Centre by putting his best efforts in various fund raising activities. His performance during this period has been very good.

The Centre recommends to the Board that the current employment contract of Dr. Ishtiaque A. Zaman be extended by another term of 3 (three) years effective July 01, 2005 under the existing terms and conditions.

*Draft resolution:*

*The Board resolves that the current employment contract of Dr. Ishtiaque A. Zaman with the Centre, be extended by another term of 3 (three) years effective July 01, 2005 under the same terms and conditions.*

## 3.5 Status of Seconded Staff Contracts

**Agenda 3.5a Executive Director, ICDDR,B**

The current secondment agreement between ICDDR,B and John Hopkins University seconding Dr. David A. Sack as the Executive Director to ICDDR,B will conclude on September 30, 2005.

The Centre seeks the Board's decision for further action to be taken by the Centre for this position.

**Agenda 3.5b Scientist, P4, Child Health Unit**
**Public Health Sciences Division**

The secondment agreement of Dr. Abdullah Hel Baqui, an Assistant Scientist of the Johns Hopkins University (JHU), Department of International Health, School of International Hygiene and Public Health, which expired on March 31, 2004 has been extended for an additional period of 1 (one) year effective April 01, 2004. It may be noted that this is a no cost extension.

This is for the information of the Board.

## 3.5 Status of Seconded Staff Contracts

**Agenda 3.5c** **Scientist, P4**
**Health Systems and Infectious Diseases Division**

The current secondment agreement of Dr. Abdullah Brooks, faculty member of the Bloomberg School of Public Health in the Department of International Health at the Johns Hopkins University (JHU), will expire on July 30, 2005. Dr. Abdullah Brooks is seconded as a Scientist to ICDDR,B and working in the Health Systems and Infectious Diseases Division.

The Centre seeks the Board's decision for further course of action needed to be taken by the Centre for this position.

**Agenda 3.5d** **Senior Operations Research Scientist, P5**
**Health Systems and Infectious Diseases Division**

The secondment agreement of Dr. Charles P. Larson, an Associate Professor of the Department of Pediatrics at the Faculty of Medicine, McGill University, Canada will expire on April 30, 2005. Dr. Larson's services will continue to be required to direct the Zinc Scale-up Project.

The Centre requests the Board's approval for initiating an extension of this contract from McGill University for another period of three years effective May 01, 2005.

This is for the approval of the Board.

## 3.6 List of established International Professional Posts

**Director's Division**

| Sl. | Job Title | Grade | Post establishment date | Remarks |
|---|---|---|---|---|
| 01 | Executive Director | ADG | January 1982 | Formerly Director |
| 02 | Deputy Executive Director | D2 | June 2002 | Vacant |
| 03 | Director, Policy & Planning | D1 | July 2000 | Formerly Associate Director |
| 04 | Director, Human Resources | P5 | April 2000 | Formerly Head |
| 05 | Director, Finance | P5 | November 2002 | Formerly Head |
| 06 | Head, External Relations & Institutional Development | P4 | November 1998 | |
| 07 | Executive Assistant to Executive Director | P1 | January 1982 | |

**Public Health Sciences Division**

| Sl. | Job Title | Grade | Post establishment date | Remarks |
|---|---|---|---|---|
| 01 | Director, PHSD | D2 | March 2002 | Vacant, Formerly Associate Director |
| 02 | Head, Health & Demographic Surveillance Unit | P5 | November 1995 | |
| 03 | Head, Reproductive Health Unit | P5 | July 1997 | Vacant |
| 04 | Social Scientist, Head, Social & Behavioural Sciences Unit | P5 | June 2002 | |
| 05 | Epidemiologist & Head, Epidemic Control Preparedness Unit | P4 | July 1996 | Currently a consultancy |
| 06 | Medical Anthropologist | P4 | January 2000 | |
| 07 | Epidemiologist and Head, Child Health Unit | P3 | November 2000 | |
| 08 | Demographer | P4 | April 1995 | Vacant |

## 3.6 List of established International Professional Posts

**Clinical Sciences Division**

| Sl. | Job Title | Grade | Post establishment date | Remarks |
|---|---|---|---|---|
| 01 | Director, CSD | D1 | January 1982 | Formerly Associate Director |
| 02 | Head, Nutrition Research Program | P4/P5 | November 2001 | Vacant |

**Laboratory Sciences Division**

| Sl. | Job Title | Grade | Post establishment date | Remarks |
|---|---|---|---|---|
| 01 | Director, LSD | D1 | January 1982 | |
| 02 | Pathologist | P4 | July 2002 | Vacant |

**Health Systems and Infectious Diseases Division**

| Sl. | Job Title | Grade | Post establishment date | Remarks |
|---|---|---|---|---|
| 01 | Director, HSID | D1 | August 2000 | Formerly Associate Director |
| 02 | Senior Operations Research Scientist | P5 | November 2001 | |
| 03 | Operations Research Scientist | P4 | February 1989 | |
| 04 | Demographic Researcher | P4 | December 1999 | |
| 05 | Scientist | P4 | July 2001 | |
| 06 | Health Economist | P4 | January 1997 | |

**Information Sciences Division**

| Sl. | Job Title | Grade | Post establishment date | Remarks |
|---|---|---|---|---|
| 01 | Director, ISD | P5 | August 2001 | Formerly Head |

## 3.7 List of established International Professional Posts

**Director's Division**

| Sl. | Job Title | Grade | Post establishment date | Remarks |
|---|---|---|---|---|
| 01 | Director | ADG | January 1982 | |
| 02 | Deputy Director | D2 | June 2002 | Vacant |
| 03 | Associate Director, Policy & Planning | D1 | July 2000 | |
| 04 | Head, Human Resources | P5 | April 2000 | |
| 05 | Head, Finance | P5 | November 2002 | Formerly Chief Finance Officer |
| 06 | Head, External Relations & Institutional Development | P4 | November 1998 | |
| 07 | Executive Assistant to Director | P1 | January 1982 | |

**Public Health Sciences Division**

| Sl. | Job Title | Grade | Post establishment date | Remarks |
|---|---|---|---|---|
| 01 | Associate Director, PHSD | D2 | March 2002 | |
| 02 | Head, Health & Demographic Surveillance Unit | P5 | November 1995 | |
| 03 | Head, Reproductive Health Unit | P5 | July 1997 | Vacant |
| 04 | Social Scientist, Head, Social & Behavioural Sciences Unit | P5 | June 2002 | |
| 05 | Epidemiologist & Head, Epidemic Control Preparedness Unit | P4 | July 1996 | |
| 06 | Medical Anthropologist | P4 | January 2000 | |
| 07 | Epidemiologist and Head, Child Health Unit | P3 | November 2000 | |
| 08 | Health Economist | P4 | January 1997 | |
| 09 | Demographer | P4 | April 1995 | Vacant |

## 3.7 List of established International Professional Posts

**Clinical Sciences Division**

| Sl. | Job Title | Grade | Post establishment date | Remarks |
|---|---|---|---|---|
| 01 | Associate Director, CSD | D1 | January 1982 | |
| 02 | Head, Nutrition Research Program | P4/P5 | November 2001 | Vacant |

**Laboratory Sciences Division**

| Sl. | Job Title | Grade | Post establishment date | Remarks |
|---|---|---|---|---|
| 01 | Associate Director, LSD | D1 | January 1982 | |
| 02 | Pathologist | P4 | July 2002 | Vacant |

**Health Systems and Infectious Diseases Division**

| Sl. | Job Title | Grade | Post establishment date | Remarks |
|---|---|---|---|---|
| 01 | Associate Director, HSID | D1 | August 2000 | |
| 02 | Senior Operations Research Scientist | P5 | November 2001 | |
| 03 | Operations Research Scientist | P4 | February 1989 | |
| 04 | Demographic Researcher | P4 | December 1999 | |
| 05 | Scientist | P4 | July 2001 | |

**Information Sciences Division**

| Sl. | Job Title | Grade | Post establishment date | Remarks |
|---|---|---|---|---|
| 01 | Head, ISD | P5 | August 2001 | |

**Agenda 4** **BOT/HR/JUN/2004**

## Human Resources Agenda Update

### 4.1 Introduction

Human Resources has the overall responsibility for recruitment, compensation and benefits, contracts administration, staff development, gender equality, the staff clinic and data management. The department has gone through an enormous amount of change in the past two years at a very quick pace.

It should also be noted that although Human Resources has been mandated implement the HR Agenda, the 19 staff members in HR spend 95% of their efforts providing mainstream HR services to the organization. Five staff members are exclusively dedicated to the staff clinic.

During the last 6 months, the department has recruited 281 individuals to the Centre, processed 727 contract extensions and 895 daily wagers. In 2003, the Dhaka staff clinic treated just over 22,000 patients. These figures are being presented in order to provide the context under which the HR Agenda is being implemented.

The HR tables in the Human Resources Committee folder have been streamlined and updated. The staffing status tables have been redesigned using the job families' information available in Navision and a new table has been added to present gender segregated data.

**Agenda 4** **BOT/HR/JUN/2004**

## Human Resources Agenda Update

### 4.2 Human Resource Information System

The Centre's new integrated MIS system for HR, finance and projects went live on February 1st, 2004 as scheduled after completing the design, the system development and the data migration phases, as well as the user acceptance test. The data migration of all HR records and payroll processing has been particularly demanding.

As expected with the implementation of a system with so much customization, it will take time to stabilize. Finance and HR have maintained a double set of records, manual and computerized for the past 4 months until the system stabilizes. The staff members of both departments are to be congratulated for their efforts during this transition period.

With the implementation of the system we are continuously updating and revising our procedures as well as seeking common understanding between departments since we are now operating from a common database.

The requisitions for recruitment, contract extensions and daily wager are now processed online including budgetary approval, which considerably reduces the turnaround time for processing. As we are progressing with the implementation we have already integrated a number of system enhancements.

To facilitate the Centre wide implementation and acceptance of Navision HR and Finance trained all Principal Investigators as well as all units in using Navision. In addition during the month of May, HR trained the staff members with little or no computer skills in using the system for viewing " self-information" and pay slip as well as leave application.

The learning curve has been steep yet we are beginning to enjoy the benefits of implementing such a system. The remaining challenge is to maximize the use of the system capabilities by all HR staff.

## Human Resources Agenda Update

### 4.3 Gender Equality

As outlined in the Gender policy, the Centre established the post of Gender Specialist to be responsible for overall gender related activities. A job description was defined and the post was announced for recruitment. Ms. Shamima Nasreen Mili joined the HR department in February. Ms. Mili has been orienting herself to the activities of the Centre including visits to the field sites. The gender policy has been translated into bangla and printed for distribution. Editing the bangla version to make it reader friendly was the first assignment of the newly appointed Gender Specialist.

Since fifty percent of the GEC members are new participants on the committee, a two-day workshop on gender awareness was conducted for the members of Gender Equality Committee (GEC) in April. A total of 21 participants attended the Gender workshop out of which 13 were female and 8 male.

Ms. Mili with the help of Gender Equality Committee (GEC) has developed and piloted a 3-hour dissemination module to raise awareness on gender issues and the policy. It is estimated that HR will conduct approximately 100 training sessions over the next year in order for all Centre staff to become familiar with the policy.

Naripokkho, a leading women's organization has been contracted to conduct an Organizational Gender Review of the Centre which started in April 2004. Key organisational structures, procedures, policies and practices are being reviewed to identify whether and how they discriminate against women or men and possible measures to overcome these biases will be identified. The emphasis of the review will be on developing specific, measurable, achievable, realistic and time-bound measures with indications of possible phasing. A preliminary report may be available for the June BoT. The first annual work plan will be presented during the November BoT meeting.

# Human Resources Agenda Update

## 4.4 Performance Review System

A new performance appraisal form has been developed and is part of the Navision system. However due to the system instability and the steep learning curve for all staff members using Navision, the decision was taken to postponed the implementation of the online system. The performance appraisal form need to be retested because of all the system changes that have taken place since the system went live in February.

The development of the performance management training module and the behavioral competencies will be completed during the upcoming months. The roll out of the new performance review system can only be considered once the system has been stable for several months and user are comfortable operating in the new environment.

## 4.5 HR Staff Retreat

The HR staff participated in a 2-day retreat, which provided an opportunity to work together as a team outside the office environment, to develop a department mission statement and to incorporate some of the training needs identified. The goal of the retreat was to develop objectives for the HR staff that are in line with the Centre's mission statement and for the department to continue the transition process from being a "policing" department one of support to the organization.

## Any other business

## 5.1 Introduction

Human Resources (HR) has the overall responsibility for the areas of employment, compensation & benefits (including the staff clinic), employee relations and training & development for the Centre's fix and short-term staff. A comprehensive HR Agenda to support the organizational activities was adopted by the BoT in 2001. This report will outline the current standing of the various HR Agenda items.

It should be noted at this time that Mr. Wahabuzzaman who has worked as Chief Personnel Officer since 1987 will be leaving the Centre on November 30, 2003. Under his leadership, the Human Resource Department benefited greatly. Mr. Wahabuzzaman has had a distinguished career with the Centre. Mr. S.K. Deb will be joining the Centre on November 16 as Senior Manager Human Resources.

## 5.2 Job Classification

The Job Classification Project has now been completed. The overall aim of the project was to have a systematic method by which jobs are measured against each other to determine the relative value and provide a basis for supporting the move towards a merit-based pay system. This effort started in 2001 with the introduction of the NZR Job Classification System. All General Services and National Officer posts have been comprehensively evaluated and clustered into13 job families.

This exercise has resulted in 130 posts or 11% of the fix-term staff being upgraded at a cost of $48,000 to the organization. These changes are inline with the original expected outcomes. The HR database reduced the number of active post titles from 460 to 175. Approximately 25% of the fix-term staff were notified of a change in designation as a result of the post title reconciliation with all other terms and conditions of their employment remaining unchanged. The job families will be available Online to all staff when the new HR information system is implemented in early 2004. HR has developed procedures to maintain the new job classification system.

## 5.3 Performance Review System

HR previously reported in November 2002 that a new Performance and Development Review System had been created for the Centre. However it was decided to build the performance review system into the new HR information system with salary increments linked with payroll. It is anticipated that this initiative will build a performance-oriented

culture and recognition of performance differentials. At this time the performance review forms have been designed.

The proposed system will consider the following:

- A common performance management framework for all staff
- Focus on review and development rather than just evaluation
- Consideration of achievements and behavioral competencies
- Provision for planning before evaluation
- Providing for clarity in setting of performance objectives by defining weightages as well as a quality and time dimension for each
- Ability to eventually build in the system recognition for performance differentials linked to merit pay.

During the first quarter of 2004 a training module will be develop to orient Centre staff, a pilot roll out of the system will occur, pre-implementation activities including developing a user guide and defining weightages for all behavioral competencies will be completed. During the second quarter the staff and managers will begin training on using the new system. Training activities are expected to continue throughout the year. The new Performance Review System will Go-Live in June 2004.

### 5.4 Human Resource Management System

The Human Resources Department with Finance and Projects has been very busy for the past 6 months working towards the development and implementation of an integrated management information system for the Centre.

This project has required the HR department to redefine all its processes and implement a new departmental structure ( Appendix 1). It will radically change the manner in which we provide services to the organization. The functional requirements have been defined and we are currently in the analysis and design phase of the project.

For the first time HR and payroll will be fully integrated. The system will allow us to maintain comprehensive employee records and give broad access to basic employee file information and access information for analysis purposes.

### 5.5 Gender Policy

Following the approval of the Gender Policy at the June 2003 BoT, a fifteen member committee has been created to support implementation of the policy. Fifty percent of the committee members served on the committee that drafted the policy. An orientation session is schedule for November 2003 for new members.

The policy is in the final stages of translation into Bangla. It will be published in a bilingual booklet format for distribution to all staff members as part of a center wide dissemination scheme. The booklet will include a forward by the Director and an executive summary.

A sub-committee is in the process of drafting a dissemination plan and will pilot a staff training session in December. It is estimated that it will take approximately 90 sessions of 3 hours to introduce the policy to the staff. In addition, the Gender Committee is reviewing a Gender Audit Proposal to be schedule in early 2004. The newly created Gender Specialist position will be advertised this month with the expectation of having the incumbent join in January 2004. The audit will provide the information to develop the first annual implementation plan as well as serve as an orientation for the new Gender Specialist.

The WHO Gender Advisory Panel has been contacted to see if we can access some of their resources. The panel meets once a year to insure that consideration of gender equity and equality as well as sexual and reproductive rights are brought into all of WHO's activities. We have been asked to submit a CV of an interested staff member for consideration as a potential candidate for the Panel when a vacancy arises.

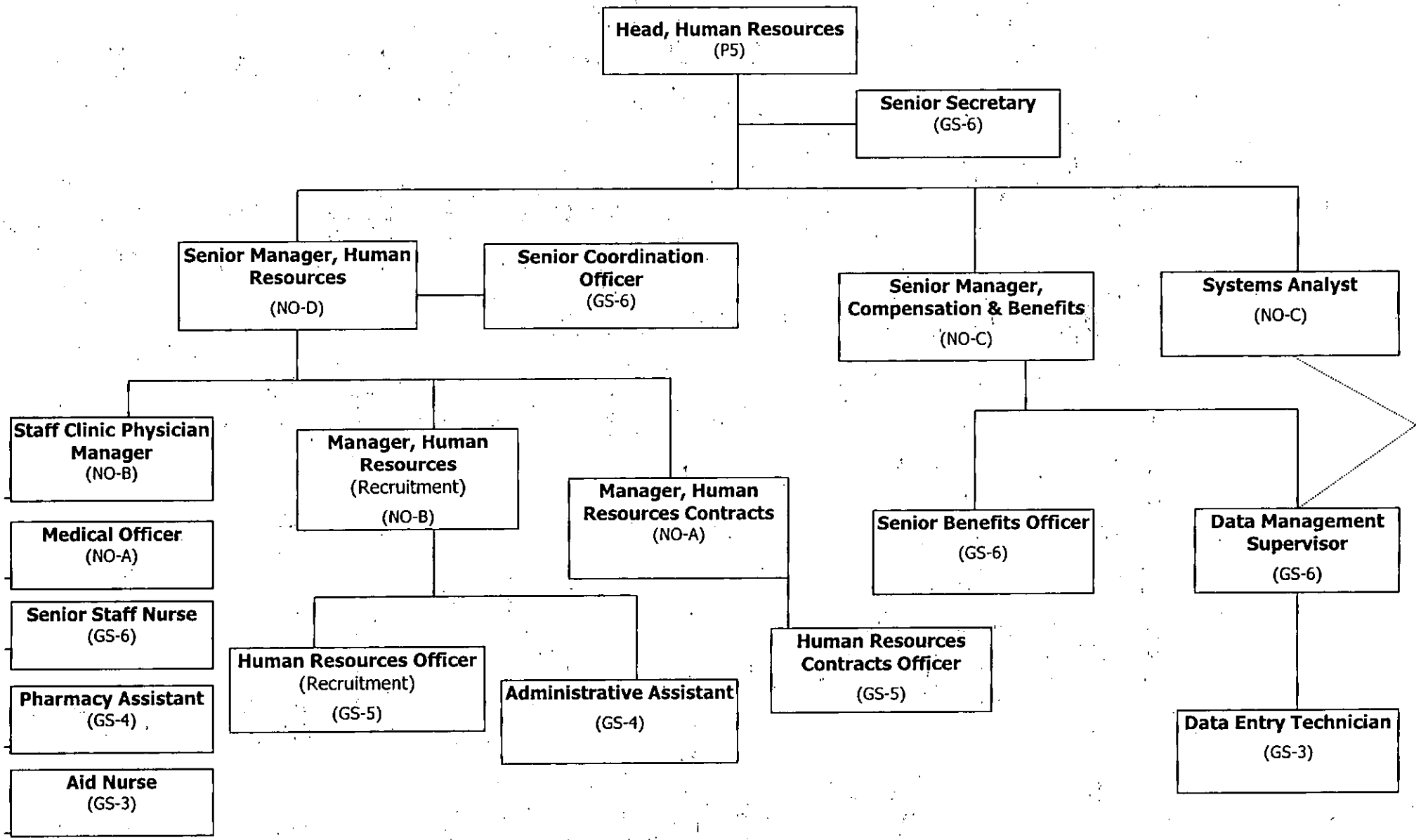
The Staff Welfare Association (SWA) is to be congratulated for their support of the Gender policy. During their annual general meeting in October, the membership adopted a resolution adding two new positions to the Staff Committee. An additional Joint Secretary and a new Women's Affairs posts were created. Moreover, three out of seven executive positions will now be reserved for woman. Both Dhaka and Matlab will be electing new committee members in December. A proposal will be given to the new SWA Committee to have their members participate in the same orientation session as the Gender Committee to provide more in depth awareness of gender issues.

### 5.6 Human Resource Plan

The Centre has done some preliminary work on determining its "essential core activities". However, more work is required before these are determined. The new information system will provide HR with an increase capacity to do some workforce planning. HR in collaboration with Training and Development has had initial discussions to develop a more coordinated approach for staff returning from study leave.

The previous initiatives reported are all essential elements towards an integrated Human Resource Plan for the Centre.

# HUMAN RESOURCES DEPARTMENT




*Effective October 01, 2003*

## Human Resources Committee Meeting
June 2004

### Human Resources
Mission Statement

As a strategic partner of the Centre, Human Resources is committed to provide quality HR management services and facilitate change management with integrity, responsiveness and sensitivity in a fair and equitable manner, in the pursuit of excellence.

### Staffing Status
October 2003 – March 2004

BOT/HR/JUN/2004

Additions : 57
Separations : 29
Net Additions: 28

Total Fixed-Term Staff : 1217
Other Categories : 751

Total : 1968

### Staffing Status
By Job Family

BOT/HR/JUN/2004

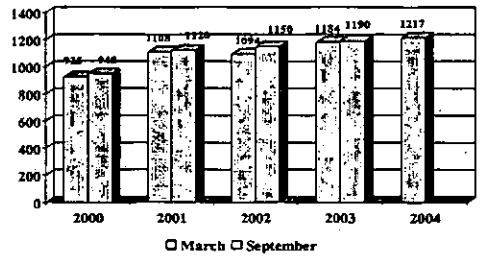
Fixed Term Staff

Other Contract Types

ICDDR,B

Fixed-Term Staffing Status
2000 – 2004

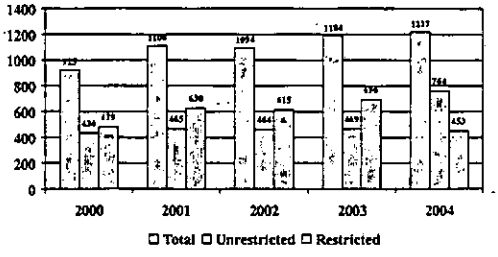
BOT/HR/JUN/2004




ICDDR,B

Fixed-Term Staffing Status
2000 – 2004

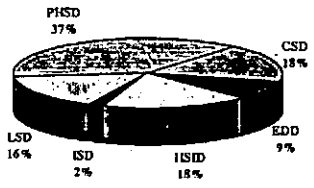
BOT/HR/JUN/2004




ICDDR,B

Staffing by Division

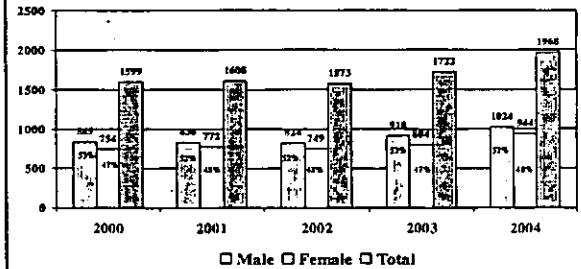
BOT/HR/JUN/2004

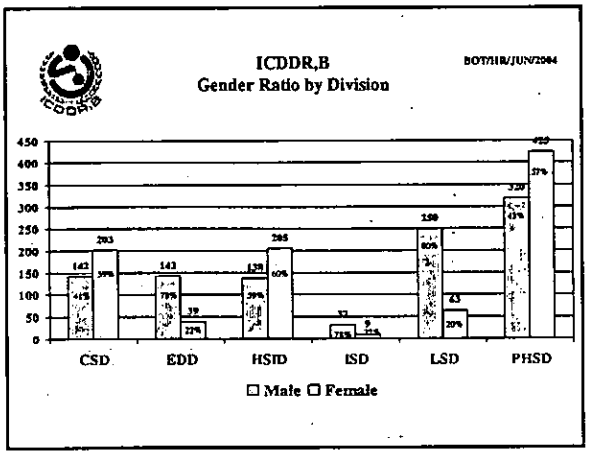


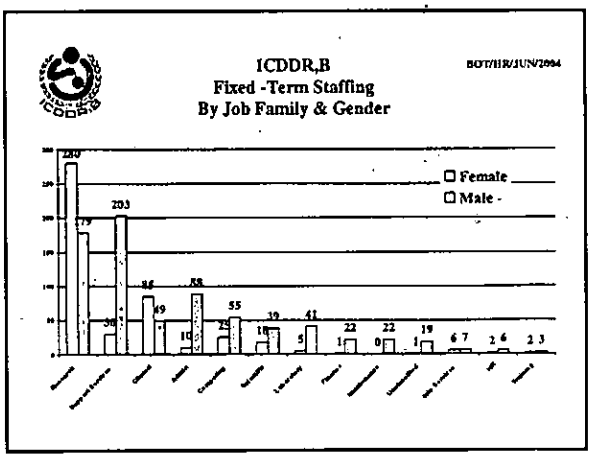

ICDDR,B

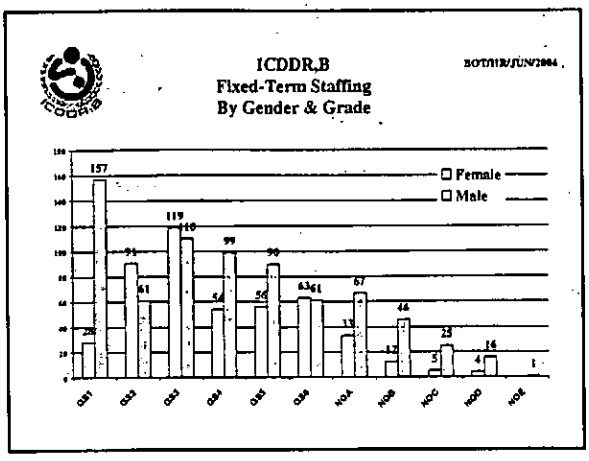
Gender Ratio
2000 – 2004

BOT/HR/JUN/2004




ICDDR,B
Gender Ratio by Division
BOT/HR/JUN/2004
450
400
350
300
250
200
150
100
50
0
CSD
EDD
HSID
ISD
LSD
PHSD
Male Female


ICDDR,B
Fixed -Term Staffing
By Job Family & Gender
BOT/HR/JUN/2004
Female
Male


ICDDR,B
Fixed-Term Staffing
By Gender & Grade
BOT/HR/JUN/2004
Female
Male

5/BT/JUNE 2004

# FINANCE COMMITTEE

# WELCOME TO FINANCE COMMITTEE

# ICDDR,B: CENTRE FOR HEALTH & POPULATION RESEARCH

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

## BOARD OF TRUSTEES MEETING
## FINANCE COMMITTEE

June 2004

# ICDDR,B BOARD OF TRUSTEES MEETING

## FINANCE COMMITTEE MEETING - JUNE 11, 2004

## AGENDA

1. Approval of Agenda.
2. 2003 Auditors' Report and Audited Financial Statements
3. Auditors' Letter to the Board of Trustees
4. Appointment of Auditors' for 2004
5. 2004 Forecast
6. Reports on:
   a) Hospital Endowment Fund
   b) Centre Endowment Fund
   c) Reserve Fund
   d) Operating Fund
7. Other Items:
   a) Overdraft Facilities
   b) Opening of new bank account
   c) Employees Separation Payment Fund
   d) Write off of Doubtful Receivables
   e) Update on Suchona
8. Draft Resolutions

**Tables [2002 – 2004] :**

| | |
|---|---|
| Table I | Revenue by Sources and Expenditure by Categories |
| Table II | Unrestricted and Restricted Revenue and Expenditure |
| Table III | Contributions from Donors |
| Table IV | Donor Contributions by Unrestricted and Restricted Funds |
| Table V | Unrestricted Projects/Programs and Management Expenditure |

**Annexure:**

**A** - Report of the Finance Committee : November 2003
**B** - 2003 Auditors' Report and Audited Financial Statements
**C** - Auditors' Letter to the Board of Trustees [DRAFT]
**D** - 2003 Auditors' Report and Audited Financial Statements for Employees Separation Payment Fund [Not Attached]
**E** - Glossary of Acronyms and Abbreviations

# 2003 AUDITORS' REPORT AND AUDITED FINANCIAL STATEMENTS

The audit was completed and the audit report was signed on March 18, 2004. The Auditors' Report and audited Financial Statements are attached as Annexure "B". Financial highlights and audited Abridged Financial Statements are included in the Centre's 2003 Annual Report.

The Auditors' Report includes two qualifications. Management does not agree with those qualifications.

The first qualification is for non inclusion of assets and liabilities of "ICDDR,B Employees Separation Payment Fund" in Centre's Account.

The aforesaid Fund being operated independent of the Centre's activities, assets and liabilities attached to the Fund should not appear in the Centre's books. The inclusion of such funds in the Centre's Statement of Financial Position would materially distort the true financial position of the Centre. Management's view has been adequately disclosed in the notes appended to the Financial Statements.

Auditors' have also qualified the deferment of ERP implementation costs amounting to $320,000. This amount has been carried forward as the implementation was not completed within 2003. This deferred expenditure will be amortized in two equal installments in 2004 and 2005 against earmarked funds.

Detailed analysis of Financial Statements [Tables (I to V)] prepared by Finance Department has been included as attachments for ready reference.

# 2002 and 2003 ACTUALS

## REVENUE

Contributions from Donors, Endowment Funds and other receipts (including exchange gain) increased from $15,991,000 in 2002 to $17,181,000 in 2003. This net increase of $1,190,000 (7%) is explained in details by components.

| | TABLE | 2002 ACTUAL | 2003 ACTUAL | Increase/(Decrease) Amount | % |
|---|---|---|---|---|---|
| **RESTRICTED** | | | | | |
| Direct | | 9,908,000 | 9,871,000 | (37,000) | **(0.4)** |
| Hospital Endowment Fund | | - | 400,000 | 400,000 | 100 |
| Centre Endowment Fund | IV | 71,000 | 49,000 | (22,000) | (31) |
| **Restricted Direct** | II | **9,979,000** | **10,320,000** | **341,000** | **3** |
| Indirect | | 1,848,000 | 1,594,000 | (254,000) | (14) |
| **Projects/Programs** | | **11,827,000** | **11,914,000** | **87,000** | **1** |
| **UNRESTRICTED** | | | | | |
| Contribution | | 3,486,000 | 4,638,000 | 1,152,000 | 33 |
| Other Receipts | | 678,000 | 629,000 | (49,000) | (7) |
| **Total Revenue** | II | **$ 15,991,000** | **17,181,000** | **1,190,000** | **7** |

**Restricted direct revenue** increased by 3.4% in 2003 mainly due to transfer of $400,000 from Hospital Endowment Fund (HEF) into Centre's operations in 2003.

**Restricted indirect revenue** in 2003 was less by 14% [$254,000] than that of 2002. This is mainly due to accrual/recovery of $390,000 in indirect cost differential against USAID/Dhaka Cooperative Agreement for 1999 to 2001 in 2002. This decrease in partially compensated by increase in indirect revenue from Gates Foundation and other donors by $136,000.

**Unrestricted revenue** increased mainly due to funding from CIDA under a new grant and increased level of contribution from SDC and The Government of People's Republic of Bangladesh. This increase was partially reduced due to withdrawal of core support by USAID/Washington and Belgium which were $338,000 and $59,000 respectively in 2002.

# 2002 and 2003 ACTUALS

## EXPENDITURE

Operating expenditure before depreciation increased by $1,100,000 (7%) from $ 15,918,000 in 2002 to $17,018,000 in 2003.

| | TABLE | 2002 ACTUAL | 2003 ACTUAL | Increase/(Decrease) Amount | % |
|---|---|---|---|---|---|
| **RESTRICTED** | | | | | |
| Direct - Operating | | 9,447,000 | 9,666,000 | 219,000 | 2 |
| - Capital | | 532,000 | 654,000 | 122,000 | 23 |
| **Restricted Direct** | II | **9,979,000** | **10,320,000** | **341,000** | **3** |
| **UNRESTRICTED** | | | | | |
| Projects/Programs | | 3,898,000 | 4,697,000 | 799,000 | 20 |
| Management | | 2,041,000 | 2,001,000 | (40,000) | (2) |
| **Total Unrestricted** | V | **5,939,000** | **6,698,000** | **759,000** | **13** |
| **Operating Expenditure (a)** | II | **15,918,000** | **17,018,000** | **1,100,000** | **7** |
| **Total Revenue (b)** | II | **15,991,000** | **17,181,000** | **1,190,000** | **7** |
| **Operating Surplus (b-a)** | II | 73,000 | 163,000 | 90,000 | 123 |
| **Depreciation (c)** | II | 956,000 | 1,001,000 | 45,000 | 5 |
| **Total expenditure after Depreciation (a + c)** | | **$16,874,000** | **18,019,000** | **1,145,000** | **7** |

**Restricted expenditure** increased in line with restricted revenue as elaborated under revenue.

**Unrestricted expenditure in projects/programs** increased by 13% mainly due to sharing of costs of studies: MINIMat ($130,000), Program of Infectious Diseases and Vaccine Sciences (PIDVS) ($64,000) mainly at Kamalapur and fall back of expenses related studies on TB, Rotavirus, Dengue, ARI and STD ($754,000) which were used to be supported by the USAID/Washington. The increase was partially reduced due to transfer of $400,000 from HEF to cover Hospital Costs.

**Unrestricted management expenditure** decreased primarily due to reallocation of capital expenses: $61,000 (in 2002) and $187,000 (in 2003) to the respective projects / programs, which was partially offset by cost of salary of a short-term international staff in ER&ID Office, effect of full year salary of Director, HR and increase in expenditure for organizing two full BoT in 2003 unlike one full board in 2002.

**Depreciation** for the year increased by $45,000 (5%) from $956,000 to $1,001,000 in 2003. The Cumulative depreciation increased by $1,001,000 from $13,864,000 to $14,865,000 as at December 31, 2003.

**Total expenditure** after depreciation increased by $1,145,000 (7%) from $16,874,000 in 2002 to $18,019,000 in 2003.

**Operating Surplus** before depreciation increased by $90,000 (123%) from $73,000 in 2002 to $163,000 in 2003 because of the net effect of changes in revenue and expenditure as noted above.

# Auditors' Letter to the Board of Trustees

Auditors' have issued a management letter to the Board of Trustees attached as Annexure "C" with respect to the following two matters:

- **Formation of Trust for Employee Separation Payment Fund**

Management recognizes that the aforesaid Fund belongs to staff participants and therefore, does not constitute an asset of the Centre. This is the rationale behind non-inclusion of the assets and liabilities of the Fund. Moreover, the inclusion of such funds in the Centre's Statement of Financial Position would materially distort the true financial position of the Centre. These facts along with the accumulated fund balance as at December 31, 2003 have been adequately disclosed in the notes appended to the Financial Statements. We are also in the process of setting up an Independent Trust for this Fund that will manage the Fund on behalf of the participating employees.

- **Endowment Funds' investments with TIAA-CREF carry higher risk of market fluctuations in view of their high equity component of around 62% of total investments.**

Management considers investments against Endowment Funds as long-term investments. The objective of these investments is to provide a stable returns along with a steady growth of the Corpus. To optimize return and minimize risks a balanced portfolio is maintained. The average Debt Equity ratio of these investments is 40:60.

These Endowment Funds Investments are governed by the Fund Investment Committee, which is constituted with eminent professionals from various related fields. An Asset Manager appointed by the Board of Trustees manages these overseas investments and send monthly report for our review. The Fund Management Committee meets every quarter and closely monitors these investments and recommends corrective measures.

Auditors' also have issued a letter to management covering minor matters. This letter is available, should any committee member wish to review it.

# APPOINTMENT OF AUDITORS' FOR 2004

KPMG, Kolkata and Hoda Vasi Chowdhury & Co, Dhaka were the joint auditors for 2003. KPMG, Kolkata was Centre's auditors' for the last year and Hoda Vasi Chowdhury & Co, Dhaka for the last five years.

The Centre's practice is usually to retain auditors for five to seven years to provide continuity in the audits and minimize audit costs.

Management is recommending the reappointment of KPMG, Kolkata and Hoda Vasi Chowdhury & Co, Dhaka as joint auditors for the year 2004.

Audit Fees for the last three years were fixed at $15,500. Management feels that the total audit fees should be increased to $16,000.

# 2004 FORECAST

## REVENUE

Contributions from Donors, Endowment Funds and other receipts (including exchange gain) were budgeted at $14,877,000 compared to a forecast of $16,559,000 for 2004. This increase of $1,682,000 (11%) comprises :

| | TABLE | 2004 BUDGET | 2004 FORECAST | Increase/(Decrease) Amount | % |
|---|---|---|---|---|---|
| **RESTRICTED** | | | | | |
| Direct - Operating | | 8,374,000 | 9,528,000 | 1,154,000 | 14 |
| - Capital | | 126,000 | 283,000 | 157,000 | 125 |
| Endowment Funds | IV | 46,000 | 200,000 | 154,000 | 335 |
| **Restricted Direct** | II | **8,546,000** | **10,011,000** | **1,465,000** | **17** |
| Indirect | | 1,436,000 | 1,660,000 | 224,000 | 16 |
| **Projects/Programs** | II | **9,982,000** | **11,671,000** | **1,689,000** | **17** |
| **UNRESTRICTED** | II | | | | |
| Contributions | | 4,148,000 | 4,168,000 | 20,000 | 0.5 |
| Exchange gain | | 100,000 | 100,000 | | |
| Other Receipts | | 647,000 | 620,000 | (27,000) | (4) |
| **Total Revenue** | II | **$ 14,877,000** | **16,559,000** | **1,682,000** | **11** |

**Restricted direct revenue** was budgeted at $8,546,000, which is expected to increase by $1,465,000 (17%). This increase was primarily due to increased-level of spending for the projects funded by the Government of Bangladesh, CDC, Gates Foundation, Gates-GoB, Sida/SAREC, USAID/Dhaka, other US sources, some small donors and also forecasting of funding for Hospital activities from HEF. This increase was partially offset by reduced level of spending in projects funded by DFID, SRC and NIH and completion of USAID/Washington projects in 2003. Although budgeted in 2004 project funding from USAID/Washington has not yet been materialized.

**Restricted indirect revenue** is expected to increase by $224,000 (16%) from budget of $1,436,000 to $1,660,000, mainly due to increase in spending as mentioned above.

**Unrestricted direct revenue** is anticipated to remain almost the same.

# 2004 FORECAST

**EXPENDITURE**

The forecast of operating expenditure for 2004 is $17,169,000 compared to budget $15,803,000. This increase of $1,366,000 (9%) comprises:

| | TABLE | 2004 BUDGET | 2004 FORECAST | Increase/(Decrease) Amount | % |
|---|---|---|---|---|---|
| **FUND REQUIRED** | | | | | |
| **RESTRICTED** | | | | | |
| Direct - Operating | | 8,420,000 | 9,728,000 | 1,308,000 | 16 |
| - Capital | | 126,000 | 283,000 | 157,000 | 125 |
| **Restricted-Direct** | II | **8,546,000** | **10,011,000** | **1,465,000** | **17** |
| **UNRESTRICTED** | | | | | |
| Projects/Programs | | 5,088,000 | 5,119,000 | 31,000 | 1 |
| Management | | 2,169,000 | 2,039,000 | (130,000) | (6) |
| **Total Unrestricted** | V | **7,257,000** | **7,158,000** | **(99,000)** | **(1.4)** |
| **Operating Expenditure (a)** | II | **15,803,000** | **17,169,000** | **1,366,000** | **9** |
| **Fund Contributed by Donor (b)** | II | **14,877,000** | **16,559,000** | **1,682,000** | **11** |
| **Shortfall (b-a)** | | (926,000) | (610,000) | (316,000) | (34) |
| **Depreciation (c)** | II | 946,000 | 912,000 | (34,000) | (4) |
| **Total Expenditure after Depreciation (a + c)** | | **$16,749,000** | **18,081,000** | **1,332,000** | **8** |

**Restricted expenditure** is expected to increase in line with restricted revenue.

**Unrestricted projects/programs expenditure** increased slightly.

**Unrestricted expenditure by management** decreased due to decrease in international salary cost for delay in recruitment for two vacant position and better recovery from support services.

**Depreciation** is forecast at $912,000 and is expected to decrease by $34,000 (4%) from $946,000 due to expiry of life of some assets.

**Total expenditure** after depreciation is forecast at $18,081,000, which is an increase of $1,332,000 (8 %) from budgeted of $16,749,000.

The **Shortfall** in the Operating account, which was budgeted at $926,000, is expected to reduce to $610,000 as per forecast 2004. The decrease in the shortfall by $316,000 (34%) is because of the net effect of changes in revenue and expenditure as noted above.

This forecast is prepared on a conservative basis including only those funding sources, which have been finalized. Since, unrestricted indirect cost is dependent on restricted project expenditure, project-spending rate has to be in line with our estimation to achieve this result. The shortfall as per forecast may be covered from contributions forthcoming from agreements expected to be finalized, as detailed in Executive Director's report, in the near future.

## REPORTS ON:

### a) Hospital Endowment Fund:

The market value of the Hospital Endowment Fund was $5,925,000 as on December 31, 2003. In 2003, donations and fund raising activities contributed $47,000 to the fund; capital gain was $457,000 and net income from investment was $122,000.

| | | (US$) |
|---|---|---|
| Balance as at January 01, 2003 | | 4,962,000 |
| Add: Donations received during the year | 38,000 | |
| Net fund raised during the year | 10,000 | |
| | | 48,000 |
| | | 5,010,000 |
| Add: Net capital gain for the year | 452,000 | |
| Net income from investment | 122,000 | |
| | | 574,000 |
| | | 5,584,000 |
| Add: Current Account with ICDDR,B | | 574,000 |
| | | 6,158,000 |
| Less: Distribution to Hospital Cost | | 400,000 |
| Balance [Cost] as on December 31, 2003 | | 5,758,000 |

The funds were invested in money market, equity mutual funds and fixed income mutual funds managed by TIAA-CREF Trust Company, USA (66%); Time Deposits with American Express Bank in Singapore (30%); and Government Bonds, Equities and Debentures in Bangladesh (4%). The market value of the Hospital Endowment Fund stands at $5,961,000 on April 30, 2004.

As per Board resolutions in November 2001 [RES/4/NOV 01] and November 2002 the Board had approved the previously authorized transfer of $200,000 each for 2001 and 2002 to be carried forward for use 2003 operations. During 2003, $400,000 was transferred to operations against carryover from 2001 and 2002.

**b) Centre Endowment Fund:**

The market value of the Fund was $3,834,000 as at December 31, 2003. Capital gain was $444,000, net income from investment was $97,000.

| | | (US$) |
|---|---|---|
| Balance as at January 01, 2003 | | 3,131,000 |
| Add: Net capital gain for the year | 444,000 | |
| Net income from investment | 97,000 | |
| | | 541,000 |
| Balance [Cost] as on December 31, 2003 | | 3,672,000 |

All the funds were invested in money market funds, equity mutual funds and fixed income mutual funds managed by TIAA-CREF Trust Company in USA. The market value of the Centre Endowment Fund stands at $3,869,000 on April 30, 2004.

Management has proposed a transfer up to $180,000 from the Centre Endowment Fund in 2004. This amount will be used for Institutional development activities, further development of the interdivisional thematic programs and other activities approved by the Board of Trustees.

**c) Reserve Fund:**

The Reserve Fund was established in 1982 to enable the Centre to attain better financial stability and to enable it to retain a satisfactory level of work in case of uneven flow of resources beyond its control. The fund comprises of donations, transfers from operating account and income earned on investment of the fund.

The balance of the Reserve Fund stands at $2,004,000 on December 31, 2003. The Fund Capital is $1,342,000. Over the years it earned an amount of $1,805,000 inclusive of $15,000 for 2003 as investment income. An amount of $1,143,000 inclusive of $16,000 for 2003 was transferred to Operating Fund to offset the Centre's cumulative operating deficit.

Time Deposit of $2,004,000 against this fund is under lien to American Express Bank Ltd., to the extent of the Centre's overdraft facility of $2,000,000.

**d) Operating Fund:**

The cumulative operating deficit has declined by $1,285,000 over the past five years ($179,000 in 2003) from its maximum of $3,922,000 at the end of 1998 to $2,637,000 as at December 31, 2003.

Much of this decline resulted from transfer of Reserve Fund earnings accumulated over past years. Current economic forecasts predict significantly lower interest rates over the next several years. Thus, it is unlikely that the primary source of past deficit reduction will continue in the near future. If modest surpluses (e.g. 0.5% of revenues i.e. $200,000) can be achieved, the reduction of deficit to $2,000,000 over the next three years would be a reasonable outcome.

## OTHER ITEMS:

### a) Overdraft Facilities:

Bank Overdraft:

The Centre's current $2 million overdraft facility with American Express Bank which carries no commitment fees will expire on July 31, 2004. Interest rates are the bank's prime rate in USA and the special rate (8.25%) negotiated by the Centre with the bank at Dhaka. The facility is used to meet temporary shortfall in the operating fund. In consequence of the large cumulative deficit and time lag in receiving contributions, there will be perennial need for overdraft from time to time to meet operating costs. This overdraft facility is secured by time deposits made out of the Reserve Fund.

In view of this, management recommends renewing the overdraft agreement of $2 million for the year to July 31, 2005.

Borrowing facilities from Hospital Endowment Fund:

By way of Board resolution in June 1995, management may borrow from the Hospital Endowment Fund up to a maximum of $750,000 to cover operating cash requirements. No fund was borrowed from the Hospital Endowment Fund till date.

### b) Opening of new bank account:

Canadian International Development Agency (CIDA) is presently funding our Core through a 5-year contribution agreement, effective from 2003. According to the agreement CIDA will disburse CND$7,500,000 during this 5 years and ICDDR,B is required to park the fund in a separate bank account. CIDA has expressed its preference to operate through Royal Bank of Canada.

Accordingly, we have initiated the process of opening an account with "Toronto Downtown Business Banking Centre" branch of Royal Canadian Bank with signatories exactly the same as with AMEX Bank.

**c) Employees Separation Payment Fund (ESPF):**

This fund was established through a resolution of the BoT meeting held in December 1983. The ESPF is being generated through joint contributions of the employees @7.4% and employer @ 14.8%. The amount of contributions is transferred to Generali Group on a quaterly basis, by the Centre. The entire fund has been invested by the Generali in US/UK Goverment Treasury Bonds and also in other investment portfolios. Profits earned from these investments are distributed among the staff members account.

The AccuRecord Inc., USA, maintains books of account of this fund. The total amount accumulated in this fund at the close of December 2003 stands at $12,044,767.

In November 2003 the Board resolved that the Centre Directorate should work with the Staff Welfare Association (SWA) to prepare a draft plan for the Employees Separation Payment Fund (ESPF) Trust. Based on the proposal from the Management Executive Committee SWA has endorsed the proposal for formation of the Trust and suggested the following designated persons will be members of this Trust:

- the Executive Director (Chairman, mandatory);
- the Director, Finance;
- the Controller, Finance;
- the Director, Human Resources;
- a Division Director;
- President, SWA;
- Vice President, Matlab SWA; and
- six subscriber staff (composed of 3 National Officers and 3 General Services Officers)

SWA has also suggested that the Secretary may be from the subscribers' side.

**d) Write off of Doubtful Receivables**

During the year 2003 provision has been made against $96,804 being the amount receivable from Swiss Red Cross relating to First Phase -1999 ($66,131) and Second Phase- 2001 ($30,673) of the Project funded by the Donor. Although efforts were made in the past as well as in recent times to recover the amount, representatives of the Donor expressed their inability to reimburse the amount.

## e) Update on Suchona

"Suchona"- the new beginning, is an effort to enhance the management capabilities by integrating Financial, Human Resources and Projects Management System.

Considering the versatility and complex operating environment of ICDDR,B "Microsoft Business Solutions (MBS) Navision Attain" Software was selected as our Enterprise Resource Planning (ERP) package. The ERP has been customized to cater our requirements. Globally, Navision does not carry out implementation and customization itself but operates through its channel partners. Taking into account the complexity of our operations and PricewaterhouseCoopers (PwC)'s experience in executing such assignments, Navision India selected PwC, India as their implementation partner.

The project was carried out by forging a combined team from ICDDR,B and PwC. A Steering Committee is in place for monitoring and taking all major decision relating to the project. The implementation of the total project including first phase of customization took 8.5 calendar months. The system is deployed effective from February 2004.

After Go-live we faced many technical as well as lots of procedural and administrative issues. This is a common phenomenon in all system implementation with major customizations. Universally this requires post go-live analysis and fine-tuning and our system was no different from others.

As a part of our effort to keep the users abreast of the changes and benefits that the system may bring in, various "Change Management" activities (e.g. workshops, presentation and distribution of handouts) were carried out during January 2004.

Training for all concerned staff members was conducted in phases. In first phase, "End user training" was rolled out in January before going live with the system. After going live, month long comprehensive training sessions were conducted by Finance and HR to cater to the training need of PI, their office managers and administrative assistants. Separate training was organized for staff from various field sites. HR has conducted training for staff members with limited or no computer skills in the month of May on the basic use of the system. One more hands-on training is scheduled to be conducted in August 2004.

Moreover, the Suchona Help Desk has been set-up to provide functional support to the users on priority basis during the office hours. The Help Desk can be contacted through personal visit, phone and e-mail. The Help Desk is expected to coordinate all communications between the users and the Suchona Technical and Functional team. Online User Manuals and the Operating Manual are also made available for ready reference.

Major components of this integrated system are Projects, Resources, HR, Payroll, Annual Budget and Forecast, Financial Accounting, Cost Accounting and On-line Requisitions.

Out of these components Project, Resources, HR and Payroll are functioning satisfactorily. A few functional and process changes are being made to iron out some integration issues between HR and Payroll. The Forecast presented to Board of Trustees was also rolled out for the first time from Suchona.

We have completed the uphill task of uploading all financial and other relevant data ensuring the quality and consistency of data. We have experienced a steep learning curve with Financial and Cost Accounting components. We are in the process of resolving various functional and technical problems. At present we are migrating data processed external to the system. Data as going into the system has been double-checked manually to ensure accuracy, which is taking more time. Uploading of financial and cost data has been completed till March. Data relating to April and May is expected to go in the system by June. Due to this we had few backlog in reporting to Donors. Principal Investigators have also faced some problems for delayed reporting. Donors and the Principal Investigators were very supportive in this regard. However, we will be soon in a position to provide report(s) regularly to PIs and Donors.

In case of On-line Requisitions we have faced few major problems basically relating to conflict of security and roles in the post go-live period. In order to keep the Centre running, HR and Finance Departments are processing requisitions in hard copies in one hand and on the other hand migrating all paper requisitions in the system. We have fixed most of the problems relating to security and also enhanced the functionalities. On-line Requisitions will be released once all paper requisitions are uploaded in the system.

All these coupled with day-to-day responsibilities have doubled the workload mainly for HR and Finance Department. Suchona technical and functional teams are also putting up an outstanding performance.

We are also using the service of a small Post Implementation Support (PIS) team from PwC. PIS team is being utilized for data migration, trouble shooting, handholding, resolving various technical and functional problems. They are also involved in second stage of development/customization that has been initiated based on the requirements, identified during the last few months of implementation along with the fine-tuning of the system for few components.

As a part of building connectivity with major field stations we have already started to look into some cost effective solution for stable connectivity with our largest field station, Matlab. Developing an adequate disaster management plan to safeguard the system is also in our future agenda.

As a whole the implementation is satisfactory and we believe that the users will be able to realize the benefits of Suchona in near future.

## DRAFT RESOLUTIONS

### RESOLUTION – 01 (Agenda No. 2)

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

The Board of Trustees accepts the audited Financial Statements of the Centre for the year ended December 31, 2003.

### RESOLUTION – 02 (Agenda No. 3)

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

The Board accepts the management response to the auditors' letter to the Board of Trustees.

### RESOLUTION – 03 (Agenda No. 4)

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

The Board agrees to the reappointment of KPMG, Kolkata and Hoda Vasi Chowdhury & Co., Dhaka as joint auditors for the year 2004 at a fee not exceeding $16,000.

### RESOLUTION – 04 (Agenda No. 5)

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

The Board of Trustees agrees to approve the 2004 forecast as presented noting that over the past five years the Centre has been able to generate annual operating surplus. The Management is encouraged to continue to take all measures possible to avoid the projected $610,000 shortfall in 2004. The Board of Trustees will review the Break-even plan of the Centre Directorate in its November 2004 Board of Trustees meeting.

**RESOLUTION – 05 (Agenda No. 6a)**

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

The Board of Trustees approves the transfer of $400,000 from Hospital Endowment Fund to the Operating fund in 2003 based on previously authorized unutilized carried over amounts of $200,000 each from 2001 and 2002.

**RESOLUTION – 06 (Agenda No. 6a)**

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 2003 may be carried over into 2004 as deemed necessary by the Executive Director; and also authorizes $200,000 to be transferred from the Hospital Endowment Fund to operations in 2004.

**RESOLUTION – 07 (Agenda No. 6b)**

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

The Board authorizes the transfer of up to $180,000 from the Centre Endowment Fund in 2004 and that such unexpended monies may be carried over into 2005.

**RESOLUTION – 08 (Agenda No. 6c)**

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

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

**RESOLUTION – 09 (Agenda No. 7a)**

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

The Board authorizes the continuation of the overdraft facility of up to $2,000,000 with the American Express Bank for the year to July 31, 2005.

**RESOLUTION – 10 (Agenda No. 7b)**

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

The Board resolved to authorize the appointment of Royal Bank of Canada as bankers to the Centre with signatories exactly the same as with American Express Bank. Additionally the Board resolved to authorize

a) the Executive Director to sign the agreement;
b) the Director, Finance together with any other Division Director to be the initial Primary Delegates; and
c) the initial primary delegates may appoint further delegates.

**RESOLUTION – 11 (Agenda No. 7c)**

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

The Board accepts the audited financial statements of the ICDDR,B Employees Separation Payment Fund for the year ended December 31, 2003.

**RESOLUTION – 12 (Agenda No. 7c)**

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

The Board resolves that the Employees Separation Payment Fund to be vested with a Trust, "Employees Separation Payment Fund Trust". The following designated persons will be members of this Trust.

- the Executive Director (Chairman, mandatory);
- the Director, Finance;
- the Controller, Finance; (Secretary)
- the Director, Human Resources;
- one Division Director;
- President, SWA;
- Vice President, Matlab SWA; and
- six subscriber staff (composed of 3 National Officers and 3 General Services Officers)

A draft relevant by-laws after approval of SWA should be presented to the BoT at the November 2004 Board of Trustees meeting.

**RESOLUTION – 13 (Agenda No. 7d)**

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

The Board resolved to authorize to write off $96,804 being irrecoverable old receivables from a Donor in 2004.

## Tables

# TABLE - I
## ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH
## UNRESTRICTED AND RESTRICTED REVENUE AND EXPENDITURE 2002 - 2004

(Amount in US$ '000)

| | 2002 ACTUAL | | 2003 ACTUAL | | 2004 BUDGET | | 2004 FORECAST | | INCREASE/ (DECREASE) FORECAST vs. BUDGET | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Amount | % | Amount | % | Amount | % | Amount | % | AMOUNT | % |
| **REVENUE** | | | | | | | | | | |
| UNRESTRICTED FUNDS | 3,486 | 22 | 4,638 | 27 | 4,148 | 28 | 4,168 | 25 | 20 | 0.49 |
| RESTRICTED FUNDS | | | | | | | | | | |
| - INDIRECT | 1,848 | 12 | 1,594 | 9 | 1,436 | 10 | 1,660 | 10 | 224 | 16 |
| - PROJECTS / PROGRAMS | 9,942 | 62 | 10,279 | 60 | 8,466 | 57 | 9,948 | 60 | 1,481 | 17 |
| **CONTRIBUTIONS** | **15,276** | **96** | **16,511** | **96** | **14,050** | **94** | **15,776** | **95** | **1,726** | **12** |
| EXCHANGE GAINS / (LOSS) (NET) | 45 | 0 | (6) | - 0 | 100 | 1 | 100 | 1 | - | - |
| OTHER RECEIPTS | 670 | 4 | 676 | 4 | 727 | 5 | 683 | 4 | (44) | (6) |
| **TOTAL REVENUE** | **15,991** | **100** | **17,181** | **100** | **14,877** | **100** | **16,559** | **100** | **1,682** | **11** |
| **EXPENDITURE:** | | | | | | | | | | |
| SALARIES AND BENEFITS - LOCAL | 7,100 | 45 | 7,563 | 44 | 7,278 | 46 | 7,692 | 45 | 414 | 6 |
| SALARIES AND BENEFITS - INTERNATIONAL | 2,648 | 17 | 2,914 | 17 | 3,390 | 21 | 3,091 | 18 | (299) | (9) |
| CONSULTANCY | 254 | 2 | 155 | 1 | 143 | 1 | 221 | 1 | 78 | 55 |
| MANDATORY COMMITTEE | 85 | 1 | 117 | 1 | 113 | 1 | 113 | 1 | - | - |
| TRAVEL | 577 | 4 | 549 | 3 | 501 | 3 | 428 | 2 | (73) | (15) |
| SUPPLIES AND MATERIALS | 2,066 | 13 | 1,975 | 12 | 2,017 | 13 | 2,422 | 14 | 405 | 20 |
| REPAIRS AND MAINTENANCE | 175 | 1 | 186 | 1 | 93 | 1 | 168 | 1 | 75 | 81 |
| RENT, COMMUNICATION AND UTILITIES | 490 | 3 | 540 | 3 | 440 | 3 | 463 | 3 | 23 | 5 |
| PRINTING AND PUBLICATIONS | 260 | 2 | 288 | 2 | 269 | 2 | 340 | 2 | 71 | 26 |
| TRAINING AND DISSEMINATION | 171 | 1 | 172 | 1 | 236 | 1 | 139 | 1 | (97) | (41) |
| STAFF DEVELOPMENT | 152 | 1 | 113 | 1 | 79 | 0 | 69 | 0 | (10) | (13) |
| OTHER EXPENDITURE | 1,238 | 8 | 1,586 | 9 | 968 | 6 | 1,586 | 9 | 618 | 64 |
| CAPITAL EXPENDITURE | 702 | 4 | 860 | 5 | 276 | 2 | 437 | 3 | 161 | 58 |
| **TOTAL OPERATING EXPENDITURE** | **15,918** | **100** | **17,018** | **100** | **15,803** | **100** | **17,169** | **100** | **1,366** | **9** |
| **SURPLUS/(DEFICIT) BEFORE DEPRECIATION** | **73** | | **163** | | **(926)** | | **(610)** | | **316** | **(34)** |
| DEPRECIATION | 956 | | 1,001 | | 946 | | 912 | | (34) | **(4)** |
| **NET OPERATING (DEFIC.) AFTER DEPRECIATION** | **(883)** | | **(838)** | | **(1,872)** | | **(1,522)** | | **350** | **(19)** |

Note: Where necessary prior years amount have been regrouped to conform with current year budget and forecast

# TABLE - II
## ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH
## UNRESTRICTED AND RESTRICTED REVENUE AND EXPENDITURE 2002 - 2004

(Amount in US$ '000)

| | 2002 ACTUAL | | | 2003 ACTUAL | | | 2004 BUDGET | | | 2004 FORECAST | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | UNRESTR | RESTR. | TOTAL | UNRESTR | RESTR. | TOTAL | UNRESTR | RESTR. | TOTAL | UNRESTR | RESTR. | TOTAL |
| **REVENUE** | | | | | | | | | | | | |
| UNRESTRICTED FUNDS | 3,486 | | 3,486 | 4,638 | | 4,638 | 4,148 | | 4,148 | 4,168 | | 4,168 |
| RESTRICTED FUNDS | | | | | | | | | | | | |
| - INDIRECT | 1,848 | | 1,848 | 1,594 | | 1,594 | 1,436 | | 1,436 | 1,660 | | 1,660 |
| - PROJECTS / PROGRAMS | | 9,942 | 9,942 | | 10,279 | 10,279 | | 8,466 | 8,466 | | 9,948 | 9,948 |
| **CONTRIBUTIONS** | **5,334** | **9,942** | **15,276** | **6,232** | **10,279** | **16,511** | **5,584** | **8,466** | **14,050** | **5,828** | **9,948** | **15,776** |
| EXCHANGE GAINS / (LOSS) (NET) | 45 | | 45 | (6) | | (6) | 100 | | 100 | 100 | | 100 |
| OTHER RECEIPTS | 633 | 37 | 670 | 635 | 41 | 676 | 647 | 80 | 727 | 620 | 63 | 683 |
| **TOTAL REVENUE** | **6,012** | **9,979** | **15,991** | **6,861** | **10,320** | **17,181** | **6,331** | **8,546** | **14,877** | **6,548** | **10,011** | **16,559** |
| **EXPENDITURE:** | | | | | | | | | | | | |
| SALARIES AND BENEFITS - LOCAL | 3,213 | 3,887 | 7,100 | 3,987 | 3,576 | 7,563 | 3,870 | 3,408 | 7,278 | 3,960 | 3,732 | 7,692 |
| SALARIES AND BENEFITS - INTERNATIONAL | 1,153 | 1,495 | 2,648 | 1,324 | 1,590 | 2,914 | 1,808 | 1,582 | 3,390 | 1,654 | 1,437 | 3,091 |
| CONSULTANCY | 33 | 221 | 254 | 8 | 147 | 155 | 4 | 139 | 143 | 7 | 214 | 221 |
| MANDATORY COMMITTEE | 85 | - | 85 | 117 | - | 117 | 113 | - | 113 | 113 | - | 113 |
| TRAVEL | (68) | 645 | 577 | (85) | 634 | 549 | (79) | 580 | 501 | (207) | 635 | 428 |
| SUPPLIES AND MATERIALS | 946 | 1,120 | 2,066 | 1,020 | 955 | 1,975 | 744 | 1,273 | 2,017 | 847 | 1,575 | 2,422 |
| REPAIRS AND MAINTENANCE | 79 | 96 | 175 | 67 | 119 | 186 | 35 | 58 | 93 | 115 | 53 | 168 |
| RENT, COMMUNICATION AND UTILITIES | 266 | 224 | 490 | 303 | 237 | 540 | 215 | 225 | 440 | 234 | 229 | 463 |
| PRINTING AND PUBLICATIONS | 116 | 144 | 260 | 204 | 84 | 288 | 182 | 87 | 269 | 204 | 136 | 340 |
| TRAINING AND DISSEMINATION | 7 | 164 | 171 | 12 | 160 | 172 | 12 | 224 | 236 | 17 | 122 | 139 |
| STAFF DEVELOPMENT | (96) | 248 | 152 | (74) | 187 | 113 | (79) | 158 | 79 | (71) | 140 | 69 |
| OTHER EXPENDITURE | 489 | 749 | 1,238 | (89) | 1,675 | 1,586 | 523 | 445 | 968 | 363 | 1,223 | 1,586 |
| INTERDEPARTMENTAL SERVICES | (454) | 454 | - | (302) | 302 | - | (241) | 241 | - | (232) | 232 | - |
| | 5,769 | 9,447 | 15,216 | 6,492 | 9,666 | 16,158 | 7,107 | 8,420 | 15,527 | 7,004 | 9,728 | 16,732 |
| CAPITAL EXPENDITURE | 170 | 532 | 702 | 206 | 654 | 860 | 150 | 126 | 276 | 154 | 283 | 437 |
| **TOTAL OPERATING EXPENDITURE** | **5,939** | **9,979** | **15,918** | **6,698** | **10,320** | **17,018** | **7,257** | **8,546** | **15,803** | **7,158** | **10,011** | **17,169** |
| **SURPLUS/(DEFICIT) BEFORE DEPRECIATION** | **74** | 0.06 | **73** | **163** | **-** | **163** | **(926)** | **-** | **(926)** | **(610)** | **-** | **(610)** |
| DEPRECIATION | 956 | | 956 | 1,001 | | 1,001 | 946 | | 946 | 912 | | 912 |
| **NET OPERATING (DEFIC.) AFTER DEPRECIATION** | **(882)** | **0.06** | **(883)** | **(838)** | **-** | **(838)** | **(1,872)** | **-** | **(1,872)** | **(1,522)** | **-** | **(1,522)** |

Note: Where necessary prior years amount have been regrouped to conform with current year budget and forecast

## Table - III

## ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH

## CONTRIBUTIONS 2002 - 2004

(Amount in US$ '000)

| Donors | 2002 ACTUAL Amount | % | 2003 ACTUAL Amount | % | 2004 BUDGET Amount | % | 2004 FORECAST Amount | % | 2004 STATUS FIRM | ESTIMATE |
|---|---|---|---|---|---|---|---|---|---|---|
| Australia - AusAID | 214 | 1.4 | 292 | 1.8 | 254 | 1.8 | 267 | 1.7 | 267 | |
| Bangladesh | 766 | 5.0 | 970 | 5.9 | 701 | 5.0 | 860 | 5.5 | 860 | |
| Belgium - BADC/BTC | 128 | 0.8 | 111 | 0.7 | 56 | 0.4 | 72 | 0.5 | 72 | |
| Canada - CIDA | 94 | 0.6 | 892 | 5.4 | 1,116 | 7.9 | 1,067 | 6.8 | 1,067 | |
| Centre for Disease Control & Prevn. (CDC) | 117 | 0.8 | 281 | 1.7 | 161 | 1.1 | 317 | 2.0 | 317 | |
| Centre Endowment Fund | 71 | 0.5 | 46 | 0.3 | 46 | 0.3 | 1 | 0.0 | 1 | |
| European Union - BHARP | 293 | 1.9 | -9 | -0.1 | | | | | | |
| Ford Foundation | 243 | 1.6 | | | | | | | | |
| Gates Foundation | | | 311 | 1.9 | 1,607 | 11.4 | 2,299 | 14.6 | 2,299 | |
| Gates - GoB Award | 413 | 2.7 | 729 | 4.4 | 228 | 1.6 | 442 | 2.8 | 442 | |
| Hospital Endowment Fund | | | 400 | 2.4 | | | 200 | 1.3 | 200 | |
| International Vaccine Institute (IVI) | 352 | 2.3 | 545 | 3.3 | 296 | 2.1 | 286 | 1.8 | 286 | |
| Japan | 410 | 2.7 | | | | | | | | |
| Netherlands | 1,856 | 12.1 | 2,312 | 14.0 | 1,186 | 8.4 | 1,243 | 7.9 | 1,243 | |
| New England Medical Center (NEMC) | 147 | 1.0 | 137 | 0.8 | 130 | 0.9 | 106 | 0.7 | 106 | |
| Saudi Arabia | 53 | 0.3 | 50 | 0.3 | 50 | 0.4 | 50 | 0.3 | 50 | |
| Sri Lanka | | | 4 | 0.0 | | | | | | |
| Sweden - Sida/SAREC | 711 | 4.7 | 937 | 5.7 | 804 | 5.7 | 968 | 6.1 | 968 | |
| Switzerland - SDC | 500 | 3.3 | 750 | 4.5 | 1,000 | 7.1 | 1,000 | 6.3 | 1,000 | |
| Swiss Red Cross (SRC) | 162 | 1.1 | 161 | 1.0 | 125 | 0.9 | 82 | 0.5 | 82 | |
| Thrasher Research Fund | 226 | 1.5 | 93 | 0.6 | 97 | 0.7 | 95 | 0.6 | 95 | |
| United Kingdom - DFID | 1,507 | 9.9 | 1,712 | 10.4 | 2,070 | 14.7 | 2,287 | 14.5 | 2,287 | |
| UNDP/UNOPS - Japan | 149 | 1.0 | 89 | 0.5 | | | | | | |
| UNICEF | 230 | 1.5 | 118 | 0.7 | 8 | 0.1 | | | | |
| USAID - Dhaka | 2,291 | 15.0 | 2,445 | 14.8 | 1,310 | 9.3 | 1,520 | 9.6 | 1,520 | |
| USAID - Washington | 1,875 | 12.3 | 525 | 3.2 | 392 | 2.8 | | | | |
| USA - National Institute of Health (NIH) | 442 | 2.9 | 470 | 2.8 | 1,070 | 7.6 | 964 | 6.1 | 964 | |
| USA - Other Sources | 289 | 1.9 | 560 | 3.4 | 378 | 2.7 | 583 | 3.7 | 583 | |
| Wyeth Pharmaceuticals, Inc. | 186 | 1.2 | 124 | 0.7 | | | | | | |
| WHO | 439 | 2.9 | 163 | 1.0 | 145 | 1.0 | 184 | 1.2 | 184 | |
| Other (Self Sustaining) | 82 | 0.5 | 64 | 0.4 | 169 | 1.2 | 136 | 0.9 | 136 | |
| Others | 1,031 | 6.8 | 1,229 | 7.4 | 650 | 4.6 | 746 | 4.7 | 746 | |
| **Total Contributions** | **15,276** | **100** | **16,511** | **100** | **14,050** | **100** | **15,776** | **100** | **15,776** | |

Note: Where necessary prior years amount have been regrouped to conform with current year budget and forecast

# TABLE - IV

## ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH

## CONTRIBUTIONS BY UNRESTRICTED AND RESTRICTED FUNDS 2002 - 2004

(Amount in US$ '000)

| Main Donor | 2002 Actual | | | | 2003 Actual | | | | 2004 Budget | | | | 2004 Jun Forecast | | | | 2004 Status | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Unrestricted | Restricted | Total | % | Unrestricted | Restricted | Total | % | Unrestricted | Restricted | Total | % | Unrestricted | Restricted | Total | % | Firm | Estm. |
| **Unrestricted Funds** | | | | | | | | | | | | | | | | | | |
| Australia - AusAID | 163 | | 163 | 1.1 | 219 | | 219 | 1.3 | 193 | | 193 | 1.4 | 201 | | 201 | 1.3 | 201 | |
| Bangladesh | 174 | | 174 | 1.1 | 335 | | 335 | 2.0 | 346 | | 346 | 2.5 | 339 | | 339 | 2.1 | 339 | |
| Belgium - BADC/BTC | 59 | | 59 | 0.4 | | | | - | | | | - | | | | - | | |
| Canada - CIDA | 48 | | 48 | 0.3 | 859 | | 859 | 5.2 | 1,115 | | 1,115 | 7.9 | 1,066 | | 1,066 | 6.8 | 1,066 | |
| Netherlands | 1,845 | | 1,845 | 12.1 | 2,116 | | 2,116 | 12.8 | 1,152 | | 1,152 | 8.2 | 1,186 | | 1,186 | 7.5 | 1,186 | |
| Saudi Arabia | 53 | | 53 | 0.3 | 50 | | 50 | 0.3 | 50 | | 50 | 0.4 | 50 | | 50 | 0.3 | 50 | |
| Sri Lanka | | | | - | 4 | | 4 | 0.0 | | | | - | | | | - | | |
| Sweden - Sida/SAREC | 269 | | 269 | 1.8 | 305 | | 305 | 1.8 | 291 | | 291 | 2.1 | 326 | | 326 | 2.1 | 326 | |
| Switzerland - SDC | 500 | | 500 | 3.3 | 750 | | 750 | 4.5 | 1,000 | | 1,000 | 7.1 | 1,000 | | 1,000 | 6.3 | 1,000 | |
| USAID - Washington | 338 | | 338 | 2.2 | | | | - | | | | - | | | | - | | |
| Others | 38 | | 38 | 0.2 | | | | - | | | | - | | | | - | | |
| **Total Unrestricted** | **3,486** | | **3,486** | **22.8** | **4,638** | | **4,638** | **28.1** | **4,148** | | **4,148** | **29.5** | **4,168** | | **4,168** | **26.4** | **4,168** | |
| **Restricted Funds** | | | | - | | | | - | | | | - | | | | - | | |
| Australia - AusAID | 10 | 41 | 51 | 0.3 | 14 | 58 | 72 | 0.4 | 12 | 49 | 61 | 0.4 | 13 | 53 | 67 | 0.4 | 67 | |
| Bangladesh | 98 | 494 | 592 | 3.9 | 94 | 540 | 634 | 3.8 | 71 | 284 | 355 | 2.5 | 104 | 417 | 522 | 3.3 | 522 | |
| Belgium - BADC/BTC | | 69 | 69 | 0.4 | | 111 | 111 | 0.7 | | 56 | 56 | 0.4 | | 72 | 72 | 0.5 | 72 | |
| Canada - CIDA | 1 | 45 | 46 | 0.3 | 1 | 32 | 33 | 0.2 | | 1 | 1 | 0.0 | | 1 | 1 | 0.0 | 1 | |
| Centre for Disease Control & Prevn. (CDC) | 23 | 94 | 117 | 0.8 | 47 | 234 | 281 | 1.7 | 31 | 129 | 161 | 1.1 | 49 | 269 | 317 | 2.0 | 317 | |
| Centre Endowment Fund | | 71 | 71 | 0.5 | | 46 | 46 | 0.3 | | 46 | 46 | 0.3 | | 1 | 1 | 0.0 | 1 | |
| European Union - BHARP | | 293 | 293 | 1.9 | | -9 | -9 | (0.1) | | | | - | | | | - | | |
| Ford Foundation | 32 | 211 | 243 | 1.6 | | | | - | | | | - | | | | - | | |
| Gates Foundation | | | | - | 75 | 236 | 311 | 1.9 | 390 | 1,217 | 1,607 | 11.4 | 557 | 1,742 | 2,299 | 14.6 | 2,299 | |
| Gates - GoB Award | 6 | 407 | 413 | 2.7 | 29 | 700 | 729 | 4.4 | 11 | 217 | 228 | 1.6 | 7 | 435 | 442 | 2.8 | 442 | |
| Hospital Endowment Fund | | | | - | | 400 | 400 | 2.4 | | | | - | | 200 | 200 | 1.3 | 200 | |
| International Vaccine Institute (IVI) | 62 | 289 | 352 | 2.3 | 103 | 442 | 545 | 3.3 | 59 | 236 | 296 | 2.1 | 57 | 229 | 286 | 1.8 | 286 | |
| Japan | 24 | 386 | 410 | 2.7 | | | | - | | | | - | | | | - | | |
| Netherlands | 2 | 9 | 11 | 0.1 | 2 | 194 | 196 | 1.2 | 4 | 30 | 34 | 0.2 | 7 | 49 | 57 | 0.4 | 57 | |
| New England Medical Center (NEMC) | 35 | 112 | 147 | 1.0 | 32 | 104 | 137 | 0.8 | 31 | 100 | 130 | 0.9 | 25 | 81 | 106 | 0.7 | 106 | |
| Sweden - Sida/SAREC | 61 | 381 | 442 | 2.9 | 112 | 520 | 632 | 3.8 | 100 | 413 | 513 | 3.7 | 118 | 524 | 642 | 4.1 | 642 | |
| Switzerland - SDC | | | | - | | | | - | | | | - | | | | - | | |
| Swiss Red Cross (SRC) | 21 | 141 | 162 | 1.1 | 21 | 140 | 161 | 1.0 | 16 | 109 | 125 | 0.9 | 11 | 71 | 82 | 0.5 | 82 | |
| Thrasher Research Fund | 15 | 212 | 226 | 1.5 | 6 | 87 | 93 | 0.6 | 6 | 91 | 97 | 0.7 | 6 | 89 | 95 | 0.6 | 95 | |
| United Kingdom - DFID | 163 | 1,344 | 1,507 | 9.9 | 176 | 1,537 | 1,712 | 10.4 | 211 | 1,859 | 2,070 | 14.7 | 235 | 2,052 | 2,287 | 14.5 | 2,287 | |
| UNDP/UNOPS - Japan | | 149 | 149 | 1.0 | | 89 | 89 | 0.5 | | | | - | | | | - | | |
| UNICEF | 18 | 212 | 230 | 1.5 | -5 | 123 | 118 | 0.7 | 1 | 7 | 8 | 0.1 | | | | - | | |
| USAID - Dhaka | 807 | 1,484 | 2,291 | 15.0 | 578 | 1,867 | 2,445 | 14.8 | 270 | 1,040 | 1,310 | 9.3 | 302 | 1,218 | 1,520 | 9.6 | 1,520 | |
| USAID - Washington | 305 | 1,231 | 1,537 | 10.1 | 105 | 420 | 525 | 3.2 | 95 | 297 | 392 | 2.8 | | | | - | | |
| USA - National Institute of Health (NIH) | 1 | 441 | 442 | 2.9 | 16 | 454 | 470 | 2.8 | 30 | 1,040 | 1,070 | 7.6 | 27 | 937 | 964 | 6.1 | 964 | |
| USA - Other Sources | 32 | 257 | 289 | 1.9 | 52 | 508 | 560 | 3.4 | 35 | 342 | 378 | 2.7 | 68 | 515 | 583 | 3.7 | 583 | |
| Wyeth Pharmaceuticals, Inc. | 39 | 147 | 186 | 1.2 | 28 | 96 | 124 | 0.7 | | | | - | | | | - | | |
| WHO | 3 | 436 | 439 | 2.9 | | 163 | 163 | 1.0 | | 145 | 145 | 1.0 | | 184 | 184 | 1.2 | 184 | |
| Other (Self Sustaining) | | 82 | 82 | 0.5 | | 64 | 64 | 0.4 | | 169 | 169 | 1.2 | | 136 | 136 | 0.9 | 136 | |
| Others | 90 | 904 | 993 | 6.5 | 108 | 1,122 | 1,229 | 7.4 | 61 | 589 | 650 | 4.6 | 73 | 673 | 746 | 4.7 | 746 | |
| **Total Restricted** | **1,848** | **9,942** | **11,790** | **77.2** | **1,594** | **10,279** | **11,872** | **71.9** | **1,436** | **8,466** | **9,902** | **70.5** | **1,660** | **9,948** | **11,608** | **73.6** | **11,608** | |
| **Total Contributions** | **5,334** | **9,942** | **15,276** | **100** | **6,232** | **10,279** | **16,511** | **100** | **5,584** | **8,466** | **14,050** | **100** | **5,828** | **9,948** | **15,776** | **100** | **15,776** | |

Note: Where necessary prior years amount have been regrouped to conform with current year budget and forecast

# TABLE - V
## UNRESTRICTED PROJECTS/PROGRAMS AND MANAGEMENT EXPENDITURE 2002 - 2004
## EXCLUDING OTHER RECEIPTS

(Amount in US$ '000)

| | 2002 ACTUAL | | | | 2003 ACTUAL | | | | 2004 BUDGET | | | | 2004 FORECAST | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Gross Costs | Recovery | Net Costs | % | Gross Costs | Recovery | Net Costs | % | Gross Costs | Recovery | Net Costs | % | Gross Costs | Recovery | Net Costs | % |
| **PROJECTS/PROGRAMS** | | | | | | | | | | | | | | | | |
| **Clinical Sciences Division** | **1,508** | **(61)** | **1,447** | **9.1** | **1,081** | **(89)** | **992** | **5.8** | **1,953** | **(65)** | **1,888** | **11.9** | **1,801** | **(53)** | **1,748** | **10.2** |
| Divisional Activity | 98 | (96) | 2 | 0.01 | 129 | - | 129 | 0.8 | 319 | - | 319 | 2.0 | 336 | - | 336 | 2.0 |
| Support Services | 163 | (78) | 85 | 0.5 | 145 | (61) | 84 | 0.5 | 161 | (65) | 96 | 0.6 | 152 | (53) | 99 | 0.6 |
| Core Funded Research | 47 | - | 47 | 0.3 | 24 | - | 24 | 0.1 | 18 | - | 18 | 0.1 | 13 | - | 13 | 0.1 |
| Hospital Services | 1,200 | 113 | 1,313 | 8.2 | 783 | (28) | 755 | 4.4 | 1,455 | - | 1,455 | 9.2 | 1,300 | - | 1,300 | 7.6 |
| **Laboratory Sciences Division** | **1,043** | **(571)** | **472** | **3.0** | **1,554** | **(530)** | **1,024** | **6.0** | **1,276** | **(463)** | **813** | **5.1** | **1,344** | **(546)** | **798** | **4.6** |
| Divisional Activity | 135 | 81 | 216 | 1.4 | 275 | (17) | 258 | 1.5 | 350 | (7) | 343 | 2.2 | 309 | (7) | 302 | 1.8 |
| Support Services | 908 | (652) | 256 | 1.6 | 1,040 | (513) | 527 | 3.1 | 926 | (456) | 470 | 3.0 | 1,035 | (539) | 496 | 2.9 |
| Core Funded Research | - | - | - | - | 239 | - | 239 | 1.4 | - | - | - | - | - | - | - | - |
| **Public Health Sciences Division** | **1,135** | **13** | **1,148** | **7.2** | **1,841** | **(146)** | **1,695** | **10.0** | **1,572** | **(124)** | **1,448** | **9.2** | **1,662** | **(158)** | **1,504** | **8.8** |
| Divisional Activity | 294 | - | 294 | 1.8 | 113 | (7) | 106 | 0.6 | 371 | - | 371 | 2.3 | 345 | - | 345 | 2.0 |
| Support Services | 215 | (75) | 140 | 0.9 | 239 | (139) | 100 | 0.6 | 206 | (124) | 82 | 0.5 | 228 | (158) | 70 | 0.4 |
| Core Funded Research | 311 | (7) | 304 | 1.9 | 1,043 | - | 1,043 | 6.1 | 520 | - | 520 | 3.3 | 578 | - | 578 | 3.4 |
| Hospital Services | 315 | 95 | 410 | 2.6 | 446 | - | 446 | 2.6 | 475 | - | 475 | 3.0 | 511 | - | 511 | 3.0 |
| **Health Systems and Infectious Diseases Division** | **475** | **-** | **475** | **3.0** | **563** | **-** | **563** | **3.3** | **526** | **-** | **526** | **3.3** | **641** | **-** | **641** | **3.7** |
| Divisional Activity | 91 | - | 91 | 0.6 | 200 | - | 200 | 1.2 | 299 | - | 299 | 1.9 | 288 | - | 288 | 1.7 |
| Core Funded Research | 384 | - | 384 | 2.4 | 363 | - | 363 | 2.1 | 227 | - | 227 | 1.4 | 353 | - | 353 | 2.1 |
| **Information Sciences Division** | **573** | **(217)** | **356** | **2.2** | **622** | **(199)** | **423** | **2.5** | **608** | **(195)** | **413** | **2.6** | **641** | **(213)** | **428** | **2.5** |
| Divisional Activity | 53 | - | 53 | 0.3 | 53 | - | 53 | 0.3 | 59 | - | 59 | 0.4 | 19 | - | 19 | 0.1 |
| Support Services | 520 | (217) | 303 | 1.9 | 569 | (199) | 370 | 2.2 | 549 | (195) | 354 | 2.2 | 622 | (213) | 409 | 2.4 |
| **TOTAL PROJECTS/PROGRAMS** | **4,734** | **(836)** | **3,898** | **24.5** | **5,661** | **(964)** | **4,697** | **27.6** | **5,935** | **(847)** | **5,088** | **32.2** | **6,089** | **(970)** | **5,119** | **29.8** |
| **MANAGEMENT** | | | | | | | | | | | | | | | | |
| Director's Bureau | 334 | - | 334 | 2.1 | 284 | - | 284 | 1.7 | 508 | - | 508 | 3.2 | 480 | - | 480 | 2.8 |
| External Relations & Institutional Development | 185 | - | 185 | 1.2 | 249 | - | 249 | 1.5 | 228 | - | 228 | 1.4 | 216 | - | 216 | 1.3 |
| Policy and Planning | 153 | - | 153 | 1.0 | 144 | - | 144 | 0.8 | 72 | - | 72 | 0.5 | 55 | - | 55 | 0.3 |
| Bot and Committee | 99 | - | 99 | 0.6 | 149 | - | 149 | 0.9 | 144 | - | 144 | 0.9 | 145 | - | 145 | 0.8 |
| Support Services | 644 | (219) | 425 | 2.7 | 796 | (502) | 294 | 1.7 | 598 | (332) | 266 | 1.7 | 674 | (449) | 225 | 1.3 |
| Human Resources | 200 | - | 200 | 1.3 | 269 | - | 269 | 1.6 | 265 | - | 265 | 1.7 | 275 | - | 275 | 1.6 |
| Finance | 483 | - | 483 | 3.0 | 534 | (81) | 453 | 2.7 | 543 | (105) | 438 | 2.8 | 576 | (120) | 456 | 2.7 |
| Other | 265 | (103) | 162 | 1.0 | 281 | (122) | 159 | 0.9 | 392 | (144) | 248 | 1.6 | 356 | (169) | 187 | 1.1 |
| **TOTAL MANAGEMENT** | **2,363** | **(322)** | **2,041** | **12.8** | **2,706** | **(705)** | **2,001** | **11.8** | **2,750** | **(581)** | **2,169** | **13.7** | **2,777** | **(738)** | **2,039** | **11.9** |
| **TOTAL PROJECTS/PROGRAMS AND MANAGEMENT** | **7,097** | **(1,158)** | **5,939** | **37.3** | **8,367** | **(1,669)** | **6,698** | **39.4** | **8,685** | **(1,428)** | **7,257** | **45.9** | **8,866** | **(1,708)** | **7,158** | **41.7** |
| **TOTAL UNRESTRICTED** | | | 5,939 | 37.3 | | | 6,698 | 39.4 | | | 7,257 | 45.9 | | | 7,158 | 41.7 |
| **TOTAL RESTRICTED** | | | 9,979 | 62.7 | | | 10,320 | 60.6 | | | 8,546 | 54.1 | | | 10,011 | 58.3 |
| **TOTAL EXPENDITURE** | | | **15,918** | **100** | | | **17,018** | **100** | | | **15,803** | **100** | | | **17,169** | **100** |

## Annexure

**A** - Report of the Finance Committee of November 2003

**B** - 2003 Auditors' Report and Audited Financial Statements

**C** - Auditor's Letter to the Board of Trustees (DRAFT)

**D** - 2003 Auditors' Report and Audited Financial Statements for Employees Separation Payment Fund (Not Attached)

**E** - Glossary of Acronyms and Abbreviations

Annexure - A

# Minutes of the Finance Committee Meeting
## 1 November 2003
## Sasakawa Training Lecture Room

A meeting of the Finance Committee of the Board of Trustees (BoT) was held on 1 November 2003 at 11.30 am in the Sasakawa Training Lecture Room.

**Present:**

Dr. Ricardo Uauy Dagach (Chair, BoT)
Dr. Kul Gautam
Prof. A K Azad Khan (Chair, Finance Committee)
Prof. Jane Kusin
Prof. Terence Hull
Dr. Claudio Lanata (Chair, HR Committee)
Dr. Halima Ramadhan Abdullah Mwenesi
Prof. David Sack (Director, ICDDR,B)
Prof. Marcel Tanner
Prof. Carol Vlassoff (Chair, Programme Committee)
Dr. I. Kaye Wachsmuth

**Absent (with regrets)**

Mr Mirza Tassaduq Hussain Beg
Prof. N. K. Ganguly
Dr. Maimunah Bte Abdul Hamid
Dr. Nobukatsu Ishikawa
Mr. AFM Sarwar Kamal
Dr. Tikki Pang

**Invited:** Scientific Council
**Minutes:** Loretta Saldanha

Dr. Ricardo Uauy Dagach, Chair, BoT, welcomed all to the meeting and invited Prof. Azad Khan to Chair the proceedings.

1. Prof. Khan outlined the process of the meeting. Following approval by the Board on the agenda he invited Mr. Neogi, Head, Finance to make his presentation.

Mr. Neogi presented an overview of the 2003 forecast (June vs November), the 2004 budget, financial update, update on foreign exchange fluctuations, a brief update on salaries and benefits, Endowment Funds, Core Fund allocation. At this point he would accept questions and continue with discussions on Employees Separation Payment Fund, Sustainability Plan (status report) in two separate session.

**2. 2003 Forecast:** The Centre is projecting a deficit of US$280,000 but will break even if the Centre can withdraw US$ 200,000 from the Hospital Endowment Fund (HEF) in 2003 depending on the year-end market value of the Endowment Funds. What has not been shown in the report is the over-allocation of USAID/W funds in 1998 by US$ 1 million which is being absorbed in 2003. If this was not the case the finances would have shown a surplus for this year.

**3. 2004 Budget:** Mr. Neogi reported the process and the basic assumption that goes into preparing this budget. He said only signed agreements are taken into consideration. The cost is projected based on information of the previous year. No funds have been allocated from the Hospital Endowment Fund. He further presented a breakdown of contributions by categories: Project funds were at 60%, overheads from projects is approximately 10% and core 20%. A further breakdown of contributions (restricted/unrestricted) by donors was also presented, with DFID leading as the largest donor of the Centre. He reminded the Board that in future with the "Suchona" project it would be possible to provide a one-year projection of the budget.

There has been a 2 million drop in projects, however, there are projects in the pipeline which have not been considered because Agreements have not been signed. Steps have been taken to break even: information on staff salaries falling back on core has been circulated to all Division Heads to enable them to plan and monitor these expenditures. No funds have been set aside for future replacement of assets (hand to mouth situation) and hence the Centre will try to generate some surplus every year for this purpose.

Comparing the forecast for 2003 vs the budget for 2004 it was shown that the revenue of the Centre has decreased by 11% but the expenditure has not decreased proportionately (only 7%).

This being the 25$^{th}$ year of the Centre as an international Centre, information on revenue and expenditure over 25 years as well information of expenditure by categories for 25 years was presented with a 5 yearly average of revenue and expenditure. The Centre has grown four-fold from 4 million to 16 million. This is a steady growth. With regard to where the Centre will plateau, Mr. Neogi reported that presently the Centre is at 70% project and 30% core funding and almost 6-7 million core funding is required. With regard to expenditure the growth is consistent with a consistent percentage increase in every expenditure e.g. salary, supplies etc. A report on funding over 10 years for core and project activities was presented.

Since contributions by donors are made in different currencies, the Centre operates in a multi-currency environment. Mr. Neogi felt that it would be interesting to see how strong the Taka has been against these currencies in the last 10 years.

**4. National and International Staff Salary and allowances:**

This agenda was discussed in a closed session of the Board.

**5. Update on the Endowment Funds (donations/growth/withdrawals)**

Detailed discussions were held at the June meeting. However, for the benefit of new members Mr. Neogi revisited this discussion. In 2001 and 2002 no funds have been withdrawn from the HEF fund. It was also reported that in 2003 the Board had agreed to allow the Centre to take a loan from the fund towards purchase of a Generator but these funds were not withdrawn for various reasons.

Allocation of Core Funds: Following a Resolution from the June Board meeting, Mr. Neogi presented information on the allocation of core funds by Division and Categories and a comparative picture for 2003 and 2004. These costs included support to the Division Heads and some divisional costs, core funded research (project activities no longer being funded by the donor) and support services.

Further information from each division showing core costs divided under the categories indicated was provided as below:

CSD: Major expenditure is the hospital. Increase in hospital due to the recruitment of full time Division Director and costs of projects falling on core.

LSD: Core funded research is expected to decrease in 2004 because of new projects. Divisional expenditures have increased because loss of Japanese support.

PHSD: Expenditure due to support to different ongoing activities. The divisional expenditures is expected to increase when a full-time Division Head is recruited. Cost of support services will increase due to decline in project support.

HSID: Consumes a small part of core funds. Core funds are being utilized to cover salary support of some international staff who are not fully funded and because of the nature of the USAID/FHRP which is 30% ICDDR,B and 70% USAID.

ISD: Consumes a small part of the core funds. Under-recovery in CIS. A major part of the funds is spent towards the Library. Efforts are being made to charge out the Library costs to projects.

Director's Division: The expenditure for the Director's Bureau – the position of Head, P&P has been budgeted up to June and the position of Deputy Director from July and hence there is a shift of cost. This also includes unrecovered costs by the support services. Expenditures in the ERID have increased because of hiring of one staff member.

Expenditures for BoT and other committees the costs have not increased over the years and HR and Finance have remained almost static.

Discussion:

Despite information on core categories, it is understood that the core structure has two components – 1) what has it been given for and, 2) how this has been spent. It was understood that the funds provided to core is seen as income and anything that is not funded is supported by core. It was felt that this was not good management. The Board felt that the Centre had made a good attempt to dissect core costs, but that efforts should be made to relate this back to the main activities and priorities of the Strategic Plan and that they would like to see for each of the divisions, what core activities are needed to fulfill the priorities of the Centre and it would help us to analyze where the Centre should invest and enable a reallocation, and hopefully assist in managing the deficit. A follow-up to the resolution of the June Board meeting was requested.

Concern was expressed on two aspects of the Pie Charts:

1) Hospital and clinical costs: With regard to the forecast on essentially the trend of business, it was felt that the Board should not endorse the Pie Chart for 2004 as if business as usual was acceptable. The concern was that these Charts indicate that business cannot be as usual and that something needs to be done to relieve the pressure of that expenditure on the activities particularly the research activities of the Clinical Sciences Division.

2) Core and Project costs: Following a suggestion to charge out library costs to projects, it was felt that the Library is a core activity and to charge it to projects will set a system where the Centre Scientists will not assist in improving the Library, but would in time suggest a radical change e.g. of shutting it down. Libraries in a research institution like this should be part of the Capital. The system of charging the project in a transparent way is a difficult system. It is an issue for the ISD. However since the new James Grant School of Public Health (BRAC) will be relying on this Library, something much more fundamental needs to be done (eg request them to support some costs). It is not something for the Finance Committee to speculate upon, but that action needs to be taken by the Centre to explore how this can be done.

**6. Other Items:**

a) Over-draft Facilities: a report on the overdraft facilities and borrowing from the Hospital Endowment Fund was provided.

b) Cheque signatories: The recommendation to include Dr. M A Salam, Associate Director and Head, CSD as a cheque signatory was approved.

**7: Employees Separation Fund Payment:**

It was agreed that with the Establishment of the Centre's Employees Separation Payment Fund, the Board resolved under Resolution # 9/Dec 1983 to accept the Fixed Income plan offered by American International Reinsurance Company (AIRCO), Bermuda, effective January 1984 under an inatermediary agreement with the Institute of International Education (IIE) New York. However, as a result of AIRCO litigation, the Management decided to transfer the Fund to ASSICURAZIONI GENERALI SpA, Channel Islands, UK with the accounts of individual members of this fund at the close of October 1987.

Subsequently, ASSICURAZIONI GENERALI SpA, transferred their business under a long term agreement with Generali Worldwide Insurance Company Limited during August 1993. The Management accordingly, approved the transfer of the Fund to Generali Worldwide Insurance Company Limited under a Novation Agreement signed on 2nd January 1994.

The Board agreed to accept the audited financial statements of the Fund, acknowledge and accept the report of transfers as made by the Management, and that the Separation Payment Fund Trust be constituted as detailed in the Resolution.

It was also suggested that the Centre's lawyer be consulted for advice since this could have implications with re to the Ordinance. It was also suggested that a meeting of the SWA with the lawyer be arranged.

**Sustainability Plan:**

Presenting the Sustainability Plan, Mr. Neogi reported on tasks accomplished which included:

- Establishment of guidelines based on the Strategic Plan
- Broad review of overall costs of the Centre as well as that of each Division.
- Strategies for Cost Optimization identified based on ":Best Practices" relevant to the Centre's activities.
- Identification of revenue augmentation opportunities for all Divisions.
- Finalization of model plans for the Hospital and Diagnostic labs.
- Market research.

He also presented the following strategies for cost optimization:

- Develop annual allocation plans for major resources.
- Regularly monitor resource utilization and performance.
- Design appropriate systems to recognize and motivate employees.
- Explore the benefits of outsourcing activities.
- Manage the contractor selection process.
- Harness technology to achieve productivity.

Prof. Azad Khan concluded by summarizing the above discussions. He said efforts are ongoing to reduce the cumulative deficit by generating a surplus and that the deficit seems to be manageable. He assured the Board that the decline in project funds can be reversed if projects in the pipeline materialize. The Centre has managed to recover the loss suffered in the year 2002 in the Endowment Funds. Much has been accomplished with regard to the sustainability plan, and that the Centre will provide a report on further progress at the June BoT meeting.

Dr. Uauy thanked Mr. Neogi for presenting an informative and detailed report. He thanked Prof. Azad for Chairing the meeting and providing inputs to questions raised.

The meeting concluded at 12.45 pm for a closed session of the Board.

Annexure - B

# AUDITORS' REPORT

## TO THE BOARD OF TRUSTEES OF INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

1) We have audited the accompanying Statement of Financial Position of INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH (ICDDR,B) as of December 31, 2003 and the related Statements of Activity (Operating Fund) and Cash Flows for the year then ended. These financial statements are the responsibility of ICDDR,B's management. Our responsibility is to express an opinion on these financial statements based on our audit.

2) We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance as to whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial presentation. We believe that our audit provides a reasonable basis for our opinion.

3) As more fully explained in Note 22, certain capital expenditures have been classified as deferred expenditure. This is not in compliance with the stated accounting policies. Had the above costs been fully expensed in accordance with the stated policies, net surplus before depreciation for the year and the net assets would have been lower by US$ 320,000.

4) As more fully explained in Note 18, ICDDR, B has not recognized the assets and liabilities pertaining to the "ICDDR, B Employees Separation Payment Fund". Although the ICDDR, B's assets and liabilities are understated by US$ 12,044,767, there is no impact on the net financial position or the Statement of Activity under audit.

5) Subject to our observation in Paragraphs 3 and 4 above, in our opinion, the financial statements referred to above, together with the notes thereon, present fairly, in all material respects, the financial position of ICDDR,B as of December 31, 2003 and the results of its activities and its cash flows for the year then ended, in conformity with the accounting policies disclosed in Note2.

Hoda Vasi Chowdhury & Co
Chartered Accountants

KPMG

Dhaka, March 18, 2004

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

STATEMENT OF FINANCIAL POSITION
AS AT DECEMBER 31, 2003

(Amount in US$)

| | Note | 2003 | 2002 |
|---|---|---|---|
| **FIXED ASSETS** | | | |
| Cost | 3 | 19,384,388 | 18,526,096 |
| Less: Accumulated depreciation | 3 | 14,865,399 | 13,864,286 |
| | | 4,518,989 | 4,661,810 |
| **INVESTMENTS** | | | |
| Hospital Endowment Fund Investments | 14 | 5,758,310 | 4,961,938 |
| Centre Endowment Fund Investments | 16 | 3,672,325 | 3,131,368 |
| | | 9,430,635 | 8,093,306 |
| **CURRENT ASSETS** | | | |
| Inventories | 4 | 419,931 | 532,363 |
| Accounts receivable | | | |
| Donors | 5 | 1,765,689 | 2,047,773 |
| Others | 6 | 1,643,865 | 813,955 |
| Cash and bank balances | 7 | 3,089,305 | 1,276,164 |
| Deposits with banks against Reserve Fund | 9 | 2,004,236 | 2,004,860 |
| | | 8,923,026 | 6,675,115 |
| **LESS: CURRENT LIABILITIES** | | | |
| Contributions received in advance | 5 | 6,064,837 | 4,249,683 |
| Accounts payable | 10 | 3,593,083 | 3,235,905 |
| Bank overdraft | 8 | 217,562 | - |
| | | 9,875,482 | 7,485,588 |
| **NET CURRENT ASSETS** | | (952,456) | (810,473) |
| DEFERRED EXPENDITURE | 22 | 320,000 | - |
| **TOTAL NET ASSETS** | | 13,317,168 | 11,944,643 |

SIGNED FOR IDENTIFICATION
BY :

For KPMG

HODA VASI CHOWDHURY & CO

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

STATEMENT OF FINANCIAL POSITION
AS AT DECEMBER 31, 2003 (Contd.)

| | Note | 2003 | (Amount in US$) 2002 |
|---|---|---|---|
| **REPRESENTED BY** | | | |
| Fixed Assets Fund | 11 | 4,518,989 | 4,661,810 |
| Hospital Endowment Fund | 15 | 5,758,310 | 4,961,938 |
| Centre Endowment Fund | 17 | 3,672,325 | 3,131,368 |
| Reserve Fund | 12 | 2,004,236 | 2,004,860 |
| Operating Fund | 13 | (2,636,692) | (2,815,333) |
| **TOTAL FUNDS** | | 13,317,168 | 11,944,643 |

The accompanying notes 1 to 23 are an integral part of these Financial Statements.

Executive Director
ICDDR,B

Member
Board of Trustees

Dhaka, March 18, 2004

This is the Statement of Financial Position referred to in our report of same date.

Hoda Vasi Chowdhury & Co
Chartered Accountants

KPMG

Dhaka, March 18, 2004

HODA VASI CHOWDHURY & CO

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

STATEMENT OF ACTIVITY (OPERATING FUND)
FOR THE YEAR ENDED DECEMBER 31, 2003

(Amount in US$)

| | Note | 2003 | 2002 |
|---|---|---|---|
| **REVENUE** | | | |
| Contributions | 5 | 16,109,623 | 15,276,264 |
| Contributions from Hospital Endowment Fund | 15 | 400,000 | - |
| Exchange differences (net) | 2 | (5,943) | 44,955 |
| Other receipts | 20 | 675,823 | 670,051 |
| | | 17,179,503 | 15,991,270 |
| **EXPENDITURE** | | | |
| Salaries and benefits - local | | 7,559,123 | 7,100,456 |
| Salaries and benefits - international | | 2,916,381 | 2,648,811 |
| Consultancy | | 154,784 | 253,658 |
| Mandatory committees | 19 | 117,474 | 85,620 |
| Travel | | 548,676 | 577,010 |
| Supplies and materials | | 1,975,248 | 2,055,008 |
| Repairs and maintenance | | 185,856 | 175,071 |
| Rent, communication and utilities | | 540,012 | 490,218 |
| Printing and publications | | 288,301 | 259,916 |
| Other expenditure | 21 | 1,775,911 | 1,569,983 |
| Capital expenditure (net) | 2(e) | 858,292 | 702,169 |
| Provision for doubtful receivable | 5(d) | 96,804 | - |
| | | 17,016,862 | 15,917,920 |
| **SURPLUS FOR THE YEAR BEFORE DEPRECIATION** | | 162,641 | 73,350 |
| Add: Depreciation for the year | 2 (f) & 3(b) | (1,001,113) | (956,023) |
| **DEFICIT FOR THE YEAR AFTER DEPRECIATION** | | (838,472) | (882,673) |

The accompanying notes 1 to 23 are an integral part of these Financial Statements.

Executive Director
ICDDR,B

Member
Board of Trustees

Dhaka, March 18, 2004

This is the Statement of Activity (Operating Fund) referred to in our report of same date.

Hoda Vasi Chowdhury & Co
Chartered Accountants

KPMG

Dhaka, March 18, 2004

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED DECEMBER 31, 2003

(Amount in US$)

| | 2003 | 2002 |
|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | |
| **Surplus for the year before depreciation** | 162,641 | 73,350 |
| **Adjustments to reconcile net cash from operating activities** | | |
| Capital expenditure (net) charged in the Statement of Activity | 858,292 | 702,169 |
| Profit (net) on sale of fixed assets | - | (22,191) |
| Provsion for doubtful receivable | 96,804 | - |
| **Decrease/(Increase) in Current Assets** | | |
| Accounts receivable | | |
| Donors | 185,280 | (349,622) |
| Others | (829,910) | (229,862) |
| Inventories | 112,432 | (56,798) |
| **Increase/(Decrease) in Current Liabilities** | | |
| Contribution received in advance | 1,815,154 | (812,912) |
| Accounts payable | 357,178 | 595,648 |
| **Cash flows from operating activities** | 2,757,871 | (100,218) |
| **CASH FLOWS USED IN INVESTING ACTIVITIES** | | |
| Acquisition of fixed assets | (858,292) | (702,169) |
| Deferred Expenditure | (320,000) | - |
| Sale proceeds of fixed assets | - | 23,171 |
| **Net cash used in investing activities** | (1,178,292) | (678,998) |
| **CASH FLOWS FROM FINANCING ACTIVITIES** | | |
| Bank Overdraft | 217,562 | - |
| Interest on Reserve Fund deposits | 15,376 | 33,452 |
| **Cash flow from financing activities** | 232,938 | 33,452 |
| Net Increase/(decrease) in cash and cash equivalents | 1,812,517 | (745,764) |
| **Cash and cash equivalents at beginning of the year** | 3,281,024 | 4,026,788 |
| **Cash and cash equivalents at end of the year** | 5,093,541 | 3,281,024 |

**Executive Director**
**ICDDR,B**

**Member**
**Board of Trustees**

Dhaka, March 18, 2004

**This is the Statement of Cash Flows referred to in our report of same date.**

**Hoda Vasi Chowdhury & Co**
**Chartered Accountants**

**KPMG**

Dhaka, March 18, 2004

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

NOTES TO THE FINANCIAL STATEMENTS
AS AT DECEMBER 31, 2003

## 1. NATURE OF ACTIVITIES

The International Centre for Diarrhoeal Disease Research, Bangladesh ("Centre") was established in 1978 by an Ordinance of the Government of The People's Republic of Bangladesh to provide for the establishment of an international Centre in Bangladesh with multinational scientific collaboration and financial contributions to conduct research in diarrhoeal diseases and the directly related subjects of nutrition and fertility with special relevance to developing countries and for matters ancillary thereto. The activities of the Centre are mainly funded by various Governments and international organisations.

## 2. SIGNIFICANT ACCOUNTING POLICIES

***Basis of preparation***

a) These financial statements have been prepared on a going concern basis, in accordance with the generally accepted accounting principles unless those differ from accounting policies stated below on the historical cost convention on the accrual basis of accounting unless expressly stated and in the manner as prescribed and approved by the Board of Trustees.

b) The preparation of financial statements requires management to make estimates and assumptions. Actual results could differ from those estimates. Any revision to accounting estimates is recognised prospectively in current and future years.

***Contributions***

c) Contributions (except those pertaining to endowment funds) have been considered as revenue on the following basis:

Central funds have been accounted for to the extent they relate to the current period and those pertaining to future periods have been carried forward.

Project funds received during the year but yet to be expensed are carried forward as contributions received in advance. Correspondingly, project expenses incurred but yet to be reimbursed by the donor are considered as contributions receivable. Project funds include overhead recoveries at rates indicated in various agreements with the donors.

d) Awards received on which the Board of Trustees have identified specific usage has been accounted for as if these were project funds as mentioned in 2(c) above

e) Contributions received in kind are not included in the financial statements.

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HODA VASI CHOWDHURY & CO

2. SIGNIFICANT ACCOUNTING POLICIES (Contd.)

*Capital expenditure*

d) Grants in kind by way of various services rendered by different donors and those directly paid by donor(s) to other organisation(s) and institution(s) for project/service work carried out by them on behalf of the Centre have not been considered in these Financial Statements. Donated fixed assets, except Land, which is not recorded, are valued at $1.

e) Capital Expenditure (expenditure on project and central support facilities and equipment) is expensed in the statement of activity in year in which it is incurred. Further, fixed assets (costing more than $ 1,000) are recorded on the face of the "Statement of Financial Position" with a corresponding contra to "Fixed Assets Fund".

f) The depreciation on these fixed assets is calculated on the "Straight line" method based on the estimated useful life [Refer Note 3(e)]. Depreciation has no effect on the cumulative Operating Fund (Refer Note 13).

*Inventories*

g) Inventories are valued at invoice price plus incidental expenses such as labour, freight, insurance, etc. Inventories issued at weighted average cost to service centres are expensed when issued. The stock of such items remaining unconsumed with the service Centres, at the year end (other than at Matlab Health Complex) not considered significant are not included in the closing stock.

*Endowment Funds*

h) Endowment funds are created out of specific donations received in earlier years and are governed by the respective bye laws (refer notes 14 and 16). Contributions received are accordingly, credited to these funds. Quoted investments in these funds are recorded at the lower of cost and market value. Unquoted investments are valued at cost.

i) Interest on investment is recorded when due except for interest on government securities that are recognised on realisation.

j) The Board of Trustees may authorise the amount of funds to be withdrawn from the endowment funds to a maximum of five percent of the balance of the funds at the end of the previous year.

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For KPMG

HODA VASI CHOWDHURY & CO

2. SIGNIFICANT ACCOUNTING POLICIES (Contd.)

*Currency conversion*

k) Transactions in currencies other than US dollar are recorded at the exchange rates prevailing at the beginning of the month in which the transaction takes place. Exchange differences arising on settlement during the year of transactions in other currencies are recongnised in the Statement of Activity for the year.

l) Year-end receivables, payables, cash and bank balances in other currencies are translated at the year-end exchange rates and the resultant exchange differences are recognized in the Statement of Activity for the year.

m) The exchange rates used for the currency conversion are calculated on the prevailing average of the buying rates of "Telegraphic Transfer Clean" and "On Demand Transfer" as published by Centre's bank and are as follows:

| Currency | Average monthly exchange rate | Year-end exchange rate | |
|---|---|---|---|
| | 2003 | 2003 | 2002 |
| | Taka | Taka | Taka |
| US $ 1.00 | 57.8295 | 58.0455 | 57.9775 |
| UK £ 1.00 | 94.2471 | 102.2820 | 92.3949 |
| EURO 1.00 | 64.8604 | 71.7907 | 59.7951 |

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For KPMG

## 3. FIXED ASSETS

(Amount in US$)

| | COST | | | DEPRECIATION | | | NET |
|---|---|---|---|---|---|---|---|
| Particulars | At January 1 2003 | Additions/ (Adjustments) in 2003 | At December 31 2003 | At January 1 2003 | Additions/ (Adjustments) in 2003 | At December 31 2003 | At December 31 2003 |
| Freehold Land | 85,508 | - | 85,508 | - | - | - | 85,508 |
| Buildings | 5,766,562 | 105,624 | 5,872,186 | 3,078,830 | 290,769 | 3,369,599 | 2,502,587 |
| Equipment | 11,219,351 | 805,576 | 12,024,927 | 9,524,158 | 658,812 | 10,182,970 | 1,841,957 |
| Furniture | 168,479 | 1,860 | 170,339 | 157,996 | 3,781 | 161,777 | 8,562 |
| Vehicles | 1,174,244 | 25,364 | 1,199,608 | 1,103,302 | 47,751 | 1,151,053 | 48,555 |
| | 18,414,144 | 938,424 | 19,352,568 | 13,864,286 | 1,001,113 | 14,865,399 | 4,487,169 |
| Capital Work in progress | 111,952 | (80,132) | 31,820 | - | - | - | 31,820 |
| 2003 | 18,526,096 | 858,292 | 19,384,388 | 13,864,286 | 1,001,113 | 14,865,399 | 4,518,989 |
| 2002 | 17,919,222 | 606,874 | 18,526,096 | 13,002,578 | 861,708 | 13,864,286 | 4,661,810 |

**Notes:**

a. Additions and disposals/write offs of fixed assets in the year comprised $858,292 and nil (2002:$702,169 and $95,295) respectively.

b. Additions and disposals/write offs for depreciation for the year comprised $1,001,113 and nil (2002: $956,023 and $94,315) respectively.

c. Two plots of land measuring 4.10 and 0.51 acres situated at Mohakhali (Dhaka) and at Matlab (Chandpur), received as donations from the Government of the People's Republic of Bangladesh and a private individual respectively, have not been valued and therefore not incorporated in these accounts.

d. Cost of buildings includes an amount of $ 103,488 spent by the Centre on the extension of the Institute of Public Health building, owned by the Government of the People's Republic of Bangladesh and which is at present partly accommodating the Centre.

e. Depreciation on fixed assets is calculated based on the following estimated useful lives:

| Particulars | Useful life (Year) |
|---|---|
| Buildings | 20 |
| Equipment | 5 |
| Furniture | 5 |
| Vehicles | 4 |

## 4. INVENTORIES

| | 2003 | 2002 |
|---|---|---|
| Supply stores | 377,622 | 436,582 |
| Maintenance stores | 53,479 | 56,277 |
| | 431,101 | 492,859 |
| Stores in transit | - | 50,605 |
| | 431,101 | 543,464 |
| Less: Provision for obsolete and slow moving stock | 11,170 | 11,101 |
| | 419,931 | 532,363 |

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5. CONTRIBUTIONS:

(Amount in US$)

| Donors | 2003 (Due)/ Advanced at 1.1.2003 | 2003 Received during the year | 2003 (Due)/ Advanced 31.12.2003 | 2003 Income for the year | 2002 Income |
|---|---|---|---|---|---|
| **Central Funds (Unrestricted)** | | | | | |
| Australia - AusAID | - | 219,375 | - | 219,375 | 163,050 |
| Bangladesh | (97,026) | 432,250 | - | 335,224 | 173,500 |
| Belgium - BADC/BTC | (123,778) | 123,778 | - | - | 59,164 |
| Canada - CIDA | - | 1,145,003 | 286,251 | 858,752 | 48,070 |
| Netherlands | 748,893 | 1,981,515 | 614,480 | 2,115,928 | 1,844,632 |
| Saudi Arabia | (50,000) | | (100,000) | 50,000 | 53,100 |
| Sweden - SIDA/SAREC | - | 304,941 | - | 304,941 | 268,946 |
| Switzerland - SDC | - | 750,000 | - | 750,000 | 500,000 |
| Srilanka | - | 4,000 | - | 4,000 | - |
| United States - AID | - | | - | - | 338,167 |
| Gates-GoB Award (e) | 1,472,361 | - | 742,714 | 729,647 | 412,639 |
| Endowment Fund - Centre | 54,066 | - | 5,440 | 48,626 | 71,446 |
| Others (c) | (37,816) | 37,816 | - | - | 37,816 |
| **Total Central Funds** | 1,966,700 | 4,998,678 | 1,548,885 | 5,416,493 | 3,970,530 |
| **Project Funds (Restricted)** | | | | | |
| Australia - AusAID | 66,097 | 146,250 | 140,111 | 72,236 | 51,108 |
| Bangladesh - WB & BINP | (87,673) | 701,543 | (20,533) | 634,403 | 592,170 |
| Belgium - BADC/BTC | 7,338 | 158,015 | 54,743 | 110,610 | 68,634 |
| Gates Foundation | - | 2,455,897 | 2,144,493 | 311,404 | - |
| European Union | (96,647) | 461 | (86,169) | (10,017) | 292,593 |
| Ford Foundation | - | - | - | - | 242,851 |
| Howard Hughes Medical Institute | 196,239 | 45,000 | 45,910 | 195,329 | 37,849 |
| International Vaccine Instt. (IVI) | 287,758 | 244,539 | (12,871) | 545,168 | 351,578 |
| Japan | (16,344) | 16,344 | - | - | 564,111 |
| Japan-JICWELS & Others | 11,338 | 70,630 | 15,575 | 66,393 | 66,921 |
| MGH-Harvard University (a) | 32,838 | 108,349 | (8,418) | 149,605 | 151,145 |
| Netherlands | 67,352 | 212,247 | 83,851 | 195,748 | 10,910 |
| New England Medical Center (NEMC) | (46,350) | 94,692 | (88,401) | 136,743 | 146,877 |
| Sweden - SIDA/SAREC | 11,034 | 810,676 | 189,741 | 631,969 | 471,804 |
| Swiss Red Cross (d) | (193,035) | 168,911 | (184,756) | 160,632 | 161,593 |
| The Johns Hopkins University (a) | (7,411) | 213,414 | 108,954 | 97,049 | 29,071 |
| The Rockefeller Foundation | 103,279 | 24,639 | (3,335) | 131,253 | 62,860 |
| Thrasher Research Fund | 41,402 | 73,865 | 21,855 | 93,412 | 226,392 |
| United Kingdom - DFID | (32,081) | 1,920,289 | (109,554) | 1,997,762 | 1,656,357 |
| United States - AID etc | (660,284) | 3,682,348 | (255,214) | 3,277,278 | 3,956,611 |
| USA-NIH (a) | (39,308) | 133,765 | (72,154) | 166,611 | 203,227 |
| UNICEF | 9,446 | 64,083 | (44,024) | 117,553 | 230,010 |
| University of Basel | 28,802 | 40,451 | 18,040 | 51,213 | 76,869 |
| University of Newcastle | - | - | - | - | 34,578 |
| University of Virginia (NIH) (a) | (12,963) | 30,808 | (38,052) | 55,897 | 63,251 |
| UNOCAL Foundation | 19,172 | - | - | 19,172 | 56,183 |
| WHO | (128,359) | 237,217 | (53,883) | 162,741 | 439,163 |
| World Bank | 1,800 | 37,178 | (9,468) | 48,446 | (66) |
| Disaster Fund (UNOCAL, Shell, Caim, Others) | 162,536 | - | 162,536 | - | 5,430 |
| Others (net) (c) | 509,234 | 1,419,768 | 654,482 | 1,274,520 | 1,055,654 |
| **Total Project Funds** | 235,210 | 13,111,379 | 2,653,459 | 10,693,130 | 11,305,734 |
| Less: Provisoins for receivable considered doubtful (d) | | | 96,804 | | |
| **Total Contributions** | 2,201,910 | 18,110,057 | 4,299,148 | 16,109,623 | 15,276,264 |
| | | | (b) | | |

(a) Includes subcontracts from the National Institute of Health (NIH), USA.

(b) (Due)/ Advanced contributions comprise as follows:

| | 2003 | 2002 |
|---|---|---|
| Accounts receivable, Donors (Due) | (1,765,689) | (2,047,773) |
| Contributions received in advance (Advanced) | 6,064,837 | 4,249,683 |
| | 4,299,148 | 2,201,910 |

(c) Contributions in 2003 from "others" for project funds include:

Canadian HC-Local Fund Management Office (LFMO), CDC-Atlanta, Circle Around the Centre, Concern, Dartmouth College, Ellison Foundation, Foundation for the Advancement of Clinical Epidemiology (FACE) Inc. George Mason Foundation,Intercell-Cistern Biotech , International Atomic Energy Agency, International Science & Technology Institute Inc., International Nutrition Foundation, New York University School, National Institute of Ageing, Nestle Foundation, Novartis Nutrition, Nutrition Third World, Plan International, Pathfinder Int'l, Proctor & Gamble, SBL Vaccines, Self Sustaining Units, Umea University, UFHP, UNAIDS, UNOPS, Uppsala University, Urban Primery Health Care, US-Japan, Wotro and Wyeth.

(d) Contributions receivable from the Swiss Red Cross aggregating $96,804 relating to earlier years are considered doubtful and hence provided for. Efforts are being initiated for recovery of such amounts.

(e) The Centre has received an award of $ 1,000,000 from the Gates Foundation, which was topped up by a matching award of $ 885,000 from the Government of Bangladesh in 2001. The Board of Trustees has earmarked these awarded amounts for specific purpose and contributions are recognised when these specified expenditure is incurred.

HUDA VASI CHOWDHURY & CO

SIGNED FOR IDENTIFICATION BY :

For KPMG

(Amount in US$)

| | 2003 | 2002 |
|---|---|---|
| **6. ACCOUNTS RECEIVABLE - OTHERS** | | |
| Advances to employees: | | |
| Investment loans | 116,688 | 111,259 |
| Festival advances | 167,773 | 152,675 |
| Others | 137,730 | 160,717 |
| | 422,191 | 424,651 |
| Receivable from Institute of Public Health | 89,523 | - |
| Operating advances to projects | 29,936 | 10,669 |
| Advances to suppliers and others | 526,725 | 370,024 |
| Deposits and other receivables | 1,811 | 8,611 |
| Current Account with Hospital Endowment Fund | 573,679 | - |
| | 1,643,865 | 813,955 |
| **7. CASH AND BANK BALANCES** | | |
| Cash in hand | 2,038 | 2,565 |
| Cash at banks: | | |
| Taka Accounts | | |
| Current account | - | 32,018 |
| Current account (convertible) | 9,057 | 45,408 |
| Time deposit | 602 | 602 |
| | 9,659 | 78,028 |
| US$ accounts | | |
| Current account | 2,274,832 | 187,841 |
| Time deposits | 800,000 | 1,000,000 |
| | 3,074,832 | 1,187,841 |
| EURO current account | 2,776 | 5,415 |
| UK£ current account | - | 2,315 |
| | 3,089,305 | 1,276,164 |
| **8. BANK OVERDRAFT** | | |
| Overdraft from banks | 217,562 | - |

Overdraft from bank is secured by lien on time deposits held with them against Reserve Fund account.

**9. DEPOSITS WITH BANK AGAINST RESERVE FUND**

| | | |
|---|---|---|
| Time deposit | 2,004,000 | 2,004,000 |
| Current account | 236 | 860 |
| | 2,004,236 | 2,004,860 |

Time deposit against this fund is under lien to a bank to the extent of the overdraft facility of $2,000,000.

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For KPMG

(Amount in US$)

| | 2003 | 2002 |
|---|---|---|
| **10. ACCOUNTS PAYABLE** | | |
| Supplies and materials | 17,327 | 94,115 |
| Expenses and other | 3,531,297 | 2,920,260 |
| Advance from Institute of Public Health | - | 161,137 |
| Security and other deposits | 44,459 | 57,218 |
| Current account with Hospital Endowment Fund | - | 3,175 |
| | 3,593,083 | 3,235,905 |
| **11. FIXED ASSETS FUND** | | |
| Balance as at January 1 | 4,661,810 | 4,916,644 |
| Add: Capital expenditure out of | | |
| Project funds | 653,004 | 522,637 |
| Central funds | 205,288 | 179,532 |
| | 5,520,102 | 5,618,813 |
| Less: Depreciation for the year Transferred to Operating Fund (Note 13) | 1,001,113 | 956,023 |
| written down value of fixed assets sold/adjusted | - | 980 |
| | 4,518,989 | 4,661,810 |

The fund reflects contributions from Donors and Centre's expenditure for fixed assets and is equal to the net book value of fixed assets.

| | | | |
|---|---|---|---|
| **12. RESERVE FUND** | | | |
| Fund Capital Account | | | |
| Balance as at January 1 | [A] | 1,342,129 | 1,342,129 |
| Fund Income Account | | | |
| Income | | | |
| Balance as at January 1 | | 1,789,731 | 1,756,540 |
| During the year | | 15,376 | 33,191 |
| Balance as at December 31 | | 1,805,107 | 1,789,731 |
| Less: Distribution to Operating Fund | | | |
| Balance as at January 1 | | 1,127,000 | 1,091,000 |
| Distribution during the year (Note-13) | | 16,000 | 36,000 |
| Balance as at December 31 | | 1,143,000 | 1,127,000 |
| | [B] | 662,107 | 662,731 |
| | [ A + B] | 2,004,236 | 2,004,860 |

The fund was established in 1982 to enable the Centre to attain better financial stability and to enable it to retain a satisfactory level of work in case of uneven flow of resources beyond its control. The fund comprises donations, transfers from operating account and income earned on investment of the fund.

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For KPMG

(Amount in US$)

| | 2003 | 2002 |
|---|---|---|
| **13. OPERATING FUND** | | |
| Balance as at January 1 | (2,815,333) | (2,925,663) |
| Add: Deficit for the year after depreciation | (838,472) | (882,673) |
| Transfer from Reserve Fund (Note-12) | 16,000 | 36,000 |
| Transfer from Fixed Assets Fund (Note 11) | | |
| Depreciation for the year | 1,001,113 | 956,023 |
| Written down value of Fixed Assets sold | - | 980 |
| | (2,636,692) | (2,815,333) |
| **14. HOSPITAL ENDOWMENT FUND INVESTMENTS** | | |
| Local investments | | |
| Shares | 99,973 | 99,973 |
| Debentures | 12,679 | 12,679 |
| | 112,652 | 112,652 |
| Less: Provision for diminution in market value | 79,409 | 73,364 |
| | 33,243 | 39,288 |
| Government securities | | |
| Bangladesh Sanchayapatra and Protirakkha Sanchayapatra | 211,560 | 211,560 |
| Cash at bank | 261,856 | 482,449 |
| Overseas investment (b) | | |
| With TIAA-CREF Trust company FSB | 3,782,985 | 3,634,514 |
| Less: Diminution in market value | - | 409,079 |
| | 3,782,985 | 3,225,435 |
| Cash on time deposit | 1,468,666 | 1,003,206 |
| | 5,758,310 | 4,961,938 |

(a) Market value of local investments as at December 31, 2003 $33,243; (2002: $39,288).

(b) Market value of overseas investments as at December 31, 2003 aggregates $3,949,466; (2002: $3,225,435).

| | | |
|---|---|---|
| **15. HOSPITAL ENDOWMENT FUND** | | |
| Investment Capital Account | | |
| Donations | | |
| Balance as at January 1 | 4,697,374 | 4,673,309 |
| Received during the year | 36,529 | 24,065 |
| Balance as at December 31 | 4,733,903 | 4,697,374 |
| Fund raising activities | | |
| Balance as at January 1 | 137,696 | 113,779 |
| Net fund raised during the year | 10,003 | 23,917 |
| Balance as at December 31 | 147,699 | 137,696 |

HUDA VASI CHOWDHURY & CO

SIGNED FOR IDENTIFICATION BY:

For KPMG

(Amount in US$)

| 15. HOSPITAL ENDOWMENT FUND (Contd.) | | 2003 | 2002 |
|---|---|---|---|
| Profit/(loss) on sale/valuation of investments | | | |
| Balance as at January 1 | | (542,929) | (169,040) |
| Net capital gain for the year | | 457,394 | 108,554 |
| Provision for diminution in market value | | (6,045) | (482,443) |
| Balance as at December 31 | | (91,580) | (542,929) |
| | [A] | 4,790,022 | 4,292,141 |
| Investment Income Account | | | |
| Income | | | |
| Balance as at January 1 | | 1,399,179 | 1,274,699 |
| Net income | | 121,637 | 124,480 |
| Balance as at December 31 | | 1,520,816 | 1,399,179 |
| Less: Distribution to hospital | | | |
| Balance as at January 1 | | 726,207 | 726,207 |
| During the year | | 400,000 | - |
| Balance as at December 31 | | 1,126,207 | 726,207 |
| | [B] | 394,609 | 672,972 |
| Current Account With Centre | [C] | 573,679 | (3,175) |
| | [A + B + C ] | 5,758,310 | 4,961,938 |

## 16. CENTRE ENDOWMENT FUND INVESTMENTS

| | | |
|---|---|---|
| Overseas investments with TIAA-CREF Trust Company FSB | 3,672,325 | 3,528,183 |
| Less: Diminution in market value | - | (396,815) |
| | 3,672,325 | 3,131,368 |

The Fund was established in 1996 to raise donations from Governments or their Agencies, Foundations, Corporations and Individuals. The income earned from the investment of those funds will be used in supporting new research initiatives and provide a stable financial base for the Centre's ongoing activities. The investment of funds is monitored by the Centre Fund Finance Committee. Included in these funds are USAID contribution of $1,000,000 (market value of the investment as at December 31, 2003 is $1,416,244; 2002: $1,156,613). Aggregrate market value as at 31 December 2003 of the investment of the funds is $3,834,284 (2002; $3,131,368).

HUDA VASI CHOWDHURY & CO

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For KPMG

(Amount in US$)

| 17. CENTRE ENDOWMENT FUND | | 2003 | 2002 |
|---|---|---|---|
| Investment Capital Account | | | |
| Donations | | | |
| Balance as at January 1 | [A] | 3,150,000 | 3,150,000 |
| Investment Income Account | | | |
| Capital gain/(loss) | | | |
| Balance as at January 1 | | (26,037) | 358,661 |
| Net capital gain/(loss) for the year | | 443,722 | 12,117 |
| Diminution in market value | | - | (396,815) |
| Balance as at December 31 | | 417,685 | (26,037) |
| Revenue Income | | | |
| Balance as at January 1 | | 267,405 | 169,531 |
| During the year | | 97,235 | 97,874 |
| Balance as at December 31 | | 364,640 | 267,405 |
| | [B] | 782,325 | 241,368 |
| Contribution to Project Fund | | | |
| Balance as at January 1 | | 260,000 | 260,000 |
| Balance as at December | [c] | 260,000 | 260,000 |
| | [A + B - C] | 3,672,325 | 3,131,368 |

## 18. EMPLOYEES SEPARATION PAYMENT FUND

The Centre operates a retirement fund called "ICDDR,B Employees Separation Payment Fund" for all national employees under an agreement with the Generali Group of UK. During the year the Centre and staff members contributed 14.8% and 7.4% of the pensionable salary respectively to the fund. The amounts so accumulated were remitted, net of employee settlements, to Generali Group on a quarterly basis by the Centre. The Generali Group is empowered to invest the fund available with them as considered profitable by them and at the end of each calendar year the profits earned from these investments are distributed among the staff members' accounts.

This accumulated fund which at December 31, 2003 was estimated at $12,044,767 (2002: $11,195,720) is not reflected in the books of account as it is not directly related to the Centre's activities.

The Board of Trustees is of the opinion that the aforesaid scheme being operated independent of the Centre's activities, assets and liabilities attached to the scheme should not appear in the Centre's books. Had these incorporated in the Centre's Statement of Financial Position on the ground that the Centre's ulitmate liability would not relinquish pending the constitution of the trust and vesting the fund to the trust, assets and liabilities of the Centre would have increased at least by the amount of fund balance at December 31, 2003 as stated above.

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SIGNED FOR IDENTIFICATION BY :

For KPMG

(Amount in US$)

## 19. MANDATORY COMMITTEES

The expenditure include an amount of $10,696 (2002: $17,845) paid as honorarium to the members of the Board of Trustees.

## 20. OTHERS RECEIPTS

| | 2003 | 2002 |
|---|---|---|
| Laboratory tests | 396,058 | 400,890 |
| Transport and equipment rental | 29,963 | 34,702 |
| Interest | 9,106 | 14,480 |
| Training Fees and dissemination | 6,235 | 9,192 |
| Cafeteria and Guest house (net of expenditure $112,102; 2002: $109,055 ) | 81,299 | 58,864 |
| Miscellaneous | 153,162 | 151,923 |
| | 675,823 | 670,051 |

## 21. OTHER EXPENDITURE

| | | |
|---|---|---|
| Training and dissemination | 172,236 | 170,842 |
| Staff development and training | 112,516 | 152,069 |
| Contractual services | 964,398 | 671,197 |
| Other services | 274,067 | 387,487 |
| Hospital patient expenses | 162,858 | 127,743 |
| Bank charges and interest | 8,470 | 4,873 |
| Legal and professional fees | 81,366 | 55,772 |
| | 1,775,911 | 1,569,983 |

## 22. DEFERRED EXPENDITURE

ICDDR,B is in the process of implementing an Enterprise Resource Planning (ERP)software. During the year cost of the software and related expenditure amounting to $200,279 has been charged in the "Statement of Activity(Operating Fund)" as capital expenditure.

$320,000 being cost of implementation and customisation, which was not completed by the end of the year, has been carried forward as deferred expenditure and to be amortised in two equal installments in 2004 and 2005.

## 23. GENERAL

Previous year's figures have been rearranged and regrouped, wherever considered necessary, to conform to the current year's presentation.

Figures appearing in these Financial Statements have been rounded off to the nearest US dollar.

Executive Director
ICDDR,B

Member
Board of Trustees

RODA VASI CHOWDHURY & CO

SIGNED FOR IDENTIFICATION BY:

For KPMG

**Hoda Vasi Chowdhury & Co**
BTMC Building (8th level)
7-9 Kawran Bazar
Dhaka-1215

**DRAFT**

Annexure - C

**KPMG**
Park Plaza, Block F, Floor 6
71 Park Street
Kolkata 700 016
India

12 April 2004

The Board of Trustees
International Centre for Diarrhoeal
Disease Research, Bangladesh (ICDDR,B)
Mohakhali, Dhaka

Dear Sir

**Auditors' Letter to the Board of Trustees, ICDDR, B - Audit of Accounts 2003**

We have audited the financial statements of ICDDR,B for the year ended 31 December 2003 jointly and issued our report thereon on 18 March 2004.

Our audit was conducted in accordance with the generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatements. In planning and performing audit of the financial statements, we reconsidered the internal control structure in order to determine our audit procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control.

In the course of our audit, we have identified some accounting and internal control weaknesses, deviations from Centre's policy and procedures and operational inefficiencies that are controllable by the management and developed recommendations concerning the matters. The matters, which are considered significant to be brought to the notice of the Board of Trustees, are enclosed to this letter. Other observations have been dealt with in a separate letter to the Centre's management. Observations, which are reported to the management, and all but one observation reported in this letter are not considered material as to modify our opinion on the fairness of the financial statements.

The purpose of issuing the management letter is to include constructive recommendations for the management to consider as part of the on-going process of improving accounting and other related controls and such recommendations are viewed by us as part of our services to your organisation.

We take this opportunity to put on record our sincere appreciation of the courtesy and co-operation extended to us during the audit of the Centre.

Yours faithfully

**Hoda Vasi Chowdhury & Co** - **KPMG**
Chartered Accountants

# Table of Contents

## 1. Formation of Trust for Employee Separation Payment Fund

### Observation

Under the current separation benefit scheme for its eligible employees, the Centre places the entire fund with a foreign fund manager for investment purposes and thereby does not reflect the investment including return thereon and the corresponding liability to the employees in its financial statements.

The Centre, under the present arrangement, cannot disown its liabilities to the employees and also the loss, if any, on deminution in value of investments, on the ground that the funds are maintained by a fund manager acting, in fact, on behalf of the Centre.

We understand that the Centre has recognised the predicament and is in the process of constituting a trust for vesting the scheme to such trust.

### Implication

In the absence of reflection of liabilities and corresponding assets in the financial statements, true and fair presentation of the Centre's financial position has not been complied with. Accordingly, the auditors' opinion on Centre's financial statements has been qualified.

### Recommendations

The Centre should precisely report the liability and the corresponding investments in its financial statements until the funds are finally vested in a trust.

### Management Comments

Management recognizes that the aforesaid Fund belongs to staff participants and therefore does not constitute an asset of the Centre. This is the rationale behind non-inclusion of the assets and liabilities of the Fund. Moreover, the inclusion of such funds in the Centre's Statement of Financial Position would materially distort the true financial position of the Centre. These facts along with the accumulated fund balance as at December 31, 2003 has been adequately disclosed in the notes appended to the Financial Statements.

We are in the process of setting up an Independent Trust for this Fund that will manage the fund on behalf of the employees participating in the Fund.

## 2. Exposure to equity instruments

### Observation

Endowment Funds' investments with overseas TIAA-CREF Trust Company carry higher risk of market fluctuations in view of their high equity component of around 62% of total investments.

As a result, the Centre had to make significant provisions in prior years (approx $ 806 thousands) for shortfall in market value of such investments. However, due to improved market conditions during the current year, the Centre has significantly recouped most of past losses and the investments currently have a positive mark to market.

Legislations for non profit organizations in most jurisdictions generally restricts equity based investments.

### Implication

Equity investments inherently have a high degree of market risk. Endowment funds are meant for specific purposes, and its return needs to be consistent to meet mandated expenditure, any realized loss would be a violation of the funds usage norms.

### Recommendations

Management should consider investment in funds which invest in debt market instruments with plans that offer periodic returns. These provide a stable returns and are comparatively less risky (especially investments in sovereign paper like government bonds).

### Management Comments

Management considers investments against Endowment Funds as long-term investments. The objective of these investments is to provide a stable returns along with a steady growth of the Corpus. To optimize return and minimize risks a balanced portfolio is maintained. The Debt Equity ratio of these investments is 40:60.

These Endowment Funds Investments are governed by Fund Investment Committee, which is constituted with eminent professionals from various related fields. An Asset Manager appointed by the Board of Trustees manages these Overseas Investments and send monthly report for our review. A Fund Management Committee meets every quarter and closely monitors the fund and recommends corrective measures. However, Auditors' recommendation noted and will be discussed in the coming Fund Management Committee meeting.

# Annexure - D

2003 Auditors' Report and Audited Financial Statements for Employees Separation Payment Fund

**Hoda Vasi Chowdhury & Co**

To
Executive Director
ICDDRB
Dhaka

*10 June 2004*

# Auditors Report

# ICDDR,B Employees Separation Payment Fund

*For the year ended 31 December 2003*

# Hoda Vasi Chowdhury & Co

## Chartered Accountants

Independent Correspondent Firm to **Deloitte Touche Tohmatsu**


## AUDITORS' REPORT ON ICDDR,B EMPLOYEES SEPARATION PAYMENT FUND

We have examined the annexed consolidated Financial Statement, comprising the Statement of Affairs of ICDDR,B Employees Separation Payment Fund as at 31 December 2003 together with the annexed Notes 1 to 5, by reference to the statements of account prepared by ICDDR,B we found the Financial Statement in agreement with the books as maintained by the Centre and examined by us, and the explanations given to us.

Dhaka, 10 June 2004

Chartered Accountants

## ICDDR,B Employees Separation Payment Fund

Statement of Affairs as at 31 December 2003

| | (Amounts in US Dollar) 2003 | 2002 |
|---|---|---|
| **MEMBERS' ACCOUNTS** | | |
| Balance on 1 January | 10,982,532.63 | 10,156,890.45 |
| Accretion during the year: | | |
| Contribution | 1,065,659.55 | 984,038.76 |
| Income earned (Net) | 572,458.17 | 543,231.33 |
| | 1,638,117.72 | 1,527,270.09 |
| | 12,620,650.35 | 11,684,160.54 |
| Less:Payments | | |
| To Separated staff members | 622,191.04 | 570,897.18 |
| For permanent partial withdrawal | 144,718.94 | 130,730.73 |
| | 766,909.98 | 701,627.91 |
| Balance at 31 December | 11,853,740.37 | 10,982,532.63 |
| **INVESTMENTS with Generali Worldwide Insurance Company Limited,Channel Islands,UK.** | | |
| Balance on 1 January | 10,982,532.63 | 10,156,890.45 |
| Addition during the year: | | |
| Contribution | 1,065,659.55 | 984,038.76 |
| Income earned (Net) | 572,458.17 | 543,231.33 |
| | 1,638,117.72 | 1,527,270.09 |
| | 12,620,650.35 | 11,684,160.54 |
| Reduction during the year due to : | | |
| Payments | | |
| To Separated staff members | 622,191.04 | 570,897.18 |
| For permanent partial withdrawal | 144,718.94 | 130,730.73 |
| | 766,909.98 | 701,627.91 |
| Balance at 31 December | 11,853,740.37 | 10,982,532.63 |

The accompaning Notes 1 to 5 are integral part of this Financial Statement

Member, Board of Trustees
ICDDR,B

Executive Director
ICDDR,B

This is the Balance Sheet referred to in our report of date

Dhaka, 10 June 2004

Chartered Accountants

# ICDDR,B Employees Separation Payment Fund

## Notes to the Financial Statement for year ended 31 December 2003

### 1 Background

The ICDDR,B Employees Separation Payment Fund (herein after referred to as the **Scheme**) was set up on 1 January 1984 in pursuance of a resolution (# 22/Dec 82) of the Board of Trustees of International Centre for Diarrhoeal Disease Research, Bangladesh (Centre) with a view to providing retirement benefit to the fixed term staff of the Centre, excluding the International Level employees. This Scheme replaced the severance pay scheme and the contributory provident fund that existed till 31 December 1983. The employees' accumulated balances on provident fund account as on 31 December 1983 were paid out to the employees, while the Centre's contributions to the said severance pay scheme till 31 December 1983 were transferred to the Scheme as the Centre's contribution for period till 31 December 1983.

The Scheme is administered by the Centre and presently managed by an overseas Fund Manager, Generali Worldwide Insurance Company Limited, a foreign investing company. In pursuance of a Novation Agreement executed by the Centre and the related parties of Generali Group named therein, management of the funds of the Scheme, which had been entrusted with the Institute of International Education (IIE) till 31 December 1991 and thereafter with Assicurazioni Generali, S.p.A, was assigned and transferred to Generali Worldwide Insurance Company Limited. Books of the Scheme are maintained overseas by a bookkeeper, AccuRecord of USA, in terms of an agreement executed with them by the Centre on 20 January 1993. Centre's as well as the employees' contributions at 14.8% and 7.4% respectively of pensionable salary are remitted to the Fund Manager on a quarterly basis for sustainable investment to ensure best possible return to the investment. Separation payment due to an outgoing employee is paid out of the Centre's and the employees' quarterly contributions to the Scheme, as gratuity comprising of the Centre's and the employee's contributions and income accrued thereon.

### 2 Significant Accounting Policies

#### a. *Basis of Accounting*

This financial statement expressed in US Dollar has been prepared on cash basis based on the periodic statements provided by the bookkeeper to the Centre. As a result, income accrued on the investments in the last quarter of a year is taken to account by the Centre in the first quarter of the next following year.

#### b. *Investment and Income thereon*

##### i. *Basis of Valuation of Investment*

In terms of the stipulations in paragraph 7 of the general conditions of the insurance policy undertaken by the Fund Manager, there would not have any effect of fluctuation in the market value of the investments and as such, investments have been stated at cost.

ii. *Return on Investment*

According to the investment policies followed by the Fund Manager, the funds under the Scheme is entitled to a minimum guaranteed return on investments based on an actuarial valuation carried out in the beginning of each accounting year. The guaranteed income based on the said actuarial valuation is distributed to the members' accounts in the first three quarters of each year. Excess of interest over the guaranteed minimum as reduced by 10% of the actual annual return on the investments is further distributed to the members' accounts in proportion to their individual balances in the fourth quarter of the year. The members also receive 50% of the profit earned on the maturity of an investment portfolio named as capital profit. The Fund Manager recovers its management fee at 0.30% of the market value of the investment portfolio at the end of each year, which is deducted from income distributable to the members. The Scheme is also entitled to a capital subsidy calculated by the Fund Manager. However, the quarterly bookkeeping charges payable to AccuRecord are borne by the Centre and as such not charged to income of the Scheme.

c. *Books of Account*

The books relating to members' individual accounts are maintained by AccuRecord, USA. The Centre does not incorporate the transactions relative to the operations of the Scheme in its books of account.

3. *Distribution of Profit*

An incoming member who joins the service any time during a quarter is not allowed any interest to be credited to his account for that quarter. Similarly, an outgoing member leaving the service of the Centre any time before end of a quarter is not entitled to the interest accrued to his account for the said quarter.

4. *Members' Account*

There was a difference of US $212.78 between the records maintained by AccuRecord,USA and the books of records maintained by the Centre, which is in the process of reconciliation.

5. *Disbursement*

The account of an outgoing employee is settled locally out of the monthly contributions remittable to the Fund Manager, based on the accumulated balance standing to his credit as reflected in the quarterly statements prepared by AccuRecord. One-time permanent withdrawal before retirement up to 50% of the total accumulation due to an employee at the time of such permanent partial withdrawal is allowed as per Centre's policy memo dated 18 December 1996

Member, Board of Trustees
ICDDR,B

Executive Director
ICDDR,B

HODA VASI CHOWDHURY & CO. DHAKA

**Annexure - E**

## Glossary of Acronyms and Abbreviations

| | |
|---|---|
| AFRIM | Armed Forces Research Institute of Medical Sciences |
| AID | Agency for International Development |
| AusAID | Australian Aid for International Development |
| BADC | Belgian Administration for Development Cooperation |
| BHARP | Bangladesh Health and Family Welfare Action Research Project |
| BIOTECH | Biotechnology |
| BoT | Board of Trustees |
| BTC | Belgian Technical Cooperation |
| CDC | Control and Prevention; Centers for Disease (CDC) |
| CHF | Child Health Foundation |
| CIDA | Canadian International Development Agency |
| Co. | Company |
| CSD | Clinical Sciences Division |
| Dev. | Development |
| DFID | Department for International Development (UK) |
| DISC | Dissemination Information Services Centre |
| DSS | Demographic Surveillance System |
| ER&ID | External Relations & Institutional Development |
| ESPF | Employees Separation Payment Fund |
| Estim | Estimated |
| EU | European Union |
| FACE | Foundation for the Advancement of Clinical Epidemiology Inc. |
| exp. | expenditure |
| FHI | Family Health International |
| FHRP | Family Health Research Project |
| Gates/GoB | Gates - Government of Bangladesh |
| GoB | Government of the People's Republic of Bangladesh |
| HHMI | Howard Hughes Medical Institute |
| HSID | Health Systems and Infectious Diseases Division |
| ICDDR,B | International Centre for Diarrhoeal Disease Research, Bangladesh |
| INC. | Incorporated |
| INF | International Nutrition Foundation |
| ISD | Information Sciences Division |
| IVI | International Vaccine Institute |
| JICWELS | Japan International Cooperation of Welfare Services |
| JHBSPH | The Johns Hopkins Bloomburg School of Public Health |
| JHU | Johns Hopkins University |
| JUN | June |
| LSD | Laboratory Sciences Division |
| LSTH&M | London School of Hygine & Tropical Medicine |
| LTD. | Limited |
| MGH | Massachusetts General Hospital |
| MSCS | Marie Stopes Clinic Society |
| NEMC | New England University School of Medicine |

| | |
|---|---|
| NOV | November |
| NYUSM | New York University School of Medicine |
| OFDA | Office of US Foreign Disaster Assistance |
| ORP | Operations Research Project |
| PHSD | Public Health Sciences Division |
| Plc | Public Limited Company |
| RES | Resolution |
| RESTR. | Restricted |
| SAREC | Swedish Agency for Research Cooperation with Developing Countries |
| SDC | Swiss Agency for Development and Cooperation |
| Sida | Swedish International Development Cooperation Agency |
| SPF | Separation Payment Fund |
| SRC | Swiss Red Cross |
| SS | Self Sustaining Funds |
| SWA | Staff Welfare Association |
| TIAA-CREF | TIAA-CREF Trust Company |
| TECHNO | Technology |
| UFHP | Urban Family Health Partnership |
| 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 |
| WHO | World Health Organization |
| WOTRO | Netherlands Foundation for the Advancement of Tropical Research |

# ICDDR,B BOARD OF TRUSTEES MEETING

## FINANCE COMMITTEE

**June 2004**

1

## OVERVIEW

- 2003 Audited Financial Statements
- 2003 Auditors' Report
- Auditors' Letter to Board of Trustees
- Update on Employees Separation Payment Fund
- Report on Endowment Funds

2

# OVERVIEW (contd..)

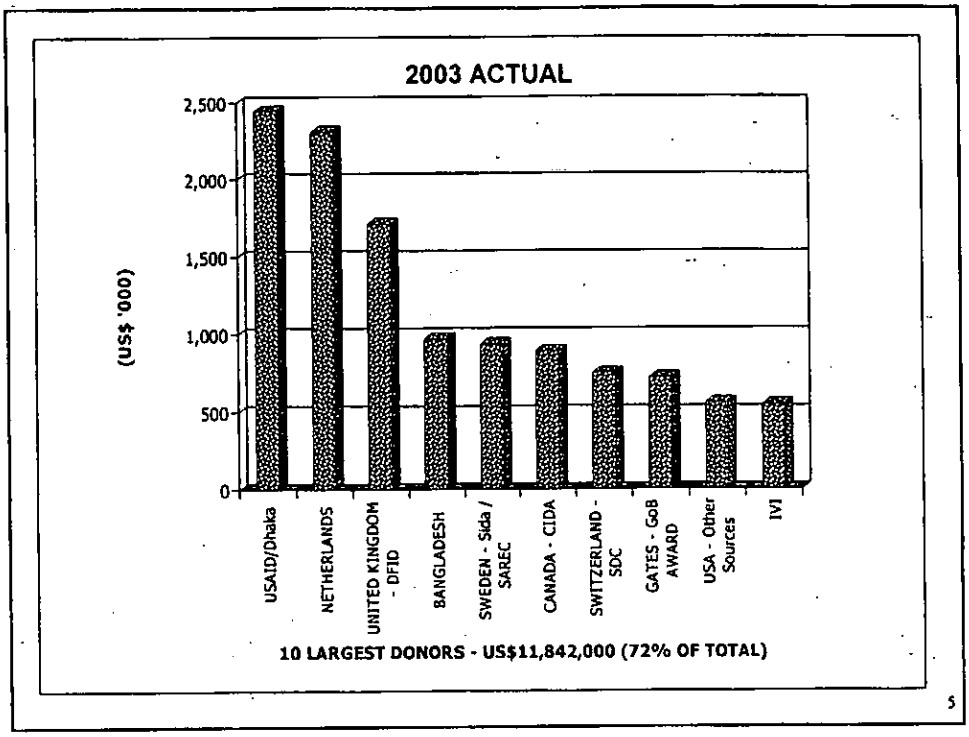
- Analysis on 2004 Forecast
- Core Fund : Allocation
- Brief update on Activity Review
- Sustainability Plan – [status report]
- Discussion on Draft Resolutions

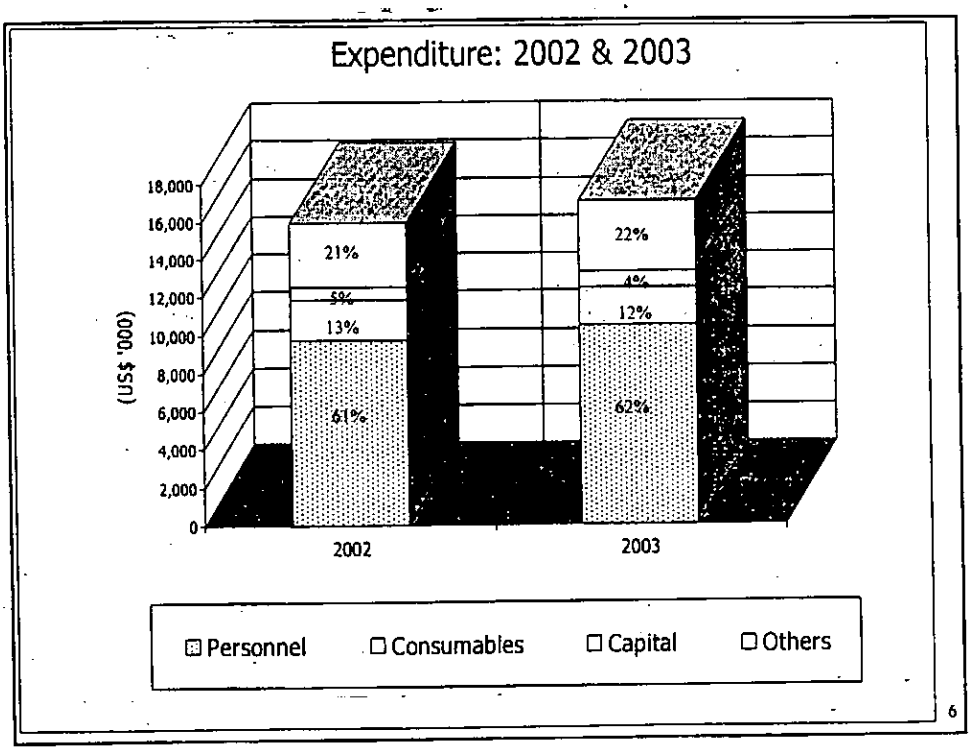
3

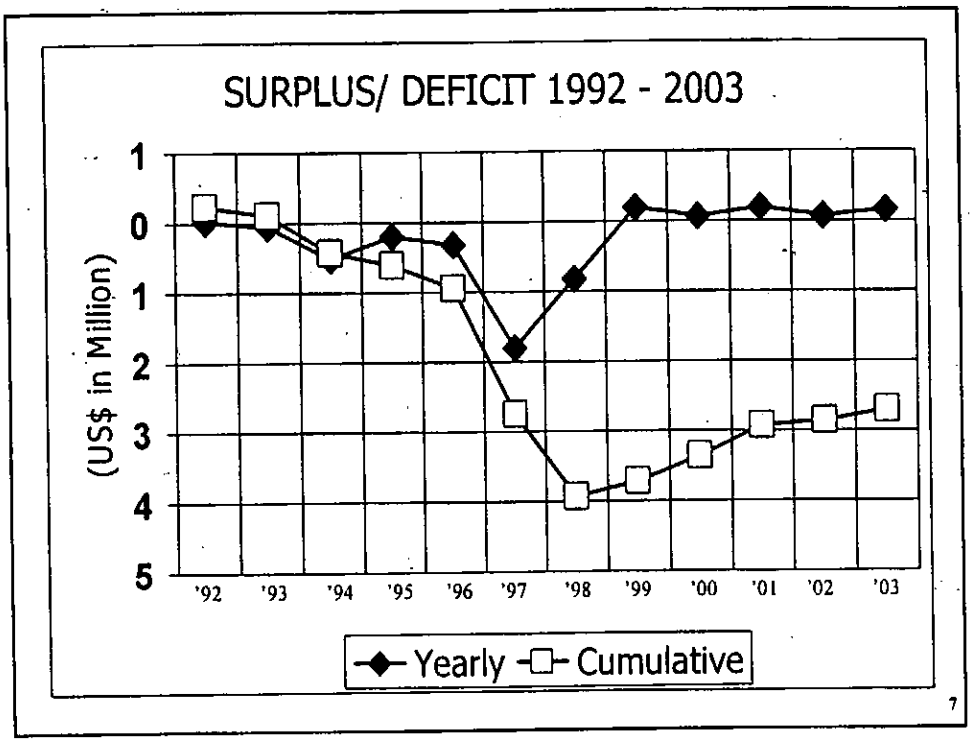
## 2003 STATEMENT OF ACTIVITY

| | (US$'000) | % |
|---|---|---|
| REVENUES: | | |
| CORE | 4,638 | 27 |
| PROJECT | 11, 873 | 69 |
| OTHER RECEIPTS | 670 | 4 |
| TOTAL REVENUE | 17,181 | 100 |
| EXPENDITURE: | | |
| SALARIES AND BENEFITS | 7,563 | 44 |
| – LOCAL | 2,914 | 17 |
| – INTERNATIONAL | 1,975 | 12 |
| SUPPLIES AND MATERIALS | 4,566 | 27 |
| CAPITAL & OTHERS | | |
| TOTAL EXPENDITURE | 17,018 | 100 |
| SURPLUS BEFORE DEPRECIATION | 163 | |
| DEPRECIATION | 1,001 | |
| (SHORTFALL) AFTER DEPRECIATION | (838) | |

4


2003 ACTUAL
(US$ '000)
2,500
2,000
1,500
1,000
500
0
USAID/Dhaka
NETHERLANDS
UNITED KINGDOM - DFID
BANGLADESH
SWEDEN - Sida / SAREC
CANADA - CIDA
SWITZERLAND - SDC
GATES - GoB AWARD
USA - Other Sources
IVI
10 LARGEST DONORS - US$11,842,000 (72% OF TOTAL)
5


Expenditure: 2002 & 2003
(US$ '000)
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
21%
5%
13%
61%
22%
4%
12%
62%
2002
2003
Personnel
Consumables
Capital
Others
6




## AUDITORS' REPORT

**Auditors' have qualified the deferment of ERP implementation costs amounting to $320,000.**

Deferred as implementation was not completed within 2003.

This deferred expenditure will be amortized in two equal installments in 2004 and 2005 against earmarked funds.

8

## AUDITORS' REPORT

**The other qualification is for non inclusion of assets and liabilities of "Employees Separation Payment Fund"**

The aforesaid Fund being operated independent of the Centre's activities, assets and liabilities attached to the Fund should not appear in the Centre's books.

Moreover, the inclusion of such funds in the Centre's Statement of Financial Position would materially distort the true financial position of the Centre.

## AUDITORS' LETTER TO BoT

**Trust for Employee Separation Payment Fund**

The process of setting up an Independent Trust for this Fund has been initiated.

This Trust will manage the Fund on behalf of the participating employees. [Draft Resolution-12]

## AUDITORS' LETTER TO BoT

### Steps taken for Formation of Trust for ESPF

Executive Committee of SWA has endorsed the proposal for formation of the Trust and suggested few designated persons as members of this Trust. [Draft Resolution-12]

2003 Accounts audited by an independent auditors' and issued clean report. [Draft Resolution-11]

The process of drafting the by-laws for the Trust is being initiated and will be placed with SWA for their input. Expected to be placed in Nov.04 BoT for approval.

## AUDITORS' LETTER TO BoT

Endowment Funds' investments with TIAA-CREF carry higher risk of market fluctuations due to high (62%) equity component

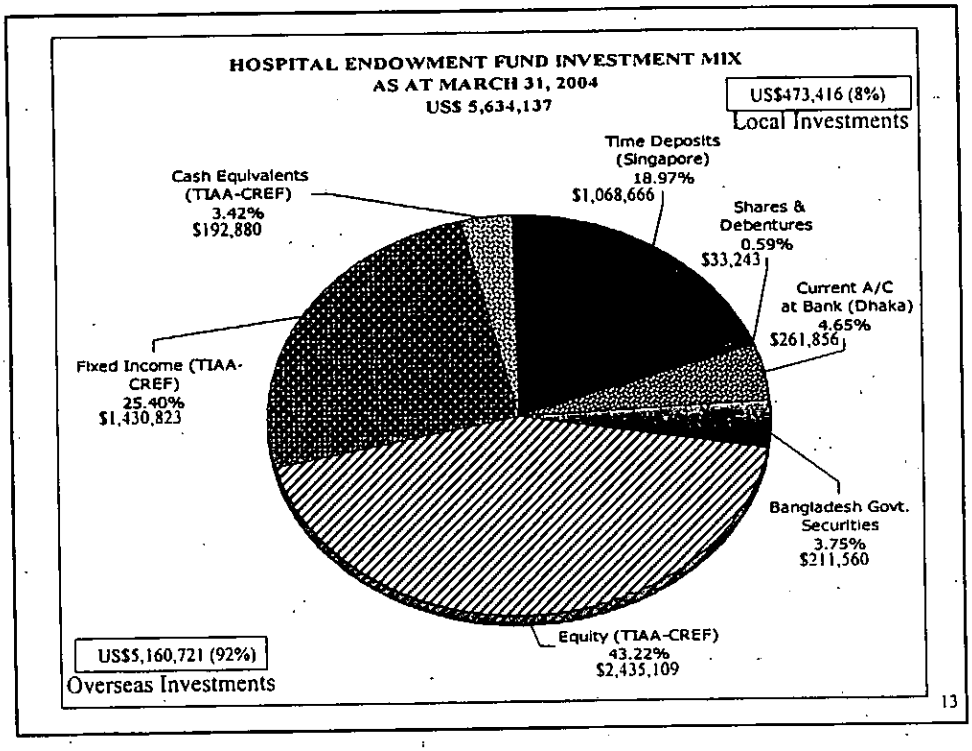
### : Conscious decision of the Management :

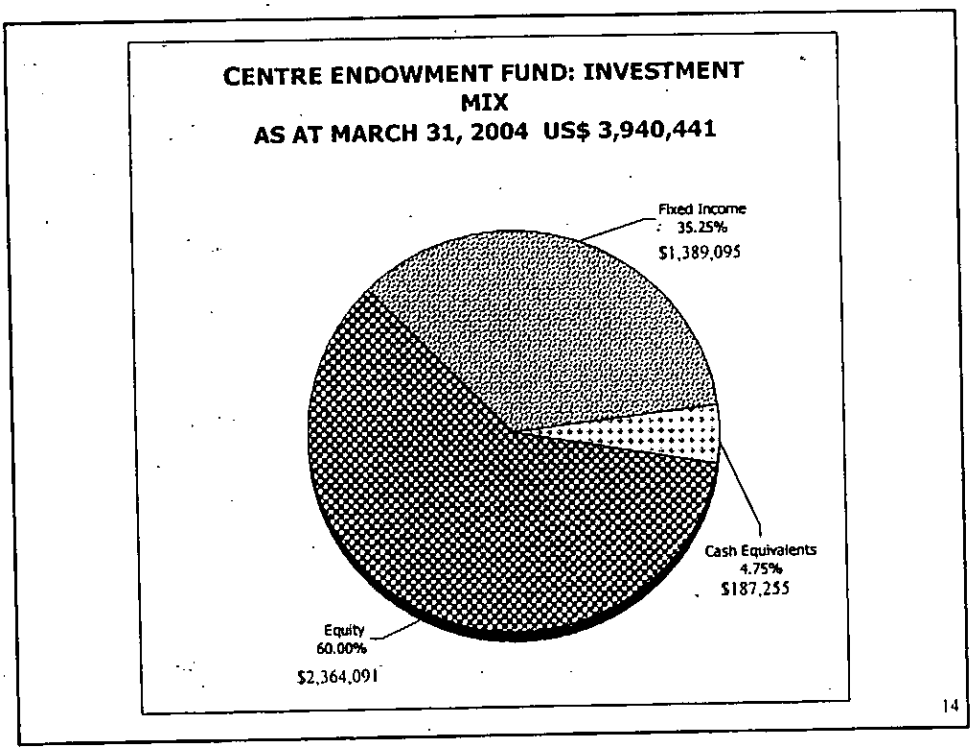
Nature : Long-term Investments.

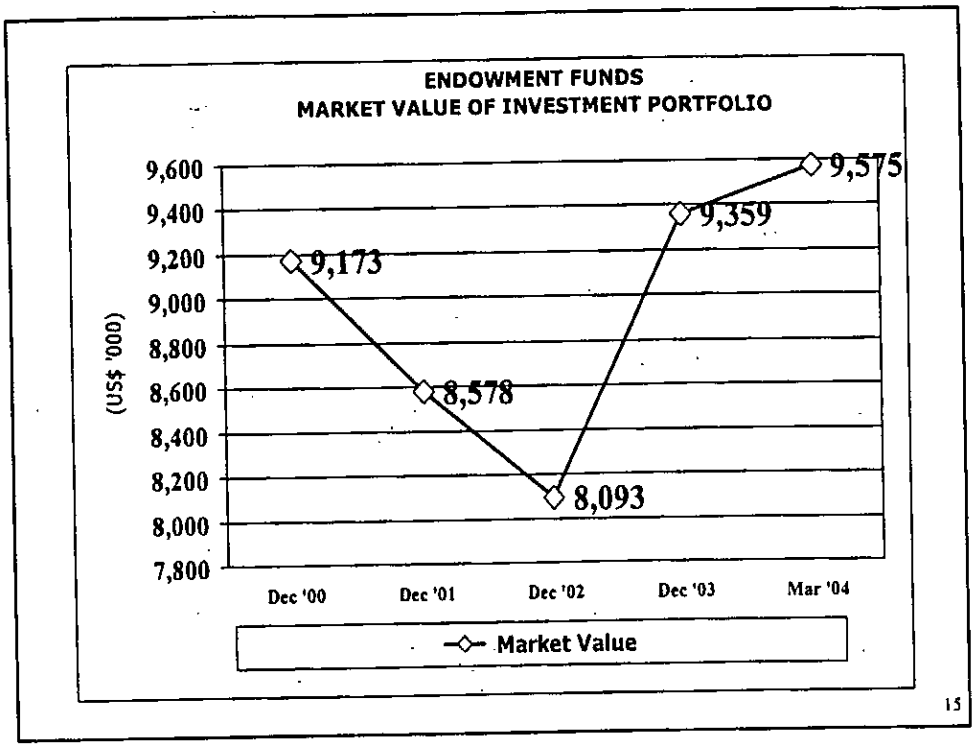
Objective : To provide a stable returns along with a steady growth of the Corpus.

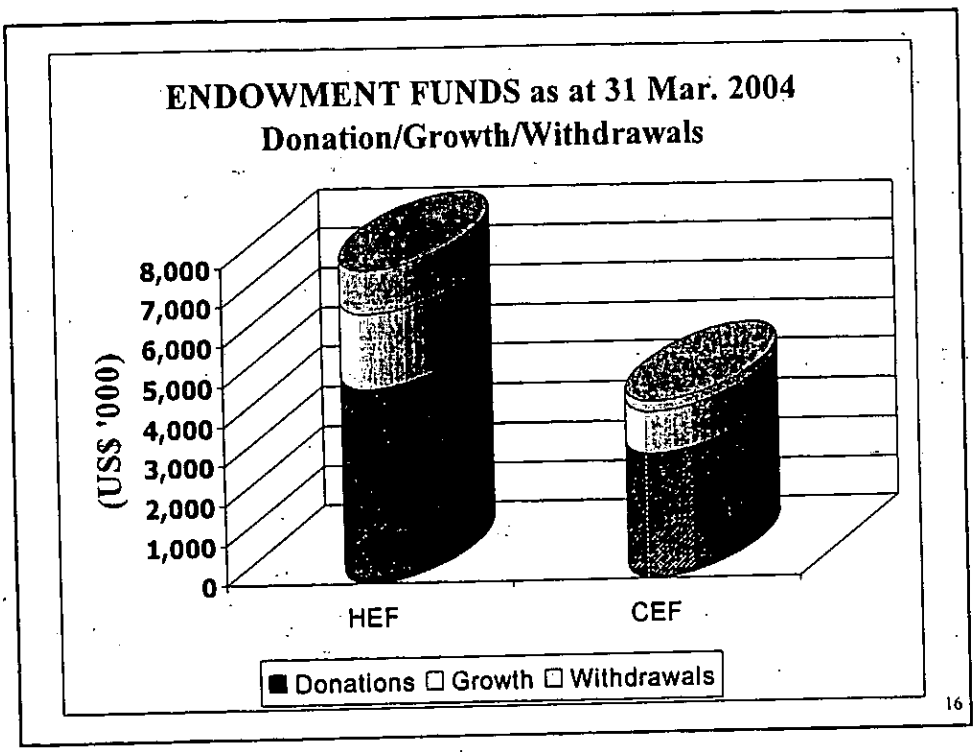
To optimize return and minimize risks.

Debt Equity Ratio : Average 40:60.


HOSPITAL ENDOWMENT FUND INVESTMENT MIX
AS AT MARCH 31, 2004
US$ 5,634,137
US$473,416 (8%)
Local Investments
Time Deposits (Singapore) 18.97% $1,068,666
Cash Equivalents (TIAA-CREF) 3.42% $192,880
Shares & Debentures 0.59% $33,243
Current A/C at Bank (Dhaka) 4.65% $261,856
Fixed Income (TIAA-CREF) 25.40% $1,430,823
Bangladesh Govt. Securities 3.75% $211,560
Equity (TIAA-CREF) 43.22% $2,435,109
US$5,160,721 (92%)
Overseas Investments
13


CENTRE ENDOWMENT FUND: INVESTMENT MIX
AS AT MARCH 31, 2004 US$ 3,940,441
Fixed Income 35.25% $1,389,095
Cash Equivalents 4.75% $187,255
Equity 60.00% $2,364,091
14


ENDOWMENT FUNDS
MARKET VALUE OF INVESTMENT PORTFOLIO
(US$ '000)
9,600
9,400
9,200
9,000
8,800
8,600
8,400
8,200
8,000
7,800
9,173
8,578
8,093
9,359
9,575
Dec '00
Dec '01
Dec '02
Dec '03
Mar '04
Market Value
15


ENDOWMENT FUNDS as at 31 Mar. 2004
Donation/Growth/Withdrawals
(US$ '000)
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
HEF
CEF
Donations
Growth
Withdrawals
16

## 2004 FORECAST– A SNAPSHOT

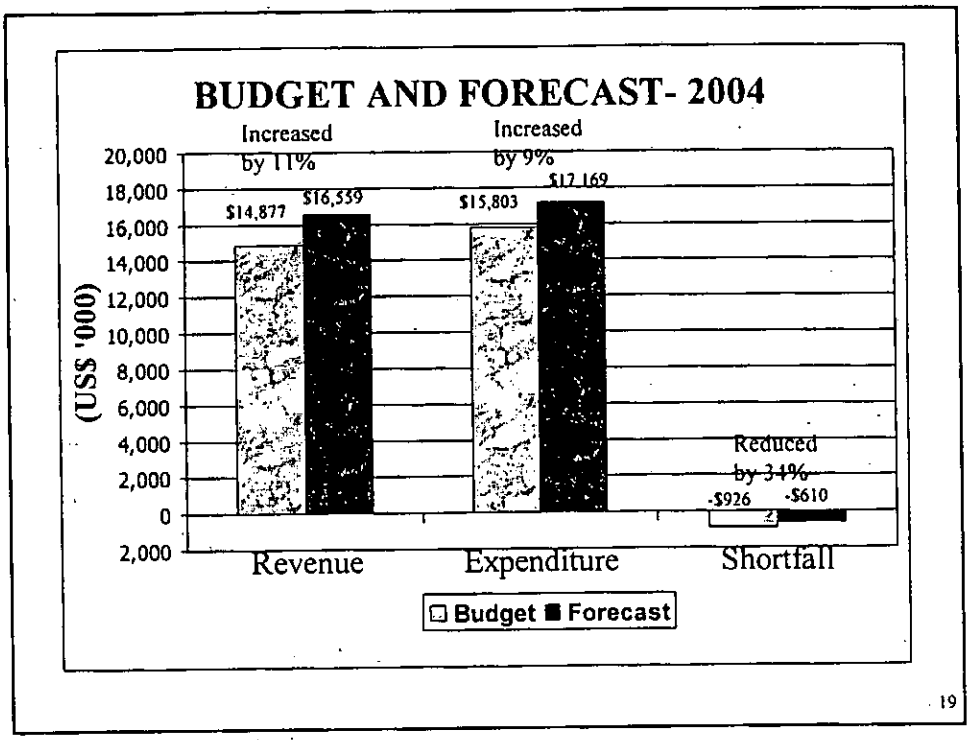
| | (US$'000) | % |
|---|---|---|
| REVENUES: | | |
| CORE | 4,168 | 25 |
| PROJECT | 11,608 | 70 |
| OTHER RECEIPTS | 783 | 5 |
| TOTAL REVENUE | 16,559 | 100 |
| EXPENDITURE: | | |
| SALARIES AND BENEFITS | 7,692 | 45 |
| – LOCAL | 3,091 | 18 |
| – INTERNATIONAL | 2,422 | 14 |
| SUPPLIES AND MATERIALS | 3,964 | 23 |
| CAPITAL & OTHERS | | |
| TOTAL EXPENDITURE | 17,169 | 100 |
| SHORTFALL BEFORE DEPRECIATION | 610 | |
| DEPRECIATION | 912 | |
| SHORTFALL AFTER DEPRECIATION | 1,522 | |

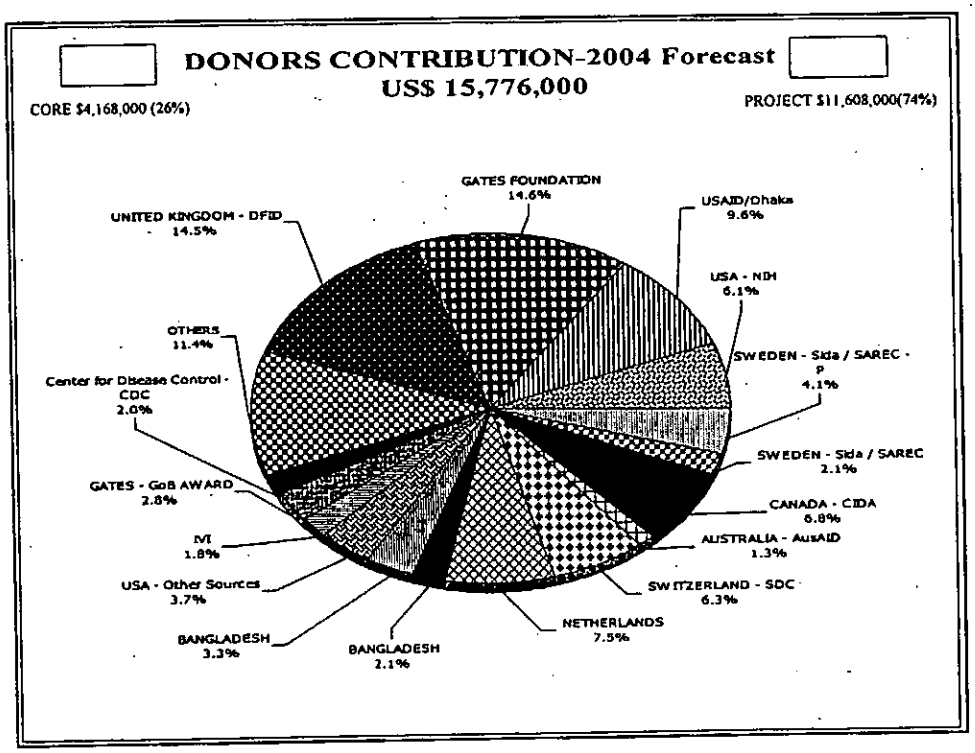
17

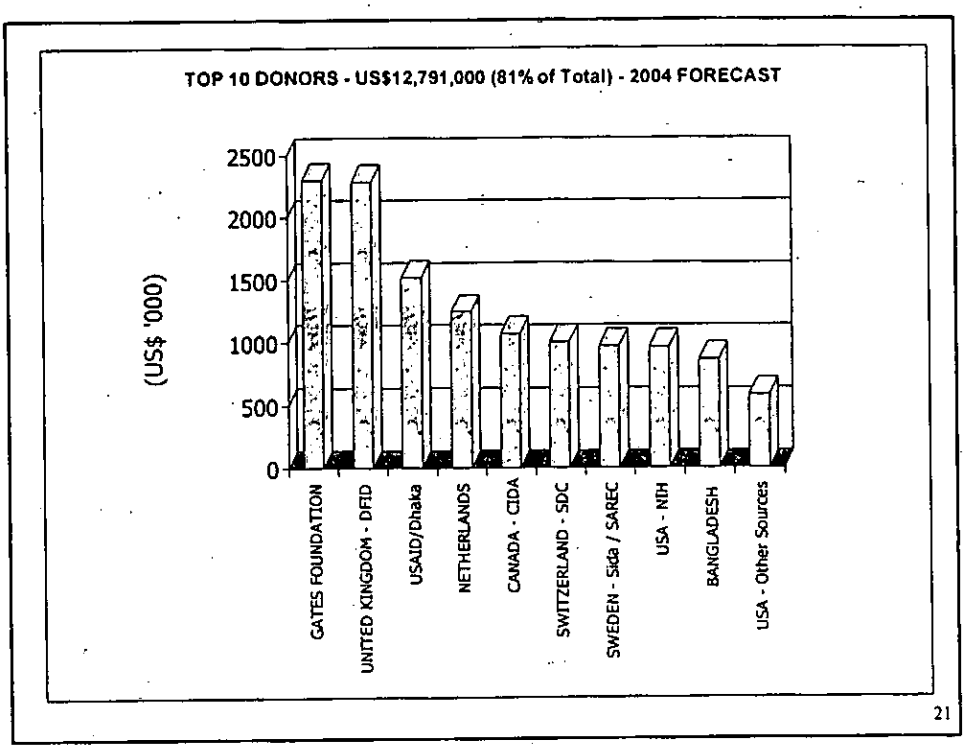
## RECONCILIATION

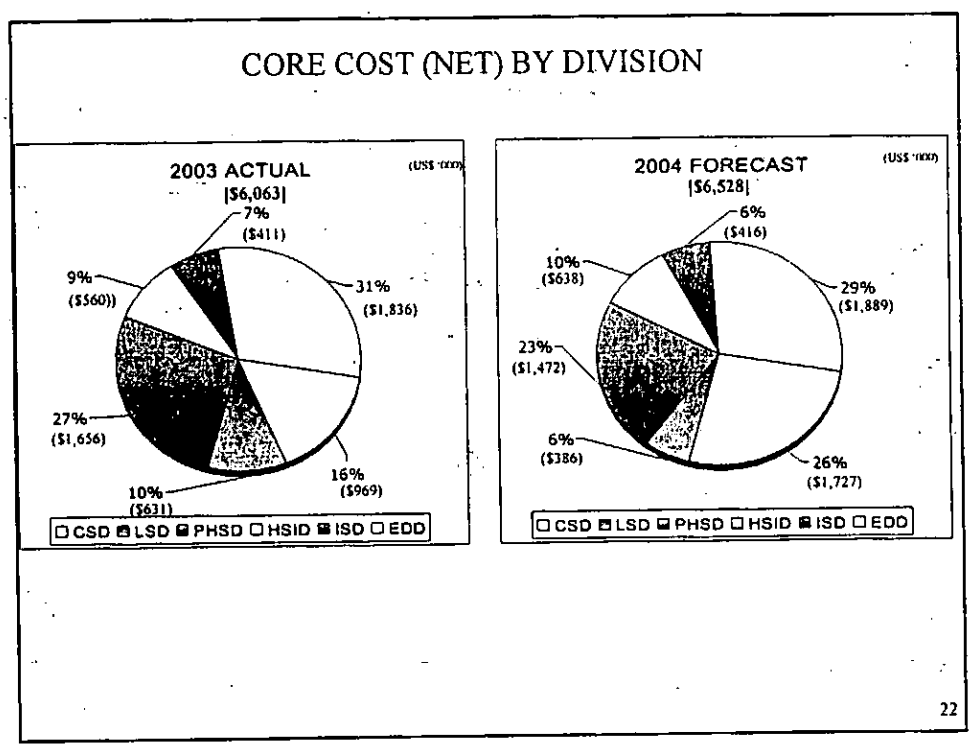
| | | (US$'000) |
|---|---|---|
| **Shortfall as per 2004 Budget** | | 926 |
| **Increased by:** | | |
| Local Salary | 90 | |
| Expenses in other areas (net) | 18 | 108 |
| **Reduced by:** | | |
| More Overhead from projects | 224 | |
| Contribution from Hospital Endowment Fund | 200 | (424) |
| **Shortfall as per June 2004 Forecast** | | 610 |

18

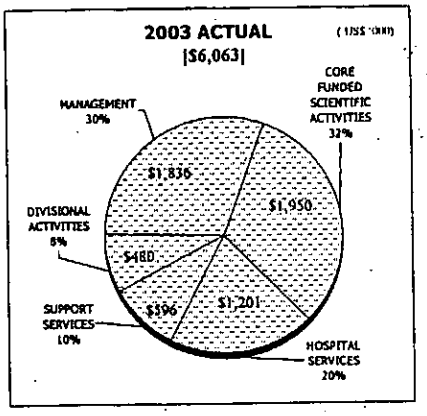

BUDGET AND FORECAST- 2004
Increased by 11%
Increased by 9%
$14,877
$16,539
$15,803
$17,169
Reduced by 34%
-$926
-$610
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
2,000
(US$ '000)
Revenue
Expenditure
Shortfall
Budget
Forecast
19

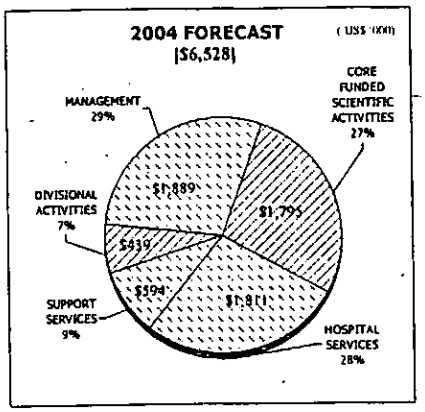

DONORS CONTRIBUTION-2004 Forecast
US$ 15,776,000
CORE $4,168,000 (26%)
PROJECT $11,608,000(74%)
GATES FOUNDATION 14.6%
USAID/Dhaka 9.6%
USA - NIH 6.1%
SWEDEN - Sida / SAREC - P 4.1%
SWEDEN - Sida / SAREC 2.1%
CANADA - CIDA 6.8%
AUSTRALIA - AusAID 1.3%
SWITZERLAND - SDC 6.3%
NETHERLANDS 7.5%
BANGLADESH 2.1%
BANGLADESH 3.3%
USA - Other Sources 3.7%
IVI 1.8%
GATES - GoB AWARD 2.8%
Center for Disease Control - CDC 2.0%
OTHERS 11.4%
UNITED KINGDOM - DFID 14.5%


TOP 10 DONORS - US$12,791,000 (81% of Total) - 2004 FORECAST
(US$ '000)
2500
2000
1500
1000
500
0
GATES FOUNDATION
UNITED KINGDOM - DFID
USAID/Dhaka
NETHERLANDS
CANADA - CIDA
SWITZERLAND - SDC
SWEDEN - Sida / SAREC
USA - NIH
BANGLADESH
USA - Other Sources
21


CORE COST (NET) BY DIVISION
2003 ACTUAL
|$6,063|
(US$ '000)
7%
($411)
31%
($1,836)
16%
($969)
10%
($631)
27%
($1,656)
9%
($560))
CSD LSD PHSD HSID ISD EDD
2004 FORECAST
|$6,528|
(US$ '000)
6%
($416)
29%
($1,889)
26%
($1,727)
6%
($386)
23%
($1,472)
10%
($638)
CSD LSD PHSD HSID ISD EDD
22

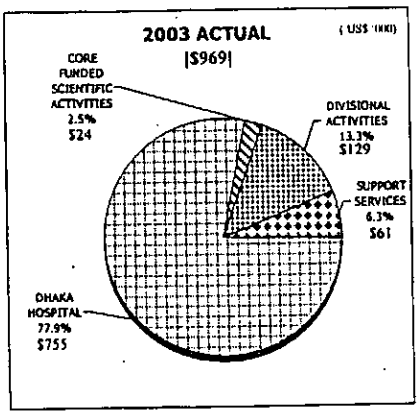
## CORE COST (NET) BY CATEGORY

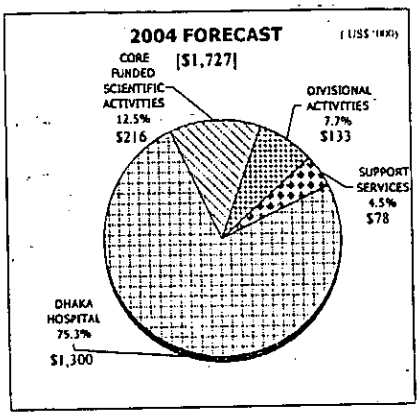



23

## CORE COST (NET) BY CATEGORY - CSD

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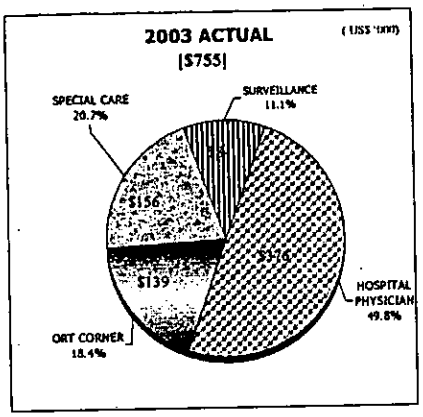
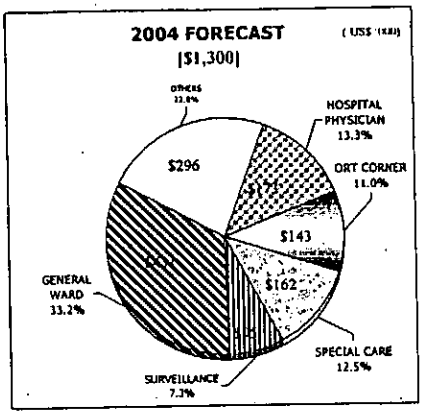
## DHAKA HOSPITAL COST (NET)

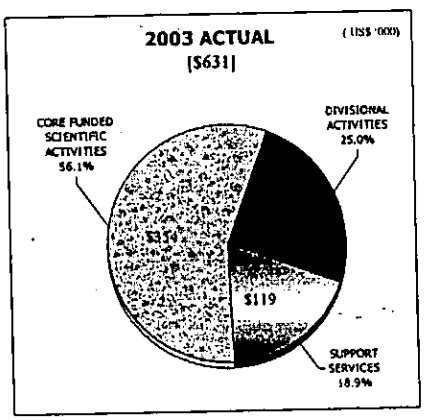
## BY CATEGORY

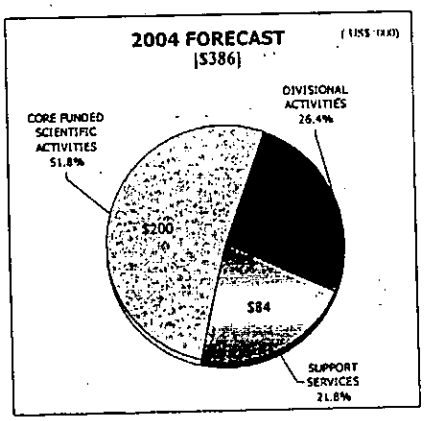



25

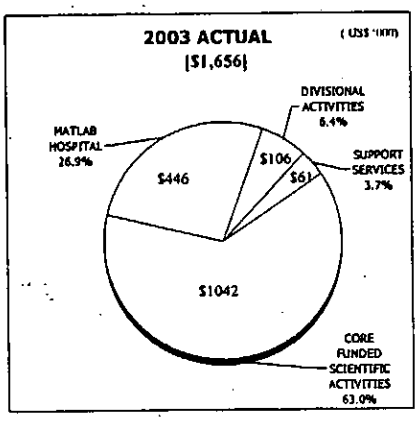
## CORE COST (NET) BY CATEGORY - LSD

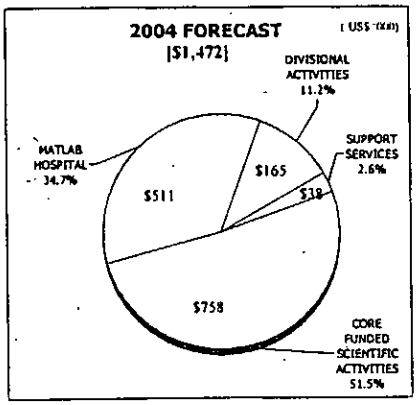



26

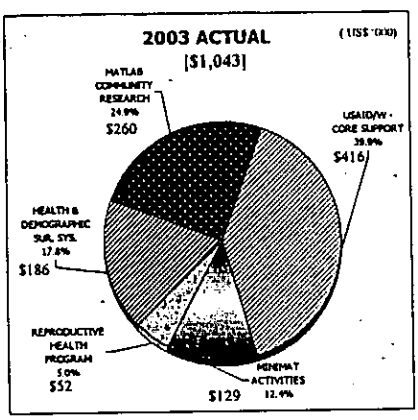
## CORE COST (NET) BY CATEGORY - PHSD

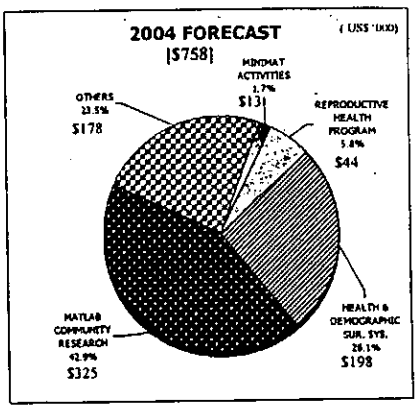



27

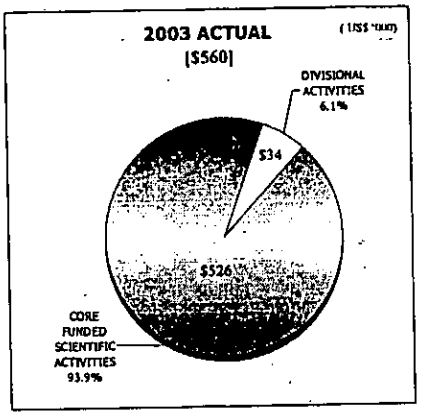
## PHSD - CORE FUNDED SCIENTIFIC ACTIVITY BY CATEGORY (NET)

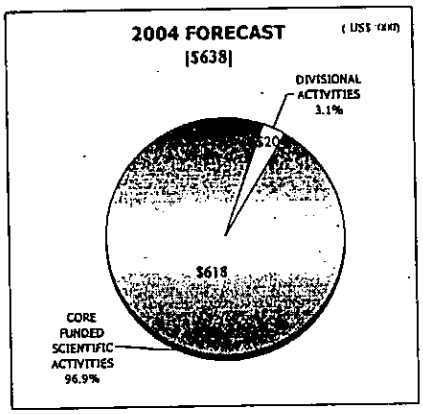



28

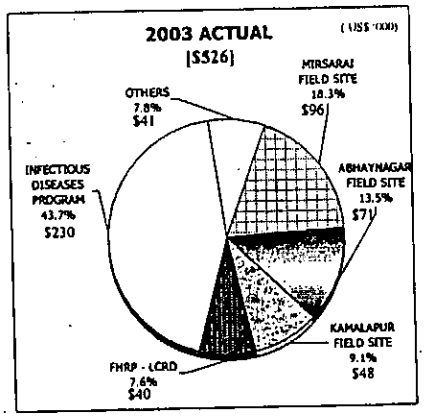
## CORE COST (NET) BY CATEGORY - HSID

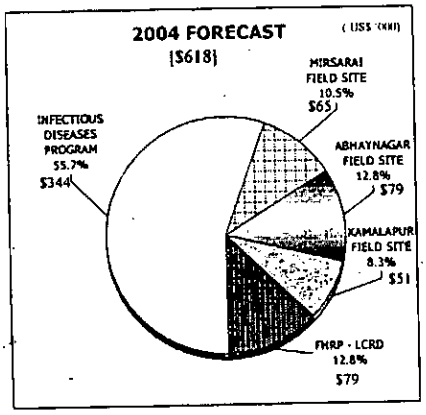



29

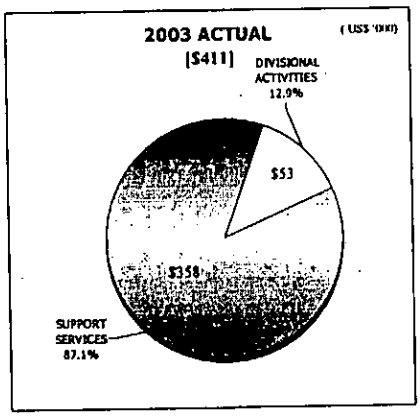
## HSID - CORE FUNDED SCIENTIFIC ACTIVITY BY CATEGORY (NET)

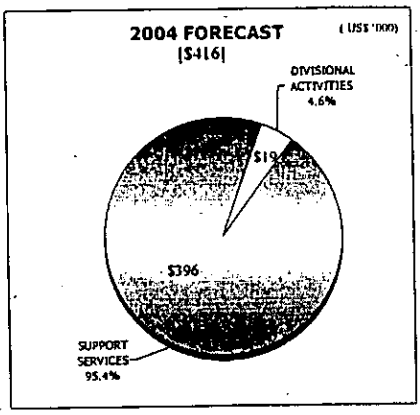



30

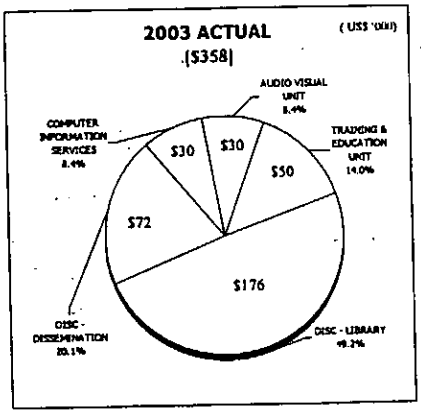
## CORE COST (NET) BY CATEGORY - ISD

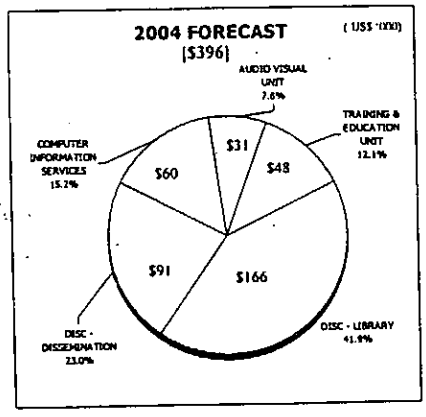



31

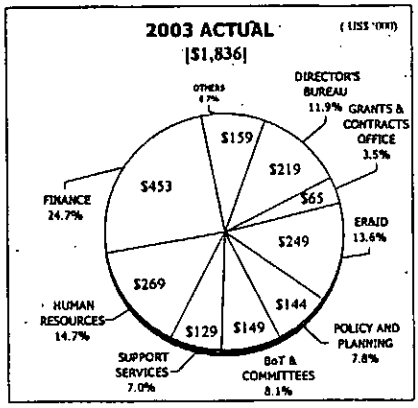
## ISD – SUPPORT SERVICES BY CATEGORY (NET)

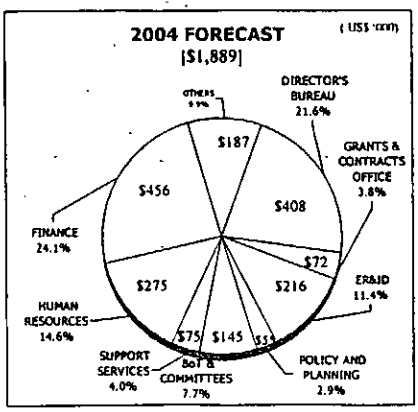



32

## CORE COST (NET) BY CATEGORY - EDD

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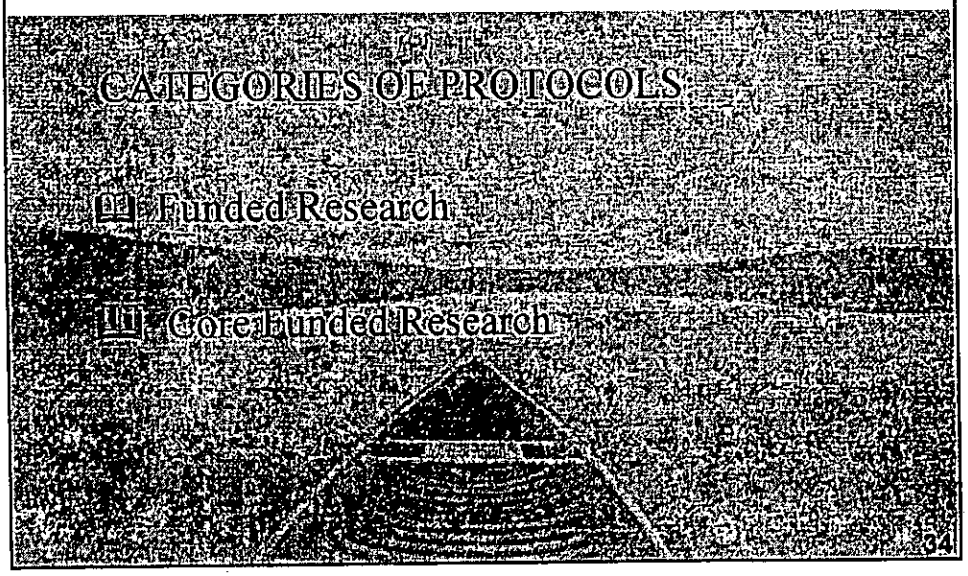
# ACTIVITY REVIEW

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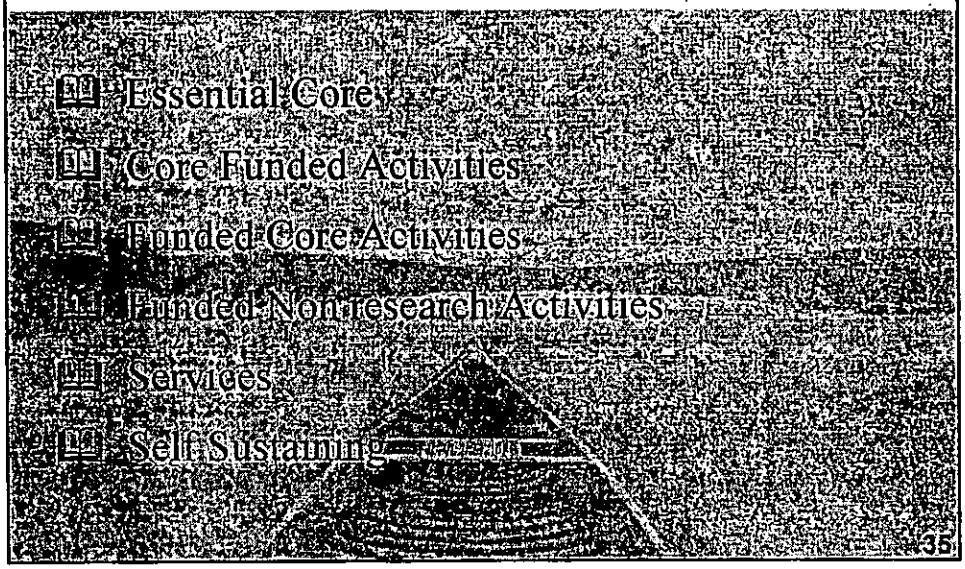
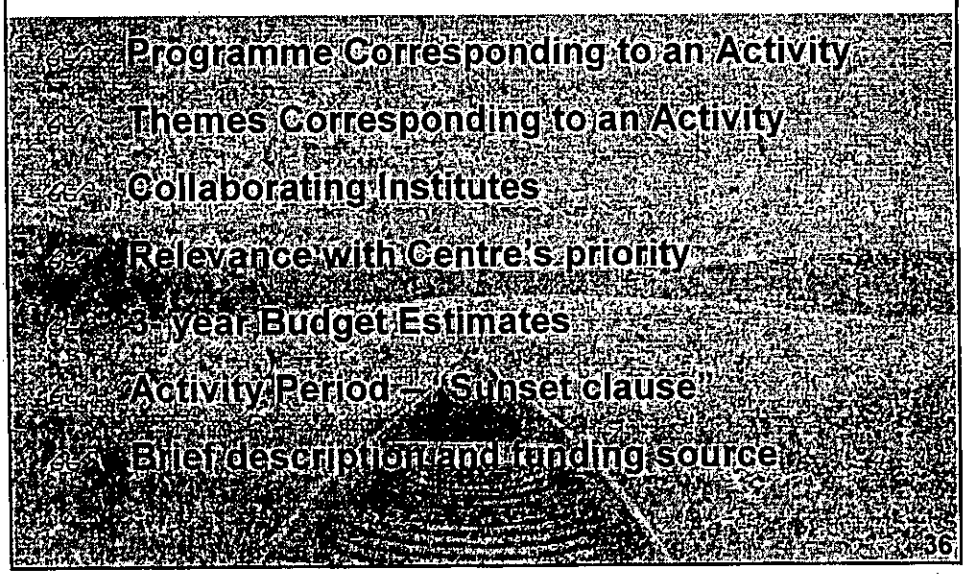
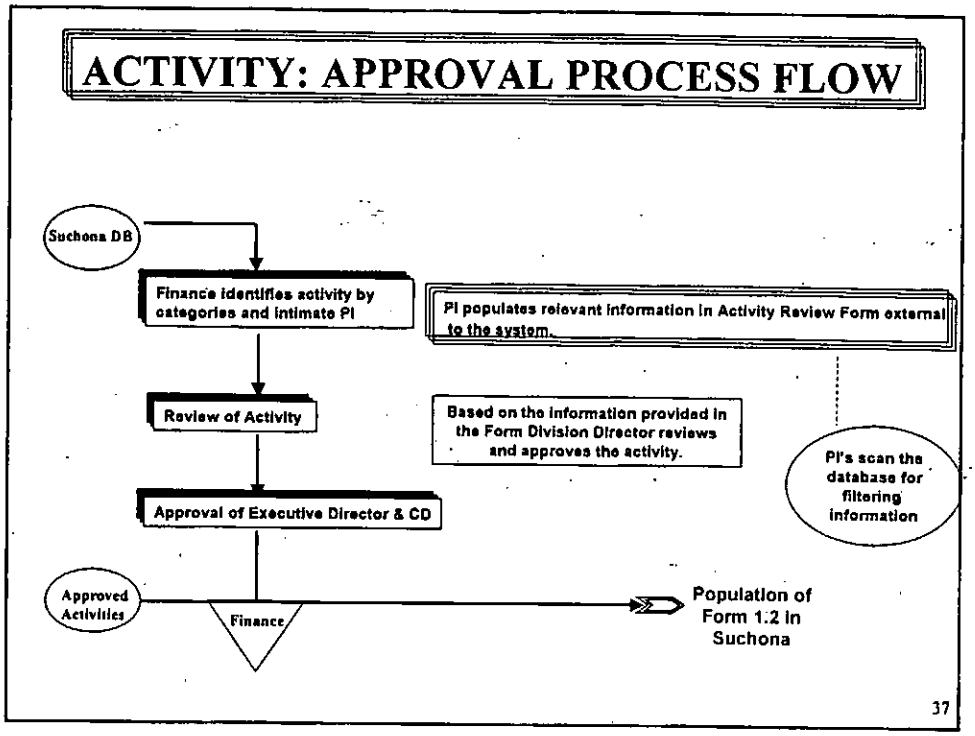
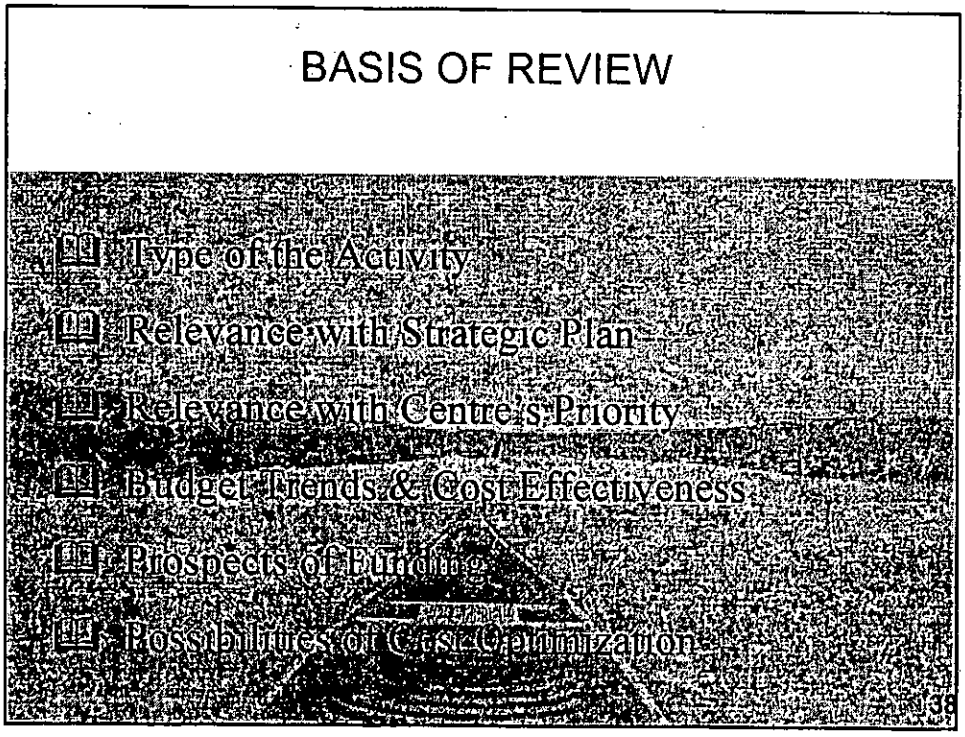
## CATEGORIES OF ACTIVITY




## INFORMATION REQUIRED




ACTIVITY: APPROVAL PROCESS FLOW
Suchona DB
Finance identifies activity by categories and intimate PI
PI populates relevant information in Activity Review Form external to the system.
Review of Activity
Based on the information providad in the Form Division Director reviews and approves the activity.
PI's scan the database for filtering information
Approval of Executive Director & CD
Approved Activities
Finance
Population of Form 1.2 in Suchona
37


BASIS OF REVIEW
Type of the Activity
Relevance with Strategic Plan
Relevance with Centre's Priority
Budget Trends & Cost Effectiveness
Prospects of Funding
Possibilities of Cost Optimization
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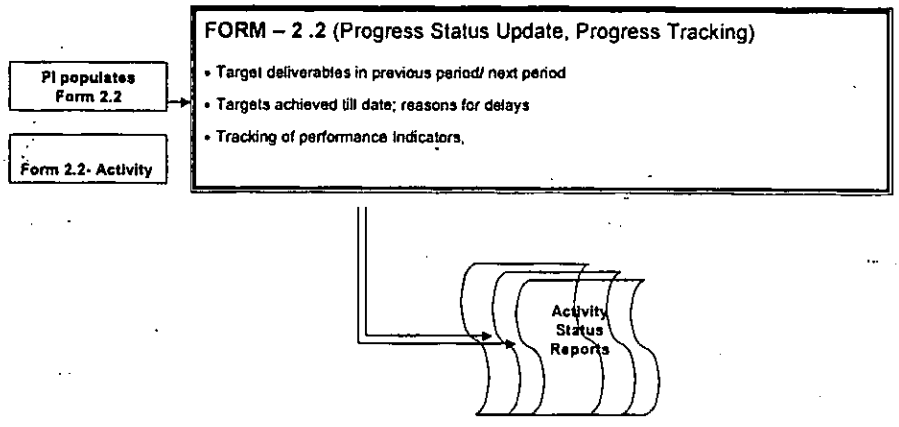
# ACTIVITY: PROGRESS TRACKING FLOW

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# Sustainability Plan- Tasks Accomplished

- Guidelines laid out based on our Strategic Plan
- Broad review of overall costs of the Center as well as that of each Division carried out
- Strategies for Cost Optimization identified based on "Best-Practices" which have relevance with our activities
- Revenue Augmentation opportunities identified in discussion with all divisions
- Draft Model Plans on Hospital and Diagnostic Lab prepared based on various options

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## Sustainability Plan- Tasks Accomplished

- Market Research completed
- Exit Interviews of Laboratory Service carried out by Health Systems & Economist Unit of HSID
- Ground work done during February and March
- Exit Interviews took place during April and May

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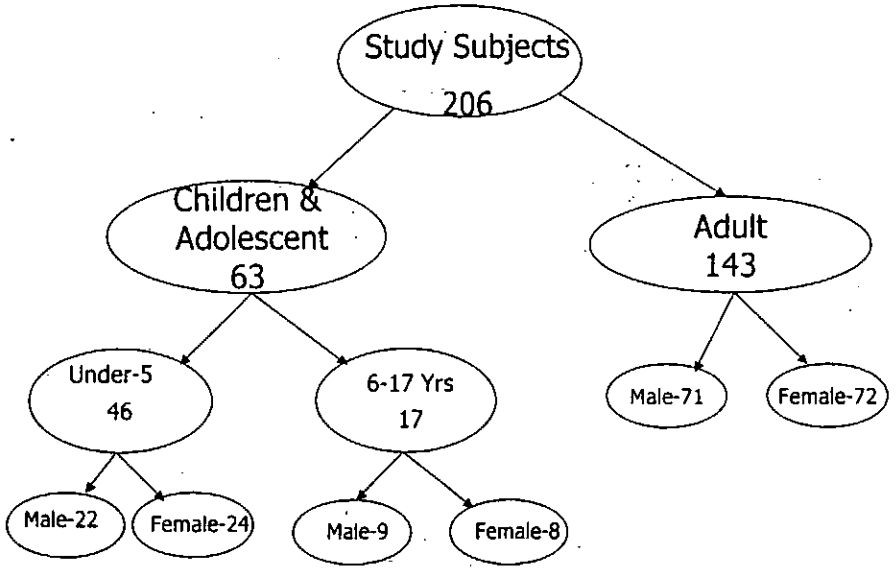
**LABORATORY SERVICES EXIT INTERVIEW**
**STUDY SUBJECTS: By age & sex**

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## Exit Interview : Findings

- Clients are mostly educated and belongs to upper strata of the society,
- Quality Factor
- Satisfied Clients
- Will be able to retain 84% of clientele if fees increase in the region 10-15%
- 75% prefer delivery of report by courier or messenger service on payment basis

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## Exit Interview : Findings

- Majority feels fees comparable with other service providers
- Feels physical facilities should be upgraded
- Missed opportunities
  - ECG, X-Rays & Ultrasound
- Prospects of growth in revenue as well as in margin
- Preference for ICDDR,B run counters near home [82%]

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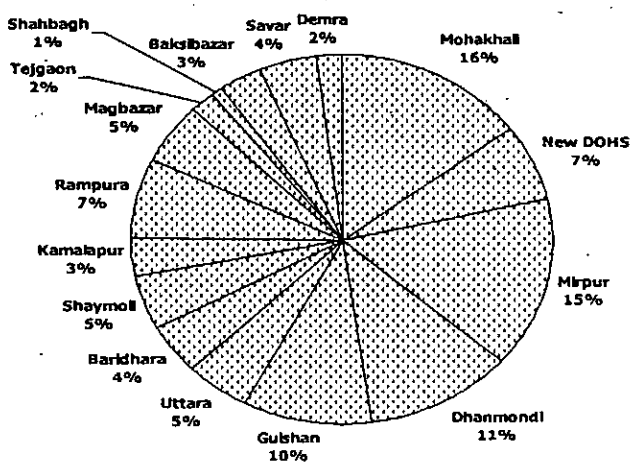
## PROPORTION OF CLIENTS BY LOCATION

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## Sustainability Plan- Way Forward

- Customize strategies for cost optimization and estimate potential savings
- Revisit the Revenue Augmentation Areas and work out feasibility
- Finalize Hospital Plan based on inputs from CSD Review and Market Research data for all the options
- Validate data obtained from Market Research and Exit Interviews of Diagnostic Lab
- Finalize Plan for Diagnostic Lab for all the options
- Identify two options in each case

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## Sustainability Plan- Way Forward

- Develop aggregate Plan at the organizational level based on all individual options
- Benchmark the plan by peer review
- Identify performance indicators for monitoring
- Built in performance indicators in "Suchona"
- Document Sustainability Plan through 2010
- Place the plan to BoT for approval
- Roll-out the approved plan in phases and monitor

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## CONCLUSION BY FINANCE COMMITTEE CHAIR

- Break-even plan –2003 implemented
- Small surplus in 2003, 5th year in a row
- $400,000 withdrawn from Endowment Fund
- 2004 forecast shows improved situation
- Endowment Funds back in the path of growth
- Integrated System in operation
- Process of determination of Essential Core has began –Activity Review
- Steps taken to form ESPF Trust
- Sustainability Plan: Market Research & Exit Interviews completed.

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6/BT/JUNE 2004

# FULL BOARD

# BOARD OF TRUSTEES
# EXECUTIVE COMMITTEE MEETING
# JUNE 2004


CENTRE
FOR HEALTH AND
POPULATION RESEARCH

## FULL BOARD
12 June 2004

**Draft**

# FULL BOARD
## Saturday 12 June 2004

**Agenda:**

| | | |
|---|---|---|
| 08:00 - 10.30 am | Approval of the Minutes<br>Discussion on November BoT Retreat | BoT, CD |
| 10.30 - 11.15 am | TEA | BoT, SC |
| 11.15 - 12.00 noon | SWA Presentation | BoT |
| 12.00 - 12:30 pm | Any Other Business<br>- Appointment to committees of the Board<br>- Extension of term of Trustee(s)<br>- Selection of new Trustees<br>- External Programme Review of the Board: ISD: June 2005 (Selection of Review Committee) | BoT |
| 12:30 - 02.00 pm | LUNCH | BoT, SC & SWA |
| 02.00 - 04.00 pm | Finalize report to Board Members | BoT, CD |
| 04.00 pm | Teleconference | BoT |
| 7:00pm | Dinner (at Heritage) | BoT, CD |

**Minutes of the Full Board Meeting**
**2 November 2003**
**Sasakawa Training Lecture Room**

A meeting of the Full Board was held on 2 November 2003 at 8.00 am in the Sasakawa Training Lecture Room.

**Present:**

Dr. Ricardo Uauy Dagach (Chair, BoT)
Dr. Kul Gautam
Prof. A K Azad Khan (Chair, Finance Committee)
Prof. Jane Kusin
Prof. Terence Hull
Dr. Claudio Lanata (Chair, HR)
Dr. Halima Ramadhan Abdullah Mwenesi
Prof. David Sack (Director, ICDDR,B)
Prof. Marcel Tanner
Prof. Carol Vlassoff (Chair, Programme Committee)
Dr. I.Kaye Wachsmuth

**Absent (with regrets):**

Mr. Mirza Tassadaq Hussain Beg
Prof. N.K. Ganguly
Dr. Maimunah Bte Abdul Hamid
Dr. Nobukatsu Ishikawa
Mr AFM Sarwar Kamal
Dr. Tikki Pang

Minutes: Loretta Saldanha

Dr. Ricardo Uauy Dagach opened the meeting.

1. **Discussions on applications for International Ranking:**

Considerable discussions were held following a review of the applications by several members of the Board as well as the process for reviewing applications. The Board specified the process it will follow to review the applicants for the Promotion of National Officer level scientists to the International Professional level. The Centre's Promotions Committee will forward a recommendation to the Chair of the Human Resources Committee according to the process outlined in the policy. The Committee will review the

recommendations and present a resolution to the Board of those approved. The BoT also requested the Centre Directorate to examine the criteria applied by the Promotions Committee in the promotion of National Officer level scientists to the International Professional level considering the variety of career path that should be recognized.

**Agenda 2: Review and Finalize Resolutions**

The Resolutions were reviewed and revised accordingly. The resolutions as finalized by the Full Board were signed by Dr. Uauy before his departure from the Centre.

**Agenda 3: Extension of Term of Board members**

The Board approved the extension of the terms of the following Board members for a second term of 3 years with effect from the date of termination of their first 3-year term:

Dr. Maimunah Bte. A Hamid
Dr. Terence H. Hull
Dr. Nobukatsu Ishikawa
Dr. Claudio Franco Lanata
Dr. I. Kaye Wachsmuth

With regard to a replacement for Prof. Carol Vlassoff, her term ending in June 2004, it was agreed that the Board and the Centre Directorate provide names of probable candidates to Dr. Sack.

Following the appointment of Professor Marcel Tanner as Chair of the Programme Committee, Prof. Vlassof's proposal, that Prof. Tanner attend the June meeting of the Executive Committee in June, was accepted.

The resolution that the Chair of the Fund Development Committee be invited to attend the June Board Meeting of the Executive Committee was noted.

**Agenda 4: Dates of the next Board meetings:**

The Board agreed to Dr. Sack's proposal to delay November Board meeting until after Eid and the June meeting to the 2nd week of June, it was agreed that:

10-13 June 2004 – Executive Committee Meeting of the Board (Phone Conference 12/13*)
25 November 2004 – BoT Retreat
26-28 November 2004 – Full Board Meeting

*to be decided.

The Full Board meeting concluded at 11.00 am

## FULL BOARD RESOLUTIONS
## 2 November 2003

**29/BT/Nov 03**

The Board approves the extension the terms of the following Board members for a second term of 3 years with effect from the date of termination of their first 3-year term.

Dr Maimunah B A Hamid
Dr Terence H Hull
Dr Nobukatsu Ishikawa
Dr Claudio Franco Lanata
Dr I Kaye Wachsmuth

**30/BT/Nov 03**

Dates of the next Board Meetings:

10-13 June 2004, Executive Committee Meeting of the BoT (Phone conference 12/13*)
25 November 2004 – BoT Retreat
26-29 November 2004 – Full Board Meeting

*to be decided

# In preparation for the Board Retreat, November 2004

The Board Retreat is intended to give the BOT an opportunity to learn more about the trends in Board Governance applied by organizations globally and how or whether such trends are readily applicable to the Centre and its BOT. The primary focus will be Basic Issues of Governance that confront like institutions in general and ICDDR,B, more specifically. In addition to understanding governance, distinguishing the roles of governance and management are key concerns of organizations. Cooperation between the management team and the BOT is best served when both Trustees and managers understand their distinctive and important roles. Our facilitator, Ms. Mary DeKuyper has identified Governance as the focal point. She is an expert on board functioning, a long time member of the U.S. Red Cross and was the facilitator for the Board retreat in 1999. Her leadership was very much appreciated by the board members at that time.

The outline / agenda reflects input from a meeting between Vanessa Brooks and Ms. DeKuyper in March, Dr. Sack's input, and review of my notes from the last retreat. During the Board meeting in June 2004, the board will review the terms of reference for the retreat and refine these and discuss them further with Ms. DeKuyper to further her preparation for the retreat agenda. Prior to the retreat, we plan to send written materials to the Board members so they will feel prepared for it.

One hope is that the retreat might result in a type of "Strategic Plan for the Board." Where does it want to be by the year 2010? What should be its makeup? What is its role? What is its style? How will it recruit future board members? What role should past board members play?

Below, is an outline for the BOT to review as a <u>first step</u> and a "guidepost" for our facilitator, Ms. DeKuyper, on how to focus the retreat. In addressing the overall question on how to improve Governance of the Centre, the BOT should review the outline and be prepared to comment on, and where necessary, modify its content.

I. Introduction
   a. Objectives of the Retreat--
      i. What do Board members want to see come out of the Retreat?
      ii. How these issues will be addressed in the Retreat.
   b. BOT Retreat in 1999 : Overview of the Observations of the Previous Board Retreat on ICDDR,B Board Strengths and Weaknesses
      i. Observations by the Trustees
      ii. Observations from the Facilitators

II. Board Governance
   a. Basic issues of Governance
   b. What is Governance?
      i. How does a board govern?
      ii. Trends is Governance
   c. BOT duties and responsibilities to the institution
      i. BOT Mandate under the Ordinance
      ii. Approaches to Problem Solving
      iii. Attitudes and Impact on the Organization's Morale
      iv. Fundraising Duties and Responsibilities

d. Identifying your strengths and weaknesses
e. If a board member has certain personal technical skills and / or opinions, are there potential conflicts between these personal interests and the duties and responsibilities as a board member?

f. A Case Study of Governance and Critical Issues That Arise: Evening Presentation

III. Issues in Governance
   a. Selecting of new Board members
      i. Criteria for Selection
      ii. The Search & Selection Process
         1. Engaging prospective Trustees in the Centre's work
         2. Garnering support from other sources
         3. How to approach prospective Trustees
         4. Prioritizing needs in the Selection Process
   b. BOT and Fundraising
   c. BOT participation in technical scientific reviews of the Centre and in the Centre's overall work
   d. Addressing Conflicts of Interests

IV. Governance v. Management
   a. Distinguishing Governance from Management
      i. What is the difference?
      ii. What management functions fall within the Board's mandate?
         1. The Ordinance
         2. Industry standards
      iii. When and under what circumstances does a Board undertake managerial tasks?
   b. Board Micromanagement of an Organization
      i. What are the indicators?
      ii. Is it ever necessary?
      iii. If so, when?
   c. General Guidelines for the BOT relationship with Management Team, Senior Staff of the Centre and the Institution as a Whole.

V. Is there life after BOT?
   a. Should some or all of the former BOT members have a role in the life of the Centre? If so, what role? Should it be formalized?
   b. Recruitment of BOT members to staff positions—does it raise conflicts?

VI. Evaluation of the Director
   a. Mechanism for providing feedback and guidance
   b. Indicators for Director performance
   c. Nurturing and selecting future directors; this may be the single most important function of a board. Is it given sufficient time and effort?
   d. At each meeting should the Board give a serious consideration of the director's performance? If the BOT feels that performance is substandard; what are the appropriate steps, and in what order?
   e. If the BOT is satisfied with the Director's performance, how can they then determine how best to support the director?

# REPORT ON BOARD OF TRUSTEES

# OF THE

# INTERNATIONAL CENTRE FOR

# DIARRHOEAL RESEARCH, BANGLADESH

# (ICDDR,B)

# GOVERNANCE SESSIONS

# NOVEMBER 4 AND 5, 1999

MARY H. DeKUYPER
CONSULTANT
DECEMBER 12, 1999

# INDEX

# INDEX - CONTINUED

# GOVERNANCE SESSIONS PARTICIPANTS

Board of Trustees

Mr. Jacques O. Martin, Switzerland (Chair of the Board)

Dr. David A. Sack, Director of ICDDR,B (Secretary of the Board)

Mr. Rolf C. Carriere, UNICEF

Prof. Rita R. Colwell, USA

Prof. Marion E. Jacobs, South Africa

Prof. A. K. Azad Khan, Bangladesh

Dr. Tawfik A. M. Khoja, Kingdom of Saudi Arabia

Prof. Peter F. McDonald, Australia

Dr. A. K. M. Masihur Rahman, Bangladesh

Dr. Tikki Pang, World Health Organization

Mr. M. M. Reza, Bangladesh

Prof. Carol Vlassoff, Canada

ICDDR,B Executive Committee

Mr. Wahabuzzaman Ahmed , Chief Financial Officer *

Prof. George Fuchs, Director of Clinical Services Division (Former Interim Director)

Prof. V. I. Mathan, Director of Laboratory Sciences Division *

Prof. Lars-Ake Persson, Director of Public Health Sciences Division *

Mr. John Winklemann, Chief Financial Officer *

Mr. Ishtiaque Zaman, Technical Cooperation Officer, External Relations and Institutional Development Office, Director's Division *

# GOVERNANCE SESSIONS PARTICIPANTS – CONTINUED

Additional Management Participants

Ms. Judith Bennett-Henry, Executive Assistant to the Director and Board of Trustees

Ms. Vanessa Brooks, Grants Administrator, External Relations and Institutional Development Office

* Participated only in the morning and briefly in afternoon session of 11/4/99.

# GOVERNANCE SESSIONS PROCESS

There had been considerable thought about the objectives and design of the Board of Trustees (BoT) governance retreat before a consultant (Mary DeKuyper) was hired. The Board Chair, Jacques Martin; Board members, Rolf Carriere and Marion Jacobs; the Interim Centre Director, George Fuchs; and the new Centre Director, David Sack had been discussing the appropriateness of a BoT governance retreat, including issues of the BoT's:

- Roles and responsibilities
- Organizational structure
- Relationship to management
- Role in fund raising
- Composition

The individuals mentioned above worked with the consultant to develop the final agenda. (See appendix, p. 20.) Another consultant (John Brown), who lives in Dhaka, was hired to assist Ms. DeKuyper. Mr. Brown will then available to work on site with Centre on any follow-up.

The first morning of the retreat (November 4th) of the retreat was designed to be a conversation about board roles and responsibilities and the board's relationship to management. The Centre's Executive Committee actively participated in the discussion.

Shortly after lunch, most of the representatives of management left the session. Remaining for the rest of the two days were Dr. Sack, Prof. Fuchs, Ms. Brooks, and Ms. Bennett-Henry. The participants discussed the various agenda items, summaries of which follow in this report. The retreat ended with assignments for future actions by the board and management. The devise of a "parking lot" was used to capture the participants' questions and concerns which were not germane to the conversation at hand or needed to be investigated after the retreat. The "parking lot" was reviewed at the end of the retreat and many of the items were added to the list of action items.

Ms. DeKuyper wrote this summary report of the retreat in order for the participants to have a record of their work. She also added a few personal observations on the retreat and the Centre's governance challenges in the future.

# SUMMARY OF RETREAT DISCUSSION

## EXPECTATIONS

The participants expressed the need to have clarity around their roles and to be able to be effective within those roles. It was perceived that it was an opportune time for the BoT to examine their governance structure, relationship with management, methods of working, and develop criteria for potential trustees. The Centre was in transition with:

- A new Centre Director was in place,
- There was an ongoing staff reorganization, and
- There were two open trustee positions, with two more to open at the end of this fiscal year.

## ROLES AND RESPONSIBILITIES OF AN EFFECTIVE BOARD AND ITS MEMBERS

- *WHAT* IS THE WORK OF THE BOARD?

  The trustees and senior management brainstormed a list of board responsibilities. (See Appendix, p. 23.) Ms. DeKuyper reviewed the "Powers and Functions of the Board" as described in the Ordinance establishing the Centre (7 (2), a through j). It was noted that there was no conflict between the list generated at the retreat and the powers delineated in the Ordinance. The Ordinance gives powers in the area of appointments of international personnel that is similar to those given to higher educational institutions but not often found in other nonprofit organizations (NGOs).

- *HOW* DO TRUSTEES FULFILL THEIR ROLES?

  The key points to consider here are:
  - The loyalty of trustees must be to the Centre as a whole. The board members must put the best interest of ICDDR,B before their own personal interest.
  - Authority is vested in the board as a whole, and no member can act for the board without express, written authority from the board. Often delegation of specific responsibilities is found in the bylaws.
  - Board members are legally responsible for board decisions whether they were present or not at the meeting where such decisions were made.
  - Board members must support all board decisions (made through consensus or formal votes) once such decisions are made.

# SUMMARY OF RETREAT DISCUSSIONS – CONTINUED

(A handout on "How Board Members Perform Their Roles" sets forth the standards described by a US Federal Judge, Gerhard Gesell and should be seen only as illustrative of good practices. See Appendix, p. 27.)

## BOARD/STAFF (MANAGEMENT) RELATIONS

The participants began with a discussion about times when the board and management worked well together. Such times seemed to have occurred when both board and management were focused on working through difficult times at the Centre. While the Centre has a Staff Welfare Association, it is important to note that the Director is *the* Patron-in-Chief for the Association and the advocate with the board for all staff, whether members of the Association or not.

It is critical for the board as a whole and officers have clear job descriptions, just as staff should have. Board committees/task forces should have focused charges, which delineate their responsibilities and limitations. Ms. DeKuyper shared one example of how policy responsibilities can be divided between the board and the executive (Director). (See Appendix, p. 28.) One should never forget that ultimately all policy development should be shared, either for information or decision making.

There was concern expressed on the role of trustees serving on external scientific reviews. The Ordinance does mandate the board to "convene" an "external Scientific Review Committee (12 (3) ). There could be a conflict of interest for those trustees serving on such a review committee, as they are not external to the ICDDR,B. The expertise of all trustees needs to be utilized by the Centre. However, this may not be the most appropriate use of such expertise.

## HOW CAN THE ICDDR,B BOARD BE ORGANIZED EFFECTIVELY?

The board needs to ask itself:

- Does the board *add* value to the Centre in ways only a board can add value?

Or

- Does the board *cost* the Centre more than it is worth – in terms of money, energy and morale?

Candid answers to these two questions can illuminate the work of the board, as well as its relationship to management, and the questions should be asked at least every other year.

There are no formulas as to what is the perfect board size, number of committees, etc. However there are some organizational principles that underlie any size or type of board. (See Appendix, p. 29.)

COMMITTEES

The Ordinance (12) sets for the following:

- *May* have an Executive Committee
- *Shall convene* an external Scientific Review Committee
- *Shall* create a Programme Coordination Committee
- *Shall* authorize an Ethical Review Committee

In addition, currently there is a Personnel and Nominating Committee and a Finance Committee.

The board needs to have sufficient committees to get its work accomplished and no more. One area to consider adding a committee could be in fund development, if the board moves actively into raising funds. (See p. 14 in this report.) Another committee that some boards in the USA have added is an Audit Committee, which serves as the link with the external auditors and exercises on behalf of the board the oversight of risk management. Many boards have begun to work mainly through task forces/groups to tackle the critical issues facing each of their organizations. These task forces can involve individuals beyond the board, such as management or other staff, clients, funders, etc., as is appropriate to the issue, and are time specific.

However the board is organized, it should be focused mainly on the critical issues that must be addressed in order for the Centre to thrive in the years ahead. As the trustees examine these issues and make decisions about them, they need to establish clear measures of success within predetermined time frames.

MEETINGS

Board meetings should be organized to facilitate in-depth discussion of critical issues and clear, appropriate decision. (See Appendix, p. 30.) The following board agenda is an example of one way to accomplish such ends.

## SUMMARY OF RETREAT DISCUSSIONS - CONTINUED

| Issues | Percentage of Board Time |
|---|---|
| Consent Agenda (Minutes, Routine Items, Approval of Auditors, etc.) | 2% |
| Reports (Opportunity for Questions, Share Items that Can Not Be Written)<br>Reports with Motions (Need Discussion Time) | 25-30% |
| Issues Discussion/Education/Training/Assessment | 50+% |
| Old Business/New Business | 5% |
| Assignments for Tasks/Action Steps Developed During the Board Meeting | 10% |
| Evaluation (What Worked at the Meeting?/What Didn't Work?) | 3% |

The Centre's board is mandated by the Ordinance to have two board meetings a year (10 (2) ). There was discussion about how to use technology for one meeting (teleconferencing?) or piggybacking on a meeting or other events where most of the trustees would be attendance any way. This could lower the expense connected to the board meetings.

INFORMATION NEEDS

Participants were asked how they felt about the amount of information they were currently receiving. The answer was "less is better." Summaries of much of the information may help cut down on the paper. The back-up material should be available to those who might need to see it.

Some boards have focused on monitoring key indicators of success at specified intervals during the fiscal year. This is also called "dashboard" oversight or "standards of excellence." The board decides what are the most critical indicators they wish to monitor – finances, quality of service, etc. – and measurements are established in order to track performance over time. (See Appendix, p. 31 for one example.)

## WHAT IS THE BOARD'S ROLE IN RASING FUNDS?

Ms. DeKuyper shared some handouts concerning the raising funds. (See Appendix, pp. 33-36.) There was considerable discussion about the legal and ethical restraints that some trustees may have in this area. Their positions with various national and international organizations/governments may prohibit their asking directly for funds. However, upon examining the many ways trustees can be involved in fund and friend raising, each trustee present agreed to become involved in this process as would be most appropriate for them. It is to be noted that the Board Chair should be commended for his act of leadership, as he was the first to commit to this activity. Before the board can get involved in raising funds in any organized manner, a clear fund raising strategy needs to be developed and fund raising professional staff needs to be hired to assist in the strategy formulation and in the support of the trustees and management in this area.

Ms. DeKuyper raised the issue of the Centre's trustees giving a personal financial contribution to ICDDR,B, as the standard in the US is for all board members to give such a gift to those nonprofits on whose boards they serve. Concern was expressed as to whether this is appropriate for the Centre's trustees or not.

There was a discussion about the performance of the current fund raising consultant, and the board decided to continue the discussion at their formal board meeting.

## BOARD DEVELOPMENT AND NOMINATING PROCESS

1. Ms. DeKuyper shared the following board development process:

- Assessment
  - Formal assessment of individual board members' performance
  - Formal self-assessment of the board by its members
  - Exit interviews of those leaving the board
  - Expertise needed to fulfill the strategic plan
- Review/update trustee job description
- Identification of criteria that are responsive to the assessment and job description
- Identification of individuals who would make excellent trustees
- Recruit new trustees
  - Who recruits? – The most appropriate individual(s). Often is a team.
  - How recruited? – Share clear expectations, honest appraisal of the

Centre's current situation (positives and negatives), future challenges. Make sure potential trustee is committed to the Centre's mission.

- Nomination and election of trustees by the board
- Orient new trustees to both the program and the governance processes
- Involve new trustees quickly in the Centre (Hard to do when meet only twice a year.)

Conflicts of interest may be personal or professional and need to be made manifest, and this can include an individual's area of research interest. Conflicts do not preclude someone from serving on a board, once they are acknowledged. In fact, individuals with conflicts may also bring expertise that is valuable to the functioning of the organization and the board. The individual who has a conflict must recuse themselves from involvement in any decision that concerns their area of conflict.

There was discussion about terms of office; particularly the need to leave the board once an individual has filled all of the terms for which he/she is eligible. The question was whether or not it was a good practice to invite someone who has left the board at the end of his/her terms to come back on the board, after the prescribed time of absence. Ms. DeKuyper stated that this does happen occasionally, but the practice needs to be used sparingly so that the perspectives brought by brand new board members can refresh the organization. However, it is also important to keep past trustees informed of the work of the Centre and as involved as one can appropriately. Ms. DeKuyper also shared the practice that some boards have instituted where they have a "probationary" year for each new trustee. At the end of that first year, if all has gone well, the new trustee becomes a term trustee and enters the standard term rotation of the board. Many boards do not automatically renew the term of under-performing trustees because they need to have every board member participating at a high level of involvement.

There was a question if it was appropriate for a board member to leave the board and join the staff and vice-versa. Ms. DeKuyper said that there is no legal reason to bar this practice, but it can cloud the delineation between board and management and may lead to inappropriate alliances between individual members of the board and management. The participants believed that at least four to six years after a trustee leaves the board would be the earliest such an individual might be considered as a potential staff member. It is truly problematical (especially for the Director) when a past Director becomes a trustee.

## SUMMARY OF RETREAT DISCUSSIONS –CONTINUED

CHARACTERISTICS/QUALITIES/QUALIFICTIONS/EXPERIENCES ICDDR,B TRUSTEES SHOULD POSSESS IN ORDER TO GOVERN/LEAD THE CENTRE IN THE NEXT THREE TO FIVE YEARS?

The Ordinance recommends the following (8 (1-4) ):

| | |
|---|---|
| ♦ Total number of board members | 16 + Director, *ex-officio* |
| ♦ LDCs (including Bangladesh) | One half to two thirds |
| ♦ GOB | Three persons |
| ♦ WHO | One person |
| ♦ UN (other than WHO) | One person (traditionally from UNICEF) |
| ♦ Members-at-large | 11 persons |
| ♦ Max from one single country (except as noted above) | 2 persons |

(Individuals qualify ..."by reason of scientific research, administration, or other appropriate experience.")

A working group of Rolf Carriere, Marion Jacobs, and Carol Vlassoff recommended the beginning of a criteria "grid" for examining potential trustees and for evaluating current trustees. (See Appendix, p. 24.) It was noted that there currently were two vacancies on the board and that two more vacancies will occur at the end of this fiscal year.

The trustees believe that board diversity is critical for effective governance of the Centre. Some of the issues discussed were:

- Geographic diversity is sought more for cultural than economic reasons and should be equitable.
- The whole person should be paramount.
- It is unhelpful to dichotomize between "scientists" and other specialists.
- Should someone from the "underprivileged" segment of society be on the board in order to have true economic diversity? Concern was expressed that appointing someone that is underprivileged could politicize the board or dilute its focus.
- Gender balance should be 50/50, and a timetable for achieving such a balance should be established. Ongoing gender sensitivity is very important in all aspects of the Centre's life.

It was noted that nominators of trustee candidates must be able to assure the board that the nominees meet the established criteria and will fit into the culture of the board.

## SUMMARY OF RETREAT DISCUSSIONS – CONTINUED

An example of a board commitment letter (See Appendix, p. 37.) was shared as illustrative of such a letter. The actual items in the letter are not meant to be suggestions for the ICDDR,B board, as the board should develop its own list of requirements that are appropriate for the Centre and its trustees.

## REVIEW OF "PARKING LOT" ISSUES

(See Appendix, p. 25 for list of parking lot items.) Most of the items that were not answered during the retreat became part of the action plan, whose formulation began at the end of the retreat. The action plans follow.

# FORMULATION OF SHORT TERM AND LONG TERM CRITICAL ISSUES AND ASSIGNMENT OF RESPONSIBLE INDIVIDUALS AND TIME FRAMES

KEY: ST = SHORT TERM
LT = LONG TERM

Words in Parens = Those Responsible When Assigned)

POSSIBILITIES OF CHANGES TO THE ORDINANCE

- Name of the Centre, as the current name does not reflect the mission and work of ICDDR,B. **LT**
- Gender language to be more inclusive or neutral **LT**
- Examine cost/benefit to opening the issue (D. Sack) **ST**

GOVERNANCE CONCERNS

- Tables of Reference for: (M. Jacobs, R. Carriere, C. Vlassoff) **ST**
  - Board as a whole
  - Committees/Task Forces (Look at establishing an Audit Committee)
  - Officers

  (Should there be remuneration of Trustees?)
- Bylaws (J. Martin, Prof. Azad, D. Sack) **ST**
  - Discover what currently exists
  - Revise, if appropriate, and have board adopt
- Board Development and Criteria for New Trustees (M. Jacobs, R. Carriere, C. Jacobs by 6/00) **ST**
  - Develop mechanisms to deal with the involvement of non-involvement in the work of the board by trustees
  - Finish the work begun at the retreat to develop criteria for potential trustees
  - Develop process for holding exit interviews with retiring trustees
  - Develop orientation process for new trustees
- Decide on whether it would be appropriate to have a generalist or specialist board or a combination (Board/management discuss, board adopts any change) **LT**
- Ethical Issues – Especially Conflict of Interest (J. Martin, D. Sack) **ST**
  - Fact finding on what exists in other international organizations, i.e. World Bank
  - Develop a code of conduct for board to adopt
  - Examine the practice of board members serving on external scientific review committees

# FORMUALATION OF SHORT TERM AND LONG TERM CRITICAL ISSUES AND ASSIGNMENT OF RESPONSIBLE INDIVIDUALS AND TIME FRAMES – CONTINUED

COMMUNICATIONS

- Develop staff communication policy within the staff and between the board and staff (D. Sack) **ST**
- Grievance Procedures, especially when the staff is unhappy with the Director – role of arbiter (J. Martin, M. Jacobs, R. Carriere, C. Vlassoff – by 6/00) **ST**
- Procedures/policies when Board Chair and Director have issues (J.Martin, M. Jacobs, R. Carriere, C. Vlassof, D. Sack) **ST**
- Clarify crisis management plan, including who speaks for the Centre, (usually the Director, unless the Director is the crisis). (D. Sack) **ST**

(An ICDDR,B board intranet will be established in the near future.)

FINANCES (D. Sack by 6/00) **ST**

- How should the board accomplish its oversight of finances?
- Develop recommendations for financial measurements and control policies

RISK MANAGEMENT (D. Sack by 6/00) **ST**

- What kind of information does the board want?
- How should the information be shared with the board?
- How can reports serve both board and management and not be burdensome to those who must produce the reports? Examine timing of reports.

ISO 9000 CERTIFICATION (Board and Management) **ST**

The Centre will seek such certification.

BOARD MEETINGS (D. Sack recommend, Board decide by 6/00) **ST**

- Number of meetings (Currently two are required by ordinance)
- Have all meetings in person and/or use technology for meetings

RESOURCE DEVELOPMENT (J. Martin appoint task force by 11/9/99) **ST**

- The role of the board and individual trustees
- Professional staffing for resource development (D. Sack)
- Decision on ending current consultant's contract (Board at 11/99 Meeting)
- Raise funds (Board and staff) **LT**

## CONSULTANT'S OBSERVATIONS

The following observations and recommendations are not in priority order.

- The Centre's board and management have been through a period of major changes. This time of transition is not over, and as such is an ideal time for both management and the board to examine how they function independently and together. I congratulate the board in recognizing this opportunity and capitalizing on it with their governance retreat. I have one word of caution, which I did share with the participants, but I believe should be mentioned again. During the time leading up to the interim directorship and during that time, the board, by necessity, played a more active role in management. This is no longer necessary, and now is the time for the board to exercise oversight of broad, institutional matters and spend time planning, along with management, for the exciting future of the Centre.

- I applaud each and every trustee participant for their agreement to assist in raising friends and funds for the Centre. Each one of them can identify potential funders, open doors, assist in developing strategies, etc. Some of them can thank donors and others can actually ask for funds directly. The Chair's leadership act of committing to work in this area certainly set the climate for such agreement.

- As a follow-up to the above paragraph, I believe that the fund raising work of the board and management needs the support of dedicated professional staff in order to greatly enlarge and diversify the Centre's funding. The Centre has a compelling story to tell, and all connected to ICDDR,B should be telling it to all they meet. However, that is only the beginning. Potential funders need to be identified, cultivated, and then asked to join with the Centre in providing the critical services and research now and into the future.
  - Do contact some development professionals, especially ones with international experience. These can be paid individuals or volunteers who have been involved as leaders in requesting funds for their organizations. Such people can help management develop the type of questions that will assist in the position description, expectations, etc. Do not forget that such an individual needs to be experienced in working with board and other volunteers in raising funds.
  - Some questions I have are:
    - Should the individual be a consultant? If yes, based where?
    - Should the individual be a member of the Centre's staff? Based where?
    - Is there a need for more than one individual? What kind of support is needed? What linkages to the rest of management?

## CONSULTANT'S OBSERVATIONS – CONTINUED

- What should be the board's fund raising structure? (I would recommend that a committee/task force be established with this specific charge. Folding fund raising into a Finance Committee often dilutes the fund development focus.) What fund raising/contribution expectations will there be for trustees, and how will that information be shared with potential trustees?
- Do not forget that any fund raising professional works with the board and management to develop strategies and then supports them in their work. Also, Development Directors can work with staff in developing grant proposals, accompany management and board to make fund raising calls, etc., but he/she should not be seen as *the* person that raises the funds.

- At some point the board, along with management, needs to decide if it is a board of scientists, who give scientific input and oversight and also govern or a board of individuals, many of whom are scientists, who govern and also provide scientific advise, when asked. I believe that the latter will make sense over the long term. The Centre will always need members from the scientific community, and it will need other experts from various fields/professions to fulfill its mission in the years ahead. The work on the desired qualities, characteristics, etc., generated during the retreat is a great starting point, as are the requirements in the Ordinance. The mission and culture of the Centre need to be reflected in the members of the board and how they are recruited and involved and in the methods of board work and interaction with the management.

- I believe the board and management would find it helpful to take the board strategic assignments and turn them (and others to be developed) into a board action plan. (See Appendix, p. 39 for one example of such a plan.) I recommend a long term, strategic plan will be developed by management and the board. This plan should include governance issues, where appropriate, as well as programmatic and financial goals.

- I would suggest that the board consider taking at least one-half day each time it meets to have a "mini-retreat." Issue discussion, education, training, and assessment could be the subject matter of such sessions. Updates on the assigned actions developed at the retreat could be the agenda at the June, 2000 board meeting, as could be developing fund raising strategies and training for raising friends and funds.

## CONSULTANT'S OBSERVATIONS - CONTINUED

- I found the candor, good listening skills, critical thinking, and support modeled during the retreat to be exemplary. Do not take such actions as a given. Continue to operate within the board and with management in a like manner, and there will be no stopping the Centre!

## WORDS OF APPRECIATION

I send thanks to all those involved at the Centre in the retreat, from the participants to the planners. I could not have gotten my work accomplished if Vanessa Brooks had not been at the other end of the e-mail "line." David Sack and George Fuchs gave great advice as Directors of the Center, as did Jacques Martin, Board Chair, and the other members of the board who were involved in the planning (Rolf Carriere and Marion Jacobs). Everyone was flexible, as we worked on the design right up to the day before the retreat.

I also send thanks to my co-facilitator, John Brown, whose expertise in facilitation and knowledge of international organizations and Bangladesh were invaluable. He made my work so much easier, as I knew he was there, listening actively and prepared to summarize the work as we went along. His notes of the retreat are the skeletal framework of this report, and he should be viewed as the "co-author."

Finally, I send my thanks to all those who work at the Centre. My tour of the Center with David Sack gave life to the written descriptions of the work of ICDDR,B. You all are about critical work, not only for Bangladesh but also for the world, and it has been an honor to play even a small part in furthering the Centre's mission.

Mary H. DeKuyper
December, 12, 1999

# APPENDIX

# ICDDR, B BOARD OF TRUSTEES RETREAT

## AGENDA

## NOVEMBER 4, 1999 MORNING SESSION

- **Opening – Introductions**
- **Expectations for the Retreat**
- **Overview of the Roles and Responsibilities of An Effective Board and its Members**
  - *What* is the work of the board?
  - *How* do trustees fulfill their governance role?
- **Board/Staff (Management) Relations**
  - Questions:
    - Tell us about a time when the board and management were working at their best together. What enabled that to happen?
    - What do we (board and management) need to do to make the relationship consistently better?
- **Job Descriptions for the Board**
  - Board Members
  - Officers
  - Committees
  - Others?
- **What is Policy?**

## NOVEMBER 4, 1999 AFTERNOON SESSION AND NOVEMBER 5, 1999 MORNING SESSION

- **How Can the ICDDR,B Board be Organized More Effectively?**
  - Structure (Size of Board, Standing and Other Committees, Task Forces, Others to Involve with the Board's Work)
  - Meetings (Frequency, Location, Agenda, Preparation for)
  - Use of Technology to Accomplish Work

- **What is the Board's Role in Raising Funds?**
  - Should all trustees be involved in raising funds?
  - If yes, how can they be involved?
    - Methods of Fund and Friend Raising
    - Need for Training
    - Current and Potential Relationship with Funders
    - Relationship to Staff in Raising Funds
    - Staffing of Board Fund Raising Sctivities
    - Other Staff Work in Raising Funds

- **Board Development (More than Nominating) Process**
  - Who should Manage the Process?
  - Identification
  - Cultivation
  - Recruitment – who should make the ask?
  - Orientation and Training

- **Succession Planning – Thinking about the Process to Assure Future Leadership**

- **Who Should Be at the Table in Order for the Board to be Most Effective in Furthering the Mission of ICDDR,B?**
  - Identification of characteristics/qualifications of potential trustees
  - Identification of individuals meeting the criteria, if possible

## NOVEMBER 5, 1999 AFTERNOON AND EARLY EVENING SESSION

- **Where Do We Go From Here?**
  - Develop list of strategic issues (What must ICDDR,B do to thrive?)
  - What is the board's role in such issues?
  - Assign individuals responsible for issues, with time frames, if possible

- **Fact Finding Going Forward**
  - What would you like to know about/from the Centre's stakeholders?
  - How can the Centre assist in developing the information?

- **Wrap-up**

# LIST OF BOARD DUTIES (GENERATED AT THE RETREAT BY TRUSTEES AND SENIOR MANAGEMENT

1. Approves the Center's budget
2. Recruits and appoints the Director
3. Trouble shoots (makes sure that problems are identified and addressed)
4. Identifies the Centre's needs
5. Approves Centre policies
6. Shares board member expertise with the Centre
7. Assists in fund raising
8. Can act as a scapegoat
9. Sounding board for the Director
10. Ambassadors for the Centre
11. Approves Centre management positions
12. Watchdogs (See #3)
13. Responsible for the financial well-being of the Centre
14. GOB partners
15. Responsible for the sustainability of the Centre (personnel, financing, etc.)
16. Ensures that there are ethical reviews of Centre's work
17. Ensures that appropriate policies, procedures, etc. are in place
18. Guards the Centre's international focus and promotes its uniqueness
19. Communicates with financial stakeholders
20. Is informed about (relevant) world issues
21. Members facilitate the Centre's value in international forums

Added by Mary

22. The board is accountable for all financial matters
23. The board defines the role of the board and management and operates within that definition
24. Ensures compliance with applicable laws and regulations
25. Ensures that there are appropriate risk management controls and financial policies
26. Ensures that there is a suitable code of conduct

# WORKING GROUP'S DRAFT OF MATRIX OF BOARD MEMBER RESOURCES

(Rolf Carriere, Marion Jacobs, Carol Vlassoff)

| QUALITY | NUMBER OF BOARD MEMBES WHO HAVE THE QUALITY (MXIMUM = 11) | |
|---|---|---|
| | QUALITY IS PRESENT | QUALITY IS STRONGLY REPRESENTED |
| ◆ Fund Raising | 7 | 6 |
| ◆ Communications | 9 | 3 |
| ◆ Governance | 8 | 3 |
| ◆ Human Resources | 9 | 2 |
| ◆ Leadership | 8 | 3 |
| ◆ Courage/Toughness | 8 | 1 + 3 |
| ◆ Information Technology | 1 | 0 |
| ◆ Trans-disciplinary | 9 | 1 |
| ◆ Global Mind | 7 | 2 |
| ◆ Gender Sensitivity | 9 | 2 |
| ◆ Culture | 9 | 4 |
| ◆ Team-working | 10 | 10 |
| ◆ Empathy/Listening Skills | 9 | 9 |
| ◆ Big Picture | 9 | 2 |

## THE CONCLUSIONS DRAWN WERE:

Board Weaknesses

- IT
- Entrepreneurism
- Diversity of Representation
- Meeting/Discussion Skills
- Institutional Memory

Board Strengths

- Fund Raising Skills
- Finance Skills
- Overall – AAA

Comments

- The Working Group's intuitions should be checked with a matrix structured to check members' perceptions of both self and all others (not personalized).
- The grid may need to be expanded, and certainly will be amended along the way, as the needs of the board and the Centre change over time.

## PARKING LOT ISSUES
(Slightly Annotated)

- Ways of Communication
- How BoT Members are Nominated
- TORs for Committees (Committees vs Task Forces which may cross-cut traditional committee mandates)
- Ordinance Issues
  - Centre's Name
  - Gender Language (In Ordinance, other documents, board deliberations)
  - Check Ordinance for whether or not the Board "receives, accepts, approves, adopts," a report (M.DeK recommends only adopting motions from reports. Financial reports can be noted and then "filed for audit." Having in the minutes that the report was given records the fact without committing the board to an opinion as to their validity.)
- Board Self-Monitoring
- Intellectual Property ***
- Rules for Communication with the Media
- Legal Recourses (Whose laws?) ***
- Staff Communication Policies
- Arbiter
- Review the Bylaws
- Crisis Management
- Ethical Issues, including Potential Trustee Conflict of Interest re: External Reviews

*** Not included in the strategic issues and not assigned in any other manner

NTRE
HEALTH AND
TION RESEARCH

# Staff Welfare Association

**International Centre for Diarrhoeal Disease Research, Bangladesh**
**(CENTRE FOR HEALTH AND POPULATION RESEARCH)**
**Mail: ICDDR,B GPO Box 128, Dhaka 1000, Bangladesh**
**Phone: 880-2-8811751-9; Ex: 2129. Fax: 880-2-882316, 8811568**

## Representation to the ICDDR,B Board of Trustees' meeting: June 2004

Honourable Chairperson of the Board of Trustees Professor Ricardo Uauy Dagach, Trustees, Professor David A Sack, Executive Director, ICDDR,B and Patron in Chief, ICDDR,B Staff Welfare Association- *Assalamu Alaikum* and Very Good Morning.

On behalf of all members of ICDDR,B Staff Welfare Association (SWA) we extend our hearty welcome to you all to the June 2004 Board of Trustees' (BoT) meeting.

We are very grateful to all of you and express our gratitude for allowing us to place our demands before you-- some are very old and some are new – for your sympathetic consideration.

1. **Local staff salary:** Since the introduction of the UN pay scale in the Centre, almost 20 (twenty) years ago the issue still remains unresolved. Local staff members are paid about 45% (average) only of the UN scale. This type of deprivation is lowering the morale of local staff members day by day.

   We would, therefore, request your honour to resolve the issue on a top priority basis so that the local staff members can get their 100% of UN comparable salary with immediate effect.

2. **Retirement age:** Currently, local staff members retire from the job at the age of 60 (sixty) years while in other UN agencies the retirement age is 62 years. We, therefore, request your honour to review this issue to increase the retirement age of local staff members to 62 (sixty two) years.

3. **Dependent allowances:** ICDDR,B staff receives medical support and allowances for their dependent children up to 21 years. Kindly note that, at this age most dependent children still remain students in their last stage of education, which is relatively more expensive than childhood education. We, therefore, strongly urge you to increase the age limit of dependent children to 25 years for availing of dependent and medical allowances. At the same time, we would also request you to increase the amount of children allowance from Tk.750.00 to Tk. 1,000.00 to meet the cost of education of dependent children.

4. **Per diem for medical evacuation staff members:** ICDDR,B provides medical support to staff members. However, critically ill staff members need to be evacuated for better treatment. Considering the financial constrain to the Centre, SWA established a Medical Assistance Fund (MAF) and has been extending financial support to those staff members

who need such evacuation. SWA can support the travel/airfare money only from the MAF. We would, therefore, request our honourable Board members and the Executive Director of the Centre to grant per diem at a different rate for a fixed period of maximum 7 (seven) days during evacuative period. This would help the evacuated staff members to meet other additional expenses such as accommodation, transportation etc.

5. **Field allowances:** There is no doubt that Matlab Field station of ICDDR,B is a unique research "field station" in the world and is contributing to improving public health in developing countries which was only possible due to hard work of staff members of Matlab Field Station, now known as Matlab Health Research Centre (MHRC). The MHRC staff members work in the community under different adverse conditions, such as severe heat, rain, cold. They walk kilometers after kilometers for data collection for research purposes and, thus, their working environment is different from those who work in the office environment. It was, therefore, a long-standing demand of staff members of MHRC to get "Field Allowance". On this issue, SWA humbly requests the supreme authority of ICDDR,B to consider a "hardship allowance" or a "field allowance" for MHRC staff members considering the nature of the work.

6. **Temporary financial support**: Due to high living costs, high education cost (private educational institutions), and other additional expenses, such as daughter's marriage ceremony, purchasing land for building a residential house or for paying a down payment for purchasing an apartment, etc., staff members need temporary financial support. In this regard SWA requests the management to establish a provision so that like National Officer (NO) level staff members car loan, GS level staff are also able to get a loan of maximum 2.5 lac repayable in 60 equal installments at an interest rate of 6% annually. Such a financial help would improve the quality of life of GS level staff members.

7. **An appeal for most senior staff members of the Centre**: We would like to make an appeal to the supreme authority, including local management, by bringing your attention to about those staff members who are working in the Centre for more than 25 years and without any change of grade in their life time, and are preparing themselves for retirement within 2-3 years. We would urge you to kindly give a grade rise as a gesture of their continued contribution to ICDDR,B.

In the conclusion we would like to say that, to uphold the morale of local staff and for the sake of justice, we would request our honourable board members and the management of the Centre to review the above matters for implementation at the earliest.

Warm regards,

11.05.04

Dr. Md. Shahadat Hossain
President,
ICDDR,B Staff Welfare Association

## APPOINTMENTS TO COMMITTEES OF THE BOARD
## JUNE 2004

The following membership on the various committees is proposed for a 2-year term, instead of a 1-year term as in the past, since henceforth the Full Board will meet on a yearly basis.

| | | |
|---|---|---|
| Dr. Ricardo Uauy Dagach | - | Chair, BoT |
| Dr. David A Sack | | Executive Director (ex-officio) |

Chair, BoT and Executive Director, ICDDR,B will remain as ex-officio members on the Committees.

**Programme Committee:**

| | | |
|---|---|---|
| Professor Marcel Tanner | - | Chair |
| Prof. Jane Anita Kusin | | Deputy |

**Human Resources:**

| | | |
|---|---|---|
| Dr. Claudio Lanata | - | Chair |
| Prof. Terrence Hull | | Deputy |

**Finance:**

| | | |
|---|---|---|
| Professor A. K. Azad Khan | - | Chair |

**National Liaison:**

| | | |
|---|---|---|
| Mr AFM Sarwar Kamal | - | Chair |
| Prof. Azad Khan | | Deputy (also Chair of Finance Committee) |

**Fund Development:**

| | | |
|---|---|---|
| Dr. Kul Gautam | - | Chair |

**Deputy and members to be nominated from list below:**

| | |
|---|---|
| Dr. Maimunah Bte Abdul Hamid | Dr. Tikki Pang |
| Dr. Nobukatsu Ishikawa | Dr. Kaye Wachsmuth |
| Prof. NK Ganguly | Mr. Mirza Tasadduq Hussain Beg |
| Dr. Halima A Mwenesi | (Replacement of Prof. Carol Vlassoff) |

## APPOINTMENTS TO COMMITTEES OF THE BOARD

**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

## Chairpersons of the Board of Trustees

Chairpersons of the Board, to date, are as follows:

| | |
|---|---|
| Dr J. Sulianti Saroso | 1979-80 and 1980-81 |
| Prof. M.A. Matin | 1981-82 |
| Prof. D.J. Bradley | 1982-83 |
| Prof. J. Kostrzewski | 1983-84 |
| Dr. I. Cornaz | 1984-85 |
| Prof. D. Bell | 1985-86, 1986-87, 1987-88 |
| Prof. D. Rowley | 1988-89 |
| Dr P. Sumbung | 1989-90, 1990-91, 1991-92 |
| Dr D. Ashley | 1992-93 |
| Dr. M. Law | 1993-94, 1994-95, 1995-96, 1996-97 |
| Mr. J. Martin | 1997-98, 1998-99, 1999-2000 |
| Prof Marian E Jacobs | Nov 2000-June 2002 |
| Dr Ricardo Uauy Dagach | July 2002-June 2005 |

## Selection of members of the Board of Trustees

**Action Required**

1. For extension (end of first term):

    a. Dr Marcel Tanner

2. To consider replacement of 1 Board member (end of 2 terms):

    a. Prof Carol Vlassoff
    (Two nominations received)

## LIST OF BOARD MEMBERS
## WITH NATIONALITY, DISCIPLINE, JOINING AND ENDING DATES
(As at June 2004)

| Name | Country | Discipline | Joining/Ending date |
|---|---|---|---|
| Mr M Tasadduq Hussain Beg | Bangladesh (GoB) | Civil Servant | Aug 2003/Jul 2006 |
| Dr Ricardo Uauy Dagach | Chile | Nutrition | Jul 1999/Jun 2005* |
| Prof N K Ganguly | India | Public Health & Nutrition | Jul 2000/Jun 2006* |
| Dr Kul Gautam | UNICEF | Management/ | July 2003/Jun 2006 |
| Dr Maimunah B A Hamid | Malaysia | Public Health | Jul 2001/Jun 2007* |
| Dr Terence H Hull | Australia | Demography | Jul 2001/Jun 2007* |
| Dr Nobukatsu Ishikawa | Japan | Social Medicine | Jan 2001/Dec 2006* |
| Prof AK Azad Khan | Bangladesh (GoB) | Gastroenterology | Sep 1999/Aug 2005* |
| Prof Jane Anita Kusin | Netherlands | Public Health & Nutrition | Jul 2000/ Jun 2006* |
| Dr Claudio Franco Lanata | Peru | Nutrition/ Epidemiology | Jan 2001/Dec 2006* |
| Prof Tikki Pang | WHO | Infectious Disease, Research & Policy | Jun 1999/May 2005* |
| Mr AFM Sarwar Kamal | Bangladesh (GoB) | Civil Servant | Sep 2003/Aug 2006 |
| Prof David A Sack | USA | Infectious Diseases | Oct 1999/Sept 2005 |
| Dr Marcel Tanner | Switzerland | Tropical Medicine | Jan 2001/Dec 2003** |
| Prof Carol Vlassoff | Canada | Public Health Trop. Diseases | Jul 1998/Jun 2004* |
| Dr I Kaye Wachsmuth | USA | Public Health & Sci. | Jul 2001/Jun 2007* |
| Dr. Halima R.A. Mwenesi | Kenya | Sociology/Tropical diseases | Jul 2003/Jun 2006 |

**Unable to serve another term without a break*
*** For extension*

Target membership: 11 members at large
3 GoB
1 Director, ICDDR,B
1 UN
1 WHO

Total: 17 members

Current composition:

| Developed Country | Region | Developing Country | Region |
|---|---|---|---|
| David A Sack (USA) Director | Nth America | AK Azad Khan (BD) | Asia |
| I Kaye Wachsmuth (USA) | Nth America | M Tasadduq Hussain Beg (BD) | Asia |
| Terence H Hull (Australia) | Pacific | AFM Sarwar Kamal (BD) | Asia |
| Jane Anita Kusin (Netherlands) | Europe | Claudio Franco Lanta (Peru) | S. Am |
| Marcel Tanner (Switzerland) | Europe | NK Ganguly (India) | Asia |
| Nobukatsu Ishikawa (Japan) | Asia | Maimunah BA Hamid (Malaysia) | Asia |
| Carol Vlassoff (Canada) | Nth America | Ricardo U Dagach (Chile) | S.Am/Carib |
| | | Dr. Halima R.A. Mwenesi | Africa |

UNICEF: Dr Kul Gautam
WHO : Prof Tikki Pang

Total: 7 Total: 8

Total: 17

Of 15 (excluding WHO and UNICEF) more than 50% must be from developing countries (including Bangladesh). Not less than 1/3 from developed countries.

As per above table:

8/15 (53.33%) are from developing countries (50%=8)
7/15 (46.67%) are from developed countries (2/3=7)

Gender: M=12
F= 05

BD = Bangladesh

**Ordinance 8 (3):** At any given time, the Board shall be so composed that, not counting the members nominated by the World Health Organization, more than 50% must come from the developing countries, including the members nominated by Bangladesh, and not less than one-third from developed countries. The Director shall be counted as coming from the developed or developing countries depending upon nationality.

A letter requesting nominations was sent to:

1. Donors
2. BoT Members
3. Ex-Board members
4. Individuals

Two nominations have so far been received:

1. Dr. Peter Tugwell

2. Dr. Tim Evans

CIDA, Dhaka suggested the following names:

1. Ms. Margaret Catley-Carlson, Chair of the Global Water Partnership, Sweden.
2. Ms. Margaret Hilson, Director, International Programs of the Canadian Public Health Association (CPHA)
3. Mr. M.G. Venkatesh Mannar, President, The Micro Nutrient Initiative, 250 Albert Street, Ottawa, ON Canada
4. Dr. Peter Tugwell, Senior Faculty in the University of Ottawa and also a Co-Director of WHO Collaborating Centre of Health Technology Assessment in Canada.
5. Mr. David Zakus, Director, Centre for International Health, University of Toronto Associate Professor, Departments of Health Policy, Management and Evaluation and Public Health Sciences, Faculty of Medicine, University of Toronto.

Mr. Robert Beadle, CIDA Dhaka contacted Ms. Margaret Catley-Carlson (also recommended by Prof. Carol Vlassoff), who has declined.

CV's are attached:

1. Dr. Peter Tugwell
2. Dr. Tim Evans

## Selection of members of the Board of Trustees

**Action Required**

1. For extension (end of first term):

    a. Dr Marcel Tanner

2. To consider replacement of 1 Board member (end of 2 terms):

    a. Prof Carol Vlassoff
    (Two nominations received)

# LIST OF BOARD MEMBERS
# WITH NATIONALITY, DISCIPLINE, JOINING AND ENDING DATES
(As at June 2004)

| Name | Country | Discipline | Joining/Ending date |
|---|---|---|---|
| Mr M Tasadduq Hussain Beg | Bangladesh (GoB) | Civil Servant | Aug 2003/Jul 2006 |
| Dr Ricardo Uauy Dagach | Chile | Nutrition | Jul 1999/Jun 2005* |
| Prof N K Ganguly | India | Public Health & Nutrition | Jul 2000/Jun 2006* |
| Dr Kul Gautam | UNICEF | Management/ | July 2003/Jun 2006 |
| Dr Maimunah B A Hamid | Malaysia | Public Health | Jul 2001/Jun 2007* |
| Dr Terence H Hull | Australia | Demography | Jul 2001/Jun 2007* |
| Dr Nobukatsu Ishikawa | Japan | Social Medicine | Jan 2001/Dec 2006* |
| Prof AK Azad Khan | Bangladesh (GoB) | Gastroenterology | Sep 1999/Aug 2005* |
| Prof Jane Anita Kusin | Netherlands | Public Health & Nutrition | Jul 2000/ Jun 2006* |
| Dr Claudio Franco Lanata | Peru | Nutrition/ Epidemiology | Jan 2001/Dec 2006* |
| Prof Tikki Pang | WHO | Infectious Disease, Research & Policy | Jun 1999/May 2005* |
| Mr AFM Sarwar Kamal | Bangladesh (GoB) | Civil Servant | Sep 2003/Aug 2006 |
| Prof David A Sack | USA | Infectious Diseases | Oct 1999/Sept 2005 |
| Dr Marcel Tanner | Switzerland | Tropical Medicine | Jan 2001/Dec 2003** |
| Prof Carol Vlassoff | Canada | Public Health Trop. Diseases | Jul 1998/Jun 2004* |
| Dr I Kaye Wachsmuth | USA | Public Health & Sci. | Jul 2001/Jun 2007* |
| Dr. Halima R.A. Mwenesi | Kenya | Sociology/Tropical diseases | Jul 2003/Jun 2006 |

**Unable to serve another term without a break*
*** For extension*

Target membership: 11 members at large
3 GoB
1 Director, ICDDR,B
1 UN
1 WHO

Total: 17 members

Current composition:

| Developed Country | Region | Developing Country | Region |
|---|---|---|---|
| David A Sack (USA) Director | Nth America | AK Azad Khan (BD) | Asia |
| I Kaye Wachsmuth (USA) | Nth America | M Tasadduq Hussain Beg (BD) | Asia |
| Terence H Hull (Australia) | Pacific | AFM Sarwar Kamal (BD) | Asia |
| Jane Anita Kusin (Netherlands) | Europe | Claudio Franco Lanta (Peru) | S. Am |
| Marcel Tanner (Switzerland) | Europe | NK Ganguly (India) | Asia |
| Nobukatsu Ishikawa (Japan) | Asia | Maimunah BA Hamid (Malaysia) | Asia |
| Carol Vlassoff (Canada) | Nth America | Ricardo U Dagach (Chile) | S.Am/Carib |
| | | Dr. Halima R.A. Mwenesi | Africa |

UNICEF: Dr Kul Gautam
WHO : Prof Tikki Pang

Total: 7 Total: 8

Total: 17

Of 15 (excluding WHO and UNICEF) more than 50% must be from developing countries (including Bangladesh). Not less than 1/3 from developed countries.

As per above table:

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7/15 (46.67%) are from developed countries (2/3=7)

Gender: M=12
F= 05

BD = Bangladesh

**Ordinance 8 (3):** At any given time, the Board shall be so composed that, not counting the members nominated by the World Health Organization, more than 50% must come from the developing countries, including the members nominated by Bangladesh, and not less than one-third from developed countries. The Director shall be counted as coming from the developed or developing countries depending upon nationality.

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2. Dr. Tim Evans

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2. Ms. Margaret Hilson, Director, International Programs of the Canadian Public Health Association (CPHA)
3. Mr. M.G. Venkatesh Mannar, President, The Micro Nutrient Initiative, 250 Albert Street, Ottawa, ON Canada
4. Dr. Peter Tugwell, Senior Faculty in the University of Ottawa and also a Co-Director of WHO Collaborating Centre of Health Technology Assessment in Canada.
5. Mr. David Zakus, Director, Centre for International Health, University of Toronto Associate Professor, Departments of Health Policy, Management and Evaluation and Public Health Sciences, Faculty of Medicine, University of Toronto.

Mr. Robert Beadle, CIDA Dhaka contacted Ms. Margaret Catley-Carlson (also recommended by Prof. Carol Vlassoff), who has declined.

CV's are attached:

1. Dr. Peter Tugwell
2. Dr. Tim Evans

## Dr. David Sack

**From:** "David A Sack, MD" <dsack@icddrb.org>
**To:** "Liz Lacasse" <elacasse@uottawa.ca>
**Sent:** Thursday, April 08, 2004 3:34 PM

Dear Dr.Tugwell:

I wanted to indicate that I am personally very pleased with your willingness to join the Board of Trustees at ICDDR,B. Our next Board meeting is in mid-June and since the sitting members select the new members, we'll be back in touch with your shortly after this meeting.

Best regards,

David
David A. Sack, MD
Executive Director, ICDDR,B
GPO Box 128
Dhaka 1000, Bangladesh
880-2-882-3031 (office telephone)
880-2-882-3116 (fax in Dhaka)
1-208-955-4437 (fax in USA in Dhaka)
dsack@icddrb.org

International Centre for Diarrhoeal Disease Research, Bangladesh
CENTRE FOR HEALTH AND POPULATION RESEARCH
Mail : ICDDR, B, GPO Box 128, Dhaka-1000, Bangladesh
Phone: 880-2-8811751-60, Telex : 642486 ICDD BJ
Fax : 880-2-8823116, 8812530, 8811568, 8826050, 9885657, 8811686, 8812529
Cable : Cholera Dhaka

29 February 2004

Dr. David Sack
Executive Director,
Centre for Health & Population Research

Dear Dr. Sack,

This is in reference to your request to recommend one-or-more Canadians who might be considered to join the Centre's Board of Trustees (BoT). I would like to formally propose Dr. Peter Tugwell as a candidate. Dr. Tugwell is an internationally renowned scientist with vast experience in global health. He is a co-founder of the Canadian Society for International Health and has been a steadfast advocate for the health of people living under poverty and in least advantaged environments. I can strongly recommend Dr. Tugwell. He would make a tremendous addition to the BoT.

Sincerely,

Dr. Charles Larson
Acting Director
HSID Division

## Md. Shah Alam

**From:** David A Sack, MD [dsack@icddrb.org]
**Sent:** Sunday, February 29, 2004 8:45 AM
**To:** shahalam@icddrb.org
**Subject:** Fw: Dr. Peter Tugwell

----- Original Message -----
**From:** Liz Lacasse
**To:** dsack@icddrb.org
**Sent:** Friday, February 27, 2004 4:57 AM
**Subject:** Dr. Peter Tugwell

Please confirm receipt of the attached letter and Dr. Tugwell's CV.

*Liz Lacasse, Executive Assistant to:*
*Dr. Peter Tugwell*
*Canada Research Chair in Health Equity*
*Director,*
*Centre for Global Health*
*University of Ottawa*
*Institute of Population Health*
*1 Stewart St.*
*Room 202*
*Ottawa, Ontario K1N 6N5*
*Tel:613 562-5800 ext 1945 Fax:613 562-5659*
*email: elacasse@uottawa.ca*

University of Ottawa Université d'Ottawa

**Institute of Population Health**
*Institut de recherche sur la santé des populations*

February 25, 2004

Dr. David A. Sack, Director
International Centre for Diarrhoeal Disease Research
Centre for Health & Population Research
ICDDR, B, GPO Box 128
Dhaka-1000, Bangladesh

Dear Dr. Sack,

I am very honoured to be nominated to join the Board.

I am very interested in serving on the Board. Please find attached my Curriculum Vitae. If you have any questions or require anything further, please do not hesitate to contact me.

Sincerely,

Peter Tugwell, MD, MSc, FRCPC
Director, Centre for Global Health
Phone: 1 613 562-5800 xt 1945
Fax: 1 613 562-5346

*1 Stewart, 3d Floor / 3ième étage*
*Ottawa, Ontario K1N 6N5 Canada*

# CURRICULUM VITAE

| | | |
|---|---|---|
| NAME: | PETER TUGWELL | |
| NATIONALITY: | Citizenship - Canadian and British | |
| MARITAL STATUS: | Married | |
| DATE OF BIRTH: | March 30, 1944 | |
| MEDICAL SCHOOL: | Royal Free Hospital Medical School<br>London University, London, England | |
| QUALIFICATIONS: | M.R.C.S., L.R.C.P. | - 1969 |
| | M.B.B.S. (London) | - 1969 |
| | M.R.C.P. (UK) | - 1971 |
| | L.M.C.C. | - 1976 |
| | M.D. (London) | - 1976 |
| | F.L.E.X. (Michigan) | - 1976 |
| | F.R.C.P.C. | - 1976 |
| | M.Sc.(Clinical Epidemiology) | - 1977 |
| | F.A.C.P. | - 1984 |
| | F.R.C.P. (UK) | - 1987 |

APPOINTMENTS:

| | |
|---|---|
| July - Dec. 1969 | Royal Free Hospital, London, England House Physician to Medical Unit (Dr. N. McIntyre and Prof. S. Sherlock). |
| Jan. - June 1970 | West Middlesex Hospital, London, England, House Surgeon to Mr. I. Cour- Palais. |
| July - Dec. 1970 | Whittington Hospital, London, England Post Registration House Physician to Dr. B. Hoffbrand. |
| Jan. - Oct. 1971 | Whittington Hospital, London, England Sr. House Physician to Dr. P.D.B. Davis. |
| Oct. 1971 - Sept. 1972 | Ahmadu Bello University Hospital, Zaria, Nigeria. Registrar in Medicine to Prof. E.H.O. Parry. |
| Oct. 1972 - July 1974 | Ahmadu Bello University Hospital, Zaria, Nigeria. Clinical Research Registrar to Prof. E.H.O. Parry. |
| July 1975 - July 1976 | McMaster University, Chief Resident in Internal Medicine. |
| July 1976 - June 1977 | McMaster University, Clinical Fellow in Rheumatology. |
| July 1977 - June 1980 | Assistant Prof. in Department of Clinical Epidemiology and Biostatistics, and Dept. of Medicine, McMaster University. |
| July 1977 - June 1991 | Attending Physician, Division of Rheumatology, Chedoke-McMaster Hospital. |
| July 1978 - June 1979 | Provincial Health Research Scientist. |
| July 1979 - June 1989 | Chairman, Dept. of Clinical Epidemiology and Biostatistics, McMaster University. |
| July 1980 - June 1984 | Associate Prof. Dept. of Clinical Epidemiology and Biostatistics, McMaster University. |
| July 1984 - June 1991 | Professor, Dept. of Clinical Epidemiology and Biostatistics and Dept. of Medicine, McMaster University. |
| Nov. 1984 - May 1985 | Visiting Professor, University of Sydney, Australia. |
| May 1987 - June 1991 | Director and Regional Coordinator for McMaster Regional Rheumatology Program. |
| Dec. 1988 - June 1991 | Chief of Internal Medicine, Chedoke Hospital, Chedoke-McMaster Hospitals; Head of Rheumatology, Chedoke-McMaster Hospitals. |
| July 1989 - June 1991 | Director of McMaster Centre for Arthritic Diseases. |
| Jan 1990 - July 1991 | Director, Rheumatology Day Hospital, Chedoke Hospital, Chedoke-McMaster Hospitals. |
| July 1991 - July 2001 | Head & Corporate Medical Director, Department of Medicine, Ottawa General Hospital and since 1998 the Ottawa Hospital. |

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|---|---|
| July 1991 - July 2001 | Professor and Chairman, Department of Medicine, University of Ottawa. |
| July 2001- present | Director, Centre for Global Health, Institute of Population Health, University of Ottawa |
| Jan 2002 - 2009 | Canada Research Chair |

NATIONAL/INTERNATIONAL COMMITTEES:

| | |
|---|---|
| 1977 - 1982 | Member, Demonstration Model Grants Review Committee, Ministry of Health, Ontario. |
| 1977 - 1979 | Chairman, Regional Service Program, McMaster University. |
| 1979 - 1982 | Member, Ontario Council of Health Task Force on High Technology. |
| 1980 - 1986 | Member, Hospital Medical Research Institute Committee on Quality of Care. |
| 1980 - 1991 | Director, McMaster International Clinical Epidemiology Training Program. |
| 1980 - 1984 | Member, Population Health Task Force, Canadian Institute for Advanced Research. |
| 1982 - 1985 | Member, Ontario Council of Health Advisory Panel. |
| 1982 - 1984 | Member, Research Grants Panel, The Arthritis Society. |
| 1982 - 1987 | Member, Clinical Research Committee, Pan-American League against Rheumatism. |
| 1982 - 1984 | Clinical Fellowship Examiner, Royal College of Physicians and Surgeons of Canada. |
| 1982 - 1984 | Member, NMR Advisory Panel, The Ontario Cancer Institute. |
| 1983 - 1988 | Co-Director, Biometry Centre for Ontario Clinical Oncology Trials Group. |
| 1984 - 1994 | Member, Board of Directors, Canadian Society for Tropical Medicine and International Health. [President 1989 - 1991] |
| 1985 - 1989 | Member, Editorial Board, Annals of Internal Medicine. |
| 1986 - 2002 | Editorial Board, Postgraduate Medical Journal (UK). |
| 1986 - 1989 | American College of Physicians Scientific Program Sub-Committee. |
| 1986 - 1988 | Member, Research Advisory Panel, Ontario Cancer Treatment & Research Found. |
| 1986 - 1989 | Member, Council of Canadian Society for Clinical Investigation. |
| 1986 - 1987 | Member, Ontario Health Research Personnel Committee. |
| 1989 - 1991 | Member, Review Committee, Pharmacoepidemiology Selections Program: The American College of Preventive Medicine and the Burroughs Wellcome Research Foundation. |
| 1989 - 1997 | Chairman, Epidemiology Committee, International League of Associations for Rheumatology. |
| 1990 - 1991 | Member of Board of Directors, Ontario Workers' Compensation Institute. |
| 1990 - 1995 | Member, Advisory Committee, University Partnerships Project, Network of Community-Oriented Educational Institutions for Health Sciences. |

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|---|---|
| 1991 - 1992 | Canadian Hospital Association: Member of Expert Working Group for the National Health Policy Reform (Vision) Project. |
| 1992 - 1996 | Member, Health Policy Committee, Royal College of Physicians and Surgeons of Ontario. |
| 1992 - 1994 | Member, External Advisory Board, Lawson Research Institute, University of Western Ontario, London, Ontario. |
| 1993 - 1994 | Chairman, Health Protection Policy Review Team, Health Protection Branch, Health and Welfare, Canada. |
| 1993 - 1996 | Member, Saskatchewan Health Methodology Advisory Panel, Regina, Saskatchewan. |
| 1994 - 1996 | Member, Subcommittee of the Future of Academic Health Sciences Centres, Provincial Coordinating Committee on Community and Academic Relations (PCCCAR), Ontario Ministry of Health. |
| 1994 - 1995 | Member, Task Force on Strengthening Regional Innovation and Business Development, Ontario Ministry of Health. |
| 1994 - 1996 | Member, Committee on Reconfiguration of Local Health Services, Ottawa-Carleton Regional District Health Council. |
| 1994 - 1996 | Member, Hospital Services Task Group, Ottawa-Carleton Regional District Health Council. |
| 1994- | Director, WHO Collaborating Centre on Health Technology Assessment |
| 1994 - | Chair, Editorial Group of the Cochrane Collaboration Review Group for Musculoskeletal Disease. |
| 1994 - 1996 | Chair, CANMEDs Committee for new training requirements for subspecialties to meet Societal Needs, Royal College of Physicians and Surgeons of Canada. |
| 1995 - 1999 | Member, Health Advisory Committee, Alberta Heritage Foundation for Medical Research, Edmonton, Alberta. |
| 1995 - 1997 | Representative for the University of Ottawa, Steering Committee, Canadian University Consortium for Health in Development (CUCHID). |
| 1995 - 1998 | Chair, Education Committee, Canadian Association of Professors of Medicine. |
| 1996 - | Member, Editorial Board: The Journal of Quality and Clinical Practice. |
| 1997 - | Member, Editorial Board: Clinical and Experimental Rheumatology. |
| 1997 - | Member, Editorial Board: American Journal of Medicine. |
| 1997 - 2000 | Member, Publication Committee, American College of Physicians. |
| 1998-2000 | Chair, Research SubCommittee, International Clinical Epidemiology Network. |
| 1999 - 2000 | President, Canadian Association of Professors of Medicine. |
| 1999 - 2000 | Member, Strategic Action working Group on Osteoporosis, The Ontario Women's Health Council. |

| | |
|---|---|
| 1999 - 2000 | Coordinator, Project to develop an international index of Health Research, Council on Health Research and Development, Geneva. |
| 2000 - | Member, Committee on Strategies for Small Number Participant Clinical Research Trials, Institute of Medicine, USA. |
| 2000 - 2001 | Member, Editorial Board, Clinical Drug Investigation & BioDrugs, Adis International. |
| 2001-2004 | Member, Advisory Committee, Musculoskeletal Disorders, Biomed Central |
| 2002 - | North American Editor, Journal of Clinical Epidemiology |
| 2002 - 2005 | Member, Oversight Committee, Canadian Medical Association Journal |
| 2002 | Member, The Coalition for Global Health Research |
| 2003 | Member, Editorial Board, The International Journal of Technology Assessment in Health Care. |
| 2003-2005 | Honorary Professor, School of Population Health, The University of Queensland |
| 2003 | Secretary General, CanUSACLEN |

UNIVERSITY OF OTTAWA COMMITTEES:

Faculty of Medicine:

| | |
|---|---|
| 1991 - 1992 | Chairman, Faculty AFP Committee |
| 1991 - 2001 | Member, Faculty Council Committee<br>Member, Faculty Advisory Board<br>Member, Special Committee on GFT Arrangements |
| 1992 - 1995 | Chairman, Ad Hoc Tri-Faculty Committee on International Health<br>Chairman, Liaison Committee for the Queen's-U of O Health Projects |
| 1993 - 1997 | Co-Chairman, Strategic Planning Academic Program Council on Health and Wellness |
| 1993 - | Member, Advisory Committee of the Institute for Research and Education in Palliative Care at the Elisabeth-Bruyère Health Centre |

Department of Medicine:

| | |
|---|---|
| 1991 - 2001 | Chair, Advisory Board<br>Chair, Departmental AFP Committee<br>Chair, TPC/Executive Committee<br>Member, Clerkship/Education Committee<br>Member, Rheumatic Disease Unit |

OTTAWA HOSPITAL COMMITTEES:

| | |
|---|---|
| 1991 - 2001 | Member, Ottawa Hospital Medical Advisory Committee |
| 1991 - 1998 | Chair, Ottawa Hospital, Dept. of Medicine, Medical Associates Executive Committee |
| 1991 - 2001 | Chair, Ottawa Hospital, Dept. of Medicine, Division/Section Heads Committee |

1992 - 1994 Member, Ottawa Hospital, Research Planning Committee

ORGANIZATIONAL MEMBERSHIPS:

Society for Epidemiologic Research

International Epidemiological Association

American Federation for Clinical Research

American Rheumatology Association

Canadian Rheumatism Association

Sydenham Society

Canadian Society for Clinical Investigation

Society for Medical Decision Making

American College of Physicians

The Canadian Public Health Association

The Canadian Society for International Health

AWARDS:

1997 Researcher of the Year Award, Ottawa General Hospital

2000 Dr. J. David Grimes Award, Research Career Achievement, Loeb Health Research Institute at the Ottawa Hospital

EDUCATION:

Graduate Courses taught:

| | |
|---|---|
| 1995-6 | International Health and Development, Carleton University |
| 1995- | Health Technology Assessment, University of Ottawa |
| 1999- | International Health and Development, University of Ottawa |
| 2000 | Health Technology Assessment, University of Ottawa |

Thesis Supervisorships:

| | |
|---|---|
| 1988 | M. Ferraz, MSc, McMaster University |
| | M. Bell, MSc, McMaster University |
| 1989 | E. Black, MSc, McMaster University |
| | H. Gatica, MSc, McMaster University |
| 1990 | M. Cardiel, MSc, McMaster University |
| | P. Riedemann, MSc, McMaster University |

| | |
|---|---|
| 1991 | I. Dans, MSc, McMaster University<br>G. Leon, MSc, McMaster University |
| 1993-94 R. | Alpizar, MSc, University of Ottawa |
| 1994 - | C. Bakker, PhD, University of Limburg, Maastricht, Holland |
| 1995 - 1996 | Z. Ortiz-Alberto, MSc, University of Ottawa |
| 1995 - 1998 | A. Cranney, MSc, University of Ottawa |
| 1992 - 1998 | M. Harrison, PhD, McMaster University |
| 1997 - 1999 | B. Shea, MSc, University of Ottawa |
| 1997 - 1999 | L.M. McAuley, MSc, University of Ottawa |
| 1998 - 1999 | Z.A. Rostom, MSc, University of Ottawa |

RESEARCH INTERESTS:

1. Evaluation of therapeutic interventions, diagnostic tests and their application to evidence based medicine.
2. Development and evaluation of strategies for assessing health technologies, quality of life, utilities and economic evaluation.
3. Evaluation of educational strategies and strategies for dissemination of evidence to consumers, clinicians and policy makers.

PUBLICATIONS:

| | | |
|---|---|---|
| Thesis: | June 1976 | M.D. Thesis (London, England)<br>Epidemiological, Clinical and Immunological Aspects of Pneumococcoccal Infection in the African Savanna<br>Supervisor - Prof. S. Sherlock and Prof. E.H.O. Parry |
| | June 1977 | M.Sc. Thesis (McMaster University)<br>Process Measures of Quality of Care<br>Supervisor - Dr. D. L. Sackett |

BOOKS:

1. Feeny D., Guyatt G.H., Tugwell P. Health Care Technology: Effectiveness, Efficiency and Public Policy; Montreal, The Institute for Research on Public Policy; 1986.
2. Sackett, D.L., Haynes, R.B., Guyatt, G.H., Tugwell, P. Clinical Epidemiology: A Basic Science for Clinical Medicine; Boston, Little, Brown and Company; 1st Edition in 1985 and 2nd Edition in 1991.
3. Tugwell P, Shea B, Boers M, Brooks P, Simon L, Strand V, Wells G, et al. Evidence Based Rheumatology. BMJ Books.

ARTICLES, MONOGRAPHS AND BOOK CHAPTERS:

1. Tugwell P, James SL. Peripheral Neuropathy with Ethambutol. Postgraduate Medical Journal. 1972; 48:667-670.

2. Tugwell P, Southcott D, Walmesley P. Free Perforation of the Colon in Crohn's Disease. The British Journal of Clinical Practice. 1972; 26(1):44-45.

3. Tugwell, P. Glucose-6-Phosphate-Dehydrogenase Deficiency in Nigerians with Jaundice Associated with Lobar Pneumonia. The Lancet. 1973; 1:968-970.

4. Tugwell, P. Seasonal Variation of Pneumococcal Infections in the African Savanna. West African Medical Journal. 1973; 5:34.

5. Whittle HC, Davidson N.McD, Greenwood BM, Warrell D, Tomkins A, Tugwell P, Zalin A, Parry EHO, Bryceson ADM, Brueton M, Duggan M, Rajokovic A. Trial of Chloramphenicol for Meningitis in Northern Savanna of Africa. British Medical Journal. 1973; 3:379-381.

6. Tugwell P, Greenwood BM. Bacteriological Findings in Pneumonia (Letter). The Lancet. 1974; 1:95.

7. Greenwood BM, Tugwell P, Whittle HC. Microbial Antigen Detection. (Letter). The Lancet. 1974; 2:598-599.

8. Whittle HC, Tugwell P, Egler LJ, Greenwood BM. Rapid Bacteriological Diagnosis of Pyogenic Meningitis by Latex Agglutination. The Lancet. 1974; 2:619-621.

9. Brueton M, Tugwell P, Whittle HC, Greenwood BM. Fibrin Degradation Products in the Serum and Cerebrospinal Fluid of Patients with Group A Meningococcal Meningitis. Journal of Clinical Pathology. 1974; 27:402-404.

10. Tugwell P, Greenwood BM. Pneumococcal Antigen in Lobar Pneumonia. Journal of Clinical Pathology. 1975; 28:118-123.

11. Harrison BDW, Tugwell P, Fawcett IW. Tuberculin Reaction in Adult Nigerians with Sputum-Positive Pulmonary Tuberculosis. The Lancet. 1975; 1:421.

12. Whittle HG, Greenwood BM, Davidson N.McD, Tomkins A, Tugwell P, Warrell DA, Zalin A, Bryceson ADM, Parry EHO, Brueton M, Duggan M, Ooomen JMV, Rajokovic AD. Meningococcal Antigen in Diagnosis and Treatment of Group 'A' Meningococcal Infections. American Journal of Medicine. 1975; 58:823-828.

13. Harrison BDW, Tugwell P, Fawcette IW. Tuberculin Reaction in Sputum-Positive Pulmonary Tuberculosis. The Lancet. 1975; 421.

14. Norman G, Tugwell P. Resident Performance Evaluation - A Comparison Among Members of the Health Care Team. Proceedings of the Fifteenth Annual Conference on Research in Medical Education: The Association of American Medical Colleges. 1976; 15:114-119.

15. Williams AO, Tugwell P, Edington GM. Glucose-6-Phosphate Dehydrogenase Deficiency and Lobar Pneumonia: Fine Structure of the Liver. Archives of Pathology. 1976; 100:25.

16. Tugwell P, Greenwood BM, Warrell DA. Pneumococcal Meningitis: A Clinical and Laboratory Study. Quarterly Journal of Medicine. 1976; 45:583.

17. Tugwell P, Williams AO. "Jaundice Associated with Lobar Pneumonia" A Clinical Laboratory and Histological Study. Quarterly Journal of Medicine. 1977; 46:97.

18. Tugwell P. A Methodological Perspective on Process Measures of the Quality of Medical Care. Clinical and Investigative Medicine. 1979; 2:113.

19. Gilbert JR, Evans CE, Haynes RB, Tugwell P. Predicting Compliance with a Regimen of Digoxin Therapy in Family Practice. Canadian Medical Association Journal. 1980; 123:119-122.

20. Tugwell P, Sackett DL, Haynes RB. On the Critical Assessment and Clinical Applicability of the Rheumatology Literature. Journal of Rheumatology. 1980; 7:765-771.

21. Chambers LW, Sibley JC, Spitzer WO, Tugwell P. Quality of Care Assessment: How to set up and use an Indicator Condition. Clinical and Investigative Medicine/Medicine Clinique et Experimentale. 1981; 4(1):41-50.

22. Sackett DL, Haynes RB, Tugwell P. Evaluation: Requirements for Clinical Application. Chapter in: Coping with the Biomedical Literature, Praeger, 1981; pp.123-157.

23. Department of Clinical Epidemiology and Biostatistics: How to Read Clinical Journals: I. Why read them and how to start reading them critically. Canadian Medical Association Journal. 1981; 124:555-558.

24. Department of Clinical Epidemiology and Biostatistics: How to Read Clinical Journals: II. To learn about a diagnostic test. Canadian Medical Association Journal. 1981; 124:703-710.

25. Department of Clinical Epidemiology and Biostatistics: How to Read Clinical Journals: III. To learn about the clinical course and prognosis of disease. Canadian Medical Association Journal. 1981; 124:869-872.

26. Department of Clinical Epidemiology and Biostatistics: How to Read Clinical Journals: IV. To determine etiology or causation. Canadian Medical Association Journal. 1981; 124:985-990.

27. Department of Clinical Epidemiology and Biostatistics: How to Read Clinical Journals: V. To distinguish useful from useless or even harmful therapy. Canadian Medical Association Journal. 1981; 124:1156-1162.

28. Ellis P, Fox K, Johnson B, Moran J, Ogilvie M, Tugwell P, Woo C. Patient Care Appraisal Handbook. Ontario Hospital Association. April 1982.

29. Norman GR, Tugwell P, Feightner JW. A Comparison of Resident Performance on Real and Simulated Patients. Journal of Medical Education. 1982; 57:708-715.

30. Bombardier C, Tugwell P. A Methodologic Framework to Develop and Select Indices for Clinical Trials: Statistical and Judgmental Approaches. Journal of Rheumatology. 1982; 9:753-757.

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310. Philadelphia Panel. Philadelphia Panel evidence-based clinical practice guidelines on selected rehabilitation interventions: Methodology. Physical Therapy, October 2001;81:1629-1640.

311. Philadelphia Panel. Philadelphia Panel evidence-based clinical practice guidelines on selected rehabilitation interventions for low back pain. Physical Therapy, October 2001;81:1641-1674.

312. Philadelphia Panel. Philadelphia Panel evidence-based clinical practice guidelines on selected rehabilitation interventions for neck pain. Physical Therapy, October 2001;81:1701-1717.

313. Philadelphia Panel. Philadelphia Panel evidence-based clinical practice guidelines on selected rehabilitation interventions for knee pain. Physical Therapy, October 2001;81:1675-1700.

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treatment paradigm for patients with knee osteoarthritis (Part 2 of 2): economic results. Osteoarthritis & Cartilage 2002; 10(7):518-527.

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clinical practice: Lessons learned. Arthritis & Rheumatism (Arthritis Care and Research). 2003 Aug;49(4): 574-584.

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PEER-REVIEWED GRANTS: (Since 1990)

1. New approaches to pain measurement in arthritis. With L. Hart, C. Goldsmith. Funding: $100,000, Ontario Ministry of Health, 1991-1993.

2. Controlled trial of hydrotherapy in rheumatoid arthritis. With L. Hart, C. Goldsmith, J. Chapman. Funding: $125,000, NHRDP, 1991-1993.

3. Pilot study to evaluate a portable, self-administered decision aid for women considering long-term hormone replacement therapy. With O'Connor A, Wells G, Elmslie T. Funding: $96,000.00, Institute for Clinical Evaluation Sciences, Sunnybrook Health Science Centre, 1994-1995.

4. OMERACT: Outcome Measures in Rheumatoid Arthritis Clinical Trials. Principal Coordinator. $300,000 from various government, industry and charity sponsors, 1991-.

5. Development and evaluation of evidence-based decision aids for seniors making choices about hormone replacement therapy. With O'Connor A, Carswell A, Ross M, Wells G, Wolfson M, Dalziel W, Elmslie T. NHRDP, Health Canada. $226,828, 1995-1996.

6. Development of a practitioner information aid and practitioner-patient interaction guide to support decision making about long-term preventive hormone replacement therapy. With A.O'Connor A, Elmslie T, Graham I, Wells G, Bunn H, Hollingworth G, Jolly E, McPherson R, Laupacis A. Institute for Clinical Evaluation Sciences, Sunnybrook Health Science Centre. $91,140, 1995-1996.

7. A randomized study of cemented versus non-cemented hip prostheses. With A. Laupacis, R. Bourne, C. Rorabeck, S. Dalice. Funding: $607,182.00, Medical Research Council of Canada, extended to March 31, 1997.

8. Canadian Cochrane Network and Centre. With R.B. Haynes et al. Funding: $100,000 from the Medical Research Council of Canada, 1995-1999.

9. Quality assessment of clinical trials. With D. Moher et al. Funding: $250,000.00, Great Britain National Health Service, 1995-1997.

10. Decision support technologies. Co-principal investigator with A. Laupacis and A. O'Connor on the Medical Research Council Program Grant and on three of the component grants: ☐ "Long-term hormone replacement therapy: an evidence-based approach to estimating the benefits, risks, costs and acceptability to post-menopausal women"; ☐ "Methodological issues in developing patient decision aids: evaluation of methods for presenting the evidence of treatment benefits and risks and clarifying values"; ☐ "Implementation and evaluation of methods and procedures for assessing changes in health states over time". Funding: $600,000.00, Medical Research Council of Canada, 1995-1998.

11. A randomized controlled trial evaluating the impact of decision aids on informed decision making of postmenopausal women considering long-term preventative HRT. Co-principal Investigator with Annette O'Connor. Funding: $120,000 Arthritis Society of Canada 1996-98.

12. WHO Collaborating Center for Health Technology Assessment: Needs-based Technology Assessment Tool Kit (Global). Principal Investigator. Funding: $96,000 IDRC, 1996-98.

13. Educating health practitioners in shared decision making. With Bunn H, O'Connor A, Doucet S, Jones L. Funding $5,000 from University Of Ottawa Teaching and Learning Grants Subcommittee. OHDEC, 1996-98.

14. CIGNA Foundation Physical Therapy Project. Principal Investigator. Tugwell P, Brosseau L, Wells G, Coyle D, Cranney A, Graham I, McGowan J. $151,058 (US), 1999-2001.

15. Capacity building of nurses and adaptation of decision-making tools in Chile. Canadian International Development Agency. Principal Investigator. $499,999, 1998-2002.

16. Arthritis Society Research Grant. A randomized trial to evaluate a decision aid for women with osteoporosis. With Cranney A, O'Connor A, Adachi JD, Jolly E. $27,115, 1999-2002.

17. Council on Health Research and Development, Geneva . Development of an index to reflect health research into equity issues. Principal Investigator. 1999-2000, $85,000.

18. Arthritis Society of Canada. Systematic evaluation of new therapies for the treatment of rheumatoid arthritis. With Wells G, Shea B, Suarez-Almazor M, Boers M, Coyle D, Maetzel A. 1998-99, $100,000.

19. Medical Research Council of Canada. Practitioner response to evidence-based patient decision aids. With Ian Graham. 2000-2002, $148,000.

20. Arthritis Society of Canada. A randomized controlled trial evaluating the impact of decision aids on informed decision making of post-menopausal women considering long-term preventive HRT. Co-principal Investigator. 1996-2000, $240,000.

21. Canadian Institute of Health Research Group Grant. Decision support tools for clinicians and patients. With O'Connor A, Graham I, Stiell, Laupacis A. 2000-2003, $616,349.

22. Royal College of Physicians and Surgeons. Development and program incorporation of evaluative tools for the essential roles and key competencies for the CANMEDS 2000 initiative. Principal Investigator, 2000-2001, $20,350.

23. Physiotherapy Foundation of Canada. Determinants of the use of evidence-based clinical practice guidelines for the treatment of lumbar and cervical pain syndromes among physiotherapists. With Lucie Brosseau, Ian Graham, Laurie Hurley, George Wells, Vivian Welch, Bev Shea. 2000-2001, $4,500.

24. Medical Research Council of Canada. With Brosseau L. The effect of low level laser therapy in the treatment of osteoarthritis of the hand: A pilot study. 2000, $7,780.

25. Arthritis Society of Canada. Systematic evaluation of new therapies for the treatment of rheumatoid arthritis. Principal Investigator. 2000-2003, $193,560..

26. CIHR. Cochrane & Knowledge Transfer Grant. Principal Investigator. 2001-2002, $100,000.

27. Arthritis Society of Canada. With Brosseau L. The development of Evidence-Based Clinical Practice Guidelines for Physical Rehab Interventions in Treatment of Rheumatoid Arthritis. 2001-2002, $59,450.

28. Arthritis Society of Canada. With Brosseau L. A RCT on Low-level Laser therapy in the Treatment of Osteoarthritis of Hand. 2001-2003, $91,653.

29. University of Ottawa. Measuring & Modeling Health Inequalities in the Canadian Population & Globally. 2001-2002, $9,600.

30. CIHR. With Andersson, N. ACADRE Training Grant. 2001-2004, $1,200,000.

31. Rockefeller Foundation. Principal Investigator. Development grant from the Rockefeller Foundation. 2002-2003, $50,000 US.

32. CIDA/PAHO/Health Canada. Principal Investigator. International Workshop on Health Equity. 2002, $100,000.

33. Canada Research Chair in Health Equity. 2002-2009, $1,400,000. Canadian Foundation for Innovation. $250,000.

34. CHIR. Principal Investigator. How do you measure an effective musculoskeletal and arthritis health consumer?. 2003-2006, $284,071.00 .

35. CHIR. Principal Investigator. International Study of Low and Middle Income (LMIC) Health Research Funding Agencies' Support and Promotion of Knowledge Translation. 2003-2005, $144,298.

**Shah Alam**

**From:** David A Sack, MD [dsack@icddrb.org]
**Sent:** Friday, April 30, 2004 7:52 AM
**To:** dasack@icddrb.org
**Subject:** Fw: Letter and CV from Dr Tim Evans

----- Original Message -----
**From:** aplinl@who.int
**To:** dsack@icddrb.org
**Cc:** ruauy@hotmail.com
**Sent:** Thursday, April 29, 2004 7:52 PM
**Subject:** Letter and CV from Dr Tim Evans

Dear Dr Sack

I have without success been trying to send you a fax. My apologies for the delay in sending you this letter.

Please find attached a letter and CV from Dr Tim Evans. Would it be possible for your office to send me your fax no. for our records.

<<Letter to Centre for Health & Population.doc>> <<Tim Evans CV2004.doc>>

Many thanks

Lynne (Aplin)

**Lynne Aplin**

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In reply please refer to:
Prière de rappeler la référence:

Your reference:
Votre référence:

Dr David Sack
ICDDR, B:Centre for Health & Population Research
GPO Box 128
Dhaka-1000
Bangladesh
Inde

23 April 2004

Dear Dr Sack

Many thanks for your letter of 13 January and for considering me to be a member on your Board of Trustees. My apologies for the delay in responding. I have spoken to Dr Demissie Habte about the Board and Dr Habte has encouraged me to submit my name for consideration.

I am enclosing my C.V. as requested and will await the decision from the Board in due course.

Many thanks for this opportunity and I look forward to hearing from you.

Yours sincerely

Tim Evans

Dr Tim Evans
**Assistant Director-General**
**Evidence and Information for Policy**

Encl.

TIMOTHY G. EVANS

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Citizenship: American and Canadian
Languages: Fluent in English and French

## EDUCATION:

| | |
|---|---|
| 1984 B.S.S. | University of Ottawa, Canada |
| 1989 D.Phil. | University of Oxford, UK (Agricultural Economics) |
| 1992 M.D. | McMaster University, Canada |
| 1992-96 | Internal Medicine Residency, Brigham and Women's Hospital, Boston |
| 1992-1996 | Research Resident, Brigham and Women's Hospital, Boston |
| 1992-1994 | Post-doctoral MacArthur Fellow, Harvard Center for Population and Development Studies |

## LICENSURE AND CERTIFICATION:

| | |
|---|---|
| 1993 | Independent Practice License, Province of Ontario |
| 1996 | Medical License, State of Massachusetts |
| 1996 | American Board of Internal Medicine |

## AWARDS AND HONORS:

| | |
|---|---|
| 1984-1988 | Rhodes Scholarship, University of Oxford, UK |
| 1986-1987 | Canadian International Development Agency Scholarship, Canada |
| 1992-1994 | MacArthur Fellowship, Harvard School of Public Health |
| 1994 | International Exchange of Experts in Rehabilitation Fellowship |
| 2002 | Faculty, Salzberg International Seminar #395 – Improving access to health care among the poor |

**EMPLOYMENT:**

2003 Assistant Director-General, Evidence and Information for Policy Cluster, World Health Organization

The Evidence and Information for Policy cluster (EIP) was established to build the evidence base to help improve the process for health systems policy decisions. EIP comprises a staff of approximately 260 people based at WHO Headquarters in Geneva. EIP makes a substantial contribution to policy debates around a variety of health systems issues. EIP continues to build the tools, methodology and information base to produce evidence and quality data.

1997-2003 Director, Health Equity Theme, The Rockefeller Foundation

Responsible for the development and implementation of program strategy aimed at redressing disparities in health. The Health Equity Theme comprises a staff of 20 persons (8 professionals) based in New York city and in the Rockefeller Foundation regional offices in Africa and Southeast Asia and makes about 120 grants/year with a total disbursement of about $30 million/year.

The HE strategy comprises three sub-themes focused on technology, capacity building and policy. The technology portfolio entitled Harnessing the New Sciences includes new product development ventures for TB and malaria drugs, AIDS and dengue vaccines and microbicides. Access initiatives included the transformation of the Children's Vaccine Initiative to the Global Alliance for Vaccines and Immunization, and a new effort on reducing barriers to access to medicines. The capacity portfolio includes a fundamental re-thinking of public health training and research policy in developing countries; enhancing vital statistics and monitoring capacity for equity; clinical trials to simplify AIDS treatment protocols; extending care to infected mothers in the setting of prevention of maternal to child transmission of HIV; and regional collaboration to strengthen disease surveillance in the Mekong Basin. The policy portfolio, Strengthening Global Leadership, includes grass-roots efforts to prevent smoking, innovative intervention research on health and work and the development of tools to enhance equity performance of health systems. Also lead the development of a new international collaboration entitled "Human Resources for Health: A Joint Learning Initiative."

Senior Management Team: Along with the President, Vice-Presidents, and Directors of other program themes at the Rockefeller Foundation (Food Security, Creativity and Culture, Working Communities and Global Inclusion), SMT is responsible for the development of foundation strategy, approval of grants over $100,000, preparation of Board of Trustee meetings and oversight on a variety of administrative matters.

ProVenEx Committee: The program venture experiment (ProVenEx) is a capital investment fund that seeks out private sector initiatives that have programmatic interest as well as a reasonable likelihood of financial solvency. Representing the health programs on this committee, I have been responsible for identifying prospective ProVenEx investments in health and leading the due diligence process towards an investment decision.

Bellagio Committee: The Bellagio conference facility runs three programs, resident scholars, teams and conferences. The committee meets three times/year to review applications for these three programs. From 1997 through 2000, I reviewed all health-related proposals as a member of the committee.

1996-1998 Attending Physician, General Internal Medicine, Brigham and Women's Hospital

Taught clinical medicine on the wards to medical students, interns and residents. Supervised a primary care clinic one afternoon per week. Coordinated evidence-based medicine Journal Club and acted as a preceptor in the evidence-based medicine for Primary Care Residency.

1995-1998 Assistant Professor, International Health Economics, Harvard School of Public Health

Responsibilities included teaching two courses in the MPH program: 1) Introduction to the practice of International Health; and 2) Measurement of health status in developing countries; supervising Master's PhD students and Bell Fellows at the Harvard Center for Population and Development Studies. Research interests included work on the broader determinants of health; the measurement of health status; equity in health; measurements of disability and handicap; priorities in health research and health policy and assessing the impact of chronic diseases. With seed grant from Sida, co-founded and led the development of the Global Health Equity Initiative (GHEI). The GHEI comprised six international, interdisciplinary working groups on critical conceptual issues related to equity: ethics; social determinants, gender, measurement, health care financing, globalization and policy. The conceptual work was complimented by in-depth national analyses undertaken by 12 teams representing a wide range of countries in the South and the North.

**Other professional activities:**

Founding Board Member, Global Forum for Health Research – 1998-2000.
Member Strategic Advisory Committee, Global Forum for Health Research – 1998-2000.
Founding Board Member, Global Alliance for Vaccines and Immunization – 1999-2001.
Member, Scientific Peer Review Group of the World Health Organization's Health System Performance Appraisal – 2001-2002.
Editorial Board, Population Health Metrics – 2003.
Board Member, Student Pugwash USA 2003-2004.

Reviewer for the following Journals: Lancet; Social Science and Medicine; Bulletin of the World Health Organization; World Development, Population and Development Review; UNDP.

Keynotes and Lectures:

Equity in Health and Health Care – Vietnam, April 1999
ASCON meeting – ICDDR,B – February 2000.
Academy for International Health Philanthropy, London, UK – May 2001
Diversity in Health, Melbourne Australia – May 2001
Women and Health, UN – November 2001
INDEPTH Annual Meeting, Addis Ababa – January 2002
Women, Children and Health, Bangkok – February 2003

Guest Lectures at Yale University, Harvard School of Public Health, University of Toronto, World Health Organization, Hyderabad University, Kerala School of Public Health, Ghana School of Public Health, Joseph P. Mailman School of Public Health at Columbia University.

**RESEARCH FUNDING:**

| | |
|---|---|
| 1986-1988 | PI: Royal Commonwealth Society for the Blind Ivermectin Distribution Study |
| 1986-1988 | PI: Edna McConnell Clark Foundation Consequences of Onchocerciasis in West Africa |
| 1993-1994 | PI: Edna McConnell Clark Foundation Study of the Burden of Trachomatous Blindness |
| 1993-1994 | Co-PI: International Exchange of Experts in Rehabilitation; Bangladesh Rural Advancement Committee: Removing Barriers to Participation in BRAC Poverty Alleviation Programs |
| 1995 | PI: Edna McConnell Clark Foundation. Setting research and policy priorities in School-Age Health |
| 1996 | Co-PI: Sida: Global Health Equity Initiative |

**PUBLICATIONS:**


1. Evans TG, Murray CJL. A critical re-examination of the economics of blindness prevention under the Onchocerciasis Control Programme. Social Science and Medicine. 1987; 25 (3): 241-249.

2. Evans TG. The socioeconomic consequences of human disease on subsistence agriculture: the case of onchocerciasis in West Africa. Unpublished DPhil thesis. 1989.

3. Evans TG. The impact of permanent disability on rural households: river blindness in Guinea. IDS Bulletin 1989; 20 (2): 41-48.

4. Evans TG, Adams AM. AIDS: a household perspective. SHAIR International Forum 1990; November.

5. Evans TG, Kanoto M. Thailand's massage parlours: the challenge of preventing an epidemic. SHAIR International Forum 1990; November.

6. Scott I, Evans TG, Cash R. Unpacking the black box. Working Paper for the BRAC-ICDDR,B Joint Project on linkages between socioeconomic development and health in Matlab, Bangladesh, 1993.

7. Evans TG, Ranson MK. An assessment of trachomatous visual impairment and its control. Unpublished document sent to the Edna McConnell Clark Foundation; 1994.

8. Evans TG. Training Manual for the International Classification of Impairments, Disabilities, and Handicaps. National Center for Health Statistics, 1994.

9. Evans TG. Socioeconomic consequences of blinding onchocerciasis in West Africa. Bulletin of the World Health Organization 1995; 73(4): 495-506.

10. Ranson MK, Evans TG. The global burden of trachomatous visual impairment: assessing prevalence. International Ophthalmology 1996; 19(5): 261-270.

11. Evans TG, Ranson MK. The global burden of trachomatous visual impairment: assessing burden. International Ophthalmology 1995; 19(5): 271-280.

12. Evans TG, Ranson MK. The cost-effectiveness and cost-utility of preventing trachomatous visual impairment: lessons from thirty years of trachoma control in Burma. British Journal of Ophthalmology 1996; 30: 1-10.

13. Evans TG, Rafi M, Adams MK, Farnsworth J, Chowdhury AMR. Barriers to accessing poverty alleviation programs in Bangladesh. Harvard Center for Population and Development Studies Working Paper 1996.

14. Evans TG. Review of Why are some people healthy and others not?. Health and Human Rights Journal 1997.

15. Adams AM, Evans TG, Mohammed R, Farnsworth J. Socioeconomic Stratification by Wealth Ranking: is it valid? World Development 1997; 25 (7): 1165-1172.

16. Evans TG, Adams AM, Mohammed R, Norris AH. Demystifying non-participation in micro-credit: A population-based analysis: World Development 1998.

17. Yach D, Shov Jensen M, Norris A, and Evans TG, Promoting Equity in Health, International Journal of Health Promotion and Education, 1998, vol. V/2, 7-13.

18. Evans TG and Norris A, Towards Policy for Equity in Health: Principles and Practice, prepared for the Health Systems Trust meeting "Measuring the Move Toward Equity in Health and Health Care", Durban, South Africa, 4-7 June 1998.

19. Chen LC, Evans TG, Cash RA. Global Public Goods in Health. In Kaul et al edt. Global Public Goods: Development Cooperation in the 21st century. UNDP 1999.

20. Evans TG and Norris A. "Policy Oriented Strategies for Health Equity" in Hung et. al. edt. Efficient, equity-oriented strategies for health, McKellar Renown Press 2000: 293-312.

21. Chen LC, Evans TG and Wirth ME. "Philanthropy and Global Health Equity" in Koop edt – Critical Issues in Global Health : Jossey-Bass, A Wiley 2001: 430-439.

22. Evans TG et al. Roundtable: "A Role for Public-Private Partnerships in Controlling Neglected Diseases?" A Landscape in Rapid Transition. Bulletin of the World Health Organization: August 2001: 79 (8):771-7.

23. Pablos-Mendez A., Chacko S., Evans TG. Market Failures and Orphan Diseases. Development, December 1999: 42 (4):79-83.

24. Evans et al. edt – Challenging Inequities in Health: from ethics to action. Oxford University Press, 2001

25. Diderichsen F, Evans TG and Whitehead M. The social basis of disparities in health, in Evans et al edt. Challenging Inequities in Health: from ethics to action. OUP 2001: 12-23.

26. Peter, F and Evans TG. Ethical dimensions of equity in health. In Evans et al edt. Challenging Inequities in Health: from ethics to action. OUP 2001: 13-24..

27. Anand S. Diderichsen F. Evans TG, Shkolnikov M and Wirth M. Measuring Disparities in Health: Methods and Indicators. in Evans et al edt. Challenging Inequities in Health: from ethics to action. OUP 2001: 48-67.

28. Liu, Y. Rao K. Evans T, Chen Y, Hsaio WC China: Increasing Health Gaps in a Transitional Economy: in Evans et al edt. Challenging Inequities in Health: from ethics to action. OUP 2001: 76-89.

29. Evans TG, Chen LC – Public Private Partnerships in health and the new democracy. Paper prepared for Conference at Trinity College Cambridge UK, July 2001

30. Whitehead MW, Dahlgren G, Evans TG "Making the invisible hand visible: health sector reforms seen through an equity lens" Lancet, Sept 20, 2001

31. Evans, TG, co-authored with S. Anand & others, "Report of the Scientific Peer Review Group on Health Systems Performance Assessment," EIP 2002/SPRG Report/E, WHO May 2002

32. Evans TG "Health-Related Global Public Goods: Initiatives of the Rockefeller Foundation" in Kaul et al. edt. Global Public Goods Financing: New Tools for New Challenges. UNDP 2002: 31-36

33. Evans, TG, Brown, HA. "Road traffic crashes: operationalizing equity in the context of health sector reform" in Nantulya VM and Sleet, DA (Eds.) The Global Challenge of Road Traffic Injuries, *Injury Control and Safety Promotion*, 2003, 10:11-12.

34. Fred Binka, Richard Cash, Lincoln Chen, Mariam Claeson, Lola Dare, Lesley Doyal, Tim Evans, Adrienne Germain, Richard Horton, Debra Jones, Peter Kilima, Mark Miller, Vasant Narasimhan, Ariel Pablos-Mendez, Sarah Ramsay, K Srinath Reddy, David Sanders, Charas Suwanwela, K R Thankappan, Suwit Wibulpolprasert. *An open letter to the Executive Board of WHO*. Lancet: 360: 9348: 1797.

35. Evans TG and Stansfield S. 2003. Health information in the new millennium: weathering or avoiding the perfect storm. Bulletin of the World Health Organization, January 2004.

36. Evans TG: Registering clinical trials: an essential role for WHO (forthcoming Lancet).

37. Evans TG, Adams O, DalPoz M, Dresch N. Human resources for health and HIV/AIDS treatment: steps towards strengthening health systems performance. Chapter submitted to Eddy et al. edt. Dealing with the HIV pandemic in the twenty first century OUP (forthcoming).

## Dr. David Sack

**From:** "Keith Bezanson" <K.Bezanson@ids.ac.uk>
**To:** "David A Sack, MD" <dsack@icddrb.org>
**Cc:** "Robert Beadle" <Robert.beadle@dfait-maeci.gc.ca>
**Sent:** Monday, June 07, 2004 12:43 PM
**Subject:** RE:

Deaar David

I apologise for not responding sooner but was in Malawi last week and out of e-mail contact.

Many thanks for your letter with its most helpful outline of ICDDRB and the functioning of its Board. I have also examined the web site and the Strategic Plan, as you suggested. Based on these, including the fact that the Board meets only twice yearly (perhaps only once if the Exec Committeee model is continued), I would be willing to become a member of the Board. You and the current trustees will obviously need to judge what my background and experience might contribute. As is clear from my CV that you have, I am not a medical doctor, a maternal and child health care specialist, an emidemiologist or a nutrition scientist. Thus, depending on what is being sought in the balance of experience of trustees, I may not provide the 'right fit' and hasten to make clear that I will in no way be troubled if not invited to serve.

I appreciate that Board membership is entirely on a pro bono basis. Before you proceed, however, I do need to seek clarification on class of air travel. Given the frequency of my travel schedule, even for charitable causes I am unwilling to travel at less than business class with established international carriers. This can be a problem for NGOs and I will understand fully if my requirement is at varience with ICDDRB policy, but would not wish to proceed if that were the case.

I look forward to hearing from you and send best regards.

Keith

-----Original Message-----
From: David A Sack, MD [mailto:dsack@icddrb.org]
Sent: Thu 03/06/2004 04:08
To: Keith Bezanson
Cc: Robert Beadle
Subject:

I am not sure if this has reached you -- and am hence resending the same.

best wishes,

David
----- Original Message -----
From: David A Sack, MD <mailto:dsack@icddrb.org>
To: k.bezanson@ids.ac.uk
Sent: Sunday, May 30, 2004 8:22 AM

# KEITH A. BEZANSON

*Curriculum Vitae*


**Personal Details:** *Date of Birth* 12 May 1941
*Nationality* Canadian and British

**Address:** Institute of Development Studies
University of Sussex
Falmer, Brighton, Sussex
United Kingdom, BN1 9RE

4 Downs View Road
Seaford
East Sussex
United Kingdom, BN25 4PT

Tel: (0) 1273 678264
Fax: (0) 01273 678349
E-mail: K.Bezanson@ids.ac.uk

Residence: (0) 1323 892472

bezanson@btinternet.com


**Education:**

1972 PhD, Stanford University, Stanford, California

1964 BA, Carleton University, Ottawa, Canada

**Languages:** English, French and Spanish.

**Experience:**

March 1997-present — Director, Institute of Development Studies (IDS)

Established as the first institute of its kind in 1967, IDS remains the largest (approximately 240 staff) and most comprehensive of development studies institutes. It enjoys a worldwide reputation for the quality of its research, teaching, policy analysis and advice on all aspects of development.

1991-1997 — President, International Development Research Centre (IDRC), Ottawa, Canada.

Founded in 1970 with the specific mandate to build and apply Science, Technology and Research systems for development, IDRC remains remains the premier organisation of its type in the world. As President and CEO, I was responsible to the Board of Governors (comprising 21 eminent leaders - 11 Canadians and 10 non-Canadians - from science, industry and public policy) for all aspects of the organisation. Annual expenditures approximate $140 million.

1988-1991 — Administrative Manager (Vice President), Inter-American Development Bank, Washington, D.C.

As one of the Bank's eight senior managers, I was directly responsible to the President for, *inter alia*:

- the organisational and structural renewal of the Bank;
- administration of the Bank's human resources (approximately 1,500 employees) and physical resources, including the development and adoption of policies to ensure their effective utilisation and the provision of administrative support and advice to all Bank units;
- preparation, presentation and management of the Bank's administrative budget of approximately $200 million;

- programme oversight for an investment budget of approximately $4 billion annually;
- supervision, control and audit of 26 field offices comprising approximately 200 international employees and 300 locally-contracted employees.

1985-1988 Canadian Ambassador to Peru and Bolivia, Lima, Peru.

Responsible for all aspects of Canada's relations with Peru (Canada's largest economic co-operation programme in Latin America).

1981-1985 Vice-President, Americas Branch, Canadian International Development Agency (CIDA), Ottawa, Canada.

Responsible for all aspects of Canadian bilateral co-operation (economic and technical) with the countries of Latin America and the Caribbean, including overall planning, programming, supervision and guidance of eight field offices and 120 headquarters personnel.

1978-1981 Director General, Multilateral Programs, Canadian International Development Agency (CIDA), Ottawa, Canada.

Responsible for all aspects of Canadian membership (policy, oversight, burden sharing, etc.) in the multilateral development banks (i.e. World Bank, Asian, African, Inter-American and Caribbean Development Banks).

1977-1978 Regional Director of Eastern Africa (Kenya, Tanzania, Uganda) Program, Canadian International Development Agency (CIDA), Ottawa, Canada.

Responsible for the planning and execution of what was at that time the largest program of Canadian economic co-operation in Africa (approximately $60 million annually).

1973-1977 Chief Planning Officer, Canadian International Development Agency (CIDA), Ottawa, Canada.

Responsible for program and project planning of all Canadian economic and technical co-operation in Anglophone Africa.

1971-1973 Director of Research, School Leaver Research Project, Ghana, West Africa.

'The School Leaver Research Project' was a comprehensive, three-year, study aimed at improving the development prospects of the entire country by improving the linkages and relationships between the education system and the national employment market. As Project Director, I was responsible for all aspects of the research, including the organisation, recruitment and supervision of a research team of up to 45 research associates and assistants.

1969-1971 Lecturer and Researcher, University of Ghana.

1968-1969 Consultant, Canadian International Development Agency (CIDA).

A study on technical assistance and capacity building in developing countries. 1968

1964-1966 Secondary School Teacher

Volunteer teacher in Nigeria under the auspices of the Canadian University Service Overseas.

**Selected Papers and Publications:**

2003 'Evaluating Development Effectiveness in Six United Nations Agencies', Report to the Department for International Development, United Kingdom.

2002 'Overlap and Duplication in the United Nations Development System: Perception, Reality and Some Solutions', Report to the Department for International Development, United Kingdom.

2002 'Global Public Goods: Some Key Questions', in **The Future is Now**, Vol.3, pp. 40-47.

2002 'Some Comments on 'Globalisation, Inequality, and Poverty since 1980', in State Secretariat for Economic Affairs (ed), **Economic Growth and Sustainable Development: Trade-off or Win-win-win Situation?,** pp 48-53, Bern: SECO.

2001 **Financing and Providing Global Public Goods: Expectations and Prospects**, with F Sagasti. Development Financing 2000, Study 2001:2, Ministry of Foreign Affairs, Sweden.

2001 'International Development at the Dawn of the 21st Century', in **Environment in the 21st Century and New Development Patterns**, K. Matsushita, ed., pp 257-270, Kluwer Academic Publishers.

2000 **A Foresight and Policy Study of the Multilateral Development Banks**, with F Sagasti, S Charpentier and R Gottschalk. Development Financing 2000, Ministry of Foreign Affairs, Sweden.

2000 'Development', author of the special section on development in the millennium edition of the **Microsoft Encarta Encyclopedia.**

2000 'A Science, Technology and Industry Strategy for Vietnam', assisted by Geoffrey Oldham and Tran Ngoc Ca, **Final UNDP-UNIDO Report to the Government of Vietnam,** Hanoi: UNDP.

2000 'Some Hopes for a New Journal on Environmental Strategies', **International Review for Environmental Strategies**, Inaugural Issue, Vol. 1, No. 1, pp 3-8, 2000.

1999 'The East Asian Crisis: a global problem requiring global solutions', with S Griffith-Jones, in **East Asia: What Happened to the Development Miracle?**, IDS Bulletin, Vol 30, No 1, January, pp 1-14.

1999 'Rethinking Development: The Challenge for International Development Organisations', **Putting People at the Center of Sustainable Development,** Wiman, R and Partonen, T (eds.), Vol 2, pp. 27-43, Stakes, Helsinki.

1999 **Viet Nam at the Crossroads: The Role of Science and Technology**, IDRC Books.

1998 'Tiger Cubs at the Crossroads: Some Policy Issues Facing Vietnam', **IDS Bulletin**, Vol 29, No 3, July.

1997 'Information Technology Support to Developing Countries: The Canadian Experience', in M R Bhavavan, ed., **New Generic Technologies in Developing Countries**, Macmillan Press, London, pp 233-250.

1996 'The elusive search: development and progress in the transition to a new century' with F. Sagasti), IDRC publications, Ottawa, Canada.

1995 'Hard choices, heavy costs must not be minimised', **Ottawa Citizen**, 26 March

1995 'Alternative funding: looking beyond the nation state' (with Ruben Mendez), **Futures**, 27 (2), March, UK

1994 'Inclusion zone politics', **The Times**, London, December

1994 'Rethinking development: a new challenge for international organisations' in Üner Kirdar and Leonard Silk (eds), **People: From Impoverishment to Empowerment**, New York: New York University Press, pp 398-407

1994 'The global crisis machine', **Ottawa Citizen**, 29 March

1994 'La edad de la incertidumbre', **Caretas**, 17 March

1993 **Hasta Donde Va El Desarollo?, La Republica**, 26 Mayo

1992 'A changing world of the strong and the weak', **The Globe & Mail**, 26 October

1992 'The collapsing vision of global development' in Üner Kirdar and Leonard Silk (eds), **A World Fit for People**, New York: New York University Press, pp 211-216

1992 'Maternal health and child survival issues: lessons learned' in the proceedings of **Health for All - Strengthening the Role of Public Health**, World Federation of Public Health Associations Sixth International Congress and 119th Annual Meeting of the American Association of Public Health Associations, Atlanta, Georgia, 10-14 November, pp 35-39

1973 **Education and Employment: Final Report of the School Leaver Research Project**, Accra, Ghana: Ministry of Education

1973 'Social goals and fiscal reality in Ghana's education system', **The Legon Observer**, 7: 9-16

1972 'Education in Ghana: the road of unemployment', **The Legon Observer**, 21: 72-49

1972 'Readings skills of some Ghanaian primary school children in their first and second languages' (with Nicolas Hawkes), **Canadian Journal of Bilingualism**, VI: 181-194

1969 **Education and Modernisation in Micronesia: A Case Study in Development and Development Planning** (with Richard Pearse), Stanford: Stanford University Press

1968 **Final Report: Planning for Education and Manpower in Micronesia** (with William J Platt and P H Sorenson), Menlo Park, California: Stanford Research Institute Press

**Selected Advisory Services and Consultancies**

2004 World Bank: Team leader/Task Manager of the review/evaluation of the public-private partnership programmes of the international agricultural research system (CGIAR).

2004 African Development Bank: Team leader/Task Manager of the comprehensive evaluation of the Bank's operations over the period 1996-present.

2003 Department for International Development: Study on 'Defining and Measuring Development Effectiveness.'

| | |
|---|---|
| 2003 | United Nations University: Chair of peer review panel on the United Nations University's 'Millennium Project'. |
| 2002 | World Bank: External Advisor to the Bank's Review of 'Information and Knowledge in the World Bank: The Bank as a Knowledge-Based Organisation. |
| 2002 | Department for International Development: Policy study on 'Problems of and solutions to overlap and duplication in the United Nations Developemnt System'. |
| 2001 | The Open University: Principal Advisor to the Open University's international course on 'Poverty and Development into the 21st Century'. |
| 2001 | Ministry of Foreign Affairs, Government of Sweden: Team Leader of research study on Global Public Goods under Sweden's 'Development Financing 2000' initiative. |
| 2001 | World Bank: Exernal Advisor to the Bank' 'Review of Development Effectiveness'. |
| 2000 | UNDP-UNIDO: Principal researcher and author of a Science, Technology and Industry Strategy for Vietnam with Special Reference to the Role of SME's. |
| 2000-present | Rio Tinto (RT): Member of the Independent Advisory Panel to RT (one of the largest of the multinational mining enterprises) on investment and development issues relating to a major proposed mining investment in Madagascar. |
| 2000 | European Commission: Team Leader in the study of 'Issues and Options concerning a European Foundation for Research for Development. |
| 2000 | Ministry of Foreign Affairs, Government of Sweden: Team Leader to 'A Foresight and Policy Study of the Multilateral Development Banks'. |
| 1999 | Consultant to UNDP/UNIDO programme which prepared a National Socio-Economic Strategy for Vietnam. |
| 1999 | Consultant to the World Bank's ARDE (Annual Report on Development Effectiveness). Two separate analyses produced on the potential and limitations of the World Bank's Comprehensive Development Framework. |
| 1999 | Consultant and member of advisory body to UNDP/UNCTAD initiative on Globalisation and Sustainable Human Development. |
| 1998 | Consultant to the World Bank's ARDE. Study produced titled 'Some Implications of the East Asian Crisis for Development Effectiveness'. |
| 1998 | Consultant to Shell Oil International. A review analysis and report provided on the effectiveness of investments by Shell in its Programme of Social Development in Nigeria. |

**Current Memberships (selected list)**

| | |
|---|---|
| Chairman | Board of Trustees of Voluntary Service Overseas (VSO) |
| Senior Research Fellow | International Institute for Sustainable Development (IISD), headquartered in Canada |
| Chairman | Board of Directors of the International Network for Bamboo and Rattan (INBAR), headquartered in China |

| | |
|---|---|
| Trustee | Institute for Global Environmental Strategies (IGES), headquartered in Japan |
| Member | International Advisory Committee to International Food Policy Research Institute (IFPRI), headquartered in Washington |
| Trustee | Tata Energy Research Institute, headquartered in India |

**Awards:**

| | |
|---|---|
| 2004 | Doctor of Science – University of Sussex |
| 1981 | Medal of Bravery - awarded by the Governor-General of Canada for a civilian act of bravery. |
| 1964 | Honour Award: Carleton University, Ottawa, Canada (one of six annual awards for academic excellence and contributions to the life of the University). |

Updated: April 2004

# External Scientific Programme Review

June 2005: Information Sciences Division (ISD)

**Name of the recommended/suggested reviewers for the ISD Review:**

**Recommended by: Dr Charles P Larson**

1. Dr. Joyce Pickering
   Associate Dean
   Undergraduate Medical Education (effective Sept. 2004)
   Faculty of Medicine
   McGill University
   Email: joyce.pickering@muhc.mcgill.ca

**Suggested by: Mr. Peter Thorpe**

2. M. Shafiqur Rahman
   Managing Director
   Knowvision Consulting
   House 44, 5th Floor, Road 15
   Banani, Dhaka 1213
   Bangladesh
   Tel: 880-2-882-4548 (o), 8814548 (r)
   Mobile: 0189-9212364
   Email: shafdmr@citechco.net

3. Dr. Hooman Momen
   Editor, Bulletin of WHO
   20 Avenue Appia
   CH-1211 Geneva 27
   Switzerland
   Email: momenh@who

4. Md. Shahjahan
   BCCP
   House # 3A, Road # 74
   Gulshan 2
   Dhaka, Bangladesh

**External Scientific Programme Reviews**
**1988-2009**

| Held prior to the BOT Meeting in: | Division |
|---|---|
| June 1988 | Clinical Sciences Division (CSD) |
| June 1989 (10-15 June) | Community Health Division<br>Reviewers: Dr. Shanti Ghosh, MCH Consultant, Formerly Family Health Advisor and Acting Regional Advisor for MCH, WHO, India, Dr. Halida Akhter, Director, Bangladesh Fertility Research Programme, Dhaka, Bangladesh, and Dr. Betty Kirkwood, Head, Maternal and Child Epidemiology Unit, Department of Epidemiology and Population Sciences, London School of Hygiene and Tropical Medicine, London WC1E 7HT. |
| April 1990 | Integrated Institutional Reviews of the Centre<br>Reviewers: Dr. C.E. Gordon Smith, Dr. David J. Sencer. |
| June 1991 | Scientific Advisory Council (Health)<br>Committee Members:<br>Yoshifumi Takeda, MD & D.Med Sci (Japan)<br>Dr. Betty Kirkwood (London)<br>Dr. J. Tulloch (Switzerland)<br>Professor J.R. Hamilton (Canada)<br>Dr. Jon E. Rohde (India)<br>Professor M.K. Bhan (India)<br>Dr. A.S. Muller (The Netherlands)<br>Dr. Norbert Hirschhorn (USA) |
| November 1991 (7-9 Nov) | Population Science and Extension Division<br>Reviewers: Dr. John Caldwell, Dr. Yagob Al-Mazrou, Dr. Jon Rohde, Dr. Peter Sumbung (all from BOT), and Dr. Barkat-e-Khuda (University of Dhaka). |
| June 1992 | Clinical Sciences Division<br>Reviewers: Dr. D. Ashley, Prof. J.R. Hamilton, Prof. V.I. Mathan (all from BOT), Dr. G. Meeuwisse (Sweden), Prof. M-Q K. Talukder (Bangladesh), Dr. D. Grant Gall (Canada). |
| November 1992 | Laboratory Sciences Division<br>Response to the June 1993 BOT Meeting.<br>Reviewers: Prof. Dr. K.M. Fariduddin, Prof. Ali Lindberg, Prof. V.I. Mathan (all from BOT), Major General M.R. Choudhury (Bangladesh Soc. For Immunology), Professor Takeshi Honda (University of Osaka, Japan). |

| | |
|---|---|
| November 1993 | Training Activities<br>Reviewer: Dr. Larry Marlow (Australia). |
| November 1993 | Community Health Division<br>Reviewers: Dr. Maureen Law, Dr. Chen Chunming, Dr. A.S. Muller (all from BOT), Dr. A.J.M. Mizanur Rahman (NIPSOM, Dhaka), Dr. Richard H. Morrow (JHU, USA), Dr. John H. Bryant (Aga Khan University, USA). |
| June 1995 | Population and Family Planning Division<br>Reviewers: Prof. John Caldwell, Major General M.R. Choudhury, Dr. John Rohde (all from BOT), Dr. Sajeda Amin (Pop Council, New York), Dr. Halida Hanum Akhter (BIRPERHT, Dhaka), Dr. Nirmala Murthy (Foundation for Research in Helath Systems, Ahmedabad). |
| November 1995 | Clinical Sciences Division<br>Reviewers: Prof. P.H. Makela (from BOT), Prof. Anne Ferguson (Edinburgh), Prof. Md. Nurul Islam (IPGMR), Dr. Graeme L. Barnes (Australia). |
| June 1996 | Laboratory Sciences Division<br>Reviewers: Prof. Rita Colwell, Prof. P.H. Makela, Prof. Fred Mhalu, Prof. Y. Takeda (all from BOT), Prof. James Kaper (USA), Prof. V.I. Mathan (India). |
| September 1996<br>(1-14 Sep) | Integrated Institutional Review of the Centre<br>Reviewers: Dr. David Sencer (USA) – Team Leader,<br>Dr. Halida Hanum Akhter (Bangladesh) – Reproductive Health/Family Planning, Dr. Mary Amuyunzu (Kenya) – Social Science, Dr. M. Jegathesan (Malaysia) – Child Survival, Mr. Derek Reynolds (UK) – Management, Prof. Stig Wall (Sweden) – Epidemiology/Demography. |
| 1997 | Personnel Administration Auditing Review |
| December 1997 | Institutional Strengthening of ICDDR,B – Bangladesh-Human Resources Report<br>Consultant: Jackie Reeves |
| June 1998 | Public Health Sciences Division<br>Reviewers: Prof. C. Victora (from BOT), Prof. Margaret Bentley, Dr. Halida Hanum Akhter. |
| August 1998 | ICDDR,B Human Resources Report<br>Human Resources Consultant: Jackie Reeves |
| November 1998 | ICDDR,B Human Resources Report<br>Human Resources Consultant: Jackie Reeves |

| | |
|---|---|
| November 1998 | Business Plan and restructuring of the Centre<br>Consultants: Messrs Jurg Frick and Matthias Scherler. |
| November 1998<br>3-6 Nov | Health & Population Extension Division<br>Reviewers: Prof. Peter McDonald, Prof. Carol Vlassoff, Major General M.R. Choudhury (all from BOT), Prof. Wim van Lerberghe, Dr. Halida Hanam Akhter. |
| November 1999 | Clinical Sciences Division<br>(No review because of Nutrition Programme Review) |
| January 2000 (24-27) | Nutrition Programme Review<br>Reviewers: Prof. Andrew Tomkins, Mr. Rolf Carriere, Prof. Nazmul Hassan, INFS, Mr. Charles Lusthaus |
| June 2000 | Laboratory Sciences Division<br>No review |
| August 23-30 | ORP Review<br>Reviewers: Prof. W. Henry Mosley, Prof. A K Azad Khan, Mr. Carel van Mels, Mr. D.K. Nath, Min. of Health, Dr. Vesta Richardson |
| June 2001 | Health & Population Extension Division<br>No review |
| June 2002<br>(June 4-5) | Laboratory Sciences Division<br>Reviewers: Dr. I K Wachsmuth, Dr. Tikki Pang (from BoT), Dr. Wanpen Chaicumpa (Thailand), Major General (Dr) ASM Matiur Rahman (Bangladesh). |
| November 2003<br>(28-30 Oct 03) | Clinical Sciences Division<br>Reviewers: Abdul-Muyeed Chowdhury (BRAC), Dr. Ahmed Al-Kabir (JSI), Dr. D Mahalanabis (India), Dr Claudio Lanata (from BoT), Prof AK Azad Khan (from BoT) & Dr. WB Greenough (JHU) |
| November 2004 | BoT Retreat (no review) |
| June 2005 | Information Sciences Division (ISD) |
| November 2006 | Public Health Sciences Division (PHSD) |
| November 2007 | Health System and Infectious Diseases (HSID) |
| November 2008 | Laboratory Sciences Division (LSD) |
| November 2009 | Clinical Sciences Division (CSD) |

International Centre for Diarrhoeal Disease Research, Bangladesh
CENTRE FOR HEALTH & POPULATION RESEARCH
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Phone : 880-2-8811751-60, Fax : 880-2-8823116, 8812530
Web : http://www.icddrb.org

10 May 2004

# Guest Lecture

| | | |
|---|---|---|
| TITLE | : | **Reducing Maternal Mortality in Paru: A quality improvement and accreditation of health services intervention.** |
| GUEST SPEAKER | : | **Dr. Claudio F. Lanata**<br>**Investigador Titular**<br>**Instituto de Investigacio Nutricional**<br>**Av. La Molina 685, Lima 12**<br>**PERU** |
| DIVISION/PROGRAMME | : | **Member**<br>**ICDDR,B Board of Trustees** |
| DATE | : | **Sunday, 13 June 2004** |
| TIME | : | **09:00 am** |
| VENUE | : | **Sasakawa Auditorium**<br>**ICDDR,B, Mohakhali**<br>**Dhaka** |

**Executive Director**

**RSVP**
**Tel: 882 3031**